Excellent health care, improved health for all

The Dudley Group NHS Foundation Trust

Board of Directors - Further reading pack
Public meeting
Thursday 11 May 2023

The launch of our surgical Robot March 2023

FURTHER READING PACK

Paper for submission to the Board of Directors on the 11th May 2023

Title:	Maternity and Neonatal Safety and Quality Dashboard
Author:	Claire Macdiarmid – Head of Midwifery
Presenter:	Claire Macdiarmid – Head of Midwifery

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

Recommendations:

The Board is invited to accept the assurance provided in this report that was considered by the Quality & Safety Committee as mortality rates, incident reporting, audit findings from Saving babies lives version 2 audit as well as plans to rectify current Midwifery and obstetric vacancies.

The Service continues to drive Improvement actions all aspects of Maternity and Neonatal services.

Summary of Key Issues:

There were no stillbirths reported during February and March 2023. There was one early neonatal death during February and 0 during March.

There was 0 serious incident reported in February and 2 during March 2023.

Adult resuscitation training compliance has improved to 91%, and neonatal resuscitation training has increased to 88.4%. rectification plans remain in place to monitor progress. CTG training and Multidisciplinary skills drills remains below 90% compliance, however the PROMPT skills drills training package is due to be introduced during May 2023.

Midwifery staffing continues to be a risk however there has been an increase in the Midwifery workforce and a reduction in the vacancy due to recruitment of both UK and internationally trained Midwives.

Maternity Safety champion meetings are ongoing.

Maternity Voices Partnership (MVP) is changing its title to the Maternity and neonatal voices partnership (MNVP).

Impact on the Strategic Goals

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

Implications of the Paper:			
Risk	Y	Risk Description:	
	On Risk Register: Y	Risk Score:	
Compliance and/or Lead Requirements	CQC	Y	Details: All Areas
	NHSE	Y	Details:
	Other	Y	Details: SBLV2

Report Journey/ Destination	Working / Exec Group	N	Date:
	Committee	Y	Date: 25/4/2023
	Board of Directors	Y	Date: 11/05/2023
	Other	N	Date:

REPORT FOR ASSURANCE

Maternity and Neonatal Safety and Quality Dashboard

Report to Quality and Safety Committee 25th April 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 **February and March 2023**, unless otherwise specified throughout.

2. BACKGROUND INFORMATION

2.1 Perinatal Mortality Overview

Stillbirths -There were 0 still births during February 2023 and 0 during March 2023

Early Neonatal Deaths – There has been 1 early neonatal death during February and 0 during March 2023.

Late Neonatal deaths -There have been 0 late neonatal deaths in February and 0 during March 2023.

2.1.2 Stillbirths

The below table details stillbirth rates (over a rolling 12 months) from 1st April 2022 to 31st March 2023. The calculations are recorded for both crude and adjusted rates:

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:

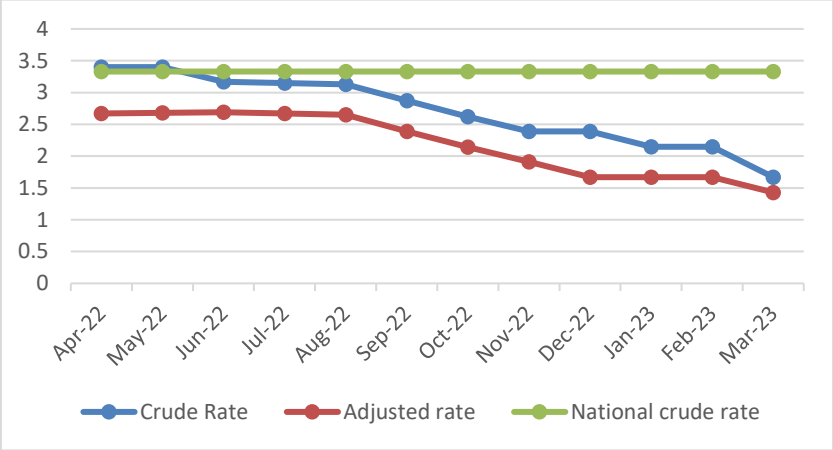
Multiple pregnancy when one or more fetus has demised preterm but delivered post 24 weeks gestation, fetal anomalies (incompatible with life) where termination of pregnancy has been declined but delivered a stillbirth. Then divided by number of babies born for the period and multiplied by 1,000.

Still birth Rates

The National stillbirth rate is 3.33 (MBRRACE 2022) and it can be seen the stillbirth rate for January 2023 at 1.67 (adjusted rate 1.43), this indicates that DGFT remain below the national stillbirth rate.

	Crude Rate	Adjusted rate	National crude rate	Number of stillbirths
Apr-22	3.4	2.67	3.33	0
May-22	3.4	2.68	3.33	0
Jun-22	3.17	2.69	3.33	1
Jul-22	3.15	2.67	3.33	0
Aug-22	3.13	2.65	3.33	2
Sep-22	2.87	2.39	3.33	2
Oct-22	2.62	2.14	3.33	0
Nov-22	2.39	1.91	3.33	0
Dec-22	2.39	1.67	3.33	1
Jan-23	2.15	1.67	3.33	1
Feb-23	2.15	1.67	3.33	0
Mar-23	1.67	1.43	3.33	0

It should be noted that there were 7 stillbirths from 01.04.22 to 31.03.2023.



2.2 Neonatal deaths

The table below details the neonatal death rates (over a rolling 12 months) for 1st April 2022 to 31st March 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.

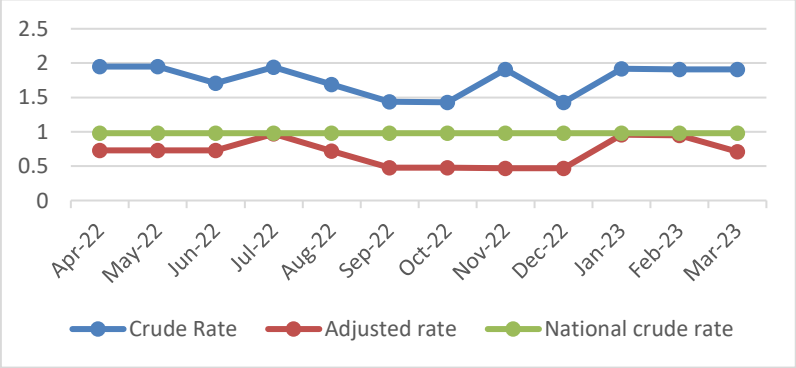
2.2.1 Early Neonatal Death Rates

The National rate for Early Neonatal deaths is 0.98 (MBRRACE 2022) and in March 2023 at DGFT the rate is 1.91 (adjusted rate 0.71).

