Board of Directors (Public session)
Further reading Pack

Thursday 13 March 2025

Our Ophthalmology Department is proud to unveil a game-changing milestone: the first-ever integration of EeRS with Medisight in the UK is on the horizon! Soon, clinicians will be able to seamlessly view and manage ophthalmology referrals directly within the Medisight platform.

This integration will allow clinicians to access referral information and review it directly in the clinic, right alongside their other clinical data, creating a smoother, more efficient workflow without the need to switch between systems.

Healthier place
Healthier people
Healthier futures

NHS
Black Country
Integrated Care Board
Business Intelligence Team

Report : BCPS - Pathology analysis

Date : 11th February 2025

BCPS - Pathology - Summary Performance

Source :BCPS excel file

Period : Jan 2021 to January 2025 :

NHS Black Country Integrated Care Board Business Intelligence Team

Urgent Histo 7 days - target 70%

YearMonth	Dudley	RWT	SWBH	Walsall
202501	37.0%	42.0%	41.0%	46.0%
202412	28.0%	36.0%	34.0%	31.0%
202411	41.0%	44.0%	40.0%	35.0%
202410	25.0%	33.0%	34.0%	32.0%
202409	20.0%	29.0%	33.0%	30.0%
202408	33.0%	39.0%	37.0%	33.0%
202407	39.0%	47.0%	47.0%	41.0%
202406	38.0%	38.0%	31.0%	34.0%
202405	23.0%	35.0%	38.0%	32.0%

Urgent Histo 7 days (without Skin) - target 70%

YearMonth	Dudley	RWT	SWBH	Walsall
202501	47.0%	50.0%	55.0%	59.0%
202412	32.0%	41.0%	39.0%	37.0%
202411	46.0%	49.0%	46.0%	45.0%
202410	33.0%	38.0%	43.0%	41.0%
202409	27.0%	33.0%	43.0%	38.0%
202408	42.0%	44.0%	45.0%	43.0%
202407	49.0%	49.0%	53.0%	52.0%
202406	47.0%	44.0%	37.0%	40.0%
202405	26.0%	40.0%	45.0%	39.0%

Urgent Histo 10 days - target 70%

YearMonth	Dudley	RWT	SWBH	Walsall
202501	63.0%	65.0%	65.0%	68.0%
202412	60.0%	60.0%	55.0%	55.0%
202411	69.0%	67.0%	67.0%	59.0%
202410	51.0%	60.0%	57.0%	52.0%
202409	44.0%	50.0%	54.0%	50.0%
202408	57.0%	62.0%	58.0%	53.0%
202407	54.0%	64.0%	62.0%	56.0%
202406	57.0%	57.0%	50.0%	53.0%
202405	46.0%	55.0%	59.0%	48.0%

Urgent Histo 10 days (without Skin) - target 70%

YearMonth	Dudley	RWT	SWBH	Walsall
202501	73.0%	70.0%	78.0%	74.0%
202412	66.0%	63.0%	59.0%	60.0%
202411	75.0%	68.0%	73.0%	65.0%
202410	59.0%	63.0%	65.0%	58.0%
202409	54.0%	55.0%	65.0%	61.0%
202408	71.0%	68.0%	68.0%	64.0%
202407	65.0%	65.0%	68.0%	64.0%
202406	57.0%	57.0%	50.0%	53.0%
202405	48.0%	58.0%	64.0%	51.0%

Routine10 days - target 70%

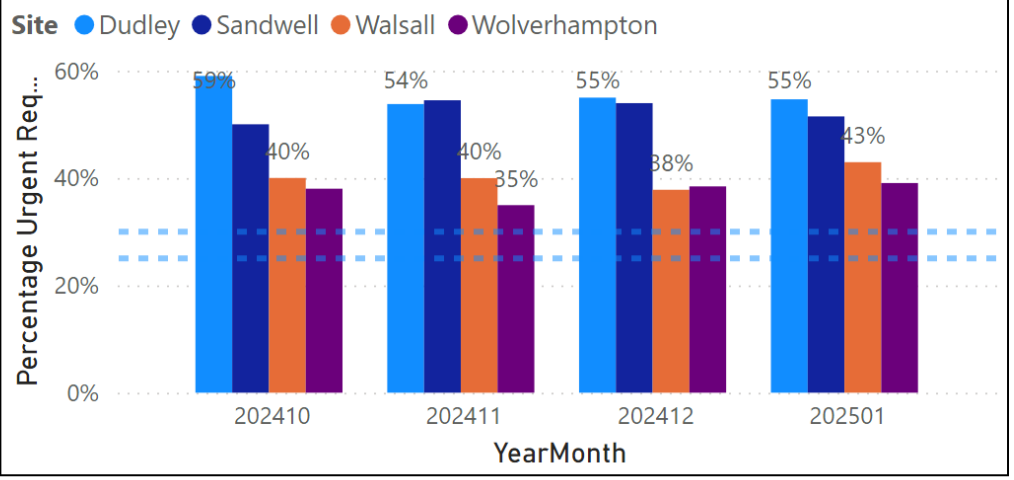
YearMonth	Dudley	RWT	SWBH	Walsall
202501	44.0%	46.0%	49.0%	40.0%
202412	28.0%	31.0%	30.0%	30.0%
202411	43.0%	33.0%	37.0%	32.0%
202410	35.0%	28.0%	28.0%	23.0%

Routine 10 days (without Skin) - target 70%

YearMonth	Dudley	RWT	SWBH	Walsall
202501	49.0%	54.0%	52.0%	41.0%
202412	31.0%	38.0%	31.0%	28.0%
202411	41.0%	35.0%	36.0%	32.0%
202410	36.0%	36.0%	30.0%	22.0%

Cancer Tumour	Reported in 10 days or less.	Reported in 7 days or less	Reported in more than 10 days.
All (EXC HAEM)	65%	41%	35%
Breast	96%	88%	4%
Colposcopy	57%	39%	43%
Gynae	71%	46%	29%
Head and Neck	80%	55%	20%
Lower GI	78%	50%	22%
Lung	85%	75%	15%
Lymphoma	100%	100%	0%
Miscellaneous	77%	69%	23%
Skin	44%	15%	56%
Upper GI	75%	48%	25%
Upper GI(Gastroenterology)	80%	46%	20%
Urology	51%	26%	49%

Percentage Urgent Requests and Standard Urgent Request Target Lower End by YearMonth and Site



Performance Update – Constitutional Standards

January 2024 Data

Trust overview

	Published																		Current				Target		For Dec 24		
	Apr-24		May-24		Jun-24		Jul-24		Aug-24		Sep-24		Oct-24		Nov-24		Dec-24		Jan-25		Feb-25						
	Plan	Actual	Plan	Actual	Plan	Actual	Plan	Actual	Plan	Actual	Plan	Actual	Plan	Actual	Plan	Actual	Plan	Actual	Plan	Unvalidated	Plan	Unvalidated	24/25	Sustainable backlog	Ranking all Trust (120)	Ranking all Midlands Trust (23)	BCICB Ranking
	FDS 28d																										21
WHT	75.3%	81.4%	75.0%	80.8%	75.5%	83.1%	75.6%	88.2%	75.0%	86.0%	75.6%	88.0%	75.2%	88.3%	76.0%	75.9%	75.8%	70.1%	76.1%	81.6%	76.4%	77.5%	77%		114	22	
RWT	75.0%	77.8%	75.0%	81.0%	77.0%	81.7%	77.0%	77.5%	76.0%	76.2%	75.0%	75.1%	77.0%	76.7%	79.0%	80.3%	78.0%	80.8%	78.0%	76.6%	79.0%	86.2%	77%		42	6	
DGH	77.0%	78.3%	77.0%	83.9%	77.0%	83.2%	77.1%	82.2%	77.0%	83.8%	77.0%	81.5%	77.0%	80.9%	77.1%	81.9%	77.1%	84.1%	77.1%	80.5%	77.0%	90.3%	77%		17	3	
SWB	75.1%	76.8%	75.7%	80.3%	75.9%	77.3%	76.2%	76.1%	75.0%	75.3%	75.2%	75.1%	75.4%	79.2%	76.0%	75.5%	76.5%	76.0%	75.4%	70.3%	77.0%	83.3%	77%		87	17	
BCICS	75.6%	78.2%	75.7%	81.5%	75.8%	81.2%	76.1%	79.9%	76.7%	79.3%	76.2%	78.4%	76.3%	80.0%	76.4%	79.0%	76.5%	78.8%	76.2%	76.7%	76.8%	85.3%	77%				
England		73.5%		76.4%		76.3%		76.2%		75.5%		74.8%		77.1%		77.4%		78.1%									
Midlands		74.9%		78.4%		78.5%		77.7%		76.6%		75.2%		77.1%		77.0%		77.1%									
	31d																										23
WHT	96.0%	94.4%	96.0%	100.0%	96.0%	96.9%	96.0%	97.6%	96.0%	98.4%	96.0%	97.3%	96.0%	98.4%	96.1%	96.0%	96.4%	98.7%	97.3%	100.0%	98.1%	100.0%	96%		16	4	
RWT	96.0%	86.1%	96.0%	90.1%	96.0%	88.9%	96.0%	91.4%	96.0%	88.0%	96.0%	88.6%	96.0%	90.2%	90.4%	90.0%	91.0%	91.6%	91.2%	84.9%	91.7%	84.5%	96%		90	16	
DGH	96.0%	91.6%	96.0%	92.2%	96.0%	90.3%	96.0%	94.5%	96.0%	89.7%	96.0%	90.8%	96.0%	92.9%	96.0%	91.7%	96.0%	94.3%	96.0%	90.7%	96.0%	97.4%	96%		72	10	
SWB	96.0%	91.9%	96.0%	93.5%	96.0%	91.6%	96.0%	91.1%	96.0%	86.3%	96.0%	84.0%	96.0%	85.9%	96.0%	86.3%	84.1%	87.2%	86.6%	87.6%	90.4%	89.8%	96%		108	21	
BCICS		88.9%		92.0%		90.3%		92.7%		89.3%		89,4%		91.0%		90.4%		92.1%		87.3%		86.9%	96%				
England		89.20%		91.8%		90.9%		91.9%		91.7%		90.6%		91.5%		91.0%		91.5%									
Midlands		88.10%		90.4%		88.6%		90.5%		90.0%		89.5%		91.1%		89.2%		90.6%									
	62d																										20
WHT	70.1%	75.9%	74.6%	79.3%	74.5%	79.3%	70.0%	76.0%	70.1%	77.4%	75.0%	73.8%	75.4%	81.6%	75.8%	84.7%	70.9%	76.2%	75.4%	76.6%	76.9%	36.8%	70%	14	47	5	
RWT	42.0%	46.2%	46.0%	49.5%	49.0%	57.2%	46.0%	53.7%	52.0%	54.6%	55.0%	61.2%	58.0%	63.9%	60.0%	65.6%	64.0%	67.4%	71.0%	62.6%	71.0%	27.8%	70%	146	92	13	
DGH	70.0%	71.9%	70.0%	66.8%	70.2%	70.3%	70.1%	74.9%	70.0%	71.5%	70.0%	71.4%	70.0%	76.4%	70.0%	70.3%	73.2%	80.5%	69.8%	66.5%	70.2%	67.0%	70%	118	24	2	
SWB	69.5%	69.7%	71.6%	64.6%	69.7%	65.7%	71.1%	66.6%	72.6%	75.8%	73.8%	71.4%	71.4%	71.9%	71.1%	67.3%	70.8%	70.1%	70.0%	70.4%	70.0%	76.1%	70%	84	86	11	
BCICS	56.30%	62.0%	59.6%	61.8%	61.3%	65.5%	62.9%	65.0%	64.6%	67.5%	66.7%	67.8%	68.0%	71.9%	69.7%	69.7%	70.0%	72.9%	70.9%	67.0%	71.0%	51.4%	70%				
England		66.6%		65.8%		67.4%		67.7%		69.2%		67.3%		68.2%		69.4%		71.3%									
Midlands		61.6%		60.5%		64.8%		63.1%		64.3%		63.4%		63.6%		65.0%		66.0%									
	62d backlog																										
WHT		52		56		56		57		68		52		44		49		35		42			63				
RWT		280		314		312		273		227		200		181		176		154		159			301				
DGH		96		104		124		86		92		102		101		88		108		95			80				
SWB		167		170		157		141		168		161		134		135		133		129			105				
BCICS																											
	104d backlog																										
WHT		18		15		13		15		13		7		10		12		8		5			25				
RWT		108		122		106		114		92		54		59		52		43		38			160				
DGH		17		26		30		23		25		26		25		23		23		23			24				
SWB		29		43		37		34		35		27		45		42		34		37			30				

Finance and Productivity Committee Chairs Report

Committee Chair: Lowell Williams

30th January 2025	
EPRR Core Standards Presentation	Substantial Assurance
Winter Plan Update	Partial Assurance
Integrated Performance Report – Month 9 2024/25	Substantial Assurance
Finance Update Month 9 2024/25	Partial Assurance
Digital Trust Steering Group Update	Reasonable Assurance
Green Plan Update	Partial Assurance

27th February 2025	
Integrated Performance Report – Month 10 2024/25	Substantial Assurance
Black Country Pathology Service Update	Reasonable Assurance
Surgery, Women and Childrens Deep Dive	Reasonable Assurance
Cyber Security Report	Substantial Assurance
PFI Performance	Substantial Assurance
Procurement Performance	Substantial Assurance

Meeting held on 30th January 2025

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE	MAJOR ACTIONS AGREED
• The Trust remained challenged in managing ambulance handovers. • The Winter Plan under delivered in respect of additional beds delivering 28 against the performance of 96. • The System is challenged to deliver a deficit of £95m in 2025/26. Delivery of the Trusts share would require substantial further cost improvement (in the region of 6% or above). • There is a continued variance to the workforce plan, although the position has improved marginally. The adjusted underlying variance is 3.7% or 227WTE. • The Trust is not on track to meet NHSE carbon emission reduction targets. The current performance is 0.3% reduction in a year. A further 5.4% reduction is needed year on year.	• The committee asked for a review COR2363 (the impact of the opening of the Midland Met on the emergency department). • The committee asked or a review of the opening of the Midland Met on the trusts long term operations. • The committee agreed the creation of a small check and challenge group to support to annual submission of the EPRR core standards. • The committee asked for a lessons learnt review of the winter plan to better inform the 2025/26 plan. • Due to concerns around carbon reduction, the committee asked for BAF 5 – carbon emissions reduction to be brought forward.
POSITIVE ASSURANCES TO PROVIDE	**DECISIONS MADE**
• The committee noted the continued strong operational performance.	• The committee agreed that the risk score for BAF 4 remained at 20. Assurance level remained positive.

• The ED redesign is on track and within budget, executive staff report positively especially on the cleanliness of the site. • The Trust remains on track to deliver the budgeted deficit of £1.59m, subject to delivering the ERF forecast in the remaining months. • Positive assurance was received from the Digital Trust Steering Group, the committee noted the Trust is supporting Bolton with the Sunrise maternity blueprint.	• The committee agreed that the risk score for BAF 7 remained at 20. Assurance level remained positive. • The committee agreed that the risk score for BAF 8 remained at 16. Assurance remained positive.

Meeting held on 27th February 2025

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE	MAJOR ACTIONS AGREED
• The level of urgent requesting to Black Country Pathology Services (BCPS) remains high. • Surgery Women and Childrens division forecast an overspend of £4.03m driven predominantly by the failure to reduce headcount, the underperformance of Cost Improvement Programmes (CIP) and under delivery of Elective Recovery Funds (ERF). • There was a deteriorating financial performance against budget in January, requiring strong performance in February and March to deliver the year end forecast through the closure of surge beds, Midland Met mitigations, achievement of ERF and CIP and increased Trauma and Orthopaedics (T&O) productivity. • The Black Country System is significantly behind the financial plan and to mitigate this stretch targets have been allocated to providers. • The Dudley Group would require a CIP of £42.5m or 7% to support the System in delivering a deficit of £95m for 2025/26. • There is a continued adverse variance to the workforce plan of 200WTE and 59WTE for bank. • The Trust potentially faces a disruptive project for the removal of Reinforced Autoclaved Aerated Concrete (RAAC).	• The committee requested a deep dive into ambulance handovers. • A deep dive into workforce and elective productivity within the Surgery, Women and Childrens division was requested. • It was requested for future BCPS reports to include workforce data.
POSITIVE ASSURANCES TO PROVIDE	**DECISIONS MADE**
• The committee noted a strong overall operational performance. • A continual improved performance was seen by the Black Country Pathology Service (BCPS) with further opportunities to develop. • Positive assurance was received from Surgery, Women and Childrens division including performance in Referral To Treatment (RTT), cancer waiting times, theatre utilisation, Getting It Right First Time (GIRFT) high intensity models and effective System working.	• The committee agreed that the risk score for BAF 4 remained at 20. Assurance level remained positive. • The committee agreed that the risk score for BAF 5 remained at 12. Assurance level remained positive. • The committee agreed to recommend the reduction in risk score of BAF risk 7 from 16 to 12 to the Board of Directors. Assurance level remained positive.

• The Trust remains marginally ahead of the deficit plan, although the performance deteriorated in February. • There was a continued improvement in PFI contract performance with reduced deficiency points. • Procurement have continued to overdeliver in year savings.	

People Committee Chairs Report

Committee Chair: Catherine Holland

28th January 2025	
• Workforce Key Performance Indicators continue to provide a good picture overall, with positive assurance that appropriate actions are in place, however increasing sickness absence is a concern, albeit recognising a seasonal trend.	**Reasonable Assurance**
• Workforce Plan (now called Performance Against Workforce Forecast) – close scrutiny, opportunity to take learning into 2025/26. It was noted that financial position is different to the workforce numbers, due to other mitigating actions	**Partial Assurance**
• ICan Project – the Board would hear directly from people employed via this route at the Board Development Day.	**Substantial Assurance**
• The Statutory & Mandatory Training Oversight group had been established; a review would be carried out. Noted that the mandatory training targets were being achieved consistently, but there were underlying hot-spots which are being addressed.	**Reasonable Assurance**

25th February 2025	
• Workforce Plan (now called Performance Against Workforce Forecast) –Assurance provided that whilst not achieving the reduction plan, the only growth is attributable to the DIHC transfer.	**Reasonable Assurance**
• Sickness absence levels remained high in January; this remains a continuing concern.	**Reasonable Assurance**
• Arising from WRES and WDES summary reports there is a concern on representation and diversity at Board level.	**Reasonable Assurance**
• Significant improvement on staff survey results in some areas and assurance provided on a programme of targeted action across areas with challenges.	**Reasonable Assurance**

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE	MAJOR WORKS COMMISSIONED/ACTIONS AGREED
January • Workforce reduction is not being achieved; the Trust was 341.21 (5.4%) adrift from plan. Adjusting for MMUH, fully funded income-backed posts (not in the plan), additional Deanery posts, ERF and escalation capacity, reduces the adverse WTE variance to 226.85 (3.7%). • There had been an increase sickness absence levels in December, this was expected with seasonal variation but is higher than expected and is partly due to the 'quademic'. There was a concern about sickness absence levels and low uptake of vaccinations (it was noted that Dudley are not an outlier and further communication, and engagement work is underway). • BAF Risk 2 – score had been uplifted to 12 (4 x 3) due to the increase in sickness absence rates, a vacancy pauses (particularly for fragile services) and challenges around vacancies for newly qualified nurses and difficulties in recruiting to fragile services. **February** • Workforce reduction is not being achieved; the Trust was 377.48 WTE (6.1%) adrift from plan. Adjusting for MMUH, fully funded income-backed posts (not in the plan), additional Deanery posts, ERF and escalation capacity, reduces the adverse WTE variance to 259.05 (4.2%). Assurance provided that whilst not achieving the reduction plan, the only growth is attributable to the DIHC transfer. • Sickness absence levels remained high in January; this remains a continuing concern. • Two new risks had been added to the corporate risk register COR2495 (as a result of the NHS Staff Council updates to the CSW Nursing Job evaluation profiles, there is a risk that the Trust fails to undertake a corrective banding exercise leading to industrial action, poor staff morale and potential costly claims via employment tribunal or civil claims) and COR2497 (failure to create a culture and environment where staff feel safe to speak up on sexual safety). Two risk scores had changed - the risk score around recruitment and retention had been downgraded from 16 to 12 due to low vacancy rates for 12 months, low turnover and high retention. The risk score for staff absence had increased from 12 to 16 due to the upward sickness absence trend.	**January** • Review statistical process control charts to measure the impact of interventions on sickness absence going forward – particularly identifying where interventions have begun, such as the sickness absence taskforce. • Work underway over the next quarter through the Be a Brilliant Place to Work and Thrive Steering Group, focusing on attraction and branding, flexible working and bullying and harassment with plans on engagement and training for the new policies. **February**

• Arising from WRES and WDES summary reports there is a concern on representation and diversity at Board level.	
POSITIVE ASSURANCES TO PROVIDE **January** • Turnover, Retention, vacancies, and mandatory training are all within the Trust targets and remain stable. • Band 2/3 – reasonably assured of the positive relationship with trade union colleagues and progression of this work. • ICan project – the Committee was very pleased to hear about the positive effects of this project. **February** • Turnover, Retention, vacancies, and mandatory training are all within the Trust targets and remain stable. • Significant improvement on staff survey results in some areas and assurance provided on a programme of targeted action across areas with challenges. • Guardian of Safe Working report provided positive assurance around exception reporting and that doctors' concerns are addressed - improvements in working hours and work schedules are underway.	**DECISIONS MADE** **January** • Agreed to the proposal to increase bursary levels for Medical Trainee Initiative programme, whilst remaining in the current financial envelope by minimally reducing the number of trainees • Agreed to retain BAF Committee assurance levels as 'Positive for BAF 2 and 3. **February** • The Gender Pay Gap report and Equality Delivery System report were approved for publication. • Agreed to retain BAF Committee assurance levels as 'Positive for BAF 2 and 3, and an increase in BAF 2 risk score, as a result of an upwards trend in sickness absence.

Integration Committee Chairs Report

Committee Chair: Vij Randeniya

29th January 2025	
Dudley Health and Care Partnerships Update	**Substantial Assurance**
Health Inequalities Update	**Reasonable Assurance**
Quarterly Strategy Report Update	**Substantial Assurance**
Dudley Primary Care Development Plan	**Substantial Assurance**
Procurement Deep Dive	**Reasonable Assurance**

26th February 2025	
Neighbourhood Health update	**Reasonable Assurance**
Prevention Programmes Deep Dive: Alcohol	**Substantial Assurance**
Involvement Report	**Substantial Assurance**
LIQA Accreditation & Migrant Project Update	**Substantial Assurance**

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE	MAJOR WORKS COMMISSIONED/ ACTIONS AGREED
29th January 2025 • During the update on Dudley Health and Care Partnerships, a matter of concern in regard to the significant cuts to the voluntary and community sector by the local authority, noting the lack of consultation and the impact on vital services. Concern to be discussed by the Executive Team. • The committee received the update on health inequalities, noting the work ongoing and to be continued to tackle health inequalities, noting the fact that we need to raise awareness and embed health inequalities in everything we do should be escalate up to Trust Board. This discussion continued in relation to staff awareness and education to health inequalities. **26th February 2025** • Representative from Dudley Council for Voluntary Services gave update on the programmes they are putting in place for migrants in Dudley but flagged that due to rise public tensions in certain community they were been advised to be careful how they promote the new offerings.	**29th January 2025** • Following a Strategy Report update, there was an action to looking at local employment data in terms of banding, ethnicity and looking at employability stats. • During the update on Procurement, the committee asked for the focus of the next Procurement Deep Dive to be around comparative data around spend within the local area and what more can be done. **26th February 2025** • Committee requested further information be shared and presented in the future about the local tensions with Dudley. • Committee requested that the next Involvement report highlights the feedback from local communities that needs to be understood by our services and confirm what we have done having received the feedback.
POSITIVE ASSURANCES TO PROVIDE	**DECISIONS MADE**
29th January 2025 • Positive assurance was received following the update on the work ongoing within Dudley Health and Care Partnerships. • During the update on Health inequalities, positive assurance was achieved on the work underway within the Trust to tackle the inequalities. • An update was received on Dudley Primary Care Development Plan, positive assurance was achieved noting the work underway as part of the plan. **26th February 2025** • Positive assurance was given around the work already underway to progress neighbourhood health within Dudley and noted the gaps that need to be addressed. • Positive assurance given about the work the Alcohol team have undertaken and the improved outcomes as a result of their work. • Committee received the first report on the Involvement work going on in Dudley.	**29th January 2025** • The decision was made to stand down the reporting of Dudley Integrated Health and Care NHS Trust Transaction Update and to report to the committee by exception only. • The committee agreed to amend the Dudley Health and Care Partnerships update to bi-monthly.

Quality Committee Chair's Report

Committee Chair: Professor Liz Hughes

28 January 2025	
Integrated Quality & Operational Performance Report	**Reasonable Assurance**
Quality Impact Assessment Report	**Substantial Assurance**
Perinatal Quality Report	**Reasonable Assurance**
Quality Priorities Report	**Reasonable Assurance**
Performance Against Workforce Forecast	**Reasonable Assurance**
Quarterly Strategy Update	**Reasonable Assurance**
Patient Safety Specialist Report	**Substantial Assurance**

25 February 2025	
Integrated Quality & Operational Performance Report	**Reasonable Assurance**
Corporate Risk Register	**Reasonable Assurance**
Perinatal Quality Report	**Substantial Assurance**
Chief Nurse & Medical Director Report	**Substantial Assurance**
Performance Against Workforce Forecast	**Reasonable Assurance**
Maternity 3 Year Delivery Plan	**Substantial Assurance**

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE

- Across the board, some of the quality indicators have seen adverse impact as a result of ongoing extreme operational pressures. The Trust has processes and monitoring in place for immediate mitigations. There is a longer-term piece of work for falls and pressure ulcers from a PSIRF perspective.
- Pre-release data indicates a rise in SHMI and HSMR, especially for stroke and sepsis. Fractured Neck of Femur position continues to improve.
- Challenges with timely patient observations noted, with improvement work in place.
- Increase in reported pressure ulcers including continual increase in community. Exploring 60/40 community/acute staffing model to support. Thematic review conducted to inform Improvement Plan; ICB will work with Trust to reduce.
- Breached threshold for IPC set by NHSE in relation to Pseudomonas, Klebsiella, MRSA and CDI.
- 3 outstanding actions in relation to Neonatal Peer Review impacted by current financial and workforce constraints.

MAJOR ACTIONS AGREED/WORK UNDERWAY

- Chest Pain Pathway group continues to meet to embed pathway requirements and drive further improvement work.

POSITIVE ASSURANCES TO PROVIDE	DECISIONS MADE
• Substantial assurance received regarding ongoing patient safety work being undertaken by the Trust. • Best practice associated with PSIRF. • No complaints received around pain management and improved responsiveness to complaints noted. Changing mindsets to focus on improving patient experience rather than negative experiences only. • Substantial assurance received for the QIA report. • Positive Digital Trust Steering Group report received. • No evidence of the current workforce reduction plan compromising quality and safety. • Session with Lead Nurses to focus on quality and safety entitled 'Fundamental of Care' is planned in April 2025. This will focus on accountability, positive leadership, health and wellbeing and how to motivate teams, especially during challenging times. • Good compliance with the 3-year service delivery plan for Maternity and Neonates and MIS year 6 compliance. Achieved timescales for PMRT requirement. • Perinatal Quality continues to show stillbirth rates and neonatal deaths below national average. Learning identified in relation to perinatal deaths, fulfilling MIS requirements. Exception report detailed in **Appendix 1**. • Screening Quality Assurance Service assessed maternity service and provided positive feedback; do not require visit due to excellent performance. • Positive assurance taken from Chief Nurse and Medical Director report responding to Lord Darzi report on patient safety; Trust benchmarking well. • Deep Dive into dementia screening completed following previous challenge and assurance gained. • Positive assurance taken from PIFU report with no areas of concern. • Good levels of assurance on work underway in matters relevant to their portfolio for Quality & Safety, Risk & Assurance, Patient Experience, Infection Control and Mortality Surveillance.	• The assurance level for BAF Risk 1.1 is no longer inconclusive assurance, moved to positive assurance. Discharge improvement assurance to be provided. • The assurance level for BAF Risk 1.2 remains as positive. • BAF refresh underway as part of Trust Strategy work.

Appendix 1

The Dudley Group NHS Foundation Trust

Paper for submission to the Quality Committee 25th February 2025 (Redacted)

Report title:	Perinatal Quality Report
Sponsoring executive:	Martina Morris, Chief Nurse and Maternity Safety Champion
Report author:	Claire Macdiarmid, Director of Midwifery

1. Summary of key issues

Stillbirth rates show a slight increase but remain below the national average rate.
Midwifery vacancy has increased, as per the dashboard in table 1: but RM vacancies are currently being advertised and recruited to.

Screening quality Assurance Service (SQAS) have assessed our service and provided positive feedback- they therefore do not require to undertake a QA visit this year due to their excellent performance.

The MBRRACE-UK Perinatal Surveillance Report for the trust was released on the 14th February 2025, which contains 2023 Perinatal mortality data for the trust. A separate report will be presented to the Quality Committee and the Executive team during March 2025. The report is now available to the public on the MBRRACE website.

MNVP feedback from December 2024 meeting is attached to the report and 15 steps is due to be undertaken in May 2025.

Saving Babies Lives Version 3 (SBLV3) is currently set for 100% compliance across all 6 elements, requires sign off by the LMNS.

2. Alignment to our Vision	
Deliver right care every time	**x**
Be a brilliant place to work and thrive	**x**

3. Report journey

LMNS Perinatal Quality Surveillance

4. Recommendations

a) Accept content of this report as evidence in compliance with SBLV2, Mortality and incidents occurring and reported and ongoing PQSM as per the requirement of the Ockenden report 2022.

5. Impact		
Board Assurance Framework Risk 1.1	X	Deliver high quality, safe person centred care and treatment
Board Assurance Framework Risk 1.2	X	Achieve outstanding CQC rating.
Is Quality Impact Assessment required if so, add date:		
Is Equality Impact Assessment required if so, add date:		

REPORT FOR ASSURANCE

Perinatal Clinical Quality Surveillance

Report to Quality Committee 25th February 2025

1 EXECUTIVE SUMMARY

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

1.2 In line with the perinatal surveillance model, the Trust is required to report the information outlined in the data measures proforma monthly to the trust board. Data contained within this report is for **January 2025**, unless otherwise specified throughout.

2. BACKGROUND INFORMATION

2.1 Perinatal Mortality Overview

Mortality data for January 2025 can also be found in table 1.

The MBRRACE-UK Perinatal Surveillance Report for the trust was released on the 14th February 2025, which contains 2023 Perinatal mortality data for the trust. Despite this being historical data, this is the most recent national data used for analysis at regional and national level. This report shows a significant increase the Neonatal death rate for this period- which was recognised and acted upon at the time and a thematic review took place as a result. A separate report will be presented to the Quality Committee and the Executive team during March 2025. The report is now available to the public on the MBRRACE website.

Table 1: Perinatal Safety data including mortality and serious incidents

2024/2025

The data should be viewed in conjunction with the Maternity Dashboard and the Director of Midwifer

	CQC Maternity Inspection April 2023 (safe and Well Led) (Previous rating from 2019)	Safe	Effective	Caring	Well-Led	Responsive
		Good	Good	Good	Good	Good

		2024 Jan	2024 Feb	2024 March	2024 Apr	2024 May	2024 Jun	2024 Jul	2024 Aug	2024 Sep	2024 Oct	2024 Nov	2024 Dec	2025 Jan
PMRT	Perinatal Mortality Review Tool cases opened in month	1	0	4	1	1	2	0	2	0	1	3	2	1
	PMRT reviewed in month	2	1	2	2	2	2	2	0	2	1	4	2	2
HSIB/ MNSI	Number of cases referred to and accepted by MNSI (with 72 hr review)	0	0	0	0	0	0	0	0	0	0	0	0	0
	Reports received from MNSI	0	0	0	1	2	0	1 (SWBH)	0	1 (RWT)	0	0	0	0
	MNSI investigations ongoing	4	4	4	3	1	1	1 (RWT)	1 (RWT)	0	0	0	0	0
	MNSI open action plans	0	0	0	1	1								
PSIRF	The number of incidents logged as moderate or above:	1	0	1	0	0	2	0	1	1	1	0	0	0
	PSII Reported	0	1	0	0	0	4	0	1	0	1	0	0	0
	PSII Completed	0	0	0	2	0	1	0	0	0	0	1	3	1
	PSII Ongoing	2	3	3	1	1	4	4	5	5	6	5	2	1
	Oustanding Investigation Actions - overdue	7	3	3	5									
	Oustanding Investigation Actions - open			6	7									
	Maternity Incidents Improvement Plan - overdue actions					12	12	10	13	18	19	13	17	13
	Maternity Incidents Improvement Plan - open actions					13	15	18	28	24	23	17	31	24
Clinical Outcome measures	Stillbirth rate (National crude rate 3.54 per 1000 births)	2.44	2.43	3.4	2.9	2.62	2.62	2.63	2.39	1.92	1.92	2.68	2.92	3.17
	Neonatal Death Rate 1.65 (> 22+0 - up to 28 days post delivery)	2.44	2.19	2.19	2.18	1.67	1.67	1.68	1.2	1.2	0.72	0.73	0.73	0.49
	Neonatal death rate only including babies born over 24/40			1.21	1.21	0.96	0.95	0.96	0.72	0.72	0.24	0.24	0.24	0.24
	Total Perinatal Mortality Rate (MBRRACE figure 5.19 per 1000 births)	4.88	4.62	5.59	5.08	4.29	4.29	4.3	3.52	3.13	2.64	3.68	3.65	5.04
	Avoidable term admission to NNU (reported quarterly)		3			4			3			5		
Appraisals	All Maternity staff (90%) (Apraisal window April-July)						93% (16.7.24)	94.30%	94.30%					
Midwifery Training	Fetal Monitoring Training (90%)*	99%	97%	98%	96%	96%	99%	98%	98%	99%	99%%	100%	98%	99.00%
	Obstetric Emergency Simulation Training (PROMPT) (90%)*	99%	97%	96%	96%	98%	99%	99%	97%	99%	100%%	100%	98%	98.00%
	Safeguarding (level 3) Adult (90%) (Database not accurate)	84%	83%	77%	70%	83%	78%	85%	90%	90%	91%	87%	91%	92.00%
	Safeguarding (level 3) Children (90%)	78%	79%	82%	79%	83%	80%	90%	94%	95%	88%	86%	89%	80.00%
	Neonatal Resusitation (90-95%)*	93%	92%	90%	86%	90%	87%	88%	90%	90%	90%	92%	94%	96.00%
	Adult Resusitation (90 - 95%)*	94%	93%	91%	86%	84%	88%	90%	91%	92%	91%	92%	93%	92.00%
Obstetrics Training	Fetal Monitoring Training (90%)*	97%	100%	100%	95%	95%	98%	98%	97%	97%	97%	100%	100%	100.00%
	Obstetric Emergency Simulation Training (PROMPT) (90%)*	92%	97%	97%	95%	100%	100%	98%	97%	97%	98%	98%	100%	98.00%
	Safeguarding (level 3) Adult (90%)	81%	73%	73%	80%	80%	93%	93%	94%	100%	100%	80%	100%	100.00%
	Safeguarding (level 3) Children (90%)	68%	68%	71%	72%	80%	80%	80%	86%	66%	73%	82%	89%	85.00%
	Neonatal Resusitation (90-95%)*	86%	85%	80%	90%	92%	87%	90%	92%	90%	97%	90%	96%	90.00%
	Adult Resusitation (90 - 95%)*	86%	85%	91%	88%	90%	91%	90%	91%	90%	97%	95%	95%	90.00%
Safe staffing	Obstetric consultant cover on delivery suite	91	91	91	91	91	91	91	91	91	91	91	91	91
	Vacancies midwifery (WTE)	0	0	0	0	0	0	0	0	0	0	0	4	9
	Obstetric Consultant vacancies (WTE)	0	0	0	0	0	0	0	0	0	0	0	0.4	0.4
	Total Red flag data: Total number of red flags (As per acuity tool)	5	1	0	14	14	12	8	2	6	4	3	3	7
	Shift Leader supernumuary at start of shift : % of time	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	1:1 care in labour achieved	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

	Birth Before Arrival (BBA)	2	1	1	3	2	2	1 (1unbooked	1	2	1	3	2	2
Service user feedback	MVP (Quarterly)	.	.	6.3.24	.	.	~~6.6.24~~	.	.	16.09.24	.	.	17.12.24	.
	MNVP Extraordinary meetings* Bereavement / Neonatal / EDI	.	.	21.3.24	25.4.24	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil
Engagement	Response Rate (%)	7.00%	11.00%	25.00%	33.00%	17.00%	20.00%	19.00%	12.00%	26.00%	11.00%	9.00%	12.00%	14%
	Recommendation Response Rate (Good/ Very Good %)	17.00%	86.00%	81.00%	82.00%	77%	89.00%	88.00%	84.00%	83.00%	76.00%	76.00%	84.00%	85%
	PALS	3	9	5	3	4	9	5	7	8	1	6	1	5
	Complaints	5	5	3	6	4	6	4	1	7	5	5	7	5
	Compliments	71	65	70	72	67	67	59	65	65	62	72	80	58
Safety Champion	Maternity Safety champions walk- about	None	Cancelled	None	none	13.5.24		24.7.24		25.9.24		04.11.2024		21.01.25
	Maternity and Neonatal Safety Champion Meeting	None	28/2/24	None	24.4.24		26.6.24		28.8.24		30.10.24		18.12.24	
	Perinatal Assurance meeting (previously Maternity Quad / MIS)	None	None	None	25.4.24	Kornferry	None	01.07.24	28.08.24			04.11.24		06.01.25
External	MNSI/NHSR/CQC or other organisation with a concern or request for action made directly with the trust	0	0	0	0	0	0	0	0	0	0	0	0	0
Legal	New Legal cases (Maternity only- Including Coroners cases and ENS claims)	0	0	0	3	0	2	0	0	1	1	0	0	2
	Ongoing Claims Cases													17
	Ongoing Early Notification Scheme Cases													5

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

Midwifery vacancy has increased. This is due to multiple reasons. The business case has now been approved internally, which allows temporary funded roles to be recruited into substantively. Unfortunately, some of the newly qualified Midwives recruited into temporary roles, have now accepted permanent jobs in other units due to this uncertainty. Vacancies are currently being advertised to allow us to recruit throughout 2025 and bring our establishment back up the Birthrate plus recommended levels. Bank is still being use to maintain safety and cover any shortfall.

There was an increase in reported red flags with 6 missed or delayed care and 1 delay in providing pain relief. On review the 6 missed or delayed care events related to the time between suitable to artificial rupture of membranes (ARM) and ARM being performed. The NICE guidance for Safe Staffing does not give a specific time frame for what constitutes a delay. The OPEL framework identifies a delay as 6 hours. The 6 cases have been reviewed, and the delay was greater than 6 hours but less than 24hrs and there were no adverse outcomes. They occurred from periods of high short-term sickness. All delays in commencement or continuation of Induction of Labour are monitored during daily staffing meeting and have oversight from the Matron team and on-call Maternity Manager.

Table 2: Regional Maternity Heatmap

Regional Maternity Heatmap

Data refreshed: 05/02/2025 09:35:07

Scoring

Region: Midlands

NHS England

Heatmap month: January 2025

Provider	Overall score	CQC Mat overall rating	Stake holder concerns	CQC S29a	CQC s31	Ext. ind. review	Coroner reg 28	Mat Oversight	MIS	CNST repay ment	Eth. DQ	CQC Mat Survey	SBL	Midw ives vac.	MSW vac.	Obs vac.	Unfilled roles	Snr L'ship not in post	Safety champs	Birthrate + (last 3 yrs)	Neonatal death rate	Perinatal death rate	Stillbirth rate
BIRMINGHAM WOMEN'S AND CHILDREN'S NHS FOUNDATION TRUST	28.0	1.0	1	0	0	0	0	0	0	0	0	4	3	1	2	3	0	0	0	0	5	5	3
CHESTERFIELD ROYAL HOSPITAL NHS FOUNDATION TRUST	26.0	3.0	1	0	0	0	0	2	3	0	0	0	3	2	0	2	0	5	0	0	1	1	3
GEORGE ELIOT HOSPITAL NHS TRUST	22.0	1.0	1	0	0	0	0	0	0	0	3	3	3	1	1	1	1	0	0	0	1	3	3
KETTERING GENERAL HOSPITAL NHS FOUNDATION TRUST	39.0	3.0	4	0	0	0	0	5	2	0	0	3	3	3	1	1	1	0	0	0	5	5	3
NORTHAMPTON GENERAL HOSPITAL NHS TRUST	28.0	3.0	1	0	0	0	0	0	2	0	0	3	3	3	2	2	0	0	0	0	3	3	3
NOTTINGHAM UNIVERSITY HOSPITALS NHS TRUST	47.0	3.0	6	0	0	5	0	5	4	0	0	3	3	2	3	4	0	0	0	0	3	3	3
SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST	41.0	3.0	4	5	0	0	0	3	0	0	0	3	3	3	3	5	0	0	0	0	3	3	3
SHERWOOD FOREST HOSPITALS NHS FOUNDATION TRUST	28.0	1.0	2	0	0	0	4	0	0	0	0	3	3	1	4	1	0	0	0	0	3	3	3
SOUTH WARWICKSHIRE UNIVERSITY NHS FOUNDATION TRUST	25.0	1.0	1	0	0	0	0	0	0	0	3	2	3	0	5	1	0	0	0	0	3	3	3
THE DUDLEY GROUP NHS FOUNDATION TRUST	22.0	1.0	2	0	0	0	0	0	0	0	0	4	3	0	0	0	0	5	0	0	1	3	3
THE ROYAL WOLVERHAMPTON NHS TRUST	26.0	1.0	2	0	0	0	0	0	0	0	0	3	3	0	0	3	1	0	0	0	5	5	3
THE SHREWSBURY AND TELFORD HOSPITAL NHS TRUST	34.0	3.0	3	0	0	0	0	5	0	0	0	3	3	0	0	3	1	0	0	0	5	5	3
UNITED LINCOLNSHIRE HOSPITALS NHS TRUST	11.0	1.0	0	0	0	0	0	0	0	0	0	1	3	0	0	0	0	0	0	0	0	3	3
UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST	40.0	4.0	6	0	0	0	0	5	3	0	0	5	3	3	0	0	0	0	0	0	5	3	3
UNIVERSITY HOSPITALS COVENTRY AND WARWICKSHIRE NHS TRUST	22.0	1.0	0	0	0	0	0	0	0	0	0	3	3	2	0	4	0	0	0	0	3	3	3
UNIVERSITY HOSPITALS OF DERBY AND BURTON NHS FOUNDATION TRUST	78.0	5.0	7	10	5	5	4	5	5	0	0	3	5	0	5	0	0	5	0	1	5	5	3
UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST	34.3	2.3	3	0	0	0	0	3	0	0	0	3	3	2	0	5	0	0	0	0	5	5	3
UNIVERSITY HOSPITALS OF NORTH MIDLANDS NHS TRUST	32.0	3.0	1	5	0	0	0	2	0	0	0	3	3	1	1	0	0	0	0	0	5	5	3
WALSALL HEALTHCARE NHS TRUST	26.0	3.0	3	0	0	0	0	0	0	0	0	3	3	1	1	1	0	0	0	0	5	3	3
WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST	32.0	1.0	3	0	0	0	0	2	2	0	3	3	3	2	4	0	0	0	0	0	3	3	3
WYE VALLEY NHS TRUST	24.0	1.0	0	0	0	0	0	2	0	0	0	3	3	0	1	0	0	5	0	0	3	3	3

2.2 Serious incidents and Maternity and Newborn Safety Investigations

There have been **0** cases referred to the Maternity and Newborn Safety Investigations (MNSI) during January 2025, by the Trust.

There has been 0 new incident response commenced during January 2025.

There has been 1 PSII concluded during January 2025 (INC153729). The incident was in relation to an intrauterine death and deterioration in the woman's clinical condition following identification and prior to delivery.

Areas identified for improvement were as follows:

- Communication and interpretation of management plans.
- Handover processes.
- Escalation of unresolved inadequate medical staffing.
- Escalation of required/ delayed obstetric review.

2.3 Perinatal Mortality Review tool (PMRT)

Quarterly report presented to Quality Committee February 2025 and Mortality surveillance group.

2.4 Coroner Regulation 28 made directly to the Trust

There were 0 Coroner regulation 28 made directly to the Trust in respect of perinatal or maternal deaths in January 2025.

2.5 Maternity Safety Champions

Maternity safety champions walkaround was due to occur on the 21st January 2025 but had to be cancelled due to high acuity across the trust. The Medical director and Chief nurse did visit the areas on the 5th and 6th February respectively. Feedback from the Chief nurse included the following:

- Staff in both areas were very polite and welcoming, which always makes such a difference.
- Neonates are 'very quiet today' with only 5 babies on the unit, so staff have used the time to catch up on cleaning, mandatory training, supporting paediatrics and ICCU.
- Staffing levels were as planned (or adequate for the current activity in the area) and bank shifts have been cancelled within neonates as they are not required given the small volume of patients.
- Both, maternity and neonatal areas, looked visibly clean and welcoming. I love the refurbished rooms in maternity – they look so calming.
- I have only managed to speak to one lady and her partner, but they were very complimentary about their care.
- No concerns raised by any of the staff.

Only minor issues were raised and no safety issues were found during either walkaround by the Chief nurse or the Medical director.

2.6 Saving Babies Lives

As of January 2025, we are reporting 100% compliance across all six elements of the Saving Babies' Lives care bundle, and we are currently awaiting validation from the LMNS to confirm this. There are no emerging themes, and the team continues to work collaboratively to maintain high standards of care. To support ongoing compliance, monthly meetings have been restructured to provide a more robust and systematic approach to monitoring and sustaining progress.

Over the last 12 months we have declared two divergence, as discussed with Regional NHSE teams

- Divergence for element 2 – 2.15 & 2.20 – Fetal medicine unit capacity
- One successfully closed divergence: Element 3 – 3.2 – Reduced fetal movement USS Capacity

To address the ongoing divergence, we are working closely with our sonography team to explore the development of a Small for Gestational Age SGA clinic. Additionally, due to ongoing pressures of our Fetal Medicine Unit across the region, we continue to maintain regular communication with the regional team to identify a sustainable solution.

The successful closure of our divergence for Element 3 – 3.2 allowed us to share best practices with the wider midwifery network, reinforcing our commitment to continuous improvement.

2.7 Antenatal and Newborn screening

The Screening Quality Assurance Service (SQAS) recently completed its annual quality review of all antenatal and newborn screening services.

Based on the evidence assessed by the QA team, SQAS does not plan to undertake a QA visit or a focussed review of one or more aspect(s) of the screening service at The Dudley Group during the 2025/26 financial year. This is due to the exceptional assurance provided by the Maternity Antenatal and Newborn screening teams, their attention to all the requirements of the programmes and their overall dedication to the service.

The SQAS team would like to acknowledge the dedicated and effective screening team that you have in place. The team are well engaged with SQAS and give assurance of safe antenatal and newborn screening programmes. Huge thank you and well done to Lead screening Midwife Melanie Bullas and Screening Midwife Tammy Ralphs, that over see all aspects of the service.

2.8 Service user feedback- Maternity and Neonatal voices partnership

An MNVP Meeting was held on the 17th December 2024. Service user representation was limited, and it is recognised that the time of year this meeting was held may have inhibited some families from attending.

Feedback received from attendees was presented to the February Quality committee for discussion.

MNVP 15 steps event is due to take place in May 2025.

2.8.1 Service user feedback- Friends and Family results Dec 24 and Jan 25 as per Perinatal Safety Data tool.

Friends and family response rate for January was 14%

Every single midwife and support worker. Amazing staff, caring. Made me feel comfortable and looked after during my 5/6 days throughout maternity ward.

Staff have been very kind and considerate throughout the whole process. Special thanks to Noma, Tracey and Harley who have made me feel comfortable and at ease. They are definitely in the right profession as all three have a lovely bedside manner. Would definitely recommend them.

Our sonographer Jordan was wonderful ! she made today a happy, memorable and positive experience. She provided lots of information and frequently checked in with us for any questions. Thankyou!

Comfy chairs for partners when on induction ward please!

Would have liked more space in shared recovery ward and own room.

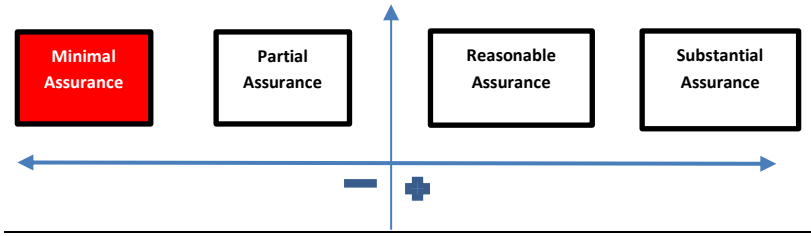
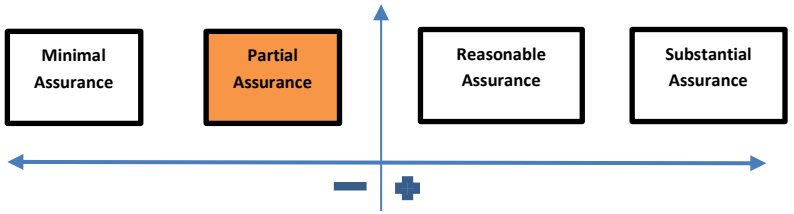
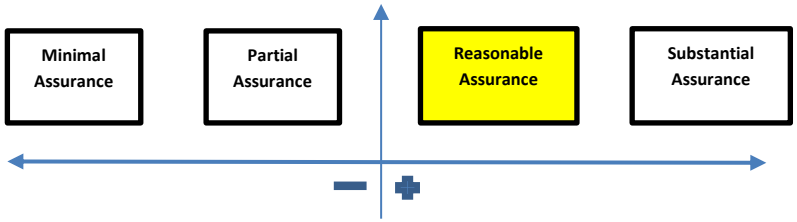
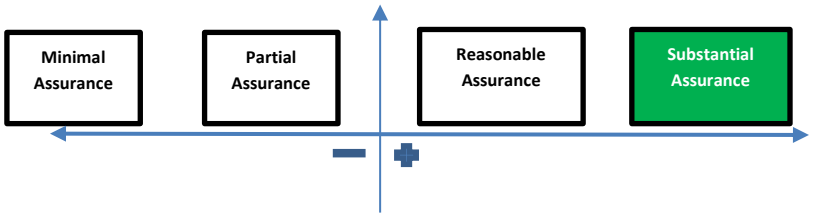
3. RECOMMENDATION(S)

3.1 The Committee is invited to accept the paper as assurance against all national standard requirements including SBLV2 and Perinatal quality surveillance model (Ockenden 2022).

