Excellent health care, improved health for all

The Dudley Group NHS Foundation Trust

Board of Directors Meeting Further reading Public meeting

Thursday 9 March 2023

Welcome to our international nurse recruits

Performance KPIs

February 2023 Report

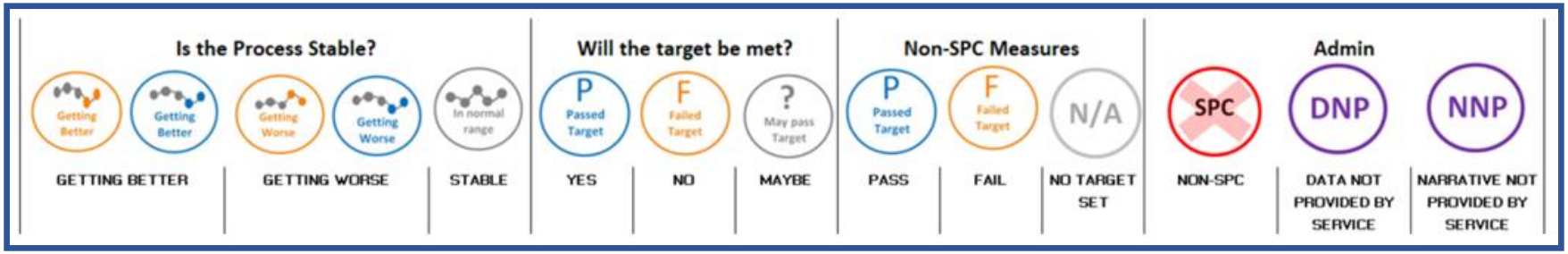
(January 2023 data), December 2022 data for Cancer)

The Dudley Group NHS Foundation Trust

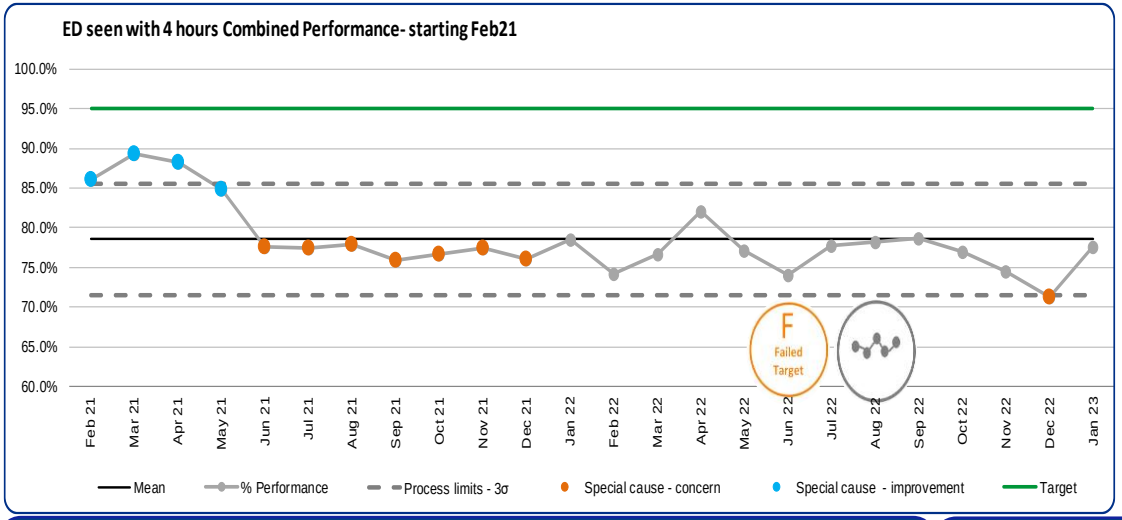
Adam Thomas, Interim Chief Operating Officer

Constitutional Performance

Constitutional Standard and KPI		Target	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Status	
Emergency Access Standard (EAS)	Combined 4hr Performance	95.0%	76.1%	76.7%	72.3%	74.7%	72.1%	77.1%	74.0%	77.8%	78.2%	78.7%	76.9%	74.6%	71.3%	77.6%		
Triage	Triage - All	95.0%	89.2%	88.2%	86.4%	86.1%	90.1%	85.4%	84.8%	86.1%	85.5%	84.3%	83.8%	80.7%	74.2%	79.5%		
Cancer	Cancer 62 Day - All	85.0%	56.2%	73.9%	56.2%	73.9%	56.2%	73.9%	69.3%	69.7%	69.7%	69.7%	69.7%	69.7%	46.6%	N/A		
	Cancer 31 Day -	96.0%	90.0%	89.6%	91.5%	92.3%	93.0%	92.6%	93.2%	94.8%	90.1%	84.9%	90.4%	83.2%	92.7%	N/A		
	All Cancer 2 Week Waits	93.0%	67.4%	64.6%	78.5%	76.0%	86.9%	96.1%	93.1%	92.3%	78.7%	77.0%	80.6%	86.1%	83.9%	N/A		
Referral to Treatment (RTT)	RTT Incomplete	92%	74.9%	73.7%	72.9%	73.6%	73.3%	73.6%	71.0%	69.3%	67.7%	65.5%	64.5%	63.3%	60.3%	59.9%		
Diagnostics	DM01 - Diagnostics achieved within 6 weeks	99%	78.1%	76.5%	82.8%	82.3%	78.1%	81.8%	83.1%	84.2%	80.7%	78.1%	76.9%	76.4%	71.0%	70.4%		
VTE	% Assessed on Admission	95%	89.5%	89.6%	94.1%	93.7%	93.6%	94.1%	93.7%	93.4%	93.0%	92.5%	86.2%	89.1%	85.7%	90.1%		



ED Performance



Latest Month	Latest Month	2nd
77.6%	56	For December 22
EAS 4 hour target 95% for Type 1 & 3 attendances	DTA 12 hour breaches - target zero	DGFT ranking out of 13 West Midlands area Trusts

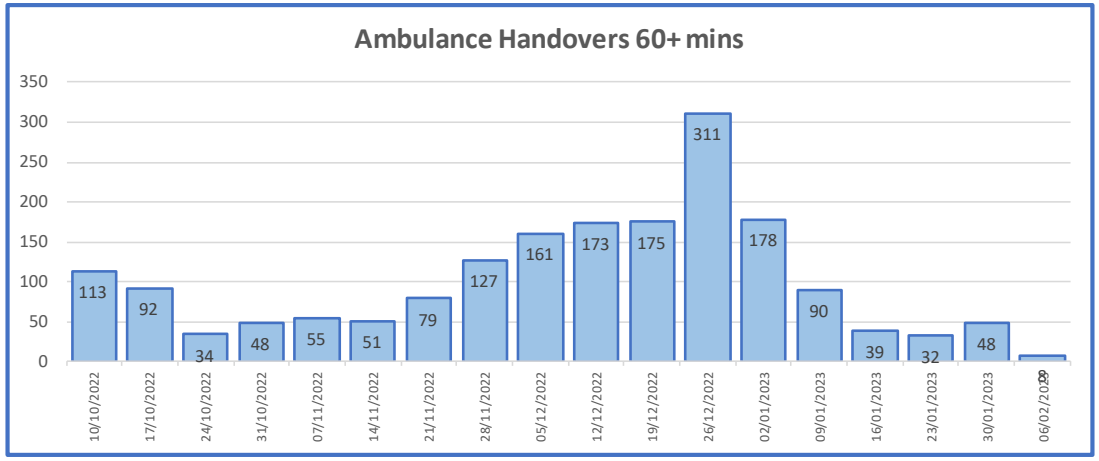
Performance

- Following an extremely challenging month in December, 4 hour ED performance improved during January, rising to 77.6%
- An improvement in Urgent and Emergency Care metrics allowed for surge and super surge capacity that was opened in December to be partially closed during January and these areas reverting to their intended use
- Time to admission continues to fall and is now at a level last seen in June 2022

Action

- Revised working practices to improve the timeliness of flow between ED, AMU and baseline wards continue to be adapted
- Discharge Lounge usage fell in December and January as this area was largely converted to inpatient use as part of surge capacity plans. Plans in place to increase usage back to November's record levels
- Capacity for the Discharge to Assess initiative was increased to 5 patients per day in January, which will support improved discharge rates

Ambulance Handovers 60+ Mins



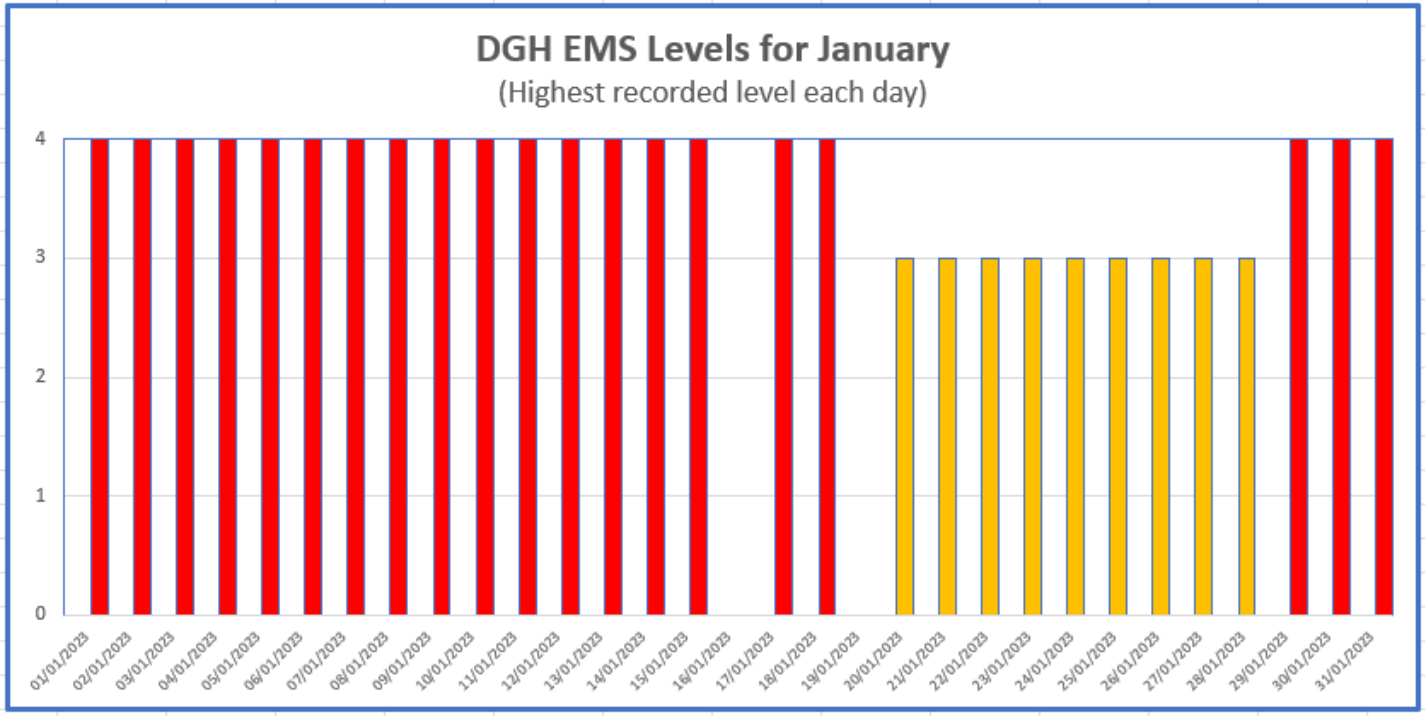
Performance

- Ambulance handover delays of over 60 minutes fell significantly in January, following significant pressure in December as a result of flu and Covid-19 attendances
- The number of continuous days with zero breaches over 1 hours increased in January
- Total ambulance delays of over 60 minutes have returned to summer 2022 levels notwithstanding conveyances remaining high

Action

- Operational plans continue to be adapted to support improved flow from ED to base wards and AMU
- Additional senior nursing support has been assigned in the form of a substrative matron with responsibility for flow across the AMU areas
- The Discharge Improvement Group continues to develop plans through its workstreams, with particular focus on Discharge to Assess and Discharge Planning on Admission models

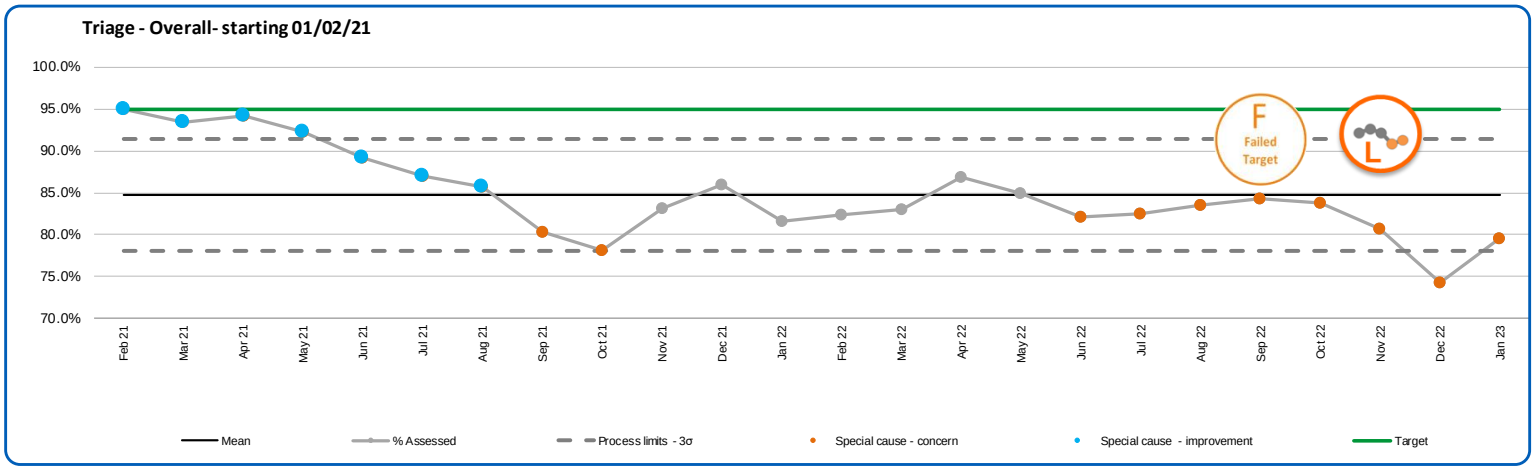
EMS Level for last month



Observations

- The number of days the Trust operated at EMS Level 4 in January reduced compared to December
- A lessening of pressure relating to flu and Covid-19 allowed for some surge areas to be returned to their day-to-day use towards the end of January

ED Triage



Latest Month

79.5%

Triage – target 95%

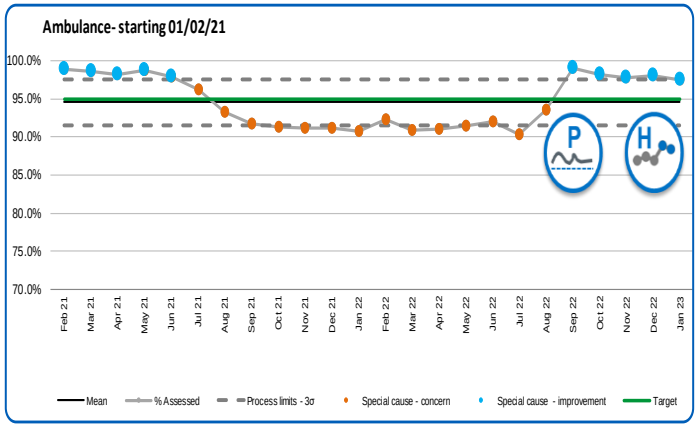
Performance

- Overall ED triage compliance improved in January by 4%
- Of the triage areas, Majors, See and Treat and Peads all saw an improvement in performance following a challenging month in December
- Ambulance triage remains steady and above target

Action

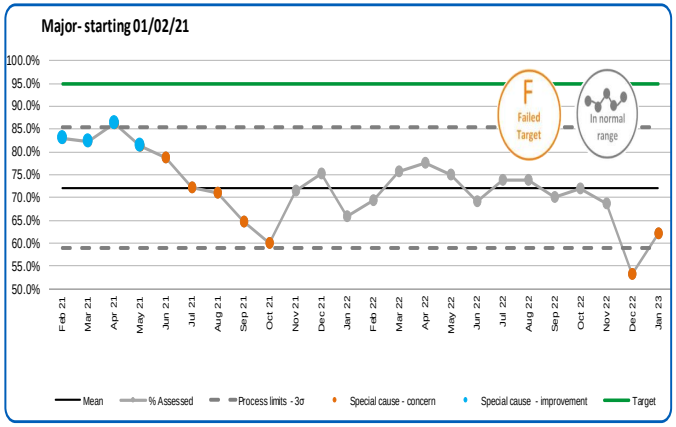
- Overall, to continue to implement workforce plan that seeks to resolve performance and substantive/agency imbalance that impacts on performance
- Review BEST (Baseline Emergency Staffing Tool) guidelines
- Plan to be devised for further training of additional Band 6 nurses to be ESI triage competent by June 2023

ED Triage



Latest Month

97.4%



Latest Month

62.2%

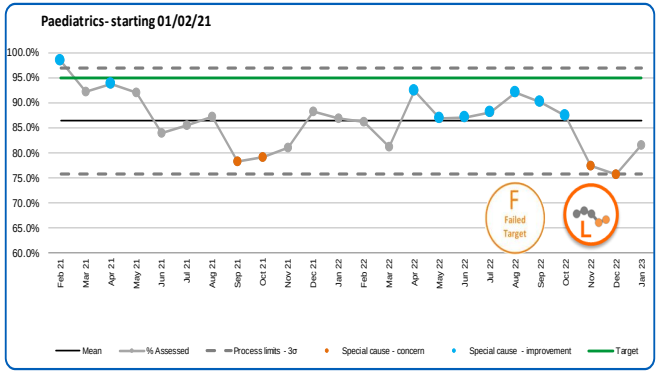
Performance

- Ambulance triage remains above target
- Majors triage saw a partial recovery in January, following a deterioration in December as a result of sustained and increased pressure and increase in ED attendances

Action

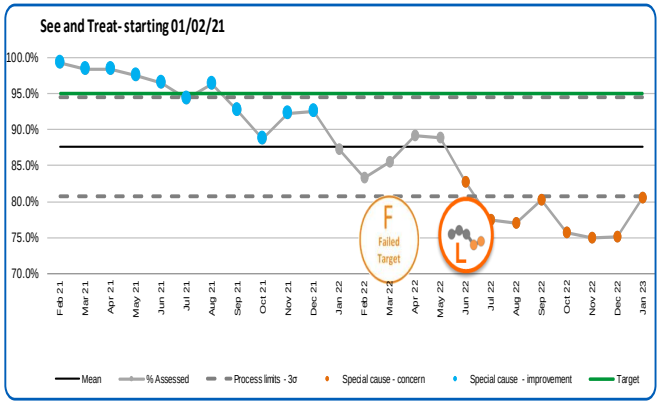
- Overall, to continue to implement workforce plan that seeks to resolve performance and substantive/agency imbalance that impacts on performance
- Review BEST (Baseline Emergency Staffing Tool) guidelines
- Plan to be devised for further training of additional Band 6 nurses to be ESI triage competent by June 2023

ED Triage



Latest Month

81.5%



Latest Month

80.5%

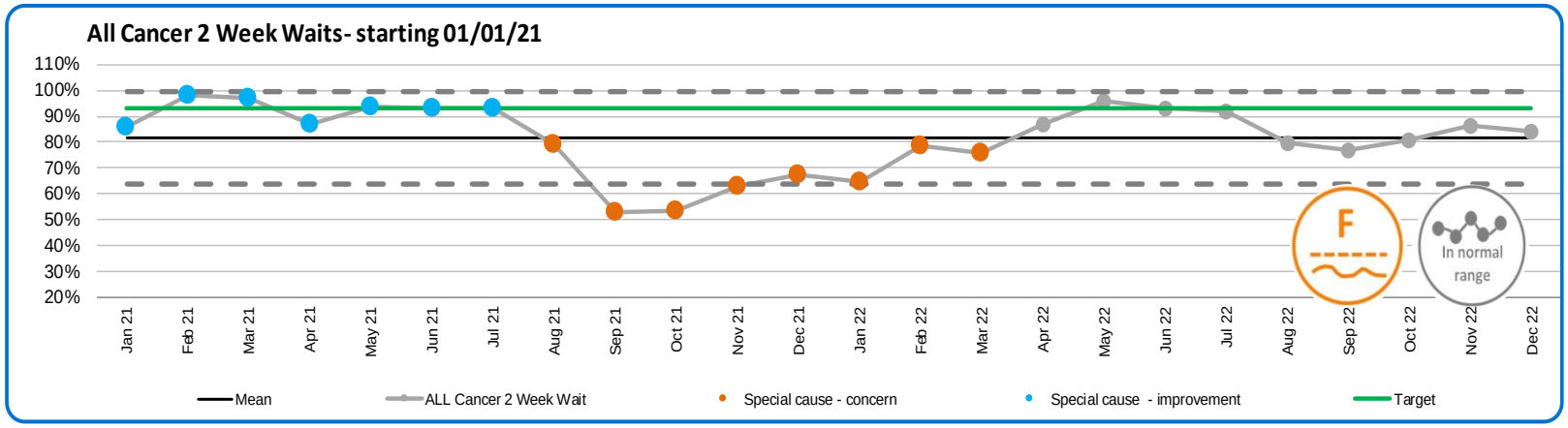
Performance

- Both peads and See and Treat triage performance improved in January following a challenged month in December
- See and Treat has returned to performance last seen in September, but remains below target

Action

- Overall, to continue to implement workforce plan that seeks to resolve performance and substantive/agency imbalance that impacts on performance
- Review BEST (Baseline Emergency Staffing Tool) guidelines
- Plan to be devised for further training of additional Band 6 nurses to be ESI triage competent by June 2023