	Crude Rate	Adjusted rate	National crude rate	Number of early NND
Apr-22	1.95	0.73	0.98	0
May-22	1.95	0.73	0.98	0
Jun-22	1.71	0.73	0.98	0
Jul-22	1.94	0.97	0.98	1
Aug-22	1.69	0.72	0.98	0
Sep-22	1.44	0.48	0.98	1
Oct-22	1.43	0.48	0.98	0
Nov-22	1.91	0.47	0.98	1
Dec-22	1.43	0.47	0.98	1
Jan-23	1.92	0.96	0.98	3
Feb-23	1.91	0.95	0.98	1
Mar-23	1.91	0.71	0.98	0

The Trust remains above the national rate of 0.98.

It should be noted that there were 8 early neonatal deaths from 01.04.23 to 31.03.2023.

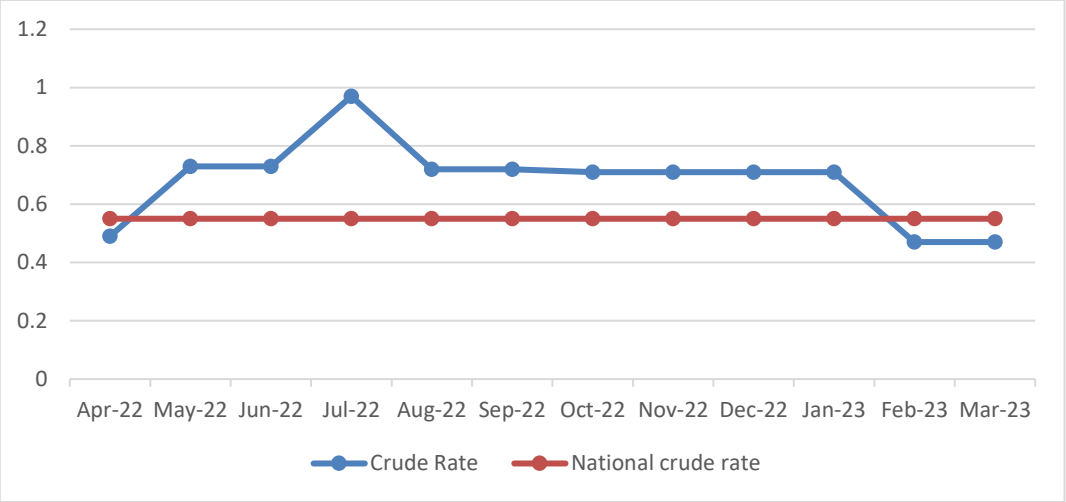


The above chart details how the crude early neonatal death rate has been consistently higher than the National rate of 0.98 (MBRRACE 2021) during the last 12 months.

2.2.2 Late Neonatal Death Rates

The National rate for Late Neonatal Deaths is 0.55 (MBRRACE 2022) and DGFT are below at 0.47.

	Crude Rate	National crude rate	Number of Late NND
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
Feb-23	0.47	0.55	0
Mar-23	0.47	0.55	0



The Trust rate is now below the national average rate of 0.55.

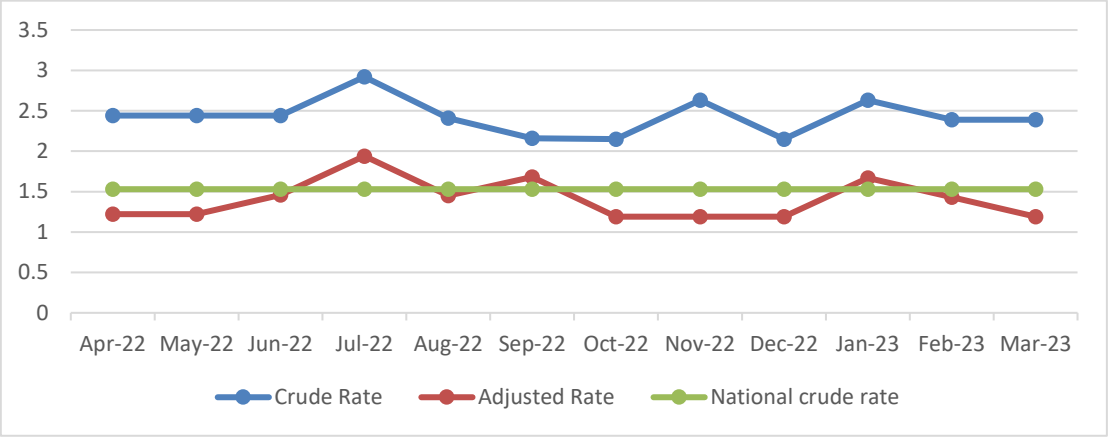
It should be noted that there were 2 late neonatal deaths from 01.04.2022 to 31st March 2023

2.2.3 Combined Neonatal Death Rates

The below chart demonstrates the crude and adjusted combined neonatal death rates from 1st April 2022 to 31st March 2023, it can be seen that the combined neonatal death rate is 2.39 (Adjusted rate 1.19) continues to be above the national rate of 1.53 (MBRRACE 2022).

	Crude Rate	Adjusted Rate	National crude rate
Apr-22	2.44	1.22	1.53
May-22	2.44	1.22	1.53
Jun-22	2.44	1.46	1.53
Jul-22	2.92	1.94	1.53
Aug-22	2.41	1.45	1.53
Sep-22	2.16	1.68	1.53

Oct-22	2.15	1.19	1.53
Nov-22	2.63	1.19	1.53
Dec-22	2.15	1.19	1.53
Jan-23	2.63	1.67	1.53
Feb-23	2.39	1.43	1.53
Mar-23	2.39	1.19	1.53



The Women and Children's service continues to report perinatal mortality rates through Divisional Governance each month and into the Trusts Mortality Surveillance Group. A quarterly report of perinatal mortality rates is presented to the Mortality Surveillance group and included in the highlight report presented at the Quality and Safety Committee to ensure that the Trust Board 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.