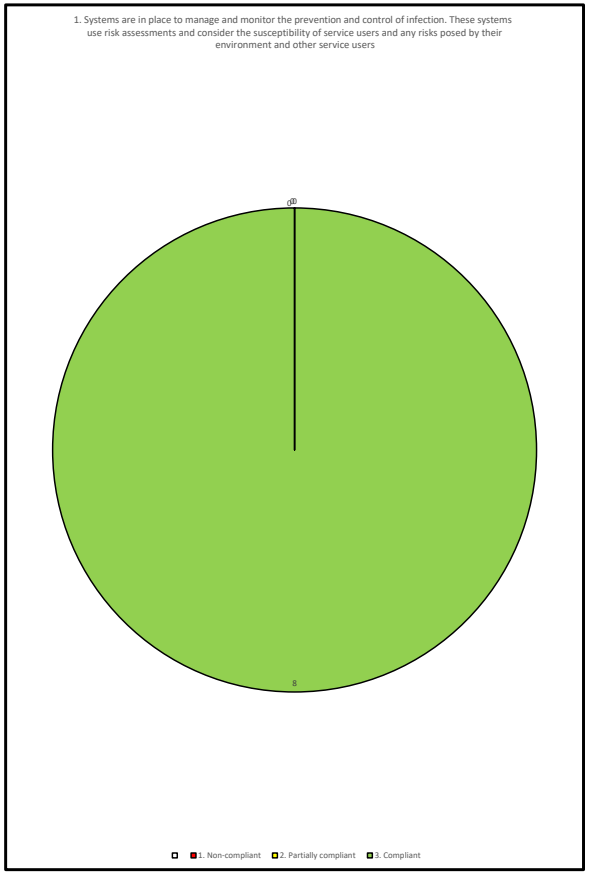
Name of Authors: Claire Macdiarmid and Basem Muammar
Title of Author Director of Midwifery and Clinical Director for Obstetrics and Gynaecology

Date 17th February 2025

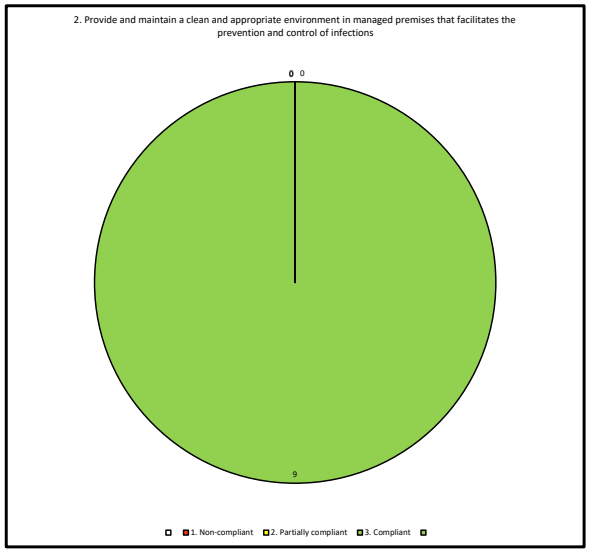
Assurance descriptors

	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)

Infection Prevention and Control board assurance framework 2024/2025 v1.4						
	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 NHSE. 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 practices, that is, that any workplace risk(s) are mitigated maximally for everyone.	DATIX reporting is encouraged. There is a Freedom to Speak up Guardian in place. There are separate DATIX streams for IPC and Decontamination incidents to be reported and actioned. 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, Quality committee and IPR. Divisions report into IPCG All outbreaks are reported internally and externally to UK HSA, ICB and NHSE. 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. IPC induction 2 training is delivered face to face at level 2 for all attendees				3. Compliant

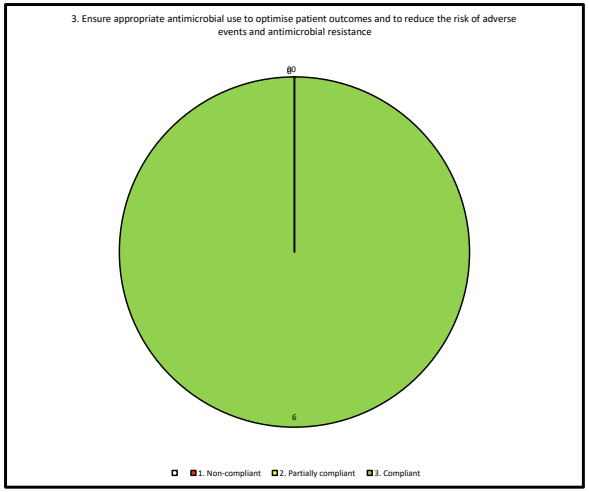


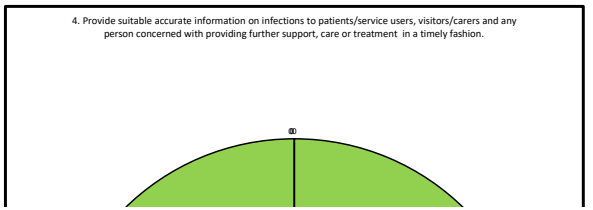
1.8	There is support in clinical areas to undertake a local dynamic risk assessment based on the hierarchy of controls to prevent/reduce or control infection transmission and provide mitigations. (primary care, community care and outpatient settings, acute inpatient areas, and primary and community care dental settings)	Risk assessments are available for use. Policies and procedures are developed to facilitate autonomy. IPC Doctor/Consultant Micrbiologist is on call out of ours for advice and support. IPC team attends daily site meetings IPC team to provide weekend on site cover for December and January 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
IPC team are porovoding weekend cover for Decembver and January.						
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 2024				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 via the Estates and Facilities report				3. Compliant



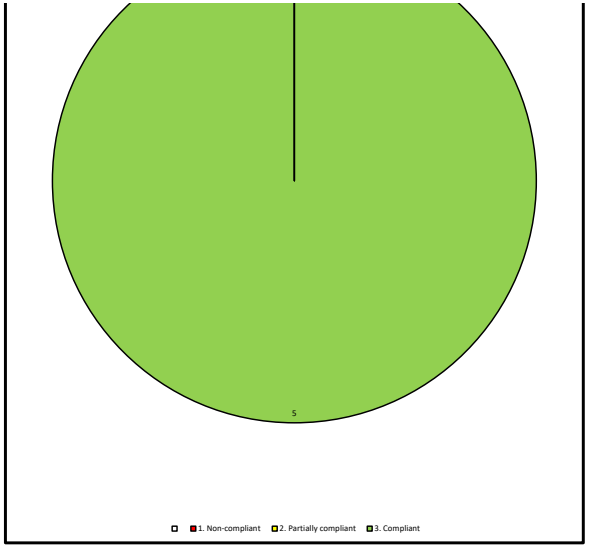
2.5	There is evidence of a programme of planned preventative maintenance for buildings and care environments and IPC involvement in the development new builds or refurbishments to ensure the estate is fit for purpose in compliance with the recommendations set out in HBN:00-09	Maintenance Controls 1.1 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.NE 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 iva the Estates and Facilities report				3. Compliant
2.7	The classification, segregation, storage etc of healthcare waste is consistent with HTM:07:01 which contains the regulatory waste management guidance for all health and care settings (NHS and non-NHS) in England and Wales including waste classification, segregation, storage, packaging, transport, treatment, and disposal.	Healthcare waste and the segregation of waste is provided by our PFI partner Mitie. A PFI partner waste group meets monthly. Waste segregation is included on the IPC induction and IPC training programmes. Waste is included on the estates and facilities report to IPCG Duty of Care visits are undertaken with the Trust and PFI partners to outside contractors including Tradebe, Elis, Biffa, Cliniwaste and Sharpsmart. Joint duty of care visits are completed annually with the Trust and PFI partners.				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, Health Edsge is in place for the track and trace of instruments		Health edge for track and traceability of sterile surgical instruments is required for renal unit. The department do have a paper based log book that is used while finance review the request.		3. Compliant

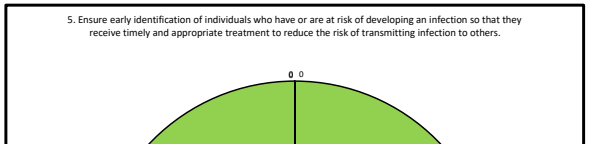
2.9	Food hygiene training is commensurate with the duties of staff **as per food hygiene regulations**. If food is brought into the care setting by a patient/service user, family/carer or staff this must be stored in line with food hygiene regulations.	Food hygiene training is undertaken by staff and 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



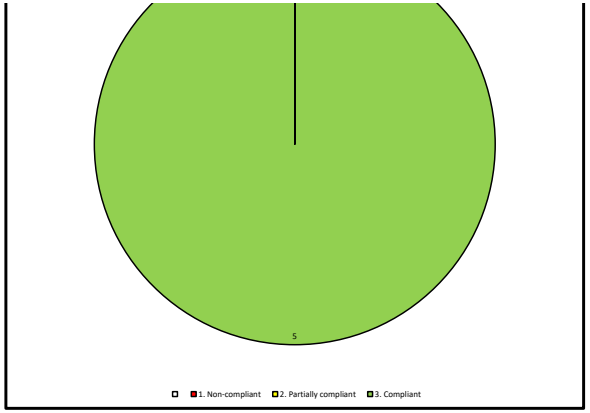


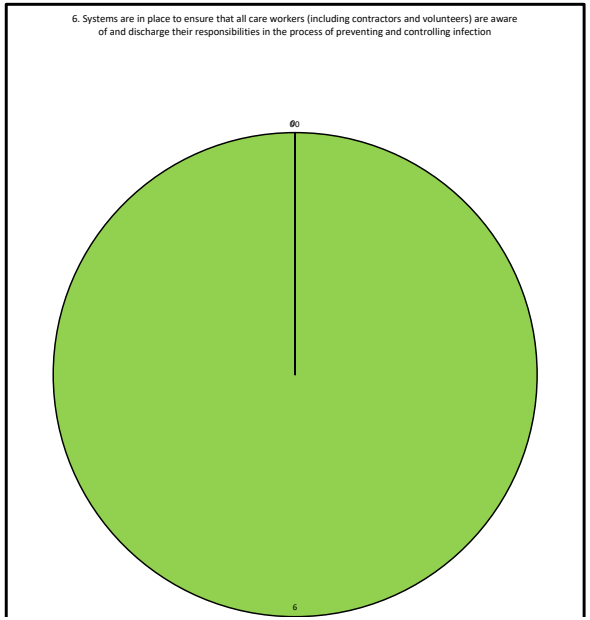
4.2	Information is appropriate to the target audience, remains accurate and up to date, is provided in a timely manner and is easily accessible in a range of formats (e.g. digital and paper) and platforms, taking account of the communication needs of the patient/service user/care giver/visitor/advocate.	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 NIPCM:						
5.1	All patients/individuals are promptly assessed for infection and/or colonisation risk on arrival/transfer at the care area. Those who have, or are at risk of developing, an infection receive timely and appropriate treatment to reduce the risk of infection transmission.	As per policy patients are screened on admission or pre-admission and placed accordingly. Nursing documentation is completed on Sunrise 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



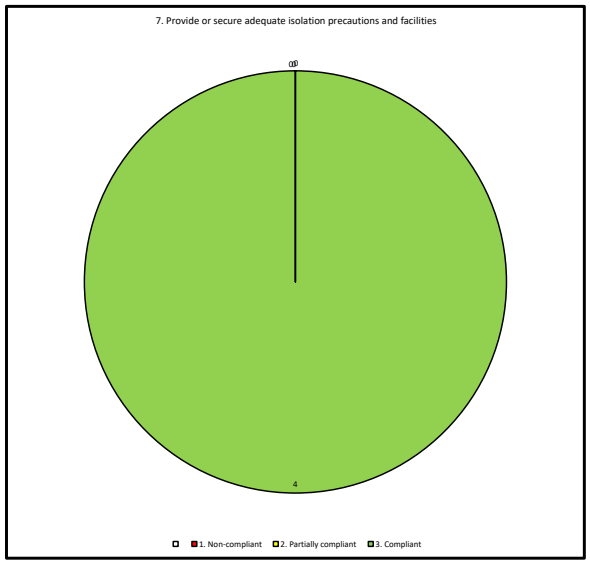


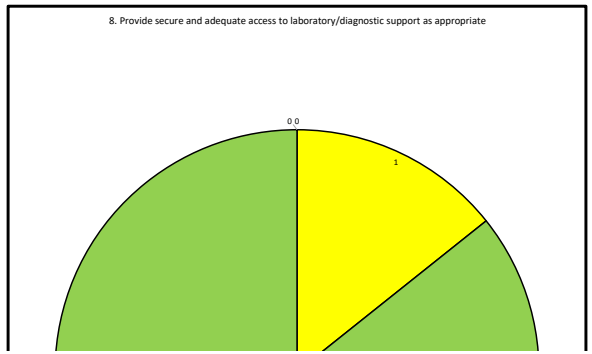
5.2	Patients' infectious status should be continuously reviewed throughout their **stay/period of care**. This assessment should influence placement decisions in accordance with clinical/care need(s). If required, the patient is placed /isolated or cohorted accordingly whilst awaiting test results and 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



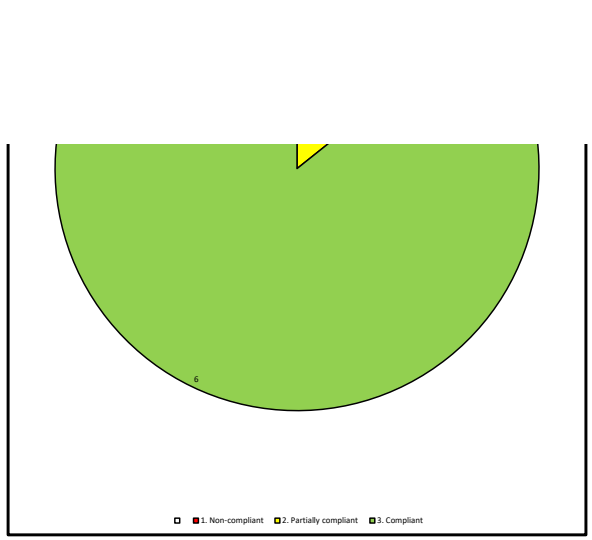


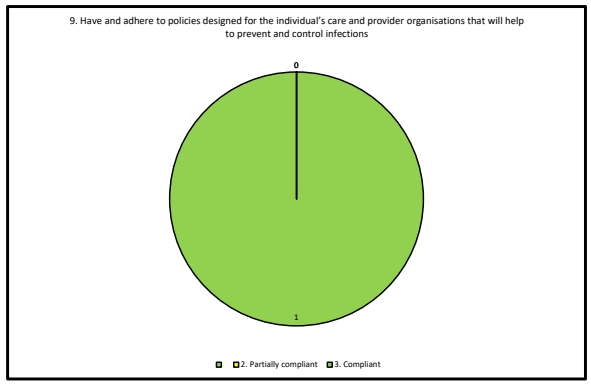
6.6	If clinical staff undertake procedures that require additional clinical skills, for example, medical device insertion, there is evidence staff are trained to an agreed standard and the staff member has completed a competency assessment which is recorded in their records before being allowed to undertake 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.	Standard Infection Preventoin and control Policy avaialbe 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 and C2 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 IPC Team has access to WinPath	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

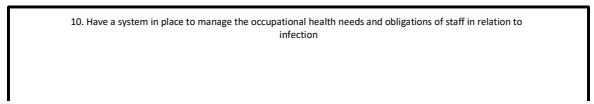




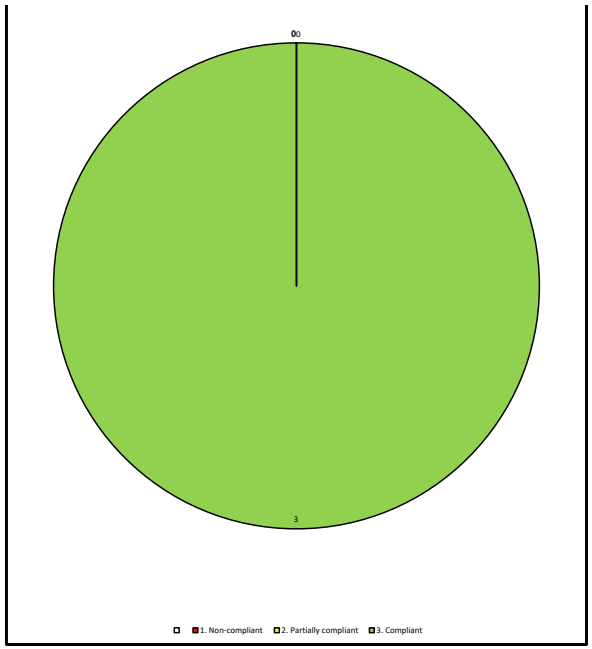
8.3	Protocols/service contracts for testing and reporting laboratory/pathology results, including turnaround times, should be in place. These should be agreed and monitored with relevant service users as part of contract monitoring and laboratory accreditation systems.	Policies and procedures in place. 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 and C2 Influenzas screening when requested or annually during flu season as advised by the Department of Health.				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, A to Z pathogen resource, and the NIPCM). Policies and procedures are in place for the identification of and management of outbreaks/incidence of infection. This includes monitoring, recording, escalation and reporting of an outbreak/incident by the registered provider.	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 IPC Team have access to Winpath 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 Staff Health and Wellbeing report into IPCG Meeting via a separate report				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



Performance KPIs

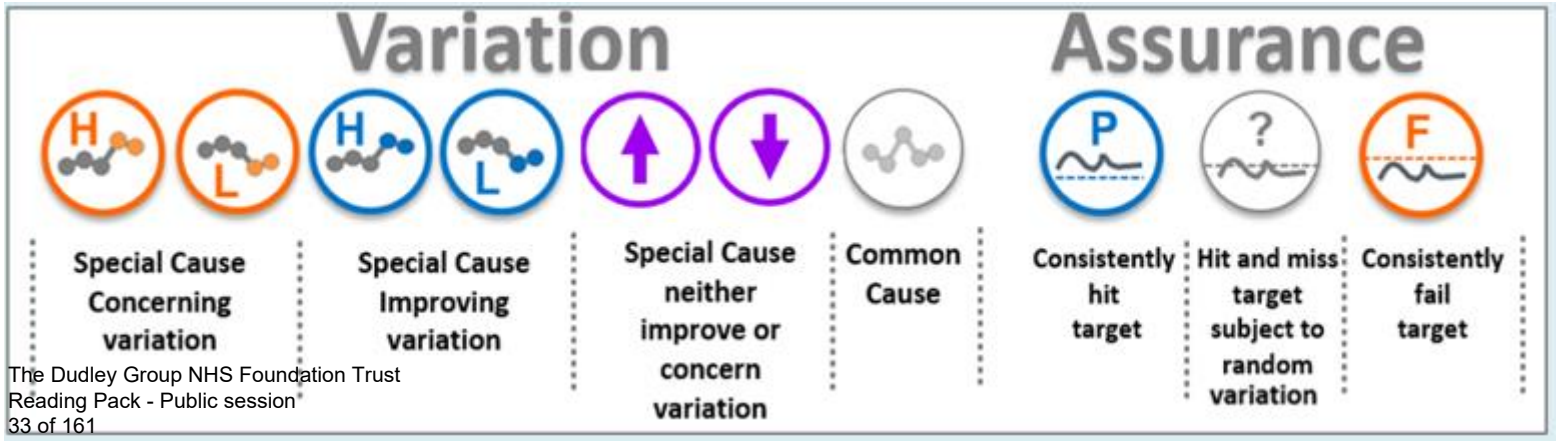
February Report (January 2025 Data for National Performance & December 2024 Data for Cancer & VTE)

The Dudley Group NHS Foundation Trust

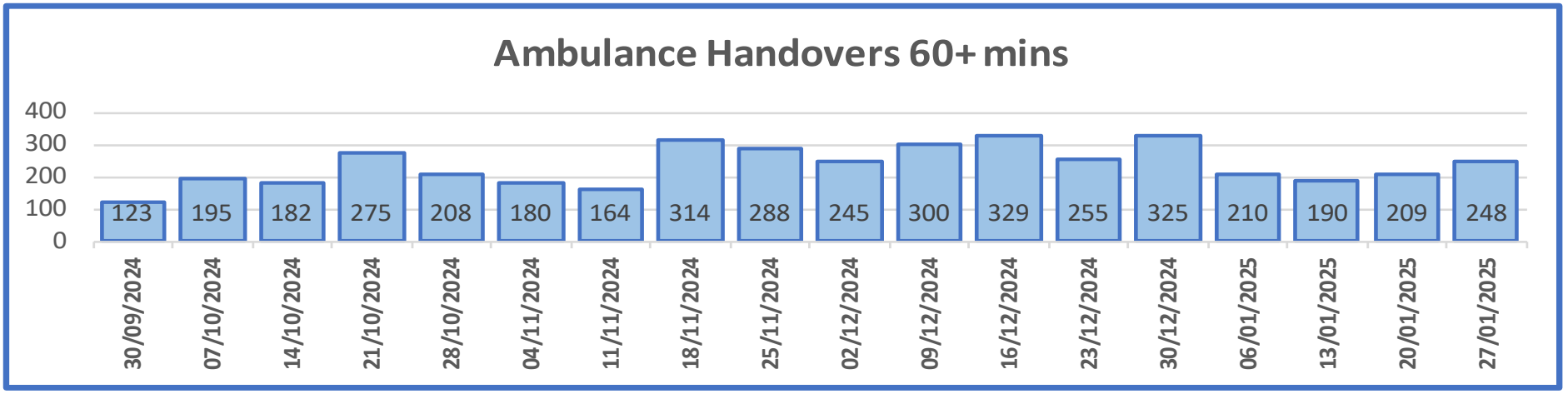
Karen Kelly, Chief Operating Officer

Constitutional Performance

Constitutional Standard and KPI		Target	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25		
Emergency Access Standard (EAS)	Combined 4hr Performance	78.0%	71.9%	73.8%	78.7%	80.3%	81.2%	81.6%	79.9%	83.6%	81.2%	81.9%	81.9%	78.1%	77.8%		
Triage	Triage - All	95.0%	84.3%	83.8%	80.7%	74.2%	79.5%	80.2%	73.3%	75.9%	81.4%	78.1%	84.3%	73.0%	76.4%		
Referral to Treatment (RTT)	RTT Incomplete	92%	55.8%	56.2%	56.5%	57.8%	58.2%	58.6%	58.6%	57.2%	57.5%	58.3%	59.2%	58.2%	58.7%		
Diagnostics	DM01 - Diagnostics achieved within 6 weeks	85%	79.7%	90.6%	91.3%	89.6%	88.4%	86.9%	88.3%	86.3%	86.2%	89.2%	90.4%	85.8%	85.2%		
VTE	% Assessed on Admission	95%	99.1%	99.3%	99.3%	98.9%	98.7%	99.0%	99.1%	99.2%	99.1%	99.1%	99.1%	98.9%	N/a		



Ambulance Handovers 60+ Mins



Performance

This month's activity saw 8,790 attendances. This has decreased when compared to the previous month of December with 9,337.

11 out of the 31 days saw >300 patients.

3031 patients arrived by ambulance; this shows an increase from the 2948 ambulances that attended last month.

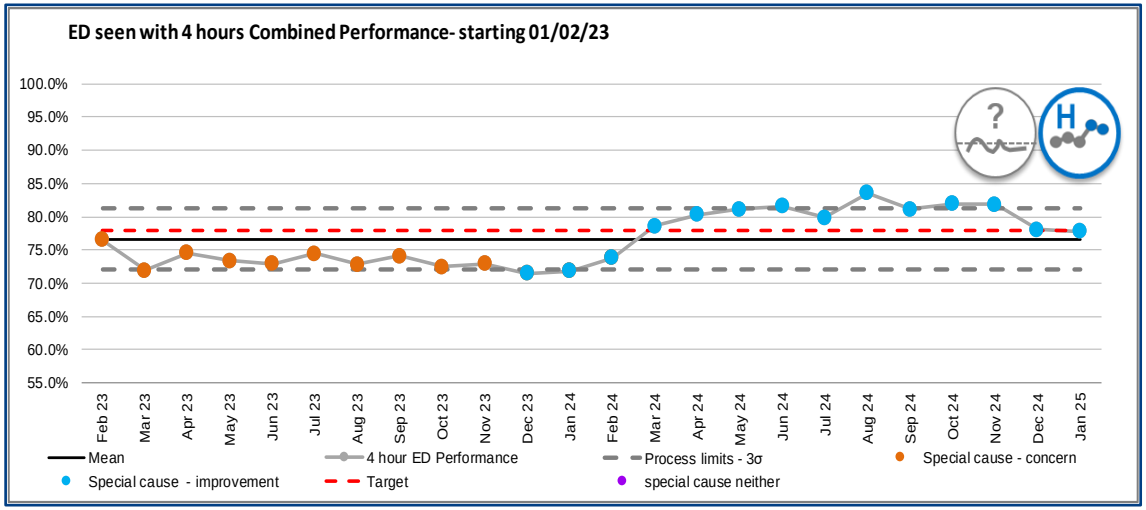
601 of these offloads took >1hr (20%). This shows an improvement when compared with last month's performance of 33%.

Over the month, the average length of stay (LOS) in ED was 215 mins for non-admitted patients and 481 mins for those waiting for a bed following a decision to admit. This represents an Improvement over both metrics when compared to last month where the LOS was 224 mins and 498 mins, respectively.

Action

- Continue to use RAT for all ambulance patients to ensure assessment, treatment and medication are given quickly.
- New front door model proposed, presence of AMU doctor, ED medic, receptionist, ambulance tracker, and triage nurse to streamline patient flow and improve efficiency. This is still under review.
- 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.
- Requirement for all CAT 3 ambulances to contact Dudley Clinical Hub, even if already presented at hospital, to explore potential community-based interventions and avoid any unnecessary hospital admissions.
- Utilise TES space (four additional beds) to support patient flow and alleviate ambulance handover delays- staffed outside ED.

ED Performance



Latest Month	Latest Month	2nd
77.8%	95	For Jan 2025
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 for January is 2nd 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 4hr 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

January 2025

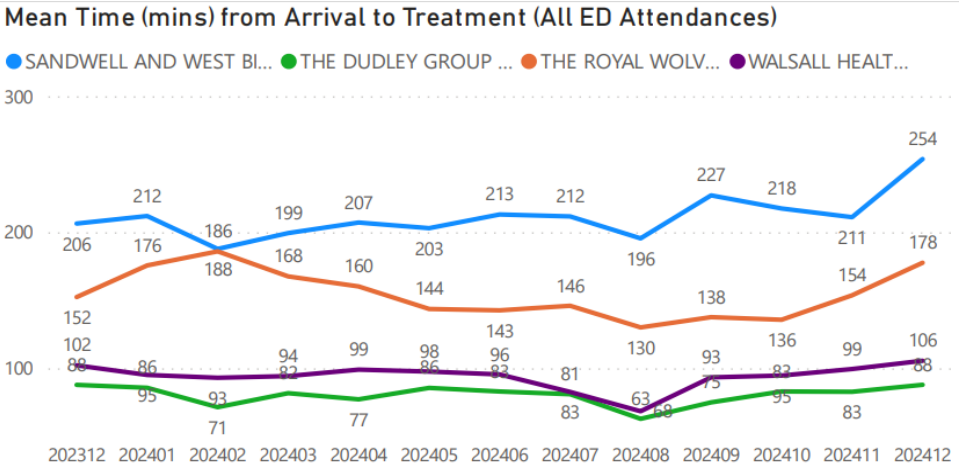
Latest Refresh
13/02/2025 10:52:47

Name	Value	National Rank
Birmingham Women's And Children's NHS Foundation Trust	84.27%	3
The Royal Wolverhampton NHS Trust	81.69%	5
The Dudley Group NHS Foundation Trust	77.78%	14
Sandwell And West Birmingham Hospitals NHS Trust	74.36%	30
Walsall Healthcare NHS Trust	72.74%	46
University Hospitals Coventry And Warwickshire NHS Trust	71.26%	52
George Eliot Hospital NHS Trust	71.03%	54
University Hospitals Of North Midlands NHS Trust	66.38%	79
Wye Valley NHS Trust	64.07%	92
South Warwickshire NHS Foundation Trust	63.98%	93
University Hospitals Birmingham NHS Foundation Trust	61.01%	104
Worcestershire Acute Hospitals NHS Trust	58.66%	116
The Shrewsbury And Telford Hospital NHS Trust	52.30%	120

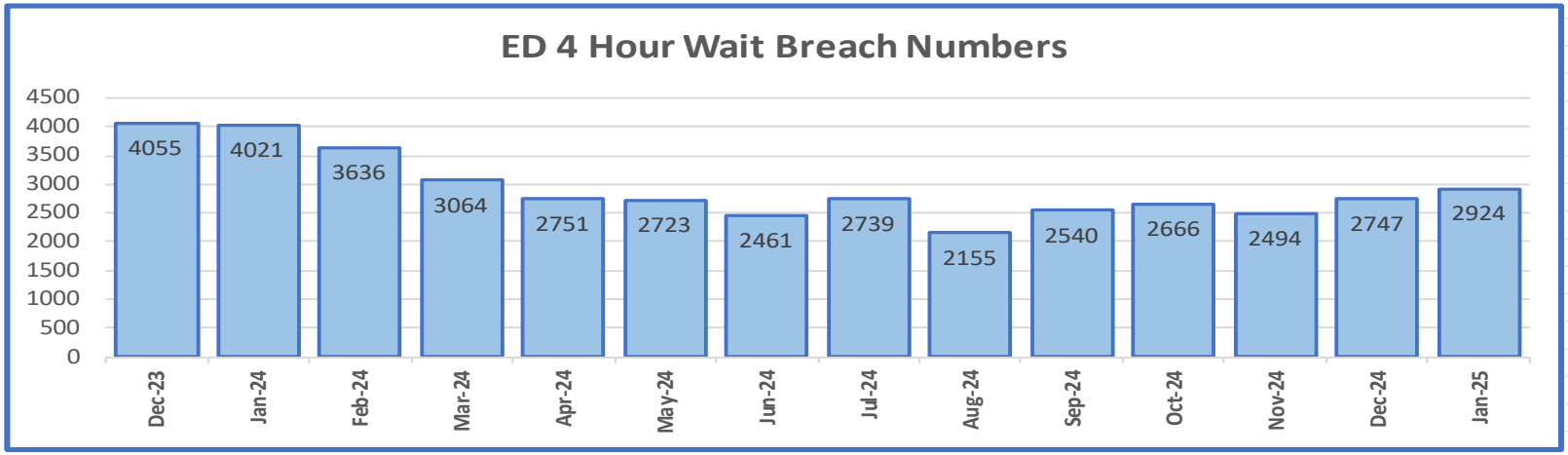
DGH

Ranking out of 122 Trusts

Source: Daily EAS - Power BI



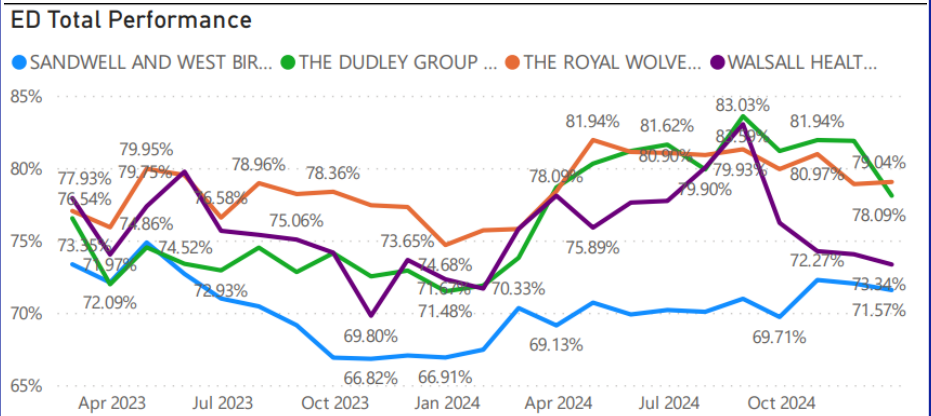
ED 4 Hour Wait Number of Breaches



Date	No. Breaches
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
Oct-24	2666
Nov-24	2494
Dec-24	2747
Jan-25	2924

Performance

ED remains the 2nd best performing department in the black country and in the top 14 nationally.

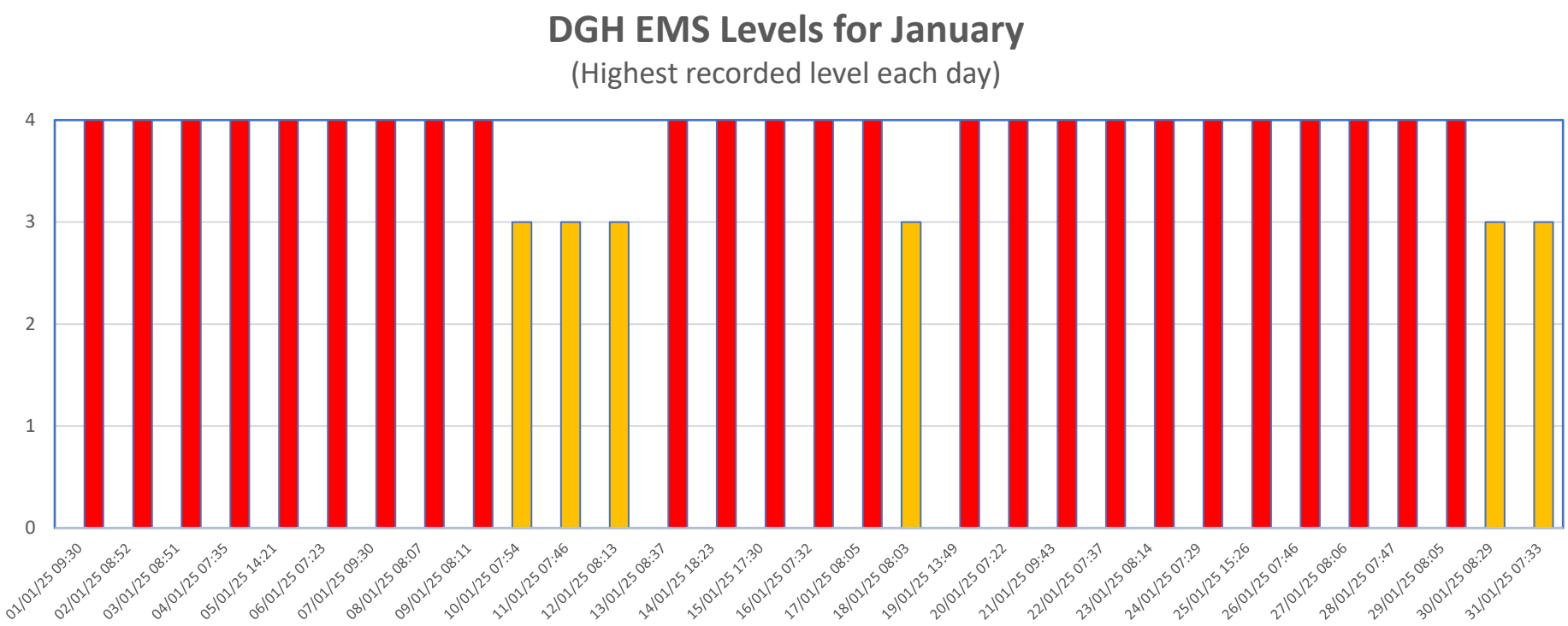


Action

- The ED performance for January was at 77.78% vs the national target of 78%.
- 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 January.

3031 patients arrived by ambulance; this shows an increase from the 2948 ambulances that attended last month.

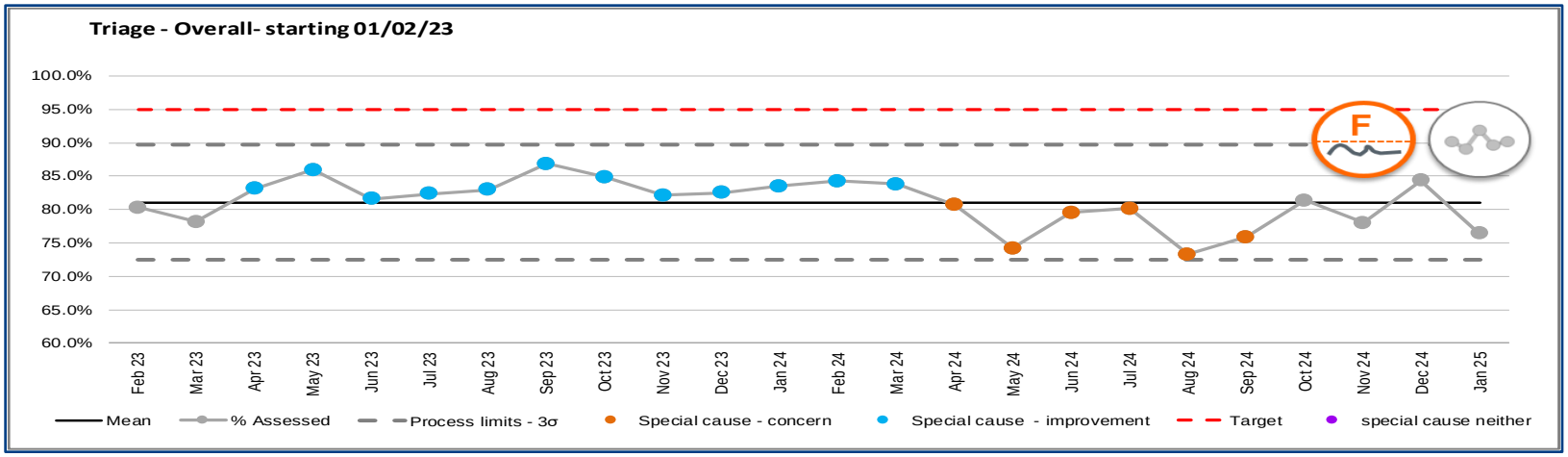
601 of these offloads took >1hr (20%). This shows an increase when compared with last month's performance of 33%.

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

76.4%

Triage – target 95%

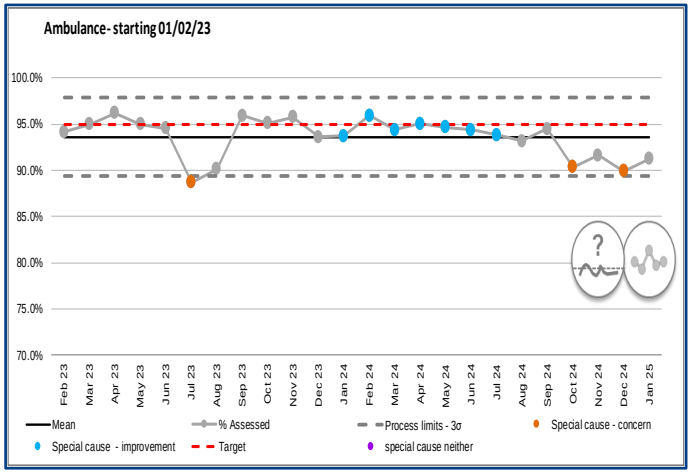
Performance

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

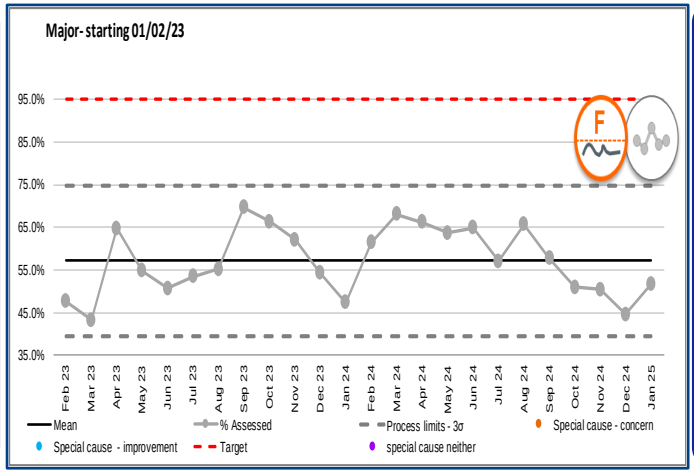
- Deputy Matron now leading on Triage improvement from October.
- Triage project has completed, and assurance report was submitted and presented to the execs with positive feedback.
- ED assurance report now submitted monthly to Execs.
- Daily triage continues to be monitored by the Deputy Matron.
-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

91.3%



Latest Month

51.8%

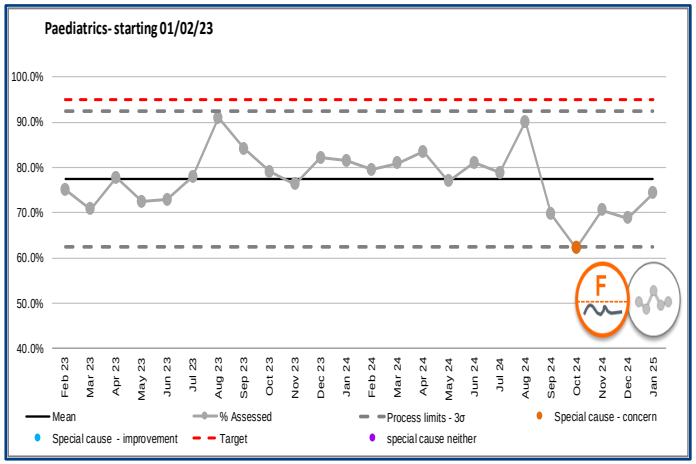
Performance

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

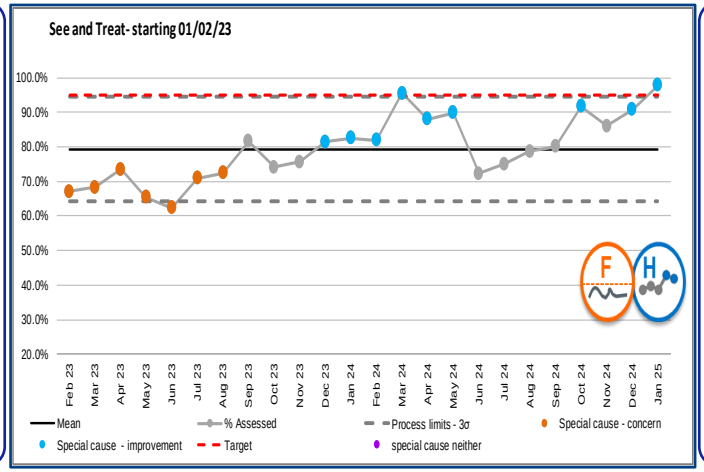
- Time spent in triage continues to be monitored
- Increased focus in direct to speciality patients being sent from UCC rather than being triaged in ED

ED Triage



Latest Month

74.4%



Latest Month

97.8%

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

- 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

	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24
28 Day Combined (75%)	79.9%	83.0%	81.3%	78.4%	83.3%	81.9%	81.6%	83.5%	82.0%	80.9%	81.9%	84.1%
31 Day Combined (96%)	81.3%	89.8%	86.7%	91.1%	92.5%	90.3%	94.1%	89.9%	90.8%	92.9%	91.7%	94.3%
62 Day Combined (85%)	58.3%	67.7%	71.5%	72.8%	67.2%	70.3%	74.4%	72.6%	71.7%	76.4%	70.3%	80.5%

Latest Month	Latest Month	Latest Month
84.1%	94.3%	80.5%
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 November 2024:

28-day Faster Diagnosis Standard (FDS)

- Performing well at 84.1% and remains above national target of 77%.. Increased focus on individual tumour site pathways.

31 day combined

- 31 day combined achieving 94.3% against national target of 96%. Surgical and diagnostic capacity and BCPS reporting delays impact performance. 31 day trajectory to achieve 96% submitted to ICB. Urology, gynae and skin are tumour sites most challenged.

62 day combined

- Achieved 80.5% and remains 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).
- Late Tertiary referrals closely monitored. Primarily head and neck, lung, gynae and urology. Actions in place to reduce. Cancer performance is reviewed at Regional Performance Tier Calls with NHSE.

Action

28-day FDS

-Performance to be sustained. Forecast shows continued achievement.

31 day combined & 62 combined

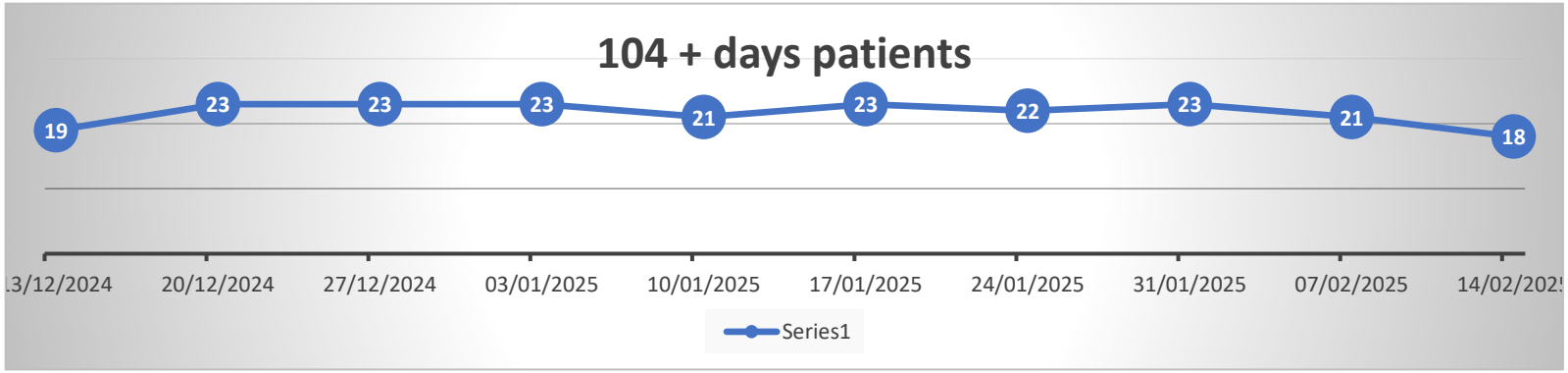
- Prostate: biopsy capacity to increase in February 25 following extra clinic being opened and nurse training nearing completion.
- Gynae: First appointment waiting times have increased extras are being provided and mutual aid has been requested.
- Skin: Nurse biopsy clinics commencing in March 2025 to support diagnostics and low grade excisional biopsy capacity.

BCPS

- Urgent 10-day Histology: 63% against national target 70%. February 25 is forecast at above 70%. E-Requesting at 47%. Compass pilot is delayed to March 2025 with wider rollout in April 2025, this will further improve compliance. Gastro are still using manual requesting due to technical issues, this is being addressed with Digital portfolio and BCPS colleagues. Urgent requesting at 55%. Task and finish group to review pathways and identify opportunities for improvement. Endoscopy and Skin focus areas to improve number of urgent samples requested.

Cancer Performance – 104 Day – Harm Review

Source: Weekly Cancer Performance



Latest Week

(14/02/25)

18

All 104 week waits, target 10 Patients

Performance

• Of the 18 over 104 days patients, urology remains the most challenged pathway with 10 patients waiting over 104 days as surgical capacity is limited.

• 8 of the 18 breaches have treatment plans / treatment dates. Those without treatment plans were awaiting surgery dates, best interest meetings or further investigations.

• Following harm review, there were 0 patients for December who are being reviewed for potential psychological harm.

• In December we treated 10 patients waiting over 104 days at DGFT and tertiary centres, this is a reduction compared to 18 in October.

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
- It is anticipated that actions taken to improve combined 62-day performance will support the reduction of patients waiting over 104 days
- Tertiary Referrals: Lung requires multiple diagnostics. PET scans and histology are causing main delays, and this is being addressed. Prostate biopsy capacity is in scope.

Cancer Benchmarking

28-Day Faster Diagnosis Standard vs Planning Trajectory

	Mar-24		Apr-24		May-24		Jun-24		Jul-24		Aug-24		Sep-24		Oct-24		Nov-24		Dec-24		Jan-25	
	Plan	Actual	Plan	Actual	Plan	Actual	Plan	Actual	Plan	Actual	Plan	Actual	Plan	Actual	Plan	Actual	Plan	Actual	Plan	Unvalidated	Plan	Unvalidated
WALSALL HEALTHCARE NHS TRUST	75.0%	86.1%	75.3%	81.4%	75.0%	80.8%	75.5%	83.1%	75.6%	88.2%	75.0%	86.0%	75.6%	88.0%	75.2%	88.3%	76.0%	75.9%	75.8%	70.1%	76.1%	80.5%
THE ROYAL WOLVERHAMPTON NHS TRUST	77.9%	80.8%	75.0%	77.8%	75.0%	81.0%	77.0%	81.7%	77.0%	77.5%	76.0%	76.2%	75.0%	75.1%	77.0%	76.7%	79.0%	80.3%	78.0%	81.0%	78.0%	77.3%
THE DUDLEY GROUP NHS FOUNDATION TRUST	75.2%	81.2%	77.0%	78.3%	77.0%	83.9%	77.0%	83.2%	77.1%	82.2%	77.0%	83.8%	77.0%	81.5%	77.0%	80.9%	77.1%	81.9%	77.1%	84.1%	77.1%	79.8%
SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST	75.8%	75.7%	75.1%	76.8%	75.7%	80.3%	75.9%	77.3%	76.2%	76.1%	75.0%	75.3%	75.2%	75.1%	75.4%	79.2%	76.0%	75.5%	76.5%	75.9%	75.4%	70.4%

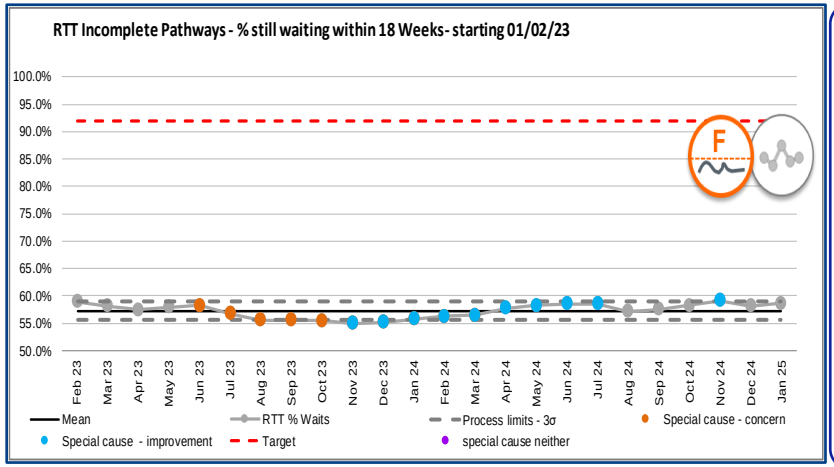
31-day CWT Trust Trajectory Progress

31-day CWT Performance	Apr-24		May-24		Jun-24		Jul-24		Aug-24		Sep-24		Oct-24		Nov-24		Dec-24		Jan-25	
	Plan	Actual	Plan	Actual	Plan	Actual	Plan	Actual	Plan	Actual	Plan	Actual	Plan	Actual	Plan	Actual	Plan	Unvalidated	Plan	Unvalidated
WHT	96.0%	94.4%	96.0%	100.0%	96.0%	96.9%	96.0%	97.6%	96.0%	98.4%	96.0%	97.3%	96.0%	98.4%	96.1%	96.0%	96.4%	98.6%	97.3%	100%
RWT	96.0%	86.1%	96.0%	90.1%	96.0%	88.9%	96.0%	91.4%	96.0%	88.0%	96.0%	88.6%	96.0%	90.2%	90.4%	90.0%	91.0%	91.5%	91.2%	82.7%
DGH	96.0%	91.6%	96.0%	92.2%	96.0%	90.3%	96.0%	94.5%	96.0%	89.7%	96.0%	90.8%	96.0%	92.9%	96.0%	91.7%	96.0%	94.5%	96.0%	92.4%
SWB	96.0%	91.9%	96.0%	93.5%	96.0%	91.6%	96.0%	91.1%	96.0%	86.3%	96.0%	84.0%	96.0%	85.9%	96.0%	86.3%	84.1%	88.8%	86.6%	89.8%

62-day CWT Trust Trajectory Progress

62-day CWT Performance	Apr-24		May-24		Jun-24		Jul-24		Aug-24		Sep-24		Oct-24		Nov-24		Dec-24		Jan-25	
	Plan	Actual	Plan	Actual	Plan	Actual	Plan	Actual	Plan	Actual	Plan	Actual	Plan	Actual	Plan	Actual	Plan	Unvalidated	Plan	Unvalidated
WHT	70.1%	75.9%	74.6%	79.3%	74.5%	79.3%	70.0%	76.0%	70.1%	77.4%	75.0%	73.8%	75.4%	81.6%	75.8%	84.7%	70.9%	80.9%	75.4%	76.3%
RWT	42.0%	46.2%	46.0%	49.5%	49.0%	57.2%	46.0%	53.7%	52.0%	54.6%	55.0%	61.2%	58.0%	63.9%	60.0%	65.6%	64.0%	67.8%	71.0%	60.3%
DGH	70.0%	71.9%	70.0%	66.8%	70.2%	70.3%	70.1%	74.9%	70.0%	71.5%	70.0%	71.4%	70.0%	76.4%	70.0%	70.3%	73.2%	79.7%	69.8%	63.9%
SWB	69.5%	69.7%	71.6%	64.6%	69.7%	65.7%	71.1%	66.6%	72.6%	75.8%	73.8%	71.4%	71.4%	71.9%	71.1%	67.3%	70.8%	70.5%	70.0%	70.2%

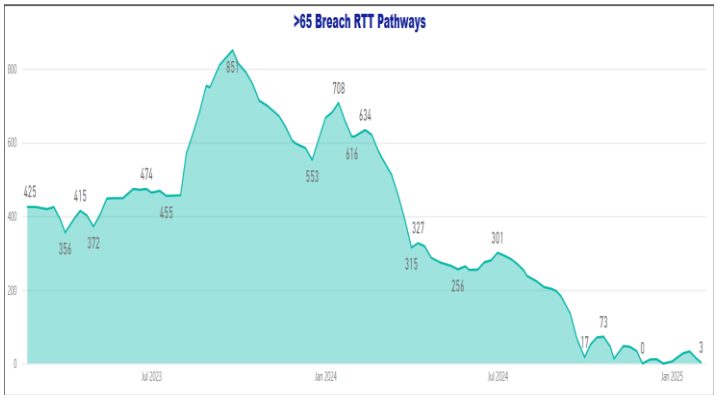
RTT Performance



Latest Month

58.7%

RTT Incomplete pathways target 92%



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

Performance

January has shown continued improvement in the RTT performance, with zero 65-week breaches reported for the month.

52-week performance remains good. We continue to overachieve against our trajectory, with the end of December position being 570 pathways ahead of plan.

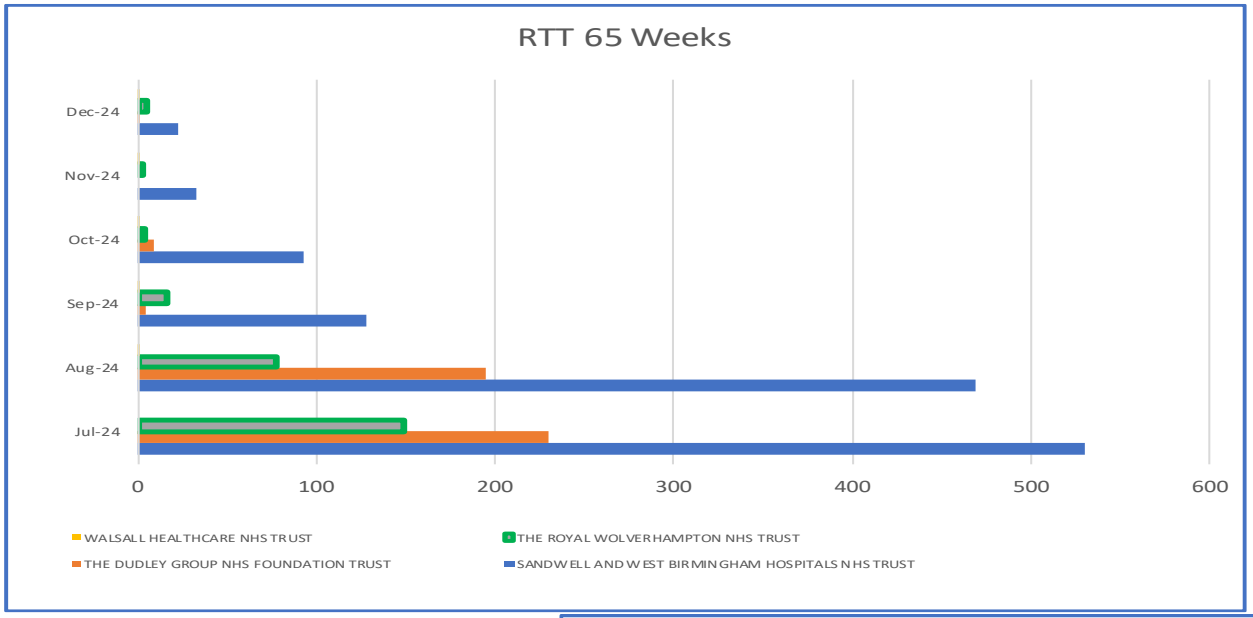
We are focused on achieving the 52 week standard for children and young people by the end of March 25, with 44 patients remaining in the cohort.