Cancer Performance – 2 Week Wait



Latest Month

83.9%

All cancer 2 week waits – target 93%

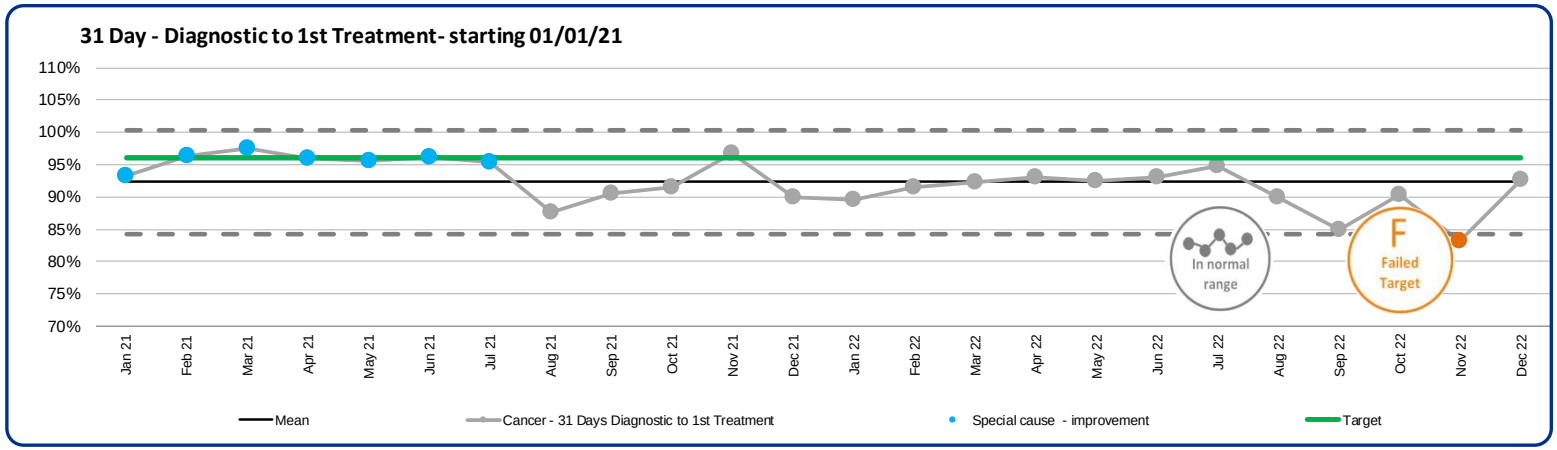
Performance

- All cancer data runs two months behind. Data included within this pack is up to and including December 2022
- 2 week wait performance fell back slightly in December to 83.9%. January's unvalidated position is similar to that of December, with February showing improved performance
- Skin and Colorectal were the most challenged tumour sites during December

Action

- Additional capacity allocated to address immediate capacity shortfalls
- Skin are prioritising OPA slots for cancer by converting follow up appointment slots in Dermatology to be used for new 2ww appointments
- Virtual triaging software for skin was launched in early February. This aims support recovery of the 2ww standard in view of the high number of referrals received and low conversation rate seen in skin
- The skin 'same day surgery' pathway trial is to be made permanent, following successful pilot results in reducing pathway length for some patient cohorts
- Full demand and capacity modelling exercise has been completed for all tumour sites. Plans being developed to implement recommendations to create correct capacity within baseline clinics

Cancer Performance – 31 Day



Latest Month

92.7%

Target 96%

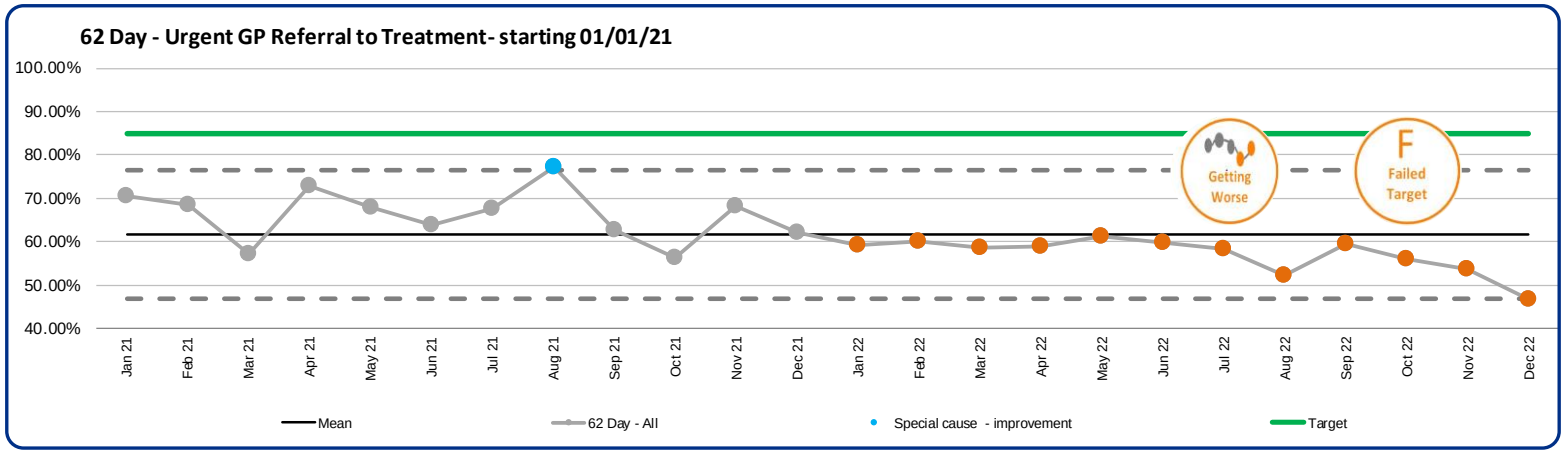
Performance

- Following a deterioration in performance in November, December saw a partial recovery of the position
- Challenged tumour sites include Urology and Skin

Action

- Focus remains on reducing the backlog of 104 day waits in order to release treatment capacity for 31 days
- Additional theatre lists are being prioritised for cancer patients in the surgical tumour sites

Cancer Performance – 62 Day



Latest Month

46.6%

Target 85%

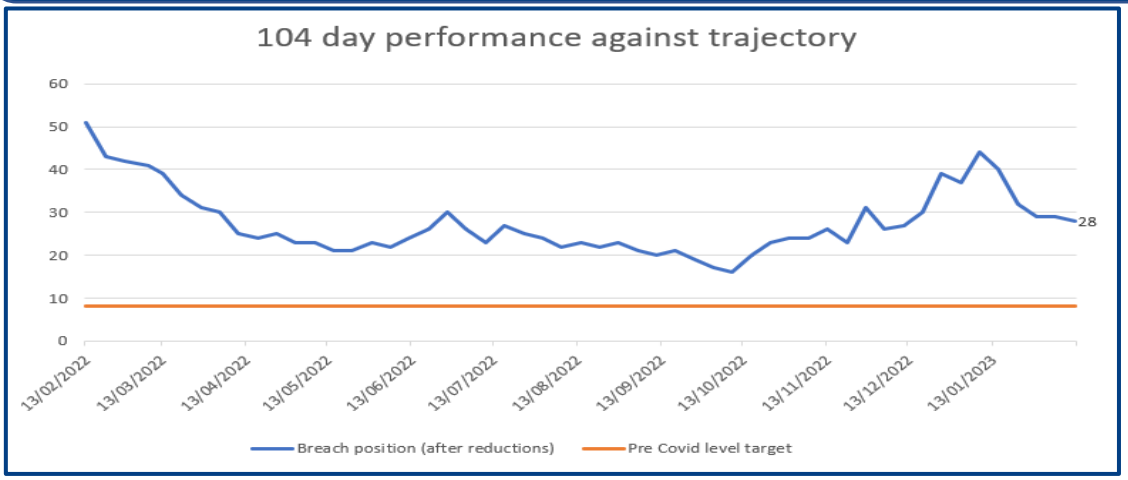
Performance

- December's performance for the 62 day standard for first definitive treatment deteriorated
- Recovery of 62 day performance is reliant on clearing the 104 day backlog position, which fell back in November and December and which had a subsequent impact on the 62 day target
- However, 104 performance in January and early February has recovered to close to autumn 2022 levels
- Skin, Urology and Colorectal remain the most challenged tumour sites

Action

- A specific project is being undertaken in Colorectal, working in collaboration with primary care, with a view to shortening time to treatment within the speciality
- Continue to focus on additional sessions in Surgery to clear the 104 day backlog
- Work is ongoing with Black Country Pathology Services to improve cancer turnaround times

Cancer Performance – 104 Day



Source: Weekly Cancer Performance

Latest Week

(06/02/23)

28

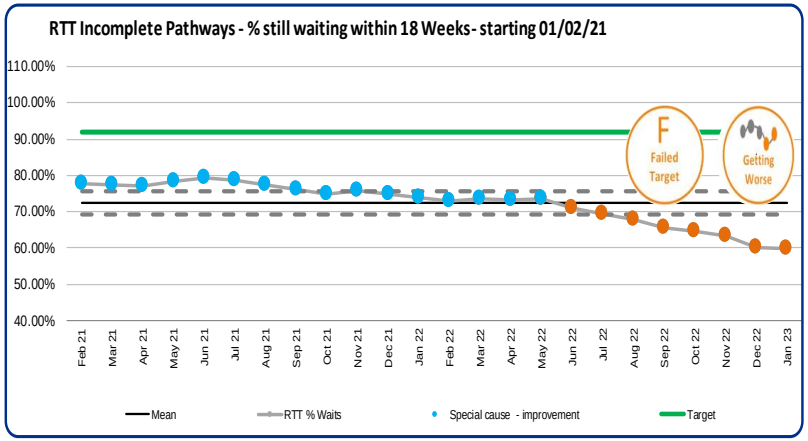
Performance

- Having seen a worsening of this position in December, there has been a recovery in recent weeks up to early February
- The total cohort waiting over 104 days was down to 28 at the end of week commencing 06/02/23, although this remains higher than during last autumn
- Tumour sites of concern include Skin and Urology

Action

- Increased senior focus remains on reducing the backlog of 104 day waits in order to release treatment capacity for 31 days and 62 day targets
- Additional theatre lists are being prioritised for cancer patients in the surgical tumour sites
- Productivity gains have been realised in some surgical tumour sites, with further productivity targets and plans developed for 23/24
- FIT testing is due to be rolled out in February in Colorectal

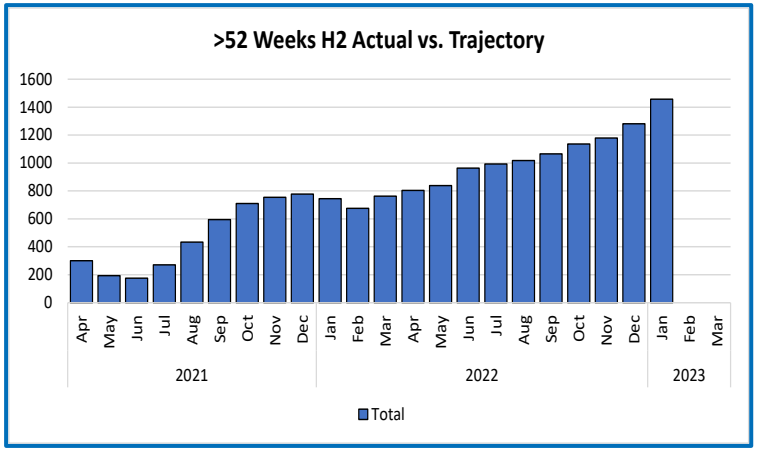
RTT Performance



Latest Month

59.9%

RTT Incomplete pathways target 92%



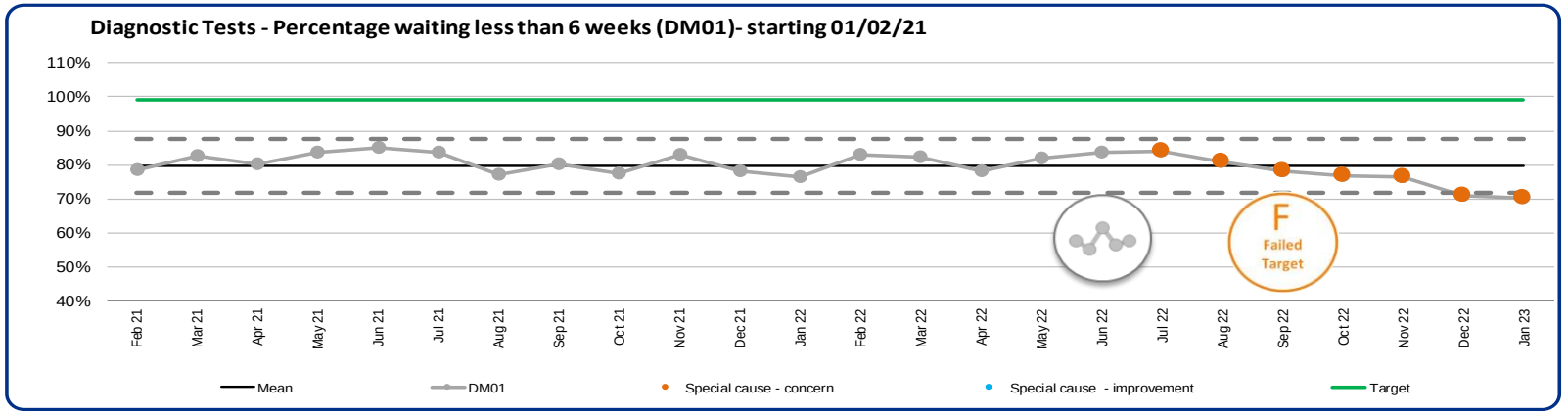
Performance

- RTT performance declined last month as the Trust focuses on clearing the backlog of patients waiting 78 weeks for treatment. The national focus and requirement is to have zero patients waiting over 78 weeks by March 2023
- The Trust remains on track to achieve zero 78+ week breaches by the end of March. There are currently 57 patients to treat, all of which have been provided with treatment dates, apart from 5
- The Trust is placed joint 1st of 20 Midlands acute Trusts for the number of 104 week breaches (0).

Action

- Focus remains on achieving the national 78 week target
- Plans and trajectories have been developed with regards to delivering against the next national target of reducing 65 week + cohort
- Trials have taken place in a number of specialties with regards to increasing throughput, particularly in Trauma and Orthopaedics, with 6 joint procedures per list

DM01 Performance



Latest Month

70.4%

DM01 combining 15 modalities - target 99%

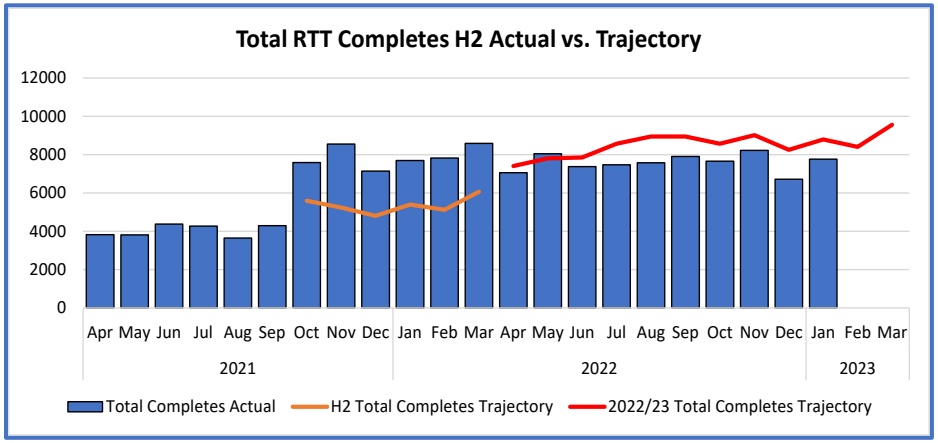
Performance

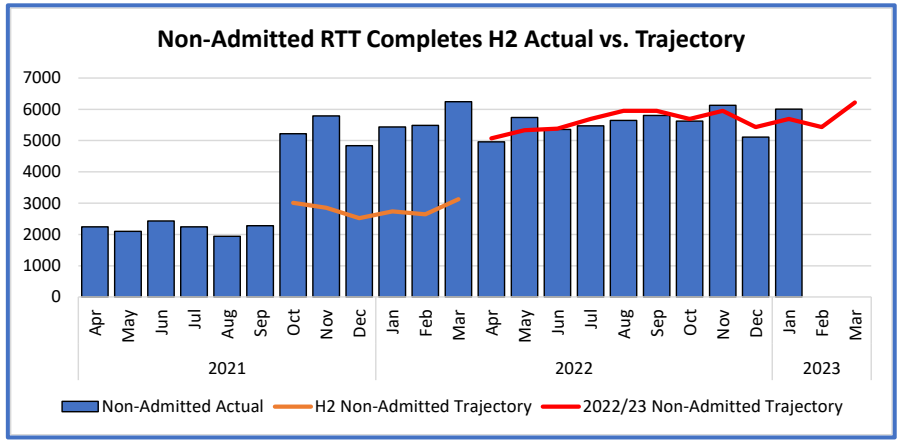
- January's DM01 performance is broadly similar to that achieved in December
- At a modality level, there has been an improvement in Flexi Sigmoidoscopy, but a fall-off in performance in most other modalities when compared to the annual plan

Action

- System level project underway to devise system-wide solutions in Cardiology

Recovery and Restoration – RTT Completes





Performance

- The Trust is making good progress in reducing the backlog of patients waiting routine procedures or treatment
- The Trust continues to have x0 104 week breaches and continues to reduce the number of patients waiting over 78 weeks – there are now just 5 patients remaining to offer treatment dates to in this category
- Mutual aid has been provided to other Black Country Trusts to support a system-wide reduction of the 78 week cohort
- The Trust has the 6th fewest number of 78 week plus breaches, compared to the 20 Midlands acute Trusts which equates to 0.27% of the total breaches for the 20 Trusts in the Region
- DGFT has the joint 6th shortest median waiting time of the 20 Midlands acute Trusts

Action

- The number of total RTT completes in the chart above is slightly behind plan. This is due to the delayed opening of the 2 new MRP facilities (by several months)
- Non-admitted RTT completes performed better than plan in January
- Plans are being finalised with regards to achieving the next national restoration and recovery milestone of reducing the 65 week + cohort

RTT Restoration and Recovery – Trust Comparisons

0-18 Week RTT Performance (Midlands Region): =6th

December 2022

Region Code	Provider Code	Provider Name	Total number of incomplete pathways	Total within 18 weeks	% within 18 weeks
Y60	RJC	SOUTH WARWICKSHIRE UNIVERSITY NHS FOUNDATION TRUST	29,649	20,484	69.1%
Y60	RLT	GEORGE ELIOT HOSPITAL NHS TRUST	14,857	10,229	68.8%
Y60	RNS	NORTHAMPTON GENERAL HOSPITAL NHS TRUST	36,417	24,168	66.4%
Y60	RK5	SHERWOOD FOREST HOSPITALS NHS FOUNDATION TRUST	47,223	31,316	66.3%
Y60	RNQ	KETTERING GENERAL HOSPITAL NHS FOUNDATION TRUST	26,007	16,068	61.8%
Y60	RNA	THE DUDLEY GROUP NHS FOUNDATION TRUST	44,350	26,732	60.3%
Y60	RX1	NOTTINGHAM UNIVERSITY HOSPITALS NHS TRUST	76,517	44,949	58.7%
Y60	RLQ	WYE VALLEY NHS TRUST	21,117	12,328	58.4%
Y60	RFS	CHESTERFIELD ROYAL HOSPITAL NHS FOUNDATION TRUST	24,002	13,966	58.2%
Y60	RBK	WALSALL HEALTHCARE NHS TRUST	33,708	18,858	55.9%
Y60	RL4	THE ROYAL WOLVERHAMPTON NHS TRUST	73,478	40,448	55.0%
Y60	RXK	SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST	71,210	38,265	53.7%
Y60	RTG	UNIVERSITY HOSPITALS OF DERBY AND BURTON NHS FOUNDATION TRUST	105,082	55,503	52.8%
Y60	RKB	UNIVERSITY HOSPITALS COVENTRY AND WARWICKSHIRE NHS TRUST	62,937	32,060	50.9%
Y60	RJE	UNIVERSITY HOSPITALS OF NORTH MIDLANDS NHS TRUST	77,889	39,500	50.7%
Y60	RXW	THE SHREWSBURY AND TELFORD HOSPITAL NHS TRUST	38,859	19,601	50.4%
Y60	RWD	UNITED LINCOLNSHIRE HOSPITALS NHS TRUST	72,526	34,010	46.9%
Y60	RWE	UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST	129,654	58,993	45.5%
Y60	RWP	WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST	69,773	30,905	44.3%
Y60	RRK	UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST	154,662	61,913	40.0%

RTT Restoration and Recovery – Trust Comparisons

Number of Patients Waiting 78+ Weeks for Routine Treatment (Midlands Region): 6th

December 2022

Region Code	Provider Code	Provider Name	Total 78 plus weeks
Y60	RLT	GEORGE ELIOT HOSPITAL NHS TRUST	1
Y60	RNS	NORTHAMPTON GENERAL HOSPITAL NHS TRUST	1
Y60	RNQ	KETTERING GENERAL HOSPITAL NHS FOUNDATION TRUST	3
Y60	RK5	SHERWOOD FOREST HOSPITALS NHS FOUNDATION TRUST	37
Y60	RJC	SOUTH WARWICKSHIRE UNIVERSITY NHS FOUNDATION TRUST	42
Y60	RNA	THE DUDLEY GROUP NHS FOUNDATION TRUST	47
Y60	RLQ	WYE VALLEY NHS TRUST	87
Y60	RKB	UNIVERSITY HOSPITALS COVENTRY AND WARWICKSHIRE NHS TRUST	119
Y60	RFS	CHESTERFIELD ROYAL HOSPITAL NHS FOUNDATION TRUST	130
Y60	RBK	WALSALL HEALTHCARE NHS TRUST	195
Y60	RXK	SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST	230
Y60	RL4	THE ROYAL WOLVERHAMPTON NHS TRUST	310
Y60	RXW	THE SHREWSBURY AND TELFORD HOSPITAL NHS TRUST	481
Y60	RX1	NOTTINGHAM UNIVERSITY HOSPITALS NHS TRUST	754
Y60	RJE	UNIVERSITY HOSPITALS OF NORTH MIDLANDS NHS TRUST	855
Y60	RWD	UNITED LINCOLNSHIRE HOSPITALS NHS TRUST	1,158
Y60	RTG	UNIVERSITY HOSPITALS OF DERBY AND BURTON NHS FOUNDATION TRUST	1,180
Y60	RWP	WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST	1,565
Y60	RWE	UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST	3,791
Y60	RRK	UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST	6,285