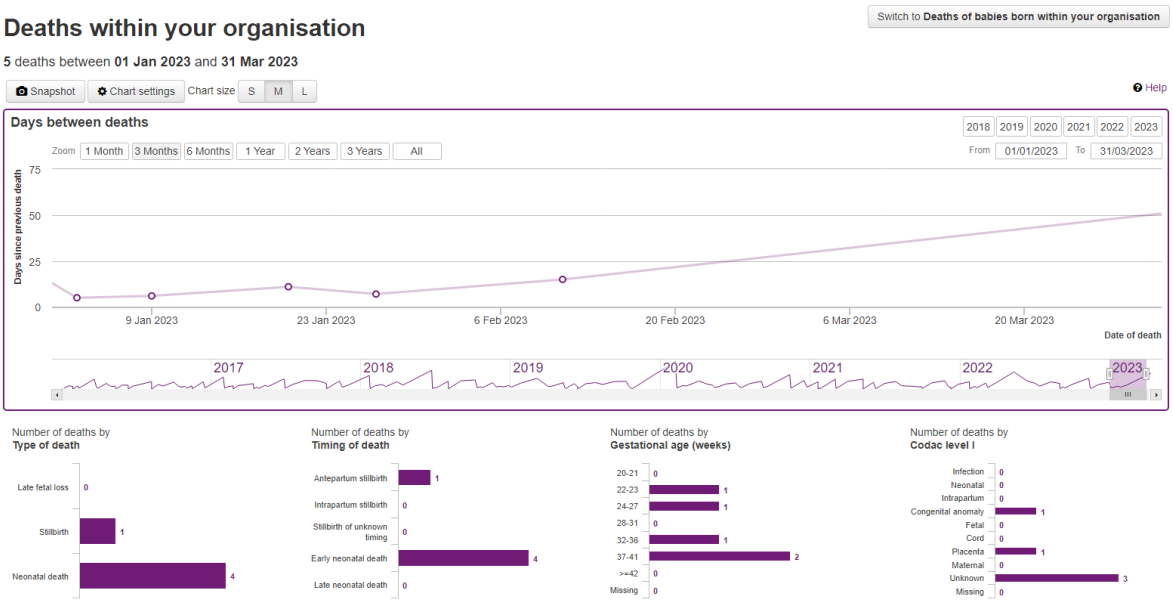
There were 0 perinatal mortality cases reported to PMRT during March 2023. 2 cases have been assigned to the trust due to receiving some antenatal care here.

2.2.4 Learning from Deaths Overdue Actions

There are currently 7 PMRT action plans with overdue actions (Appendix 1). All PMRT actions are assigned within Datix (incident reporting system) to allow for monitoring and escalation. An overdue action report has been circulated to the action leads for their attention and closure.

2.3 PMRT real time data monitoring tool

3 months of data (January, February, and March 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 of 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

DGFT executive summary from HSIB up to 31/3/23

Executive Summary

Cases to date	
Total referrals	26
Referrals / cases rejected	5
Total investigations to date	21
Total investigations completed	18
Current active cases	3
Exception reporting	No cases currently have exceptions

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 monthly 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 February or March 2023.

2.6 Maternity Serious Incidents

There was 0 serious incident reported in Maternity during February 2023.

There were 2 serious incidents reported in March 2023:

INC121413 - occurred 25.12.22 - Stillbirth - Baby thought to have ascites however PM identified no abnormalities.

INC125855 07.03.23 neonatal serious incident involving the baby with NEC which was sent to BWH and sadly passed away.

There are 7 further ongoing maternity SI investigations.

INC114798 - 5L Antepartum haemorrhage/postpartum haemorrhage admission to ITU – One action remains to be closed.

INC123352 - Neonatal death- Being investigated by HSIB and internal trust HR investigation.

INC116047 – HSIB investigating, baby sent for therapeutic cooling - final report received action plan being developed.

INC122415 - HSIB investigating, baby sent for therapeutic.

INC99624 - HSIB investigating, baby sent for therapeutic - 3 actions awaiting closure.

INC113069 - Delay IOL with Chorioamnionitis 4 open actions

INC122908 – Neonatal death- being investigated by HSIB - in progress.

2 serious incidents have been closed during March- both were investigated by HSIB. INC107799 and INC11261.

2.7 Maternity action plans

2.7.1 Ockenden Report final

A deep dive into the Ockenden actions will be presented in the June 2023 Meeting.

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 (SBLV2)

2.8.1 An external audit was commissioned by the trust, to assess our compliance with the SBLV2 recommendation (Appendix 1). The findings of this audit share the declared position by the trust as part of CNST year 4 submission. Action plans are underway to ensure compliance with element one. (Appendix 1). NHS England, LMNS are working wit the trust to undertake a more in-depth review of the tool, and results will be bought to this meeting when received. Initial positions expect to be lower than previous declared positions and action plans formed following this baseline.

SBLV3 is expected to be published Spring 2023. The trust is also undertaking use of the SBLV2 compliance tool. Results are expected imminently (NHSE and LMNS).

2.8.2 Mandatory and Maternity specific training

Mandatory training remains on the risk register for adult and neonatal resuscitation as well as obstetric multidisciplinary skills drills and CTG training.

As of the 1st May 2023, if Maternity staff (medical and midwifery teams) are not fully trained and compliant in CTG training, they will be unable to work in intrapartum areas, or interpret CTGs. This is in line with the rest of the LMNS.

	Current compliance	RAG Rating	Rectification plans
Multi-Professional Emergency Training/Skills Drills	84%		National obstetric training program PROMPT has been purchased and a faculty has been identified. To commence April 2023/May 2023
CTG/ fetal Monitoring Training	86%		Additional sessions are scheduled for late April to ensure compliance above 90%, and to allow staff that are out of date to attend before the cut off date of the 1st May as per above comment.
Neonatal resuscitation	88.4%		All staff that are non-compliant have been allocated a time to attend training- back fill midwife will cover their clinical duties whilst they update. Ad-Hoc training performed on Maternity ward
Adult resuscitation	91%		Ongoing work to remain within green for compliance.

2.9 Maternity staffing

International Recruitment of Midwives

We have 24 international midwives now in post.

4 are now practicing independently and are counted within the Midwifery staffing establishment.

A further 5 have passed their OSCE but are not able to fully practice independently due to competence with fetal monitoring.