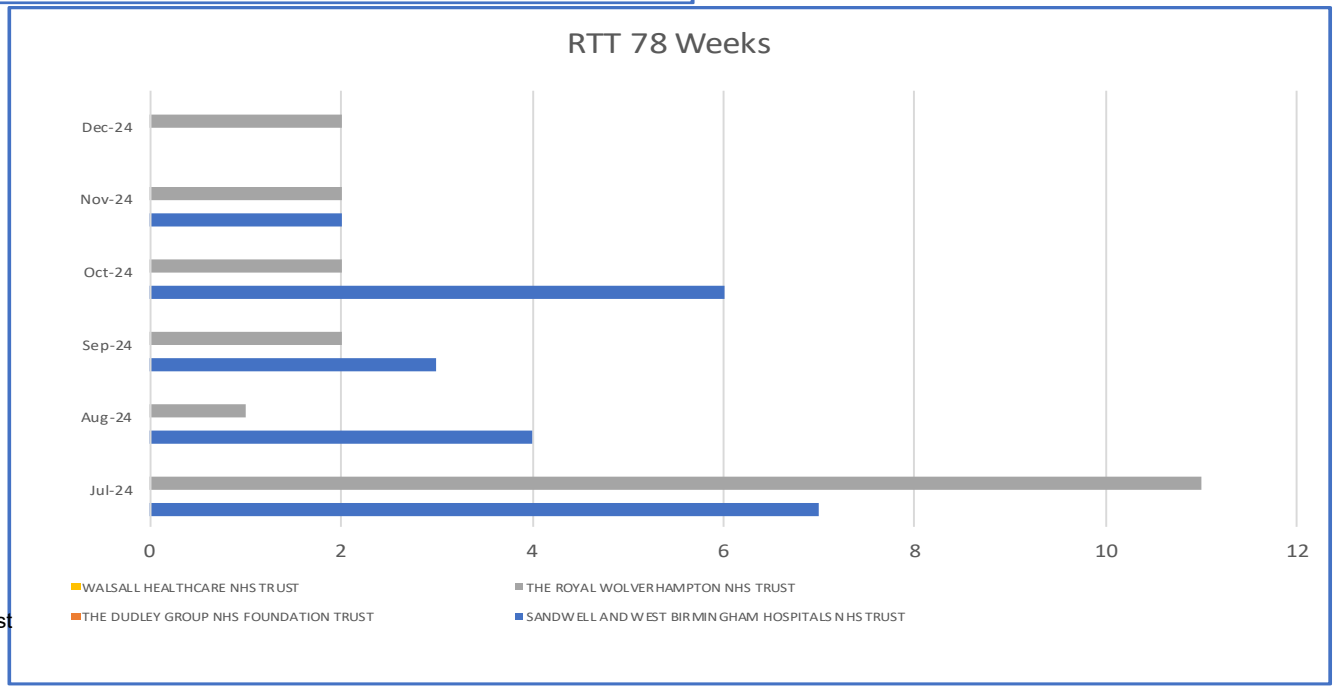
January RTT position 58.7% vs 92% national target, a continued improvement month on month.

Action

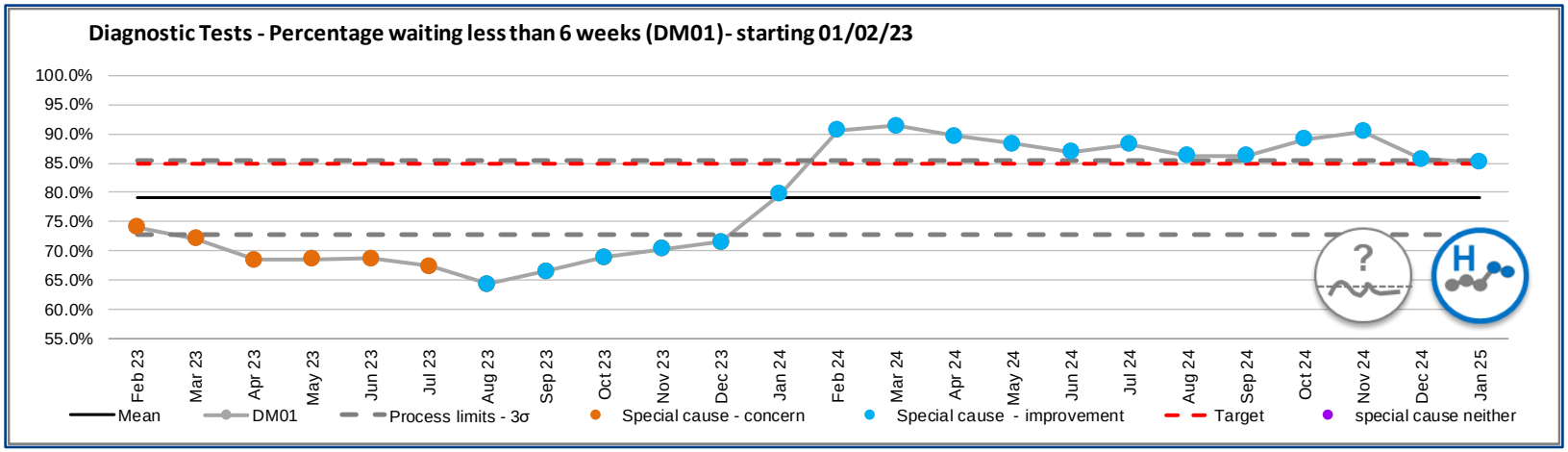
- Outsourcing to support Neurology and Dermatology has been increased though there continues to be some challenges in meeting the 65 week target though performance against 52 week clearance by March 25 looks good.
- Gynaecology service exploring outsourcing model to support reduction in waits for first outpatient appointments.
- Operational plans are being worked on for submission to the ICB 14th March ensuring forecasts align with the improvement targets. This will provide information at a speciality level for directorates to develop action plans against revised expectations set out in 'Reforming Elective Activity for Patients' planning guidance.
- Additional focused weekend children's day case sessions in half term to support achievement of 52-week standard for Children and Young People.

RTT Benchmarking





DM01 Performance



Latest Month

85.2%

DM01 combining 15 modalities - target 85%

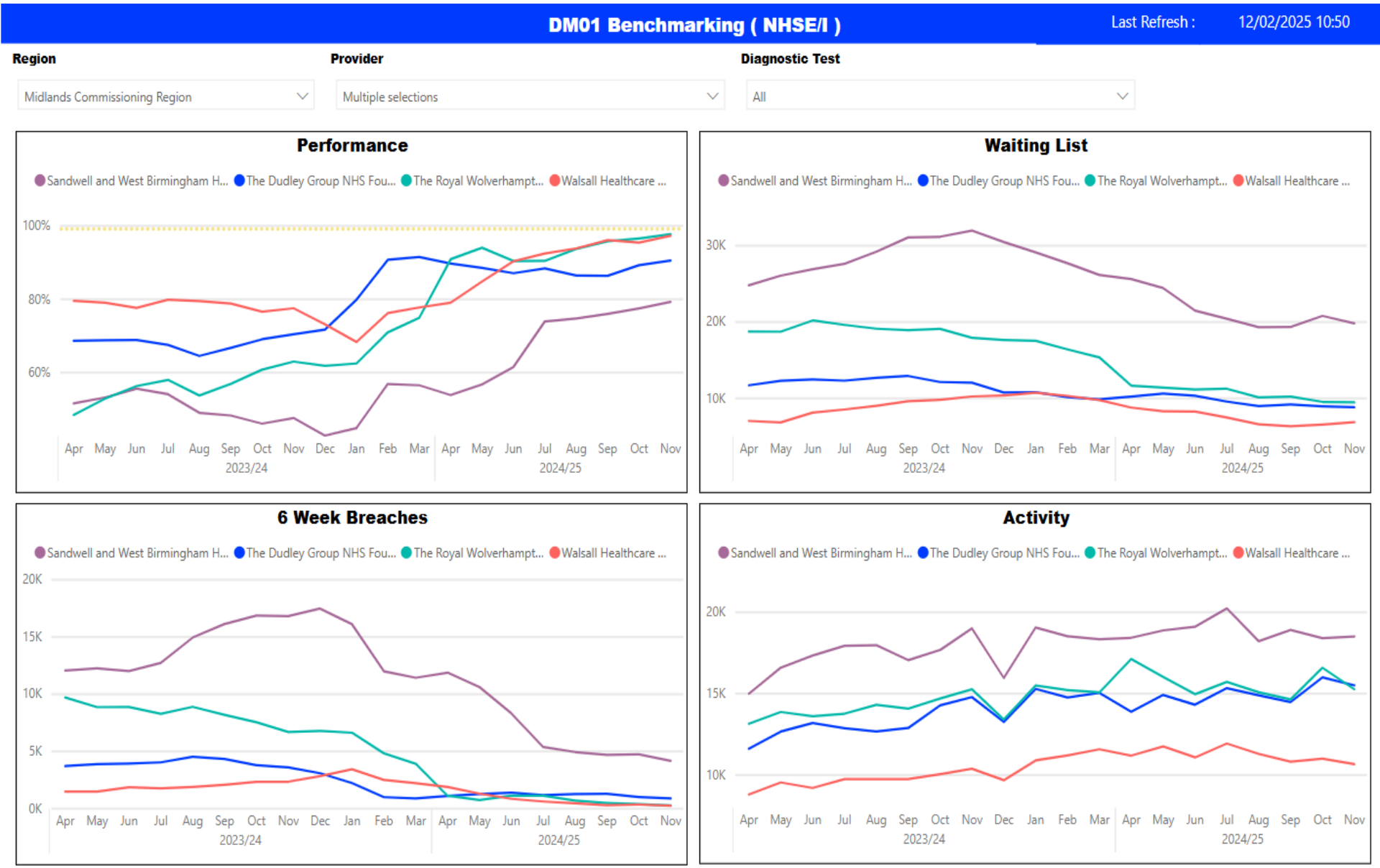
Performance

- January DM01 performance achieved 85.2%.The overall backlog of patients waiting to be seen is reducing month on month. NHSE target by end of March 2025 is to report zero 13 week breaches and 95% of patients to be seen within 6 weeks.
- Dexa and Endoscopy continue to perform well at 95% or above. Sleep Studies, Cardiac MRI and Cardiac CT remain challenged. NOUS has seen a reduction in 6+ week breaches,
- Sleep studies achieved 47.5% in January. There is a recovery plan to increase capacity to improve this position.
- NOUS achieved 87.7% in January. The majority of over 6 week breaches are specialist consultant scans. System mutual aid continues to be provided to SWBH (600 slots a month) and remains under review.
- Audiology achieved 93.5% in January, an improvement compared to 89.6% last month.
- Of the 132 breaches over 13 weeks in January, 62 were cardiac MRI, 22 cardiac CT and 40 sleep studies. Patients waiting between 6 and 12 weeks are area of focus.

Action

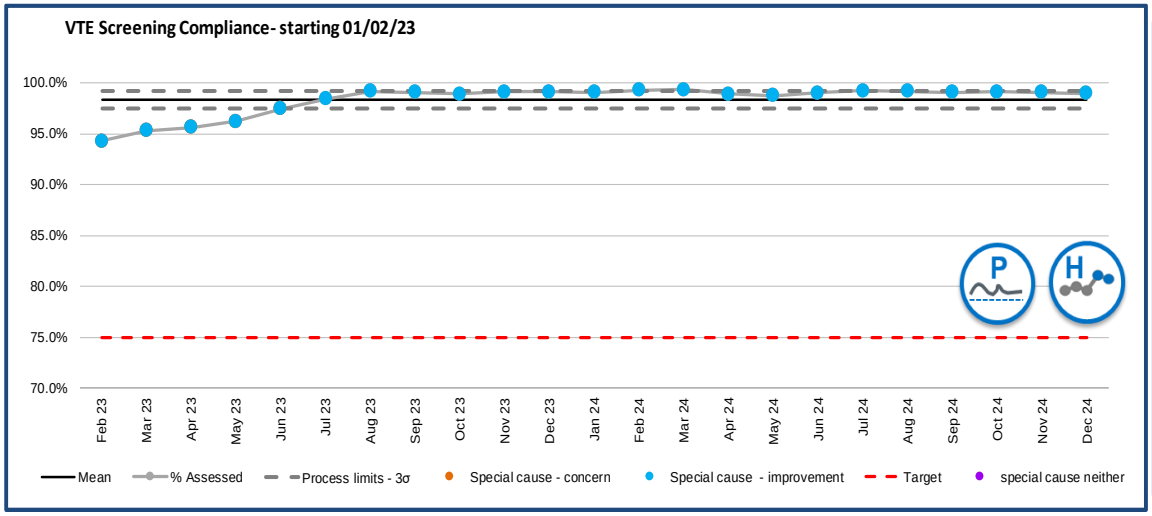
- Short term recovery plan for sleep studies using bank continues. Plan to commence respiratory in CDC before end of March.. Increased staffing and additional equipment will provide extra capacity.
- Cardiology and Imaging working in collaboration to increase capacity. This includes potential to increase number of unsupervised slots at RHH and consider number of additional supervised lists to support MRI and CT pressures. Apps training mid February and job plan review will provide additional capacity on new CDC CT scanner at Guest. RWT are able to provide mutual aid for very small volume of patients and this will commence in February. NOUS performance impacted primarily by head and neck and gynae. Return of Sonographer led head and neck lists will reduce reliance on consultant led lists. Additional consultant led lists are being scoped.
- Diagnostic performance is reviewed with NHSE on fortnightly system tiering call.
- A trajectory has been developed to reduce 13 week breaches to zero by end of March 2025.

DM01 Benchmarking



Source: Imaging Cardiology CRIS Dashboard - Power BI

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



Latest Month	Latest Month	Latest Month
98.9%	98.9%	99.0%
Trust overall Position	**Medicine & IC**	**Surgery, W & C**

Performance

VTE performance sustained above the standard of compliance in consecutive months since March 2023.

Action

Ward level reporting is available, and this is being monitored as part of the ward performance reviews.

Screening Programmes

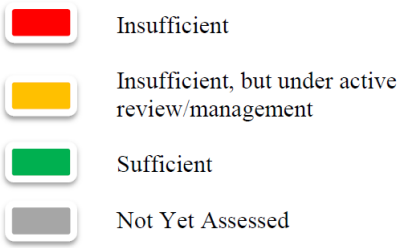
Screening Programme Performance for IPR (F&P)

Description	Comments	Reference	Target	Q1	Q2
NHS Abdominal Aortic Aneurysm Screening Programme (AAA) 2023/24 (@ ICB level)	Percentage of abnormal screens reviewed ≤ 21 days of the initial screen date within the reporting period.	AAA-S12	Acceptable: ≥60.0% Achievable : ≥95.0%	16.67%	29.41%
NHS Breast Screening Programme 2023/24 (@ ICB level)	The proportion of eligible women who have a technically adequate screen less than or equal to 6 months from date of first offered appointment	BSP-S03a	Acceptable: ≥70.0% Achievable : ≥80.0%	69.00%	77.00%
NHS Colposcopy Intervention/treatment 6 week appointment 2023/24	Proportion of women who are offered a colposcopy within 6 weeks of referral due to a positive HR-HPV test and negative cytology OR borderline changes or low-grade dyskaryosis.	CSP-S11	>=99% Green <99% Red	87.00%	100.00%
NHS FASP Trisomy screening 2023/24	Indequate samples for Downs/Edwards/Patau screening a) Combined samples	FA4	To be Set	0.70%	1.20%
NHS FASP Trisomy screening 2023/25	Indequate samples for Downs/Edwards/Patau screening a) Quadruple samples	FA4	To be Set	0.70%	2.00%
NHS Infectious Diseases in Pregnancy Screening 2023/24	The proportion of pregnant women eligible for human immunodeficiency virus (HIV) screening for whom a confirmed screening result is available at the day of report	ID1(IDPS-S01)	>=99% Green 95%-99% Amber <95% Red	99.80%	99.90%
NHS Infectious Diseases in Pregnancy Screening 2023/24	The proportion of pregnant women eligible for hepatitis B screening for whom a confirmed screening result is available at the day of report	ID3(IDPS-S02)	>=99% Green 95%-99% Amber <95% Red	99.80%	99.90%
NHS Infectious Diseases in Pregnancy Screening 2023/24	The proportion of pregnant women eligible for syphilis screening for whom a confirmed screening result is available at the day of report	ID4(IDPS-S03)	>=99% Green 95%-99% Amber <95% Red	99.80%	99.90%
NHS FASP Fetal Anomaly scan 2023/24	The proportion of pregnant women eligible for NIPT screening for whom a conclusive screening result is available at the day of report.	FASP NIPT-S01	Thresholds are not set for this metric	81.00%	80.00%
NHS Sickle Cell and Thalassaemia screening 2023/24	The proportion of pregnant women having antenatal sickle cell and thalassaemia screening for whom a screening result is available ≤10 weeks + 0 days gestation	ST2	>=75% Green 50%-75% Amber <50% Red	43.20%	50.10%
NHS Newborn Blood Spot screening 2023/24	The proportion of first blood spot samples that require repeating due to an avoidable failure in the sampling process	NB2 (NBS-S06)	<=1% 1%-2% Amber >=2% Red	0.80%	1.00%
NHS Newborn Hearing Screening 2023/24	Coverage	NHSP-S01 & KPI NH1	>=99.5% Green 98%-99.5% Amber <98% Red	98.50%	Not Yet Available
NHS Newborn and Infant Physical Examination screening 2023/24	Coverage	ANNB NIPE NP1	>=97.5% Green 95%-97.5% Amber <95% Red	96.60%	95.90%
NHS Newborn and Infant Physical Examination screening 2023/24	Timeliness	ANNB NIPE NP3	>=95% Green 90%-95% Amber <90% Red	85.20%	91.40%
Child Vision screening commenced in September				Not Yet Avaialble	

Kitemark Explanation

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

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



Click HERE for full kitemark explanation & policy

Quality KPIs
February 2025 Report (January 2025 Data)

Martina Morris Chief Nurse
Dr Julian Hobbs Medical Director

The Dudley Group
NHS Foundation Trust

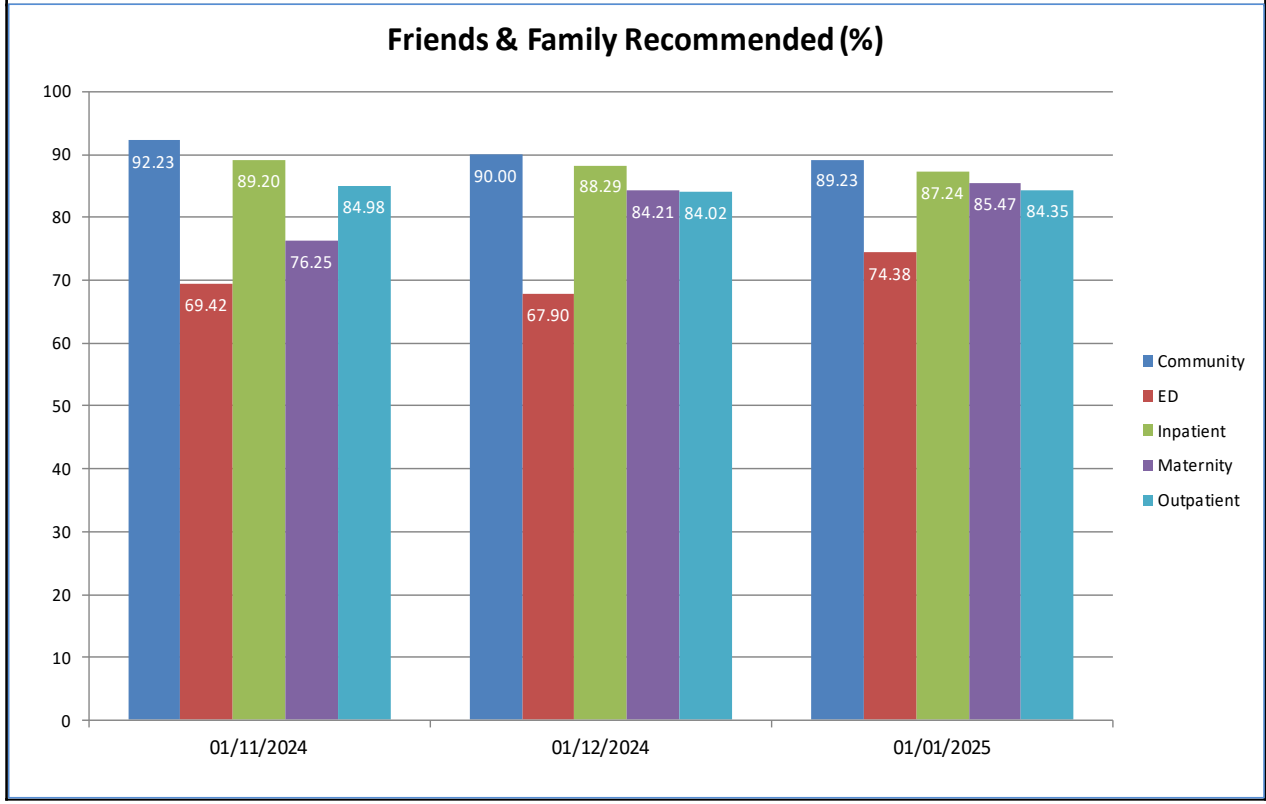
CARE
RESPECT
RESPONSIBILITY

Contents / Icon Key

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	January 2025
Trust Performance	See Graph
Performance Target / KPI	Above national average/% positive scores are increasing



What are the charts showing us

Overall, 83% of respondents have rated their experience of Trust services as 'very good/good' in January 2025, an improvement of 2% since December 2024. A total of 6% of patients rated their experience of Trust services as 'very poor/poor' in January 2025, an improvement of 1% from the previous month (7%).

In December 2024/2025, the A&E Department received the lowest percentage score for patients rating their overall experience as 'very good/good' at 74% in January 2025, however this score has seen an improvement since December 2024 (68%). The percentage 'very poor/poor' scores for the A&E Department remain the highest of all departments at 13%, a decrease of 3% since the previous month. Community services received the highest positive ratings this month at 89%, a recurring theme from the previous month. There were no patients who rated their overall experience as very poor/poor in the Maternity Department.

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

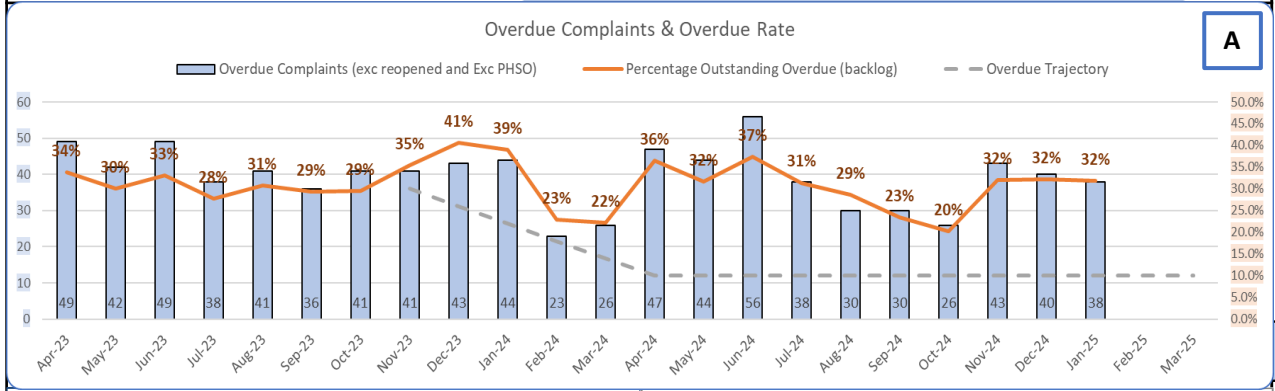
Key Points to Note

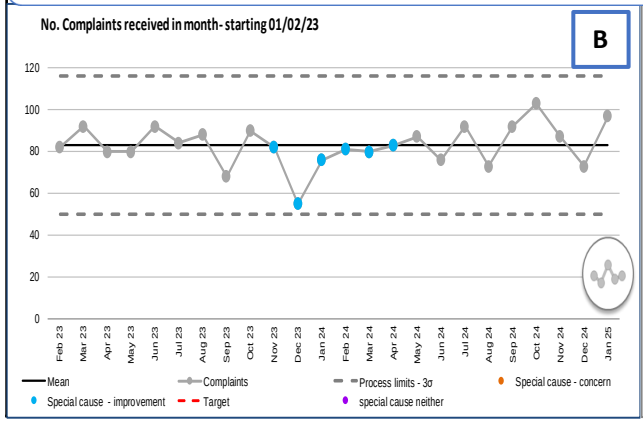
The improvement in overall positive scores for the Trust in January 2025 and a 6% improvement in percentage positive scores for the A&E department.

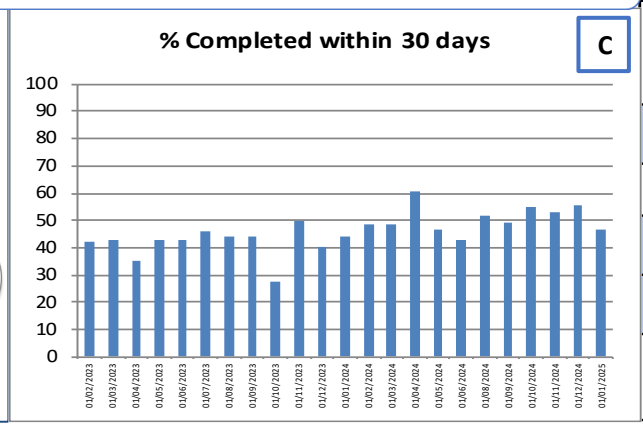
Complaints

Background	*Monitoring compliance against complaint responses*

Performance	
Date	January 2025
Trust Performance	A) 38 & 32% B) 97 C) 46.9%
Performance Target / KPI	49.3% against KPI of 90% response rate







What are the charts showing us

In January 2025, PALS received 312 concerns, 12 comments and 152 signposting contacts totalling 476 compared to 338 in December 2024. The main theme being appointment delays and cancellations.

The Trust received 97 new complaints in January 2025 compared to 73 for December 2024. Of the 97 complaints received, all were acknowledged within 3 working days. The main theme for complaints for January 2025 was communication.

In January 2025, the Trust closed 114 complaints compared to 93 in December 2024. All complainants are given a 30-working day timeframe. Of those 114 closed, 51 (44.7%) were closed within 30 working days. Not including re-opened complaints and Ombudsman cases, there were 98 complaints closed (first response) and of those 98 complaints, 46 were within 30 working days (46.9%), which is an increase of 8.8% on last month's response rate of 55.7% (first response complaints). The Trust is not attaining its 90% response rate KPI.

As of 31 January 2025, there were 147 complaints open in total (this includes reopened complaints and Ombudsman cases) with 66 in backlog (44.8% in backlog). There were 119 complaints open (excluding reopened complaints and excluding Ombudsman cases) with 38 of those in backlog 31.9%). Of those 119 complaints; 14 are local resolution meetings, 11 are with complaints (including those in the final stages of review), 94 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

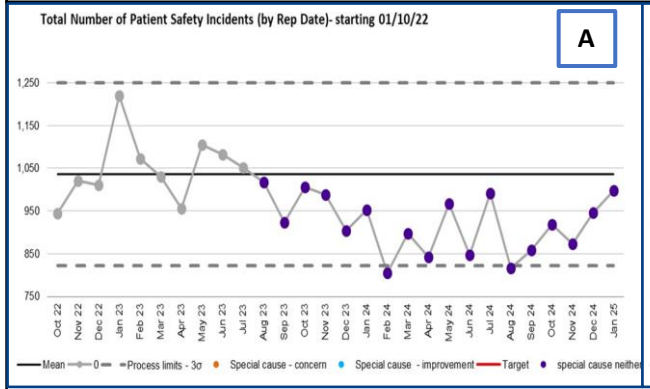
Key Points to Note

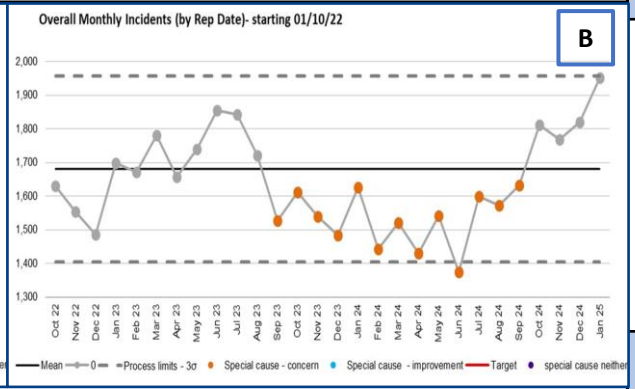
There is a slow increase in the response rate each month.

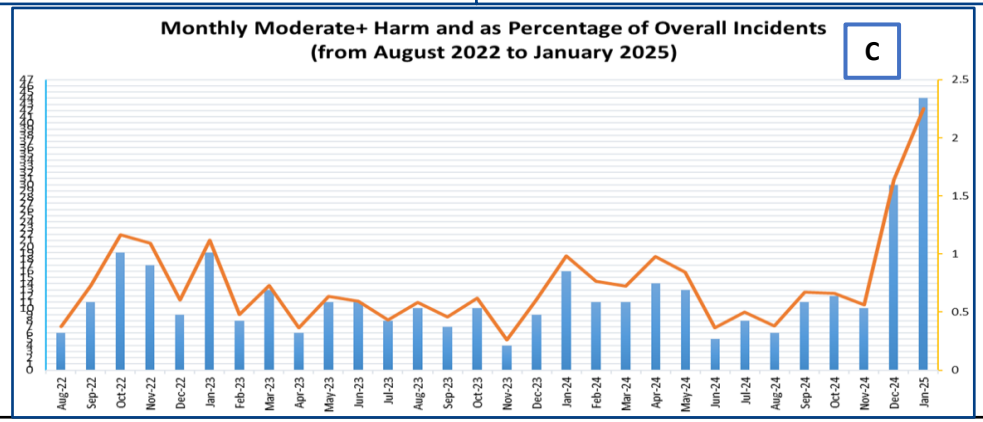
Incidents

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

Performance	
Date	January 2025
Trust Performance	A) 998 B) 1952 C) 2.25% (44)
Performance Target / KPI	N/A







What are the charts showing us

The overall number of incidents and patient safety incidents reported in January has continued to increase; the monthly number of patient safety incidents is slowly increasing but remains below the rolling average but within expected limits/natural variation.
The number of incidents reported to result in significant harm (moderate/severe/death) has **increased** during December. Harm levels in the reporting month (January) **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 January.

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 has now returned to similar levels s reported pre LfPSE transition however this will be closely monitored to ensure a sustained improved position. 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 sustained impact of this work. It is important to note that the downward trend initially seen post transition is apparent across the system and wider NHS and was not unique to Dudley Group.
The proportion of incidents resulting in significant harm remains low how there was an increase in the percentage and number of incidents resulting in significant harm during December. This mainly pertains to an increase in the number of falls and pressure ulcer incidents resulting in significant harm (please see latter sections of this report)
Harm levels in January are still under review at the time of reporting and will be refreshed in the next report

Mitigations / Timescales / Blockers

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.
The Trust have improvement groups aligned to Falla and Pressure Ulcers and are reviewing and up-dating improvement plans in accordance the findings of PSIRF responses.

Risk Register

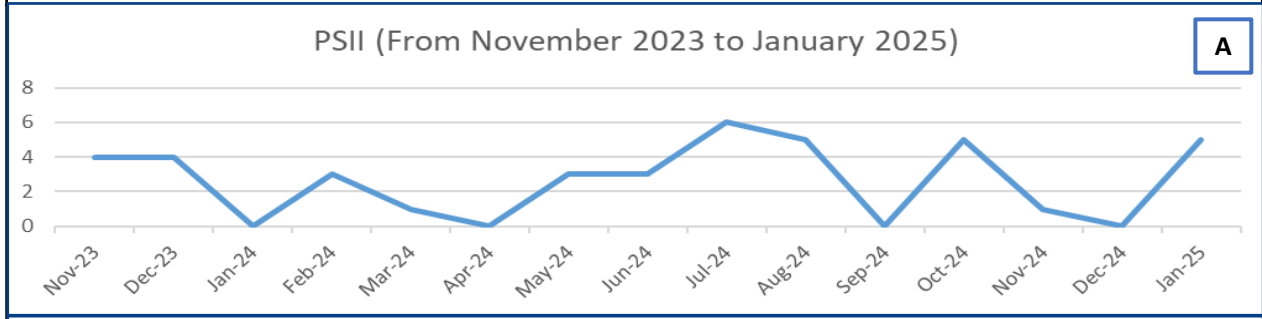
N/A

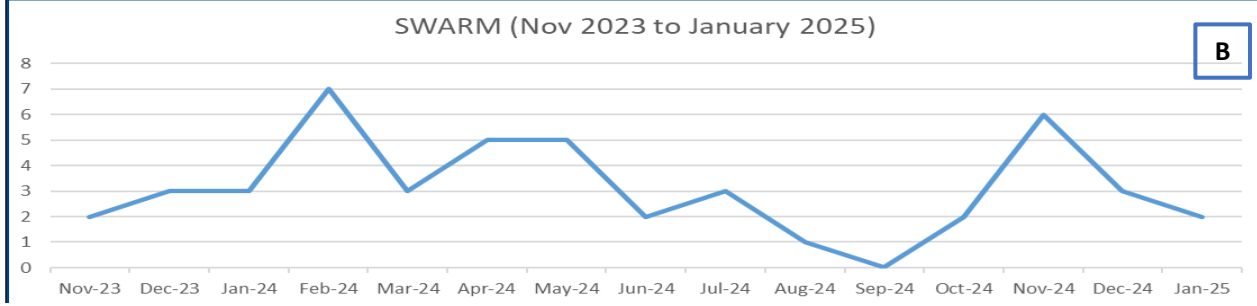
Key Points to Note

Incidents

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

Performance	
Date	January 2025
Trust Performance	A) 5 B) 2
Performance Target / KPI	N/A





Doc Compliance (12 Months)	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Total
Compliant	18	10	10	11	6	10	7	3	11	8	16	19	129
In Progress												3	3
Total	18	10	10	11	6	10	7	3	11	8	16	22	132

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 5 new PSII/ full investigations launched in January. The monthly numbers are consistent with natural variation.

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 2 new Swarm reviews commissioned in December; a decrease in reporting.

Statutory duty of candour compliance is being closely monitored to ensure appropriate enactment can be evidenced. There are no breaches in the regulation however at the time of report writing there are 3 incidents where the notification is in progress. These have been appropriately chased and escalated vis the Governance Framework

Areas Impacting on Compliance

The numbers of responses launched monthly appear to be fluctuating in line with natural variation and there are no significant trends in terms of numbers.
In terms of trends in relation to areas/services, cases reviewed at the Incident Decision and Learning Group appear to align to known priority areas for improvement., namely Gynaecology and paediatrics. These areas have single improvement plans that are currently under review

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.

Risk Register

nil

Key Points to Note

nil

Safer Staffing - Dashboard

Date	January 2025

Safer Staffing Summary Jan — Days in Month 31

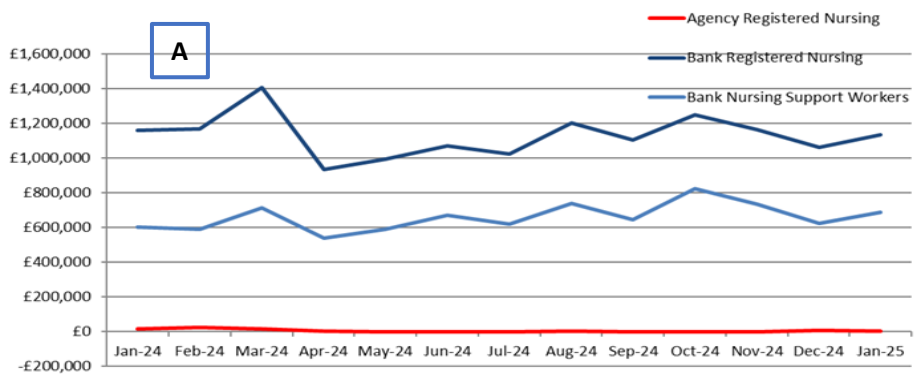
Ward	Day RN Plan	Day RN Actual	Day CSW Plan	Day CSW Actual	Night RN Plan	Night RN Actual	Night CSW Plan	Night CSW Actual	RN Day %	CSW Day %	RN N %	CSW N %	Sum 24:00 Occ	Actual CHPPD Registered	Care staff	Total
B1	127	101	63	59	62	62	51	49	79%	93%	100%	96%	418	4.43	2.96	7.39
B2(H)	124	107	194	184	93	87	184	176	86%	95%	94%	96%	734	3.17	5.75	8.92
B2(T)	124	109	131	114	93	82	115	106	88%	87%	88%	92%	725	3.16	3.64	6.80
B3	194	185	205	173	186	179	173	164	95%	85%	96%	95%	1,185	3.61	3.41	7.02
B4	226	182	267	197	187	178	212	185	80%	74%	95%	87%	1,309	3.23	3.50	6.72
B5	253	215	175	143	243	222	111	102	85%	82%	91%	92%	1,136	4.71	2.53	7.24
B6	97	72	80	45	63	58	82	74	74%	57%	92%	91%	492	3.09	2.92	6.02
C1 A	126	131	147	111	93	90	118	112	104%	76%	97%	95%	736	3.51	3.63	7.14
C1 B	129	124	136	122	93	90	99	90	95%	90%	97%	91%	736	3.40	3.37	6.77
C2	283	232	64	70	249	225	63	62	82%	108%	90%	99%	556	9.65	2.79	12.43
C3	217	226	433	370	187	176	417	400	104%	85%	94%	96%	1,605	3.01	5.64	8.65
C4	209	165	74	63	125	92	68	75	79%	84%	74%	110%	675	4.45	2.35	6.80
C5 A	121	106	171	106	93	93	142	133	87%	62%	100%	94%	740	3.26	3.87	7.13
C5 B	162	151	130	102	155	150	101	93	93%	78%	97%	92%	732	4.84	3.20	8.03
C6	97	89	99	79	93	85	72	68	92%	80%	91%	94%	574	3.57	3.08	6.65
C7	218	166	194	179	156	147	189	178	76%	92%	94%	94%	1,097	3.35	3.91	7.25
C8	259	246	226	181	217	200	186	171	95%	80%	92%	92%	1,324	3.95	3.19	7.13
CCU_PCCU	256	238	70	47	218	214	40	31	93%	67%	98%	78%	768	6.91	1.21	8.13
Critical Care	525	452	124	87	527	465			86%	70%	88%		540	20.37	1.93	22.30
AMU	551	525	465	398	498	530	468	451	95%	86%	106%	96%	2,468	5.02	4.13	9.15
Maternity	852	795	262	189	527	515	156	142	93%	72%	98%	91%	1,391	9.01	2.79	11.80
MECU	93	91	34	27	93	92			98%	80%	99%		225	9.76	1.34	11.10
NNU	389	258			268	225			66%		84%		314	18.40	0.00	18.40
TOTAL	**5,630**	**4,965**	**3,743**	**3,044**	**4,519**	**4,255**	**3,047**	**2,863**	**88%**	**81%**	**94%**	**94%**	**20,480**	**5.19**	**3.43**	**8.61**

Safer Staffing

Background

Performance	
Date	January 2025
Trust Performance	A) B)
Performance Target / KPI	N/A

A



A - Bank Usage

B – Top 10 depts. using Bank & Agency, Jan 2025

Area	Nursing Vacancy %	Agency Registered Nursing	Bank Registered Nursing	Bank Nursing Support Workers	Grand Total
Discharge Lounge	10%	£0	£92,401	£56,141	£148,542
Emergency Department Nursing	13%	£0	£102,157	£39,820	£141,977
Ward AMU 2	-5%	£0	£52,408	£29,820	£82,227
Ward AMU 1	9%	£0	£44,744	£36,506	£81,250
Theatres Weekend Lists		£0	£55,745	£21,271	£77,017
I.T.U.	-5%	£0	£66,224	£7,422	£73,646
Ward C8	10%	£0	£36,780	£34,841	£71,621
Ward B4	5%	£904	£34,477	£27,744	£63,126
Ward C7	5%	£0	£31,597	£30,952	£62,549
Ward AMU Assessment	25%	£0	£32,057	£24,318	£56,375

What are the charts showing us

- Safe staffing % and CHPPD both up marginally in Jan25 compared to Dec 24.
- Chart A - note increase in bank costs for registered nursing and support workers back to usual levels in Jan25.
- Table B - Note Agency expenditure below relates to prior period usage (Oct22 on B4). There remains no nursing agency being used in recent months

Areas Impacting on Compliance

Unfunded additional capacity in discharge lounge (fully bedded), super surge (26 beds), AMU 1&2 10 additional beds.
In response to 45-minute ambulance handover, 4 additional beds open in ED Imaging.

Mitigations / Timescales / Blockers

Aim to close additional beds by March 2025.
Trust wide rota to assist with staffing these areas.
Lack of social care to facilitate discharge of medically fit patients
7-day census for a focus around discharge

Risk Register

Key Points to Note

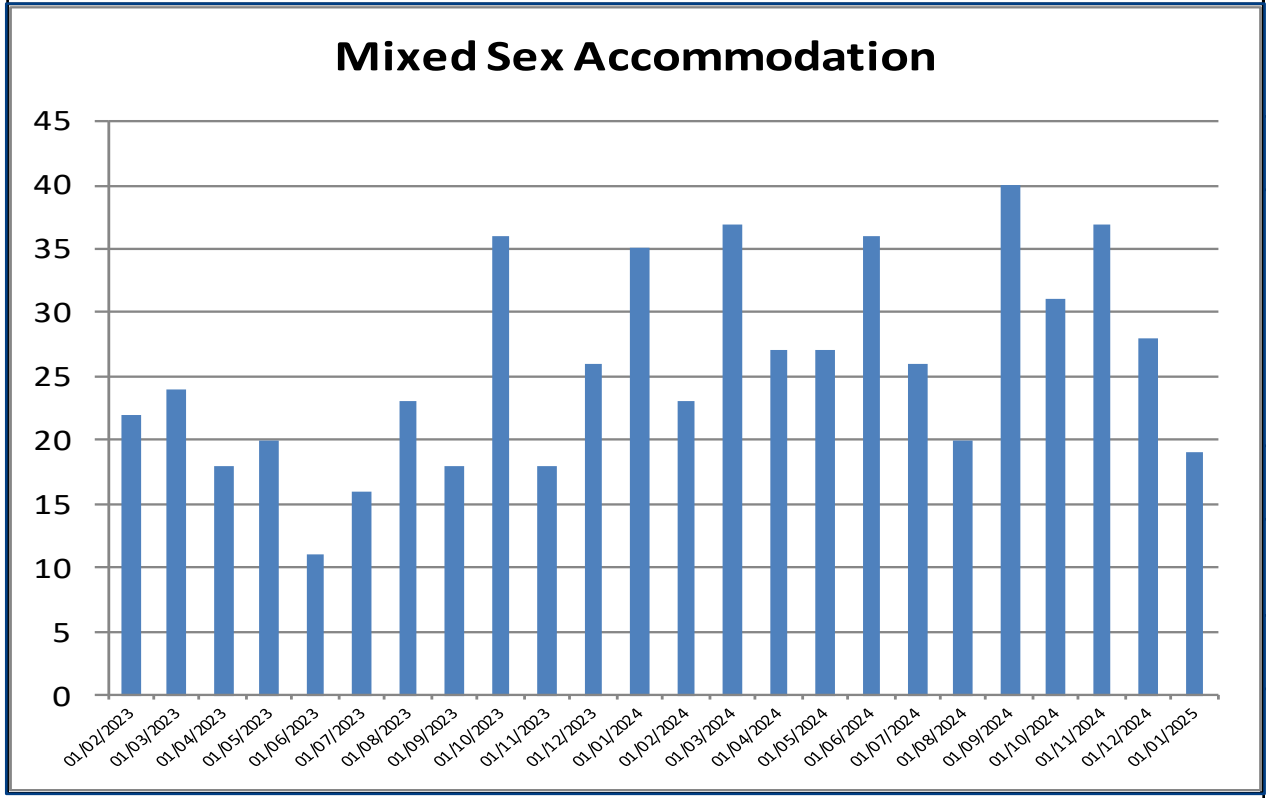
- Additional capacity impacting on Lead Nurses and Matrons having to work clinically 2 days per week.
- Temporary Escalation SOP (TES) has been approved at Q&S Group.
- Working with the divisions to review the impact of red flags generated on the safer care tool, to patient care and staffing numbers

- **Recruitment and Retention of staff**
- We have recruited 41 out of the 51 nursing graduates who qualified in September, even with reduction of vacancies available
- Of the 399 nurses/midwives recruited as part of the international recruitment programme, we have had only 20 nurse's leave the trust, giving us a retention rate of 95%

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	January 2025
Trust Performance	19
Performance Target / KPI	0



What are the charts showing us

There were 19 mixed sex breaches in January 2025, which although an improvement on the previous month, continues to be a significant number of reported breaches.

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

Critical Care have reviewed their previously archived SOP for managing mixed sex breaches. The management detail from this has been added to their operational policy, so it is confirmed there is no need for the SOP to be reactivated.

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

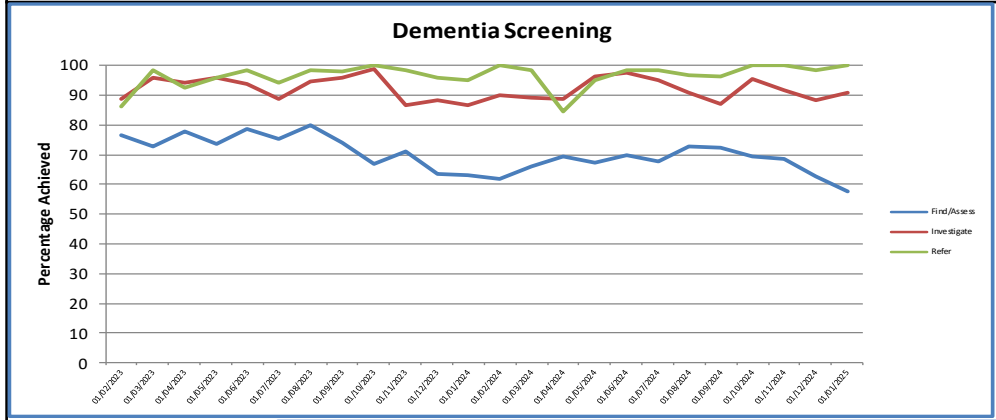
Key Points to Note

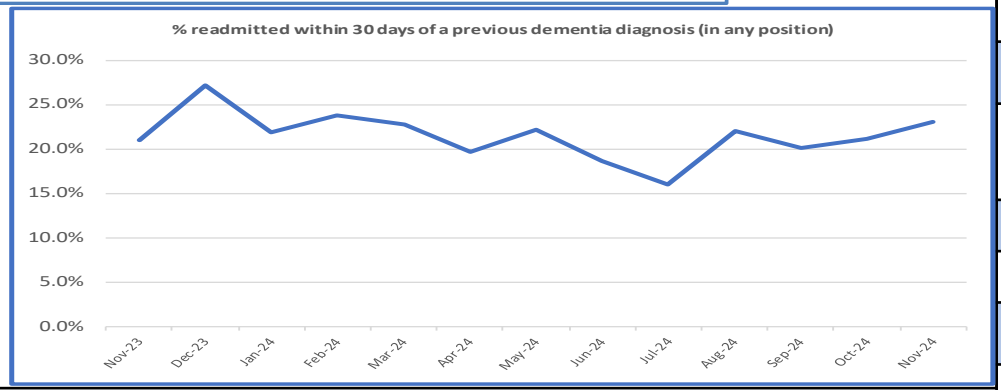
This is impacted by the high number of wardable patients on the unit making cohorting in bays challenging.

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	January 2025
Trust Performance	Find) 57.61% / Investigate) 90.91% / Refer) 100%
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 inpatient staff using the AMT4 and the subsequent investigation and referral by the dementia and delirium team using the FAIR process. Following another data review, it has been identified that the work completed in May 2024 to review data, has provided assurance that compliance levels are being reached. However, this data was not being pulled into compliance reports. **Compliance rates for January 2025 are 97%. Assess and Investigate is 66% and Refer is 100% as per the new data sweep.** This will be evidenced in future reports as the previous 12 months of data consistently indicates that Find data is 90% or higher. **The new data was not able to be pulled into this report, hence old, inaccurate data is being displayed on the chart.**

The second chart shows the number of patients with dementia who were readmitted within 30 days of discharge. The latest available data is for November 2024 where there is an increase in line with winter months.

Areas Impacting on Compliance

The Dementia and Delirium Team are working at reduced capacity, which is in line with Investigate levels as they do not have the ability to respond to every referral before they are discharged. Despite this, the patients that they do work with have a high level of input regarding support and referral.

As part of the wider work around trying to resolve the compliance data, the communications team are going to share within the Trust a Patient Safety Bulletin and screensaver regarding dementia screening. The high-level presence of dementia, the need to screen and diagnose early and staff to understand the process remains valid and an important area to be raised.

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. November data 2024 is a little higher than for November 2023.

Mitigations / Timescales / Blockers

A Band 4 Nursing Associate post has been recruited to. Start date is pending the external examination board confirming completion of passing the course. The Admiral Service is in the process of development with a soft launch process, building across the acute hospital wards.

Risk Register

Key Points to Note

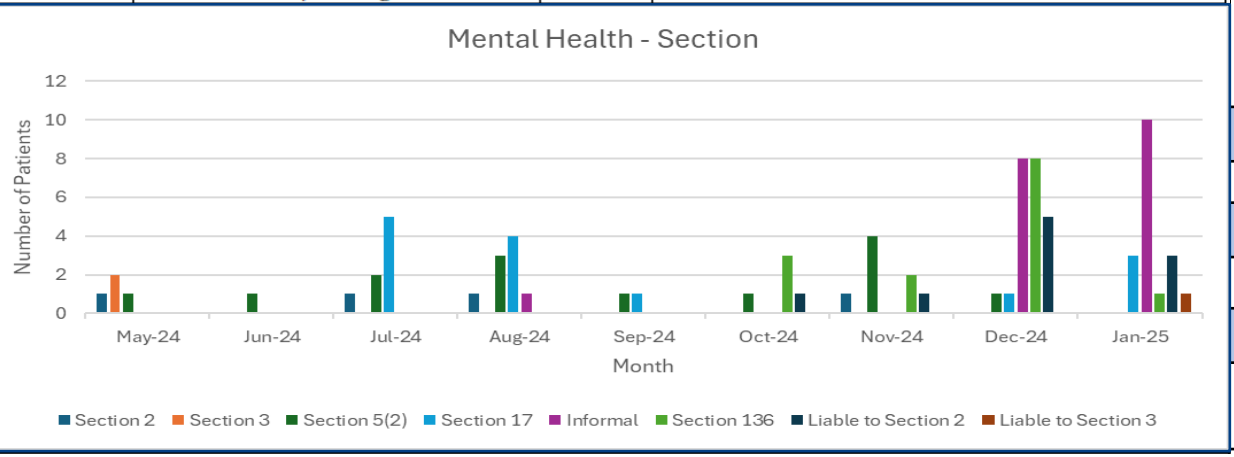
Query if the August doctor rotation impacts on readmission rates.

Mental Health

Background

Performance	
Date	January 2025
Trust Performance	
Performance Target / KPI	CQC compliant

Date of Admission	Section (Locate details C/O Rio if not on Sunrise and upload docs to Sunrise)	Amount	Comments
Jan-25	17 from external Trust	3	x1 s17 leave was incorrect and not rectified. 2x patients discharged prior to requesting leave
Jan-25	Section 136	1	
Jan-25	Liable to section 2	3	
Jan-25	Liable to Section 3	1	
Jan-25	Informal in ED pending admission	10	



What are the charts showing us

There have been no patients detained to DGFT during January 25.
There has been MHA activity from patients visiting the acute hospital as 3 patients were on section 17 leave from MH units.
ED has MHA activity as there were 3 patients liable to section 2 and 1 patient liable to section 3, all would become active MHA detentions when a mental health bed is identified, and they are admitted to that unit.
There has been a reduction in 136 activity as there was only 1 recorded for January 2025.
Section 136 and liable to detention data has only been recorded formally from December through manually reviewing ED MH activity data and development of databases from Sunrise data.

Areas Impacting on Compliance

There are concerns that not all patients on section 17 leave to the acute hospital are being captured as they are not being reported as standard. They are identified either by chance, when manually reviewing ED data or the occasional Datix.
A Trust screensaver has been in place for December 2024 to highlight the need to report all MHA activity.
MHA awareness training for all staff in Trust is available weekly. Section 5(2) bite size training is available daily and has been advertised via In the Know and Mental Health Hub Page. It is accessed via a QR code and so pre-booking does not need to take place for section 5(2) training. Attendance for this training has been very low, often with no staff attending.
The new MHA policy has been ratified and live. The new MHA SOP is live as of 11.01.25. The documents need to be shared and advertised to ensure that staff become aware of the new processes. The new 135 SOP is also pending ratification before this is live.

Mitigations / Timescales / Blockers

Risk Register

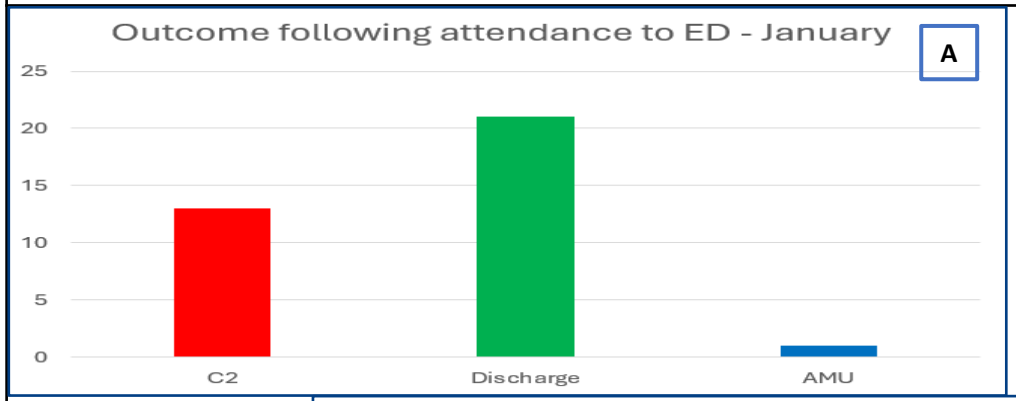
Key Points to Note

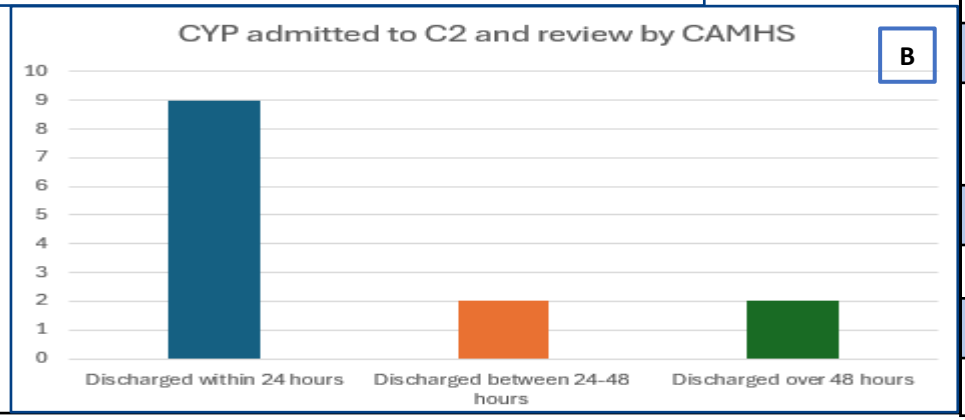
MHA data and how to identify this from patient activity is under constant review and development to ensure maximum transparency of this activity.