RTT Restoration and Recovery – Trust Comparisons

Number of 104 Week Breaches (Midlands Region): =1st

December 2022

Region Code	Provider Code	Provider Name	104 plus
Y60	RLT	GEORGE ELIOT HOSPITAL NHS TRUST	-
Y60	RNS	NORTHAMPTON GENERAL HOSPITAL NHS TRUST	-
Y60	RK5	SHERWOOD FOREST HOSPITALS NHS FOUNDATION TRUST	-
Y60	RJC	SOUTH WARWICKSHIRE UNIVERSITY NHS FOUNDATION TRUST	-
Y60	RNA	THE DUDLEY GROUP NHS FOUNDATION TRUST	-
Y60	RKB	UNIVERSITY HOSPITALS COVENTRY AND WARWICKSHIRE NHS TRUST	-
Y60	RFS	CHESTERFIELD ROYAL HOSPITAL NHS FOUNDATION TRUST	-
Y60	RBK	WALSALL HEALTHCARE NHS TRUST	-
Y60	RXK	SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST	-
Y60	RL4	THE ROYAL WOLVERHAMPTON NHS TRUST	-
Y60	RWD	UNITED LINCOLNSHIRE HOSPITALS NHS TRUST	-
Y60	RWP	WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST	-
Y60	RXW	THE SHREWSBURY AND TELFORD HOSPITAL NHS TRUST	1
Y60	RTG	UNIVERSITY HOSPITALS OF DERBY AND BURTON NHS FOUNDATION TRUST	1
Y60	RNQ	KETTERING GENERAL HOSPITAL NHS FOUNDATION TRUST	2
Y60	RLQ	WYE VALLEY NHS TRUST	2
Y60	RRK	UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST	3
Y60	RX1	NOTTINGHAM UNIVERSITY HOSPITALS NHS TRUST	6
Y60	RJE	UNIVERSITY HOSPITALS OF NORTH MIDLANDS NHS TRUST	48
Y60	RWE	UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST	112

RTT Restoration and Recovery – Trust Comparisons

Median Waiting Time (Midlands Region): =6th shortest

December 2022

Region Code	Provider Code	Provider Name	Average (median) waiting time (in weeks)
Y60	RLT	GEORGE ELIOT HOSPITAL NHS TRUST	11.4
Y60	RJC	SOUTH WARWICKSHIRE UNIVERSITY NHS FOUNDATION TRUST	11.6
Y60	RK5	SHERWOOD FOREST HOSPITALS NHS FOUNDATION TRUST	12.0
Y60	RNS	NORTHAMPTON GENERAL HOSPITAL NHS TRUST	12.3
Y60	RNQ	KETTERING GENERAL HOSPITAL NHS FOUNDATION TRUST	13.2
Y60	RNA	THE DUDLEY GROUP NHS FOUNDATION TRUST	13.8
Y60	RX1	NOTTINGHAM UNIVERSITY HOSPITALS NHS TRUST	14.1
Y60	RLQ	WYE VALLEY NHS TRUST	14.3
Y60	RFS	CHESTERFIELD ROYAL HOSPITAL NHS FOUNDATION TRUST	14.4
Y60	RBK	WALSALL HEALTHCARE NHS TRUST	15.4
Y60	RL4	THE ROYAL WOLVERHAMPTON NHS TRUST	15.5
Y60	RXK	SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST	16.2
Y60	RTG	UNIVERSITY HOSPITALS OF DERBY AND BURTON NHS FOUNDATION TRUST	16.7
Y60	RKB	UNIVERSITY HOSPITALS COVENTRY AND WARWICKSHIRE NHS TRUST	17.5
Y60	RJE	UNIVERSITY HOSPITALS OF NORTH MIDLANDS NHS TRUST	17.6
Y60	RXW	THE SHREWSBURY AND TELFORD HOSPITAL NHS TRUST	17.7
Y60	RWD	UNITED LINCOLNSHIRE HOSPITALS NHS TRUST	19.6
Y60	RWE	UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST	20.5
Y60	RWP	WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST	21.4
Y60	RRK	UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST	24.3

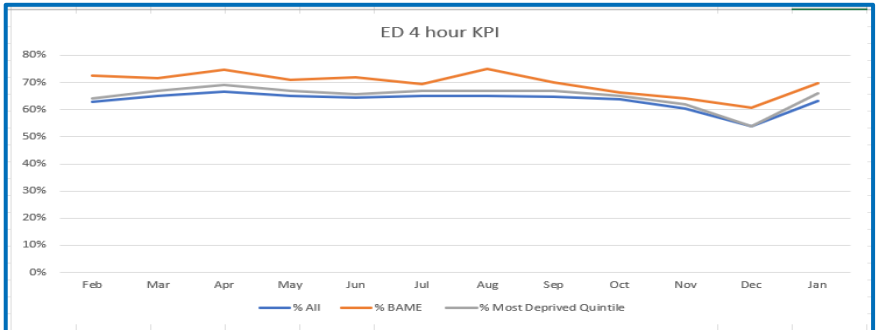
Cancer Restoration and Recovery – Trust Comparisons

2 Week Wait: 2nd ICS

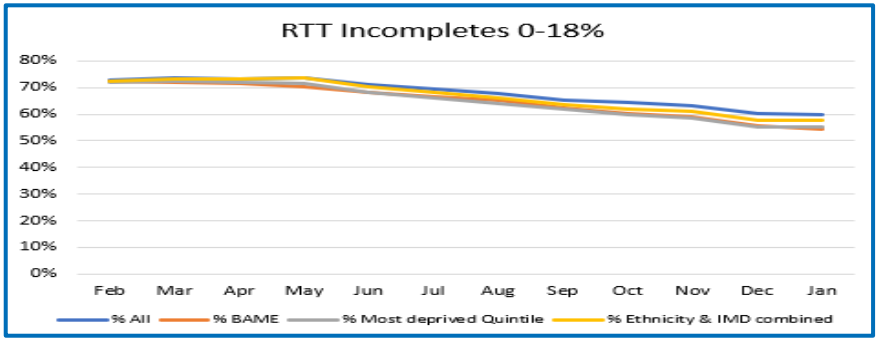
December 2022

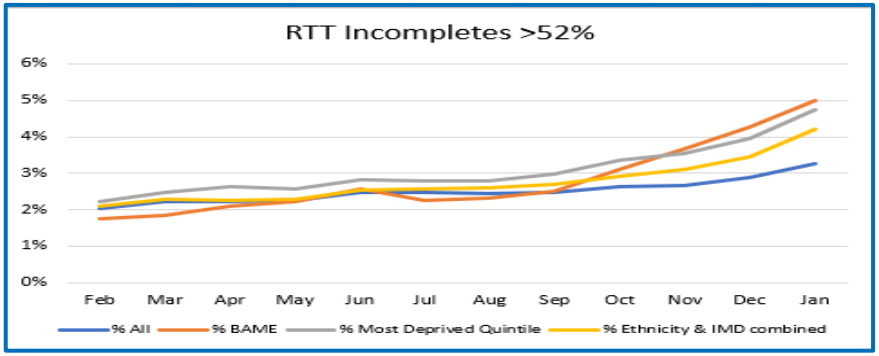
	PERCENTAGE
ACCOUNTABLE PROVIDER	**SEEN WITHIN 14 DAYS**
SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST	96.10%
THE DUDLEY GROUP NHS FOUNDATION TRUST	83.91%
THE ROYAL WOLVERHAMPTON NHS TRUST	83.59%
WALSALL HEALTHCARE NHS TRUST	82.56%
ALL ENGLISH PROVIDERS	80.29%

Health Inequalities



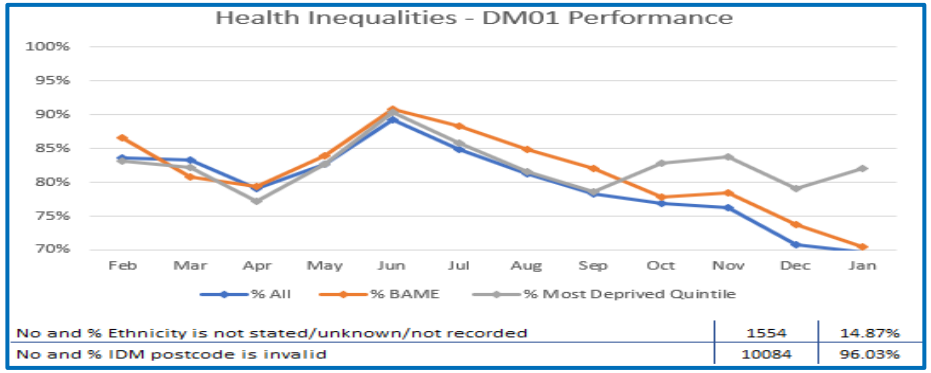
No and % ethnicity is not stated/unknown/not recorded	274	3.66%
No and % IMD postcode is invalid	26	0.30%



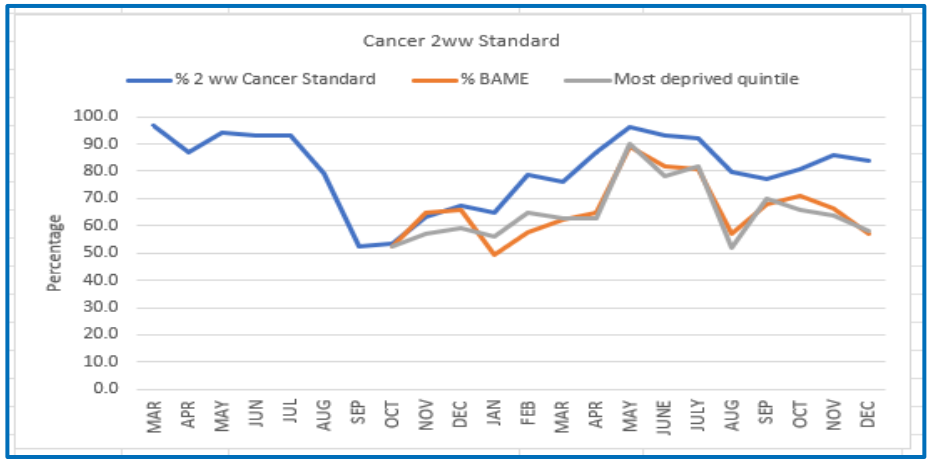


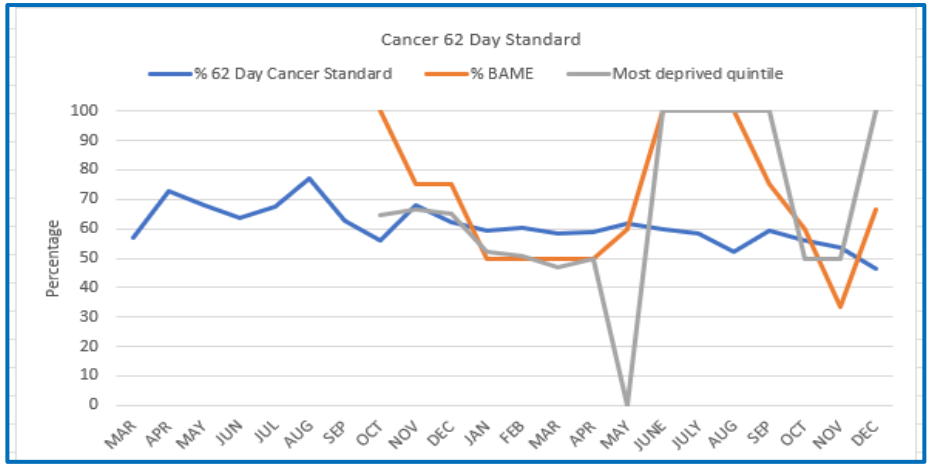
No and % ethnicity is not stated/unknown/not recorded	18243	40.7%
No and % IMD postcode is invalid/missing	12718	28.4%

Please note: As a significant number of missing ethnicity & IMD are for patients currently on ASI or RAS, these will be shorter waits excluded from the "BAME" and "IMD 1&2" figures, causing an downward skew of their performance. The yellow line shows performance for only those RTT waits with both a recorded ethnicity and IMD decile, and is therefore more comparative than the blue line of total waiting list figures.



No and % Ethnicity is not stated/unknown/not recorded	1554	14.87%
No and % IDM postcode is invalid	10084	96.03%





Workforce KPI Report

January 2023

Alan Duffell

Interim Chief People Officer

NHS
The Dudley Group
NHS Foundation Trust

Summary

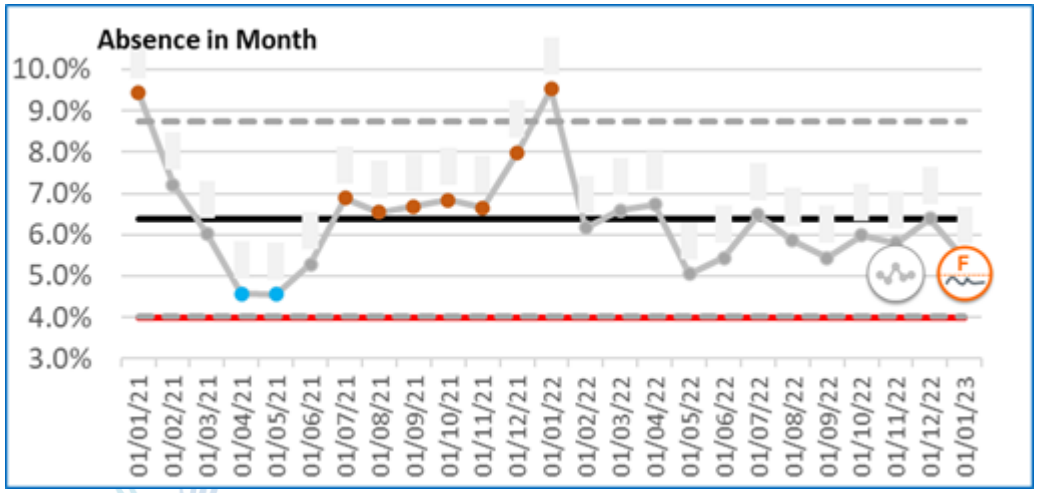
The Dudley Group NHS Foundation Trust

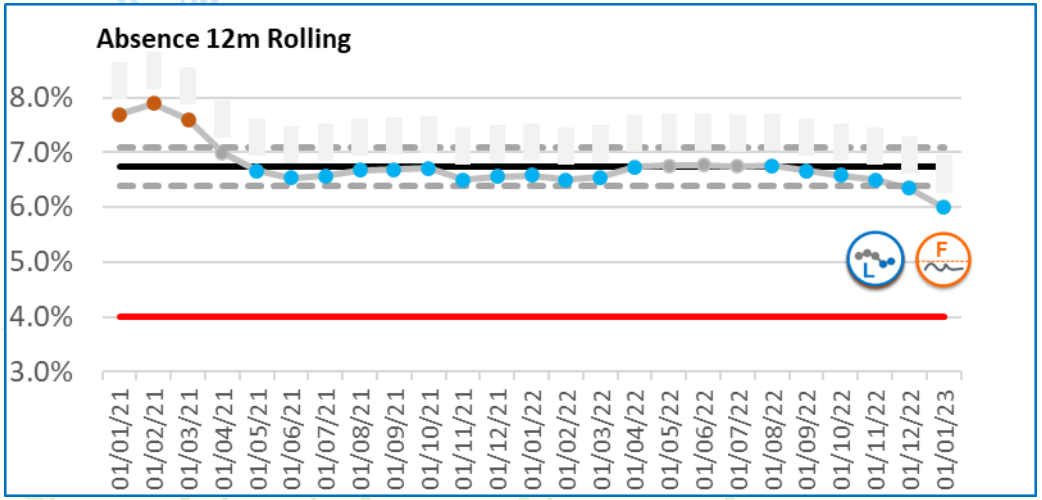
Absence – In Month	**5.43%**	↓	**Sickness Absence** • In-month sickness absence for January is 5.43%, a decrease from 6.39%, in December 2022. • The rolling 12-month absence shows a reduction from 6.34% in December 2022 to 6.00% in January 2023. This data has increased absence due to COVID-19 being represented across the full year figure.
Absence - 12m Rolling	**6.00%**	↓	
Turnover	**8.04%**	↓	**Turnover** • Turnover (all terminations) has decreased from 8.90% in December 2022 to 8.04% in January 2023. • Normalised Turnover (voluntary resignation) has decreased from 4.67% in December 2022 to 4.17% in January 2023.
Normalised Turnover	**4.17%**	↓	
Vacancy Rate	**8%**	↓ ↑	**Vacancy Rate** • The vacancy rate has remained at 8%. • The total vacancies are 494.10, which remains consistent with December 2022.
Mandatory Training	**85.27%**	↓	**Mandatory Training** • Statutory Training has decreased from 86.68% in December 2022 to 85.27% in January 2023 (as of 23/02/23 - this is 86.10%).
Appraisals	**63.7**	↑	**Appraisals** • The appraisal rate has increased from 62.3% in December 2022 to 63.7 in January 2023 (as of 01/03/23 - this is 67.4%).

CARE RESPECT RESPONSIBILITY

Sickness Absence

The Dudley Group NHS Foundation Trust





In Month - Sickness Absence

In-month sickness absence for January 2023 is 5.43%, a reduction from 6.39% in December 2022.

Rolling 12 M - Sickness Absence

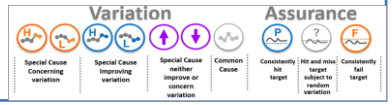
The rolling 12-month absence shows a reduction from 6.34% in December 2022 to 6% in January 2023.

This data has increased absence due to COVID-19 being represented across the full year figure.

Assurance

All COVID-related absence is reviewed and supported by the operational HR teams.

The HR team continue to sensitively support the management of long and short-term absence cases as appropriate.

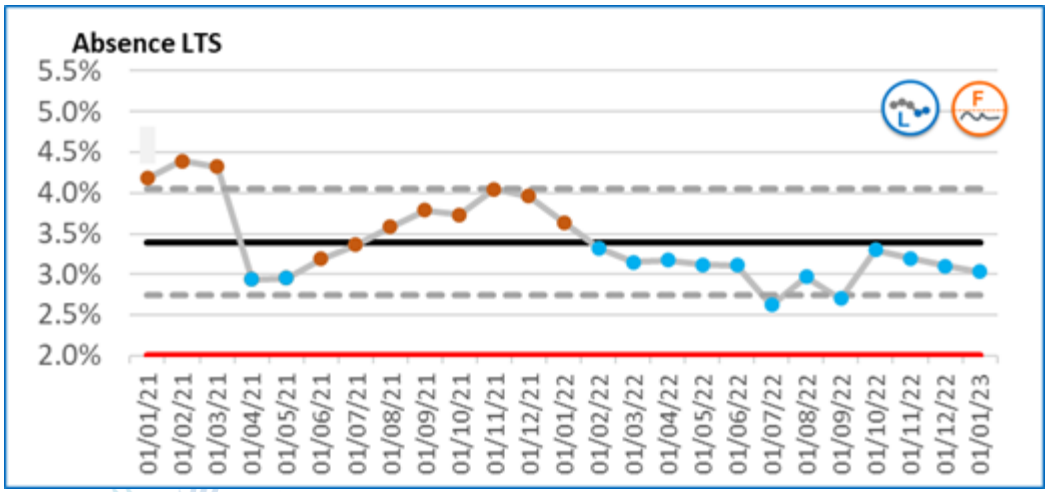


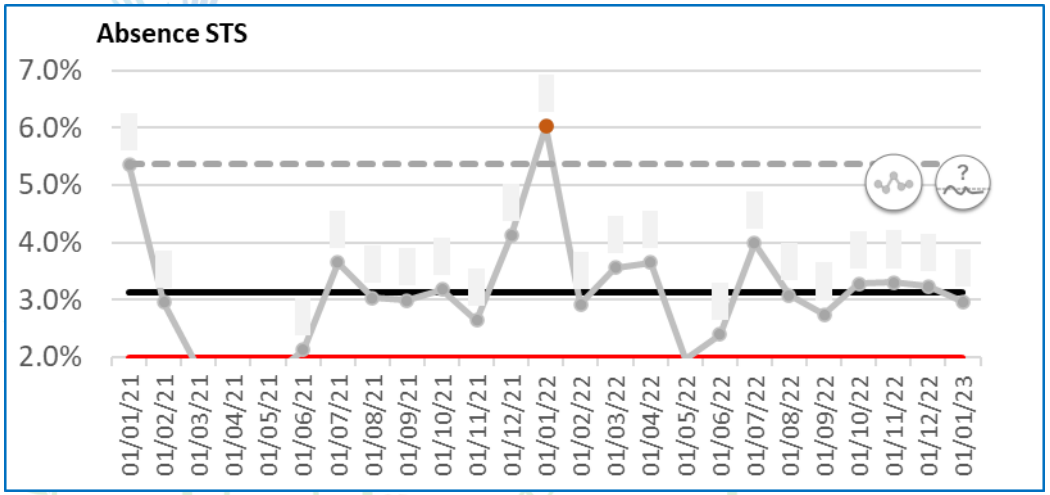
	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23
Absence in Month	9.53%	6.17%	6.60%	6.74%	5.06%	5.44%	6.48%	5.87%	5.44%	5.98%	5.80%	6.39%	5.43%
Absence 12m Rolling	6.58%	6.50%	6.55%	6.73%	6.76%	6.77%	6.74%	6.76%	6.66%	6.58%	6.50%	6.34%	6.00%

CARE RESPECT RESPONSIBILITY

Long-term and Short-term Absence

The Dudley Group NHS Foundation Trust





Long-Term and Short-Term Sickness Absence

Long-term absence continues to decline. Whilst the table shows improvement, indicating long-term absence is well managed, there is variation, and we are consistently above target.

Short-term absence has had a significant amount of variation, directly correlated to COVID-19, there is some evidence that the rate is now becoming consistent, but it is above target.

Assurance

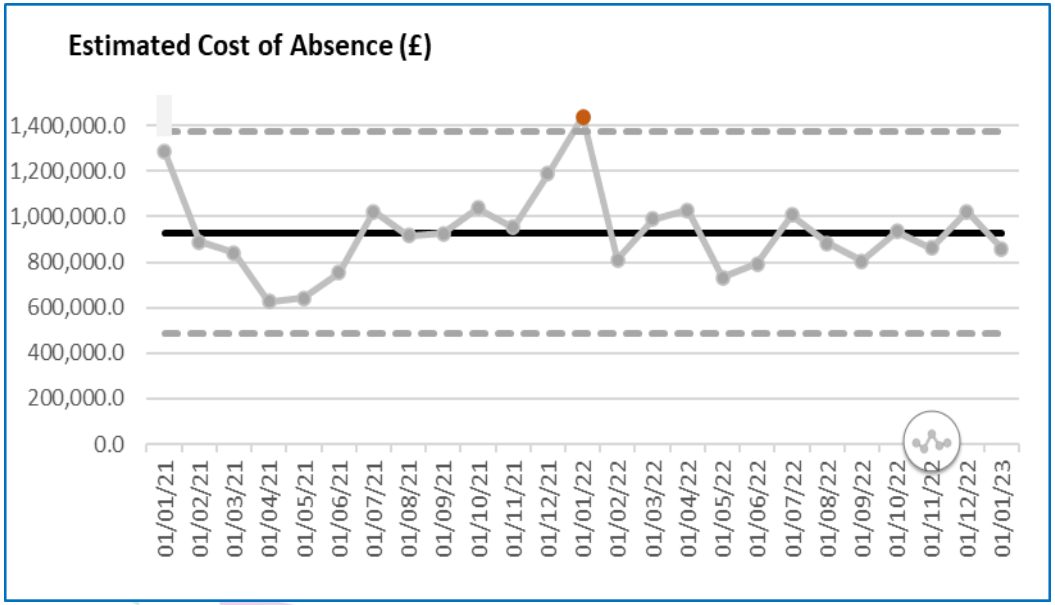
The HR Business Partners will support divisions to review both short-term absence and long-term absence and to review the plans in place to ensure that all long-term sickness at 6months+ and for all short-term persistent absence is being managed robustly.