3 have passed their OSCE and are awaiting to receive their NMC Pin numbers.

3 are awaiting their OSCE resit.

9 are awaiting to sit their OSCE for the first time.

We have 3.0 WTE Band 6 midwives due to commence in post to join the community midwifery teams. This will fill all community vacancy; our overall vacancy for Midwifery staffing across the unit sits at 10.3WTE.

Nine students due to qualify in September 2023- plan is to offer all students midwifery roles (pending passing their BSc). We are representing the trust at an LMNS Maternity recruitment event in May 2023.

We have successfully recruited to the post of Maternity governance lead. They will commence in post Summer 2023.

Despite not recruiting to the consultant midwife post first time around, we have received several expressions of interest since the closing date and are currently readvertising this post.

The regional Midwifery sitrep is now completed 7 days per week, which allows declaration of OPAL status to the region. It collects data relating to workload and any delays associated. It collates some data relating to acuity of the department and links to birth-rate plus acuity scores. It also allows quick reference of neighbouring units with the capacity and ability to support as required.

2.9.1 Obstetric staffing

Currently fully established on consultant line with 16 consultants in post, 2 locums in post until new substantive consultants start. Ms Alex Buzouki, Gynaecology Oncology, commences July 2023 and Mr Alaa Eldee, O&G consultant start date to be confirmed. Mr Morsi returned from sabbatical 17th April 23.

1.0WTE locum consultant post advertised internally (financed by an accumulation of vacancies) to support current gaps in out of hours created by amended duties.

Obstetrics is prioritised over gynaecology on call and substantive staff are used to fill this role.

Bereavement/Birth trauma, antenatal and fetal medicine lead roles remain vacant and have been included in the job plans for the new consultants.

4.0 fixed term Trust grade level 2 doctors have been recruited to post, awaiting confirmation of acceptance. Issues around recruitment abroad and recognition of previous experience have been escalated at divisional level.

There remain gaps in the deanery provision, 1.0 WTE fixed term level 1 doctor post has been advertised to cover this, interview dates have been arranged. We have maintained a 1:10 tier 1 rota as 2.0 MTIs have joined. The MTIs are expected to join the registrar rota in April.

2.10 Maternity safety champions

A Maternity safety champion meeting occurred on the 6th of April 2023 attended by safety champions for maternity, neonatal and board level champions. Areas of discussion were:

- Plans for staffing and workforce and progress with international recruitment.
- CQC Maternity survey results and subsequent work
- Improvement work progress
- Neonatal safety champion update
- Risks and risk register
- Ockenden progress.

2.11 Service user feedback

Post natal, well supported and cared for. Kept informed, all Doctors informative, especially Dr Banerjee, felt very well informed. All midwifes, Natalie and support staff.

All staff were very friendly, helpful and supportive. Nothing was too much trouble. Heather, support midwife staff very supportive, experienced, nothing was too much trouble. Put mind at ease.

Felt looked after at all stages of my stay, really friendly and helpful staff. Always came around to introduce themselves once they'd swapped shifts and always checked to see if I was OK, if there was anything I needed.

Excellent care and genuine kindness from start to finish. Must mention:-
Sonographer Jordan - fully explained everything and great sense of humour
Midwife Michelle - lovely
Consultant Jack Lowe - absolutely fab. Really reassuring, taking time to explain everything thoroughly and answered all questions. Wonderful!

Pain relief process to be improved for early labour stages.

Cup of tea
Free parking
Ice machine

2.11.1 Maternity Voices Partnership

The maternity voices partnership meets quarterly with services users, and staff representatives, and are currently engaged in a number of co-production project with the trust s to ensure the families of Dudley are involved in all decision making about the service.

Maternity voices partnership is changing its title to **Maternity and Neonatal Voices partnership (MNVP)**

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 2023.

3.2 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(S)

4.1 The Committee is invited to accept the assurance provided in this report as current position with maternity staffing, mortality data, serious incidents and SBLV2.

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

Date 14/4/2023

Appendix 1 - Maternity Review – Saving Babies Lives (SBL)

THE DUDLEY GROUP NHS FOUNDATION TRUST

Maternity Review – Saving Babies Lives (SBL) - including interviews with key personnel and testing in selected areas of the SBL Guidance

Internal Audit Report: 12.22/23

FINAL

2 March 2023

SECTION 1 - EXECUTIVE SUMMARY

With the use of secure portals for the transfer of information, and through electronic communication means, remote working has meant that we have been able to complete our assignment and provide you with the assurance you require. It is these exceptional circumstances which mean that 100 per cent of our assignment has been conducted remotely.

Background

Saving Babies Lives (SBL) is the Government's ambition for halving the stillbirth rate in the UK by 2030, which ran alongside the commitment to reduce the rate by 20 per cent by 2020. SBL is a Clinical Negligence Scheme for Trusts (CNST) submission requirement. Trust Boards must consider how its organisation is complying with the 'SBL care bundle version two', published in April 2019. Trusts can implement an alternative intervention to deliver an element of the care bundle if it has been agreed with their Integrated Care Board (ICB), noting that Dudley Group NHS Foundation Trust has not requested this. However, should this be required, the Trust would initially engage with the Local Maternity and Neonatal System. It is important that specific variations from the pathways described within SBLCBv2 are also agreed as acceptable clinical practice by their Clinical Network.

There are five elements within the 'SBL care bundle version two' (April 2019) that Trusts must achieve to be compliant:

1. Reducing smoking in pregnancy;
2. Risk assessment, prevention, and surveillance of pregnancies at risk of foetal growth restriction;
3. Raising awareness of reduced foetal movement;
4. Effective foetal monitoring during labour; and
5. Reducing pre-term birth.

The fifth area was added in 2019 in response to the Department of Health's 'Safer Maternity Care' report.

For the purposes of this audit, we agreed with management that we would select a sample of the SBL elements to review the current progress for implementation by the Trust and to share any best practice that has been seen elsewhere. This review was led by RSM's Clinical Nurse Specialist (CNS) who can share such insights from working elsewhere and similar audits undertaken. Our sample included elements one, two and three.

As part of our review, we conducted interviews with the SBL Lead Midwife and the Deputy Matron for Maternity as well as reviewing key documentation provided to us.

Conclusion

The Trust has dedicated resources to support compliance with the requirements of Saving Babies Lives and invested resource into prevention services to support women to stop smoking in pregnancy and beyond.