Mental Health - CYP

Background

Performance	
Date	January 2025
Trust Performance	A) C2, 13 D/C,21 AMU,1 B)<24,9 24-48,20 >48,2
Performance Target / KPI	CQC compliant





What are the charts showing us

During January 2025, 35 children with mental health concerns attended the Trust. Of which, 21 CYP were reviewed within ED and discharged. Out of the remaining 14, 13 were admitted to C2 and 1 admitted to AMU. ED were able to discharge 21 CYP when they were medically fit, who did not require admission to the Trust. There were no self-discharges during January. There were no children detained under the MHA to the Trust. C2 saw 13 CYP being admitted following review within paediatric ED. There were 9 CYP that were discharged within 24 hours of admission, 2 CYP remained on the ward for 24-48 hours, and 2 remained admitted for over 48 hours.

For children that required an admission for over 48 hours, one was due to treatment for an overdose and the other delay was due to family dynamics. All CYP were reviewed by CAMHS when they were medically fit and discharged home with a follow up appointment. The children that have been discharged from C2 went to their usual place of residence. All CYP that attended either had a referral or were known to CAMHS.

Areas Impacting on Compliance

January has seen a 51.4% increase in the number of patients that have attended compared to December. It is unclear as to why the number of attendees has increased again. It may be due to returning to school after the Christmas break and the start of revision for GCSE exams. There is also home/family life to take into consideration. Reasons for CYP attending included deliberate self-harm, overdose, suicidal ideation, hallucinations and low mood.

Mitigations / Timescales / Blockers

With the monitoring of the out of area attendances, Sandwell patients are continuing to have a greater representation within the Trust. This may be due to RHH being closer to patients' homes then the new 'MET' hospital that has been built.

Risk Register

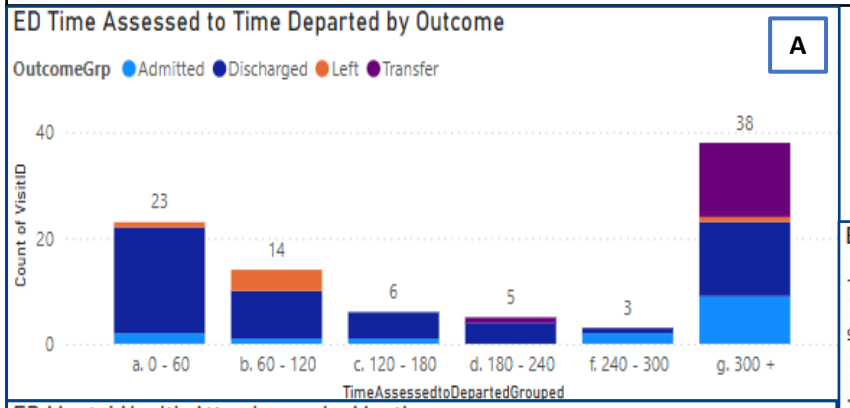
Key Points to Note

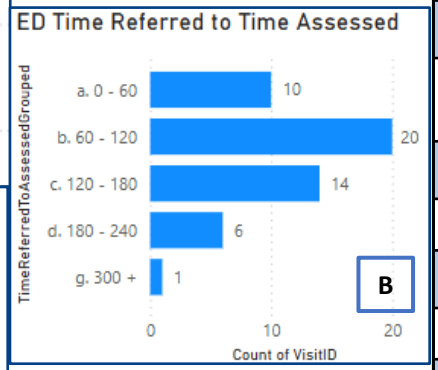
There were no MHA detentions to the Trust and no CYP requiring a tier 4 bed.

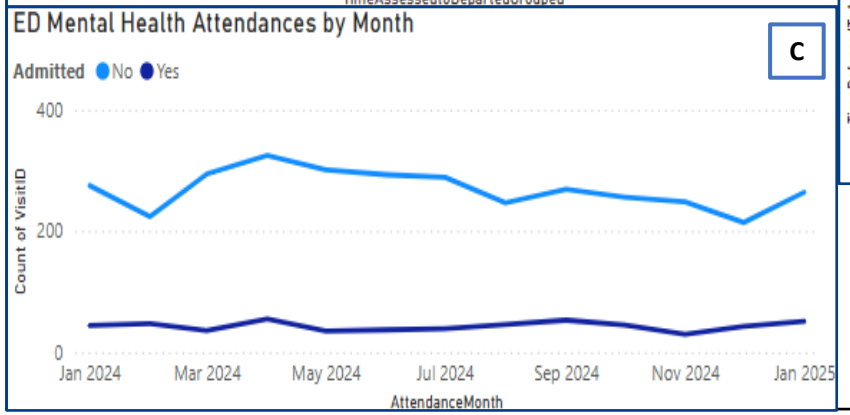
Mental Health - ED

Background

Performance	
Date	January 2025
Trust Performance	A) B) C)
Performance Target / KPI	CQC compliant







What are the charts showing us

During January 2025, ED mental health activity indicates a small increase in the number of patients that require admission as well as those discharged from ED. There was more MH activity In January than during the previous 3 months, but less than during January 2024.
The number of patients requiring transfer and admission to a MH unit from ED is largely consistent.
In terms of the length of time that patients remain in ED awaiting a MH bed to be admitted to does vary. Extremes over January have included lengthy waiting times of note, the greatest being 2 patients waiting over 70 hours, 1 patient over 59 hours, 1 patient over 44 hours, 2 in excess of 25 hours and another waiting over 20 hours. This applies to patients who are awaiting admission informally and patients who are liable to be detained.
Reviewing reasons for why MH patients may be seen by MHLS beyond 1 hours consists of a number of themes, including pending MHA assessments, requiring a medical review, increased wait times during nights shifts, in particular when delays for a medical review and when pending treatment for physical health before patients are assessed by MHLS. Increased wait times are noted during hand over periods and when the team have cited a large number of patients to assess.

Areas Impacting on Compliance

MHLS are contracted to assess patients within 1 hour of referral. 41 patients were seen outside of this timeframe due to the reasons identified above. At times, the delay to assess is minimal.

Mitigations / Timescales / Blockers

January is typically a period of increased mental health crisis, typically following Christmas and New Year.

Risk Register

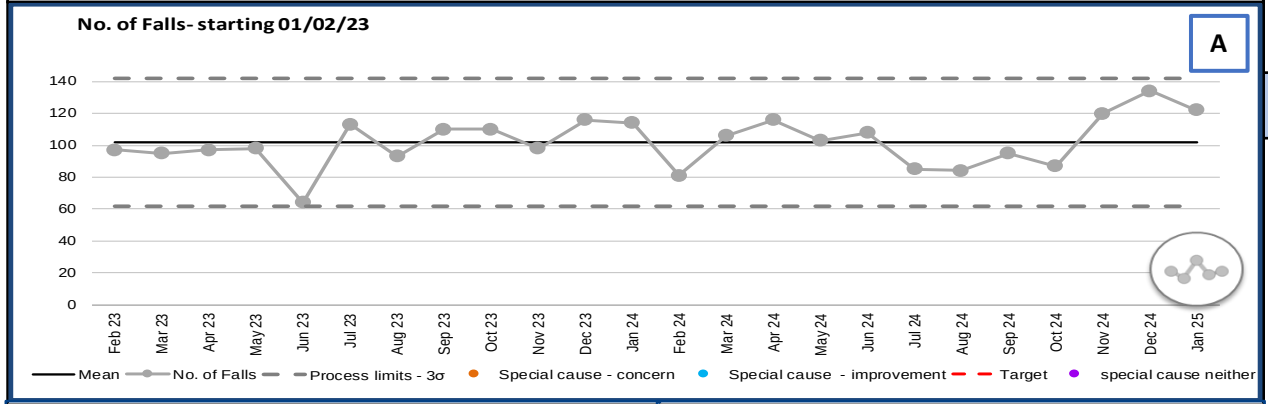
Key Points to Note

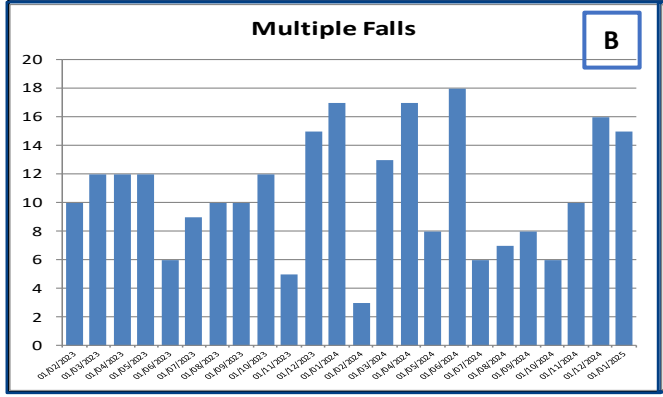
Core 24 identifies that the assessment need for physical and mental health should be a parallel process, and the assessment should commence with MHLS if the patient is accessible to commence this. NICE guidelines identify to not delay the psychosocial assessment until after medical treatment is completed

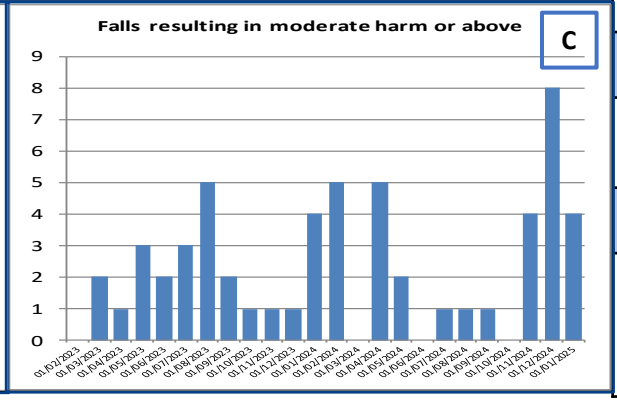
Falls

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	January 2025
Trust Performance	A) 122 B) 15 C) 4
Performance Target / KPI	







What are the charts showing us

The overall number of recurrent and inpatient falls have decreased by 14%-20%. Similarly, the number of moderate harm falls have declined by half in January in comparison to December. The ongoing peak in recurrent falls may be linked to seasonal pressures and additional inpatient occupancy that further impact the staffing levels and capacity.

Areas Impacting on Compliance

Additional capacity and demand
Additional inpatient occupancy

Mitigations / Timescales / Blockers

- Ongoing focus support to ward areas with high risk of falls
- Thematic review 3 in final stages in refining themes and trends
- Mapping back to basic falls training workshops with areas seeing high numbers of falls/ identified learning

Risk Register

There are no risks related to falls

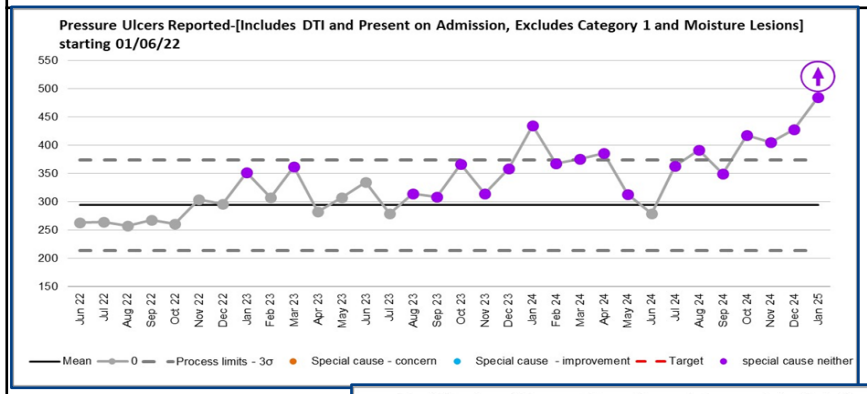
Key Points to Note

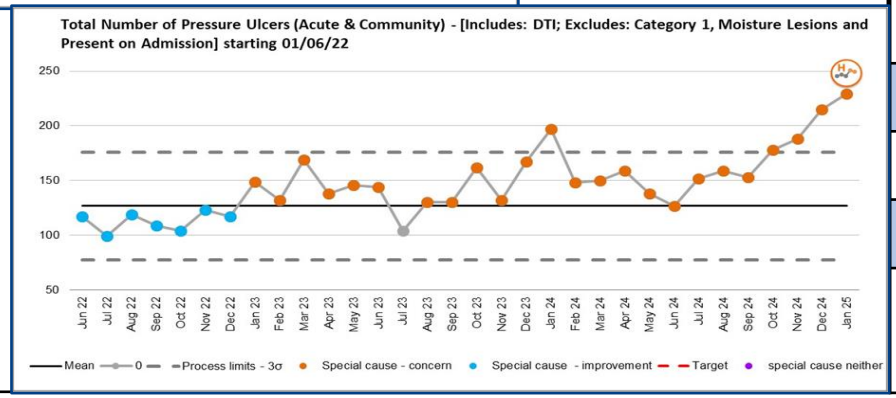
- Dr Duja and Geriatric registers to collaborate with falls in setting an audit to review gaps in multifactorial assessment .
- Regionally, organisations have seen a similar picture regarding increase of falls over winter.

Pressure Ulcers

Background	Trend against pressure ulcer prevention performance

Performance	
Date	January 2025
Trust Performance	See chart
Performance Target / KPI	





What are the charts showing us

There were 229 pressure ulcers acquired under Trust care reported during the period (excludes POA, category 1, 2 and moisture lesions). Of those reported incidents, 66 incidents required a shortened investigation and presentation at the weekly pressure ulcer group.

Areas Impacting on Compliance

Workforce challenges continue with 1 wte on LTS, 1 0.8wte undertaking a phased return .
Overall, January saw another increase in pressure ulcers reported, with community seeing a continual upward trend since November 24.
A deep dive into the change in practice to measure the impact has been done and has confirmed this has not had a negative impact on our patients and or the upward trend in pressure ulcers.
Community colleagues have carried out a deep dive into deep tissue injuries following a period of heightened numbers, no themes or commonalities identified.

Mitigations / Timescales / Blockers

Transition to Purpose T continues although there has been issues with IT requests.

Risk Register

Challenges with workforce to deliver the contract.

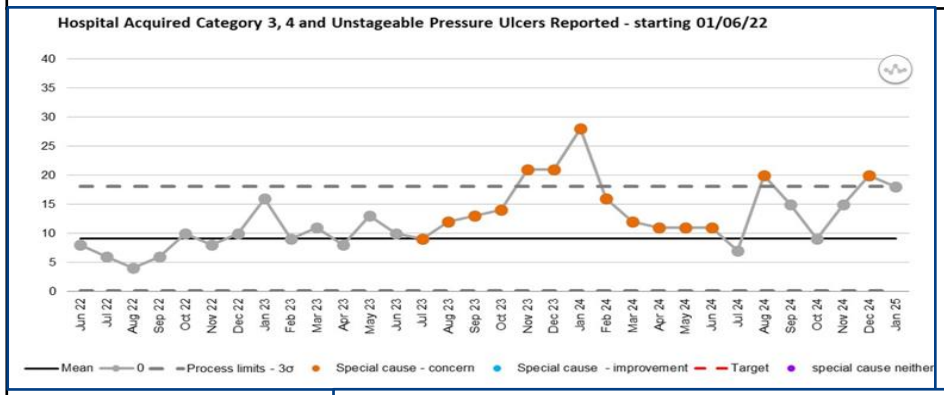
Key Points to Note

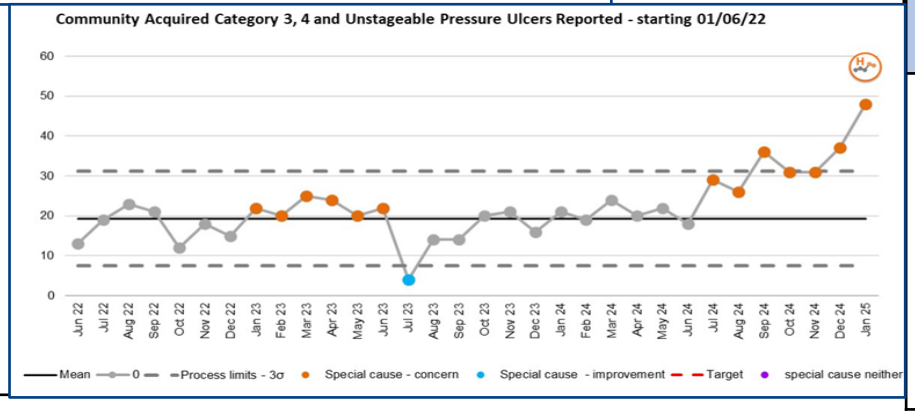
Tissue viability reviewing a 60/40 acute and community support model, to enhance skills, knowledge and management of wounds across all teams.

Pressure Ulcers

Background	Trend against pressure ulcer prevention performance

Performance	
Date	January 2025
Trust Performance	See chart
Performance Target / KPI	





What are the charts showing us

See detail on slide 15

Areas Impacting on Compliance

Workforce challenges.

Mitigations / Timescales / Blockers

As per slide 15

Risk Register

Challenges with workforce to deliver the contract.

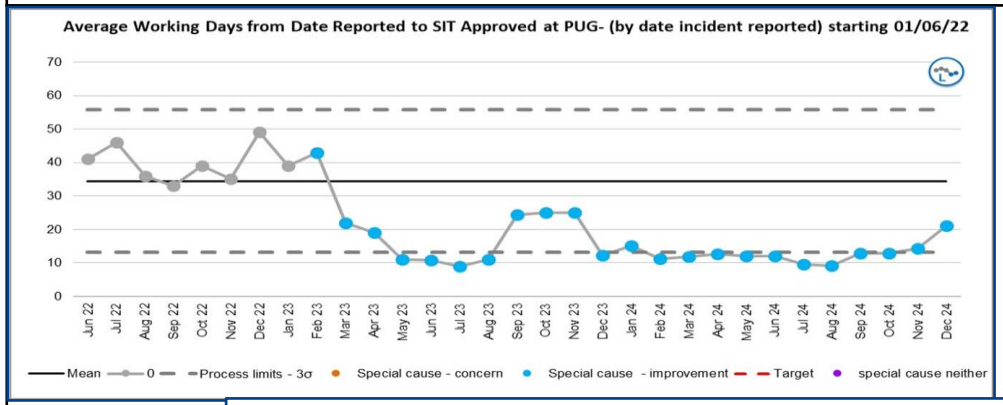
Key Points to Note

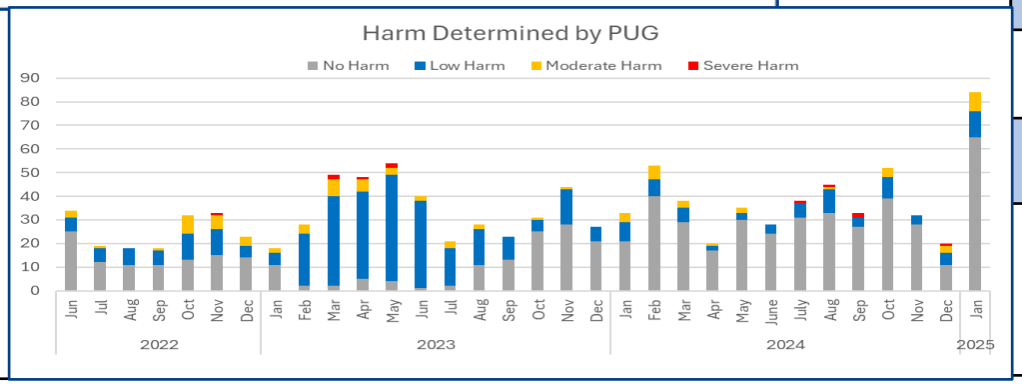
Workforce model continues to be a challenge recorded on the risk register as a 20.
Deep dive being conducted around the continual increase in overspend for community equipment, with a continual increase in demand. Actions in place to manage equipment spend across the Trust. Aiming to create a managed service by October 2025, proposal out to tender with discussions of a combined/ mirrored model to Sandwell. This should create some efficiencies whilst allowing our small team of experts to focus on care provision. Tender for new equipment contract to cover hospital, community and bariatric equipment has been submitted by procurement and published by HTE. Interim contract extension with drive for 6 months to commence April 2025.

Pressure Ulcers

Background	Trend against pressure ulcer prevention performance

Performance	
Date	January 2025
Trust Performance	See chart
Performance Target / KPI	





What are the charts showing us

There is an average of 21 working days between reporting and review of all category 3,4 and unstageable pressure ulcers. This is an increase in the time to review from the previous month caused by the festive period and having to cancel several PUG meetings due to capacity.
There were 84 SITs reviewed in January, it was determined by the group that there were 11 low harm, 8 moderate harm and no severe harm or no harm.

Areas Impacting on Compliance

Workforce challenges across all teams.

Mitigations / Timescales / Blockers

Each reported category 3, 4 and unstageable pressure ulcer is reviewed by the pressure ulcer group to determine level of harm and further work to strengthen the PSIRF model continues.

Risk Register

Risk identified on risk register remains an overall score 20 .

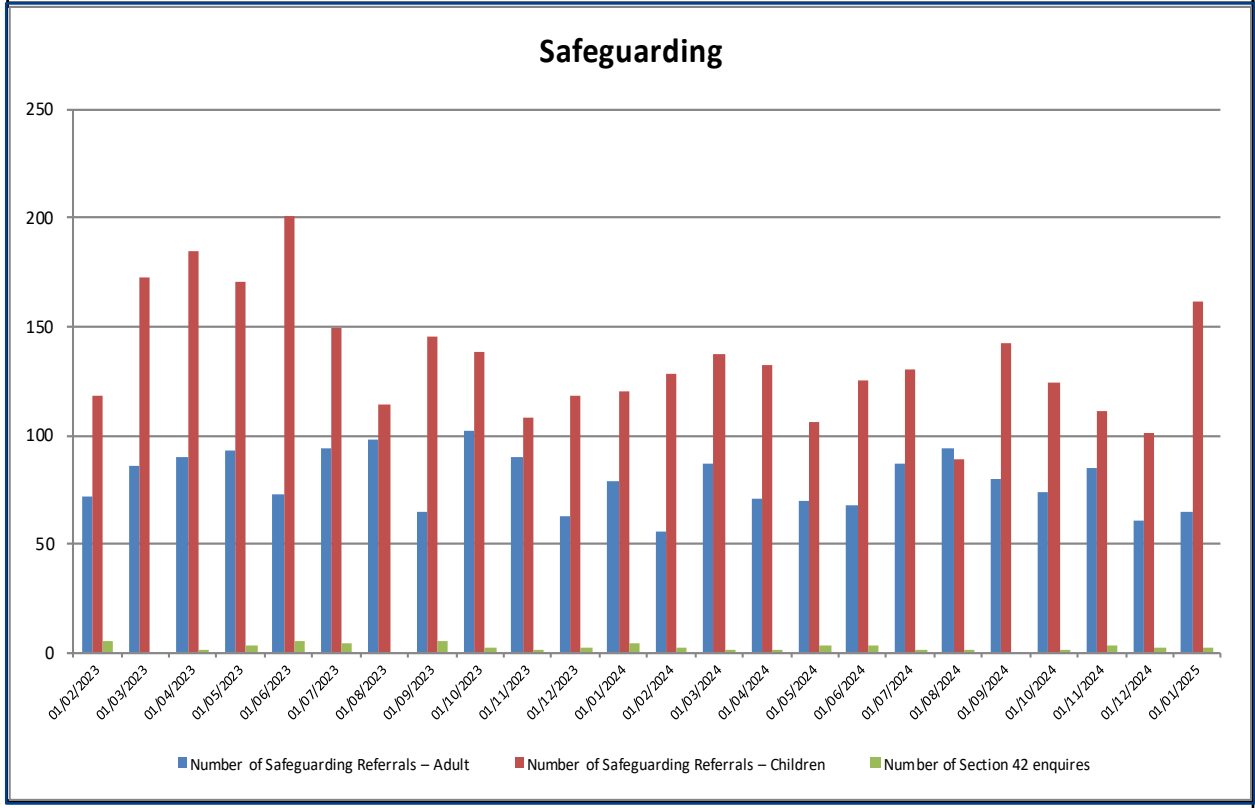
Key Points to Note

As detailed on previous slide

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	January 2025
Trust Performance	Adult) 65 / Children) 161 / Section 42) 2
Performance Target / KPI	



What are the charts showing us

The charts provide information regarding the number of safeguarding referrals for adults and children where staff have recognised potential or actual abuse of adults or children and provides the number of safeguarding enquiries against the Trust regarding standards of our care.

This month has seen a significant increase in safeguarding children's referrals, this could be attributed to children returning to school as we have seen an increase in peer on peer and mental health related referrals. The Safeguarding children's team have also noted an improvement in staff professional curiosity which could also have increased referrals.

There was also an increase in domestic abuse referrals during January which reflects the general trend in reporting of domestic abuse in January. Victims of DA may have delayed seeking help during December due to social or financial dependence on their abuser. The increase could also be a result of the recent DA awareness raising campaign undertaken by the Safeguarding team leading staff to be more proactive in identifying cases of DA.

There have been 2 S42 enquiries caused to the Trust, neither of these enquiries are in relation to care provided in Trust. The concerns raised are around the neglect and acts of omission within 24-hour care placements funding by CHC.

Areas Impacting on Compliance

Whilst contractual compliance set by the ICB is 85% for level 2 and level 3 safeguarding training, the Trust continue to report on a compliance target of 90%. Compliance with both children and adult level 2 and level 3 safeguarding is under both ICB and Trust compliance target.

Mitigations / Timescales / Blockers

Registered Children's nurses and Midwifes receive regular safeguarding supervision and compliance is good at 94% .

Risk Register

New risk has been added relating to staff awareness and actions in identifying victims of domestic abuse. An action plan to improve staff recognition and response to domestic abuse is underway.

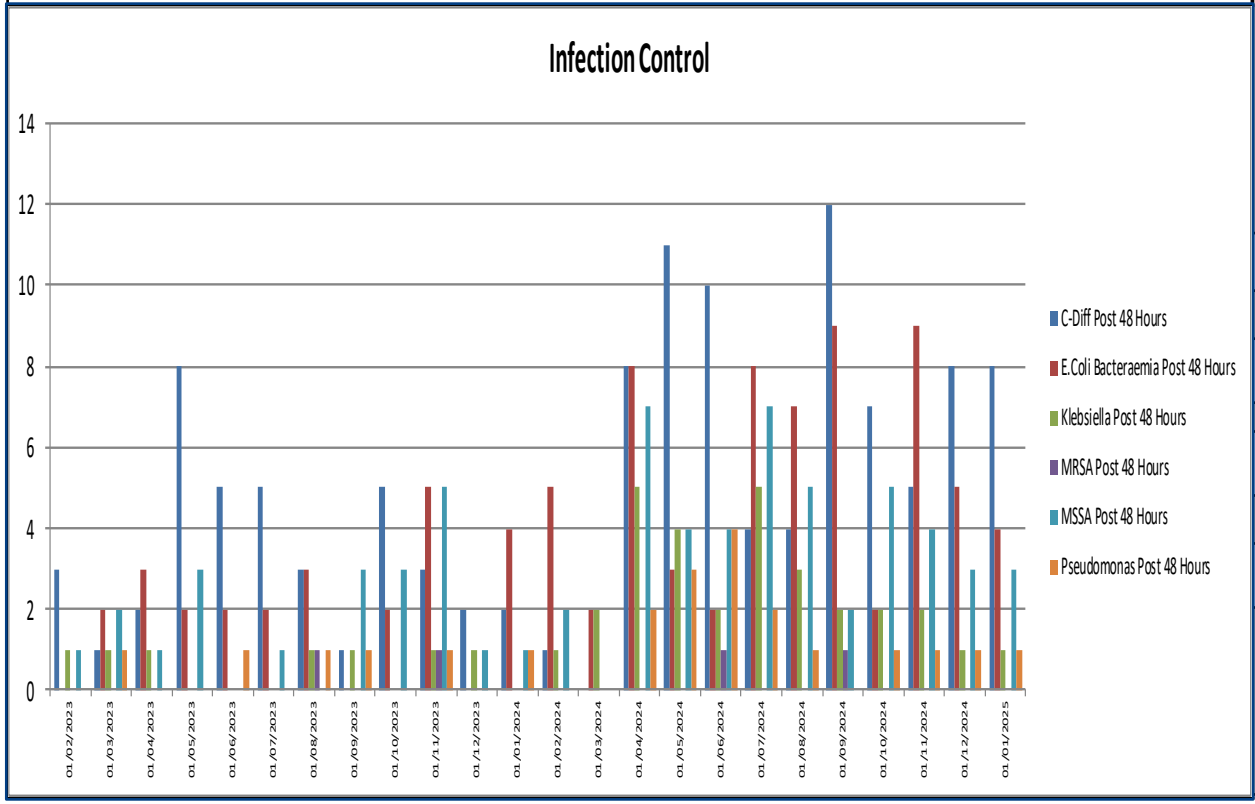
Key Points to Note

The safeguarding team are working with the patient safety team to develop a system for monitoring actions from Section 42 enquiries to support and provide evidence of learning being embedded into practice.

Infection Control

Background	IPC Healthcare Associated Data

Performance	
Date	January 2025
Trust Performance	Threshold reached for MRSA, Kelbsiella and Pseudomonas BSI HCAI infections
Performance Target / KPI	HCAI reportable infections



What are the charts showing us

The Trust has received thresholds from NHSE for 2024/2025 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 two COHA MRSA bacteraemia one in June and one is September 2024. Meetings were held, and learning is being disseminated throughout the Trust.
The trust has reported 8 HOHA cases of CDI and 6 COHA in January 2025 this shows year to date as a total of 83 against a threshold of 73. Threshold increased by NHSE from 42 for 2023/2024. The trust attends the ICB task and finish CDI group. CDI continues to increase nationally. The IPC are currently carrying out a deep dive into CDIs
4 HOHA and 3 COHA cases of E coli BSI. January shows year to date as a total of 66 against a threshold of 75
1 HOHA and 0 COHA cases of *Pseudomonas aeruginosa* BSI. 5 of the COHA cases relate to one patient. January shows year to date as a total of 16 against a threshold of 12. Threshold reduced from 16. A deep dive into the data has shown no themes or trends.
11 HOHA and 1 COHA cases of *Klebsiella spp.* BSI. January shows year to date as a total of 28 against a threshold of 19. Threshold reduced from 24
3 HOHA and 2 COHA MSSA bacteraemia cases but there is no threshold set. January shows year to date total of 46.
The IPC Team only report on COHA and HOHA other areas including COIA and COCA are reported by the ICB

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.

Risk Register

The trust has a risk on the Trust and system risk registers for CPE screening. The Trust has a CPE policy in place.

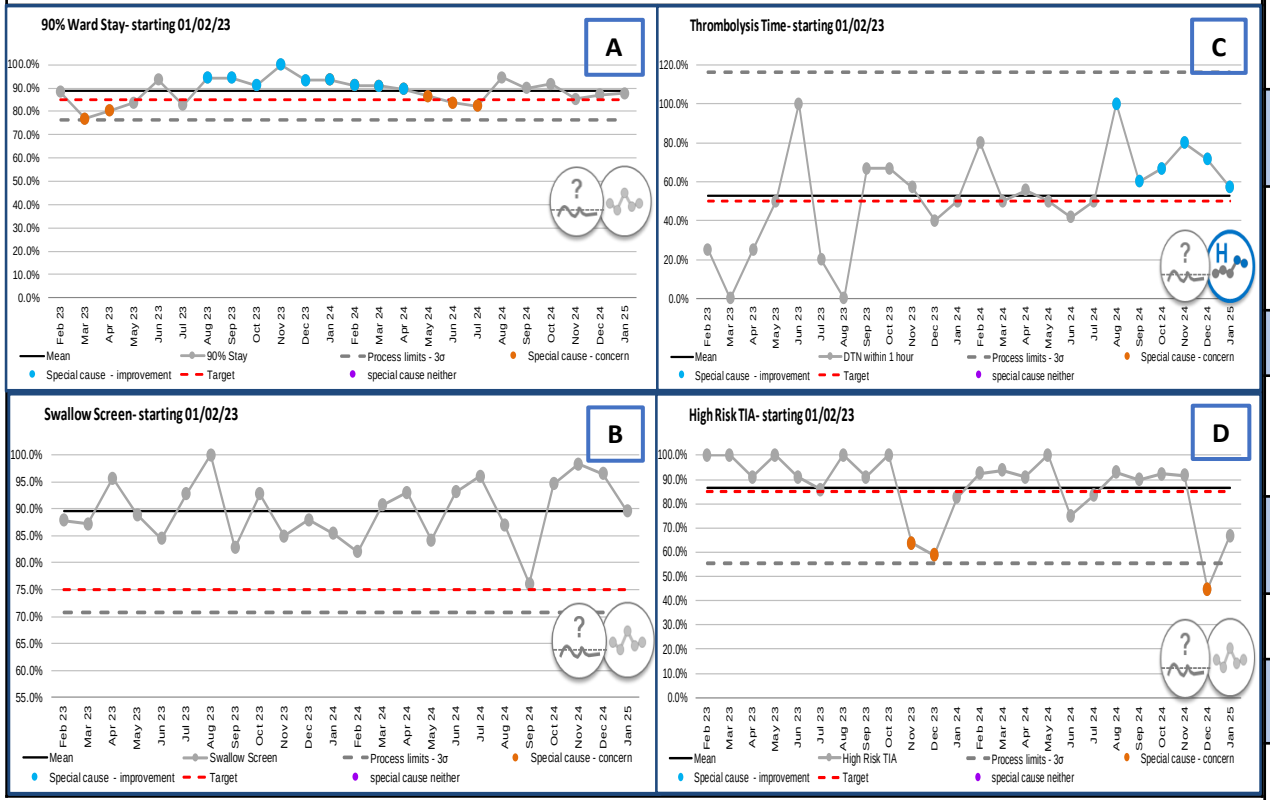
Key Points to Note

The Trust reported 0 COVID-19 outbreaks.
The Trust reported 4 Norovirus outbreak
The trust reported 1 Influenza A 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	December 2024 / January 2025
Trust Performance	A) 87.1% / B) 96.6% / C) 71.4% / D) 45%
Performance Target / KPI	85% / 70% / 50% / 85%



What are the charts showing us

Chart A, shows that 90% ward stay achieved 87% in both December and January and is compliant with the 85% performance target. Chart B shows that swallow screen performance is compliant with the 70% performance target in both December (96%) and January (90%) and achieved SSNAP level A.
Chart C shows that thrombolysis was compliant with the 50% performance target in both December (71%) and January (57%) and achieved a SSNAP level A. Chart D shows that the HR Tia performance is not compliant in December. However, The validated position on the Acute Stroke care report for December shows that HR TIA achieved 100% which is SSNAP level A. HR TIA achieved 67% in January however, this is an unvalidated position.
***Data for December 24 and January 25 currently unvalidated.**

Areas Impacting on Compliance

All areas are currently compliant with performance. **Under performance in HR TIA in January 25 (67%) is due to the data not yet being validated; All patients referred for HR TIA are seen within 24 hours as per Stroke guidelines.**

Mitigations / Timescales / Blockers

- DGFT Stroke team are part of the Thrombolysis Acute Stroke Collaborative (TASC) network and will be working together over the next 12 months to identify further improvements that could improve processes to enable DGFT to improve the thrombolysis pathway .

Risk Register

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

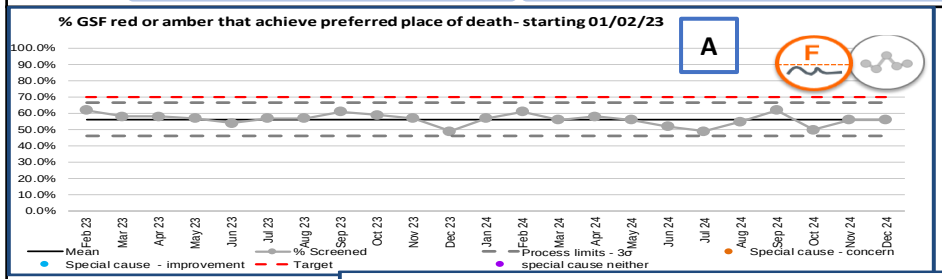
Key Points to Note

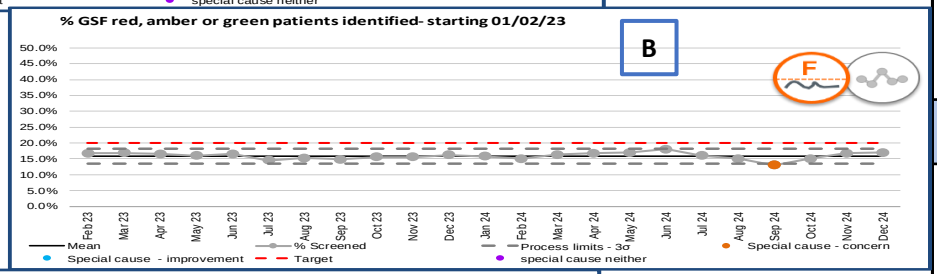
Russell hall hospital is currently 2nd out of 9 trusts in comparison to our peers and continued to maintain a SSNAP score of 77 in Q2 which is a SSNAP level B.

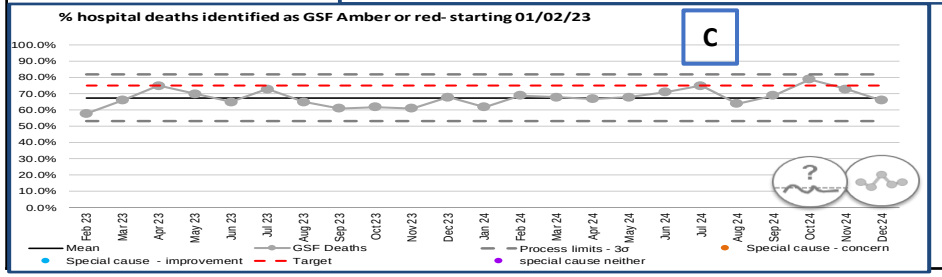
Gold Standards Framework (One Month in Arrears)

Background	KPI based on Nacel and Nice Guidance

Performance	
Date	December 2024 (one month behind)
Trust Performance	A) 56.0%/ B) 17.0%/ C) 66.0%
Performance Target / KPI	70%/20%/75%







What are the charts showing us

The identification of GSF patients has seen an increase from October to 17% in December 2024.

Areas Impacting on Compliance

Need for continued education on the wards – time taken for specialist palliative care team

Mitigations / Timescales / Blockers

- GSF bundle on sunrise to replace GSF document – awaiting confirmation from configuration team regarding timeline
- Specialist palliative care team support all wards regarding GSF identification including reviewing those patients GSF identified on a previous admission

Risk Register

Rapid Discharge added to the risk register as no assurance regarding standards fast track or rapid discharge.

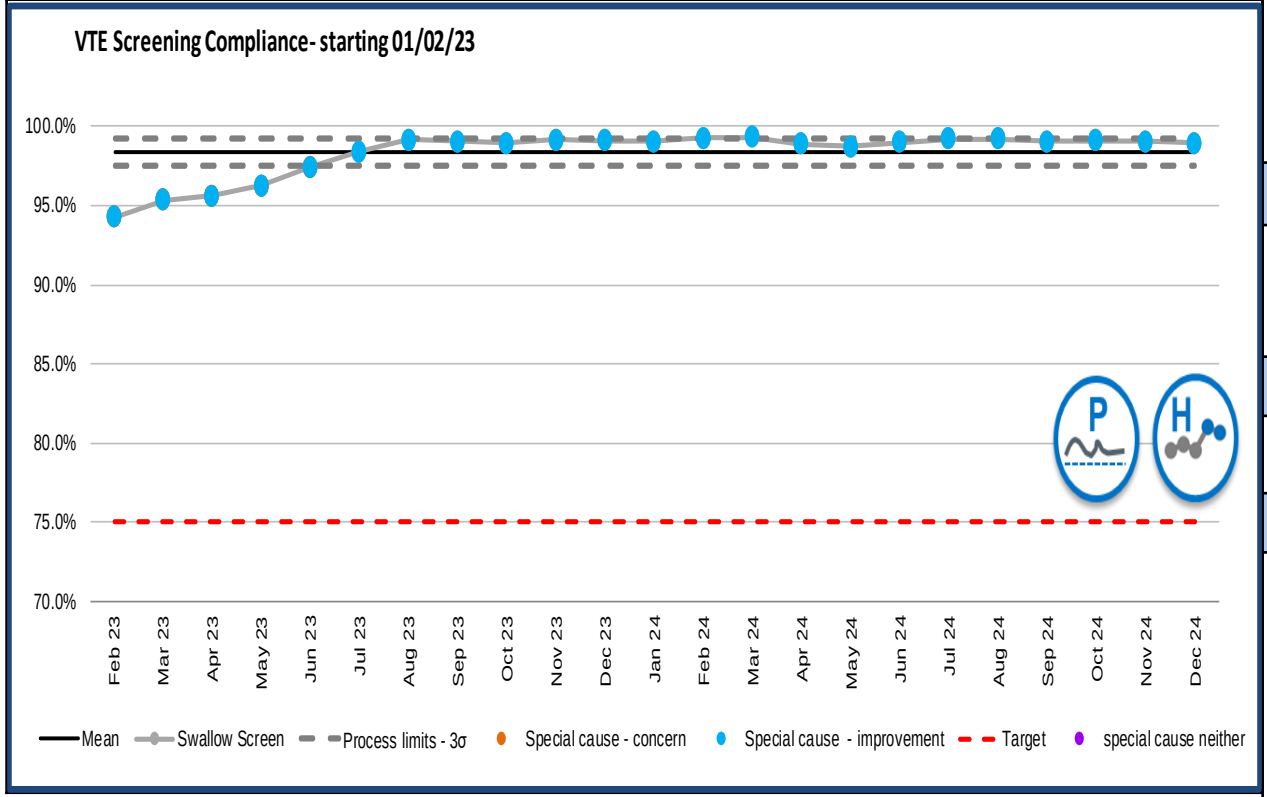
Key Points to Note

Improvement in identification of GSF patients in past two months (November and December 2024)
Fast track on the risk register

VTE (One Month in Arrears)

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

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



What are the charts showing us

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- 05/02/2025 - 159 cases of Hospital associated thrombosis 43 cases potentially preventableVTE
Main themes identified

- Missed/not signed for doses (inappropriate omissions)
- Delays in/failure to prescribe prophylaxis following risk assessment
- Although compliance with first assessment meets target, we are concerned about quality of assessments some are inappropriately identifying patient not at risk of VTE when they have risk factors

Thematic review being undertaken biannually to identify common issues and action plan to address presented at Risk and Assurance Meeting

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 the Incident Decision and Learning Group.

Risk Register

*P*otential 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

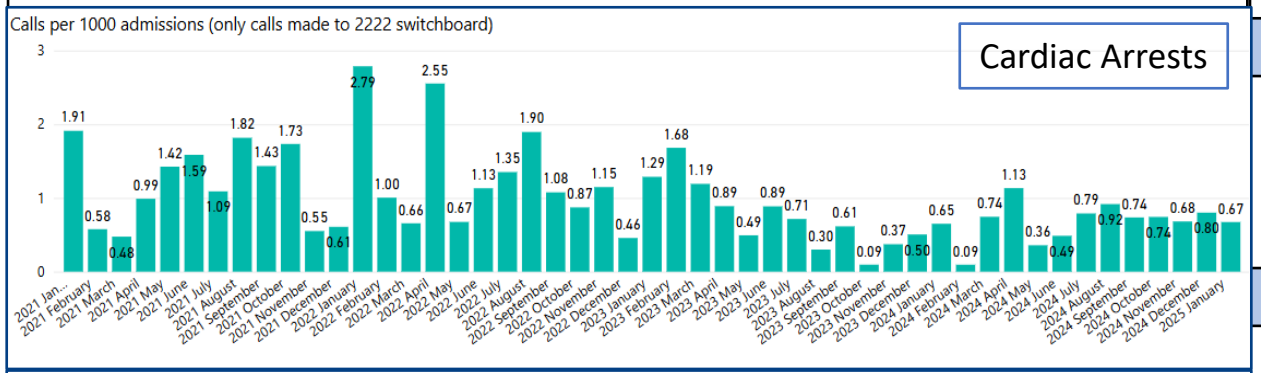
Key Points to Note

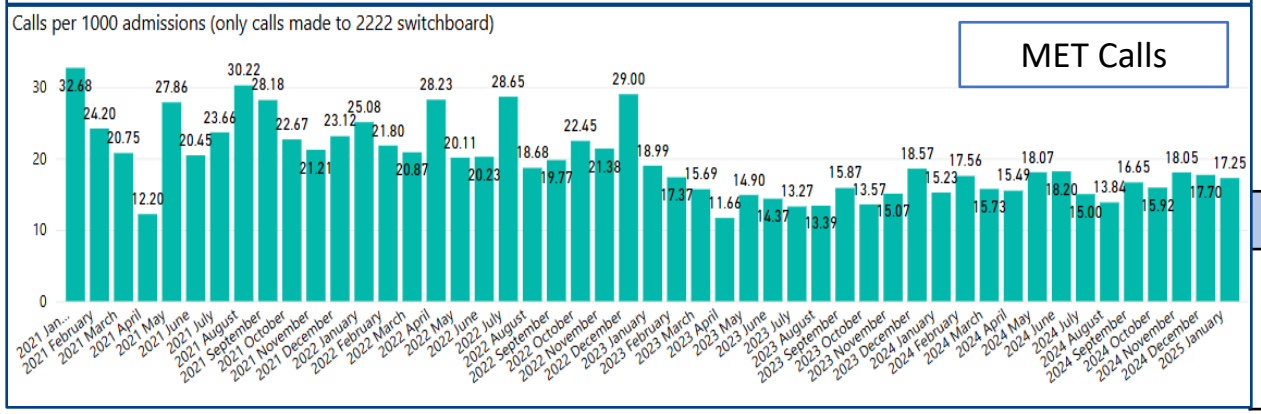
- All incidents of hospital associated thrombosis reported on Datix
- Where issues identified reported back to responsible team to investigate further and action
- Patient safety team contacted and asked to review whether requires discussion at WMOH
- Concerns raised at Thrombosis Group meeting at how 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
- Mandatory training programme updated awaiting learning and development to deploy

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	January 2025
Trust Performance	Cardiac arrests 0.67 /MET calls 17.25
Performance Target / KPI	N/A





What are the charts showing us

9 cardiac arrests (0.67/1000 beds) in January one was a member of the public outside of the main reception, two of the others had a previous treatment and escalation plan, one not reviewed on this admission and one awaiting endorsement by the consultant, CPR commenced for both patients who are now deceased.

Areas Impacting on Compliance

An increase from 42.49% to 44.86% (of 1421 inpatients) had a documented treatment, escalation & resuscitation plan (TERP) in January, of which 86% of the documents contained DNACPR decisions (39% of all inpatients) and 13% were for full active treatment (6% of all inpatients).

Mitigations / Timescales / Blockers

- 48% of patients triggering on the deteriorating patient pathway (DPP) received a senior clinical review within 60 mins of trigger in January an increase from December (46%).
- 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. There is no medical emergency team at Guest or Corbett (nurse & AHP bleep holders will respond).
- 25% 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.

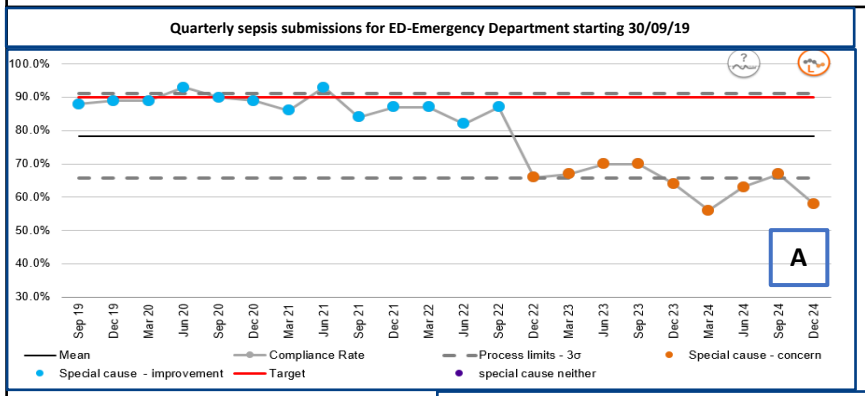
Key Points to Note

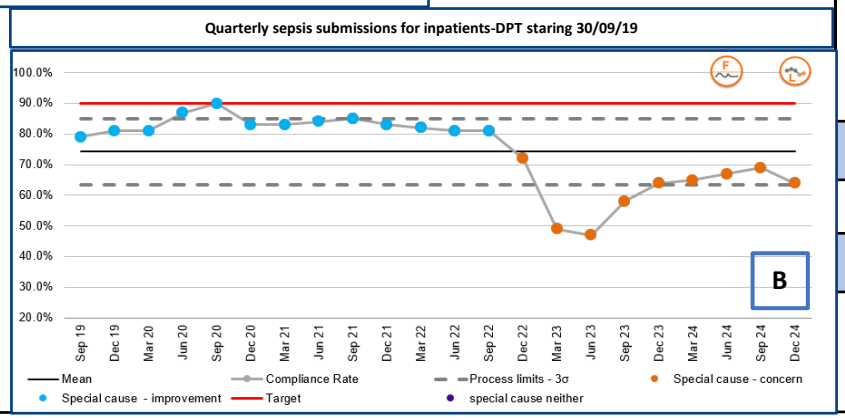
- More robust plans (with instructions of who to escalate to & when) are required by parent teams to reduce 2222 calls as 25% of triggers resulted in a TERP document.
- Two patients received CPR rather than a peaceful end of life due to delays in reviewing or documenting the TERP on this admission

Sepsis

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

Performance	
Date	January 2025 (Q3 2024/2025)
Trust Performance	A) 58% B) 64%
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 (58%)
B) inpatients who undergo sepsis screening and who, where screening positive, receive IV antibiotic treatment <=1hour of time zero (64%)

Areas Impacting on Compliance

- Delays of documentation of vital signs at the point of care
- Delays in commencing screening tool at time zero
- Delay in senior clinical review will impact time available to administer antibiotics
- Increase in additional patients to standard ward format is impacting on timeliness of treatment of inpatients with suspected sepsis

Mitigations / Timescales / Blockers

- Education focus on sepsis within paediatric ED/C2 and deteriorating patient pathway (DPP) as part of paediatric RADAR (Recognise Acute Deterioration, Action & Response) 12 week programme commencing end of February
- Countdown timers and icons to remind of time zero and outstanding DPP actions
- ED sepsis improvement plan project group due to meet in February to formulate action plan based upon deep dive analysis of the 263 December patient journeys

Risk Register

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

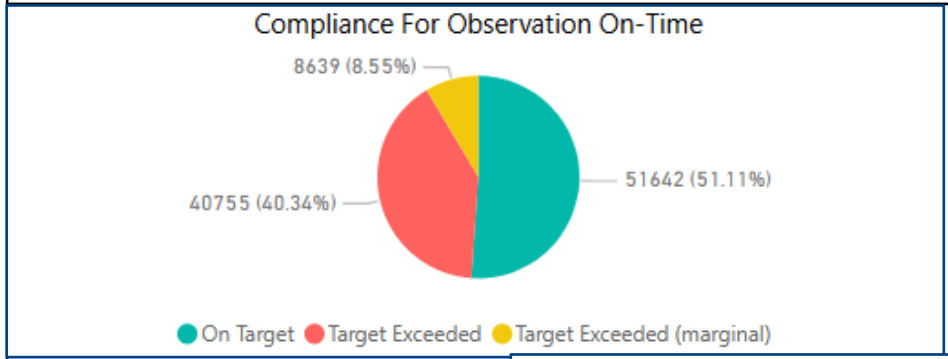
Key Points to Note

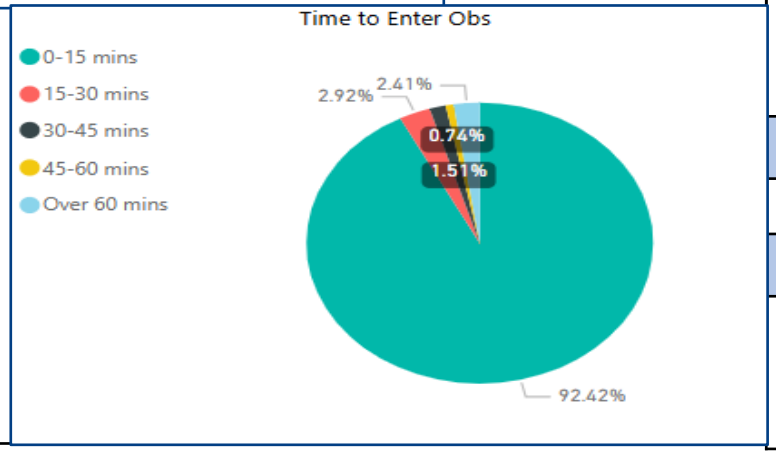
- Jan data for ED has increased from 50% in Dec to 57% (from total 263 patients in Dec v 198 patients in Jan)
- Jan data for inpatients has decreased to 59% from 66% Dec (from total 61 patients in Dec v 71 in Jan)
- Analysis of Dec ED data has been reported into DPG and R&A, action plan being formulated by MIC division

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	January 2025
Trust Performance	51.11% on time/92.42% 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, [NEWTT = neonatal – not on EPR]).
The compliance for observations (vital signs) on time demonstrates an increase in compliance from 50.41% to 51.11% of all vital signs recorded in the past 4 weeks.
2.4% of vital signs have been documented over 60minutes after they have been recorded, this indicates staff are writing vital signs on paper then documenting later rather than at the point of care.