	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23
Absence LTS	3.64%	3.32%	3.15%	3.17%	3.12%	3.11%	2.62%	2.97%	2.70%	3.30%	3.20%	3.10%	3.03%
Absence STS	6.03%	2.93%	3.56%	3.65%	1.96%	2.40%	3.99%	3.08%	2.74%	3.28%	3.30%	3.24%	2.97%

CARE RESPECT RESPONSIBILITY

Estimated Cost of Absence

The Dudley Group NHS Foundation Trust



Estimated Cost of Absence

The estimated cost of absence for January 2023 is £859,668 compared to £1,023,406 in December 2022.

It should be noted that the estimated cost of absence refers only to sick pay and does not include any cover arrangements.

	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23
Estimated Cost of Absence (£)	£ 1,438,038	£ 811,909	£ 988,046	£ 1,027,706	£ 732,834	£ 793,277	£ 1,006,272	£ 882,113	£ 804,352	£ 935,886	£ 861,583	£ 1,023,406	£859,668

CARE RESPECT RESPONSIBILITY

Sickness Absence

The Dudley Group
NHS Foundation Trust

Top 10 Departments By Time Lost (January)

Department	Absence FTE	Available FTE	Absence FTE %
253 Maternity Unit Serv	376.84	5,708.19	6.60%
253 Ward EAU Serv	369.44	5,236.14	7.06%
253 Critical Care Serv	358.56	4,068.00	8.81%
253 Emergency Dept Nursing Serv	340.73	3,910.93	8.71%
253 Pharmacy Department Serv	297.61	4,586.43	6.49%
253 Pathology - Phlebotomy Serv	276.11	1,883.71	14.66%
253 Therapy Department Serv	238.63	3,975.57	6.00%
253 Ward CCU Serv	177.00	1,818.31	9.73%
253 Imaging - Radiographic Aides Serv	157.99	1,275.57	12.39%
253 GI Unit Serv	154.04	1,849.31	8.33%

Top 10 Departments By Absence Rate (January)

Department	Absence FTE	Available FTE	Absence FTE %
253 Ambulatory Neurology CNS Serv	53.80	86.80	61.98%
253 Acute Oncology Serv	42.00	93.00	45.16%
253 Specialist Nursing COPD Serv	11.00	31.00	35.48%
253 Charitable Funds Fundraising Serv	28.00	80.60	34.74%
253 Ileostomy Service Serv	7.20	21.45	33.56%
253 Electronic Patient Records Serv	16.00	62.00	25.81%
253 Clinical Nurse Spec GI Serv	35.72	152.52	23.42%
253 CNS Colorectal Serv	59.41	268.25	22.15%
253 AAA Screening Serv	40.00	186.00	21.51%
253 Creditor Payments Serv	29.00	136.40	21.26%

Top 10 Absence Reasons By FTE Days Lost (12m)

Absence Reason	Headcount	Abs Occurrences	FTE Days Lost	%
S10 Anxiety/stress/depression/other psychiatric illnesses	155	162	1,856.86	20.3
S13 Cold, Cough, Flu - Influenza	395	408	1,453.59	15.9
S25 Gastrointestinal problems	232	237	742.93	8.1
S12 Other musculoskeletal problems	74	76	738.73	8.1
Other	118	121	604.63	6.6
S99 Unknown causes / Not specified	71	71	552.36	6.0
S30 Pregnancy related disorders	44	58	443.31	4.8
S26 Genitourinary & gynaecological disorders	41	42	337.57	3.7
S28 Injury, fracture	32	32	325.85	3.6
S19 Heart, cardiac & circulatory problems	20	21	292.93	3.2

Top 10 Absence Reasons By Absence Days Lost (12m)

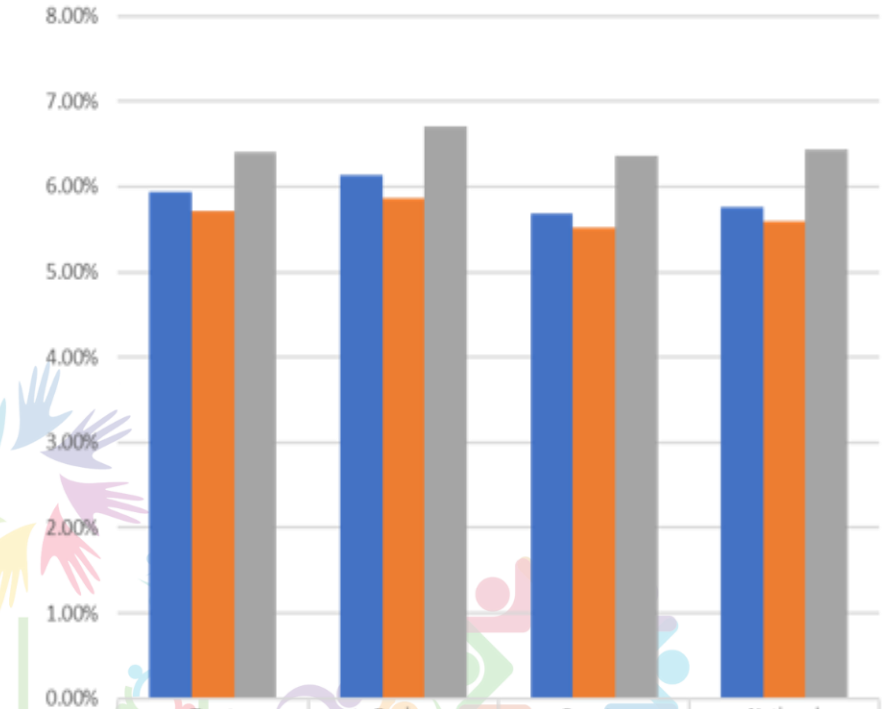
Absence Reason	Headcount	Abs Occurrences	Abs Days	Abs Estimated Cost	%
S10 Anxiety/stress/depression/other psychiatric illnesses	155	162	2,252	£172,791.87	21.2
S13 Cold, Cough, Flu - Influenza	395	408	1,655	£158,277.27	15.5
S12 Other musculoskeletal problems	74	76	869	£62,546.93	8.2
S25 Gastrointestinal problems	232	237	845	£60,603.37	7.9
Other	118	121	691	£58,618.79	6.5
S99 Unknown causes / Not specified	71	71	613	£49,189.02	5.8
S30 Pregnancy related disorders	44	58	508	£44,283.42	4.8
S26 Genitourinary & gynaecological disorders	41	42	427	£31,442.98	4.0
S28 Injury, fracture	32	32	363	£30,751.16	3.4
S19 Heart, cardiac & circulatory problems	20	21	340	£41,964.33	3.2

Absence Reasons

- Excluding COVID-19 the most common reasons for absence are Anxiety, Stress, and Depression (ASD) and cough, cold and flu.
- The departments ranked absence by time lost will be the focus for the HR Business Partners.

Absence Benchmarking

The Dudley Group
NHS Foundation Trust



	Trust	Region	Country	National
2022 / 10	5.94%	6.13%	5.69%	5.76%
2022 / 11	5.72%	5.87%	5.52%	5.59%
2022 / 12	6.41%	6.70%	6.36%	6.44%

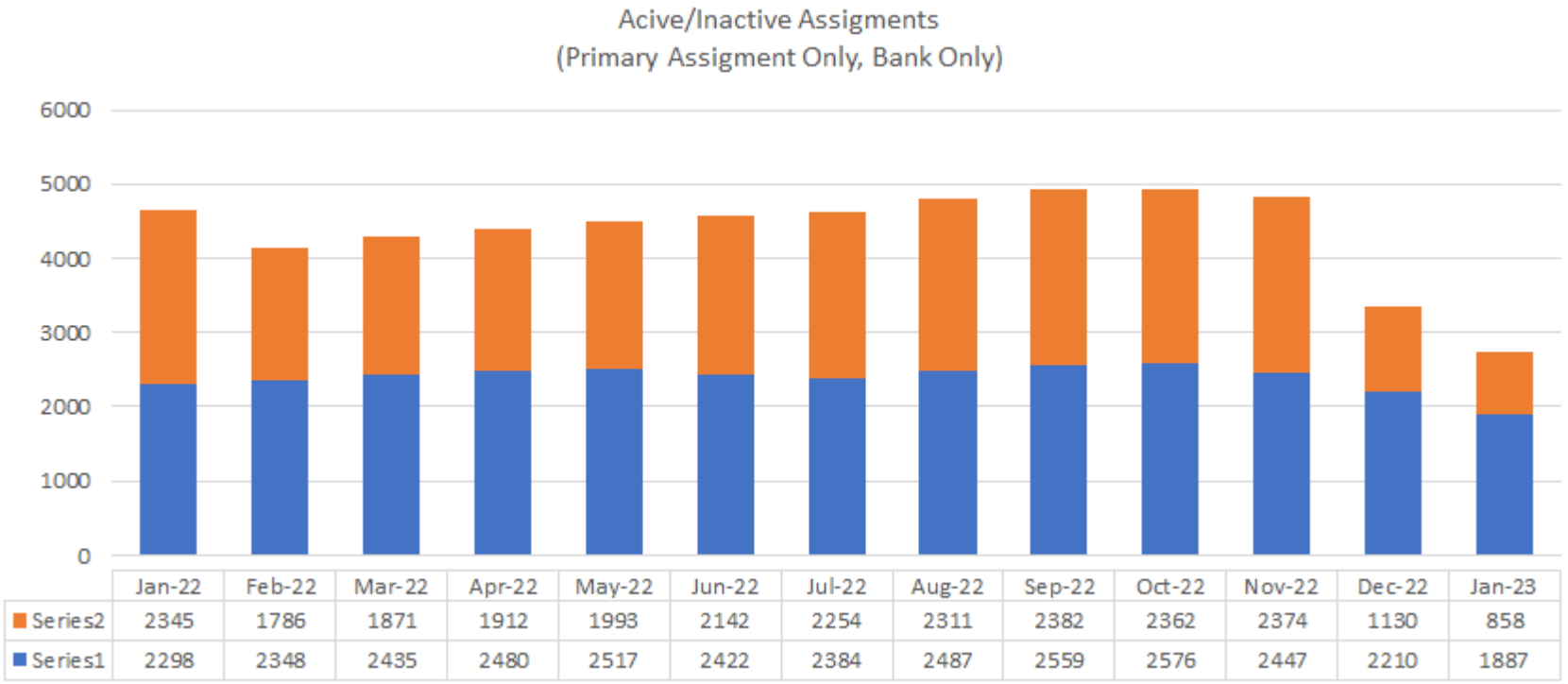
Benchmarking

- National and Regional benchmarking data is only available until end of December.
- Due to local differences in timeframes and methods used for recording sickness absences, national and regional comparative data is subject to change. DGH absence includes COVID related absences and is refreshed each month twelve months in arrears.
- In December the Trust's sickness absence rate was slightly lower than the regional and national sickness absence figures.

CARE RESPECT RESPONSIBILITY

Active / Inactive Assignments

The Dudley Group NHS Foundation Trust



	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23
Series2	2345	1786	1871	1912	1993	2142	2254	2311	2382	2362	2374	1130	858
Series1	2298	2348	2435	2480	2517	2422	2384	2487	2559	2576	2447	2210	1887

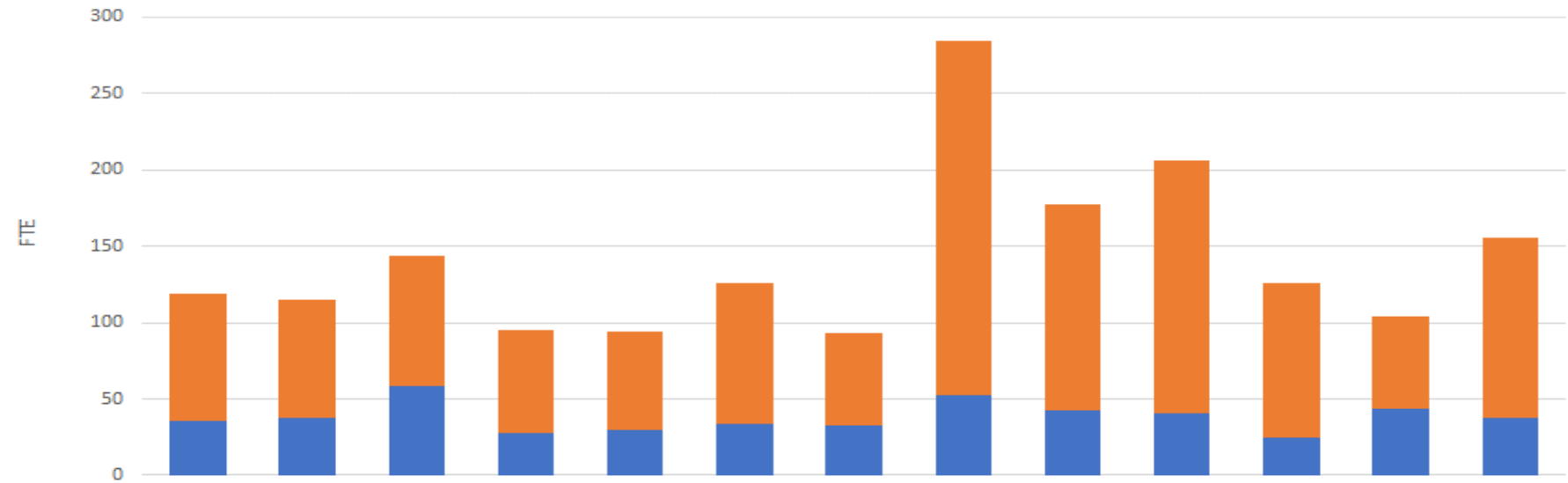
Bank Efficiency

There are 2745 bank assignments registered on the Trust's Staff Bank, a reduction from 3340 in January 2023. This corresponds with the data cleanse exercise currently taking place in relation to inactive bank staff.

We now have 858 inactive records as opposed to the 1130 previously recorded as inactive (not worked in 17 week period).

CARE RESPECT RESPONSIBILITY

Starters and Leavers



	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23
Starters FTE	82.77	76.75	85	67.42	64.05	92.43	61.12	232.11	135.04	165.91	101.32	59.87	118.15
Leavers FTE	36.01	37.64	58.75	27.83	30.04	33.33	32.19	52.26	42.2	40.19	24.91	43.76	37.76

Starters vs Leavers

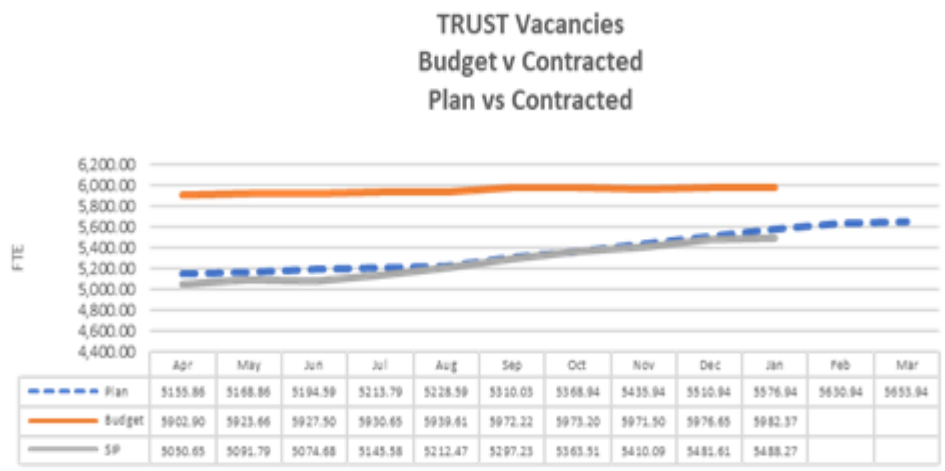
- Starters have exceeded leavers in the Trust since October 2021, this is evidenced by a steady increase in staff in post from 1st April 2022 from 5,050 to 5,488.27 in January 2023.

Assurance

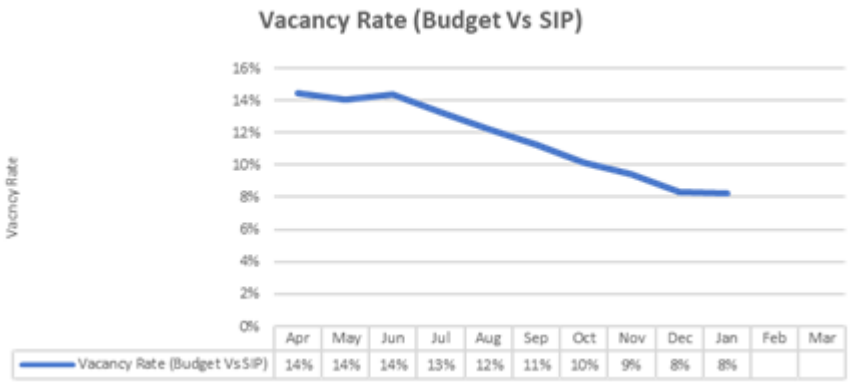
- Work is currently underway to refresh the Trust recruitment and retention plan; identifying high impact areas of focus over the next twelve months.

Recruitment/Vacancies/Turnover - TRUST

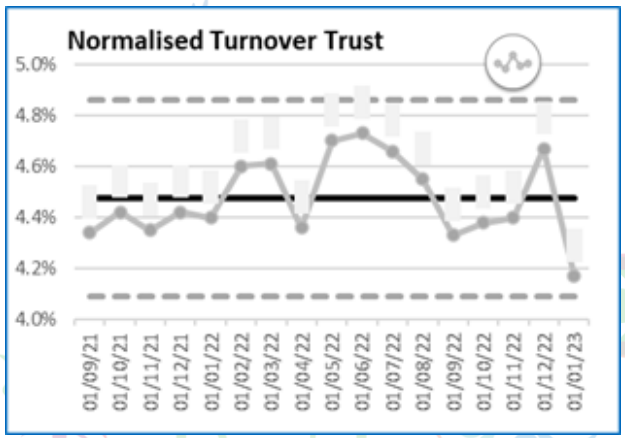
The Dudley Group
NHS Foundation Trust

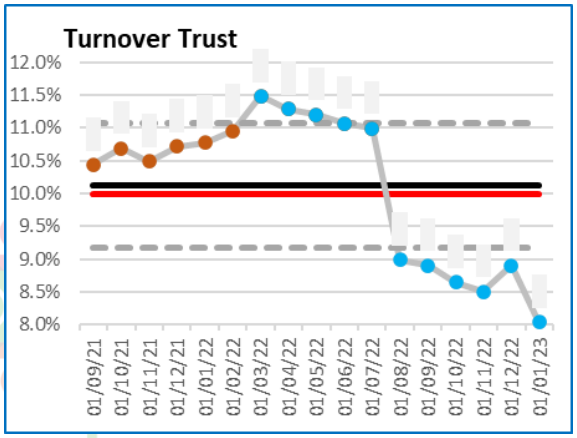


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Plan	5155.86	5168.86	5184.59	5213.79	5228.59	5310.03	5368.94	5435.94	5510.94	5576.94	5630.94	5653.94
Budget	5902.90	5923.66	5927.50	5930.65	5939.61	5972.22	5973.20	5971.50	5976.65	5982.37		
SIP	5050.65	5091.79	5074.68	5145.58	5212.47	5297.23	5363.51	5410.09	5481.61	5488.27		



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Vacancy Rate (Budget Vs SIP)	14%	14%	14%	13%	12%	11%	10%	9%	8%	8%		





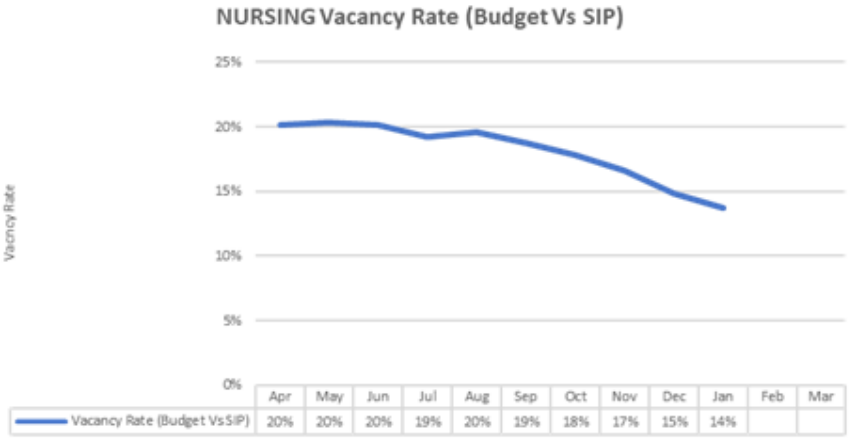
	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23
Trust Turnover	10.77%	10.95%	11.49%	11.29%	11.20%	11.07%	11.00%	8.99%	8.90%	8.64%	8.50%	8.90%	8.04%
Trust Normalised Turnover	4.40%	4.60%	4.61%	4.36%	4.70%	4.73%	4.66%	4.55%	4.33%	4.38%	4.40%	4.67%	4.17%

- Contracted WTE staff has increased from 5481.61 in December 2022 to 5488.27 in January 2023. This is 88.67 WTE under the workforce plan.
- The total vacancies stand at 481.15 WTE in January 2023, this is broadly consistent with December 2022. This equates to a vacancy factor of 8%.
- There are recruitment offers in place for 389.33 WTE of the vacancies and recruitment activity for a further 337.92 WTE.
- Overall staff turnover (rolling 12 months average) is at 8.04%, with normalised turnover at 4.17%.