Of the three elements reviewed we were provided with evidence and documentation to support the Trust's assessments of 'not met' (Element1) and 'met' (Elements 2 and 3). Where the requirement has not been met there is an action plan in place. We identified that one action is overdue within the Element 1 action plan, and it is not clear if the implementation of these actions will move the status of the action to met.

There are also two posts (SBL Lead Midwife and a Foetal Monitoring Lead Midwife) which were recruited to for a defined period of time, until 31 March 2023. The future of these posts has not yet been assessed or determined.

Key findings

The Trust has two essential posts that support the implementation and monitoring of SBL. These include:

- An SBL Lead Midwife - 22.5 hours fixed term (contract expires 31 March 2023); and
- A Foetal Monitoring Lead Midwife - 15 hours fixed term (contract expires 31 March 2023).

However, both of these roles are currently of a temporary nature, therefore consideration should be given to measuring the impact of these roles to determine the impact of retaining/removing these posts.

Element one has been assessed by the Trust as 'not met' therefore an action plan is required. Review of the action plan that is in place to improve the compliance of Carbon Monoxide (CO) monitoring, we noted an outstanding amber action, which had an implementation date of 31 October 2022. The action related to the monthly monitoring of CO booking rates and corresponding feedback to Clinical Teams. An update was provided on 20 September 2022, which stated that the team were discussing where data should be taken from and suggested monthly monitoring. The Trust should consider revisiting the action to see if it is still relevant or resolved. In addition, whilst the action plan sets out some steps it is not clear how this will ensure that the key targets are met.

Additional Feedback

The Trust has an SBL Lead Midwife in post who leads and advises on SBL actions and levels of compliance. The SBL Lead Midwife offers advice and guidance to maternity staff and delivers training. A comprehensive and easy to understand presentation is regularly received by staff. The presentation covers the activities and initiatives that the Trust is taking to promote compliance of the five elements.

The Trust has a dedicated public health service for pregnant patients, this is led by Public Health Midwives and supported by 'Band Four' Health in Pregnancy Support Workers. This service receives funding from Dudley Public Health which has been commissioned until March 2025. The role of Public Health Specialist Midwives is to provide expertise and leadership, alongside colleagues in Maternity, and promote the prevention of ill health and reduce avoidable health inequalities by supporting patients to have healthy pregnancies. They support the SBL Lead Midwife to ensure the Trust is compliant with the elements of the SBL care bundles.

Through our discussions it was established that the Trust has pathway support for pregnant patients who smoke. They offer support to use nicotine replacement patches via Dudley General Practitioners (GPs) and Sandwell, supported by the Dudley Health Pregnancy Support Service (HPSS) and support patients (and their partners and significant others) to stop smoking in pregnancy. The HPSS practitioners provide expertise in behaviour change techniques, treating nicotine addiction and providing ongoing support throughout pregnancy to maintain their quitting.

During the pandemic, face-to-face bookings were carried out remotely by community midwives. During this period the Trust has reflected and focused on what is better for local patients. As part of Dudley Improving Practice, the Trust has supported a project within maternity, which has resulted in the implementation of many improvements within the service, including the launch of five community hubs throughout the area. These hubs offer patients more choice of venue and environment in which they can make their first booking with a midwife.

Each patient can access their notes electronically. Furthermore, the Trust has a series of easy-to-read patient information leaflets available on their public-facing website. The Trust is additionally working towards having cards in place, where midwives will be able to handout stickers with a link or QR code to all patients so that they can access the leaflets from their phones or tablets. Hard copies of leaflets are additionally available, in addition to a variation of leaflets translated into the most used languages.

The Trust has a 'Birth Reflection Service' that is offering patients and their families an opportunity to discuss their own personal journey. The Trust has recognised that some patients (or partners) may require a reflective discussion of events surrounding labour and birth which can help bring some clarity, understanding and hopefully resolve any unanswered questions.

The Trust will soon be implementing GROW 2.O, which is an app that all Trusts can access, and gives the Trust the ability to view fundal height measurement plots and care management for patients cared for by out-of-area midwives.

The Trust's SBL presentation includes data that covers all aspects of SBL, as well as guidance on how midwives and others can implement SBL in practice, identified inclusion of the following key areas:

- Completion of Growth Assessment Protocol (GAP) score audit for more in-depth analysis of missed cases, including antenatal management and Ultrasound Scans (USS) accuracy percentage;
- Raising awareness to midwives regarding the importance of completing intrapartum documents fully with the birthweight centile, and Small-for-Gestational-Age (SGA) detection questions answered accurately;
- SBL session on their multi-professional training to provide more clarity over growth surveillance pathway; and
- GAP training yearly for all staff.

SECTION 2 - DETAILED FINDINGS AND ACTIONS

Element (including Trust status)	Measure	Status as at January 2023
Element one *Process Indicators:* A. Percentage of women where Carbon Monoxide (CO) measurement at booking is recorded: B. Percentage of women where CO measurement at 36 weeks is recorded **Trust Status: Not met** 	A Trust will fail Safety Action six if the process indicator metric compliance is less than 80%. If the process indicator scores are less than 95% Trusts must also have an action plan for achieving >95%.	A CNST update was presented to the December 2022 Trust Board which reported that part A of this element was not being met and the Trust was currently 62% compliant. This was substantiated through discussions with key personnel such as the Trust's Saving Babies Lives Lead (SBL). It was reported that *"The reason that this has not been met is due to the technical data of the element that specifies that the CO reading must be taken three days either side of the woman's booking date. Including all women in area and out of area. The Trust has continued to undertake telephone pregnancy booking appointments due to staff availability. This test requires face to face contact with the midwife and therefore a delay in CO monitoring has taken place. The team then ensures this is completed at the dating ultrasound scan. CO monitoring is undertaken at all other face to face appointments which is why we are compliant with process indicator b). Due to improvements in staffing levels, we will be in a position to cease all telephone bookings by the 01 January 2023. This will enable indicator a) to be met in 2023."* Some key points to note as part of our review of the supporting evidence is that whilst the Trust has complied with the requirement for an action plan as compliance is below 95%, we noted the following: • The Trust has an action plan in place to improve the update of CO testing at booking for pregnant patients. The action plan is dated October 2022 and records a total of four actions of which three are marked as implemented. However, we noted an outstanding amber action, which had an implementation date of 31 October 2022. The action related to the monthly monitoring of CO booking rates and corresponding feedback to Clinical Teams. The actions included a comment (recorded on the 20 September 2022) to state that discussions were being held around the data source and undertaking monthly monitoring. The Trust should revisit the action to see if it is resolved. • The action plan does not set out clear tangible targets and measures to improve compliance with the indicator. The action plan should be revisited to ensure that it captures clear steps to improve compliance, including accountable officers and implementation dates.