Areas Impacting on Compliance

- IT resources are in high demand compared to availability leading to staff writing vital signs on paper and transcribing onto the EPR.
- Vital signs are often continued in EOL patients unnecessarily, these patients may be scoring highly on NEWS2 requiring increased monitoring that can be uncomfortable. It is written in the note entry to reduce the frequency rather than discontinuing, or use of individualised orders and frequency orders.

Mitigations / Timescales / Blockers

- Wellness questions are included in vital signs charts – 821 patients reported feeling worse in last 4/52, 106 required an urgent senior clinical review & 39 an emergency senior clinical review, 317 increased monitoring whilst 623 continued with original plan.
- Individual areas are asked to ensure timings for vital signs are taken from the EPR tracking board and not from handover sheets or whiteboards.

Risk Register

ASM2413, UC2350

Key Points to Note

- Ensuring vital signs are documented at the point of care would increase the compliance of vital signs on time.
- Call for concern was activated for 7 patients in January.
- Compliance with vital signs recording is being added to the 25-26 quality and safety delivery plan

Quality KPI Dashboard

Background

Performance	
Date	January 2025
Trust Performance	AMaT RAG: Red <85%; Amber 85.1 - 94%; Green 94.1% +
Performance Target / KPI	N/A

Priority 1 AMaT audits August 2024 – January 2025

Audit	Frequency	Compliance over last 6 periods					
Tissue Viability SKIN audit (CQUIN 12)	M	96.6%	96.7%	97.1%	96.5%	97.6%	96.3%
Hand Hygiene '5 moments' audit (v2)	M	98.7%	98.4%	98.5%	98.8%	98.6%	98.3%
Hand Hygiene Environment Audit	M	98.8%	99.0%	98.9%	99.0%	98.8%	98.7%
Matron In Patient Audit	M	91.0%	84.0%	86.3%	87.3%	90.5%	90.8%
Matron Audit - Out Patient Areas	M	93.3%	94.2%	95.5%	96.7%	96.7%	96.4%
Standard of Documentation Audit	Q	N/A	N/A	95.8%	96.6%	97.5%	97.6%
Lead Nurse In Patient Audit	M	92.7%	92.5%	93.9%	91.7%	94.2%	93.2%

The Quality Working Group are considering realigning the AMaT green RAG rating compliance. DGFT is currently set at 94%. Neighbouring Trusts are working to 90%, the same target DGFT had under its previous audit system 'Perfect Ward'.

What are the charts showing us (AMaT and Appendix 1/2)

- Patient observations not completed on time – focussed review taking place.
- Increased staff sickness across most areas - seasonal illness present
- Mandatory training compliance for priority 1 subjects declining but remains above expected target.
- Slight decrease in patient falls with harm correlating with an improvement in falls risk assessment on admission.
- Decrease in the inpatient and community patient FFT results, but an improvement noted in maternity FFT.
- All AMaT priority 1 audits remain above 90%.

Areas Impacting on Compliance

- MUST not completed within 6 hours of admission/transfer
- No lead nurse for A4 or AMU assessment
- 10 additional beds on AMU and 4 trollies in ED x-ray to meet capacity demand.

Mitigations / Timescales / Blockers

- Monthly quality reviews with Matrons and Lead Nurses to ensure action plans are in place to address areas of concern in Medicine and SWC Division. Community already have a robust review system in place.
- Lead Nurses/Senior nursing/midwifery/AHP staff are working on wards in clinical shifts to deliver patient care, this affects timely completion of quality audits and actions.
- Staffing review in progress.
- Priority 1 audits have been altered to accept data up until last day of month to support audit submission compliance.

Risk Register

- Nil reported

Key Points to Note

- Pilot of audit flexible frequency continues for 'Standard of documentation audit'.
- Capacity and staffing pressures impacting on ability to complete quality audits.

Chief Nurse Dashboard (Inpatient areas)

Date	January 2025

WardGroup	Budget WTE	Contracted WTE	Vacancy %	Sickness %	All Unavailability %	Parenting	All Unavailability	Total CHPPD	Mandatory Training %	%FFT Inpatient, Good & VeryGood	Open Complaints (at the end of previous month)	Pressure Ulcers (Cat 3 & above)	Moisture Associated Skin Damage	Falls with Harm	Cardiac Arrest Calls	Total Positive C-Diff Cases	Patient Observations Completed On Time %
AMU	218.0	199.1	8.7%	7.3%	29.5%	13.0	58.8		92.3%		18	0	0	0			49%
CCU	54.1	49.0	9.4%	8.8%	31.6%	4.6	15.5		94.4%		1	0	4	0	1		44%
Critical Care	120.4	127.0	-5.5%	10.2%	39.3%	15.5	49.9		93.9%	100%	1	0	2	0			55%
Discharge Lounge	11.9	11.7	1.6%	11.9%	42.3%	1.4	4.9		94.4%			1	0	1			8%
ED	188.7	164.2	13.0%	10.4%	37.8%	15.9	62.1		92.9%		17	0	2	0			83%
ESH	73.7	72.3	1.9%	6.1%	24.0%	3.7	17.3		93.8%	58%	4	0	0	1			54%
FMNU	44.6	41.2	7.5%	9.9%	22.4%	0.2	9.2		96.2%			0	0	0			20%
Maternity	150.8	164.1	-8.8%	9.9%	40.9%	14.5	67.0		91.4%		4						52%
MECU	21.4	20.8	3.2%	0.7%	20.3%		4.2		95.6%	100%		0	0	0	1		37%
Neonatal Unit	48.0	60.7	-26.4%	7.8%	33.6%	3.2	20.4		92.6%	100%							
Renal Unit	37.5	36.8	1.7%	15.1%	33.4%	2.2	12.3		93.9%								58%
SDEC	71.0	64.4	9.3%	7.5%	30.2%	2.8	19.5		90.3%	97%	7			0			77%
Ward A2											1			0			41%
Ward B1	31.0	30.6	1.2%	9.1%	29.8%	3.1	9.1		97.4%	82%	1			0			67%
Ward B2 Hip	50.0	51.1	-2.2%	9.8%	32.5%	4.2	16.6		92.1%	0%	1	0	0	0			25%
Ward B2 Trauma	42.1	44.4	-5.5%	10.6%	28.5%	0.0	12.7		97.1%	73%	1	0	5	0			23%
Ward B3	64.2	63.8	0.7%	10.9%	30.9%	2.9	19.7		89.1%	75%		0	7	0			46%
Ward B4	80.1	74.3	7.3%	10.3%	33.8%	6.4	25.1		90.9%	78%	6	0	8	0	1		45%
Ward B6	25.2	23.9	5.2%	14.2%	32.0%	0.1	7.6		93.9%	0%	1	0	0	2			22%
Ward C1A	37.4	34.3	8.2%	10.2%	32.0%	3.1	11.0		90.0%	50%	1	0	0	0	2		24%
Ward C1B	38.1	37.1	2.6%	7.5%	25.2%	0.8	9.4		93.6%								19%
Ward C2	58.1	53.4	8.2%	8.6%	25.6%	2.7	13.7		88.7%	93%	1						63%
Ward C3	56.5	52.5	7.1%	2.7%	19.3%	2.1	10.2		92.0%	100%	5	0	1	1			16%
Ward C4	64.2	63.1	1.7%	12.4%	35.6%	6.8	22.5		90.2%	50%	2	0	2	0			51%
Ward C5	87.8	84.2	4.1%	8.7%	32.9%	4.1	27.7		94.5%	75%	2	0	1	0	1		26%
Ward C6	31.8	35.9	-12.9%	11.9%	34.6%	3.0	12.4		89.4%	88%				0			48%
Ward C7	64.1	61.6	3.9%	11.9%	40.8%	5.8	25.1		96.2%	85%		0	2	0			38%
Ward C8	81.9	76.3	6.9%	10.6%	29.6%	2.0	22.5		91.3%	86%	7	0	0	0	1		19%
Total	**1,852.6**	**1,797.6**	**3.0%**	**9.4%**	**32.6%**	**124.3**	**586.4**		**92.9%**	**84%**	**81**	**1**	**34**	**5**	**7**		**48%**

WardGroup	Hand Hygiene 5 moments audit (v2)	Hand Hygiene Environment Audit - Monthly	Lead Nurse In Patient Audit	Matron In Patient Audit	Standard of Documentation Audit	Tissue Viability SKIN audit (CQUIN 12)
AMU	100.0%	98.7%	91.3%	93.5%	97.9%	97.3%
CCU	100.0%	100.0%	98.0%	92.9%	93.4%	100.0%
Critical Care	91.1%	100.0%	94.4%	88.5%	95.1%	98.4%
Discharge Lounge	100.0%	100.0%	n/a	96.4%	93.8%	n/a
ED	98.5%	100.0%	n/a	n/a	96.0%	n/a
ESH	100.0%	100.0%	87.4%	n/a	n/a	93.2%
FMNU	96.9%	100.0%	97.2%	100.0%	95.0%	98.9%
Maternity	100.0%	100.0%	n/a	n/a	n/a	68.4%
MECU	100.0%	100.0%	94.2%	86.0%	100.0%	100.0%
Neonatal Unit	n/a	n/a	n/a	n/a	n/a	n/a
Renal Unit	99.1%	97.3%	n/a	n/a	n/a	n/a
SDEC	100.0%	100.0%	n/a	n/a	100.0%	n/a
Ward A2	n/a	100.0%	n/a	n/a	100.0%	n/a
Ward B1	100.0%	100.0%	96.9%	96.2%	100.0%	100.0%
Ward B2 Hip	100.0%	94.7%	96.6%	89.7%	96.0%	97.8%
Ward B2 Trauma	94.4%	88.9%	88.5%	86.2%	97.5%	89.7%
Ward B3	98.4%	94.7%	96.3%	84.5%	97.2%	100.0%
Ward B4	100.0%	100.0%	89.3%	89.3%	n/a	91.7%
Ward B6	93.5%	89.5%	93.7%	90.9%	97.3%	94.0%
Ward C1A	100.0%	94.7%	96.4%	94.5%	100.0%	100.0%
Ward C1B	n/a	n/a	94.1%	94.2%	n/a	100.0%
Ward C2	93.8%	100.0%	n/a	n/a	94.3%	n/a
Ward C3	97.8%	100.0%	97.8%	94.7%	100.0%	98.8%
Ward C4	96.7%	100.0%	87.6%	96.5%	n/a	95.2%
Ward C5	100.0%	94.7%	96.5%	83.9%	99.7%	100.0%
Ward C6	n/a	94.7%	91.7%	87.7%	96.6%	n/a
Ward C7	96.2%	94.7%	97.5%	93.1%	94.7%	96.1%
Ward C8	100.0%	89.5%	80.0%	86.0%	100.0%	96.6%
Total	**96.3%**	**97.7%**	**93.2%**	**91.1%**	**97.8%**	**96.5%**

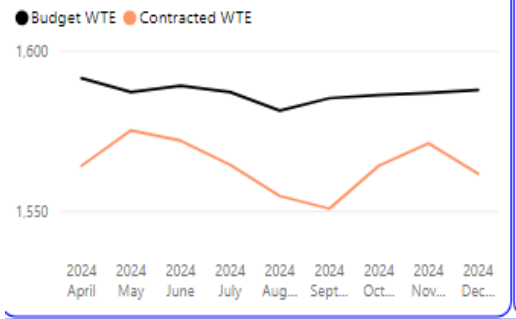
WardGroup	Has a falls risk assessment been completed?	MUST or MUAC completed	Waterlow completed
AMU	100.0%	61.5%	100.0%
CCU	100.0%	100.0%	100.0%
Critical Care	80.0%	90.0%	100.0%
Discharge Lounge	n/a	n/a	n/a
ED	n/a	n/a	n/a
ESH	90.0%	30.0%	90.0%
FMNU	100.0%	100.0%	100.0%
Maternity	n/a	n/a	n/a
MECU	100.0%	80.0%	80.0%
Neonatal Unit	n/a	n/a	n/a
Renal Unit	n/a	n/a	n/a
SDEC	n/a	n/a	n/a
Ward A2	n/a	n/a	n/a
Ward B1	80.0%	100.0%	90.0%
Ward B2 Hip	100.0%	100.0%	100.0%
Ward B2 Trauma	100.0%	100.0%	100.0%
Ward B3	100.0%	90.0%	100.0%
Ward B4	100.0%	100.0%	100.0%
Ward B6	100.0%	100.0%	100.0%
Ward C1A	100.0%	80.0%	100.0%
Ward C1B	100.0%	100.0%	100.0%
Ward C2	n/a	n/a	n/a
Ward C3	100.0%	100.0%	100.0%
Ward C4	60.0%	60.0%	80.0%
Ward C5	100.0%	100.0%	100.0%
Ward C6	100.0%	25.0%	87.5%
Ward C7	100.0%	100.0%	100.0%
Ward C8	75.0%	37.5%	100.0%
Total	**93.3%**	**78.0%**	**96.3%**

Chief Nurse Dashboard Trends (Inpatient areas 1)

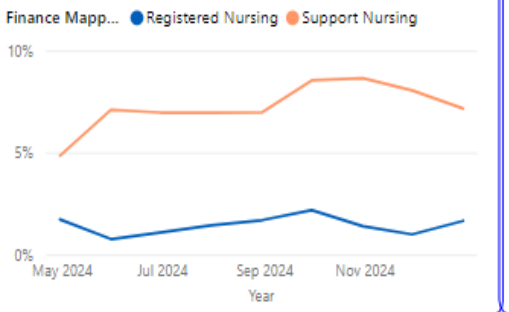
Date	January 2025

Workforce

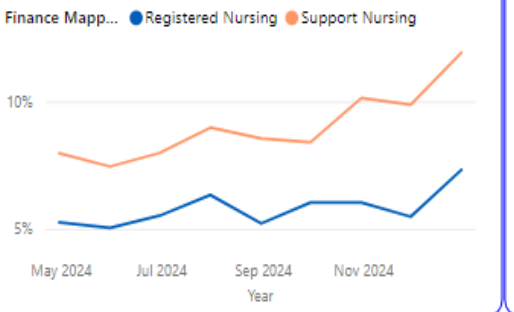
Budget & Contracted WTE



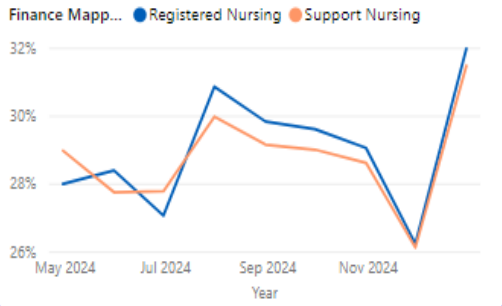
Vacancy %



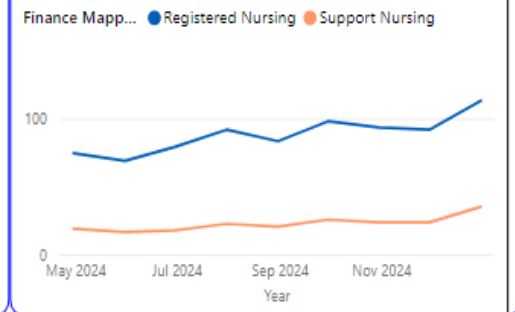
Sickness %



All Unavailability %

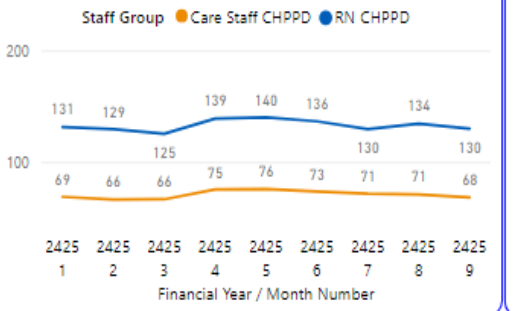


All Unavailability WTE

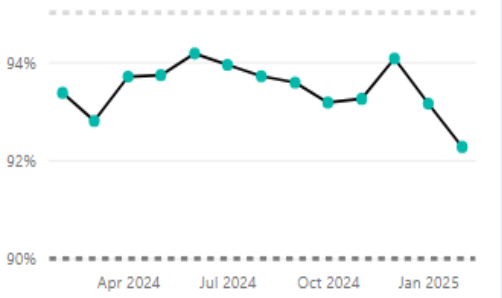


Workforce

Total Staff Care Hours Per Patient Per Day...



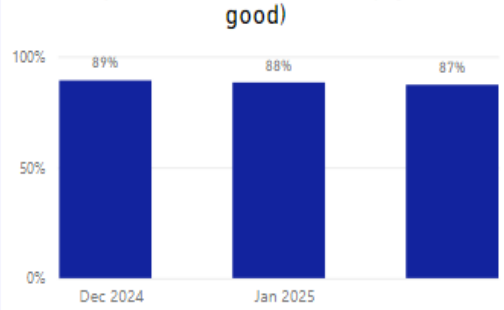
Mandatory Training



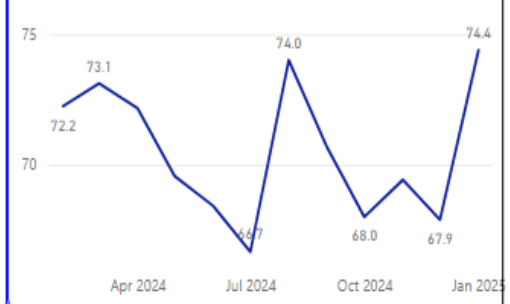
Patient Voice

Open Complaints (at end of each month)

FTT Inpatient - % Positive (very good or good)



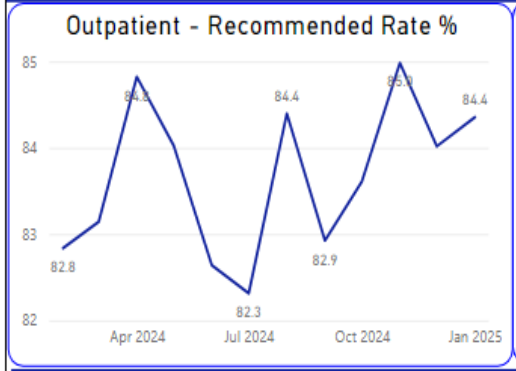
ED - Recommended Rate %

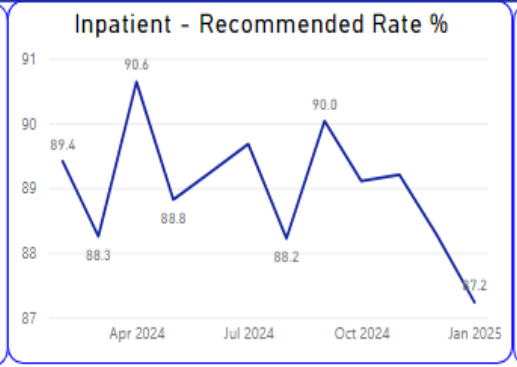


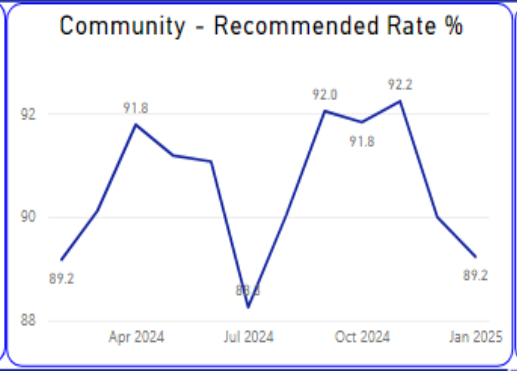
Chief Nurse Dashboard Trends (Inpatient areas 2)

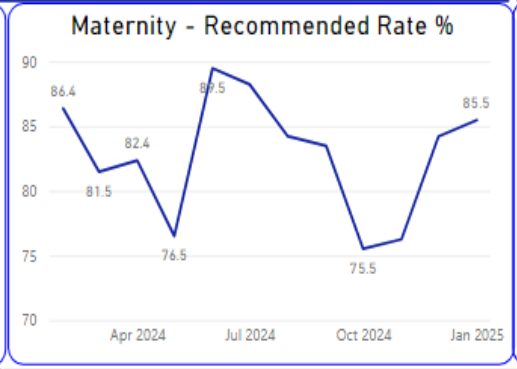
Date	January 2025

Patient Voice

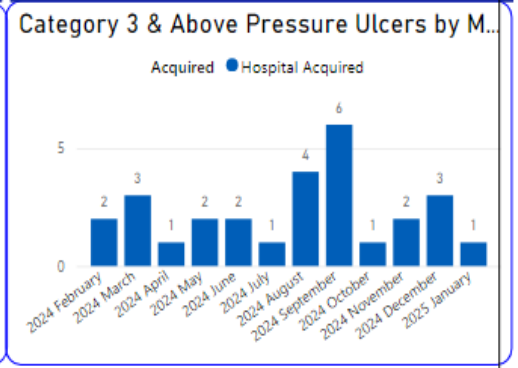




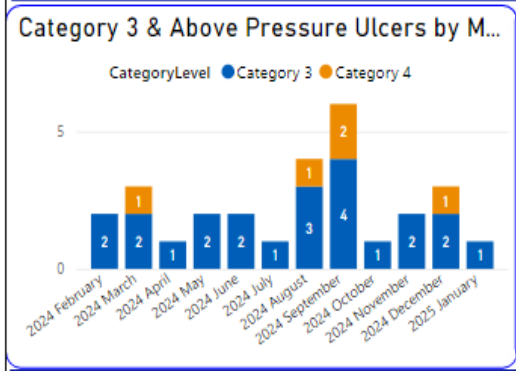


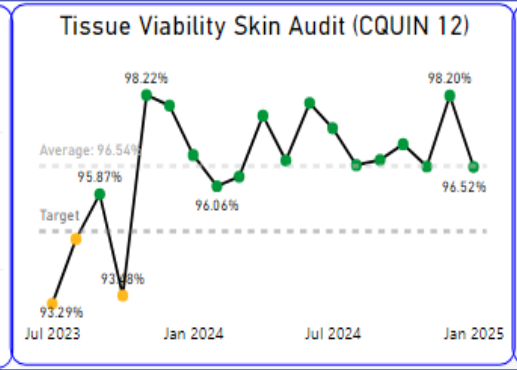


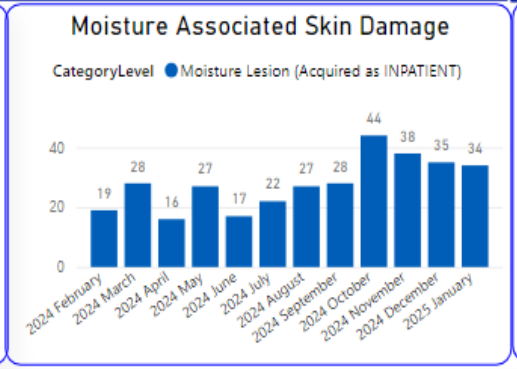
Pressure Ulcers



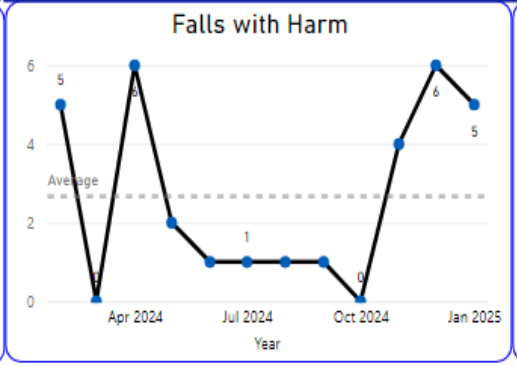
Pressure Ulcers

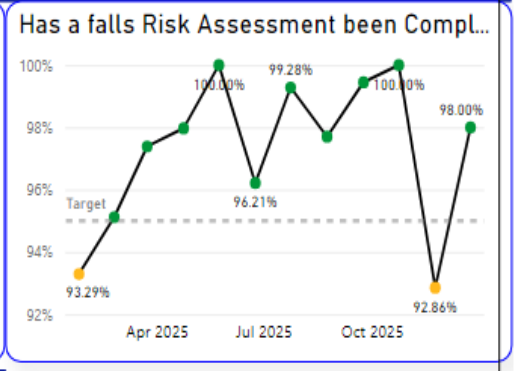






Falls

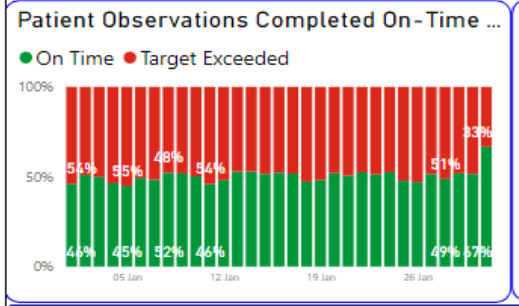


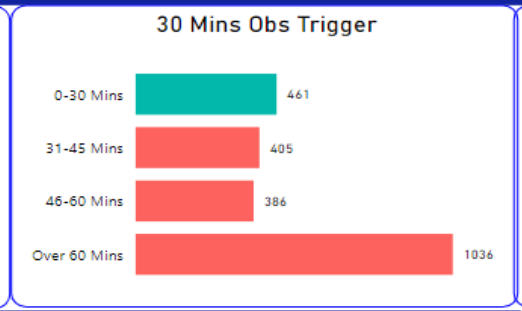


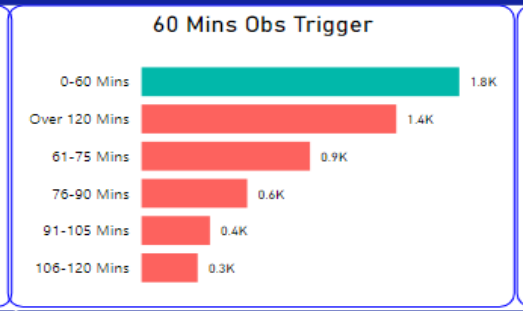
Chief Nurse Dashboard Trends (Inpatient areas 3)

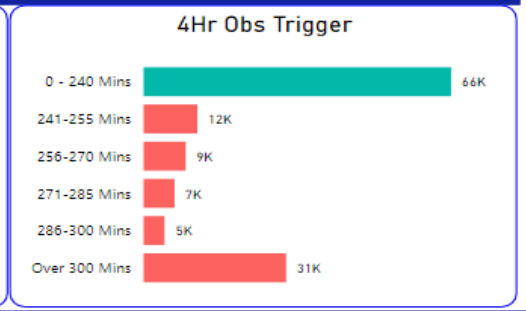
Date | January 2025

Deteriorating Patient

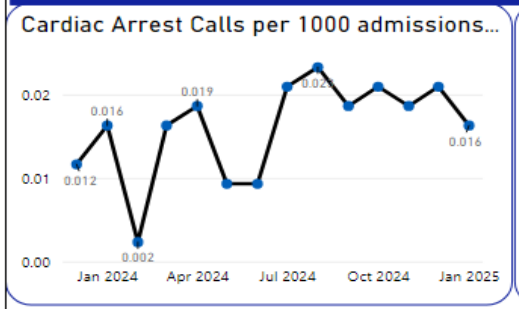


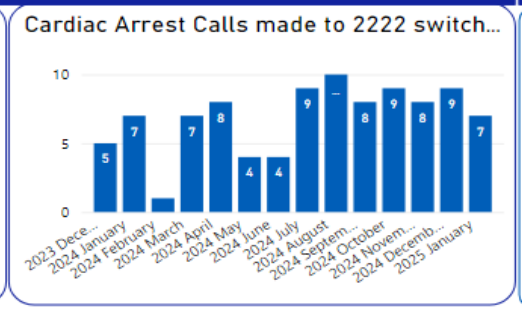




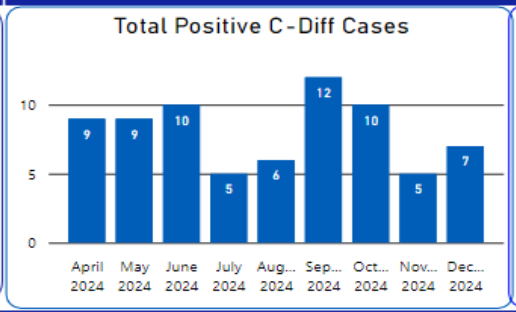


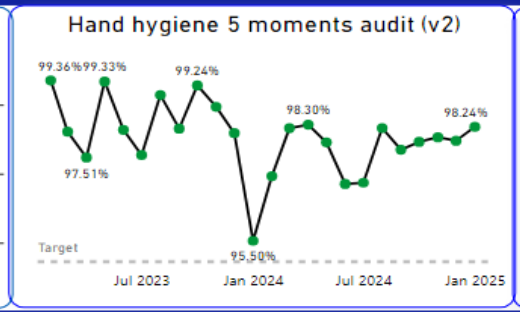
Number of cardiac arrests

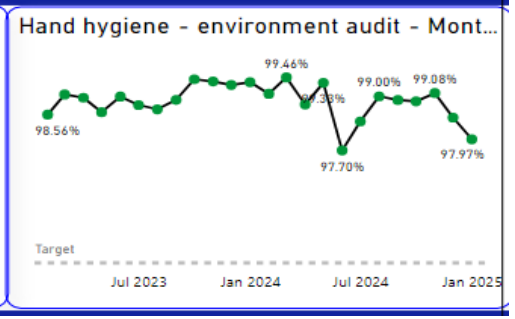




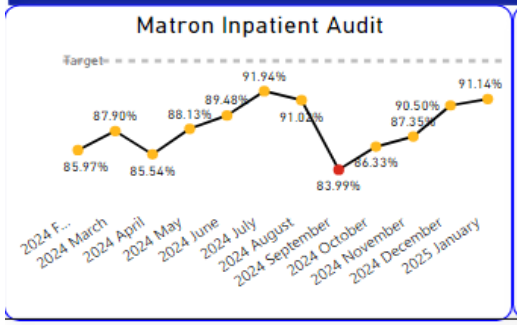
Infection Control

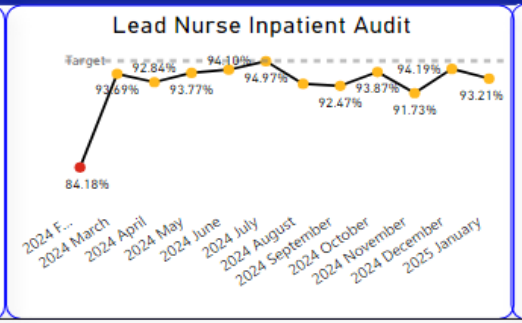




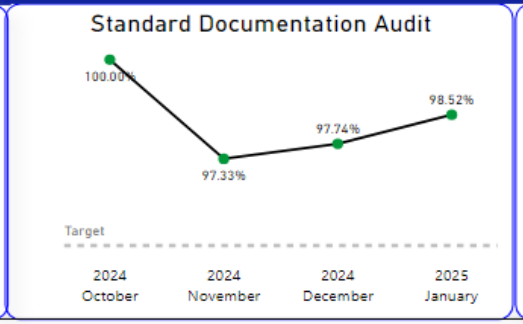


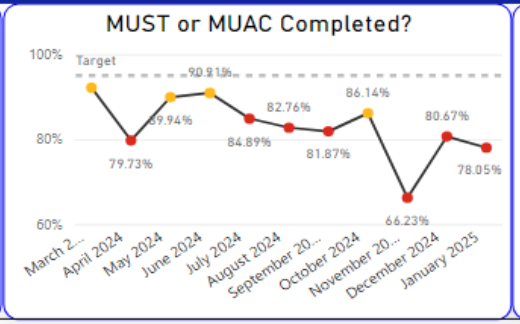
General Patient Care Metrics

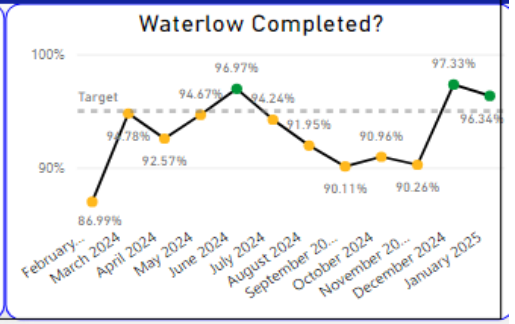




General Patient Care Metrics



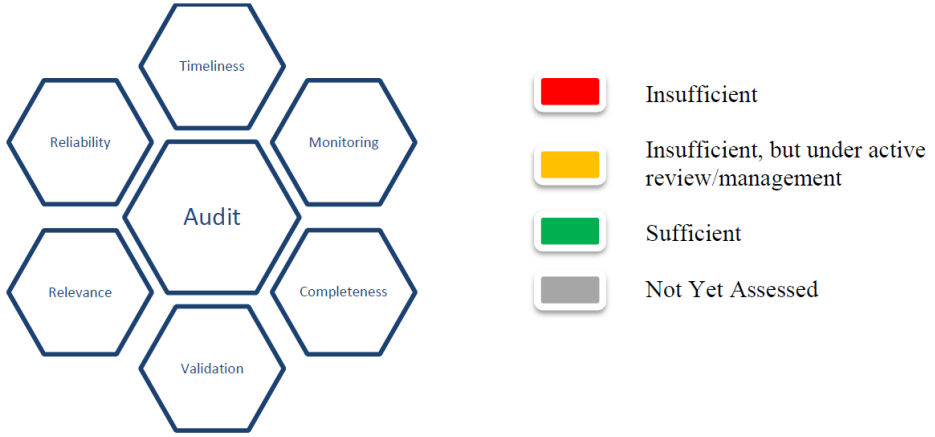




Kitemark Explanation

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

Workforce KPI Report

January 2025

The Dudley Group
NHS Foundation Trust

CARE
RESPECT
RESPONSIBILITY

Summary

The Dudley Group NHS Foundation Trust

Metric	Rate	Target	Trend	
Absence – In Month	5.96	<=5%	↑	**Sickness Absence** In-month sickness absence for January 2025 is 5.96% an increase from 5.95% in December 2024.
Absence - 12m Rolling	5.28%	<=5%	↑	The rolling 12-month absence has increased from 5.23% in December 2024 to 5.28% in January 2025.
Turnover	7.17%	<=8%	↑	**Turnover** Turnover (all terminations) has increased from 7.15% in December 2024 to 7.17% in January 2025.
Normalised Turnover	3.08%	<=5%	↑	Normalised Turnover has increased from 3.02% in December 2024 to 3.08% in January 2025. 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)	92.2%	>=80%	=	**Retention** The 12-month retention rate has remained static at 92.2%.
Vacancy Rate	5%	<=7%	=	**Vacancy Rate** The vacancy rate has remained static at 5%.
Mandatory Training	90.60%	>=90%	↓	**Mandatory Training** Statutory Training decreased from 92.16% in December 2024 to 90.60% in January 2025. Overall, it has remained above 90% target for a sustained period.

Exceptions/Improvement/Actions

The Dudley Group
NHS Foundation Trust

METRIC	SUMMARY
Sickness	In January 2025, People Committee noted that there was reasonable assurance that mitigations were in place to support attendance at work. However, the committee noted concern over the trend showing an increase in sickness absence rates. Both the in-month figure and the rolling 12-month figure in January 2025 have increased again since December 2024. The in-month figure does fluctuate from month to month, we usually see a peak in December and January each year but would expect this to start decreasing again from February/March. However, overall sickness has been higher than the previous year. As well as the mitigations already in place a taskforce group is focusing on targeted intervention for teams with the highest levels of sickness absence. The HR team have recently reviewed their approach to tackling short-term sickness. Each month going forwards they will identify hot spot areas and audit to check that the absence is being managed and provide guidance where needed.
Turnover	Whilst there has been a very slight increase in turnover and normalised turnover, the rate continues to remain below Trust target and retention rates are high. The recruitment and retention journey was ratified early in the year and work to embed the journey and its deliverables continue with oversight from the Being a Brilliant Place to Worth and Thrive. Some key successes from the group to date include the introduction of flexible working profiles, the Dudley I-Can project success, the AHP deep dive and the work undertaken to support fragile services and the progressing work around anti-bullying and anti discrimination. The Trust continues to have a high retention rate and this is a measure of the success of the work undertaken to date.
Statutory and Mandatory training	Performance overall continues to be stable and above target – although there was a decrease in January. This is a seasonal trend and reflects operational challenges and the impact on ability to complete training. In addition, there have been ongoing challenges in moving across training completed by Place staff. This should now be resolved and any outstanding training to be completed has been advised. There remain variations at Staff Group, Division and Subject level and a detailed review of variation and action to address is underway with plans to report in March. Changes to programme requirements will start to be implemented from March 2025 linked to the national review.

CARE RESPECT RESPONSIBILITY

Exceptions/Improvement/Actions

The Dudley Group
NHS Foundation Trust

SUMMARY

People Policy Update

Current Policy position		
	Jan-25	Feb-25
Policies in date	19	20
Policies past their review date	19	18
Policies reaching review dates in next 6 mo	3	3
New policies in development	2	2

Policies past their review date		
	Jan-25	Feb-25
Not started	2	0
Under review	7	9
Being removed	1	1
With SRC/LNC for comments	7	7
Due for ratification	2	0
Awaiting publication	0	2

During 2023 and 2024 there were a high number of People policies that simultaneously reached their review dates within a short period of time, meaning that the People Directorate has fallen behind.

Significant effort was undertaken across 2024 to review People policies to bring them back in date. Unfortunately this has caused a small backlog due to resources available to the Staff Representative Committee (SRC) and the Local Negotiating Committee (LNC) to support in reviewing and ratifying the policies.

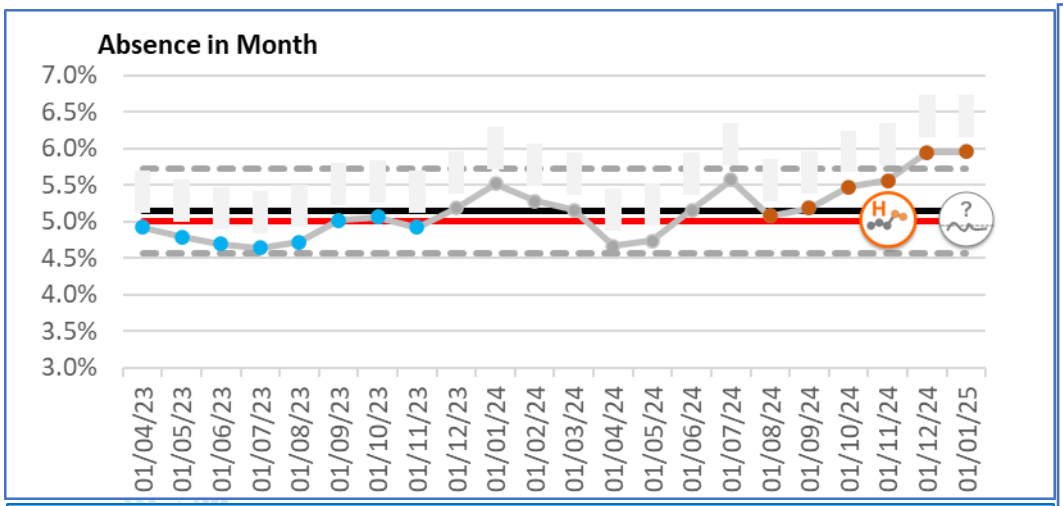
All policies out of the review date and those due for review in the next 6 months have been assigned.

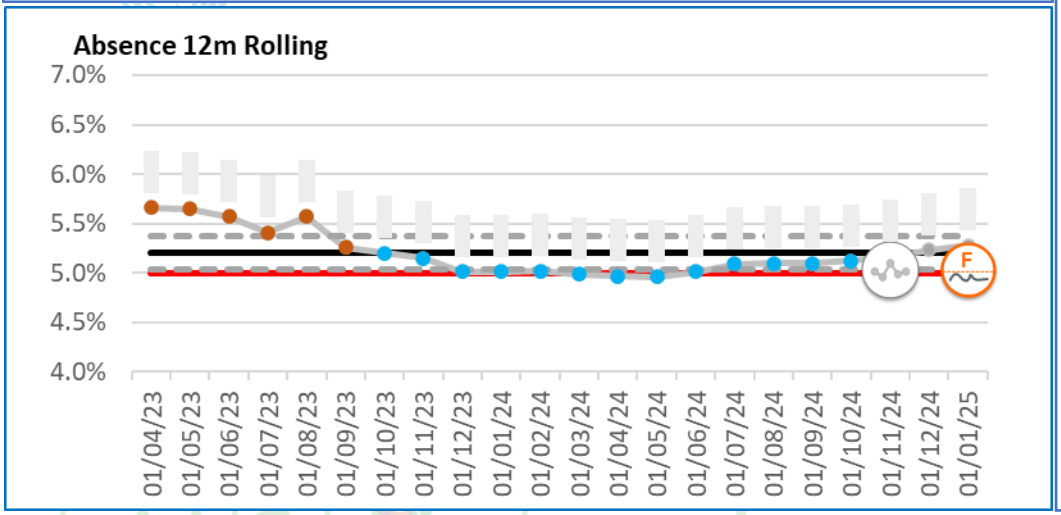
Achievement in month – ratification of Grievance and Anti-Bullying, Anti-Discrimination Policy

CARE RESPECT RESPONSIBILITY

Sickness Absence

The Dudley Group NHS Foundation Trust





In-Month Sickness Absence

In-month sickness absence for January 2025is 5.96%, an increase from 5.95% in December 2024.

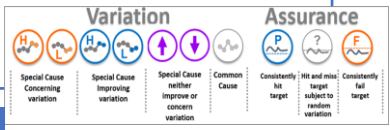
Rolling 12 M Sickness Absence

The rolling 12-month absence for January 2025 is 5.28%, an increase from 5.28% in December 2024.

Assurance

There are a number of mitigations currently in place to support reduction of absence:

- Policy re-launch – policy has been in place now for over 12 months
- Newly refreshed absence management training for managers – attendance and feedback has been positive
- Wellbeing journey launch as part of the People Plan
- Monthly reports of all long-term sickness cases – ensuring early intervention and monitoring of all cases
- Monthly reports of higher levels of short-term absence
- Taskforce established in Sept 2024 to tackle rising absence rates
- Winter Vaccination programmes
- In house Occupational Health service, established EAP provision and staff Physio service

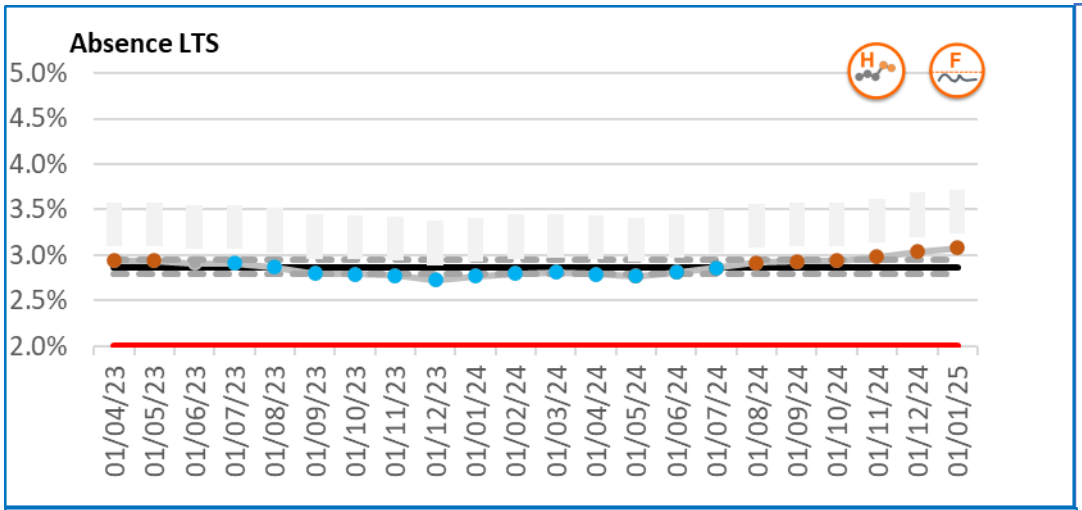


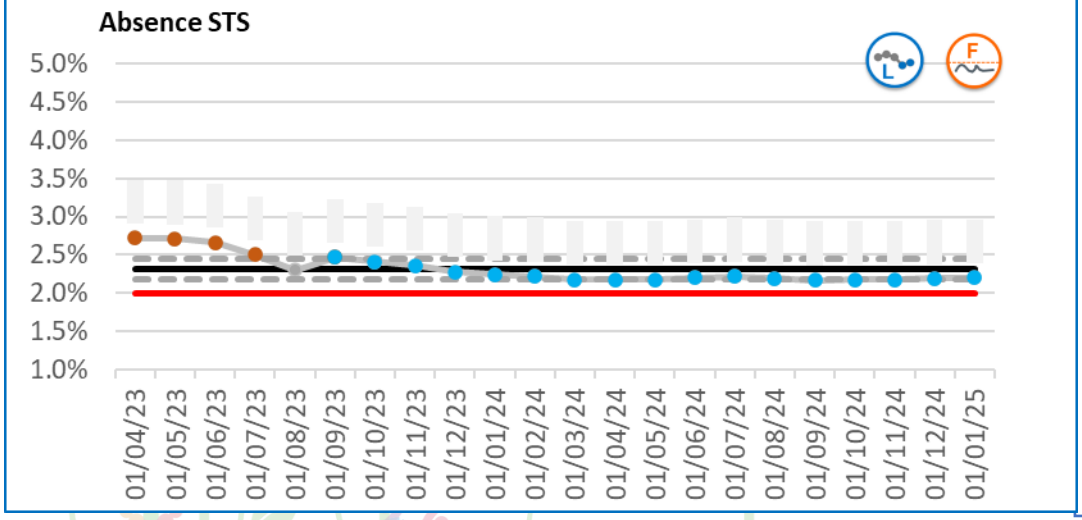
	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25
Absence in Month	5.28%	5.16%	4.67%	4.74%	5.16%	5.57%	5.08%	5.18%	5.47%	5.56%	5.95%	5.96%
Absence 12m Rolling	5.02%	4.99%	4.97%	4.96%	5.01%	5.09%	5.10%	5.10%	5.12%	5.16%	5.23%	5.28%

CARE RESPECT RESPONSIBILITY

Long-Term and Short-Term Absence

The Dudley Group NHS Foundation Trust





Long-term sickness absence has increased from 3.04% in December 2024 to 3.08% in January 2025. Short-term sickness has increased slightly to 2.20% in January 2025, from 2.19% in December 2024.

In January 2025 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 49% of all FTE days lost and short-term absence accounted for 51% of all FTE days lost.

As of 31st January 2025 there were 142 long-term absences open across the Trust.

- 112 cases are between 28 days and 6 months
- 14 cases between 6 months and 12 months
- 4 cases over 12 months in length

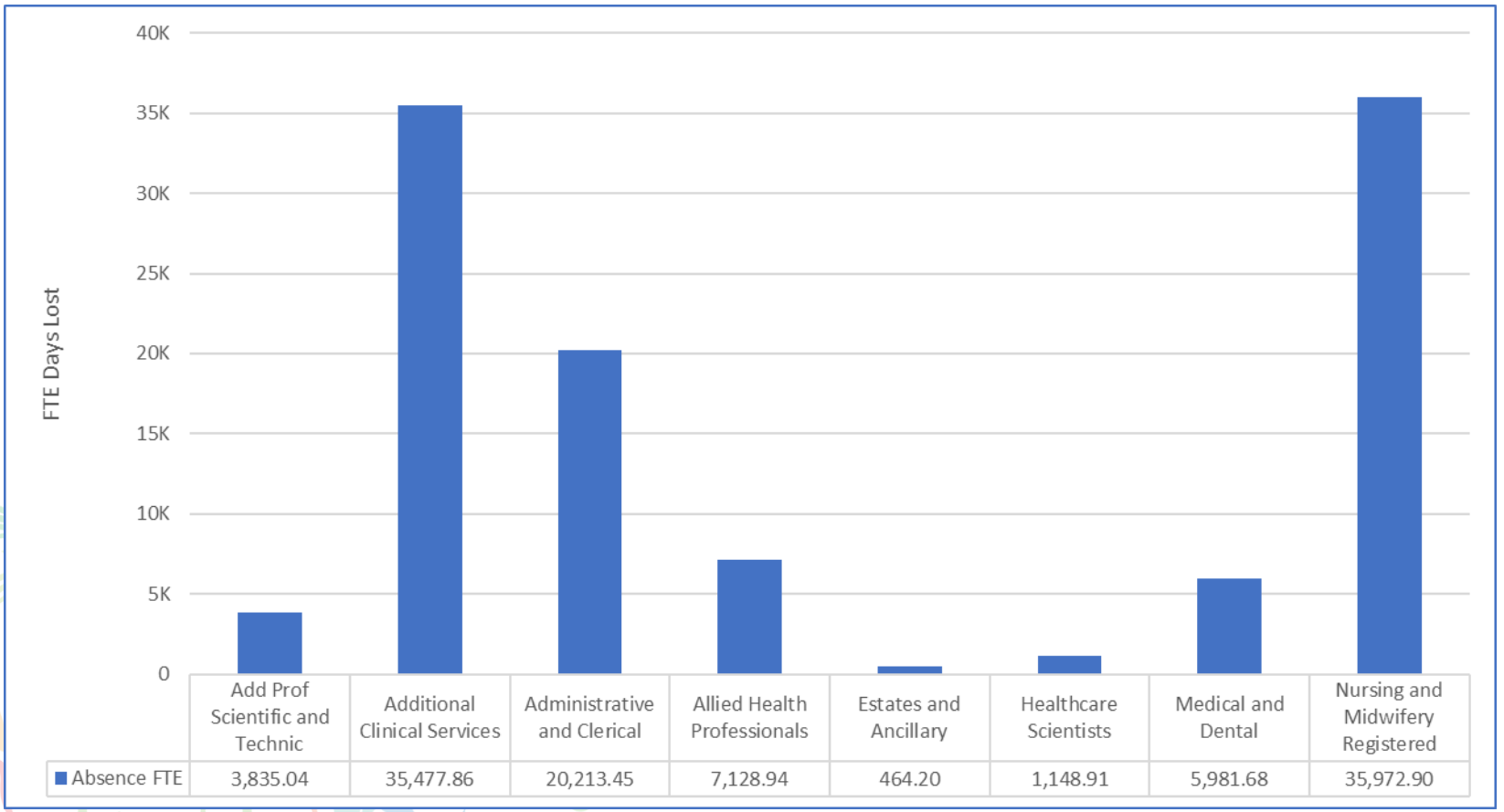
What next

- Education and training for managers on recording sickness absence (some short-term identified as being long-term, which is why this is required)
- Develop and launch sickness absence hub page with useful resources and linked to wellbeing pages also
- Meet with 4 hot spot areas to develop a bespoke intervention package
- Continued work on the Occupational Health contract

	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25
Absence LTS	2.80%	2.81%	2.79%	2.77%	2.81%	2.86%	2.92%	2.93%	2.94%	2.98%	3.04%	3.08%
Absence STS	2.22%	2.18%	2.18%	2.20%	2.22%	2.19%	2.17%	2.18%	2.18%	2.19%	2.20%	

Sickness Absence- Staff Groups

The Dudley Group
NHS Foundation Trust



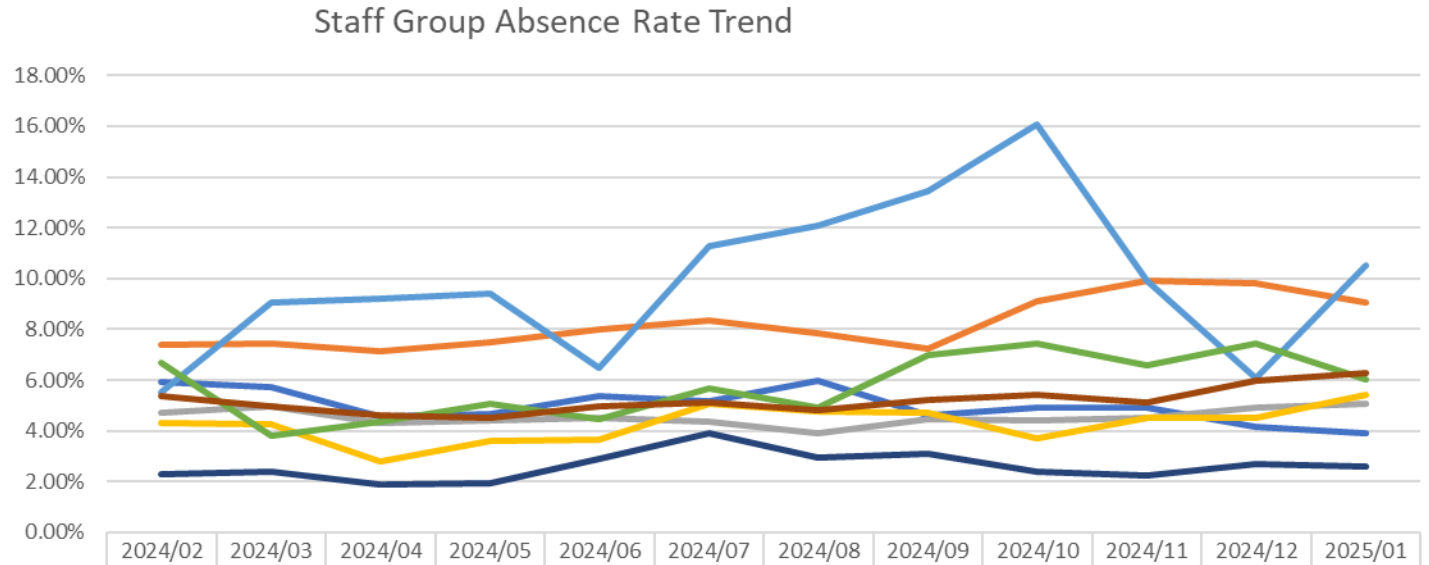
	Add Prof Scientific and Technic	Additional Clinical Services	Administrative and Clerical	Allied Health Professionals	Estates and Ancillary	Healthcare Scientists	Medical and Dental	Nursing and Midwifery Registered
Absence FTE	3,835.04	35,477.86	20,213.45	7,128.94	464.20	1,148.91	5,981.68	35,972.90

Year-to-date Nursing and Midwifery and Additional Clinical Services have lost the most FTE days as a result of sickness absence. Proportionately admin and clerical staff have a high rate of sickness absence.