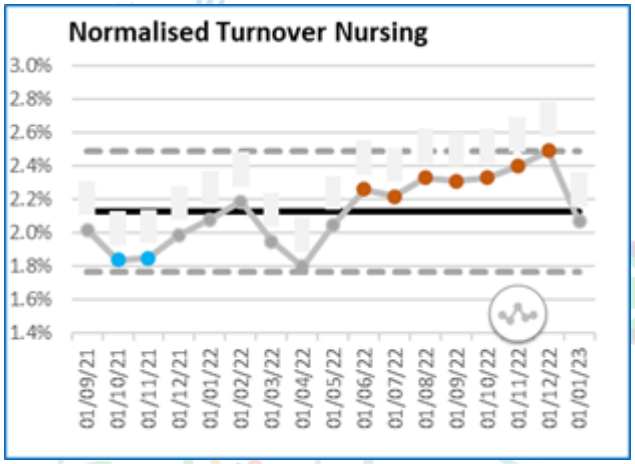
Recruitment/Vacancies/Turnover – Registered Nursing

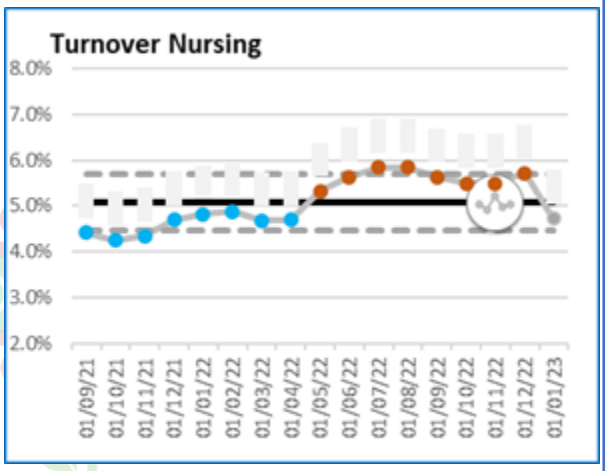
The Dudley Group NHS Foundation Trust

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Plan	1611.84	1611.84	1616.84	1621.84	1621.84	1671.84	1721.84	1766.84	1816.84	1866.84	1916.84	1936.84
Budget	1967.59	1977.69	1971.66	1971.70	1977.90	1980.64	1988.08	1984.82	1983.48	1983.85		
SIP	1570.65	1576.32	1574.49	1593.63	1590.93	1609.95	1633.29	1655.63	1688.98	1711.3		



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Vacancy Rate (Budget Vs SIP)	20%	20%	20%	19%	20%	19%	18%	17%	15%	14%		



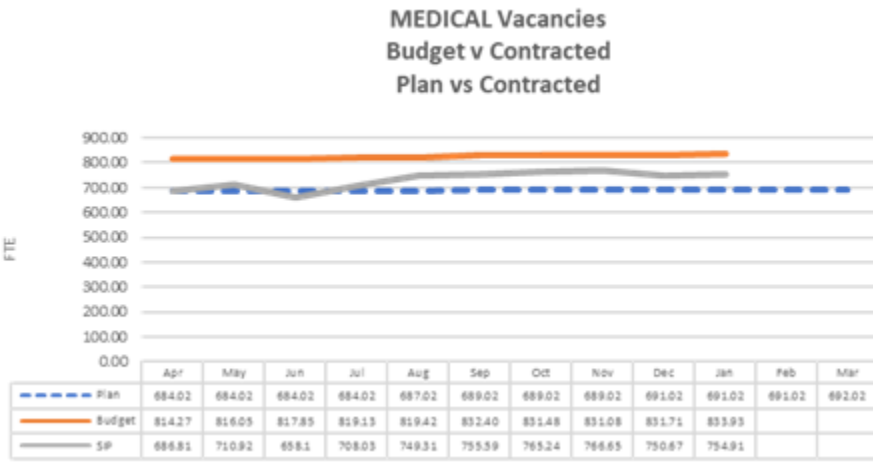


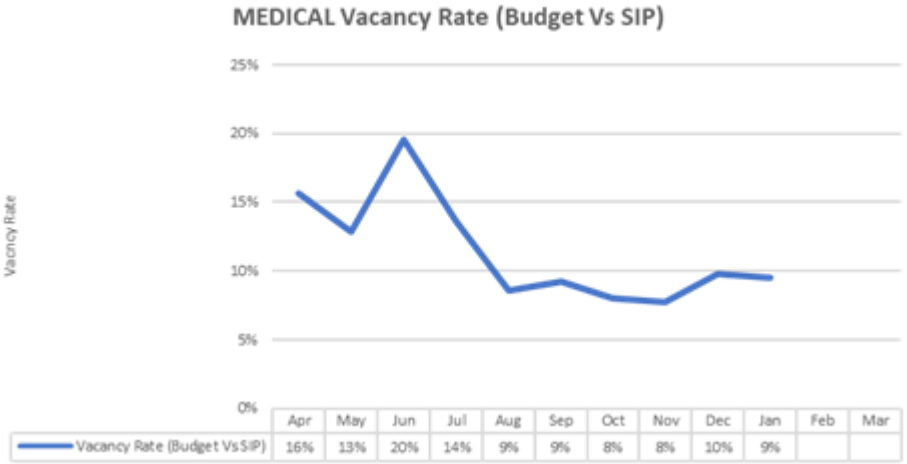
	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23
Nursing Turnover	4.82%	4.88%	4.68%	4.70%	5.33%	5.64%	5.84%	5.84%	5.63%	5.50%	5.50%	5.72%	4.72%
Trust Normalised Turnover	2.08%	2.19%	1.95%	1.80%	2.05%	2.26%	2.22%	2.33%	2.31%	2.33%	2.40%	2.49%	2.07%

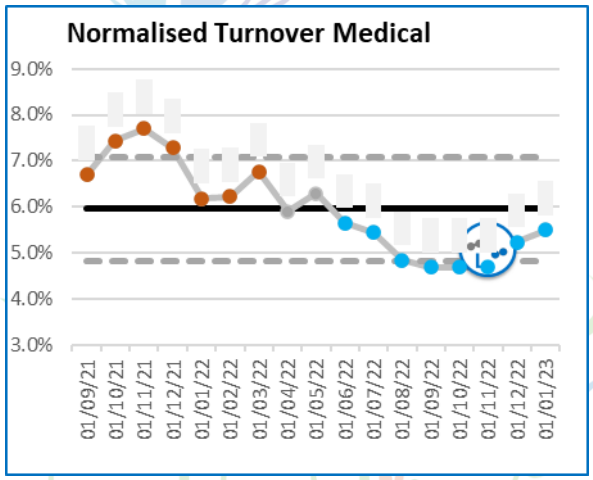
- Contracted WTE for nursing staff has increased from 1688.98 in December 2022 to 1711.30 in January 2023. This is 155.54 WTE under the workforce plan.
- The total nursing vacancies reported stands at 267.01, a reduction from 294.5 WTE in December 2022. This is a reduction from 15% to 14%.
- It should be noted that there are 180 WTE graduate nurses and international nurses in post awaiting either their registration or completion of their OSCE. On completion this provides a nursing vacancy of 87.01 WTE.
- Staff turnover for nursing (rolling 12 months average) is at 5.72%, with

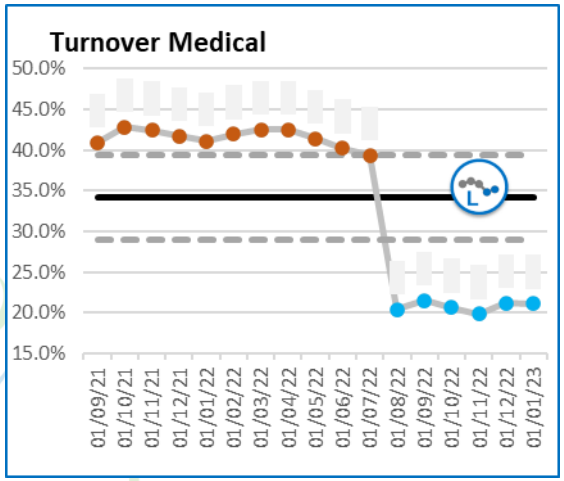
Recruitment/Vacancies/Turnover – Medical & Dental

The Dudley Group NHS Foundation Trust



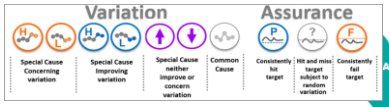






- Contracted WTE for medical and dental staff has increased from 750.67 WTE in December to 754.91 WTE in January 2023 this is still 63.89 WTE above plan.
- The total medical and dental vacancies stands at 78.31 WTE. The vacancy rate is 9%.
- Staff turnover for medical and dental (rolling 12 months average) has reduced to 21.12% (mainly due to rotation), with normalised turnover increasing to 5.50%.

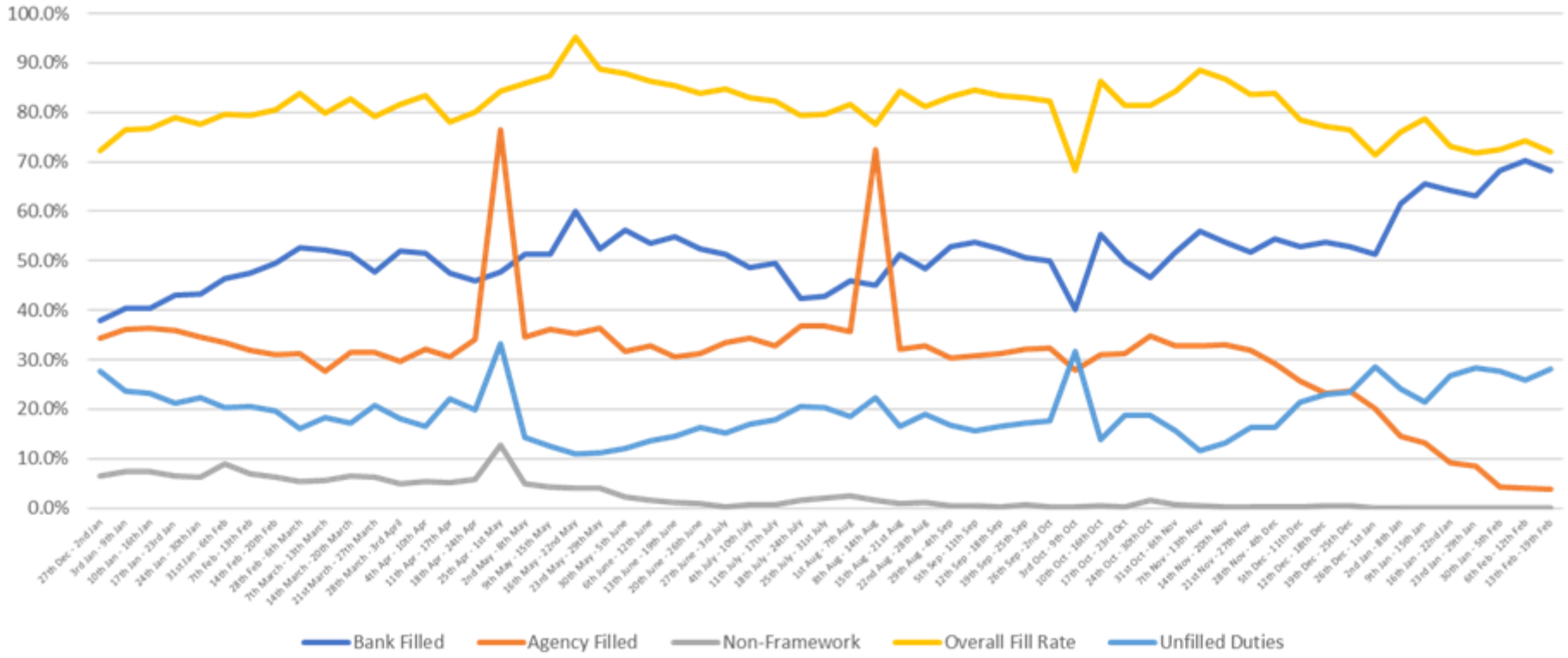
	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23
M&D Turnover	41.09%	42.00%	42.50%	42.50%	41.40%	40.21%	39.37%	20.42%	21.52%	20.63%	19.90%	21.18%	21.12%
M&D Normalised Turnover	6.19%	6.22%	6.77%	5.90%	6.30%	5.66%	5.44%	4.85%	4.69%	4.69%	4.69%	5.24%	5.50%



CARE RESPECT RESPONSIBILITY

Registered
Overall Fill Rates

The Dudley Group
NHS Foundation Trust

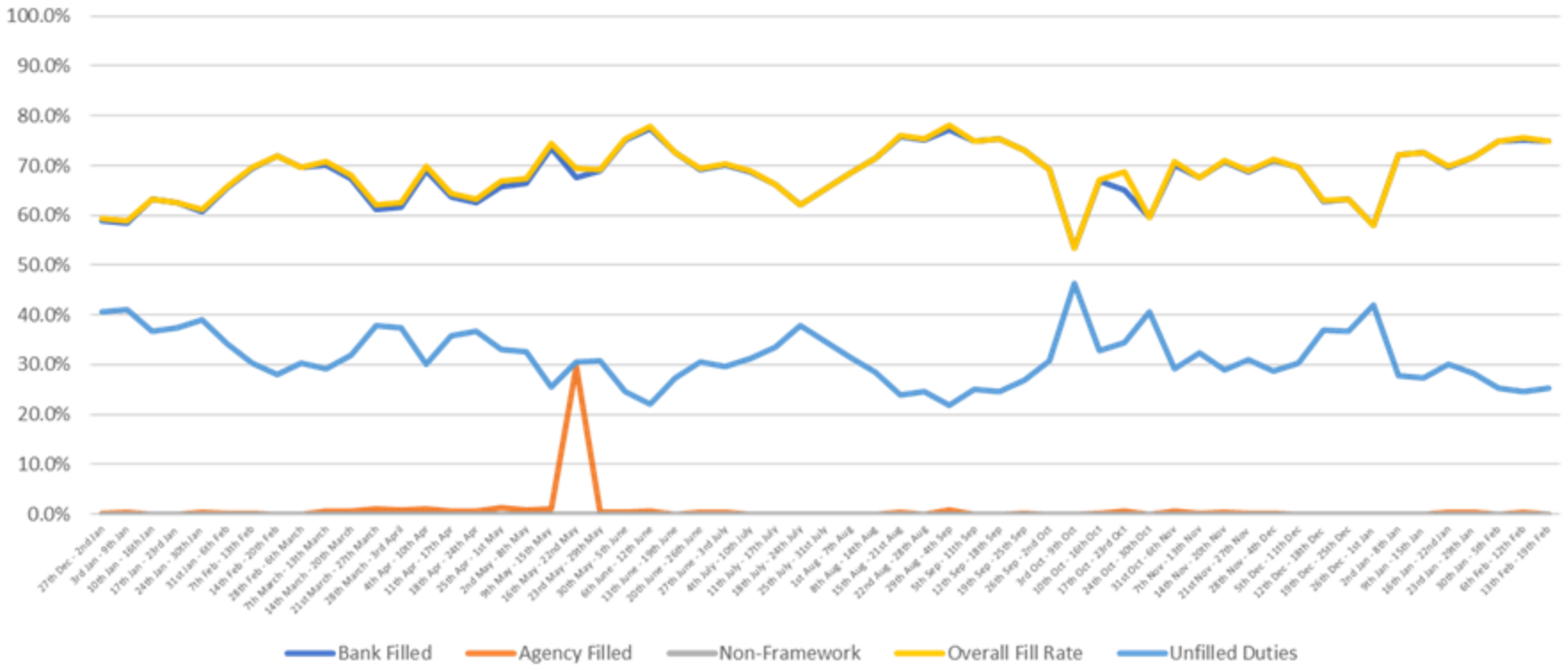


- The overall fill rate has reduced steadily from November through to February, reporting at just over 70%, compared to just under 90% in November. This is directly attributable to the reduction in agency usage and whilst there has been an increase in bank usage from just over 50% to just under 70%, we have seen a corresponding drop in overall fill.

CARE RESPECT RESPONSIBILITY

Un-Registered Overall Fill Rates

The Dudley Group NHS Foundation Trust

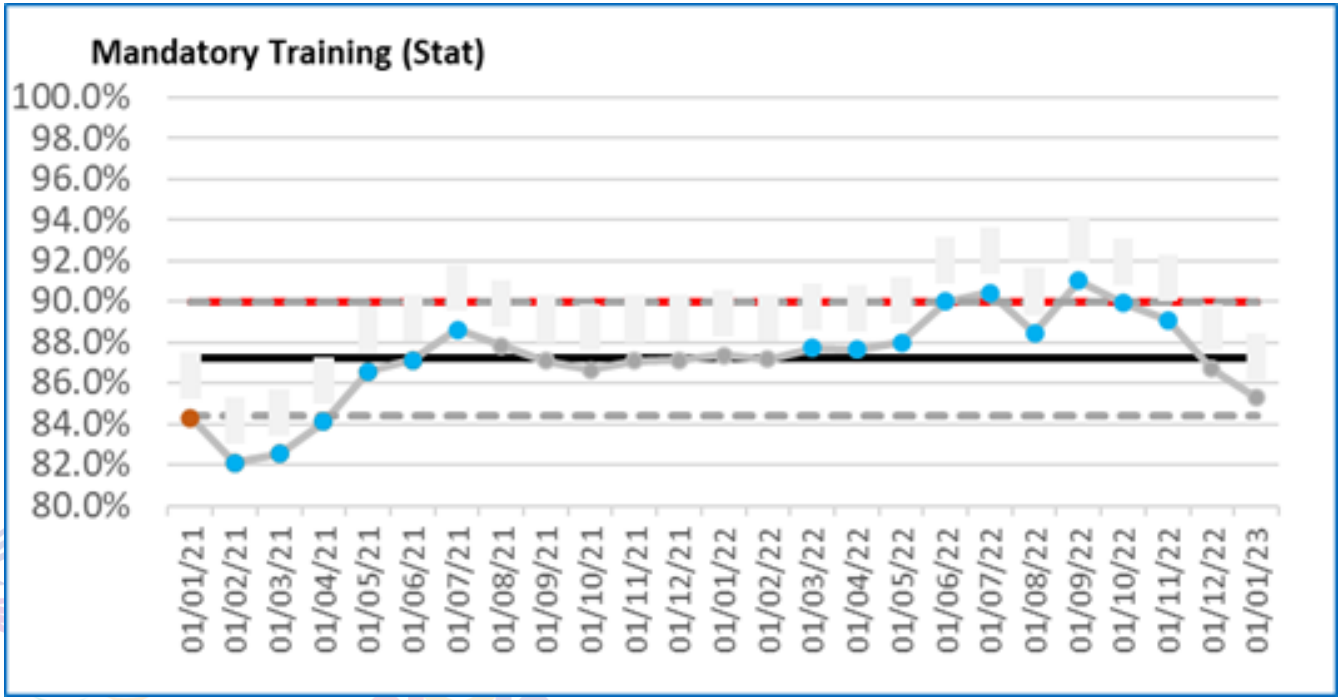


- We have seen a continued rise in bank fill rates from just under 60% in December to 75% in February 2023.

CARE RESPECT RESPONSIBILITY

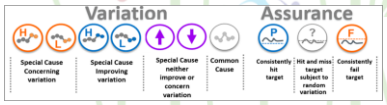
Mandatory Training

The Dudley Group
NHS Foundation Trust



There is a declining statutory training compliance trend in Q4, which is a replication of the same trend over the previous two years. However, overall compliance in Jan 23 is 2.23% lower than Jan 22. Factors which could be contributing towards this: the subject owners for Moving and Handling have a backlog of data entry which may falsely decrease reported compliance rate. Work is underway to address the backlog. The email reminder for those whose training was expiring ceased to function for an undefined number of months in Q3/4. This system error has been rectified and reminders are now back in place.

	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23
Mandatory Training (Stat)	87.35%	87.15%	87.72%	87.63%	87.98%	89.97%	90.43%	88.44%	91.00%	89.90%	89.10%	86.68%	85.27%



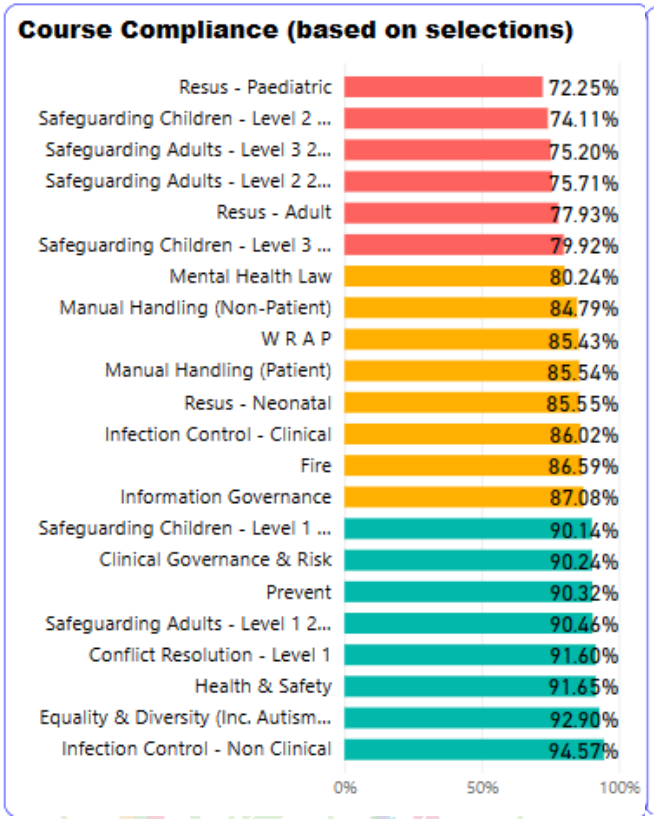
CARE RESPECT RESPONSIBILITY

Mandatory Training – Priority 1

The Dudley Group NHS Foundation Trust

Latest Reporting Period: February 2023	Trust	CS	Corporate	MIC	Surgery
	85.27%	89.59%	88.46%	81.79%	85.26%

Course Compliance



Depts by no. required to achieve 90%

Ward/Service (based selections)

Group5Description	Actual	No. >90%	%' tage
253 Emergency Dept Nursing Serv	1,542	261	76.98%
253 Ward C8 Serv	896	189	74.35%
253 Maternity Unit Serv	2,390	162	84.30%
253 General Surgery Medical Staff Serv	494	147	69.38%
253 Medical Staff - Acute Medicine Serv	799	146	76.16%
253 Ward C4 Serv	424	128	69.16%
253 Ward C7 Serv	763	127	77.22%
253 Ward B5 Serv	882	125	78.89%
253 Ward EAU Serv	1,847	123	84.41%
253 Critical Care Serv	1,683	122	83.94%
253 Ward CCU Serv	680	112	77.36%
253 Theatres Recovery & Anaesth Serv	668	109	77.40%
253 FMN Ward Serv	446	105	72.87%
253 Ward C5 Area B Serv	522	96	76.09%
253 MOC Medical Staff Serv	454	73	77.60%
253 Ward B3 Serv	687	72	81.49%
253 Main Theatre Other Specialities Serv	308	70	73.50%
253 Urology Medical Staff Serv	144	70	60.75%
253 Theatres T&O Serv	237	66	70.53%
253 Cardiology Clinical Measurement Serv	369	62	77.19%
Total	64,953	2950	86.09%

Statutory Training overall compliance has dipped below target after having been above target throughout some periods of 2022. The five subjects requiring most improvement are Resuscitation Paediatric, Safeguarding Children Level 2, Safeguarding Adults Level 3 & 2 and Resuscitation Adult.