		The non-compliance with the maternity incentive scheme has been added to the risk register with associated actions for completion. Each action has a defined Clinical Lead, and we were informed that this is monitored via the Maternity Governance Group.
		Management action: The Trust should review the outstanding action in the Carbon Monoxide (CO) action plan to ascertain whether it is still relevant, or whether the action has been resolved. An update will be provided and reported to the appropriate forum for monitoring. **(Medium)** **Responsible Officer: Claire MacDiarmid** **Implementation Date: November 2023**
Element two *Process indicators:* Percentage of pregnancies where a risk status for fetal growth restriction (FGR) is identified and recorded using a risk assessment pathway at booking and at the 20-week scan. **Trust Status: Met** 	A Trust will fail Safety Action six if the process indicator metric compliance is less than 80%. If the process indicator scores are less than 95% Trusts must also have an action plan for achieving >95%.	**Guidelines** The Trust has a Foetal Growth Restriction (FGR) and Small for Gestational Age (SGA) Guidance (ratified on 7 December 2022). The Trust has a comprehensive diagram that shows the patient pathway for the confirmed management of FGR/SGA which they are using as prompts to encourage staff thinking. Since the introduction of new guidance, after a woman has given birth and if an undetected FGR takes place, staff can carry out a Route Cause Analysis using the guidance to ask those questions of how could this have been missed. **The Midwives prompts** The following prompt is used: Think, has the patient had any growth scans? If the answer is yes don't tick 'Low risk pregnancy'. All staff must complete GAP training on a yearly basis, which is located under the 'Growth Assessment Protocol' e-learning programme. The GAP program is provided online via E Learning for Health. The program focusses on supporting midwives and doctors to monitor foetal growth. GROW 2.0 software is also coming soon to the Trust which will assist staff in carrying out risk assessments through pregnancy and will help to identify slow growth. The software will include: • Fully electronic applications; • Assistance of the risk assessment throughout pregnancy; • Mother's app to view growth chart; • Auto-plots symphysis-fundal height and estimation of foetal weight measurements; • Identification of slow and accelerated growth; • Plotting twins and calculating twin-twin discordance; and • Includes automated growth surveillance audit. **Audits** We were provided with the statistics for the quarter two (Q2) and three (Q3) audits showing the results below the 3rd centile.

		This showed:
		• In Q2 and Q3 there were 62 babies with a birthweight below 3rd centile delivered after 38/40 weeks. Of these, three did not have growth scans. These included:
		  ○ One maternal request to delay induction of labour until 38/40; and
		  ○ Two midwife-led care by out-of-area midwife (no Ultrasound Scan),
		• 32 had growth scans but FGR (<3rd) not detected, therefore not delivered before 38/40.
		• Of these 35 babies, only three were not detected, managed, and delivered by 40/40.
		These audits demonstrate that the Trust are monitoring FGR. Each quarter they are looking at their performance, for example they are checking to ensure that the FLOW CHART guidance is being followed and that women are not being missed. They use this information to discuss practice. You can see three babies were not detected. The results of this in house audit will form part of their quality dashboards.

Element three *Process indicators*: A. Percentage of patients booked for antenatal care who had received reduced foetal movements leaflet/information by 28+0 weeks of pregnancy. B. Percentage of patients who attend with Reduced Foetal Movements (RFM) who have a computerised Cardiotocography (CTG) (a computerised system that as a minimum provides assessment of short-term variation). **Trust Status: Met**	A Trust will fail Safety Action 6 if the process indicator metric compliance is less than 80%. If the process indicator scores are less than 95% Trusts must also have an action plan for achieving >95%.	We were provided with the output of the Clinical Audit Report (extract from the Audit Management and Training (AMAT) system) which covers a period of 2 November 2022 to 16 November 2022. As part of the Audit report the following results were identified based on a sample population of 20: • Percentage of patients booked for antenatal care who had received RFM leaflet/information by 28+0 weeks of pregnancy: 100 per cent; • Percentage of patients that had foetal movements discussed at each subsequent appointment: 100 per cent; and • Percentage of patients who attend with RFM who have a computerised CTG: 95 per cent. Therefore, the Trust is using this evidence to demonstrate that they are compliant with the indicators. No action plan is required. The audit is automated via the AMAT software and therefore the Trust should continue to undertake this audit regularly. This will be monitored as part of the ongoing CNST compliance.

General Observation: The Trust has two essential posts that support the implementation and monitoring of SBL. These include: • An SBL Lead Midwife - 22.5 hours fixed term (contract expires 31 March 2023); and • A Foetal Monitoring Lead Midwife - 15 hours fixed term ((contract expires 31 March 2023). Both roles support the delivery of SBL but are not currently substantive and are due to expire in the coming months. We have raised a management action to consider these posts considering this report	**Management action 2** The Trust should review the effectiveness of the introduction of the Saving Babies Lives (SBL) Lead Midwife and Foetal Monitoring Lead Midwife positions and consider the impact of these roles should they be terminated. This would provide a view as to whether these roles should be made substantive. **(Medium)** **Responsible Officer: Claire MacDiarmid** **Implementation Date: November 2023**

APPENDIX A: SCOPE

Scope of the assignment

The internal audit assignment has been scoped as an advisory piece of work as to how The Dudley Group NHS Foundation Trust manages the following area:

Objective of the area under review
To review a sample of requirements within the CNST action plan to validate the Trusts reported status and best practice in respect of the implementation of the Saving Babies' Lives care bundle version two (SBLCBv2), published in April 2019.

Our review will focus on the following three core standards for the SBL action area six which are as follows:

Element one

Process Indicators:

- Percentage of women where Carbon Monoxide (CO) measurement at booking is recorded.
- Percentage of women where CO measurement at 36 weeks is recorded.

Element two

Process indicators:

- Percentage of pregnancies where a risk status for fetal growth restriction (FGR) is identified and recorded using a risk assessment pathway at booking and at the 20-week scan.