CARE RESPECT RESPONSIBILITY

Sickness Absence- Staff Groups

The Dudley Group NHS Foundation Trust



	2024/02	2024/03	2024/04	2024/05	2024/06	2024/07	2024/08	2024/09	2024/10	2024/11	2024/12	2025/01
Add Prof Scientific and Technic	5.92%	5.71%	4.58%	4.64%	5.37%	5.14%	5.97%	4.61%	4.89%	4.91%	4.18%	3.88%
Additional Clinical Services	7.41%	7.45%	7.14%	7.50%	7.98%	8.35%	7.86%	7.22%	9.08%	9.90%	9.84%	9.07%
Administrative and Clerical	4.71%	4.98%	4.29%	4.43%	4.53%	4.34%	3.93%	4.47%	4.42%	4.52%	4.91%	5.06%
Allied Health Professionals	4.31%	4.26%	2.81%	3.59%	3.63%	5.05%	4.76%	4.73%	3.70%	4.49%	4.49%	5.43%
Estates and Ancillary	5.52%	9.06%	9.19%	9.38%	6.46%	11.28%	12.10%	13.45%	16.07%	9.89%	6.05%	10.53%
Healthcare Scientists	6.68%	3.82%	4.34%	5.09%	4.47%	5.67%	4.93%	6.98%	7.44%	6.56%	7.44%	6.01%
Medical and Dental	2.28%	2.38%	1.90%	1.95%	2.92%	3.89%	2.96%	3.09%	2.37%	2.22%	2.67%	2.59%
Nursing and Midwifery Registered	5.35%	4.98%	4.61%	4.52%	4.99%	5.12%	4.82%	5.24%	5.42%	5.12%	5.99%	6.30%

In January 2025, Estates and Ancillary staff group saw the biggest increase in absence. Absence rates for the following staff groups also increased:
Allied Healthcare Professionals
Admin and Clerical

Additional clinical services has the second highest sickness absence but there was a slight reduction from November and December 2024.

CARE RESPECT RESPONSIBILITY

Reasons for Absence

The Dudley Group NHS Foundation Trust

Top 10 Absence Reasons by FTE Days Lost

Absence Reason	Headcount	Abs Occurrences	FTE Days Lost	%
S10 Anxiety/stress/depression/other psychiatric illnesses	806	1,039	24,986.47	22.7
S13 Cold, Cough, Flu - Influenza	2607	3,574	13,025.97	11.8
S25 Gastrointestinal problems	2061	2,821	10,928.72	9.9
S12 Other musculoskeletal problems	576	722	10,428.13	9.5
S30 Pregnancy related disorders	284	762	5,970.21	5.4
S99 Unknown causes / Not specified	638	776	5,725.56	5.2
S28 Injury, fracture	234	248	5,704.81	5.2
S26 Genitourinary & gynaecological disorders	373	478	4,907.84	4.5
S11 Back Problems	332	389	4,532.23	4.1
S98 Other known causes - not elsewhere classified	267	350	3,696.23	3.4

Top 10 Absence Reasons by Absence Days

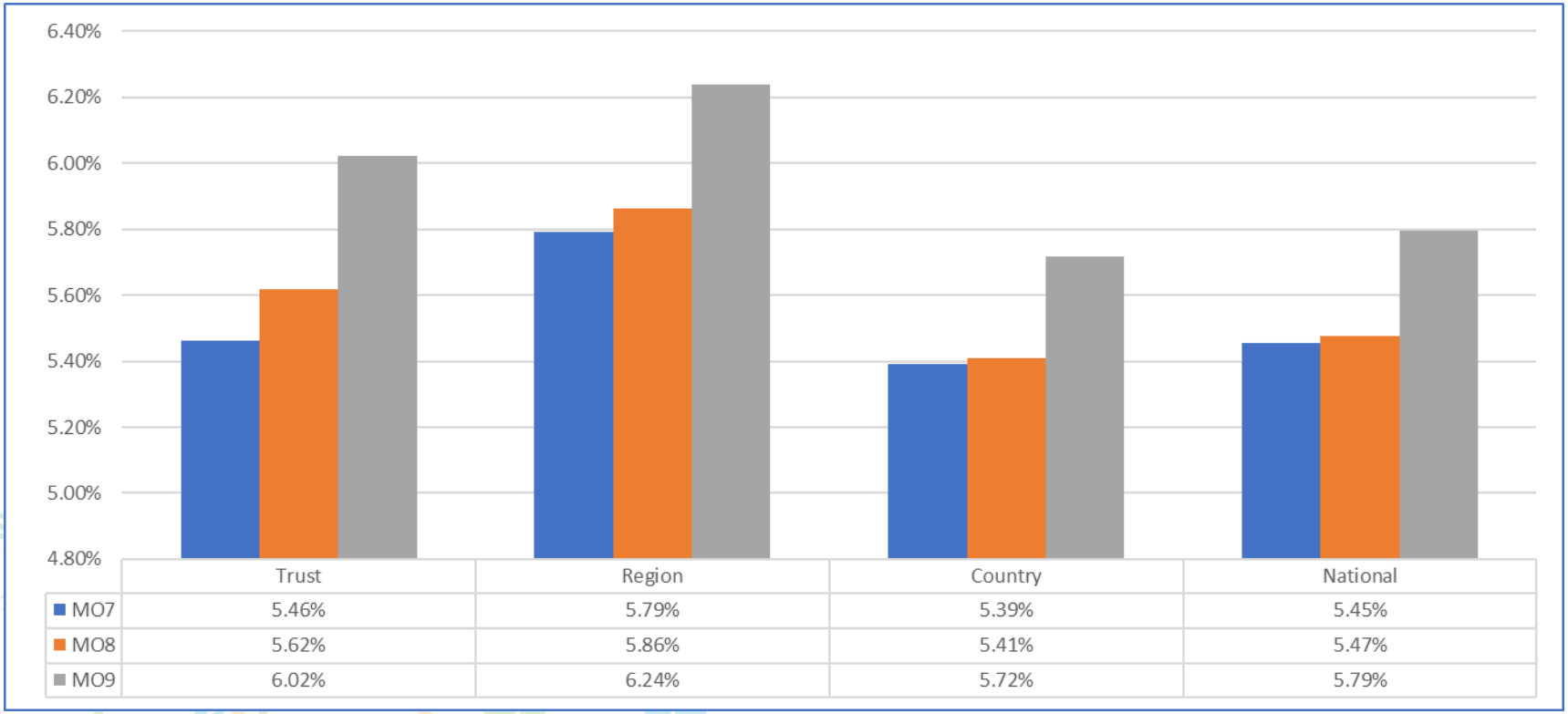
Absence Reason	Headcount	Abs Occurrences	Abs Days	%
S10 Anxiety/stress/depression/other psychiatric illnesses	806	1,039	29,583	23.0
S13 Cold, Cough, Flu - Influenza	2607	3,574	14,884	11.6
S25 Gastrointestinal problems	2061	2,821	12,479	9.7
S12 Other musculoskeletal problems	576	722	12,405	9.7
S99 Unknown causes / Not specified	638	776	7,030	5.5
S28 Injury, fracture	234	248	6,840	5.3
S30 Pregnancy related disorders	284	762	6,639	5.2
S26 Genitourinary & gynaecological disorders	373	478	5,687	4.4
S11 Back Problems	332	389	5,387	4.2
S98 Other known causes - not elsewhere classified	267	350	4,038	3.1

- Anxiety/Stress/Depression/Other Psychiatric illness continues to be the top reason for absence that causes the greatest 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 the remainder of 24/25 and moving into next year will be around short-term absence and reducing the number of episodes.

CARE RESPECT RESPONSIBILITY

Absence Benchmarking

The Dudley Group NHS Foundation Trust

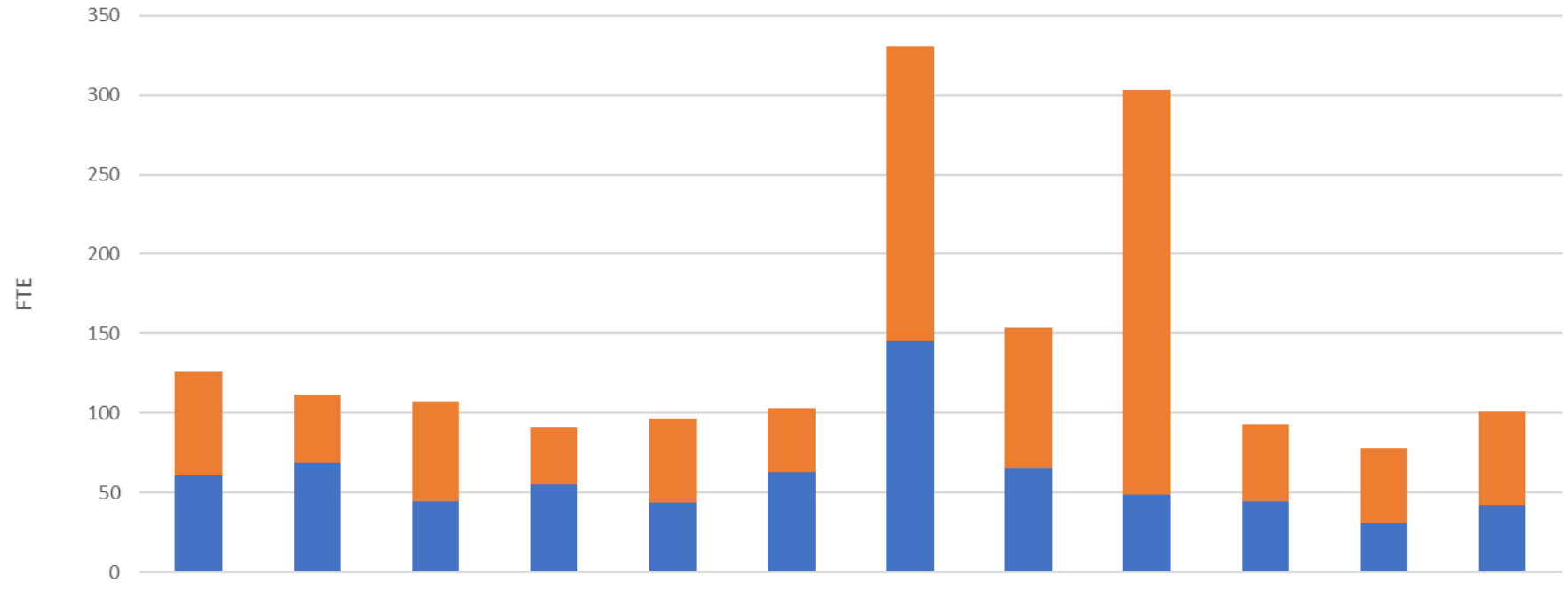


	Trust	Region	Country	National
MO7	5.46%	5.79%	5.39%	5.45%
MO8	5.62%	5.86%	5.41%	5.47%
MO9	6.02%	6.24%	5.72%	5.79%

- National and Regional benchmarking data is only available until end of December 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 December 2024 (M09) the Trust's sickness absence rate was lower than the Region but higher than the Country and Nationally.

Starters and Leavers

The Dudley Group NHS Foundation Trust



	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25
Starters FTE	65.39	43.48	62.83	35.54	52.59	40.54	184.76	88.73	254.59	49.03	46.87	58.71
Leavers FTE	60.87	68.38	44.5	55.34	43.66	62.61	145.51	65.12	48.58	44.25	30.94	42.05

Starters vs Leavers

- This month we have seen more starters than leavers in January 2025.

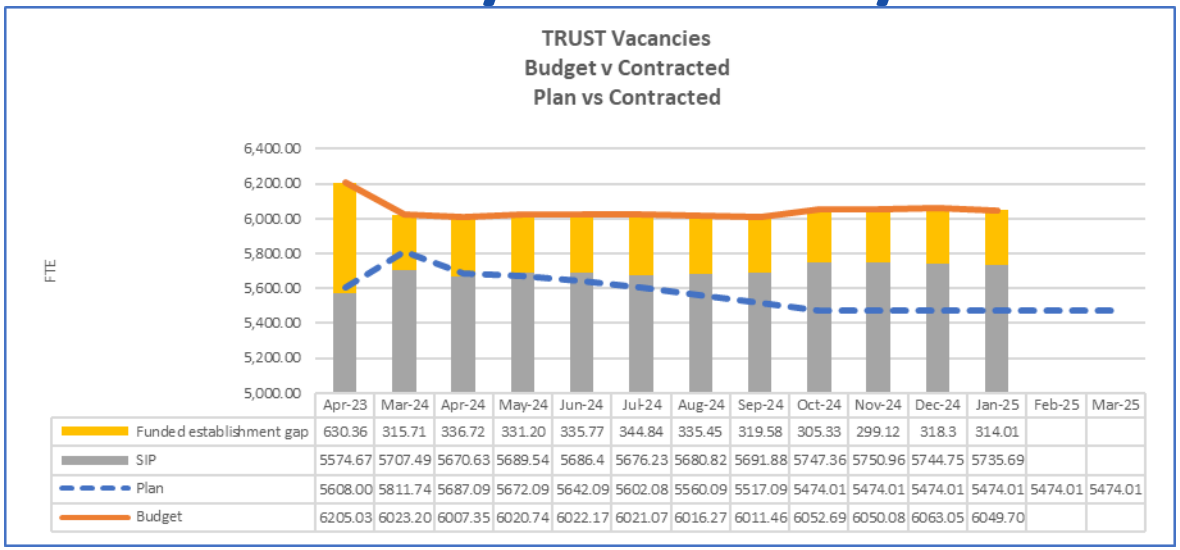
Assurance

- 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.

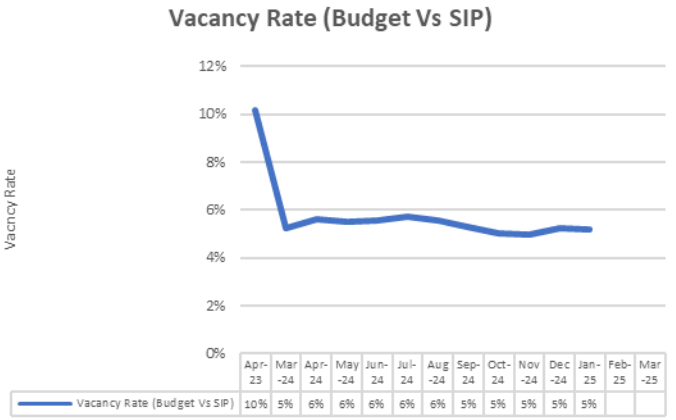
CARE RESPECT RESPONSIBILITY

Recruitment/Vacancies/Turnover - TRUST

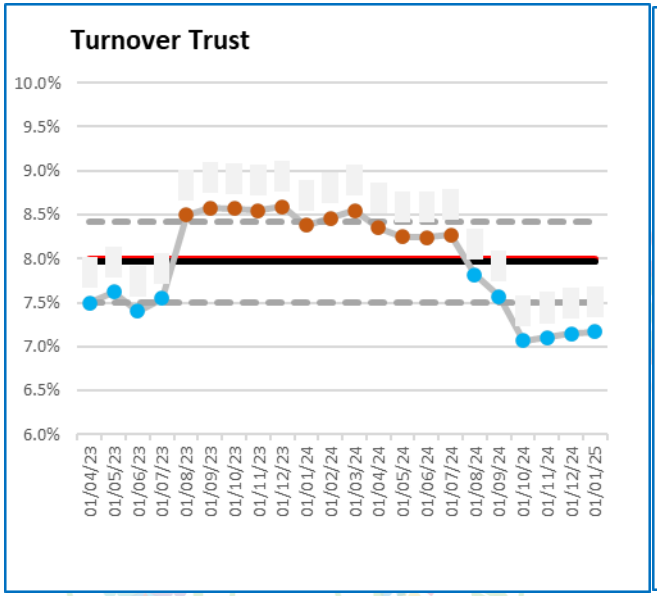
The Dudley Group
NHS Foundation Trust

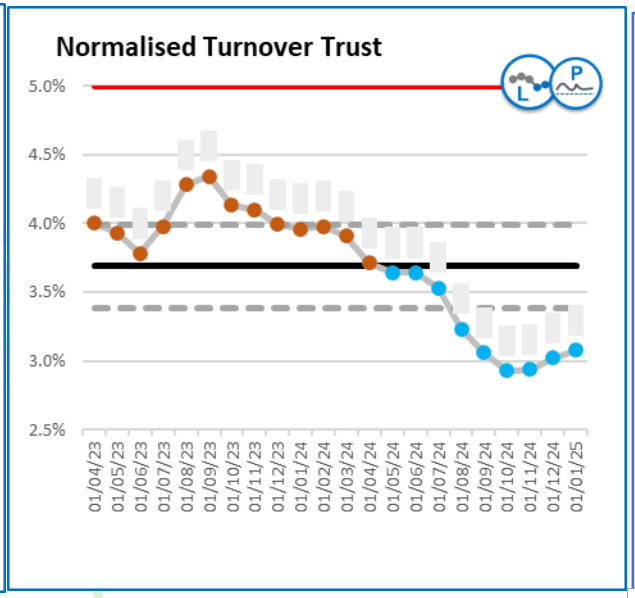


	Apr-23	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Funded establishment gap	630.36	315.71	336.72	331.20	335.77	344.84	335.45	319.58	305.33	299.12	318.3	314.01		
SIP	5574.67	5707.49	5670.63	5689.54	5686.4	5676.23	5680.82	5691.88	5747.36	5750.96	5744.75	5735.69		
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	6052.69	6050.08	6063.05	6049.70		



	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%	5%	5%	5%	5%		





Contracted WTE staff has decreased from 5744.75 WTE in December 2024 to 5735.69 WTE in January 2025.

For substantive staff this is 261.68 WTE above the workforce plan (more staff than we said we would have).

Total vacancies stand at 314.01 WTE in December 2024. This equates to a vacancy rate of 5%.

Overall staff turnover (rolling twelve months average) is at 7.17% with normalised turnover at 3.08% in January 2025.

	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25
Trust Turnover	8.46%	8.55%	8.35%	8.25%	8.24%	8.27%	7.82%	7.57%	7.07%	7.10%	7.15%	7.17%
Trust Normalised Turnover	3.58%	3.91%	3.71%	3.64%	3.64%	3.53%	3.23%	3.06%	2.93%	2.94%	3.02%	3.08%

Top 5 Departments - High Vacancies

The Dudley Group
NHS Foundation Trust

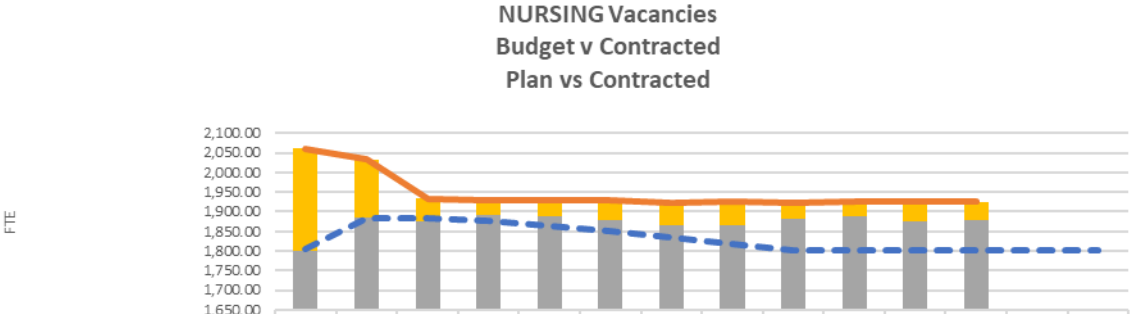
Cost Centre Description	Budget WTE	Contracted WTE	Vacancy WTE	Vacancy %
Emergency Department Nursing	139.31	122.08	17.23	12%
Therapy Department	141.82	125.61	16.21	11%
Phlebotomists	68.76	54.85	13.91	20%
Ward AMU Assessment	55.02	41.12	13.90	25%
Pharmacy Department	185.63	173.01	12.62	7%

- 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 and implement succession planning.
- AMU are actively recruiting into their vacancies. Department is struggling to fill the Band 3 roles due to Band 2/3 work pending.
- 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 continue to be an ongoing progress.
- Phlebotomy have 6 WTE in the pipeline leaving vacancies at 7.37 WTE. The remaining vacancies are being held due to forthcoming changes in the service delivery and premises where it is envisaged a reduction in the workforce requirement.

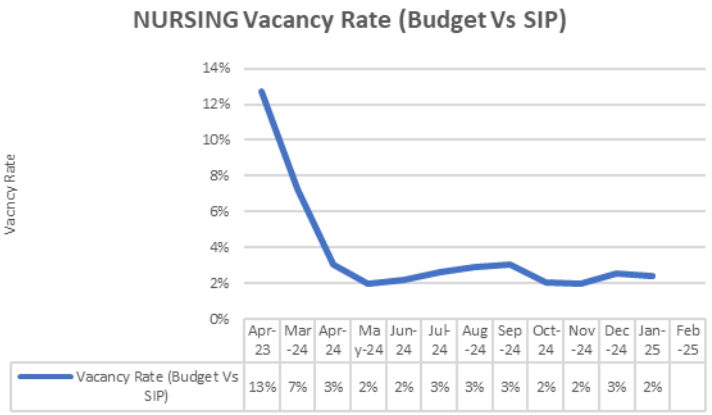
CARE RESPECT RESPONSIBILITY

Recruitment/Vacancies/Turnover - Registered Nursing & Midwifery

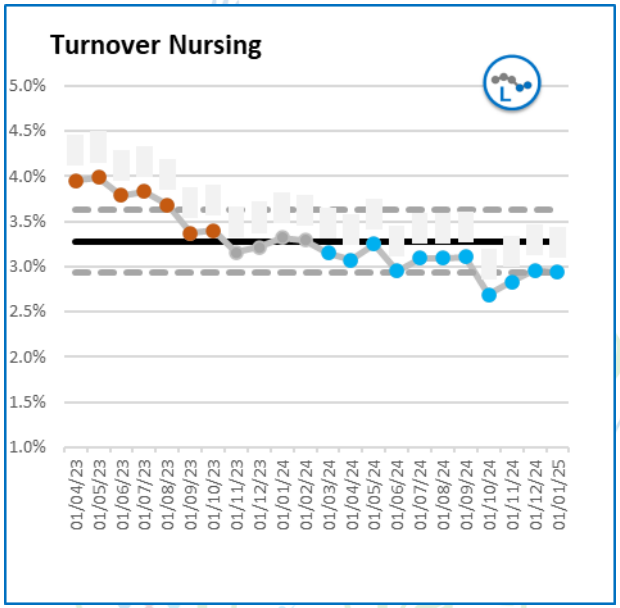
The Dudley Group NHS Foundation Trust

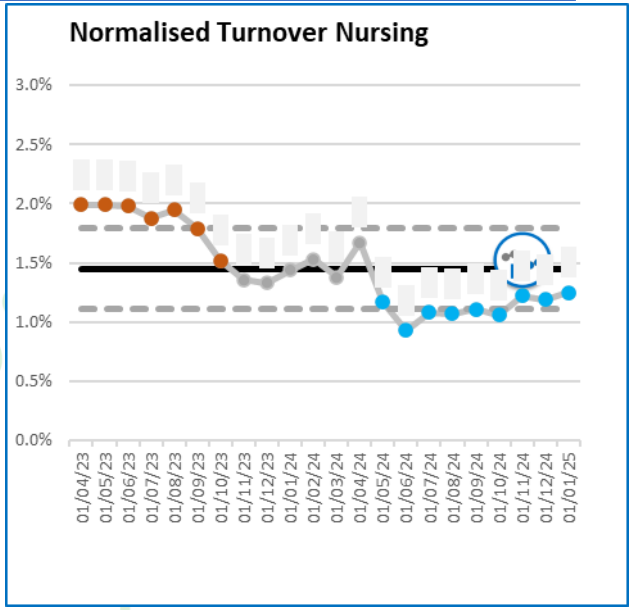


	Apr-23	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Funded establishment gap	261.76	147.84	59.13	38.43	42.08	50.6	56.28	58.02	39.61	38.5	49.31	45.49		
SIP	1799.22	1885.26	1874.52	1892.37	1888.65	1878.85	1866.93	1866.5	1881.69	1887.09	1876.23	1879.9		
Plan	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	1921.30	1925.59	1925.54	1925.39		



	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%	2%	2%	3%	2%	





Contracted WTE for nursing and midwifery staff in January 2025 is 1879.9 WTE, compared with 1876.23 WTE in December 24.

This is 79.33 WTE above the workforce plan (more staff than we said we would have).

The total nursing and midwifery vacancies reported stands at 45.49 WTE, which equates to a vacancy rate of 2%.

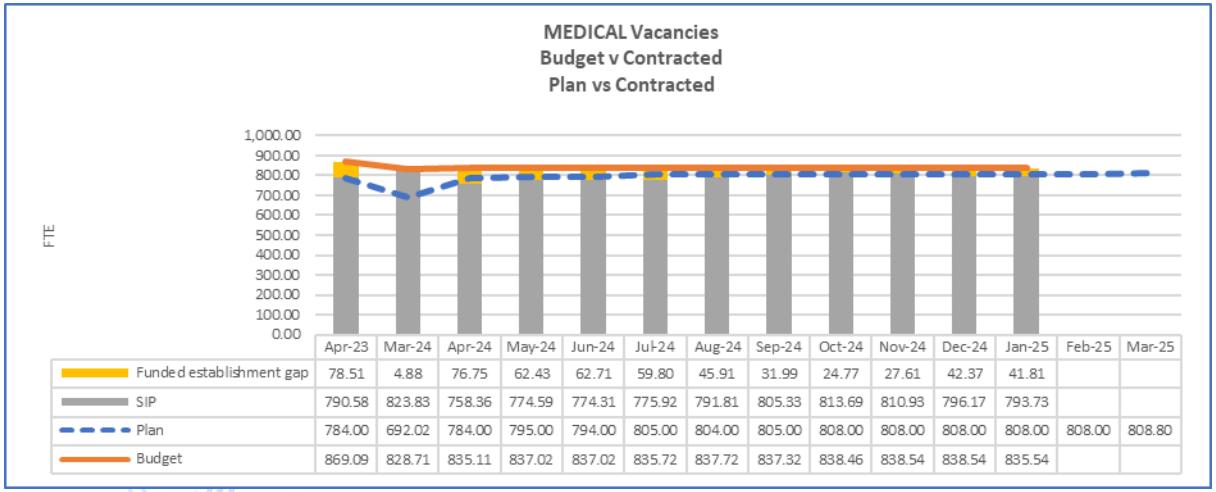
Staff turnover for nursing (rolling 12 months average) is at 2.94%, with normalised turnover at 1.25% in January 2025.

	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25
Nursing Turnover	3.24%	3.15%	3.07%	3.25%	2.95%	3.09%	3.09%	3.11%	2.69%	2.83%	2.96%	2.94%
Nursing Normalised Turnover	1.53%	1.38%	1.67%	1.17%	0.93%	1.08%	1.07%	1.11%	1.06%	1.22%	1.19%	1.25%

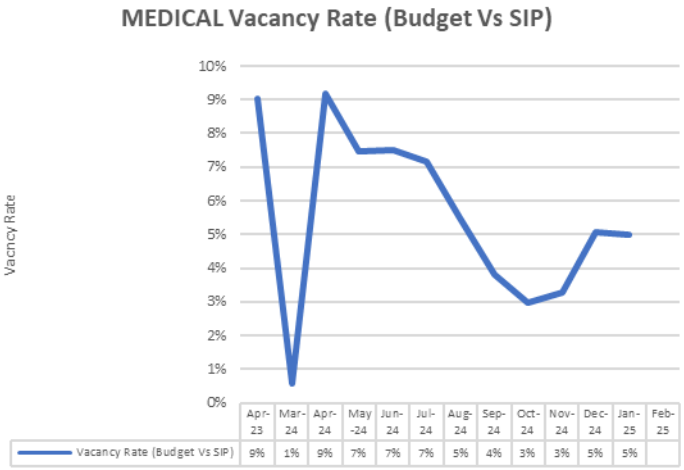
CARE RESPECT RESPONSIBILITY

Recruitment/Vacancies/Turnover - Medical & Dental

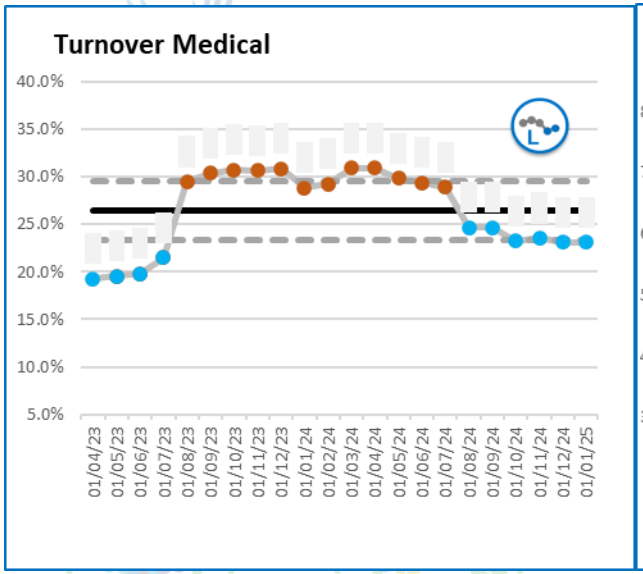
The Dudley Group NHS Foundation Trust

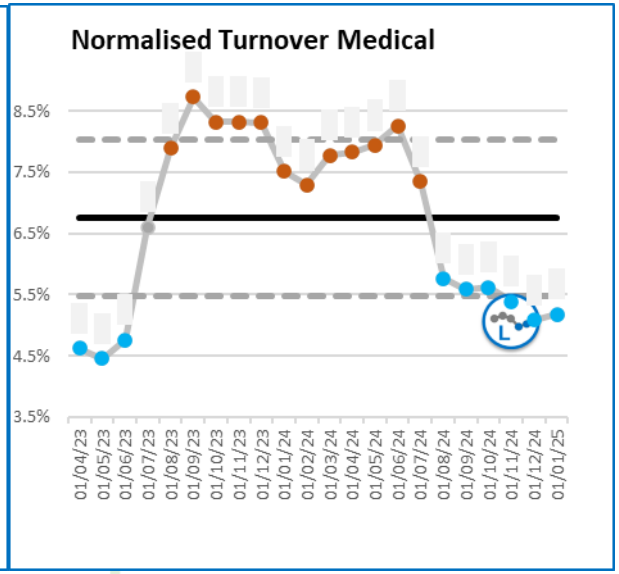


	Apr-23	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Funded establishment gap	78.51	4.88	76.75	62.43	62.71	59.80	45.91	31.99	24.77	27.61	42.37	41.81		
SIP	790.58	823.83	758.36	774.59	774.31	775.92	791.81	805.33	813.69	810.93	796.17	793.73		
Plan	784.00	692.02	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	838.46	838.54	838.54	835.54		



	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%	3%	3%	5%	5%	





Contracted WTE for medical and dental staff was 793.73 WTE in January 2025, a decrease from 796.17 WTE in December 2024. This is 14.27 WTE below plan (less staff than we said we would have).

The total medical and dental vacancies stands at 41.81 WTE. The vacancy rate is 5%.

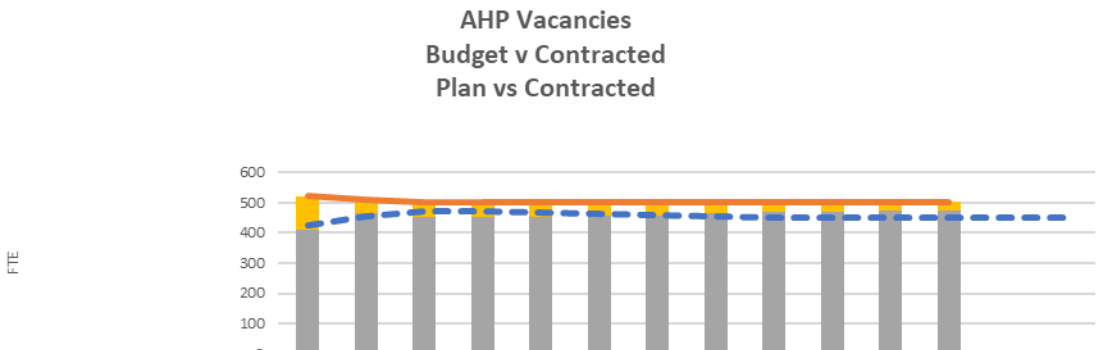
Staff turnover for medical and dental (rolling 12 months average) is 23.09% with normalised turnover at 5.18%. It should be noted that Deanery rotations are included in overall turnover.

	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25
M&D Turnover	29.19%	30.86%	30.86%	29.83%	29.34%	28.86%	24.64%	24.66%	23.21%	23.53%	23.08%	23.09%
M&D Normalised Turnover	7.29%	7.78%	7.83%	7.94%	8.26%	7.35%	5.77%	5.59%	5.62%	5.39%	5.09%	5.18%

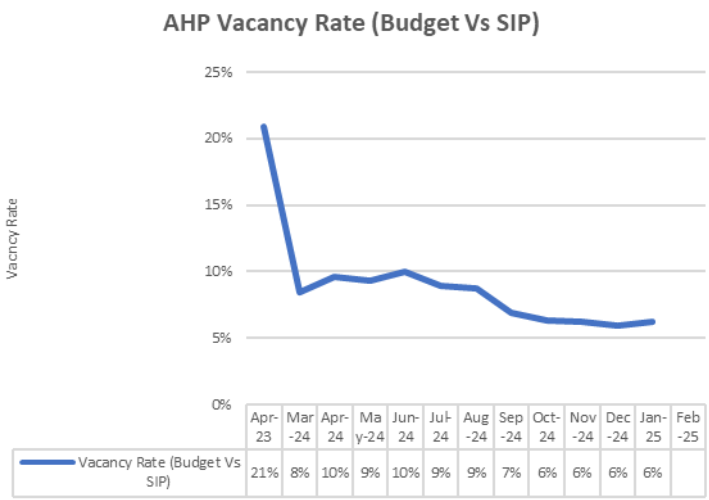
CARE RESPECT RESPONSIBILITY

Recruitment/Vacancies/Turnover - Allied Health Professional

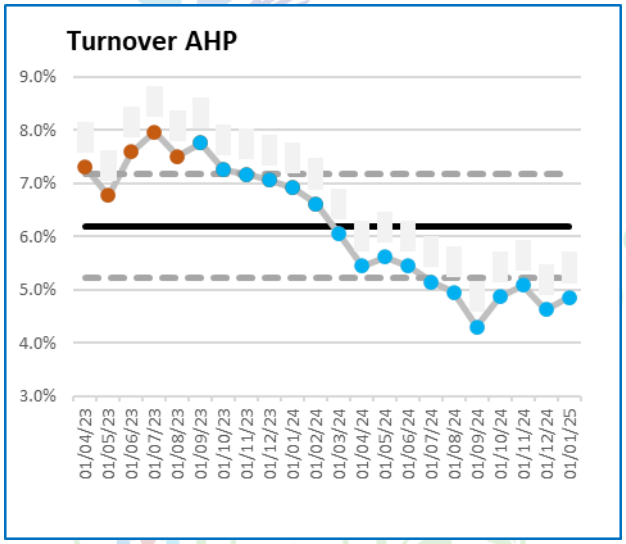
The Dudley Group NHS Foundation Trust

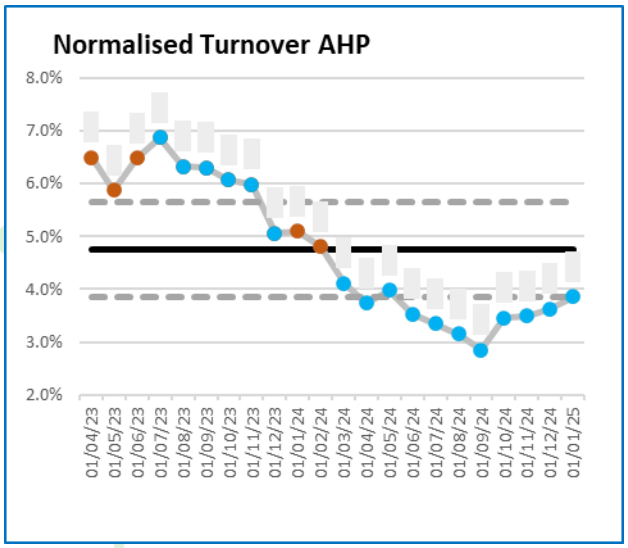


	Apr-23	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Funded establishment gap	108.64	43.12	48.14	46.93	50.33	44.78	44.04	34.54	31.56	31.25	29.88	31.26		
SIP	412.38	466.43	454.38	454.1	451.78	456.02	458.47	465.2	469.02	470.66	473.55	472.32		
Plan	424.00	456.38	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	500.58	501.91	503.43	503.58		



	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%	6%	6%	6%	6%	





Contracted WTE for AHP's has decreased to 472.32 WTE in January 2025, from 473.55 WTE in December 2024.

This is 21.10 WTE above the workforce plan (more staff than we said we would have).

The total AHP vacancies in January 2025 is 31.26 WTE this is a vacancy rate of 6%.

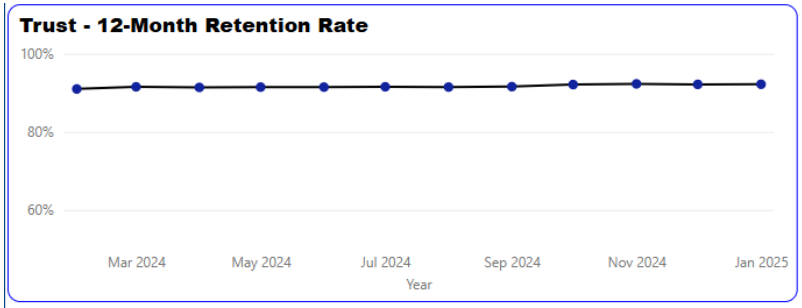
Staff turnover for AHP's (rolling 12 months average) is 4.85%, the normalised turnover is 3.86%.

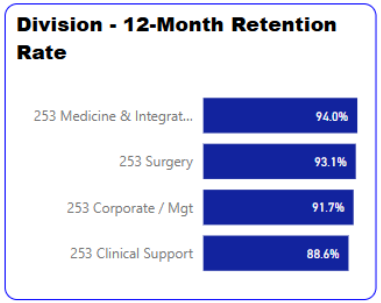
	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25
AHP Turnover	6.01%	5.03%	5.45%	5.61%	5.45%	5.15%	4.95%	4.30%	4.87%	5.08%	4.63%	4.85%
AHP Normalised Turnover	4.81%	4.12%	3.74%	3.98%	3.53%	3.35%	3.16%	2.85%	3.46%	3.49%	3.63%	3.86%

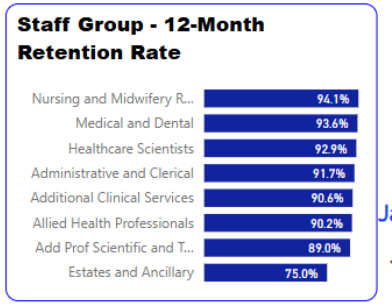
CARE RESPECT RESPONSIBILITY

Retention

The Dudley Group
NHS Foundation Trust

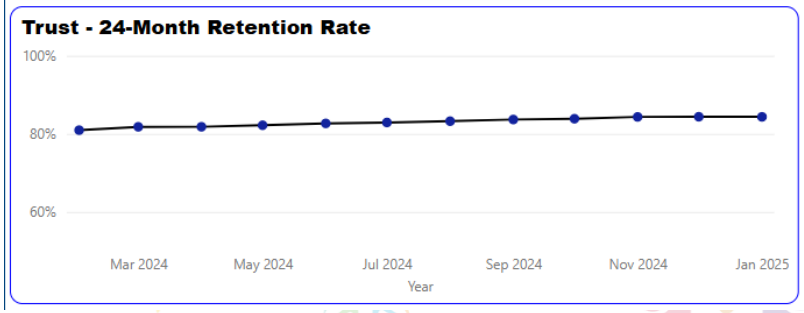


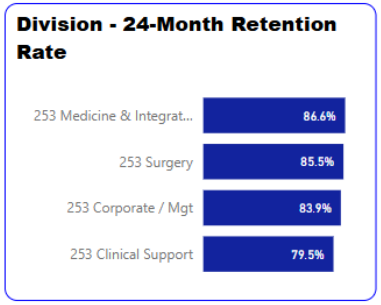


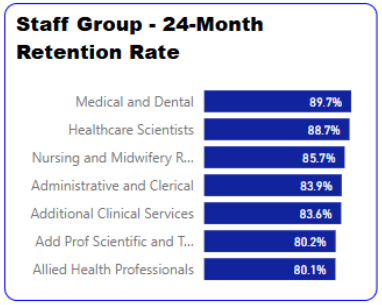


January 2025

12-Month Trust 92.2%







24-Month Trust 84.4%

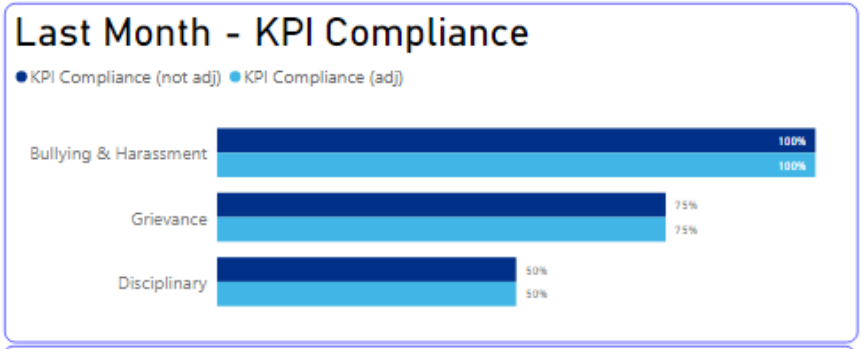
The retention rate has remained static at 92.2% in January 2025.

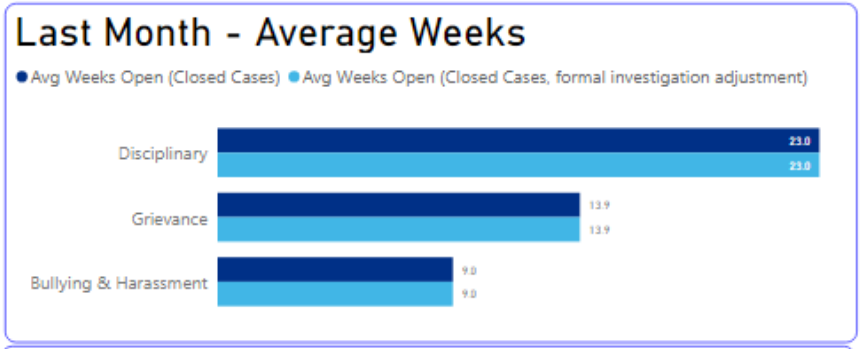
The division with the lowest 24-month retention rate is CCCS at 79.5% and both Additional Professional, Scientific and Technical staff and Allied Health Professionals are two staff groups that lower retention rates.

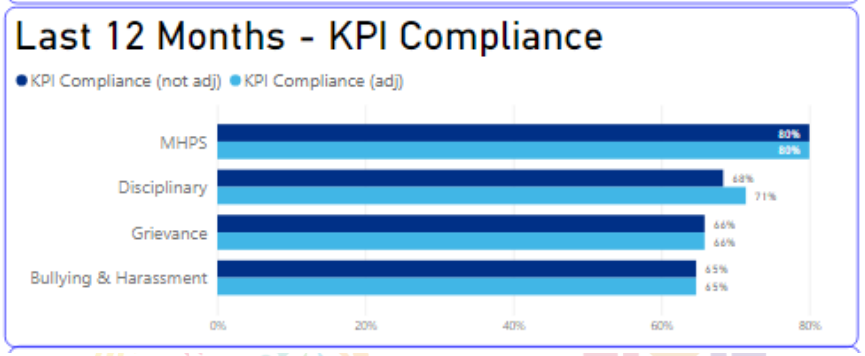
CARE RESPECT RESPONSIBILITY

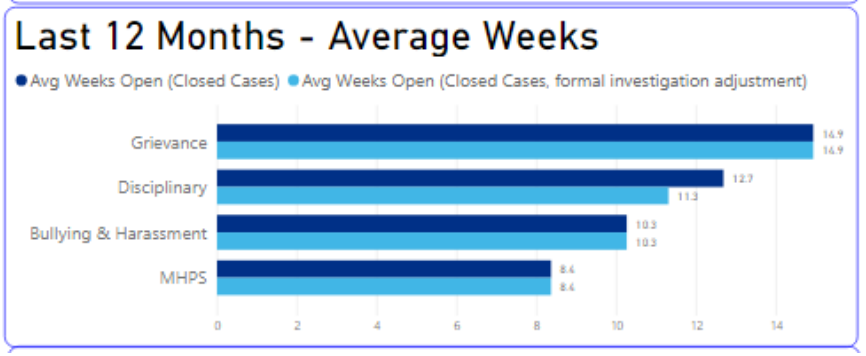
Employee Relations Casework KPI

The Dudley Group NHS Foundation Trust









In month – disciplinary cases has the lowest compliance rate for completing investigations within 12 weeks. In month 2 cases were closed that were historical cases where outside agencies were involved, which often protracts the timescale.

Over the last 12 months, the lowest compliance is with regards to bullying and harassment formal cases. Only 65% of bullying cases meet the 12-week KPI and on average take 16.9 weeks to complete.

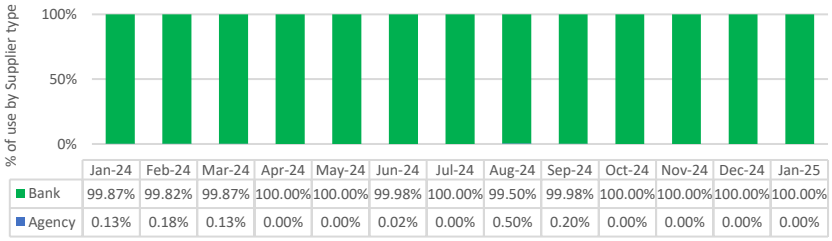
There is a project to embed an anti bullying and anti discrimination culture across the organisation during 2025, as reported via the Being a Brilliant Place to Work and Thrive sub-committee.

CARE RESPECT RESPONSIBILITY

Bank and Agency Usage

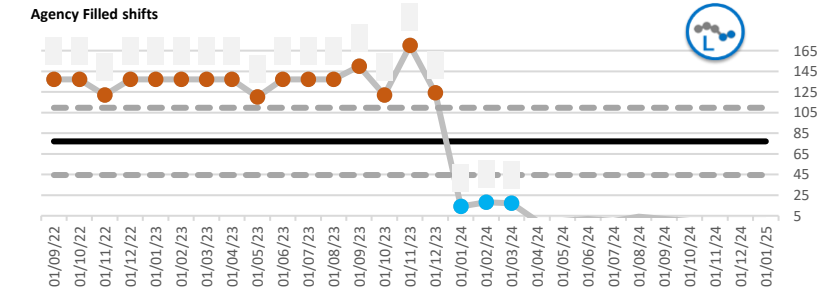
The Dudley Group NHS Foundation Trust

Bank v Agency (actual use) by Supplier Type

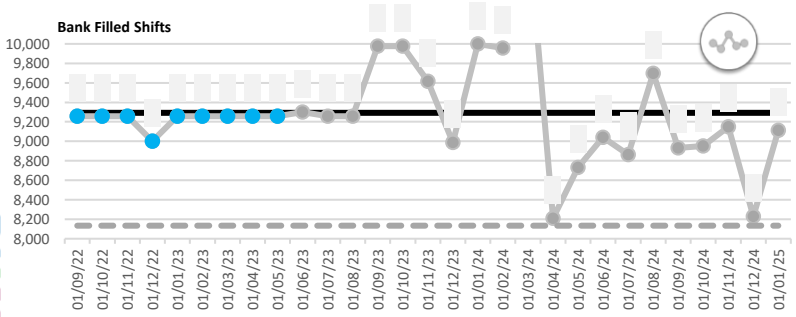


	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25
Bank	99.87%	99.82%	99.87%	100.00%	100.00%	99.98%	100.00%	99.50%	99.98%	100.00%	100.00%	100.00%	100.00%
Agency	0.13%	0.18%	0.13%	0.00%	0.00%	0.02%	0.00%	0.50%	0.20%	0.00%	0.00%	0.00%	0.00%

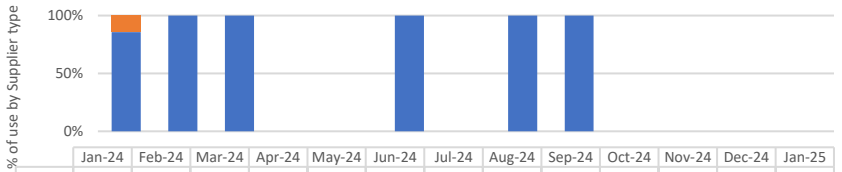
Agency Filled shifts



Bank Filled Shifts

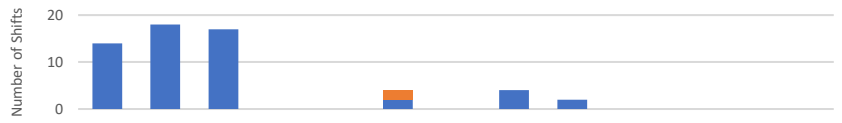


Agency (actual use) by Framework Type



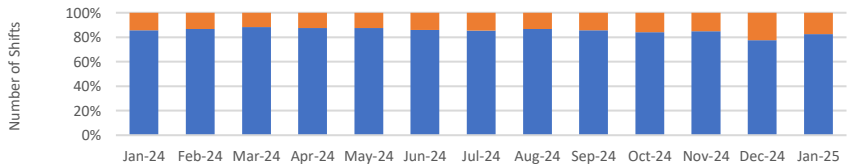
	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25
NFW	2	0	0	0	0	0	0	0	0	0	0	0	0
FW	12	18	17	0	0	2	0	4	2	0	0	0	0

Agency - Filled / Unfiled



	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25
Unfilled Shifts	0	0	0	0	0	2	0	0	0	0	0	0	0
Filled shifts	14	18	17	0	0	2	0	4	2	0	0	0	0

Bank - Filled / Unfiled



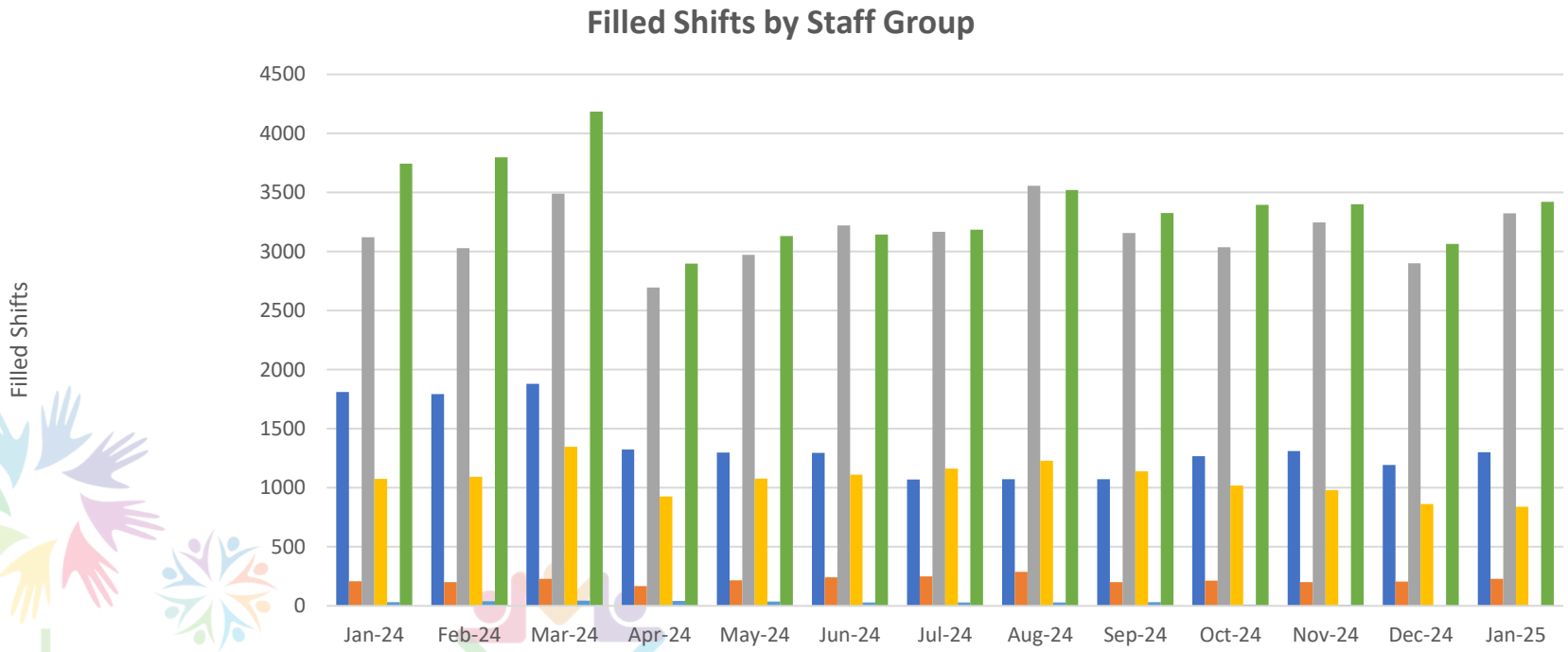
	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25
Unfilled Shifts	14%	13%	12%	13%	12%	14%	15%	13%	14%	16%	15%	22%	17%
Filled Shifts	86%	87%	88%	87%	88%	86%	85%	87%	86%	84%	85%	78%	83%

After a slight decline in bank fill rates to 78% in December 2024, the fill rates in January 2025 have increased to 83%.
Agency continues to be banned and no nursing agency shifts were worked in January 2025

CARE RESPECT RESPONSIBILITY

Bank Usage by Staff Group

The Dudley Group NHS Foundation Trust



	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25
A&C	1812	1793	1881	1324	1299	1296	1069	1073	1073	1268	1312	1193	1300
Add Prof Scientific and Technic	208	201	230	168	215	242	249	288	202	213	202	206	228
Additional Clinical Services	3120	3028	3490	2696	2972	3221	3168	3558	3156	3036	3247	2901	3323
AHP	1076	1094	1348	926	1078	1111	1161	1229	1138	1019	979	861	838
Healthcare Scientists	32	38	44	43	36	30	28	28	31	11	8	4	4
Nursing & Midwifery Registered	3743	3799	4186	2898	3131	3144	3184	3522	3326	3396	3400	3065	3420

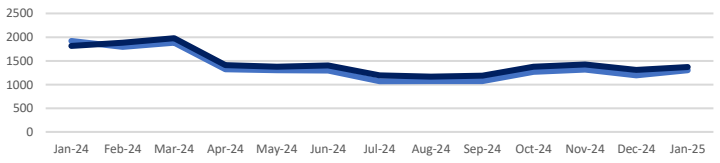
There was an increase in bank across all staff groups in January 2025 compared with December 2024, except Healthcare scientists.