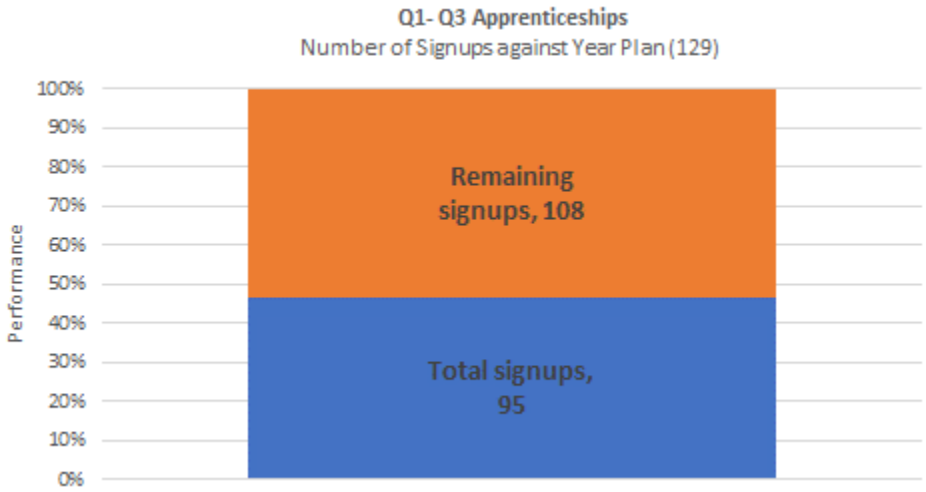
External web page under development which will hopefully ease to access online modules, which is particularly applicable to Safeguarding subjects.

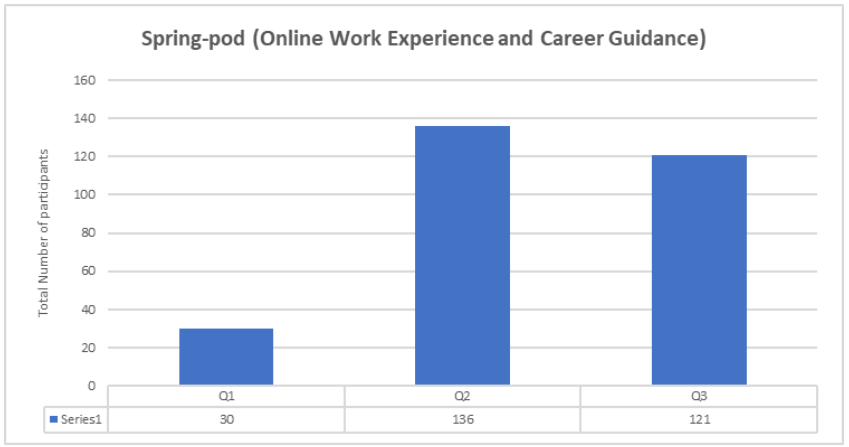
All divisions are below the organisation's target of 90% compliance.

CARE RESPECT RESPONSIBILITY

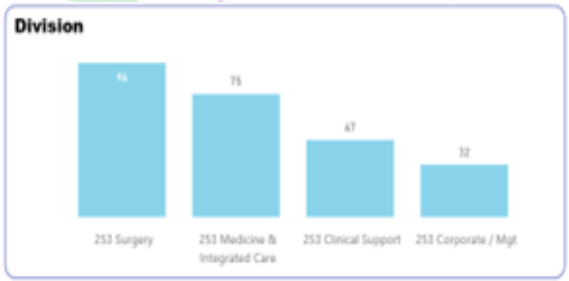
Apprentices and Work Experience

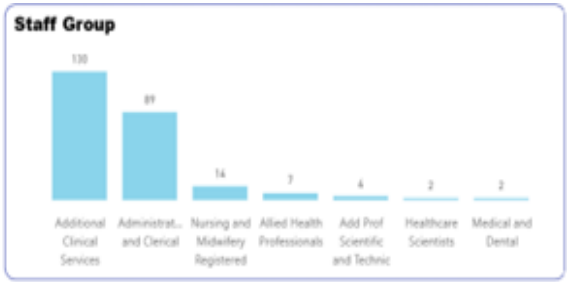
The Dudley Group NHS Foundation Trust

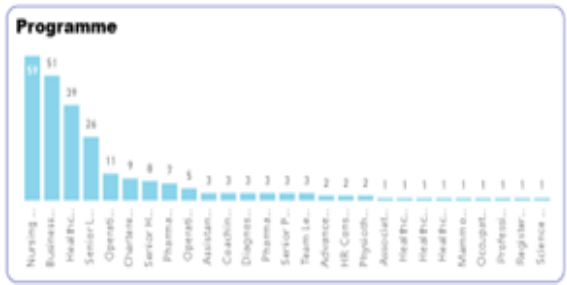


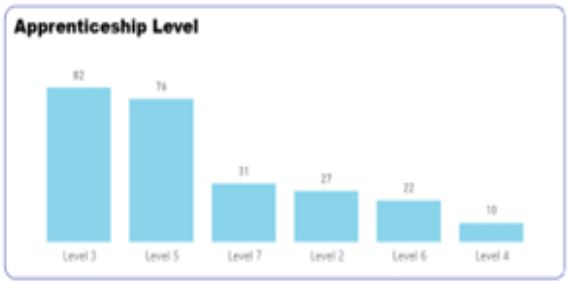


Active Apprenticeships breakdown









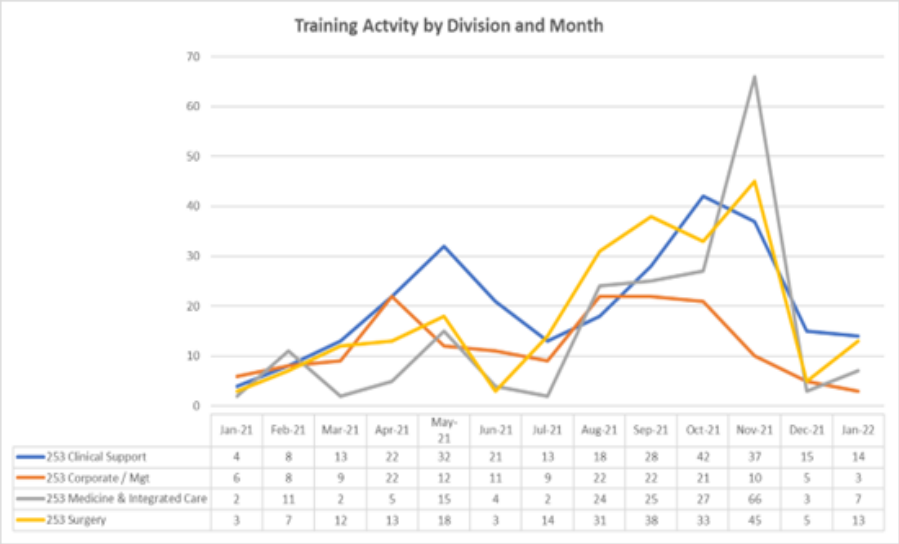
Total Active Apprenticeships **247**

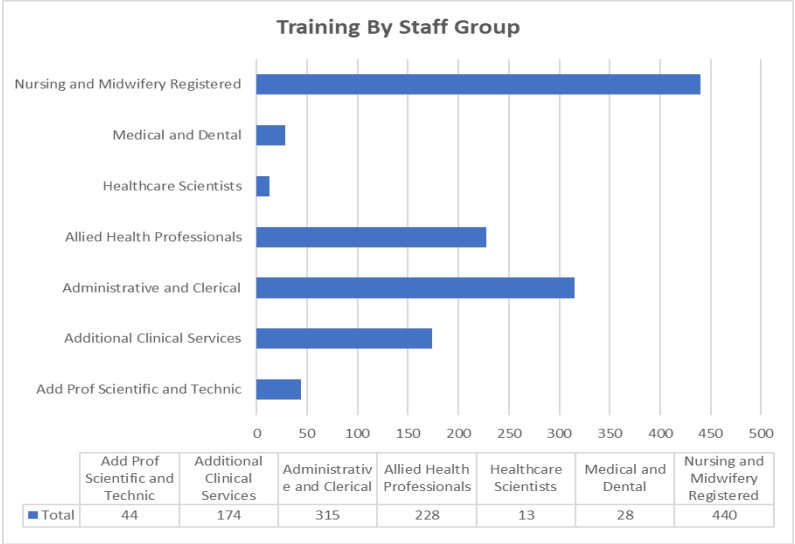
Activity continues to expand the sign ups with current recruitment to the third cohort of NHS specific Ops/Dept Manager Level 5 programme and adding the Chartered Manager Level 6 and Level 7 Senior leader programmes.
We are on track against target for 2022/23.
The Trust is currently not facing any Levy expiry until April 2024. We are sponsoring a number of apprentices in other organisations through Levy transfer.

CARE RESPECT RESPONSIBILITY

Organisational Development

The Dudley Group NHS Foundation Trust





Course	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Total
253 Bespoke Training							8		6					14
253 Living The Values				9	20				14	19				62
253 Managers Essentials	1	5	15	26	30	8	16	13	12	18	11	12	24	191
253 Welcome 2 Dudley Induction	10	16	16	27		20	5	6	11	18	9	3	7	148
253 Wellbeing	4	13	5	0	27	11	9	76	70	68	138	13	6	440
Grand total	15	34	36	62	77	39	38	95	113	123	158	28	37	855

Training activity continues to increase – with focus on ensuring that Manager's Essentials courses are delivered to capacity and reach all managers. 460 managers have attended to date. Additional bespoke sessions run across targeted areas – this is mostly wellbeing support, Living the Values (behaviours into action) and team development. Core programmes now running include: Developing Leaders, Living the Values, Wellbeing, Welcome to Dudley, Leadership for All. Additional programmes will run from April and the Trust learning prospectus will be launched at a learning event on 23rd March. This provides details of freely accessible training and development for all staff. Communication training soon to be launched, April dates have been circulated. Alongside planned programmes there is significant additional support to teams with challenges with action plans in place to support improvement.

Appraisal

The Dudley Group
NHS Foundation Trust

Trust	CS	Corporate	MIC	SWC
63.7%	72.0%	82.4%	57.8%	57.1%

Rates by Staff Group

StaffGroup	Total Staff	Valid Appraisal 2022/23 (All Reviews)	Rate
Add Prof Scientific and Technic	203	144	70.9%
Additional Clinical Services	1499	789	52.6%
Administrative and Clerical	1229	917	74.6%
Allied Health Professionals	455	356	78.2%
Healthcare Scientists	53	36	67.9%
Nursing and Midwifery Registered	1986	1213	61.1%
Total	**5425**	**3455**	**63.7%**

Rates by Division

Division	Total Staff	Valid Appraisal 2022/23 (All Reviews)	Rate
253 Clinical Support	1234	889	72.0%
253 Corporate / Mgt	635	523	82.4%
253 Medicine & Integrated Care	1722	996	57.8%
253 Surgery	1834	1047	57.1%
Total	**5425**	**3455**	**63.7%**

Appraisals are due to be completed between April and June each year. Due to the pandemic, this has been relaxed during 2020 and 2021. Changes to the appraisal process were introduced in early 2022.
The above has impacted the performance in 2022 and currently the reported compliance is well below expected.
The official window for appraisals has expired - we are continuing to work with Divisions to achieve compliance by the end of 2022/23. This includes engagement with teams/services around their understanding of the new process, reporting systems and addressing any barriers raised. Some progress has been made but this is slow.

The Dudley Group NHS Foundation Trust

Paper for submission to the Public Board
9th March 2023

Title:	Infection Prevention and Control Board Assurance Framework
Author:	Liz Watkins - DDIPC
Presenter:	Liz Watkins - DDIPC

Action Required of Committee / Group					
Decision	**Approval**	**Discussion**	Y	**Other**	N

Recommendations:

The Board is asked to review and note the contents of the new Infection Prevention and Control Board Assurance Framework V1.11 in providing assurance of the continued actions within the IPC BAF ensuring compliance with the Health and Social Care Act (2008, updated 2015)

Summary of Key Issues:

This paper is to demonstrate Trust compliance with the Health and Social Care Act 2008 (updated 2015) and highlight gaps in assurance for action. In May 2020 NHSE requested that the Infection Prevention Board Assurance Framework template is completed and shared with Trust board.

One of the key areas to combating the COVID-19 pandemic relates to robust infection prevention and control standards and practices across the Trust.

The framework adopts the same headings as the Health and Social Care Act 2008 (updated 2015) listing the 10 criterions.

The colour coded matrix over the page (before the detailed IPC BAF) demonstrates the many areas which the trust can give assurance as evidence of compliance can be confirmed.

The areas highlighted in yellow show the additional areas new to the report:

Updated issues:

- Zoning continues
- Changes to COVID-19 testing reduction and postponement of a symptomatic testing.
- New SOP developed and circulated.
- Twice weekly LFD testing for staff has been postponed.
- Mask wearing has been removed for non-clinical areas and communal areas only.

There are no red non-compliant areas, there is one amber area with mitigations in place. The IPC Group and wider Trust team continue to progress this work stream.

Impact on the Strategic Goals	
Deliver right care every time	**Y**
Be a brilliant place to work and thrive	
Drive sustainability (financial and environmental)	**Y**
Build innovative partnerships in Dudley and beyond	
Improve health and wellbeing	**Y**

Implications of the Paper:			
Risk	N	Risk Description:	
	On Risk Register: N	Risk Score:	
Compliance and/or Lead Requirements	CQC	Y	Details: Safe, Effective, Well-led
	NHSE	Y	Details: The IPC BAF was requested by NHSE
	Other	N	Details:

Report Journey / Destination	Working / Exec Group	Y	Date:
	Quality and Safety Committee	Y	Date: 24/02/23 – no recommendations made
	Board of Directors	Y	Date: 09/03/23
	IPC Group Meeting	Y	Date: 30/11/22 – no recommendations made.

BAF Compliance Matrix	KEY	No Gaps	Gaps Identified with mitigation	Gap No Mitigation	No line of enquiry

	0.1	0.2	0.3	0.4	0.5	0.6	0.7	0.8	0.9	0.10	0.11	0.12	0.13	0.14	0.15	0.16	0.17	0.18	0.19	0.20	0.21	0.22
1																						
2																						
3																						
4																						
5																						
6																						
7																						
8																						
9																						
10																						

1	No GAPs identified
2	No GAPs identified
3	No GAPs identified
4	No GAPs identified
5	No GAPs identified
6	No GAPs identified
7	No GAPs identified
8	DGFT currently does not undertake LFD testing for in-patients if they have had COVID-19 within 90 days prior to transfer to alternative places of care. A system agreed SOP is in place for discharge to care homes
9	No GAPS identified
10	No GAPS identified

Infection Prevention and Control board assurance framework

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**					
	Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	**RAG**
1.01	Systems and processes are in place to ensure that: • A respiratory plan incorporating respiratory seasonal viruses that includes: ○ point of care testing (POCT) methods for infectious patients known or suspected to have a respiratory infection to support patient triage/placement according to local needs, prevalence, and care services ○ segregation of patients depending on the infectious agent taking into account those most vulnerable to infection e.g. clinically immunocompromised. ○ A surge/escalation plan to manage increasing patient/staff infections.	The Trust has policies and procedures in place to identify alert organisms in patients admitted to the Trust POCT testing is available in ED for COVID-19.	Currently being updated and training provided to include RSV and Flu	POC testing training for staff in ED completed November 2022	

	○ a multidisciplinary team approach is adopted with hospital leadership, operational teams, estates & facilities, IPC teams and clinical and non- clinical staff to assess and plan for creation of adequate isolation rooms/cohort units as part of the plan.				
1.02	• Organisational /employers risk assessments in the context of managing infectious agents are: ○ based on the measures as prioritised in the hierarchy of controls. ○ applied in order and include elimination; substitution, engineering, administration and PPE/RPE. ○ communicated to staff. ○ further reassessed where there is a change or new risk identified e.g. changes to local prevalence.	Risk assessments are completed and reviewed. IPC policies and procedures are available on the Hub. IPC Has a risk register which is presented at the bi-monthly IPCG meeting			
1.03	• the completion of risk assessments have been approved through local governance procedures, for example Integrated Care Systems.	Risk assessments are shared with the Integrated care Board when required.			

1.04	• risk assessments are carried out in all areas by a competent person with the skills, knowledge, and experience to be able to recognise the hazards associated with the infectious agents.	IPC and risk registers and risk assessments are reviewed by the governance teams and presented bimonthly at IPCG meeting. Health and Safety team is aviable for support when completing risk assessments.			
1.05	• ensure that transfers of infectious patients between care areas are minimised and made only when necessary for clinical reasons.	Transfers only take place due to clinical need for a side room, need to cohort, need to attend specialist services. etc.	In exceptional circumstances infection patients may need to be moved for capacity and flow reasons. DATIX to be completed if this is required.	Datix to be completed and IPC Team/ site capacity team to be involved in decision making.	
1.06	• resources are in place to monitor and measure adherence to the NIPCM. This must include all care areas and all staff (permanent, flexible, agency and external contractors).	IPC In the Built Environment policy available on the Hub. Standard infection precautions policy available on the Hub IPC Audits are undertaken and recorded on AMAT these include all members of the hospital team including PFI partners and contractors. Issues identified are fed back to the parties involved.			
1.07	• the application of IPC practices within the NIPCM is monitored e.g., 10 elements of SICPs	Standard infection precautions policy available on the Hub			

		IPC audits based on IPS QUIP tools are used to audit			
1.08	• the IPC Board Assurance Framework (BAF) is reviewed, and evidence of assessments are made available and discussed at Trust board level.	The IPC BAF is completed and updated monthly. It is presented to the IPCG bi-monthly. Quality and Safety Committee and then Board at regular intervals.			
1.09	• the Trust Board has oversight of incidents/outbreaks and associated action plans. • the Trust is not reliant on a single respirator mask type and ensures that a range of predominantly UK made FFP3 masks are available to users as required.	The IPC BAF is completed and updated monthly. It is presented to the IPCG bi-monthly. Quality and Safety Committee and then Board at regular intervals. The Trust is not reliant of one type of FFP3 masks. The Trust has access to respirator hoods and JSP ½ masks.			
2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections					
	Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
2.01	Systems and processes are in place to ensure that: • the Trust has a plan in place for the implementation of the National Standards of Healthcare Cleanliness and this plan is monitored at board level.	New 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			

		Minuted Cleaning meeting with PFI partners			
2.02	• the organisation has systems and processes in place to identify and communicate changes in the functionality of areas/room	Minuted Cleaning meeting with PFI partners			
2.03	• cleaning standards and frequencies are monitored in clinical and non-clinical areas with actions in place to resolve issues in maintaining a clean environment.	Cleanliness audits completed and presented at IPCG Stars on the doors are displayed on the entrances to area			
2.04	• enhanced/increased frequency of cleaning should be incorporated into environmental decontamination protocols for patients with suspected/known infections as per the NIPCM (Section 2.3) or local policy and staff are appropriately trained.	New Decontamination of the Environment Policy incorporating the National standards of Cleanliness adopted April 2022 Touch Point cleaning is increased during an outbreak of infection			
2.05	• manufacturers' guidance and recommended product 'contact time' is followed for all cleaning/disinfectant solutions/products.	Cleaning schedules and dilution charts are provided by Mitie and available in domestic cupboards. Changes to cleaning products are agreed at the Cleaning meeting			

2.06	• For patients with a suspected/known infectious agent the frequency of cleaning should be increased particularly in: ○ patient isolation rooms ○ cohort areas ○ donning & doffing areas – if applicable ○ 'Frequently touched' surfaces e.g., door/toilet handles, chair handles, patient call bells, over bed tables and bed/trolley rails. ○ where there may be higher environmental contamination rates, including: toilets/commodes particularly if patients have diarrhoea and/or vomiting	New Decontamination of the Environment Policy incorporating the National standards of Cleanliness adopted April 2022 Frequency of cleaning is reviewed and increased in areas with active outbreaks of infection. Touch point cleaning is increased for the duration of the outbreak The trust utilises Clinell wipes for decontamination of medical devices and surfaces-Gamma state the wipe are against enveloped viruses and that 60 seconds contact time is required. Sporicidal Wipes in use throughout the Trust to clean commodes and bed pans. These were measures to assist with the prevention of Healthcare Associated infections. UV cleaning was introduced in the Trust commenced 4/11/2022 providing both proactive and reactive enhanced decontamination			

2.07	• The responsibility of staff groups for cleaning/decontamination are clearly defined and all staff are aware of these as outlined in the National Standards of Healthcare Cleanliness • A terminal clean of inpatient rooms is carried out: ○ when the patient is no longer considered infectious ○ when vacated following discharge or transfer (this includes removal and disposal/or laundering of all curtains and bed screens). ○ following an AGP if clinical area/room is vacated (clearance of infectious particles after an AGP is dependent on the ventilation and air change within the room).	New Decontamination of the Environment Policy incorporating the National standards of Cleanliness adopted April 2022 and shared with PFI partners Terminal cleans are undertaken by Mitie Curtain changes are included as part of the terminal clean Following an AGP rooms are left fallow if required. Natural ventilation is used in some clinic rooms.			
2.08	• reusable non-invasive care equipment is decontaminated: ○ between each use ○ after blood and/or body fluid contamination ○ at regular predefined intervals as part of an equipment cleaning protocol ○ before inspection, servicing, or repair equipment.	Standard infection precautions policy available on the Hub Decontamination policy updated September 2022 available on the Hub Green I am clean stickers in use throughout the Trust Reusable non-invasive medical devices are decontaminated using universal wipes or Chlorine releasing agent in line			

		with Trust policy and/or manufactures instructions.			
2.09	• compliance with regular cleaning regimes is monitored including that of reusable patient care equipment.	Green I am clean stickers in use throughout the Trust IPC audits and Quality walk rounds are recorded on AMAT. PLACE visits completed November 2022			
2.10	• ventilation systems, should comply with HBN 03:01 and meet national recommendations for minimum air changes https://www.england.nhs.uk/publication/specialised-ventilation-for-healthcare-buildings/	Ventilation is maintained by PFI partner. Ventilation committee meet monthly Mitie Ventilation policy updated October 2022			
2.11	• ventilation assessment is carried out in conjunction with organisational estates teams and or specialist advice from the ventilation group and/ or the organisations, authorised engineer and plans are in place to improve/mitigate inadequate ventilation systems wherever possible.	Ventilation assessments and Pre planned maintenance is undertaken by Mitie PFI partner. Ventilation committee meets monthly			
2.12	• where possible air is diluted by natural ventilation by opening windows and doors where appropriate	Wards and clinical areas are encouraged to open windows to allow for natural ventilation.			

3. Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance					
	Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
3.01	Systems and process are in place to ensure that: • arrangements for antimicrobial stewardship (AMS) are maintained and a formal lead for AMS is nominated	Well established AMS Group in the Trust, which reports to Drugs and therapeutics and Medicines management Group.			
3.02	• NICE Guideline NG15 https://www.nice.org.uk/guidance/ng15 is implemented – Antimicrobial Stewardship: systems and processes for effective antimicrobial medicine use	Systems and processes are in place and reviewed regularly as per NG15.			
3.03	• 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 https://www.gov.uk/government/publications/antimicrobial-stewardship-start-smart-then-focus are followed	We have AMS ward rounds for ensuring good practice, the ward rounds include, • Critical care ward rounds • OPAT ward rounds • C diff ward rounds • Carbapenems and Tazocin ward rounds.			

3.04	• contractual reporting requirements are adhered to, and boards continue to maintain oversight of key performance indicators for prescribing including: ○ total antimicrobial prescribing. ○ broad-spectrum prescribing. ○ intravenous route prescribing. adherence to AMS clinical and organisational audit standards set by NICE: https://www.nice.org.uk/guidance/ng15/resources	All KPIs including the total consumption, broad-spectrum antibiotics consumptions, IV to oral switch are reported internally and externally via Medicines management Group, Drugs and Therapeutics, Area clinical effectiveness Group and Infection prevention and control Group.			
3.05	• 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).	We have an AMS team comprising of 2 FTE Pharmacists and a Consultant Microbiologist. Currently exploring the means to expand the team, which will improve the service further.			
4. Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion.					
•	**Key lines of enquiry**	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
4.01	Systems and processes are in place to ensure that: • IPC advice/resources/information is available to support visitors, carers, escorts, and patients with good practices e.g. hand hygiene, respiratory etiquette, appropriate PPE use	November 2022 Open visiting is allowed. Visitors are requested to wear Type IIR Fluid resistant surgical facemasks Signage is placed on entrances to wards and other clinical			

		settings stating restricted access. A zoning and screening SOP is in place. IPC page on the Hub IPC Policies and procedures available on the Hub Regular internal and external communications are issued on IPC advice and practices			
4.02	• visits from patient's relatives and/or carers (formal/informal) should be encouraged and supported whilst maintaining the safety and wellbeing of patients, staff and visitors	November 2022 Open visiting is allowed. Visitors are requested to wear Type IIR Fluid resistant surgical facemasks Signage is placed on entrances to wards and other clinical settings stating restricted access. A zoning and screening SOP is in place. IPC page on the Hub IPC Policies and procedures available on the Hub Regular internal and external communications are issued on IPC advice and practices			
4.03	• national principles on inpatient hospital visiting and maternity/neonatal services will remain in place as an absolute minimum standard. national guidance on visiting patients in a care setting is implemented.	National guidance for visiting is followed.			

4.04	• patients being accompanied in urgent and emergency care (UEC), outpatients or primary care services, should not be alone during their episode of care or treatment unless this is their choice.	National guidance for visitors is followed, partners, friends and relatives are actively encouraged to attend.			
4.05	• restrictive visiting may be considered by the incident management team during outbreaks within inpatient areas This is an organisational decision following a risk assessment and should be communicated to patients and relatives.	Visiting is reviewed during outbreak management. This is communicated to the ward and relatives. Visiting is risk assessed and the Trust will try to accommodate visitors for end of life and those requiring support in the event of an outbreak. All cases will be reviewed individually to deliver personal centred care.			
4.06	• there is clearly displayed, written information available to prompt patients' visitors and staff to comply with handwashing, respiratory hygiene and cough etiquette. The use of facemasks/face coverings should be determined following a local risk assessment.	Poster are displayed at the entrance to the wards and at main entrances. Masks are available at the entry to clinical areas.			
4.07	• if visitors are attending a care area to visit an infectious patient, they should be made aware of any infection risks and offered appropriate PPE.	Side room have source and protected isolation signs displayed. Information is displayed at the outbreak to wards which have infections.			

4.08	• Visitors, carers, escorts who are feeling unwell and/or who have symptoms of an infectious illness should not visit. Where the visit is considered essential for compassionate (end of life) or other care reasons (e.g., parent/child) a risk assessment may be undertaken, and mitigations put in place to support visiting.	Information is provided to patients on their appointment letter. Posters are displayed throughout the hospital. Patients are triaged on attendance at clinics. Risk assessments are completed for those essential visitors.			
4.09	• Visitors, carers, escorts should not be present during AGPs on infectious patients unless they are considered essential following a risk assessment e.g., carer/parent/guardian.	Patients undergoing AGP's should not be accompanied unless essential where a risk assessment is completed and documented in the patients notes.			
4.10	• implementation of the supporting excellence in infection prevention and control behaviours Implementation Toolkit has been adopted where required C1116-supporting-excellence-in-ipc-behaviours-imp-toolkit.pdf (england.nhs.uk)	Toolkit reviewed and adopted where required Posters and signage in us throughout the Trust			
5. Ensure prompt identification of people 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 other people					
	Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
5.01	Systems and processes are in place to ensure that:				

	• all patients are risk assessed, if possible, for signs and symptoms of infection prior to treatment or as soon as possible after admission, to ensure appropriate placement and actions are taken to mitigate identified infection risks (to staff and other patients).	There is the zoning document for in-patient admissions which covers patient placement**.** Documents are available n the Hub ED have a flow chart describing the designated 'red area' which is separate to the rest of ED with dedicated staff for suspected COVID-19 patients. Point of care testing in place in ED.			
5.02	• signage is displayed prior to and on entry to all health and care settings instructing patients with symptoms of infection to inform receiving reception staff, immediately on their arrival (see NIPCM).	Isolation policy aviable on the Hub. Source and protective isolation door signs available for use with a SOP for use available on the Hub.			
5.03	• the infection status of the patient is communicated prior to transfer to the receiving organisation, department or transferring services ensuring correct management /placement	Patients are transferred and handed over prior to discharge or transfer to the ward this information includes a patient infectious or potential infectious statius.			
5.04	• triaging of patients for infectious illnesses is undertaken by clinical staff based on the patients' symptoms/clinical assessment and previous contact with infectious individuals, the patient is placed /isolated or cohorted accordingly whilst awaiting test results. This should	Patients are monitored for symptoms of COVID-19 and are screened if required. Patients' observations are input into sunrise which will set an alert when news scores are triggered. Requests are made via the Sunrise system; the results are			

	be carried out as soon as possible following admission and a facemask worn by the patient where appropriate and tolerated.	reported via this system also. New cases which occur within the hospital setting 2> days after admission are contact traced by the IPCT.			
5.05	• patients in multiple occupancy rooms with suspected or confirmed respiratory infections are provided with a surgical facemask (Type II or Type IIR) if this can be tolerated.	All inpatients are required to wear a type II fluid resistant surgical face mask if able to or tolerate. Non compliance or exemption is documented in the patients notes			
5.06	• patients with a suspected respiratory infection are assessed in a separate area, ideally a single room, and away from other patients pending their test result and a facemask worn by the patient where appropriate and tolerated (unless in a single room/isolation suite).	ED has a red area for triaging potentially infectious patients Single cubicles are available in ED Patients are required to wear IIR fluid resistant surgical face masks,. If they are able to do so. If requested it is documented in the patients notes.			
5.07	• patients with excessive cough and sputum production are prioritised for placement in single rooms whilst awaiting test results and a facemask worn by the patient where appropriate and tolerated only required if single room accommodation is not available.	Isolation matrix available in the isolation policy on the Hub with score chart to determine the priority for a side room. A datix must be completed if a side room cannot be made available.			

5.08	• patients at risk of severe outcomes of infection receive protective IPC measures depending on their medical condition and treatment whilst receiving healthcare e.g., priority for single room protective isolation	Isolation policy and SOP available Protective isolation signs available Patients who are deemed extremely vulnerable are triaged for side rooms if available DATIX are completed if this cannot be met.			
5.09	• if a patient presents with signs of infection where treatment is not urgent consider delaying this until resolution of symptoms providing this does not impact negatively on patient outcomes.	all patients and visitors attending outpatient appointments Instructions are provided by latter prior to the appointment on what to do if you are unwell or have symptoms of COVID-19. Patients are triaged on arrival at outpatient appointments on arrival who decide if the appointment /procedure can continue or needs to be rearranged.			
5.10	• The use of facemasks/face coverings should be determined following a local risk assessment.	November 2022.All visitors and staff are required to wear facemasks in clinical areas including wards and outpatients. It is not mandated in public spaces including the restaurants and corridors.			
5.11	• patients that attend for routine appointments who display symptoms of infection are managed appropriately, sensitively and according to local policy.	Face mask wearing is advised for all patients and visitors attending outpatient appointments Instructions are provided by latter prior to the appointment on what to do if you are unwell or have symptoms of COVID-19.			

		Patients are triaged on arrival at outpatient appointments on arrival who decide if the appointment /procedure can continue or needs to be rearranged.			
5.12	• Staff and patients are encouraged to take up appropriate vaccinations to prevent developing infection	A staff vaccination programme is promoted via the IPC team and at mandatory training. Regular communications are provided to staff regarding vaccine availability Patients are encouraged to be vaccinated			
5.13	• Two or more infection cases linked in time, place and person trigger an incident/outbreak investigation and are reported via reporting structures.	Outbreak, isolation and specific micro-organism policies available via the Hub. All outbreaks are reported via the NHSE OTKA outbreak reporting and management system. All outbreaks of infection are reported via IPCG Meeting.			
6. Systems 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					
	Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
6.01	Systems and processes are in place to ensure that: • IPC education is provided in line with national guidance/recommendations for all staff commensurate with their duties.	IPC mandatory for both clinical and nonclinical training via e learning has continued, face to face training recommenced March 2022.			

		Training on PPE donning and doffing available HUB information with links to UK HSA guidance and videos. The core IPC mandatory training has been updated to include specific COVID-19 training. Trust compliance for IPC training is monitored via the IPC Group bimonthly. Mandatory training scores for the Trust have an objective of 90%.			
6.02	• training in IPC measures is provided to all staff, including: the correct use of PPE	Training on PPE donning and doffing available HUB information with links to UK HSA guidance and videos. 5 moments audits are undertaken, and acts and omissions fed back at the time of audit. Scores are collected via AMAT			
6.03	• all staff providing patient care and working within the clinical environment are trained in hand hygiene technique as per the NIPCM and the selection and use of PPE appropriate for the clinical situation and on how to safely put it on and remove it (NIPCM);	Annual Hand Hygiene assessments for care staff were launched in May 2022 PPE training is included in the annual IPC training. Bespoke training is available	Plan to roll out hand hygiene assessments to all staff Information has been shared with Mitie for use with their staff.		

		A Standard Infection Precautions policy is available on the Hub			
6.04	• adherence to NIPCM, on the use of PPE is regularly monitored with actions in place to mitigate any identified risk	PPE adherence is monitored via IPC audits and clinical visits. 5 moments of hand hygiene audit are recorded on AMAT.			
6.05	• gloves and aprons are worn when exposure to blood and/or other body fluids, non-intact skin or mucous membranes is anticipated or in line with SICP's and TBP's.	A Standard Infection Precautions policy is available on the Hub PPE adherence is monitored via IPC audits and clinical visits. 5 moments of hand hygiene audit are recorded on AMAT.			
6.06	• hand hygiene is performed: ○ before touching a patient. ○ before clean or aseptic procedures. ○ after body fluid exposure risk. ○ after touching a patient; and ○ after touching a patient's immediate surroundings.	A Standard Infection Precautions policy is available on the Hub PPE adherence is monitored via IPC audits and clinical visits. 5 moments of hand hygiene audit are recorded on AMAT.			
6.07	• the use of hand air dryers should be avoided in all clinical areas. Hands should be dried with soft, absorbent, disposable paper towels from a dispenser which is located close to the	Warm air dryers are avoided in clinical areas. They are available for use in patients' toilets in communal areas e/g public toilets on corridors.			

	sink but beyond the risk of splash contamination (NIPCM)	Clinical hand wash basins have liquid soap and paper towels available for use.			
6.08	• staff understand the requirements for uniform laundering where this is not provided for onsite.	A Standard Infection Precautions policy is available on the Hub A uniform and workwear policy is available on the Hub. Posters are displayed at entrances advising staff not to wear scrubs to and from work. Changing facilities are available for use.			
7. Provide or secure adequate isolation facilities					
	Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
7.01	Systems and processes are in place to ensure: • that clear advice is provided; and the compliance of facemask wearing for patients with respiratory viruses is monitored (particularly when moving around the ward or healthcare facility) providing it can be tolerated and is not detrimental to their (physical or mental) care needs.	COVID-19 Leaflets available for download from.GOV.uk website. Facemasks are advised when in patients and in all clinical areas. Non-compliance with face mask wearing is documented in patients' notes. Visitors to clinical areas are requested to wear face IIR fluid resistant surgical facemask provided by the Trust			

7.02	• patients who are known or suspected to be positive with an infectious agent where their treatment cannot be deferred, care is provided following the NIPCM.	Patients are screened on admission either on the ward or via POC testing in ED. They are then moved to a ward or side room. If the patient is on a theatre list or planned surgery, a discussion is held with the consultant and anaesthetist to determine if their surgery should proceed or be rearranged.			
7.03	• patients are appropriately placed i.e.; infectious patients are ideally placed in a single isolation room. If a single/isolation room is not available, cohort patients with confirmed respiratory infection with other patients confirmed to have the same infectious agent.	Patients are screened on admission either on the ward or via POC testing in ED. They are then moved to a ward or side room. Patients are risk assessed Patients are cohort nursed if required in conjunction with the IPC Team A zoning SOP is available via the hub Patients are isolated or cohorted if possible, DATIX are completed if there is a delay. Audits are undertaken by IPCT and wards. Audit scores updated to AMaT.			
7.04	• standard infection control precautions (SIPC's) are applied for all, patients, at all times in all care settings	A Standard Infection Precautions policy is available on the Hub			

7.05	• Transmission Based Precautions (TBP) may be required when caring for patients with known / suspected infection or colonization	Standard infection prevention and control and transmission-based precautions are followed. A Standard Infection Precautions policy is available on the Hub			
8. Secure adequate access to laboratory support as appropriate					
	Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
8.01	There are systems and processes in place to ensure: • Laboratory testing for infectious illnesses is undertaken by competent and trained individuals.	All swabs are sent to BCPS accredited lab at Royal Wolverhampton Hospital. POC testing in ED is undertaken by trained competent staff.			
8.02	• patient testing for infectious agents is undertaken promptly and in line with national guidance.	Patients are swabbed if they meet COVID-19 admission screening criteria or become symptomatic. A COVID-19 screening SOP is available on the Hub. Patients are screened for other organisms if required			
8.03	• staff testing protocols are in place for the required health checks, immunisations, and clearance	COVID-29 and flu immunisations are available for all staff. New starters are referred to SHAW for pre-employment screening, clearance and vaccinations if required.			

8.04	there are regular monitoring and reporting of the testing turnaround times, with focus on the time taken from the patient to time result is available	All COVID-19 swabs are processed via the BCPS at the Royal Wolverhampton lab			
8.05	• inpatients who go on to develop symptoms of infection after admission are tested/retested at the point symptoms arise.	Swabbing and zoning SOP in place and available via the Hub			
8.06	COVID-19 Specific • patients discharged to a care home are tested for SARS-CoV-2, 48 hours prior to discharge (unless they have tested positive within the previous 90 days), and result is communicated to receiving organisation prior to discharge. Coronavirus (COVID-19) testing for adult social care services - GOV.UK (www.gov.uk)	SOP in place for discharging of patients to care homes Patients are PCR tested if non covid positive 48 hours prior to discharge Rapid swab testing is available to facilitate discharge.	The Trust is unable to undertake LFD testing on in patients due to the Governance procedures required and the recording of the result on the patient's own NHS record	SOP in place for discharging of patients to care homes detailing swabbing procedures. This has been shared and agreed buy the ICB	
8.07	• for testing protocols please refer to: COVID-19: testing during periods of low prevalence - GOV.UK (www.gov.uk) C1662_covid-testing-in-periods-of-low-prevalence.pdf (england.nhs.uk)	SOPs in place for COVID-19 testing these are available on the Hub.			
9. Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections					
	Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	

9.01	Systems and processes are in place to ensure that • resources are in place to implement, measure and monitor adherence to good IPC and AMS practice. This must include all care areas and all staff (permanent, flexible, agency and external contractors).	IPC policy adherence is completed by IPCT visits, training and via Saving Lives audits. AMR Pharmacist attended IPCG Meetings Staff m The Trusts liaises regularly with MITIE and Summit			
9.02	• staff are supported in adhering to all IPC and AMS policies.	IPC policy adherence is completed by IPCT visits, training and via Saving Lives audits. IPC polices are in place and in date. IPC Polices are available via the Hub.			
9.03	• policies and procedures are in place for the identification of and management of outbreaks of infection. This includes the documented recording of an outbreak.	IPC polices are in place and in date. IPC Polices are available via the Hub. Outbreak and isolation policies aviable on the Hub. All outbreaks of infection are recorded on the NHSE OTKA database and reported via IPCG.			

9.04	• all clinical waste and infectious linen/laundry used in the care of known or suspected infectious patients is handled, stored and managed in accordance with current national guidance as per NIPCM	Clinical waste is handled and stored as per national guidance. Standard IPC precautions policy is available via the Hub Laundry is re-processed via Elis			
9.05	• PPE stock is appropriately stored and accessible to staff when required as per NIPCM	A central store is maintained by procurement, who distribute PPE according to need to ensure adequate stocks, there is out of hours access. On entrance to clinical areas there is available stock of PPE. Staff obtain replacement stock directly from procurement. IPCT sit on PPE Cell meetings with Health and Safety, Procurement, and clinical skills. Half face respirators have been purchased and distributed by the trust.. FFP3 masks are aviable via Clinical Education Team. A Mitie helpdesk is available on site.			
10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection					
	Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	

10.1	Systems and processes are in place to ensure that: • staff seek advice when required from their occupational health department/IPCT/GP or employer as per their local policy.	Information regarding SHAW and staff health and wellbeing is available on the Hub. SHAW is on site with Clinics available in Sedgely. Training is available for all staff in donning and doffing. PPE audits including donning and doffing are undertaken.			
10.2	• bank, flexible, agency, and locum staff follow the same deployment advice as permanent staff.	Information regarding SHAW and staff health and wellbeing is available on the Hub. SHAW is based on site with Clinics available in Sedgely.			
10.3	• staff understand and are trained in safe systems of working commensurate with their duties.	Full mandatory training programme available via the learning and development team. Competencies are assessed and monitored.			
10.4	• a fit testing programme is in place for those who may need to wear respiratory protection.	Fit testing is available for all staff required to wear FFP3 masks. Fit testers are available throughout the Trust			
10.5	• where there has been a breach in infection control procedures staff are reviewed by occupational health. Who will: ○ lead on the implementation of systems to monitor for illness and absence.	Staff are referred to SHAW when required.			

	○ facilitate access of staff to treatment where necessary and implement a vaccination programme for the healthcare workforce as per public health advice. ○ lead on the implementation of systems to monitor staff illness, absence and vaccination. ○ encourage staff vaccine uptake.	A staff vaccination programme is delivered Policies and procedures are available SHAW report bi-monthly to IPCG Meeting A staff vaccination programme is promoted via the IPC team and at mandatory training. Regular communications are provided to staff regarding vaccine availability			
10.6	• staff who have had and recovered from or have received vaccination for a specific respiratory pathogen continue to follow the infection control precautions, including PPE, as outlined in NIPCM.	Policies, procedures and SOPs for respiratory pathogens are available on the Hub			
10.7	• a risk assessment is carried out for health and social care staff including pregnant and specific ethnic minority groups who may be at high risk of complications from respiratory infections such as influenza or severe illness from COVID-19. ○ A discussion is had with employees who are in the at-risk groups, including those who are pregnant and specific ethnic minority groups.	Line managers of 'at-risk' groups have been tasked with completing risk assessments to identify risks and consider adjustments where appropriate with the support of Staff Health & Wellbeing and HR. Staff members identified as vulnerable are being supported appropriately to ensure both			

	○ that advice is available to all health and social care staff, including specific advice to those at risk from complications. ○ Bank, agency, and locum staff who fall into these categories should follow the same deployment advice as permanent staff. ○ A risk assessment is required for health and social care staff at high risk of complications, including pregnant staff.	their physical and psychological wellbeing is supported. There has been an active programme of undertaking risk assessments for all staff, this is an on-going process which line managers will review appropriately. The risk assessment process is ongoing, and returns continue to be monitored. The Trust commenced COVID-19 vaccination programme in October 2022. Advice and support is available via the Hub			
10.8	• testing policies are in place locally as advised by occupational health/public health.	Testing polices are available via the Hub.			
10.9	• NHS staff should follow current guidance for testing protocols: C1662_covid-testing-in-periods-of-low-prevalence.pdf (england.nhs.uk)	Current asymptomatic COVID-19 testing of staff was postponed in August 2022. Symptomatic staff are advised to undertake LFD testing which is available via the Gov.uk website Staff in an outbreak area may be offered PCR tested following discussion and agreement with			

		the IPC team and/or Microbiologist.			
10.10	• staff required to wear fit tested FFP3 respirators undergo training that is compliant with HSE guidance and a record of this training is maintained by the staff member and held centrally/ESR records.	All FFP3 fit testers are trained Health & Safety are keeping and maintaining records of all staff members that have undertaken FFP3 Face Fit Testing Training.			
10.11	• staff who carry out fit test training are trained and competent to do so.	FFP3 fit testers are training and competent to undertake FFP3 testing			
10.12	• fit testing is repeated each time a different FFP3 model is used.	FFP3 fit testing is undertaken when new FFP3 masks are introduced.			
10.13	• all staff required to wear an FFP3 respirator should be fit tested to use at least two different masks	Staff are fit tested to the masks available at the time.	It is not always possible to fit test to two masks depending on availability of the FFP3 masks supplied	JSP ½ masks are available for staff to use.	
10.14	• those who fail a fit test, there is a record given to and held by employee and centrally within the organisation of repeated testing on alternative respirators or an alternative is offered such as a powered hood.	Staff are referred to SHAW of they are unable to be fit tested to a mask. JSP ½ masks are provided for those who are unable to fit tested to a mask The trust ordered replacement reusable respirators (half face and hood systems) Small, Medium, and large respirators			

		have arrived at the trust and have been distributed.			
10.15	• that where fit testing fails, suitable alternative equipment is provided. Reusable respirators can be used by individuals if they comply with HSE recommendations and should be decontaminated and maintained according to the manufacturer's instructions	Staff are referred to SHAW of they are unable to be fit tested to a mask. JSP ½ masks are provided for those who are unable to fit tested to a mask The trust ordered replacement reusable respirators (half face and hood systems) Small, Medium, and large respirators have arrived at the trust and have been distributed.			
10.16	• members of staff who fail to be adequately fit tested: a discussion should be had, regarding re deployment opportunities and options commensurate with the staff members skills and experience and in line with nationally agreed algorithm.	Proforma Risk assessments are available on the Hub for completion. Risk assessments are completed for staff with copies held in personnel files. Staff are referred to SHAW of they are unable to be fit tested to a mask. JSP ½ masks are provided for those who are unable to fit tested to a mask The trust ordered replacement reusable respirators (half face and hood systems) Small, Medium, and large respirators			

		have arrived at the trust and have been distributed.			
10.17	• a documented record of this discussion should be available for the staff member and held centrally within the organisation, as part of employment record including Occupational health.	Risk assessments are completed for staff with copies held in personnel files. Documents for SHAW are held within that department with copies forwarded to managers for their records.			
10.18	• boards have a system in place that demonstrates how, regarding fit testing, the organisation maintains staff safety and provides safe care across all care settings. This system should include a centrally held record of results which is regularly reviewed by the board.	Staff fit testing records are held centrally. Health & Safety are keeping and maintaining records of all staff members that have undertaken FFP3 Face Fit Testing. The trust ordered replacement reusable respirators (half face and hood systems) Small, Medium, and large respirators have arrived at the trust and have been distributed. Staff are recommended to be fit tested annually or if there are any changes. Fit testers are available throughout the trust. FFP3 masks and JSP1/2 masks are available throughout the Trust.			