Element three

Process indicators:

- A. Percentage of patients booked for antenatal care who had received reduced foetal movements leaflet/information by 28+0 weeks of pregnancy.
- B. Percentage of patients who attend with Reduced Foetal Movements (RFM) who have a computerised Cardiotocography (CTG) (a computerised system that as a minimum provides assessment of short-term variation).

We will look to ensure that the Trust has evidence to support the current compliance status reported against each of the elements. We will seek to identify any areas of best practice from other organisations that we work with.

Limitations to the scope of our work:

- Testing of the SBLCBv2 will be on a sample basis only and will be agreed with management. It was determined that the review would focus on element one, two and three.
- We have not confirmed who the SBL presentation was provided to and have not reviewed the associated attendance registers.
- The focus of our work was not to validate the percentage compliance figures reported but to ensure that there was supporting evidence and documentation as to how the reported status for each was decided. We have therefore not reviewed any reported data from an accuracy perspective.
- Testing has been at a point in time only and does not provide any future guarantees.
- Our work does not provide absolute assurance that material errors, loss or fraud do not exist.

Debrief held	8 February 2023	**Internal audit Contacts**	Mike Gennard, Head of Internal Audit Mike.Gennardl@rsmuk.com / 07778 514762
Draft report issued	27 February 2023		
Responses received	2 March 2023		Alex Hire, Senior Manager Alex.Hire@rsmuk.com / 07970 641757
Final report issued	2 March 2023		
			Laura Gough, Manager Laura.Gough@rsmuk.com / 07436 268324
		Client sponsor	Mary Sexton, Chief Nurse
		Distribution	Mary Sexton, Chief Nurse

rsmuk.com

Paper for submission to the Board of Directors on the 11th May 2023

Title:	Infection Prevention and Control Board Assurance Framework
Author:	Liz Watkins - DDIPC
Presenter:	Mary Sexton – Chief Nurse and DIPC

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

Recommendations:

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.

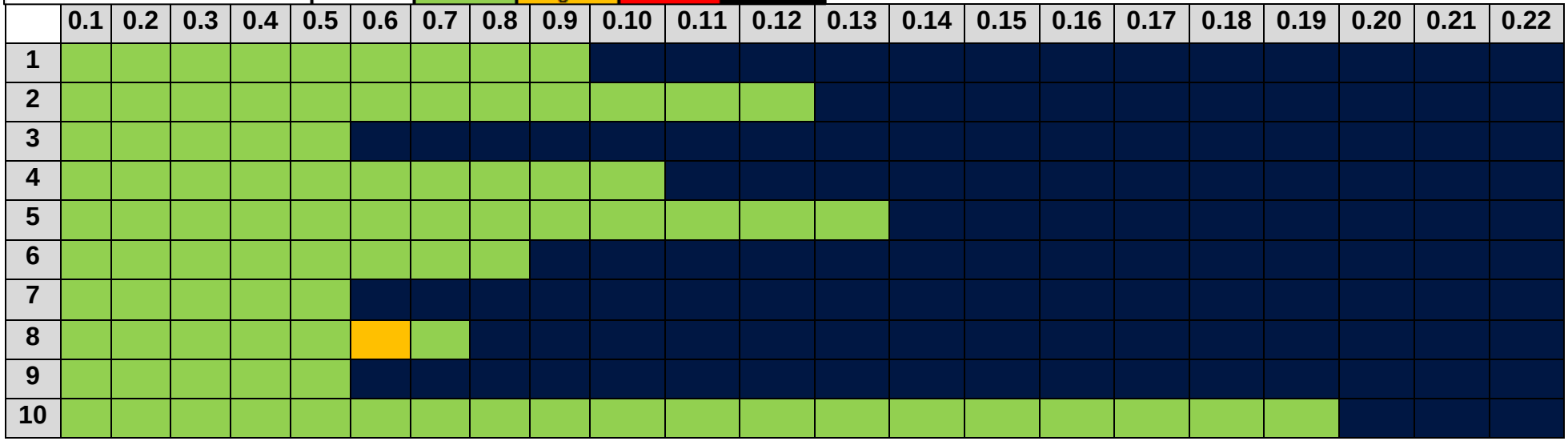
There are no red non-compliant areas, there is one amber area with mitigations in place. The IPC Group and wider Trust team continue to progress this work stream.

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: *Inc risk ref number*	
	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 *(if applicable)*	Working / Exec Group	Y	Date:
	Quality and Safety Committee	Y/N	Date: 24/02/23 – no recommendations made
	Board of Directors	Y	Date: 11th May 2023
	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