CARE RESPECT RESPONSIBILITY

Bank Fill Rates

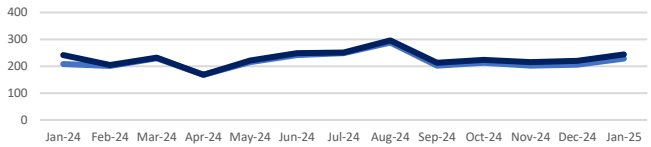
The Dudley Group
NHS Foundation Trust

Bank A&C Filled / Requested



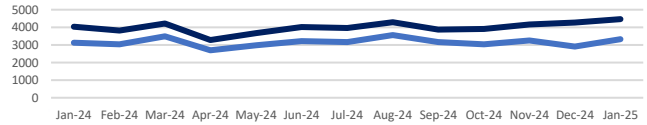
	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25
A&C Filled	1919	1793	1881	1324	1299	1296	1069	1073	1072	1268	1312	1193	1300
Total Request	1812	1885	1977	1406	1377	1401	1194	1166	1184	1373	1422	1308	1368

Bank Add Prof Scientific and Technic Filled / Requested



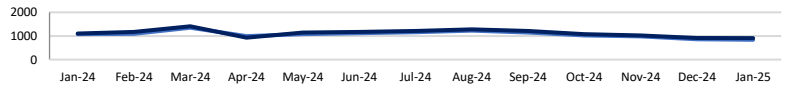
	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25
Add Prof Scientific and Technic Filled	208	201	230	168	215	242	249	288	202	213	202	206	228
Total Request	241	205	232	168	221	249	251	296	213	224	215	220	244

Additional Clinical Services Filled / Requested



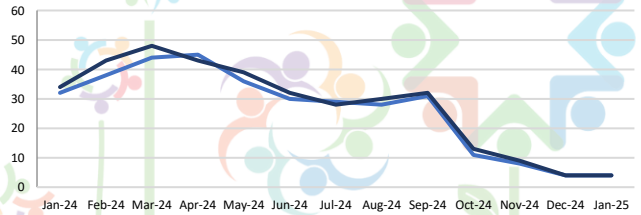
	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25
Additional Clinical Services Filled	3120	3028	3490	2696	2972	3221	3168	3558	3156	3036	3247	2901	3323
Total Request	4027	3819	4211	3278	3667	4019	3959	4293	3870	3904	4158	4275	4464

AHP - Filled / Requested



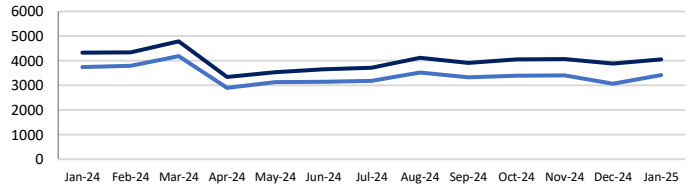
	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25
AHP Filled	1076	1094	1348	990	1078	1111	1161	1229	1138	1019	979	861	838
Total Request	1109	1165	1410	926	1140	1170	1218	1278	1214	1074	1017	921	909

Regsistered Filled / Requested



	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25
Healthcare Scientists Filled	32	38	44	45	36	30	29	28	31	11	8	4	4
Total Request	34	43	48	43	39	32	28	30	32	13	9	4	4

Regsistered Filled / Requested



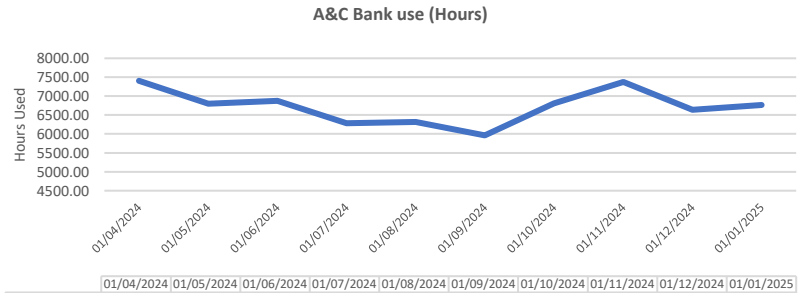
	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25
Nursing & Midwifery Registered Filled	3743	3799	4186	2898	3131	3144	3184	3522	3326	3396	3400	3065	3420
Total Request	4330	4342	4787	3339	3534	3649	3712	4112	3907	4049	4066	3890	4056

CARE RESPECT RESPONSIBILITY

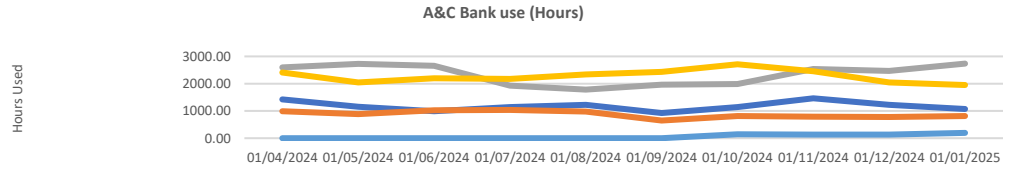
A&C Bank Use

Hours Used

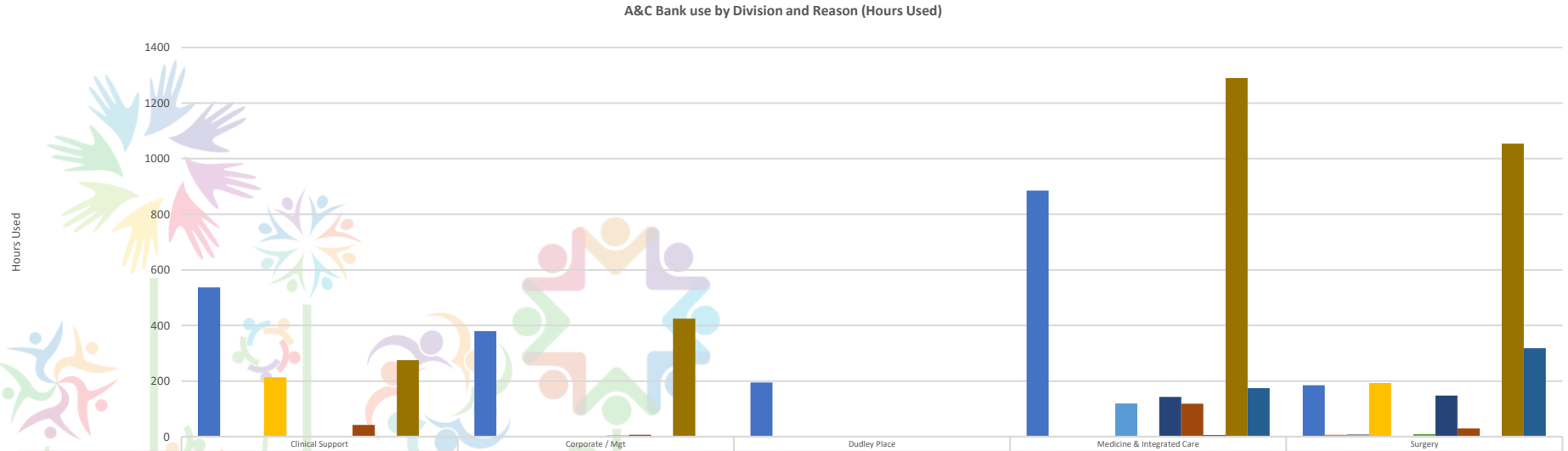
The Dudley Group
NHS Foundation Trust



	01/04/2024	01/05/2024	01/06/2024	01/07/2024	01/08/2024	01/09/2024	01/10/2024	01/11/2024	01/12/2024	01/01/2025
A&C	7404.62	6798.75	6876.65	6283.42	6320.33	5962.47	6806.07	7375.88	6639.98	6764.63



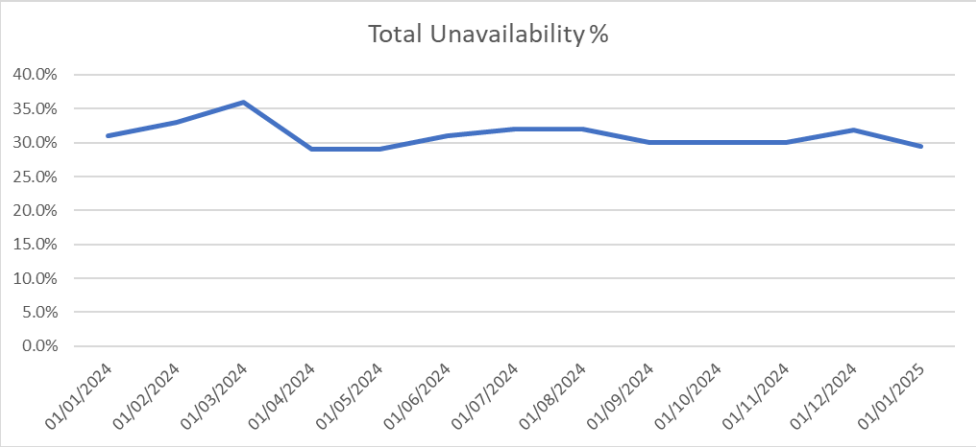
	01/04/2024	01/05/2024	01/06/2024	01/07/2024	01/08/2024	01/09/2024	01/10/2024	01/11/2024	01/12/2024	01/01/2025
Clinical Support	1417.92	1153.58	994.50	1143.58	1219.00	923.00	1137.67	1463.17	1220.33	1068.50
Corporate / Mgt	987.75	879.50	1022.75	1036.58	981.33	647.50	818.00	788.67	772.00	815.25
Medicine & Integrated Care	2592.62	2721.92	2656.15	1924.41	1782.66	1963.92	1992.17	2534.92	2467.32	2735.88
Surgery	2406.33	2043.75	2203.25	2178.83	2336.58	2428.05	2711.15	2453.88	2045.83	1950.50
Dudley Place	0.00	0.00	0.00	0.00	0.00	0.00	147.08	135.25	134.50	194.50



	Clinical Support	Corporate / Mgt	Dudley Place	Medicine & Integrated Care	Surgery
Additional Activity	537	380	194.5	884.7166667	185.5
Annual Leave (Overbooked/Emergency)	0.5				7.5
Extra Clinic					7.5
Increase in capacity - beds/patients	213				192.5
Maternity				120	
Secondment/ Paid Backfill					7.5
Sickness Long Term		4		143.5	148.25
Sickness Short Term	42.75	7		118.5	30
Special Leave				4.5	
Vacant Post	477.33	424.25		1290.166667	3[illegible]
Waiting List Initiative				174.5	

Rostering KPI

The Dudley Group
NHS Foundation Trust

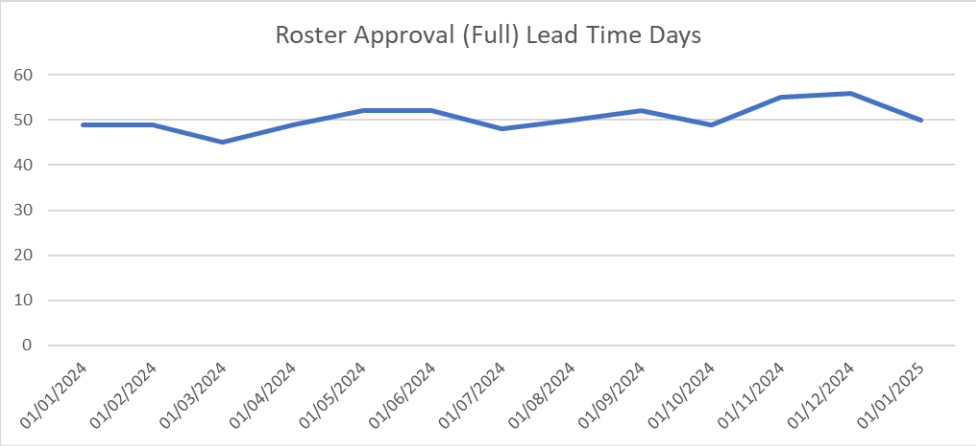


Unavailability is where staff are absent from their normal daily work but still consuming their contracted hours.

30%, made up of Annual Leave 12%, Sickness 8%, Parenting 5% , Other Leave 1%, Study Day 2% & Working Day 2%.

Budgeted percentage is 22%.

If actual unavailability is higher than budgeted, then either costs will exceed budgets (e.g. backfilling absence with temp staff), or units will be short staffed.



The number of days between the full approval (publishing) of the roster and the roster live date. Short lead times generate staff morale issues due to poor notice of their roster, and higher agency usage or unfilled duties as there is less lead time for the bank to fill gaps.

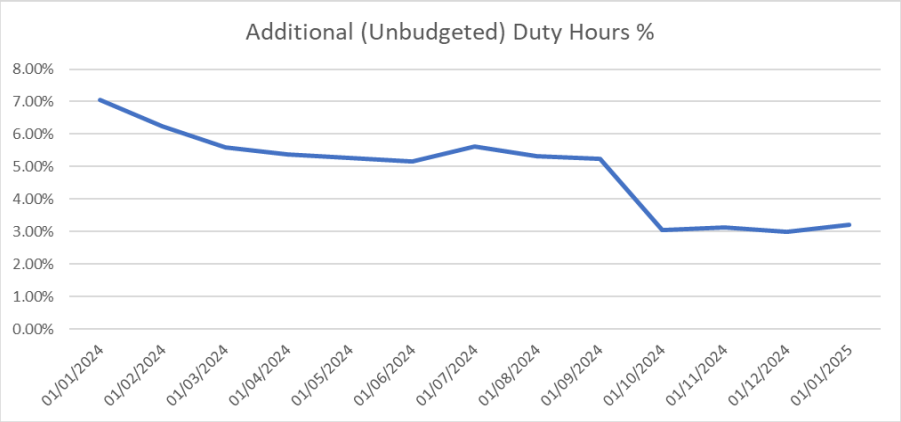
50 Days. Trust target is 55 days, NHSIE minimum is 42 days.

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

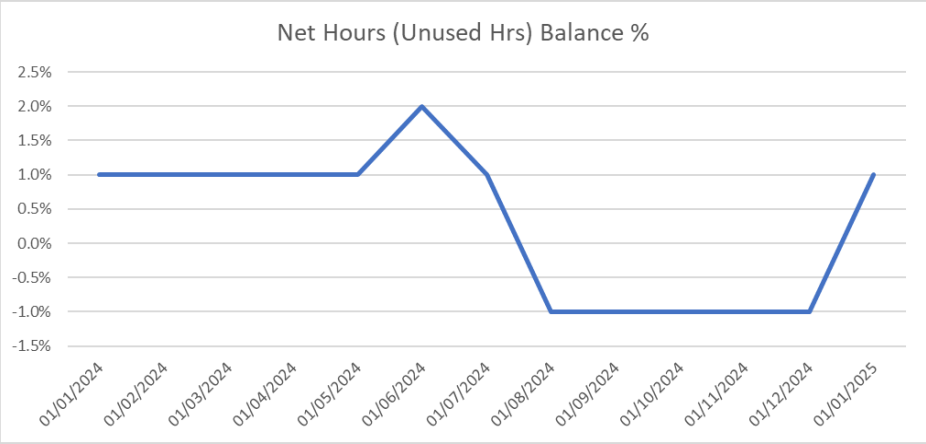
Rostering KPI

The Dudley Group
NHS Foundation Trust



% of assigned duty hours that are in addition to the budgeted demand e.g. 4 staff rostered when only 3 are required. This may be due to legitimate increased demand (e.g. increased acuity)

Departments with the highest percentage of additional duty hours are Discharge Lounge, C5 A, C3, B6 ward & C1 A
Most common reasons are Increase in Capacity & 1:1.



The % contracted hours left unused - e.g. if a staff member is contracted and paid for 150 hours but only works 144 hours there are 6 hours unused.

Net unused hours increased in January 2025. Confirm and Challenge have discussed how to support managers to manage the operational pressures, alongside responsibilities to scrutinise rosters.

In January 2025 the Trust have implemented a rule that bank cannot be worked where there are hours owing.

CARE RESPECT RESPONSIBILITY

New Loop App

The Dudley Group
NHS Foundation Trust

Loop - Unique users last 6 months

4,365

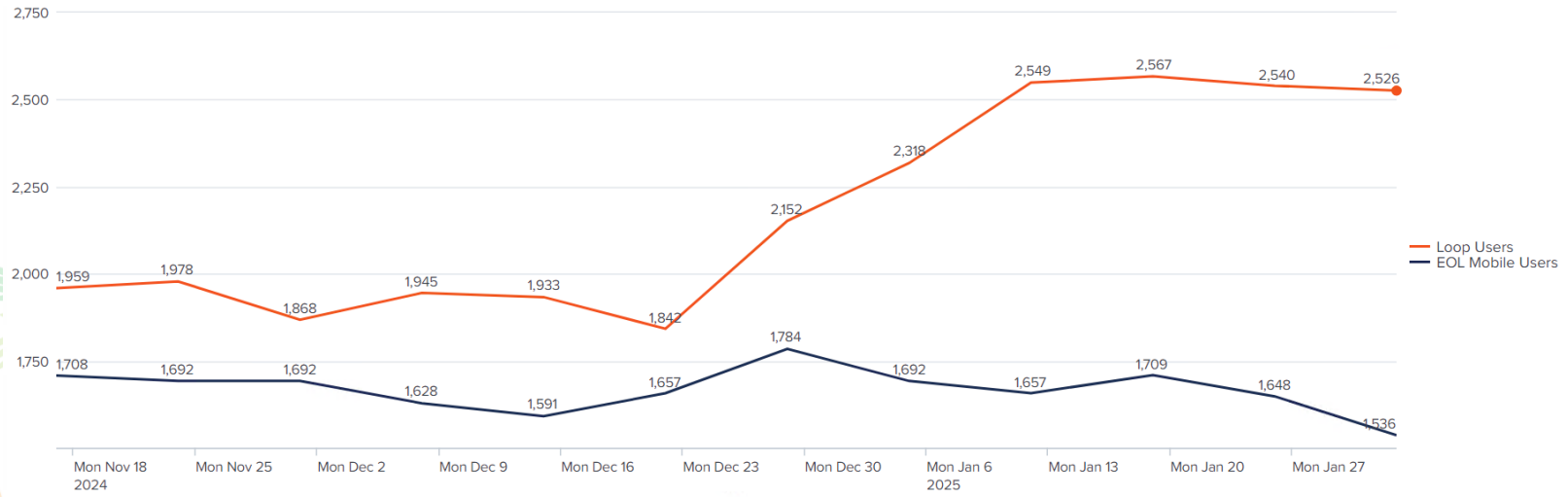
Number of unique users who have logged into Loop

Average EOL Mobile/Tablet Users (Last 12 Weeks)

1,666

Average number of unique users logging into EOL using a mobile or tablet device over the last 12 weeks

Loop vs EOL Mobile/Tablet usage



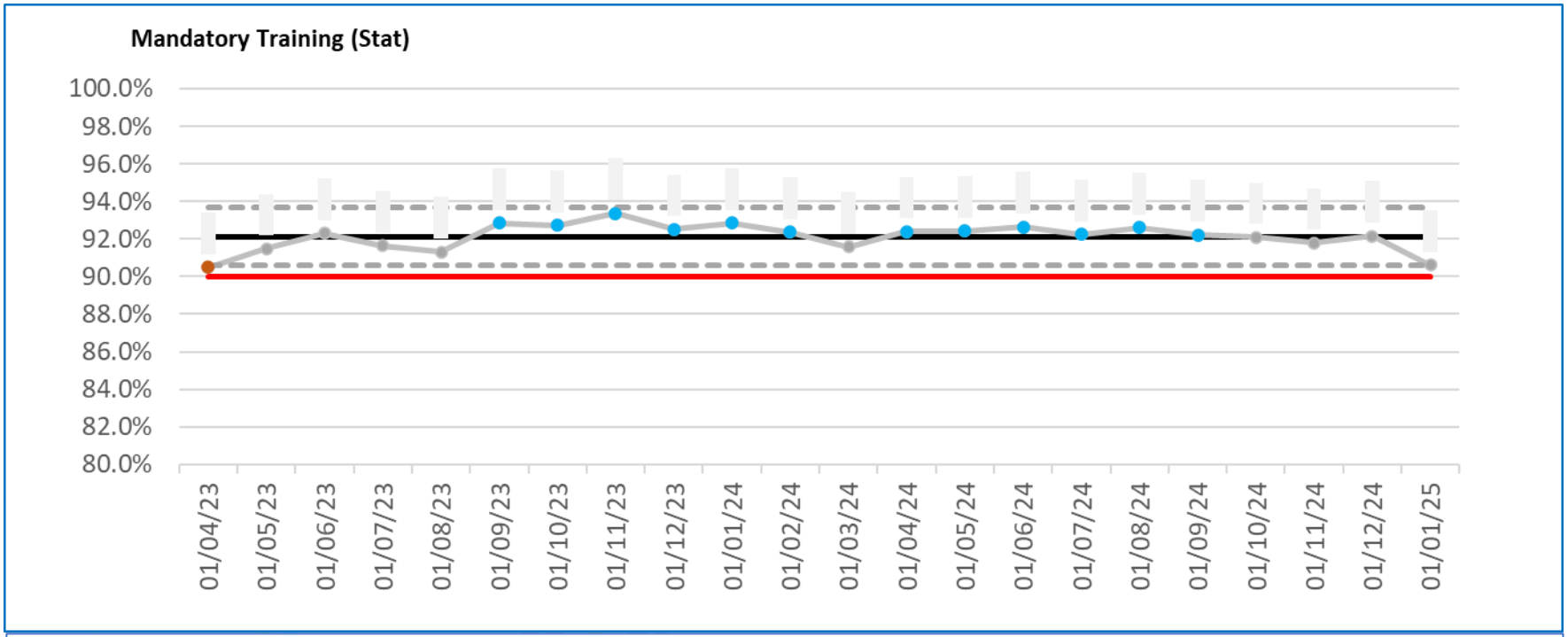
On 9th September 2024 we launched the new Allocate Loop app/website to replace the existing Employee Online (EOL) website which is due to be shut down on 31st March 2025.

We have had a successful launch with 4,365 users logging in so far. Loop now accounts for more log ins than EOL. We will be carrying on the comms to ensure all staff are using the app and we will be targeting those who continue to use Employee Online (EOL).

CARE RESPECT RESPONSIBILITY

Mandatory Training

The Dudley Group
NHS Foundation Trust



The overall rate for January has maintained above trust target performance. This is sustained above target compliance for over 12 months.
There is variation at Staff Group, Division and Subject and further work is planned to review areas of under-performance.
Challenges in transferring Place Division compliance have impacted overall Trust compliance in January before the updated reports are in place.

	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25
Mandatory Training (Stat)	92.37%	91.59%	92.39%	92.44%	92.65%	92.24%	92.60%	92.22%	92.09%	91.79%	92.16%	90.60%

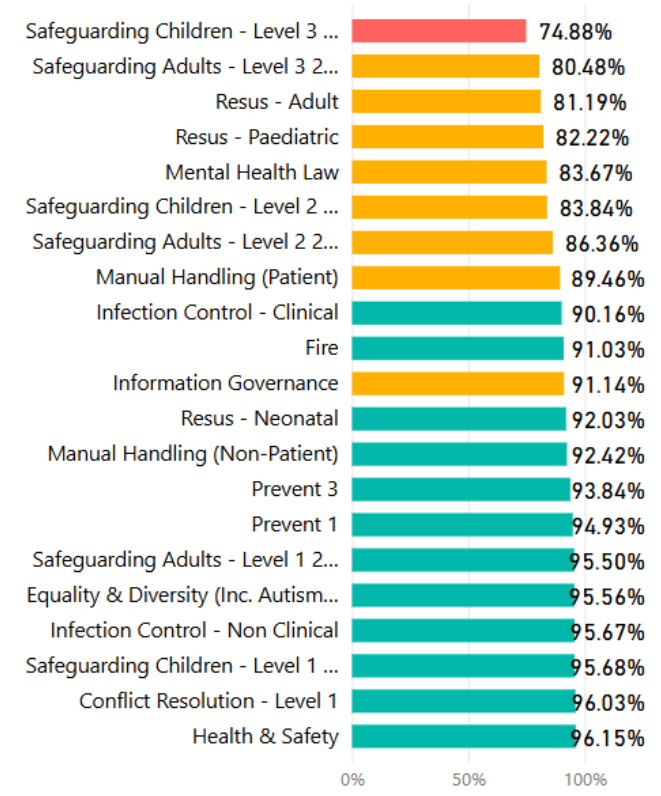
Mandatory Training – Priority 1

The Dudley Group NHS Foundation Trust

Month: January 2025	Trust	CS	Corporate	MIC	Surgery	Place
	90.60%	94.66%	93.23%	90.71%	90.64%	55.77%

Course Compliance

Course Compliance (based on selections)



Depts by no. required to achieve 90%

Ward/Service (based selections)

Group5Description	Actual	No. to Target	%' tage
253 Medicines Management Serv	319	210	54.34%
253 MOC Medical Staff Serv	332	110	67.61%
253 CHC & Intermediate Care Serv	174	102	56.86%
253 GP Clinical Leadership/Advisor Serv	41	88	28.67%
253 High Oak Practice Serv	95	83	48.22%
253 Dudley & Netherton PCN ARRS Serv	132	79	56.41%
253 Brierley Hill & Amblecote PCN - ARRS Serv	134	73	58.26%
253 Medical Staff - Acute Medicine Serv	844	72	82.98%
253 General Surgery Medical Staff Serv	448	69	78.04%
253 Enhanced Care Home Team Serv	39	67	33.33%
253 Pathology - Phlebotomy Serv	650	51	83.54%
253 Medical Staff - Respiratory Serv	264	49	76.08%
253 Halesowen PCN ARRS Serv	105	46	62.87%
253 Medical Staff - GI Serv	181	45	72.11%
253 Medical Staff (Vascular) Serv	149	45	69.30%
253 Maxillofacial Surgery Medical Staff Serv	65	43	54.16%
253 Medical Staff Cardiology Serv	227	43	75.66%
253 Theatres Emergency & Other Serv	454	41	82.54%
253 Urology Medical Staff Serv	153	41	71.16%
253 Medical Staff (Older People) Serv	242	39	77.56%
Total	**64,204**	**-430**	**90.60%**

Statutory Training remains above target across all divisions with the exception of the Place Division. This should improve after January's data update.

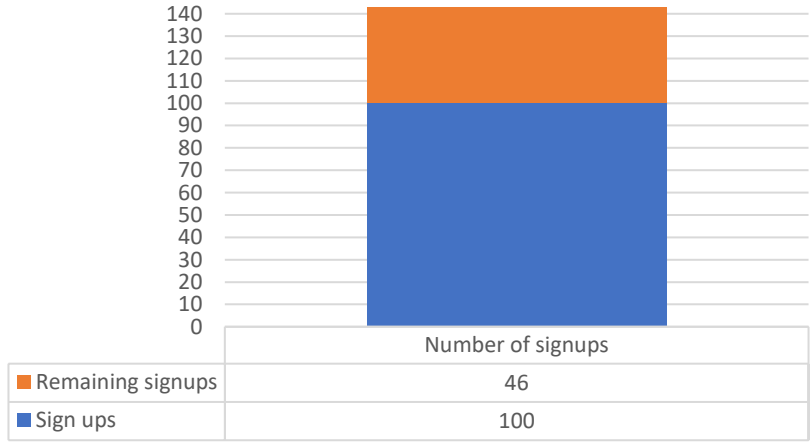
There is currently only one red rated subject – Safeguarding Children Level 3.

Work continues to address action in this area.

CARE RESPECT RESPONSIBILITY

Apprenticeships

The Dudley Group NHS Foundation Trust



Total Active Apprenticeships : 279	
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
Expired Levy October 24	£50,652
Expired Levy November 24	£0
Expired Levy December 24	£20,444.53
Expired Levy January 25	£23,195.08

Apprenticeship activity and Levy Spend have been impacted by the recruitment freeze.

It is likely that this will mean that the apprentice sign-up target for 2024/25 will not be achieved.

It is likely that lower activity will also impact on Levy expiry – having seen increased loss of funds over the last 2 months.

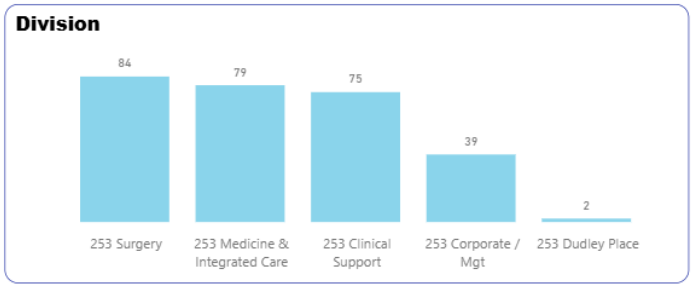
Sign ups during January – March will have a positive impact on this.
We have also accepted additional requests for Levy Transfer.

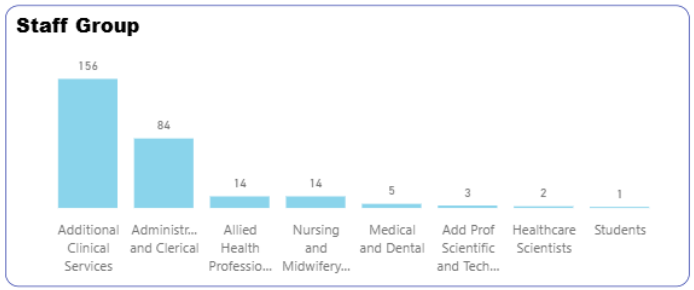
Some additional activity is planned duing Quarter 4 – for both clinical apprenticeships and for internal staff development apprenticeships.

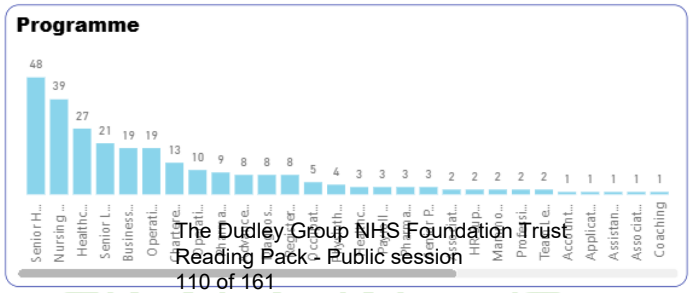
Work continues to promote internal apprenticeship opportunities in order to compensate for the lack of new apprentice opportunities.

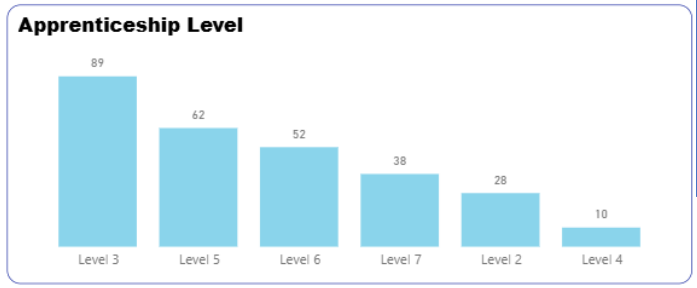
Details on changes to the Apprentice Levy to the Skills and Growth Levy are still not confirmed.

Active Apprenticeships breakdown









CARE RESPECT RESPONSIBILITY

Work Experience and Widening Participation

The Dudley Group NHS Foundation Trust

Employability Programmes

The ICAN programme is currently completing activity in the final months of Phase 1.

10 participants on paid work experience placements that commenced in September (3 clinical/ 7 Non-clinical). Work is underway to support transition into any vacancies and to support job-searching due to recruitment freeze limiting internal opportunities. These will be supported by the ICan team once their placements are completed to ensure they are signed up to the Bank for any temporary work opportunities and in a talent pool to access any internal vacancies that might be available. We are also working with external partners to identify work opportunities for this cohort.

9 participants were recruited to the third cohort of the Clinical Support Worker ICAN training programme in December 2024. 3 candidates have withdrawn – leaving 6 on the programme. 1 candidate has been offered a substantive post and the remaining 5 are still working on their Care Certificate and competencies – due to complete in March.

Work continues to secure ongoing funding for the programme – some elements of the programme have a high confidence around continuation (CSW programme, Into Employment support). There is a high interest in the partnership elements and the Work Experience elements from West Midlands Combined Authority but we are still awaiting confirmation of funding for April 2025 onwards.

Evaluation activity continues to ensure we have captured impact and outcomes from the programme. This will be available at the end of March 2025.

Careers Education Information Advice and Guidance (CEIAG)

There is no specific update in this area for January.

Ambassadors

There are 81 active careers ambassadors in the Trust Work is underway to identify how to use these more effectively and to recruit and diversify the ambassador's workforce with a clear plan in place by March 2025 and success metrics agreed.

Work Experience

The next cohort of central clinical work experience will be held in Spring 2025.
Medical Work Experience is now open for recruitment for June 2025.

Initial planning has commenced with Dudley Academies Trust around specific schools' work experience activities – a date has been agreed to pilot this programme in May.

Work Related Learning:

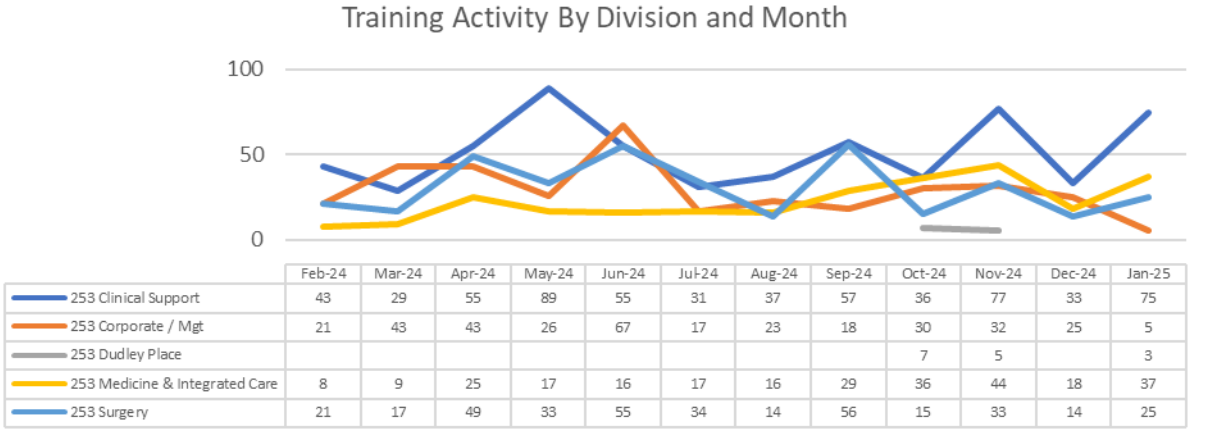
The next Behind the Scenes event is planned for late in Q4.

Other partnership activity is being planned with Dudley Academies Trust and Windsor Academies Trust.

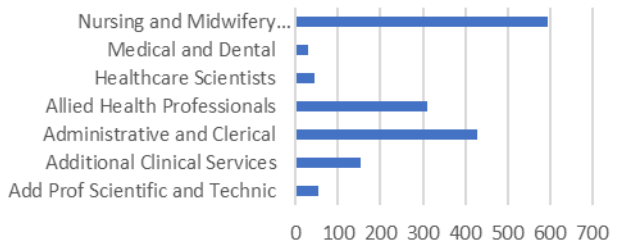
CARE RESPECT RESPONSIBILITY

Organisational Development

The Dudley Group
NHS Foundation Trust



	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25
253 Clinical Support	43	29	55	89	55	31	37	57	36	77	33	75
253 Corporate / Mgt	21	43	43	26	67	17	23	18	30	32	25	5
253 Dudley Place									7	5		3
253 Medicine & Integrated Care	8	9	25	17	16	17	16	29	36	44	18	37
253 Surgery	21	17	49	33	55	34	14	56	15	33	14	25

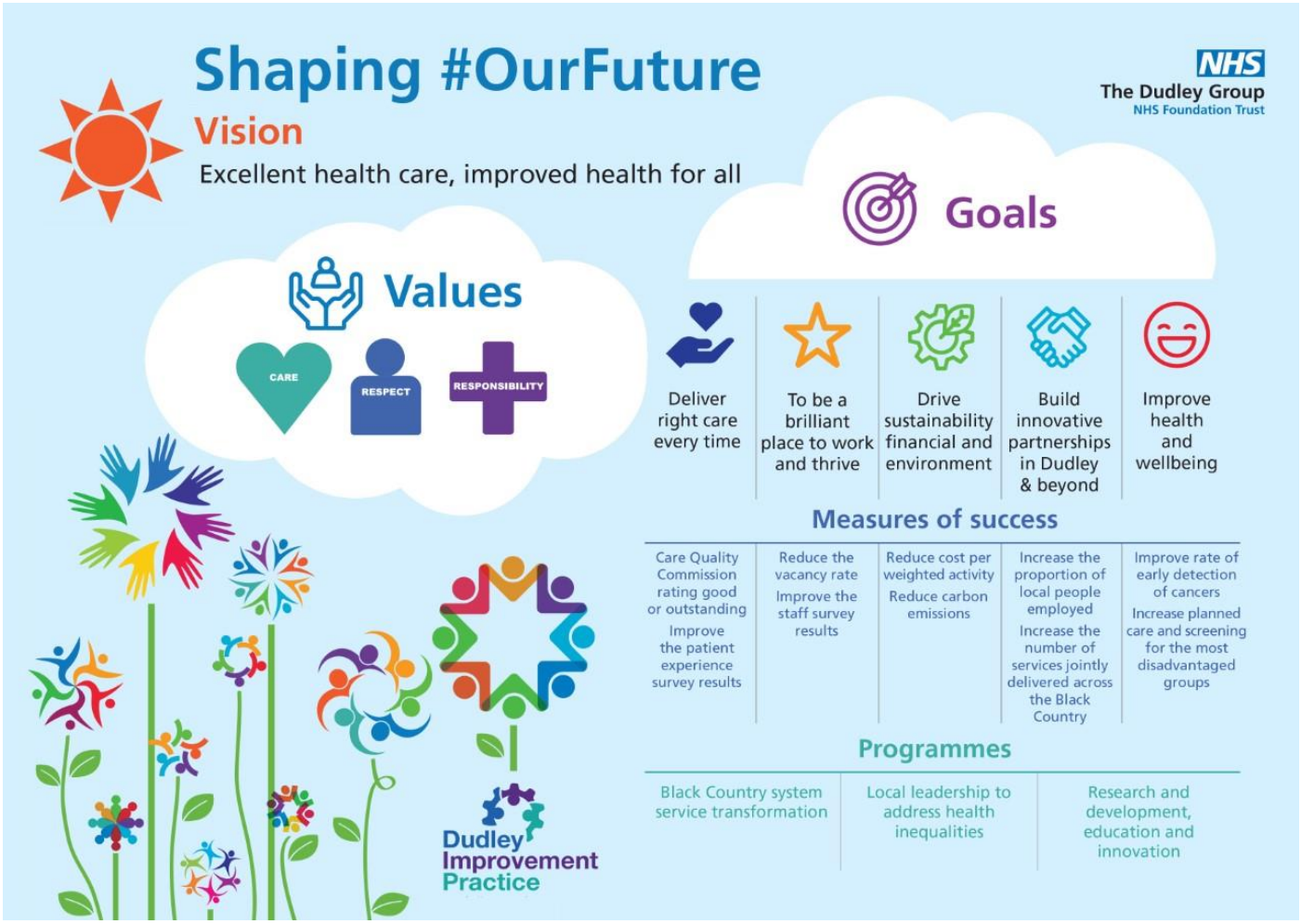


Course	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Grand Total
253 Resilience Training										8			8
253 Admin Essentials			14			10					14		38
253 Annual Review Training		12	45	43	19								119
253 Bespoke Training				21	23	6		10		17			77
253 Coaching		5			8		7		4	8		9	41
253 Communications 1	4	8	6		13	10	3	11	15	11	10	4	95
253 Communications 2	10		3		21		13		15	7	7	7	83
253 Developing Leaders	8												8
253 Flexible Working			8	16		9		5					38
253 Leading People at Dudley		6	12	8	3	4	9	4	3	7		4	60
253 Leading with Confidence Introduction								8	12		19		39
253 Living The Values	20	11	32	12	32	11		2	13	26		67	226
253 Local Induction Training		2		11		6	17			14			50
253 Managers Essentials	21	23	28	26	35	10	12	40	19	36	17	15	282
253 Report Writing and Presenting											4		4
253 Resolving Conflict & Honest Conversations										4			4
253 Welcome 2 Dudley Induction	12	13	7	15	7	4	13	21	21	12	2	9	136
253 Wellbeing 1	11	6	11	8	13	12	12	6	14	12	10	5	120
253 Wellbeing 2	7	6	3	5	9	11	4	10		16			71
253 Wellbeing 2 - Team Wellbeing for Managers												7	7
253 Wellbeing Adhoc					10			37				18	65
253 Wellbeing Champions		6	3			6			8	8	5		36
253 Workforce Planning								6		5	2		13
Grand Total	93	98	172	165	193	99	90	160	124	191	90	145	1620

Training activity has increased in January with additional courses and increased demand for Manager's Essentials. Promotion continues across the organisation to ensure effective utilisation of training.

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

Quarter 3: October – December 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 ratings unchanged during Q3		There have been no new CQC inspections during Q3. During this quarter a meeting took place between the Trust and the CQC relationship leads where presentations were provided by speciality leads on the progress made with action plans since the last inspections. No concerns were raised by the CQC at or after the meeting. Work continued on the CQC self-assessments across the 10 core services in preparation for Executive Director review and sign off. Unfortunately, due to site pressures the 'confirm and challenge' session arranged for December had to be cancelled. Work has commenced to integrate Primary care into the self-assessment process and other compliance related activities. Core service review of surgery has taken place (internal quality and safety	CQC self-assessments to be reviewed by executive directors and Trust Board in preparation for sharing with the Black Country Provider Collaborative. Finalisation of the Surgery Core Service Review findings and subsequent improvement work. Undertaking of the Primary Care self assessment with presentation at Quality and safety Group at the end of Q4.

			review) – the report is being finalised for sharing in Q4.	
Improve our patient experience results to top quartile performance (England) by 2025	There are no patient experience surveys to report in Q3.			
Achieve NHS Constitution targets (Referral to treatment, diagnostics, cancer, emergency access)			**Emergency Performance** In November ED 4-hour performance was at 81.62% vs the national target of 78%. 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. On going focus on: GP letter patients straight to SDEC/Surgical SDEC. Agree new streaming template with UCC for patients with letters to go direct to Speciality. Re-run of heat mapping exercise for nurses and medics in ED. Joint working with Surgery to ensure proactivity to take patients from ED even when full. Organizational agreement that specialties must take patients directly and not wait to assess them in ED. Extra Validation resource.	Continue to drive the Trust's performance against the national standards with local recovery plans.

			Cancer Performance The 28 day Faster Diagnostic Standard (FDS) achieved 80.9% (October 24 validated) against the constitutional standard of 77%. 31-day combined decision to treat performance achieved 92.9% in October against the national target of 96%. Surgical and diagnostic capacity and BCPS reporting delays impact performance. 31 day trajectory to achieve 96% submitted to ICB. Performance against the 62 Day combined target achieved 76.4% in October which is above the national target of 70%. **DM01 Performance** November's DM01 performance achieved 90.4%. All modalities, with exception of Sleep Studies, are achieving above 90%. **Black Country Pathology Service (BCPS)** Urgent 10-day histology is 51% against National 70% target, November forecast is 69%. E-Requesting at 47%. Further improvement underway. IT issue in Gastro now resolved. Compass pilot begins in December 2024 with wider rollout in January 2025. Urgent requesting at 59%, Task and finish group is in place to review	

			pathways and identify opportunities for improvement. **<u>Elective Restoration & Recovery</u>** We continue to perform well with Elective Restoration and Recovery. We are now focusing on patients at 65 weeks. There is an accelerated target date in December due to the festive period with clearance expected by the 22nd December. The most challenging specialties continue to be Neurology, Dermatology and Gynaecology with high numbers also to clear in General Surgery. The next target for focus is the 52 week wait patients being treated by the end of March 25. We are now looking to book all 52 week first outpatient appointments that would breach in March 25 by the end of November 24. This is a challenging ask, but the teams are currently working on plans to achieve. **November RTT position 59.2% vs 92% national target**, a continued improvement month on month.	
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		During Q3, 2024/25 there were 263 new complaints received. In comparison to Q3, 2023/24, there were 227 new complaints received; this is an increase of 15.8% for the quarter.	The complaints team continue to offer an informal approach (PALS route) to address concerns where applicable to reduce the number of formal complaints received.

	anticipated number of new complaints received would be 812 for 2024/25. At the end of Q3 (2024/25) the Trust has received in total 766 complaints. This is a difference of 46 complaints between the target financial year figure (812) and the current figure (766). On average, the Trust received 87 complaints per month for Q3 2024/25 and therefore it is predicted this target will be unachievable with the potential to increase the number of complaints received from last financial year by 12% (this is based on receiving the average of 87 complaints per month for the last quarter, Q4).		From April 2023 to December 2023 (Q1, Q2 and Q3), 719 complaints were received, compared to 766 in Q1, Q2 and Q3 2024. This is an increase of 6.5% increase.	

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 Q3 2024/25, the Trust closed 288 complaints, 145 (50.3%) were closed (this is all complaints closed including reopened complaints) within 30 working days which is an increase in the response rate from Q2, (2024/25) (47.1%) of 3.2%. The number of complaints closed for Q3 (2024/25) where there was a first response only (not including reopened and Ombudsman cases) was 253. Of those 253, 138 of those were closed within 30 working days. The average response rate of closed complaints where there is a first response only is 54.5%. This is an increase from Q2 (2024/25) (48.1%) of 6.4%. This remains above the response rate for 2023/24 but is still not at 90% target response rate.	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 81% of respondents rated their experience of Trust services as 'very good/good' in December 2024/2025, in comparison to 83% in November 2024/2025. A total of 7% of patients rated their experience of Trust services as 'very poor/poor', an increase of 1% since the previous quarter. In December 2024/2025, the A&E Department received the lowest percentage score for patients rating their overall experience as 'very good/good' at 68%, a decrease of 2% since	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. 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.

			November 2024/2025. The percentage 'very poor/poor' scores for the A&E Department remain the highest of all departments at 16%, an increase of 3% since the previous month. Community services received the highest positive ratings this quarter at 90%, a recurring theme from the previous quarter. Community received the lowest scores from patients rating their overall experience as 'very poor/poor' at 2%.	
Reduction in incidents resulting in significant harm (moderate, severe, death)	The percentage and number of incidents resulting in significant harm remains low. Following validation, the monthly percentage of incidents resulting in moderate/severe harm or death remains below 1% and the actual numbers remain consistent with the previous 12 month period		PSIRF response tools continue to be utilised and developed to review system-based factors contributing to incident occurrence. Single improvement plans are in place for a number of the speciality areas and work continues to widen their utilisation. Monitoring forums in place. A programme of action effectiveness checks to be undertaken to ensure actions have been embedded/sustained in practice and are having the desire impact. Work continues to promote reporting through newly up-dated training programmes	Work to promote incident reporting through training and awareness raising particularly in the newly transferred Place services to take place in Q4. Work to further review and strengthen the improvement metrics to assess the impact of incident action plans to take place in Q4
Standardised Hospital Mortality Index (SHMI) (quarterly) better	Latest SHMI is 99.75 v an England average of 100. (Reporting period Sep23-Aug 24)		Mortality Surveillance Group continues to monitor mortality indicators and related work plans on a monthly basis.	Working group to continue driving condition specific SHMI reduction. Embedding of Martha's Rule

than England average			Specific workstreams ongoing relating to #NOF, Stroke and Chest Pain pathways. AQ pathway work continues	
Re-admission within 28 days better than England average	8.59% (Sep23-Aug24) v England average of 8.03%		Ongoing review of readmission data via divisional governance structures.	Continue to monitor readmissions at speciality level via local governance meetings Review of condition specific readmissions
Eliminate 65 week waits by Sept 24 and reduce 52 week waits			**Elective Restoration & Recovery** We continue to perform well with Elective Restoration and Recovery. We are now focusing on patients at 65 weeks. There is an accelerated target date in December due to the festive period with clearance expected by the 22nd December. The most challenging specialties continue to be Neurology, Dermatology and Gynaecology with high numbers also to clear in General Surgery. The next target for focus is the 52 week wait patients being treated by the end of March 25. We are now looking to book all 52 week first outpatient appointments that would breach in March 25 by the end of November 24. This is a challenging ask, but the teams are currently working on plans to achieve. November RTT position 59.2% vs 92% national target, a continued improvement month on month.	Continue to drive the Trust's performance against the national standards with local recovery plans.
Improve productivity (reduce DNA rate to			**GIRFT Further Faster 20 Programme**	Continue to drive and work towards the National GIRFT / GIRFT Further Faster 20 programme.

better than England average, increase PIFU to 5%, theatre utilisation at 85%)			The trust continues to drive the GIRFT Further Faster Programme, as well as Specialty GIRFT Meetings since July 2023, with key priorities delivering on Outpatients Pre-Appointments / Reducing and managing DNAs / Remote Appointments / Outpatient throughput / Patient Initiative Follow Ups across 17 core outpatient services. Improving Pathways through: - Diagnostics / Surgical Pathways / Theatres. **Trust DNA Performance Model Hospital October 24 – 6%** (CSS 7.9%, MIC 4.9%, SWC 6.7%) **<u>Theatres</u>** **Theatre utilisation increased to over 85% in November 24.** Theatre managers are still working on the prioritisation of on-time starts and the importance of accurate data entry, especially in light of the changes to Model Hospital data validation. Improved utilisation during high turnover lists has been maintained. Patient throughput has improved slightly will hopefully increase over time with these improvements. Multiple specialties are often exceeding 90% utilisation. A delegation from the Trust attended a recent GIRFT event at the Royal College of Surgeons to listen to and discuss the experiences of similar	

			Trusts in their Hub Optimisation Plans as part of our deferral for Elective Surgical Hub accreditation. Advice received will be used to ensure our plans are in line with the requirements of a successful accreditation in 2025. From October 2024 DGFT is now a part of the GIRFT Further Faster 20 initiatives, announced by the Secretary of State in September 2024, to target support for systems to improve and streamline pathways for patients and spread good practice in areas with high levels of economic inactivity. This is an opportunity for resource and focus to be placed in areas where we can have substantial impact to reduce the waiting list and continue to build on work we have already commenced. It is an opportunity to further improve care across our communities and link together Primary and Secondary care. It is also in line with the government's economic policy focus. We have more work to do to ensure that the GIRFT Further Faster 20 programme embeds further within the Trust, and we are creating a Trust GIRFT delivery group, clinically led to provide guidance, challenge and direction to all specialties. Through the Trust GIRFT delivery group, Clinical & Operational leads will be nominated to set objectives with their	

			Specialty triumvirate colleagues to ensure delivery, supported by Corporate Teams where necessary - Strategy and Transformation, Finance, HR, Improvement Practice.	

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	Field work complete on 29th November. Response rate for 2024 is 49%. Results expected January but embargoed until March so will be included in Q4 update.		Delivery of fieldwork between 1st October and 29th November with increased response rate from 2023 survey (46%). Action plan activity and support to teams identified from 2023 survey continue to be delivered with monitoring through People Committee.	Review and communicate results across the whole organisation. Focus on actions on bullying and harassment to continue work started during 2024. Launch of anti-bullying and anti-discrimination policies during Q4. Identifying challenged teams for bespoke support with activity to commence in Q4/ Q1 25/26.
Reduce vacancy rates to 7% or below	Vacancy rates as reported in October 2024 were 5%. The rate has remained consistently at 7% or below for 12 months.		Being a Brilliant Place to Work and Thrive Committee as sub-committee to People Committee is now well established and working well across key themes of: Flexible Working, Exit and Stay process, Marketing and Branding, Anchor Institute and Place and Bullying and Harassment. Additionally having a core focus across staff group professional leads including Medical, Nursing, AHP's, Support roles and MAP's	Careers at Dudley brand to be launched Flexible working to be included in appraisal paperwork New anti bullying, anti discrimination policy to be launched Further planning for behind the scenes and centralised work experience programme Re-launch of exit and stay processes
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	Nursing and Midwifery and AHP turnover remains low. Nurse retention rates over a 24 month period is 84.5%. AHP retention rates over a 24 month period is 79.6%		Undertaken an audit of all right to work checks recorded in ESR. Retention Lead appointed and working with Nursing to ensure individuals are supported to renew their VISA's.	Support worker workforce under review – deep dive. Appoint to level 6 degree apprenticeships in Podiatry Review role of Dudley Ambassador and ensure fragile services are represented

			Deep dive action plan into AHP workforce underway. Fragile services are supported via the Being a Brilliant Place to Work and Thrive group.	Strengthen partnership with Worcester University Placement capacity scoping for Orthoptics trainees
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	New policy is awaiting ratification. Results are annual – expected Q4.		Developed a new anti-bullying, anti discrimination policy, as well a sexual misconduct policy in the style and format of the national policy – aligning it to the national sexual misconduct policy	• Policy launch expected in Feb 25 subject to policy ratification • Toolkits to be developed • Training to be developed and commence delivery • Deliver communication and engagement plan
Raising concerns - I feel safe to speak up staff survey results better than England average	Results are annual – expected quarter 4.		Activity undertaken over the last quarter to improve reporting and recording of concerns. This included the Freedom to Speak Up conference, promotion of training to senior leaders and line managers, ward and team walk arounds.	Ongoing delivery of Freedom to Speak Up Action Plan. Review and ratification of updated Freedom to Speak Up Strategy. Ongoing listening actions and feedback on responses. Revised reporting to Steering Group.
Recommend trust as a place to work staff survey results better than England average	Results are annual – expected quarter 4.		Activity outlined in Staff Survey plans has continued during Quarter 3 to include: Managers Essentials and Manager Induction, increasing network of wellbeing champions and wellbeing support activity, EDI networks and champions delivering on programme of work. Sustained operational pressures are likely to impact on this score in 2024 survey.	Review results during Quarter 4. Identify areas that are below organisation benchmark for ongoing support. Continue with delivery of existing programmes of work through Dudley People Plan and Journeys – monitored through the Being a Brilliant Place to Work sub-group and People Committee.