10.19	• staff who have symptoms of infection or test positive for an infectious agent should have adequate information and support to aid their recovery and return to work.	Regarding a positive COVID-19 result staff are advised to stay off work for a minimum of 5 days and can return to work after two negative LFD tests on day 6 and 7 if they are apyrexial for 48 hours, in line with UK HSA guidance. The Trust have increased the Staff Health and Wellbeing provision, including access to an Occupational Health Physician and 24/7 access to personalised, on-demand advice and support from our team of mental health, financial, and legal experts			

The Dudley Group
NHS Foundation Trust

REPORT FOR ASSURANCE

Maternity and Neonatal Safety and Quality Dashboard
Report to Public Board of Directors 9th March 2023

1 EXECUTIVE SUMMARY

1.1 This report outlines locally and nationally agreed measures to monitor maternity and neonatal safety as outlined in the NHSEI document "Implementing a revised perinatal quality surveillance model" (December 2020). The purpose of the report is to inform the committee and 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 Ockendon and progress made in response to any identified concerns at provider level.

1.2 In line with the perinatal surveillance model, we are required to report the information outlined in the data measures proforma monthly to the trust board. Data contained within this report is for **December 2022 and January 2023**, unless otherwise specified throughout.

2 BACKGROUND INFORMATION

2.1 Perinatal Mortality Overview

Stillbirths -There were 1 still births during December 2022 and 1 during January 2023

Early Neonatal Deaths – There has been 1 early neonatal deaths during the months of December 2022 and 3 during January 2023.

Late Neonatal deaths -There have been 0 late neonatal deaths in December 2022 and 0 during January 2023.

2.1.2 Stillbirths

Crude stillbirth rates: Calculated from the total number of stillbirths for the period divided by number of births within the period multiplied by 1,000.

Adjusted stillbirth rates: Calculated from the total number stillbirths for the period less:

Multiple pregnancy when one or more fetus has demised preterm but delivered post 24 weeks gestation, fetal anomalies (incompatible with life) where termination of pregnancy has

been declined but delivered a stillbirth. Then divided by number of babies born for the period and multiplied by 1,000.

Still birth Rates

The National stillbirth rate is 3.33 (MBRRACE 2022) and it can be seen the stillbirth rate for January 2023 at 2.15 (adjusted rate 1.67), this indicates that DGFT remain **below** the national stillbirth rate.

	Crude Rate	Adjusted rate	Number of stillbirths
Feb-22	3.14	2.66	0
Mar-22	3.61	2.89	2
Apr-22	3.4	2.67	0
May-22	3.4	2.68	0
Jun-22	3.17	2.69	1
Jul-22	3.15	2.67	0
Aug-22	3.13	2.65	2
Sep-22	2.87	2.39	2
Oct-22	2.62	2.14	0
Nov-22	2.39	1.91	0
Dec-22	2.39	1.67	1
Jan-23	2.15	1.67	1

It should be noted that there were 9 stillbirths from 01.02.22 to 31.01.2023 and of these 2 had known congenital anomalies.

2.2 Neonatal deaths

The table below details the neonatal death rates (over a rolling 12 months) for 1st February 2022 to 31st January 2023. The calculations are recorded for both crude and adjusted rates:

Crude early neonatal death rates – Calculated from the total number of early neonatal deaths divided by number of live births multiplied by 1,000.

Adjusted neonatal death rates- Calculated from the total number of early neonatal deaths less:

Babies delivered prior to 24 weeks gestation or with known congenital anomalies, then divided by the number of live births for the period and multiplied by 1,000.

Crude late neonatal death rates – Calculated from the total number of late neonatal deaths divided by number of live births multiplied by 1,000.

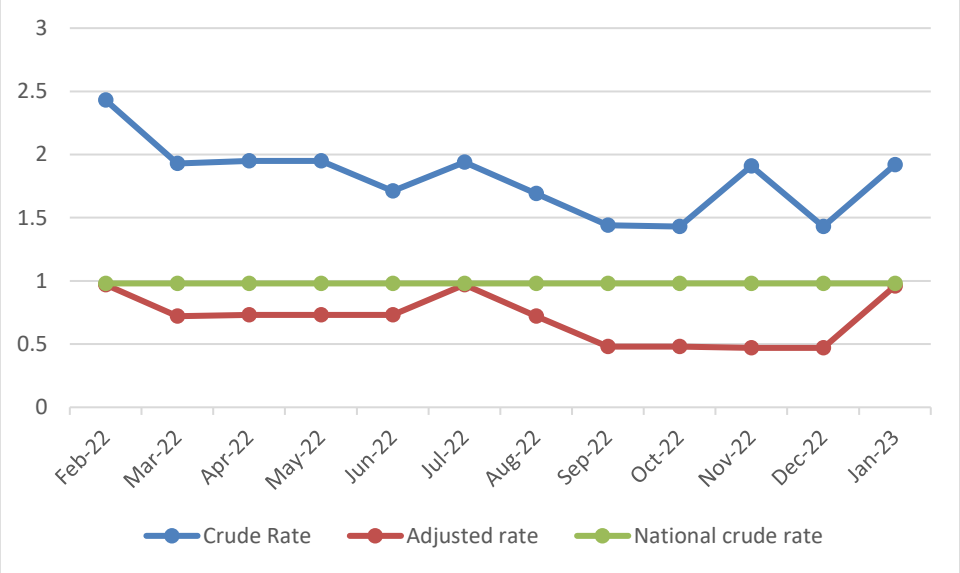
2.2.1 Early Neonatal Death Rates

The National rate for Early Neonatal deaths is 0.98 (MBRRACE 2022) and in January 2023 at DGFT the rate is 1.92 (adjusted rate 0.96). **There has been an increase in early neonatal death rate in January 2023**, this is due to 1 neonatal death at 22+3 and 2 term neonatal deaths, both of which have been accepted by coroners. HSIB investigations have been commenced and the Trust has reported as a serious incident.

N.B the rates for November and December have been amended from previous reports as a 21+ week NND had not been included.

	Crude Rate	Adjusted rate	Number of early NND
Feb-22	2.43	0.97	1
Mar-22	1.93	0.72	0
Apr-22	1.95	0.73	0
May-22	1.95	0.73	0
Jun-22	1.71	0.73	0
Jul-22	1.94	0.97	1
Aug-22	1.69	0.72	0
Sep-22	1.44	0.48	1
Oct-22	1.43	0.48	0
Nov-22	1.91	0.47	1
Dec-22	1.43	0.47	1
Jan-23	1.92	0.96	3

It should be noted that there were 8 early neonatal deaths from 01.02.22 to 31.01.2023.

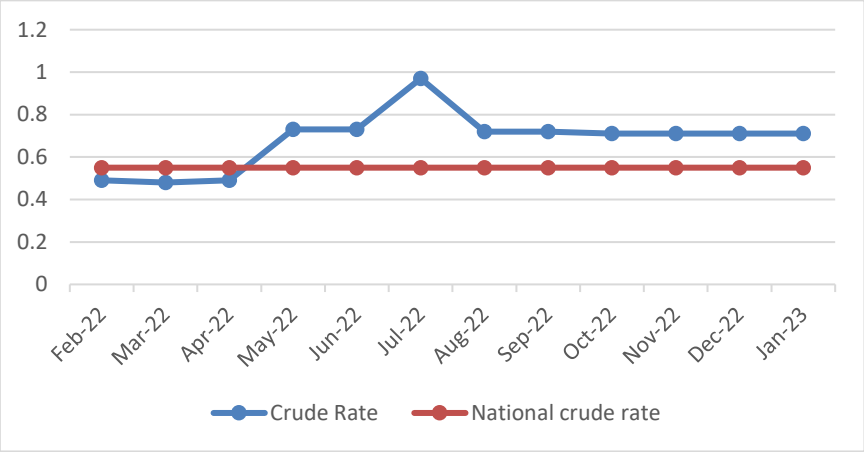


The above chart details how the crude early neonatal death rate has been consistently higher than the National rate of 0.98 (MBRRACE 2021) during the last 12 months. However, it should be observed that 5 of these cases were babies born between 19 and 24-weeks' gestation.

2.2.2 Late Neonatal Death Rates

The national rate for Late Neonatal Deaths is 0.55 (MBRRACE 2022). The Trusts **late neonatal death rate remains above the national rate at 0.71.**

	Crude Rate	National crude rate	Number of Late NND
Feb-22	0.49	0.55	1
Mar-22	0.48	0.55	0
Apr-22	0.49	0.55	0
May-22	0.73	0.55	1
Jun-22	0.73	0.55	0
Jul-22	0.97	0.55	1
Aug-22	0.72	0.55	0
Sep-22	0.72	0.55	0
Oct-22	0.71	0.55	0
Nov-22	0.71	0.55	0
Dec-22	0.71	0.55	0
Jan-23	0.71	0.55	0

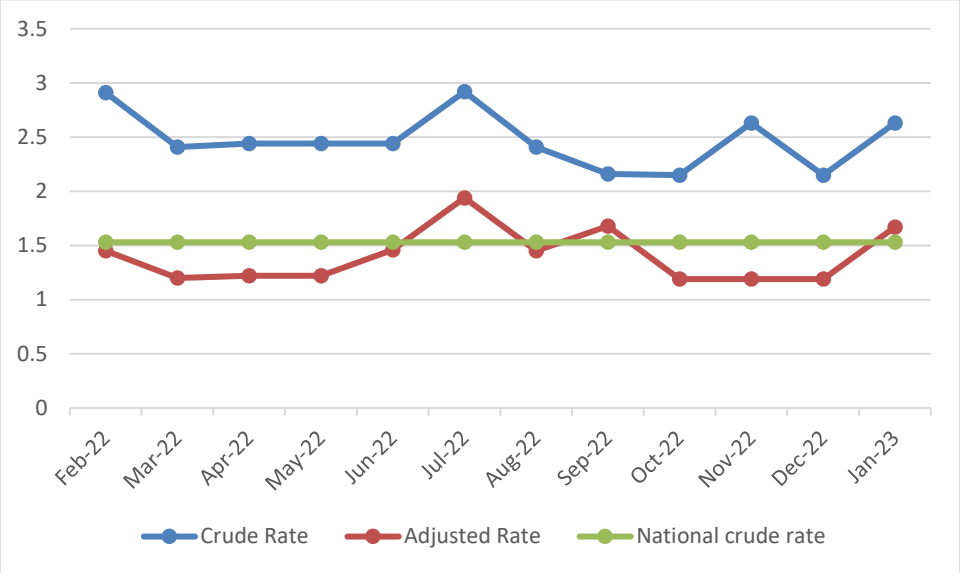


It should be noted that there were 3 late neonatal deaths from 01.02.2022 to 31.01.2023, 2 of these cases were sudden infant deaths and both cases received Maternity care at a neighbouring Trust.

2.2.3 Combined Neonatal Death Rates

The current combined neonatal death rate for the Trust is 2.63 (Adjusted rate 1.67**). This is above the national rate of 1.53 (MBRRACE 2022).**

	Crude Rate	Adjusted Rate
Feb-22	2.91	1.45
Mar-22	2.41	1.2
Apr-22	2.44	1.22
May-22	2.44	1.22
Jun-22	2.44	1.46
Jul-22	2.92	1.94
Aug-22	2.41	1.45
Sep-22	2.16	1.68
Oct-22	2.15	1.19
Nov-22	2.63	1.19
Dec-22	2.15	1.19
Jan-23	2.63	1.67



The Women and Children's service continues to report perinatal mortality rates through Divisional Governance and also features at the Trusts Mortality Surveillance Group. A quarterly overview of perinatal mortality rates will be included in the Mortality Surveillance group report and presented to the Trust Board to ensure that they have oversight.

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

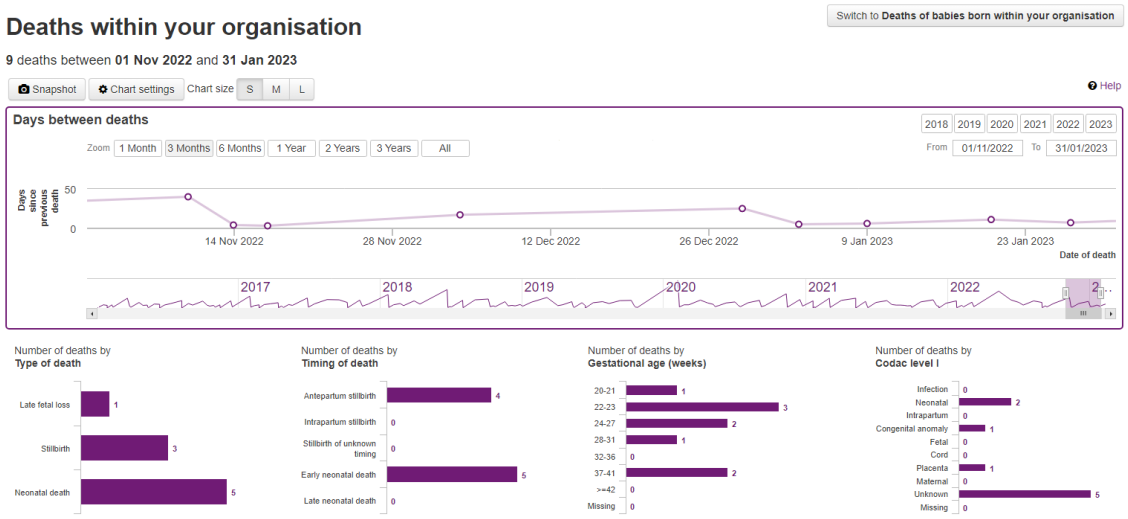
In addition to the NPMRT database we are required as a Trust to report the following to MBRRACE

- **Late fetal losses** – the baby is delivered between 22 weeks+0 days and 23 weeks+6 days of gestation (or from 400g where an accurate estimate of gestation is not available) showing no signs of life, irrespective of when the death occurred
- **Stillbirths** – the baby is delivered from 24 weeks+0 days gestation (or from 400g where an accurate estimate of gestation is not available) showing no signs of life, irrespective of when the death occurred
- **Early neonatal deaths** – death of a live born baby (born at 20 weeks+0 days gestation of pregnancy or later or 400g where an accurate estimate of gestation is not available) occurring before 7 completed days after birth
- **Late neonatal deaths** – death of a live born baby (born at 20 weeks+0 days gestation of pregnancy or later or 400g where an accurate estimate of gestation is not available) occurring between 7 and 28 completed days after birth.

A national report is produced by MBRRACE annually highlighting themes of good practice and recommendations for changes in practice. Additionally, MBRRACE carry out confidential enquiries based on identified themes from their main reports.

2.3 PMRT real time data monitoring tool

3 months of data (November 2022, December 2022 and January 2023) showing deaths of babies who were born within our organisation, including babies who died elsewhere.



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

2.4 Healthcare Safety Investigation Branch HSIB and Maternity Serious Incidents SIs

Since April 2018, the Healthcare Safety Investigation Branch HSIB has been responsible for the investigations into specific maternity incidents. These include:

- Intrapartum stillbirth
- Early neonatal deaths
- Potential severe brain injury
- Maternal deaths (up to 42 days postnatal).

It was announced during 2022 that HSIB would split into two organisations and the **Maternity and Newborn Safety Investigations Special Health Authority** (MNSI) would be responsible for Maternity and Neonatal investigations as specified above. This was originally planned for April 2023, but it was announced on the 9th February 2023 that this change has been delayed for at least 6 months due to difficulties in establishing board and leadership across both organisations.

2.4.1 Investigation progress update

Cases to date	
Total referrals	24
Referrals / cases rejected	4
Total investigations to date	20
Total investigations completed	17
Current active cases	4
Exception reporting	No cases currently have exceptions

Please note 3 cases have been referred to HSIB During the month of January 2023. 1 case related to a baby sent for therapeutic cooling, and 2 cases relate to term neonatal deaths. Both of these cases have also been referred to the coroner.

Each of these are treated as RCA/SI investigations in respect of Trust reporting and following receipt of the HSIB report and production of our local action plan the reporting through appropriate governance processes is carried out.

All learning continues are shared across the Black Country and West Birmingham LMNS on a monthly basis via the quality and safety workstream.

2.5 Coroner Regulation 28 made directly to the Trust

There were 0 Coroner regulation 28 made directly to the Trust in respect of perinatal or maternal deaths in December 2022 or January 2023.

2.6 Maternity Serious Incidents

There was 0 serious incident reported in Maternity during December 2022.

There were 3 serious incidents reported in January 2023.

There are 7 further ongoing maternity SI investigations.

2.7 Maternity action plans

2.7.1 Ockenden Report final

An Ockenden update meeting is scheduled for March 2023 to provide an updated position**.**

Date of assessment	Total actions					
July 2022	87	19%	53%	18%	2%	8%
September 2022 (updated)	87	5.5%	46%	21%	21%	5.5%
December 2022	87	4%	43.5%	22%	25%	5.5%

	Limited or non-compliance
	Partially compliant
	Fully compliant
	Fully compliant- with assurance
	Nationally led actions

2.8 Saving Babies Lives V2

2.8.1 An external audit has been commissioned on compliance with SBLV2. SBLV3 is expected to be published spring 2023. The trust is also undertaking use of the SBLV2 compliance tool. Results are expected March 2023 (NHSE and LMNS).

SBLV3 is expected to launch during the Summer of 2023.

2.9 Maternity safety champions

A Maternity safety champion meeting occurred on the 18th January 2023 attended by safety champions for maternity, neonatal and board level champions. Areas of discussion were:

- CNST progress and the cause of non-compliance
- Plans for staffing and workforce and progress with international recruitment
- Staff culture action plan
- Maternity Voices and womens voice
- Improvement work progress
- CQC expected visit (December 2022) and KLOE for the visit
- Quality and safety review that took place November 2022- and associated actions from this.
- Neonatal safety champion update
- Risks and risk register

2.10 ICB Peer review of maternity services

On the 16th February 2023, a peer review of maternity services was undertaken by the ICB and the LMNS. Initial verbal feedback was given on the day, and a report is expected within two weeks:

- The team raised concerns relating to mandatory training but noted this was on the risk register with associated actions and development of a new program of obstetric skills drills.
- Maternity specific training as recommended to be logged centrally on the ESR system- this is currently underway.
- The wider maternity program of QI work was highly praised including theatre utilisations, telephone triage, community hubs
- The band 5 preceptorship week was highly commended
- Introduction of clinical educators and an enhanced Practice development team was noted as good practice
- Visibility of the head of Midwifery was noted by the team as good practice
- Recommendation to adopt the RCM leadership manifesto with the introduction of a director of Midwifery and supportive leadership network below this role.
- More work to be undertaken to strengthen the voice of the woman and use of the MVP, the current recruitment to the consultant midwife post was praised.

The final report will be shared with the committee once received. The maternity team will be involved in the peer review of the other 3 sites across the LMNS.

2.11 Service user feedback

Staff very understanding and caring. Midwife "Amy" made me feel very comfortable during induction of labour. Nothing too much for Midwives and CSW's regarding aftercare.

My Midwives, Julie and Lucy on labour ward were so amazing, caring and supportive, i couldn't have been without them, I felt safe and cared for. Carole and Heather were so attentive and helpful, felt i could ask loads of questions and for help, they were lovely.

Everyone was caring and attentive. lovely staff, great food, we were both treated with dignity and always felt comfortable.

To be kept informed more.
Partners to be able to stay overnight/longer hours once baby is born.

3 RISKS AND MITIGATIONS

3.1 Midwifery staffing continues to be a risk and remains on the risk register- the score had increased to reflect the increasing vacancy that we have seen over the course of 2022. Ongoing midwifery recruitment including international recruitment is in progress as per workforce plan, and vacancy has substantially reduced since November 2022. The risk will be reduced to reflect this throughout March 2023.

3.2 There have been a cluster of serious incidents within maternity services during January 2023 and these are being investigated within the organisation as well as by external agencies.

3.3 The requirements for evidence of assurance are very specific, and significant in its amount. The Trust Board is required to receive and minute detailed information particularly in relation to serious incidents, perinatal mortality, and safety champion engagement.

4. RECOMMENDATION

4.1 The Board is invited to accept the assurance provided in this report as current position with maternity staffing, mortality data and position with the number of reported serious incidents (SIs).

Name of Author: Claire Macdiarmid
Title of Author Head of Midwifery

Date 27/2/23