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 2022/23 were published in Q3 and show that the overall trust position has improved, with the cost per weighted activity unit (WAU) in the third highest quartile. Medical and nurse staffing costs per WAU remain in the highest quartile. Implied productivity growth compared to 19/20 shows that trust is in the highest quartile nationally being one of a few to be showing a positive variance 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 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)	Since the last carbon report, the Trust has reduced emissions by **1.5%.** The average annual change in		The Green Plan is currently under review, we have gathered feed from staff in Q2 from Make it Happen and will use this to improve	The Green Plan is due to be finalised at the end of Q4.

	emissions is **0.3%,** totalling a reduction of 7% from the baseline year (2019/20). To meet net zero, we need to reduce emissions by **5.4%** each year for the next eight years		as well embed the latest targets and plans from NHSE. The Energy and Estate Sub-Group are now meeting bi-monthly to progress action and deliver energy savings. Mitie have carried out some work that provided carbon savings in 23/24 however this work was essential maintenance to ensure the operation such as a new gas boiler and utilise waste heat from combined heat & power (CHP). **Pharmacy returns** project has re-dispensed 2,130 drugs saving £63,309 and 8.1tOC2e. Comparing wastage weights from medicines for pre-returns and the duration of the return project, the overall pharmaceutical waste has been reduced by 3.8 tonnes, reducing waste costs by £3,725. **Nitrous Oxide:** The manifold has been supplied with 1,098,000 litres with no clinical use resulting in 537tCO2e. Working with Mitie to decommission the manifold. **Travel**: Working with TfWM to offer new and existing staff free and discounted travel. From July-November 2024. 403 codes were issued, with 119 staff travelling, and only 2% of offers were activated, resulting in 3,910 bus journeys, saving staff **£28,672.** For patients, 410 were issued with 10 patients travelling 497 journeys. New offers are to be launched in January. **Engagement:** Met with primary care networks to promote the Greener NHS	Deliver quick win energy savings and calculate the impact of this work on energy use and carbon emissions. Develop a long-term decarbonisation plan and outline investment required. More communications are planned to promote the work of the greener pharmacy team and raise awareness of the returns process. Estates are requesting Mitie/PFI to decommission the manifold. More travel offers will launch in the 2025 with communications are planned to promote the new bus offers, new cycle-to-work scheme and other sustainable travel modes. Complete a review of the impact of the changes to the emissions cap of lease vehicles via NHS Fleet Solutions. In December the Trust received a donation of Springtime bulbs, these will be planted in January at South Block entrance and maternity entrance. Green Team members and volunteers will be supporting the planting days.

			goals, promote patient travel support and gain feedback on what additional support is required to meet net-zero.	
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 the end of Q3 the Trust remains ahead of plan by £812k.		• Position has deteriorated but remains better than plan. • Deterioration links to inclusion of band 2 to 3 clinical support worker issue and impact of Midland Metropolitan Hospital opening alongside other emergency pressures. • Forecast agreed to deliver plan but risk with Surgery and Medicine.	• Re-forecast required to determine likelihood of delivering target; • Series of actions to be implemented across system including complete vacancy freeze (initially for 8 weeks)
Deliver recurrent cost improvement programme of £31.896m	• Additional CIP of £2.34m identified above plan • We are forecasting a delivery of 97% of the Programme plan • YE forecast underperformance estimated to be £0.9m • At month 9 we have delivered £21.75m against a plan of £22.03m • Includes £350k CIP from the new Place division to March 2025		• Corporate services and SWC have both over delivered against their divisional targets Corp by £2.24m and SWC by £105k. • ERF overperformance has been used to support under delivery of the 4% workforce reduction schemes across the Trust. Forecast Delivery for ERF is £10.84m against a plan of £5.74m by year end.	• Close the forecast gap of £0.9m further (3% of the overall programme plan)
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		November position 158.06 wte behind target but adjusted to 63.98 wte due to: - Surge Beds (36.26 WTE) - ERF delivery (47.63 WTE) - Midland Met/Winter (10.19 WTE)	• Executive led confirm and challenge meetings • Additional bank controls • Performance monitoring through Finance Improvement group and

			November shows slight increase from October (9 wte). It is forecast there will have been a 74 WTE increase in bank since April 2024, 90 WTE of which is because of a MMUH mitigations, additional activity (ERF) and surge capacity challenges.	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	Remains at 68% - unchanged from previous quarter		Reported figure was 68% during Q2. Ongoing work to promote local work opportunities through ICan – into work scheme promoting opportunities and work experience and novice CSW placements. Branding sub-group is developing campaign tools and website presence for launch during Quarter 4. Launch of Cohort 2 paid work experience (9 NHS candidates; 10 Council candidates); Launch of Cohort 3 CSW Novice programme.	Ongoing delivery of ICan programme – all programmes will be ending by 31st March as at the current time. Evaluation of activity is underway and due to report back by 31st March. Exploring future funding options for ICan workstreams. Developing proposals for business as usual activities following ICan testing of processes. Branding and website development for Careers @ Dudley.
Increase the number of services delivered jointly across the Black Country	The Dudley Place Division was established in October 1st following the safe transfer of services and staff from DIHC. The Trust continues to play an active role in the Dudley Health and Care Partnership with routine reporting to the Integration Committee established.		• DHCP Deep Dive #1 into unplanned emergency admissions from care homes resulted in an Action Plan which was agreed by all partners. Monthly updates are reported to the DHCP outlining barriers and progress. • DHCP Deep Dive #2 was completed. Report to DHCP Board, then to Integration Committee in January/February. • 16/17 Partnership KPIs remain on track with a deep dive into childhood vaccinations planned for the new year as the only KPI below	• Deep Dive #3 – Childhood Vaccinations. • Work in partnership with the ICB to influence the review into place governance as part of the ICB Operating Model. • Launch of the Volunteer into Health pilot. Black Country is one of 15 recipients of a share of £10m, delivered through a partnership between NHS Charities Together, NHS England, and CW+. • Mobilisation of the WorkWell programme with ongoing engagement with the employment

			expected – in line with national uptake rates. • WorkWell engagement event took place in January and referrals are live. Expressions of interest for funding were received by 5 Dudley organisations with 2 successfully granted funds.	and skills voluntary and community sector. • Launch of the Womens Health Hub.
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)	32 Local People have been placed in jobs through the programme. Cohort 1 NHS Paid Work Experience – all candidates have now obtained employment at Dudley Group. 15/16 CSW Novices have obtained jobs. Expect target to be achieved by March 31st 2025.		Cohort 2 Paid Work Experience launched in September with 9 candidates in a range of clinical and non clinical roles supporting clinical services. Launch of Cohort 3 CSW Novice programme in December. Evaluation activity underway with interviews and focus groups for both Council and NHS cohorts complete. Celebration and showcase event held with West Midlands Combined Authority.	Ongoing support into work through work trials, application support and work experience for Cohort 2 work experience. Delivery of Cohort 3 CSW Novice programme. Evaluation activity and output evaluation report to be delivered by 31st March 2025. Exploration and identification of funding post 31st March.
Improve discharge processes (30 discharges per day from MOFD list, 90% of patients to be discharged within 24 hours once known to system partners, reduce number of incomplete discharges on the complex list – no more than 5% failed per day, 30% of In-patient's discharges are home for lunch for each RHH ward	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 we are provided with 33 planned discharges daily with an average of 20 facilitated each day. To mitigate 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. • Incomplete discharges increased from 93 in October to 133 in November. Main areas of concern were patients becoming medically	• Work with IT to combine systems for live updates to support efficiencies with information on medication and transport status and prevent duplication

			unwell (48% increase) from October to November and other issues were Medication and transport delays.	

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 Q2 24/25 shows a staging completeness of 84% against 607 patients diagnosed and discussed at an MDT. Stage group data for the same quarter shows 68% were diagnosed at stage 1 or 2, which is an increase on the previous quarter (61.8%) Lung cancer screening occurred throughout the quarter (2 months in Kingswinford and 1 month at Merry Hill)		• 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. • Work with primary care to improve flow of information from third party provider • Additional nursing support to programme identified and recruited	• Continue to monitor data with MDT teams to complete as much missing data as possible. • Monthly round of scanning to continue, with additional days planned to ensure this year's trajectory is met • Prepare for transition to Black Country wide programme team
Increase planned care and screening from disadvantaged groups (Breast screening uptake 70% or greater)	Q4 data. OP and elective attendances have increased from 19/20 in the lower IMD and BAME but overall remain below those		HEAT tool submitted for AAA screening and projects identified to target socio-economic status or geographic deprivation, specifically low decile areas by visiting and contacting every GP practice and pharmacy (Project 1), and by	Promotional Information being produced in collaboration with TransActual to target transgender/nonbinary individuals that may benefit from AAA screening. CYP-Super Saturdays scheduled monthly (based on surgeon availability).

	expected for the local population.		experiences linked to protected characteristics i.e. people with a language barrier and ethnicities (Project 2) Gynae continue to audit access to screening for those requiring support. CYP- Super Saturdays for surgery, supported by play teams. ND clinics continue at family hubs. Collaboration with Health and Housing group to support with repairs/rehousing for CYP with asthma. LD champions in surgery. LD team supporting patients for elective preparation, during appointments/procedures and after care. Teaching rolled out across surgery.	Recruit into externally funded family support worker for asthma specifically to sign post to address HIE in particular housing, health and finance. Improve access to diagnostics for asthma in CYP by creating a CDC at Brierly Hill. Applying for external funding for a family support worker for CYP with Diabetes to address HIE Explore the use of the LD flags in elective care.
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 Q1 69.84% Validated data. Uptake Q2 76.99%. Uptake Q3 68.63%. Too early to be credible data.		We are in discussions with the LGBTQ+ team at the Trust, and the content of the script is due early January, along with an ask to Trust staff to volunteer from the LGBTQ+ communities to be filmed discussing the invitation, breast/chest aware/signposting PHAMS have identified two women who are willing to be filmed on behalf of women with a learning disability diagnosis. The script has yet to be scoped, but ideally ICB dependent, finished early 2025.	Working in Partnership with West Midlands Cancer Alliance who are providing the funding for an A4 one page insert and to be added to all screening invitations for the period of 12 months across the three sites. First time invitees and perpetual DNA's will both receive targeted messaging prior to their appointments, followed up by scripted surveys to ascertain the reasons behind attending/DNA. These will be delivered via Accurx. Data, collated by the screening admin team, and fed back to WMCA. This is also being trialled by City, Sandwell and Walsall Breast Screening

			As a Service we continued to be part of the Cancer Champion Training Programme, delivering key messages to trainees from community/primary care Attending over ten events requested by GP's, ICB, and Faith Places with October being Breast Cancer Awareness Month. We continue to share our materials, pamphlets and videos with other Trusts and currently designing a leaflet aimed at those who have transitioned male to female/ female to male, this will give them the knowledge required to make an informed choice around their breast/chest screening appt.	Service, again for a period of 12 months, followed by an audit. Dudley and Netherton PCN will be due for screening early 2025, however we are having to relocate from the previous Stafford Street site due to Dudley Council having insufficient parking spaces. PH Dudley will re-introduce a targeted approach by accessing GP's, Pharmacies and Optical Services near those practices due to be screened. Face to Face events within GP Practices will continue, with a focus on text messages to women invited to the service for the first time (50-54), since data both nationally and service wide shows it a group least likely to attend an invitation. We will continue to train Cancer Champions both community and primary based to enable signposting to take place. This is particularly important in the Black African and Caribbean communities, where myths and misinformation's still need addressing. We continue to work with PH Dudley and PH Wolverhampton in engaging with Practice managers to foster strong working relationships, with the aim to increase uptake. This is particularly relevant in Wolverhampton who are consistently low in uptake.

				The Service has put forward a project to develop a Cancer Screening Guide for Primary Care, to be utilised across the ICB, & to include City & Sandwell. This will focus on breast screening coding GP uptake, the role of practice involvement by sharing best practice. Implement a Teams Channel for all PCN Cancer Co-ordinators. With the role of a CC being to increase uptake for cancer screening, we feel this will help to develop a close working relationship, a safe space for colleagues to develop their own PCN role by shared learning. Information can be cascaded, and signposts developed

Report to the Public Trust Board: 13th March 2025

CQC Well-led Review

1. Background

1.1 The CQC inspected this organisation against the trust well-led framework in January and February 2019. In July 2019 they rated well-led as 'Requires Improvement' because diagnostics imaging at Russells Hall and Corbett the well-led domain were rated as inadequate. Urgent and emergency care, maternity, children and young people, outpatient department at Russells Hall and Corbett Well Led domain were rated as requires improvement. Surgery at Russells Hall and Corbett, critical care unit, end of life care at Russells Hall and community well-led domain were rated as good.

In 2017, Deloittes completed an external developmental review of the Well-led Framework and recognising the plans already in place by the new leadership team, recommendations made were supplementary to those plans already in place.

In 2021/22 DCO and partners, led by Giles Peel FCG and Professor Mike Bewick FRCP FRCGP MICP undertook an external developmental review and concluded that the previous two years had seen further improvements – a step change – in leadership at many levels. We produced a Board agreed well-led improvement plan that has been completed with a final closure report submitted to Board.

The Trust has recently received a number of CQC inspections, these include:

February 2023 - Unannounced CQC Inspection of Paediatric emergency department, where the overall rating for this service did not change, report published

April 2023 Emergency Department - Unannounced CQC Inspection of the Emergency Department. No impact on ratings, report published

April 2023 Maternity - Announced inspection of Maternity as part of the national maternity inspection programme. Full Core Service Inspection moving from 'Requires improvement' in May 2019 to 'Good' overall

May 2023 Emergency Department - Unannounced CQC Inspection of the Emergency Department. Full Core Service Inspection. The rating remained the same as issued in April 2021, which "requires improvement" overall.

June 2023 Children and Young People - Full Core Service Inspection of Children & Young People moving from 'Requires improvement' in April 2021 to 'Good' overall

July 2024 Mental Health - Announced Mental Health Act monitoring visit, no impact on ratings, report published

2. Introduction

2.1 In April 2024, the Care Quality Commission (CQC) published new guidance for trusts on assessing the well-led key question under its new approach. The guidance was developed jointly by the CQC and NHS England (NHSE) and aims to provide a consistent understanding of what it means to be a 'well-led' trust and reflect shared expectations across regulators. It incorporates key developments in health and care policy and best practice.

2.2 This paper sets out to provide an overview of the guidance, other relevant NHS frameworks and a suggested self-assessment process for the Trust to undertake, followed by an externally commissioned well-led developmental review.

3. New CQC approach to regulation

3.1 In 2023, the CQC published its revised regulation approach which included a new assessment framework applicable to providers, local authorities and integrated care systems. The five key questions (safe, effective, caring, responsive and well-led) and four ratings (outstanding, good, requires improvement, inadequate) remain central to the approach but several changes were set out:

a. Quality statements setting clear expectations and focussing on specific topic areas would replace the previous key lines of enquiry (KLOEs), prompts and ratings characteristics.
b. Six new evidence categories were introduced to organise information under these statements.
c. Registration would also be based on the framework.

Rather than the previous inspection regime the new approach includes:

- Using a range of information flexibly and frequently; assessment is no longer tied to specific dates or driven by previous ratings.
- Collecting evidence on an ongoing basis, using this data to decide which services to visit and subsequently updating ratings at any time.
- Using inspections/site visits as a tool to support evidence collection rather than the primary method of collecting evidence.
- Scoring evidence to make judgements more structured/consistent.
- Producing shorter and more simpler reports with more detailed scoring methods (within the four key ratings) to enable tracking of changes within ratings.

4. Well-led quality statements

4.1 The CQC acknowledge that good leadership has a significant impact on staff morale, patient experience and enables better patient care and more sustainable health and care services. Eight quality statements maintain a focus on leadership, culture and governance and these are listed below:

1. Shared direction and culture	2. Capable, compassionate and inclusive leaders	3. Freedom to speak up	4. Workforce equality, diversity and inclusion
We have a shared vision, strategy and culture. This is based on transparency, equity, equality and human rights, diversity and inclusion, engagement, and understanding challenges and the needs of people and our communities in order to meet these.	We have inclusive leaders at all levels who understand the context in which we deliver care, treatment and support and embody the culture and values of their workforce and organisation. They have the skills, knowledge, experience and credibility to lead effectively. They do so with integrity, openness and honesty.	We foster a positive culture where people feel that they can speak up and that their voice will be heard	We value diversity in our workforce. We work towards an inclusive and fair culture by improving equality and equity for people who work for us.
5. Governance, management and sustainability	**6. Partnerships and communities**	**7. Learning, improvement and innovation**	**8. Environmental sustainability**
We have clear responsibilities, roles, systems of accountability and good governance. We use these to manage and deliver good quality, sustainable care, treatment and support. We act on the best information about risk, performance and outcomes, and we share this securely with others when appropriate.	We understand our duty to collaborate and work in partnership, so our services work seamlessly for people. We share information and learning with partners and collaborate for improvement.	We focus on continuous learning, innovation and improvement across our organisation and the local system. We encourage creative ways of delivering equality of experience, outcome and quality of life for people. We actively contribute to safe, effective practice and research.	We understand any negative impact of our activities on the environment and we strive to make a positive contribution in reducing it and support people to do the same.

Annex 1 provides more detail on each of the quality statements including what each statement means and what good looks like.

5. Assessment of the well-led questions

5.1 The first trust-level assessments using the single assessment framework will cover all eight quality statements under the well-led question with the intention of setting a baseline and building confidence in judgements and ratings under the new approach.

5.2 Following a well-led assessment, reports will now be structured around the eight quality statements and include an overall rating, a score and a summary of key findings for each evidence category. The score will be out of 100 and calculated from individual scores provided against each of the eight quality statements. Judgement statements will explain what each score means.

5.3 The new approach to regulation is now in use by the CQC across England. At the time of writing the paper, the Trust does not have a date for the first planned local assessment.

6. Other relevant documents

6.1 There are several frameworks which should be considered alongside the well-led guidance. Efforts have been made by national bodies to align expectations on providers.

a. The NHS Leadership Competency Framework (LCF)

The LCF, published in February 2024 by NHSE, is for chairs, chief executives and all board members in NHS systems and providers as well as for any aspiring leaders of the future. It is designed to support:

- The appointment of diverse, skilled and proficient leaders.
- The delivery of high-quality, equitable care and the best outcomes for patient, service users, communities and colleagues.
- Organisations to develop and appraise all board members.
- Individual board members to self-assess against the six competency domains and identify development needs.

The framework contains six competency domains:

i. Driving high-quality and sustainable outcomes.
ii. Setting strategy and delivering long-term transformation.
iii. Promoting equality and inclusion, and reducing health and workforce inequalities.
iv. Providing robust governance and assurance.
v. Creating a compassionate, just and positive culture.
vi. Building a trusted relationship with partners and communities.

Within each of the leadership competency domains are a series of 'I' statements indicating personal actions and behaviours that board members are required to demonstrate in undertaking their roles. A full list of these can be found in **Annex 2.**

b. NHS England Fit and Proper Person Framework

The development and publication of the LCF responded to recommendations from the Kark Review (2019) and forms part of the NHSE Fit and Proper Person Framework for board members published in August 2023.

The purpose of the framework is to strengthen individual accountability and transparency for board members, enhancing the quality of leadership within the NHS and ultimately impact on patient safety. It places requirements on NHS trusts to ensure robust processes are in place for new board level appointments, monitoring and reviewing whether existing board members are fit for their role and principles for conducting investigations into concerns about the fitness of a director.

The framework applies to all executive and non-executive directors and was effective from 30 September. The Trust made the required annual submission in July 2024.

c. NHS Oversight Framework

In trust-level assessments of the well-led question, the CQC will work closely with NHSE who will use the NHS Oversight Framework to identify where trusts may benefit from/require support. The results of NHSE oversight and assessment and of trusts will be used by CQC in their assessments.

The NHS Oversight Framework outlines NHSE's approach to NHS Oversight, aligning with the NHS Long Term Plan and Operational Planning and Contracting Guidance and reflecting the changes enabled by the Health and Care Act 2022. A set of oversight metrics are used to indicate potential issues and prompt further investigation/support. These are split into five themes; quality of care, access and outcomes; preventing ill health and reducing inequalities; people; finance and use of resources and leadership and capability.

7. Reviews of leadership and governance using the well-led framework

7.1 It is widely considered good practice for trusts to regularly review their leadership and governance and NHSE strongly encourage providers to use the well-led framework to undertake such reviews as part of their continuous improvement.

7.2 Recognising providers will wish to tailor the scope of such reviews to the new well-led guidance, new NHSE guidance on developmental reviews is currently under development. In the meantime, providers are signposted to the 2017 guidance which remains broadly relevant in planning and running developmental reviews.

a. Developmental reviews of leadership and governance using the well-led framework: guidance for NHS trusts and NHS foundation trusts (2017).
NHSE highlight that regular developmental reviews of leadership and governance are good practice, particularly in identifying areas that would benefit from further targeted development work (rather than assessing current performance). Ahead of any external review, the board of the organisation should initially reflect on its own performance with a self-assessment against the well-led framework. Whilst information and evidence may be collected from board members individually, this should be collated and presented to the full board for discussion and challenge.

b. Local development review

In line with NHSE guidance and generally accepted best practice, a locally managed developmental review is planned for the Trust against the CQC well-led question for 2024/25.

Board members will be requested to individually complete a self-evaluation questionnaire against the eight quality statements, and provide reasons for their assessment. Results will be collated and presented to the Trust Board for sign-off at the 1June 2025 Board Workshop. **Annex 3** provides a blank version of the proforma.

8. Recommendation

8.1 The Public Trust Board is recommended to:

a. **COMPLETE** a self-assessment against the CQC's eight well-led quality statements during November 2024
b. **SUPPORT** the proposal to commission an external provider-level well-led developmental review

Helen Board
Board Secretary

January 2025

Annex 1: CQC well-led quality statements
Annex 2: Leadership Competency Framework domains and associated 'I' statements
Annex 3: Trust Board well-led self-evaluation proforma

Appendix 1: CQC well-led quality statements

What is this statement	What good looks like	Subtopics covered
Shared direction and culture We have a shared vision, strategy and culture. This is based on transparency, equity, equality and human rights, diversity and inclusion, engagement, and understanding challenges and the needs of our people and our communities in order to meet these.		
Leaders ensure there is a shared vision and strategy and that staff in all areas know, understand and support the vision, values and strategic goals and how their role helps in achieving them. Staff and leaders ensure that the vision, values and strategy have been developed through a structured planning process in collaboration with people who use the service, staff and external partners. Staff and leaders demonstrate a positive, compassionate, listening culture that promotes trust and understanding between them and people using the service and is focused on learning and improvement. Staff at all levels have a well-developed understanding of equality, diversity and human rights, and they prioritise safe, high-quality, compassionate care. Equality and diversity are actively promoted, and the causes of any workforce inequality are identified and action is taken to address these. Staff and leaders ensure any risks to delivering the strategy, including relevant local factors, are understood and have an action plan to address them. They monitor and review progress against delivery of the strategy and relevant local plans	The trust has an aspirational vision and a statement of values, with a realistic strategy and robust plan for delivery with clear objectives and timescales. These have been produced together with people who use the trust's services, staff and system partners. The strategy is based on a clear understanding of: • quality of care • improvement • finances • operational performance. It explicitly addresses challenges for workforce, estates, procurement, and information technology. It is clear which leader is responsible and accountable for delivering each component of the trust's strategy and delivery plan. The trust's strategy and plan considers the wider local and national context, and is aligned to the strategies and plans of relevant integrated care partnerships, health and wellbeing boards, integrated care boards, place-based partnerships, and provider collaboratives. This is to ensure that services are high quality and planned to meet the needs of relevant population groups. There are joint strategies and plans with relevant integrated care boards and, where appropriate, other key system partners. The trust transparently monitors and reviews how it delivers its objectives. This is supported by effective governance structures and clear systems of accountability at all levels. These structures support multidisciplinary, integrated working and effective risk mitigation and management. The trust understands the challenges to delivering the strategy, including relevant local health and care system factors. It has a realistic action plan to address them. Staff feel positive and proud to work in the trust. They understand the vision, values and strategic goals and their role in achieving them. Most staff are aware of, and	Strategy and vision Organisational culture Values Addressing social impact

What is this statement	What good looks like	Subtopics covered
	demonstrate, the vision and values of the trust. Staff understand the importance of equality and human rights in their work and the factors that can lead to closed cultures. Delivering for patients and communities and tackling health inequalities is at the heart of the trust's ways of working. Compassion is shown at all levels within the organisation and with people who use services. The trust has a strong emphasis on the safety and wellbeing of staff. There is a culture of collaboration, openness, integrity, respect, and collective responsibility. Staff have co-operative, supportive and appreciative relationships, and teams and system partners come together quickly to resolve conflicts constructively. The trust has mechanisms to identify and address behaviours that are inconsistent with the values of the NHS. These enable staff to raise concerns without fear of reprisal or repercussions.	
Capable, compassionate and inclusive leaders We have inclusive leaders at all levels who understand the context in which we deliver care, treatment and support and embody the culture and values of their workforce and organisation. They have the skills, knowledge, experience and credibility to lead effectively. They do so with integrity, openness and honesty.		
Leaders have the experience, capacity, capability and integrity to ensure that the organisational vision can be delivered and risks are well managed. Leaders at every level are visible and lead by example, modelling inclusive behaviours. High-quality leadership is sustained through safe, effective and inclusive recruitment and succession planning. Leaders are knowledgeable about issues and priorities for the quality of services and can access appropriate support and development in their role. Leaders are alert to any examples of poor culture that may affect the quality of people's care and have	The trust's leaders have the experience, capacity, capability and integrity to ensure that the trust's strategy and plan are put into practice through practical actions to benefit patients and address risks to quality (including safety) and performance. The board has an appropriate mix of skills and experience to enable its members to exercise effective and visible leadership, including clinical leadership, across the trust. Leaders at all levels within the trust promote and demonstrate a culture of health, wellbeing, safety and compassion at work. This enables individual members of staff and teams to perform at their best, and is reflected in care for patients. Leaders influence and promote equality and human rights in their roles. They demonstrate and actively encourage compassionate, inclusive and supportive relationships among staff so that they are all respected and valued equally. Leaders proactively seek out and listen to the views of the people they lead and demonstrate an understanding of their role in preventing and detecting closed cultures early.	Leadership competency, support and development Safe recruitment of Leaders / FPPR Compassionate and capable leaders Roles and accountability Succession Planning / talent

What is this statement	What good looks like	Subtopics covered
a detrimental impact on staff. They address this quickly.	When something goes wrong, people are informed and supported, and the duty of candour is followed. Leaders across the trust routinely consider the holistic health and wellbeing of staff in the way they communicate and the language they use, in strategic and operational plans, and performance reporting. Leaders seek to ensure a safe and secure working environment for staff and proactively manage and mitigate risks. They support staff to be empowered, understand discrimination and its effects and how to build equity in their roles. This helps to develop the skills to test innovations to deliver high-quality care for all. Leaders at all levels understand and demonstrate their responsibility to model positive behaviours through leading with integrity, openness and honesty. They understand that successful leadership is not just about what they deliver as an organisation, but how it is delivered. The trust has development activities and interventions for leaders that are centred around their principles and behaviours, to help leaders learn more about what exemplary behaviours entail. The trust proactively sustains compassionate, inclusive, collaborative and capable leadership through its: • leadership strategy and development programmes • processes for effective selection, retention, deployment and support • succession planning. These are visible to staff. Leaders actively encourage and support staff at all levels to develop themselves and they provide opportunities through formal and informal training.	management
Freedom to speak up We foster a positive culture where people feel that they can speak up and that their voice will be heard.		
Staff and leaders act with openness, honesty and transparency. Staff and leaders actively promote staff empowerment to drive improvement. They encourage staff to raise	The trust has a culture of speaking up. All staff at all levels within the trust are equally encouraged and empowered to speak up. They feel safe to speak up without fear of detriment, that is without experiencing disadvantageous and/or demeaning treatment as a result.	Speaking up culture Freedom to speak up guardian

What is this statement	What good looks like	Subtopics covered
concerns and promote the value of doing so. All staff are confident that their voices will be heard. There is a culture of speaking up where staff actively raise concerns and those who do (including external whistleblowers) are supported, without fear of detriment. When concerns are raised, leaders investigate sensitively and confidentially, and lessons are shared and acted on. When something goes wrong, people receive a sincere and timely apology and are told about any actions being taken to prevent the same happening again.	All staff are confident that their voices will be heard. Managers across the trust feel confident to listen and act when someone speaks up and improvements happen as a result. These are communicated back to those who raise matters. Leaders are seen to promote Freedom to Speak Up through actively demonstrating positive behaviours. Appropriate training and support is available to equip freedom to speak up leads to actively support the Freedom to Speak Up Guardian. The trust's policies and procedures positively support this process.	Whistleblowing Closed cultures
Workforce equality, diversity and inclusion We value diversity in our workforce. We work towards an inclusive and fair culture by improving equality and equity for people who work for us		
Leaders take action to continually review and improve the culture of the organisation in the context of equality, diversity and inclusion. Leaders take action to improve where there are any disparities in the experience of staff with protected equality characteristics, or those from excluded and marginalised groups. Any interventions are monitored to evaluate their impact. Leaders take steps to remove bias from practices to ensure equality of opportunity and experience for the workforce within their place of work, and throughout their employment. Checking	The trust takes an anti-discriminatory approach to continually review and improve the culture of the organisation in relation to equality, diversity and inclusion. All staff are treated equitably, including those with protected equality characteristics under the Equality Act 2010 and those from excluded and marginalised groups. The trust takes necessary steps to fully empower these staff in their roles throughout their employment. The trust develops equitable processes and structures, ensuring that all staff are treated ethically. It uses national mandated programmes relating to workforce equality to achieve this aim. Any interventions taken as a result are monitored to evaluate their impact. There is evidence of actions the trust has taken to prevent and address bullying and harassment at all levels. This has a clear focus on those with a protected equality	Fair and equitable treatment of staff Staff human rights Well-being of workforce Gender pay gap Workforce diversity Flexible working arrangements

What is this statement	What good looks like	Subtopics covered
accountability includes ongoing review of policies and procedures to tackle structural and institutional discrimination and bias to achieve a fair culture for all. Leaders take action to prevent and address bullying and harassment at all levels and for all staff, with a clear focus on those with protected characteristics under the Equality Act and those from excluded and marginalised groups. Leaders make reasonable adjustments to support disabled staff to carry out their roles well. Leaders take active steps to ensure staff and leaders are representative of the population of people using the service. Leaders ensure there are effective and proactive ways to engage with and involve staff, with a focus on hearing the voices of staff with protected equality characteristics and those who are excluded or marginalised, or who may be least heard within their service. Staff feel empowered and are confident that their concerns and ideas result in positive change to shape services and create a more equitable and inclusive organisation.	characteristic and those from excluded and marginalised groups. The trust is taking active steps to promote diversity by ensuring: • staff equality profiles are representative of local communities • staff at management grades and leaders at board level reflect the staff profile. There is fairness in recruitment and career progression with equally good outcomes for staff in equality groups. The trust takes action to address ethnicity and gender pay gaps. Disciplinary and capability processes are fair and are evaluated to ensure no detriment based on any protected equality characteristic. Reasonable adjustments are made to support disabled staff to carry out their roles well. There are effective and proactive ways of engaging with and involving staff. These have a specific focus on hearing and empowering the voices of staff with equality characteristics, including staff equality networks. Their concerns and ideas result in positive change to shape services, create a more equitable and inclusive organisation and address health inequalities. When improving equality and inclusion, the trust considers the experiences and needs of staff working under different contractual arrangements such as agency, bank and contracted-out staff. Feedback from staff reflects both the data from nationally mandated programmes and corresponding feedback and commitments made by senior leaders regarding workforce equality.	WRES and WDES
Governance, management and sustainability We have clear responsibilities, roles, systems of accountability and good governance. We use these to manage and deliver good quality, sustainable care, treatment and support. We act on the best information about risk, performance and outcomes, and we share this securely with others when appropriate.		
There are clear and effective governance, management and accountability arrangements. Staff understand their role and responsibilities. Managers can account for the actions, behaviours and performance of staff.	The trust's board members and senior leaders can show evidence that they understand and effectively meet their personal accountability for the organisation's: • quality of care and outcomes for patients • workforce • operational and financial performance.	Roles, responsibilities and accountability

What is this statement	What good looks like	Subtopics covered
The systems to manage current and future performance and risks to the quality of the service take a proportionate approach to managing risk that allows new and innovative ideas to be tested within the service. Data or notifications are consistently submitted to external organisations as required. There are robust arrangements for the availability, integrity and confidentiality of data, records and data management systems. Information is used effectively to monitor and improve the quality of care. Leaders implement relevant or mandatory quality frameworks, recognised standards, best practices or equivalents to improve equity in experience and outcomes for people using services and tackle known inequalities.	The trust has clear governance, assurance, risk and accountability structures. These interact well with each other and support effective decision making. They provide robust assurance that risks are effectively and sustainably mitigated, and the quality of care is consistently sustained. Trust staff at all levels are clear about roles and responsibilities. When planning services, improvements or efficiency changes, the trust understands the impact of decisions on its workforce, quality of care, and financial sustainability, including for the wider health and care system. The trust has a robust financial governance framework. It manages financial risk effectively and actively engages with system partners to support the delivery of system-wide financial balance. The trust's governance and management of partnerships, joint-working arrangements and third parties is effective and supported by effective and robust assurance systems. The trust regularly reflects on and reviews its governance and leadership across the organisation to ensure continuous improvement and development. The trust has clear processes, robust data and suitable information systems to effectively identify, manage, escalate and sustainably mitigate current and future risks. These include: • estates and equipment • cyber and information governance risks to the quality of care • safety • workforce • operational delivery • finance performance. The trust implements appropriate measures and training to minimise the impact of incidents, such as software or hardware failures, cyber-attacks and or/data breaches. Delivering good quality care is underpinned by evidenced-based decisions, up-to-date information and knowledge and relevant data. Staff are actively supported to access upto-date guidance on quality, standards and good practice. Clinical and internal audit processes, information governance, cyber security, and library and knowledge services function well. They have a positive impact in driving improvements in the quality of care and internal systems of control. Trusts can show evidence of effective and sustained action to resolve concerns raised.	Governance quality assurance and management Cyber security and DPST Emergency preparedness, including climate events Sustainability, including financial and workforce Data security/data protection Statutory and regulation requirements Workforce planning External recommendations (e.g. safety alerts) Records/digital records

What is this statement	What good looks like	Subtopics covered
	Leaders at all levels of the organisation receive and analyse relevant, timely, accurate, valid and reliable data. This supports them to gain insight into patient experience, performance and use of resources, and make changes to improve as necessary. The trust has clear structures and systems of accountability, and it uses performance information to hold staff to account. Data is triangulated with clinical insight, observation and feedback from staff and patients to gain robust assurance. The trust shares data and information externally with integrated care boards, placebased partnerships, and provider collaboratives. It does this in line with data protection legislation and in a timely way as required. There are processes and plans to enable the trust to be prepared to deal with emergencies such as internal incidents, significant equipment failures or extreme weather events.	
Partnerships and communities We understand our duty to collaborate and work in partnership, so our services work seamlessly for people. We share information and learning with partners and collaborate for improvement.		
Staff and leaders are open and transparent, and they collaborate with all relevant external stakeholders and agencies. Staff and leaders work in partnership with key organisations to support care provision, service development and joined-up care. Staff and leaders engage with people, communities and partners to share learning with each other that results in continuous improvements to the service. They use these networks to identify new or innovative ideas that can lead to better outcomes for people.	The trust's leaders at all levels are committed to identifying opportunities to improve services, tackle unwarranted variation and health inequalities, and strengthen resilience. They do this by consistently and proactively collaborating with partners to agree and deliver ambitious outcomes for the health of populations. Leaders at the trust invest time in building relationships, understanding perspectives, and constructively engaging with: • partners within integrated care boards • place-based partnerships • provider collaboratives • any other relevant forums, including primary and social care partners. The trust proactively engages in shared planning and decision-making and takes responsibility for the agreed delivery of services and improvements. The trust's board can demonstrate that it is meaningfully taking the views of partners into account, to understand impacts for the wider health and care system and what is in the best interests of local populations, as part of the decision-making process. Leaders collaborate with partner organisations to address challenges in the service and the wider integrated care system to meet local needs. Partner organisations	Sharing good practice and learning Integration health and social care Partnership working and collaboration

What is this statement	What good looks like	Subtopics covered
	include community groups with a focus on those that represent people who are more likely to have poor access, experience and outcomes from care. Leaders at all levels support a culture of proactively seeking the views of, listening to and acting on feedback from patients, carers and communities. The trust has a diverse range of formal and informal ways of working with people and communities to ensure different groups can take part, co-ordinating engagement and sharing insights with partners where relevant. People and communities, particularly those who are more likely to have poor access, experience and outcomes from care, are empowered, supported and involved in the design, testing, roll-out and evaluation of new ways of delivering care, as well as delivering continuous improvements to existing care models. The trust can demonstrate to its communities how they have influenced services and are involved in governance. It acts on people's views and concerns to shape culture and deliver high-quality services for all while addressing health inequalities. The governance and management of partnerships, joint working arrangements and third parties is effective, accessible, transparent and supported by effective assurance systems and data sharing arrangements. The trust is open, transparent and collaborative with all relevant stakeholders about performance. This is to build a shared understanding of challenges to the system and the needs of the population, and to design improvements to meet them.	
Learning, improvement and innovation We focus on continuous learning, innovation and improvement across our organisation and the local system. We encourage creative ways of delivering equality of experience, outcome and quality of life for people. We actively contribute to safe, effective practice and research		
Staff and leaders have a good understanding of how to make improvement happen. The approach is consistent and includes measuring outcomes and impact. Staff and leaders ensure that people using the service, their families and carers are involved in developing and evaluating improvement and innovation initiatives.	The trust has a systematic approach to improvement. It works to embed a quality improvement method aligned with the NHS improvement approach to support increased productivity and enable improved health outcomes for people. Improvement capability is enabled across the trust. All teams can access in-house expertise and/or an external partner for support to improve. Staff at the trust work together across teams and services to improve services by: • facilitating and promoting research • using research evidence • offering opportunities to take part in research	Innovation Learning and improvement Research Learning from deaths

What is this statement	What good looks like	Subtopics covered
There are processes to ensure that learning happens when things go wrong, and from examples of good practice. Leaders encourage reflection and collective problem-solving. Staff are supported to prioritise time to develop their skills around improvement and innovation. There is a clear strategy for how to develop these capabilities and staff are consistently encouraged to contribute to improvement initiatives. Leaders encourage staff to speak up with ideas for improvement and innovation and actively invest time to listen and engage. There is a strong sense of trust between leadership and staff. The service has strong external relationships that support improvement and innovation. Staff and leaders engage with external work, including research, and embed evidence-based practice in the organisation.	• implementing innovations. Staff are actively encouraged to improve how the trust uses its resources. They can access analytical experts to support specific improvement projects to do this. There is appropriate strategy, governance, oversight, evaluation and accountability to ensure research, innovation and improvement projects are taken forward effectively. This incorporates learning from patient safety events and appropriate data protection requirements. The trust participates effectively in national improvement initiatives. Plans to improve services take into account the resources required to deliver them. Leaders build a shared purpose and vision that provides the strategic goals for all the trust's improvement activities and alignment of improvements to individual processes. There are clear goals for research, improvement, and innovation in terms of outcomes for people who use services and staff. There is evaluation against these goals. The trust invests in its people and culture. It gives those closest to the point of care the opportunities to develop skills. This includes through continued professional development and through leaders being role models for research, innovation and improvement. This helps to ensure quality improvement is embedded in the way all staff work. The trust has a culture of research, innovation and improvement and staff feel supported by leaders, with support and reflection if new approaches do not work. The trust invests in delivering digital transformation in line with its digital and data strategy. This empowers staff by giving them the tools, services and skills they need to do their jobs effectively. There are plans to build capacity and capability for developing the behaviours and skills needed to facilitate and nurture research, innovation and improvement. In doing this, leaders make effective use of data and team coaching to enhance their workplace and practices. There is an active approach to finding out what has worked elsewhere and examples of ideas that have been successfully adopted. The trust uses digital tools to transform pathways, increase productivity and improve services. It works proactively to enable applications for research funding and recruitment to research trials. There are robust processes to ensure the timely adoption of proven	

What is this statement	What good looks like	Subtopics covered
	innovation and processes to identify promising innovations that align with local health needs working with system partners. The trust has a structured approach to quality assurance, quality management, quality improvement and quality planning, as recommended by the National Quality Board. Insights gained from responding to patient safety incidents feed into the trust's improvement efforts. The trust's patient safety incident response plan (PSIRP) demonstrates a thorough understanding of ongoing improvement work and demonstrably takes this into consideration as part of patient safety incident response planning. People and communities, particularly those who are more likely to have poor access, experience and outcomes from care, are involved and empowered to take part in identifying clinical and care needs, research opportunities, and in developing and coproducing improvements and innovations. This aims to actively tackle and reduce health inequalities.	
Environmental sustainability We understand any negative impact of our activities on the environment and we strive to make a positive contribution in reducing it and support people to do the same.		
Staff and leaders understand that climate change is a significant threat to the health of people who use services, their staff, and the wider population. Staff and leaders empower their staff to understand sustainable healthcare and how to reduce the environmental impact of healthcare activity. Staff and leaders encourage a shared goal of preventative, high quality, low carbon care which has health benefits for staff and the population the providers serve, for example, how a reduction in air pollution will lead to significant reductions in coronary heart disease, stroke, and lung cancer, among others. Staff and leaders have Green Plans and take action to ensure the settings in which they provide care are	The trust's leaders demonstrate a commitment to environmental sustainability. The trust has appropriate governance and support from leaders, with a board member who is responsible for approving and delivering their net zero targets and Green Plan. These targets are also represented in the Integrated Care Board Green Plan. The trust can demonstrate that it has taken all reasonable steps to minimise the adverse impact of climate change on health. It does this through processes and interventions to simultaneously improve patient care and reduce carbon emissions and environmental harm, while tracking their progress. The trust communicates these actions to its workforce, patients and partners in the system. The trust makes its workforce aware of their individual carbon footprint in the context of their role and enables and supports them to reduce this.	Staff awareness and education Carbon reduction (e.g. travel, transport, medicines, supply chain) Health promotion and prevention Estates and facilities (e.g., energy saving measures, lower

What is this statement	What good looks like	Subtopics covered
as low carbon as possible, ensure energy efficiency, and use renewable energy sources where possible. Staff and leaders take active steps towards ensuring the principles of net zero care are embedded in planning and delivery of care. Low carbon care is resource efficient and supports care to be delivered in the right place at the right time.		carbon options incl. recycling) Efficient service delivery with resource optimisation

Appendix 2: Leadership Competency Framework domains and associated 'I' statements

What does good look like	Competencies
1. Driving high quality and sustainable outcomes	
I am a member of a unitary board which is committed to ensuring excellence in the delivery (and / or the commissioning) of high quality and safe care within our limited resources, including our workforce. I seek to ensure that my organisation* demonstrates continual improvement and that we strive to meet the standards expected by our patients and communities, as well as by our commissioners and regulators, by increasing productivity and bringing about better health and care outcomes with lasting change and improvement	**1. I contribute as a leader:** a. to ensure that my organisation delivers the best possible care for patients b. to ensure that my organisation creates the culture, capability and approach for continuous improvement, applied systematically across the organisation **2. I assess and understand:** a. the performance of my organisation and ensure that, where required, actions are taken to improve b. the importance of efficient use of limited resources and seek to maximise: i. productivity and value for money ii. delivery of high quality and safe services at population level c. the need for a balanced and evidence-based approach in the context of the board's risk appetite when considering innovative solutions and improvements **3. I recognise and champion the importance of:** a. attracting, developing and retaining an excellent and motivated workforce b. building diverse talent pipelines and ensuring appropriate succession plans are in place for critical roles c. retaining staff with key skills and experience in the NHS, supporting flexible working options as appropriate **4. I personally:** a. seek out and act on performance feedback and review, and continually build my own skills and capability b. model behaviours that demonstrate my willingness to learn and improve, including undertaking relevant training

What does good look like	Competencies
2. Setting strategy and delivering long-term transformation	
I am a member of a unitary board leading the development of strategies which deliver against the needs of people using our services, as well as statutory duties and national and local system priorities. We set strategies for long term transformation that benefits the whole system and reflects best practice, including maximising the opportunities offered by digital technology. We use relevant data and take quality, performance, finance, workforce intelligence and proven innovation and improvement processes into account when setting strategy.	**1. I contribute as a leader to:** a. the development of strategy that meets the needs of patients and communities, as well as statutory duties, national and local system priorities b. ensure there is a long-term strategic focus while delivering short-term objectives c. ensure that our strategies are informed by the political, economic, social and technological environment in which the organisation operates d. ensure effective prioritisation within the resources available when setting strategy and help others to do the same **2. I assess and understand:** a. the importance of continually understanding the impact of the delivery of strategic plans, including through quality and inequalities impact assessments b. the need to include evaluation and monitoring arrangements for key financial, quality and performance indicators as part of developing strategy c. clinical best practice, regulation, legislation, national and local priorities, risk and financial implications when developing strategies and delivery plans **3. I recognise and champion the importance of long-term transformation that:** a. benefits the whole system b. promotes workforce reform c. incorporates the adoption of proven improvement and safety approaches d. takes data and digital innovation and other technology developments into account **4. I personally:** a. listen with care to the views of the public, staff and people who use services, and support the organisation to develop the appropriate engagement skills to do the same b. seek out and use new insights on current and future trends and use evidence, research and innovation to help inform strategies.
3. Promoting equality and inclusion, and reducing health and workforce inequalities	
I am a member of a unitary board which identifies, understands and addresses variation and inequalities in the quality of care and outcomes to ensure there are improved services and outcomes for all patients and communities, including our workforce, and continued improvements to health and workforce inequalities.	**1. I contribute as a leader to:** a. improve population health outcomes and reduce health inequalities by improving access, experience and the quality of care b. ensure that resource deployment takes account of the need to improve equity of health outcomes with measurable impact and identifiable outcomes c. reduce workforce inequalities and promote inclusive and compassionate leadership across all staff groups **2. I assess and understand:** a. the need to work in partnership with other boards and organisations across the system to improve population health and reduce health inequalities (linked to Domain 6) **3. I recognise and champion:** a. the need for the board to consider population health risks as well as organisational and system risks

What does good look like	Competencies
	4. I personally: a. demonstrate social and cultural awareness and work professionally and thoughtfully with people from all backgrounds b. encourage challenge to the way I lead and use this to continually improve my approaches to equality, diversity and inclusion and reducing health and workforce inequalities.
4. Providing robust governance and assurance	
I understand my responsibilities as a board member and how we work together as a unitary board to reach collective agreement on our approach and decisions. We use a variety of information sources and data to assure our financial performance, quality and safety frameworks, workforce arrangements and operational delivery. We are visible throughout the organisation and our leadership is underpinned by the organisation's behaviours, values and standards. We are seen as a Well Led organisation and we understand the vital importance of working collaboratively.	**1. I contribute as a leader by:** a. working collaboratively on the implementation of agreed strategies b. participating in robust and respectful debate and constructive challenge to other board members c. being bound by collective decisions based on objective evaluation of research, evidence, risks and options d. contributing to effective governance and risk management arrangements e. contributing to evaluation and development of board effectiveness **2. I understand board member responsibilities and my individual contribution in relation to**: a. financial performance b. establishing and maintaining arrangements to meet statutory duties, national and local system priorities c. delivery of high quality and safe care d. continuous, measurable improvement **3. I assess and understand:** a. the level and quality of assurance from the board's committees and other sources b. where I need to challenge other board members to provide evidence and assurance on risks and how they impact decision making c. how to proactively monitor my organisation's risks through the use of the Board Assurance Framework, the risk management strategy and risk appetite statements d. the use of intelligence and data from a variety of sources to recognise and identify early warning signals and risks – including, for example, incident data; surveys; external reviews; regulatory intelligence; understanding variation and inequalities. **4. I recognise and champion:** a. the need to triangulate observations from direct engagement with staff, patients and service users, and engagement with stakeholders b. working across systems, particularly in responding to patient safety incidents, and an understanding of how this links with continuous quality improvement **5. I personally:** a. understand the individual and collective strengths of the board, and I use my personal and professional knowledge and experience to contribute at the board and support others to do the same.
5. Creating a compassionate, just and positive culture	
As a board member I contribute to the development and ongoing maintenance of a compassionate	**1. I contribute as a leader:** a. to develop a supportive, just and positive culture across the organisation (and system) to enable all staff to work effectively for the benefit of patients, communities and colleagues

What does good look like	Competencies
and just learning culture, where staff are empowered to be involved in decision making and work effectively for their patients, communities and colleagues. As a member of the board, we are each committed to continually improving our approach to quality improvement, including taking a proactive approach and culture.	b. to ensure that all staff can take ownership of their work and contribute to meaningful decision making and improvement c. to improve staff engagement, experience and wellbeing in line with our NHS People Promise (for example, with reference to equality, diversity and inclusion; freedom to speak up; personal and professional development; holding difficult conversations respectfully and addressing conflict) d. to ensure there is a safe culture of speaking up for our workforce **2. I assess and understand:** a. my role in leading the organisation's approach to improving quality, from immediate safety responses to creating a proactive and improvement-focused culture **3. I recognise and champion:** a. being respectful and I promote diversity and inclusion in my work b. the ability to respond effectively in times of crisis or uncertainty **4. I personally:** a. demonstrate visible, compassionate and inclusive leadership b. speak up against any form of racism, discrimination, bullying, aggression, sexual misconduct or violence, even when I might be the only voice c. challenge constructively, speaking up when I see actions and behaviours which are inappropriate and lead to staff or people using services feeling unsafe, or staff or people being excluded in any way or treated unfairly d. promote flexible working where possible and use data at board level to monitor impact on staff wellbeing and retention
6. Building trusting relastionships with partners and communities	
I am part of a board that recognises the need to collaborate, consult and co-produce with colleagues in neighbouring teams, providers and systems, people using services, our communities and our workforce. We are seen as leading an organisation that proactively works to strengthen relationships and develop collaborative behaviours to support working together effectively in an integrated care environment.	**1. I contribute as a leader by:** a. fostering productive partnerships and harnessing opportunities to build and strengthen collaborative working, including with regulators and external partners b. identifying and communicating the priorities for financial, access and quality improvement, working with system partners to align our efforts where the need for improvement is greatest **2. I assess and understand:** a. the need to demonstrate continued curiosity and develop knowledge to understand and learn about the different parts of my own and other systems b. the need to seek insight from patient, carer, staff and public groups across different parts of the system, including Patient Safety Partners **3. I recognise and champion:** a. management, and transparent sharing, of organisational and system level information about financial and other risks, concerns and issues b. open and constructive communication with all system partners to share a common purpose, vision and strategy

Appendix 3

The Dudley Group NHS Foundation Trust

CQC well-led self-evaluation proforma for Board members

Name:	

Please indicate your agreement with each Quality Statement by selecting one of the rating options below by inserting an 'X' in the grey shaded box. Provide 5 reasons to support your position.

1. **We have a shared vision, strategy and culture. This is based on transparency, equity, equality and human rights, diversity and inclusion, engagement, and understanding challenges and the needs of people and our communities in order to meet these.**

Strongly Disagree	Disagree	Slightly Disagree	Neither Agree nor Disagree	Slightly Agree	Agree	Strongly Agree

a.	
b.	
c.	
d.	
e.	

2. **We have inclusive leaders at all levels who understand the context in which we deliver care, treatment and support and embody the culture and values of their workforce and organisation. They have the skills, knowledge, experience and credibility to lead effectively. They do so with integrity, openness and honesty**.

Strongly Disagree	Disagree	Slightly Disagree	Neither Agree nor Disagree	Slightly Agree	Agree	Strongly Agree

a.	
b.	
c.	
d.	
e.	

3. **We foster a positive culture where people feel that they can speak up and that their voice will be heard.**

Strongly Disagree	Disagree	Slightly Disagree	Neither Agree nor Disagree	Slightly Agree	Agree	Strongly Agree

a.	
b.	
c.	
d.	
e.	

4. **We value diversity in our workforce. We work towards an inclusive and fair culture by improving equality and equity for people who work for us.**

Strongly Disagree	Disagree	Slightly Disagree	Neither Agree nor Disagree	Slightly Agree	Agree	Strongly Agree
a.						
b.						
c.						
d.						
e.						

5. **We have clear responsibilities, roles, systems of accountability and good governance. We use these to manage and deliver good quality, sustainable care, treatment and support. We act on the best information about risk, performance and outcomes, and we share this securely**

Strongly Disagree	Disagree	Slightly Disagree	Neither Agree nor Disagree	Slightly Agree	Agree	Strongly Agree
a.						
b.						
c.						
d.						
e.						

6. **We understand our duty to collaborate and work in partnership, so our services work seamlessly for people. We share information and learning with partners and collaborate for improvement.**

Strongly Disagree	Disagree	Slightly Disagree	Neither Agree nor Disagree	Slightly Agree	Agree	Strongly Agree
a.						
b.						
c.						
d.						
e.						

7. **We focus on continuous learning, innovation and improvement across our organisation and the local system. We encourage creative ways of delivering equality of experience, outcome and quality of life for people. We actively contribute to safe, effective practice and research.**

Strongly Disagree	Disagree	Slightly Disagree	Neither Agree nor Disagree	Slightly Agree	Agree	Strongly Agree
a.						
b.						
c.						
d.						
e.						

8. We understand any negative impact of our activities on the environment and we strive to make a positive contribution in reducing it and support people to do the same.

	Strongly Disagree	Disagree	Slightly Disagree	Neither Agree nor Disagree	Slightly Agree	Agree	Strongly Agree
a.							
b.							
c.							
d.							
e.							

Thank you for participating in this Board CQC well-led self-evaluation