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			

Workforce KPI Report

FURTHER READING PACK

The Dudley Group NHS Foundation Trust

Alan Duffell
Interim Chief People Officer

Summary

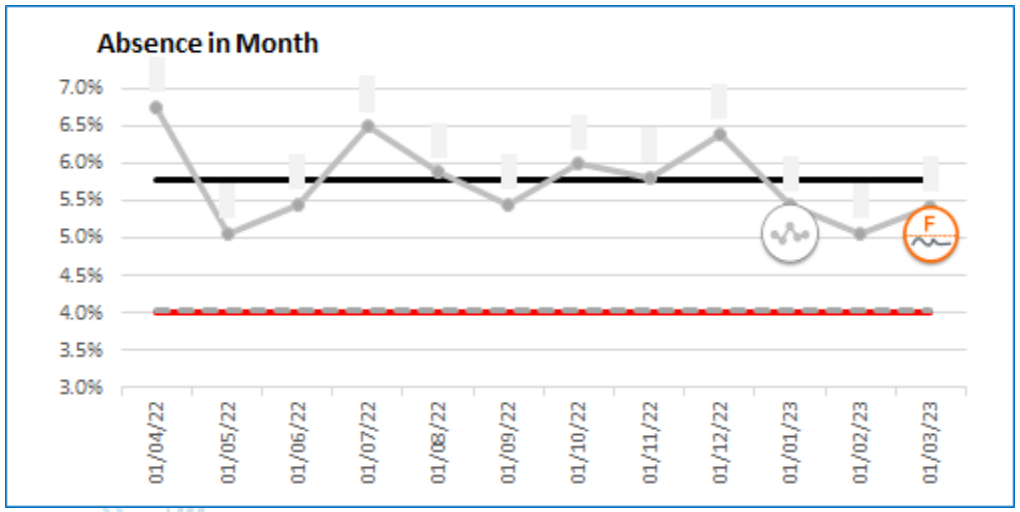
The Dudley Group NHS Foundation Trust

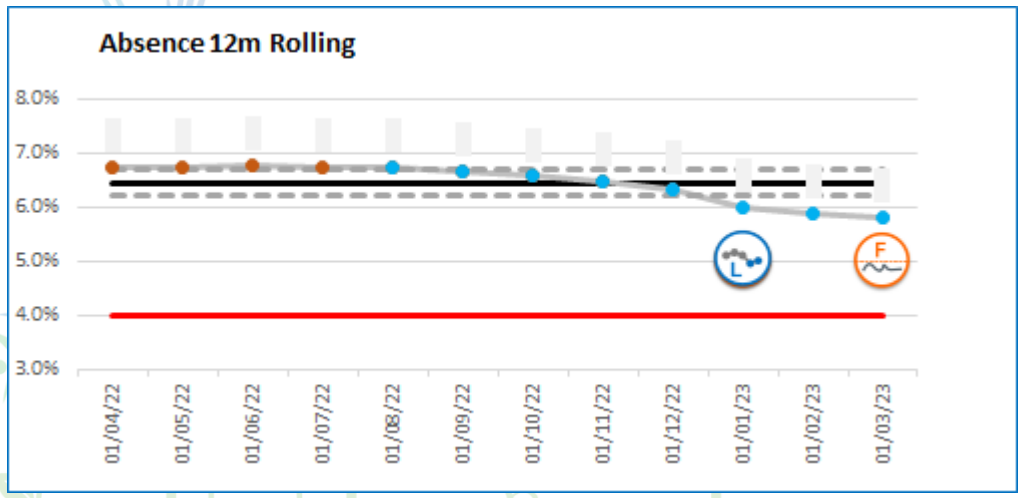
Absence – In Month	**5.42%**	↑	**Sickness Absence** • In month sickness absence for March is 5.42% an increase from 5.06% in February. • The rolling 12-month absence shows a reduction from 5.90% in February to 5.81% in March 2023. The impact of COVID-19 being represented across the full year figure is starting to reduce.
Absence - 12m Rolling	**5.81%**	↓	
Turnover	**7.38%**	↓	**Turnover** • Turnover (all terminations) has decreased from 7.84% in February to 7.38% in March 2023
Normalised Turnover	**3.99%**	↓	• Normalised Turnover (voluntary resignation) has decreased from 4.14% in February to 3.99% in March 2023.
Vacancy Rate	**7%**	→ ←	**Vacancy Rate** • The vacancy rate has remained at 7% • The total vacancies in March are 402.33 WTE a reduction from 434.13 WTE in February 2023
Mandatory Training	**86.82%**	↑	**Mandatory Training** • Statutory Training has increased from 85.45% in February 2023 to 86.82% in March 2023 . (As of 25/04/23 – this is 87.61%)
Appraisals	**70.8%**	↑	**Appraisals** • The appraisal rate has increased from 68.7% in February 2023 to 70.8% in March. The 22/23 appraisal window has now closed and the 23/24 window runs from April-July (As of 25/04/23– this is 3.4%)

CARE RESPECT RESPONSIBILITY

Sickness Absence

The Dudley Group NHS Foundation Trust





In-Month Sickness Absence

In month sickness absence for March is 5.42% an increase from 5.06% in February. it should be noted that whilst short term and long term have show a decrease, the overall increase from February is due to February being a short month.

Rolling 12 M Sickness Absence

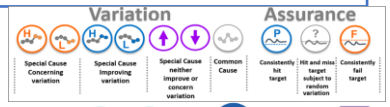
The rolling 12-month absence shows a reduction from 5.90% in February to 5.81% in March 2023. The impact of COVID-19 being represented across the full year figure is starting to reduce.

Assurance

Reducing the length of absence is key, to support this we are reviewing how we can support overall wellbeing for our staff members, including the development of a wellbeing strategy.

The main objective is to avoid absences and, where absences do occur, reduce their length, so early intervention is key and is supported by the following discrete pieces of work:

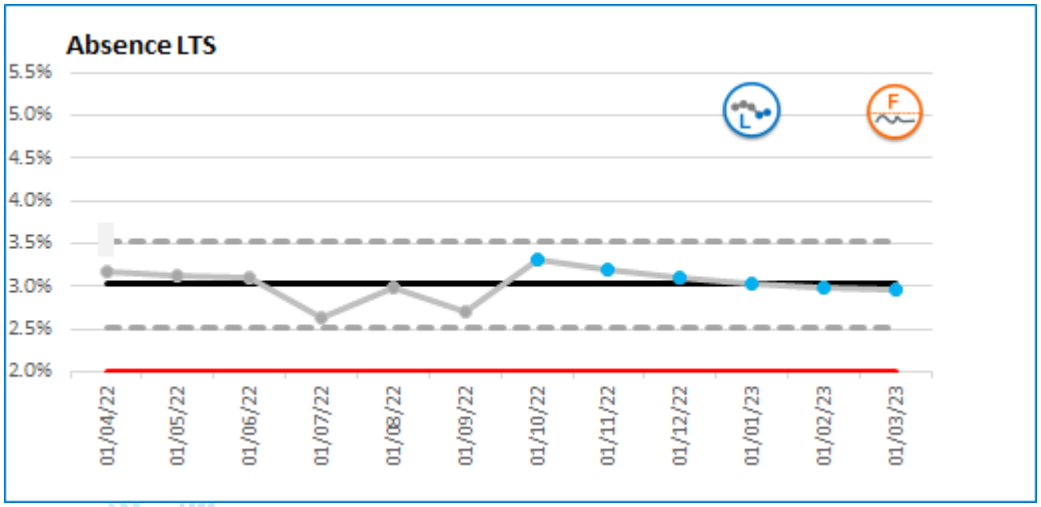
	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
Absence in Month	6.74%	5.06%	5.44%	6.48%	5.87%	5.44%	5.98%	5.80%	6.39%	5.43%	5.06%	5.42%
Absence 12m Rolling	6.73%	6.76%	6.77%	6.74%	6.76%	6.66%	6.58%	6.50%	6.34%	6.00%	5.90%	5.81%

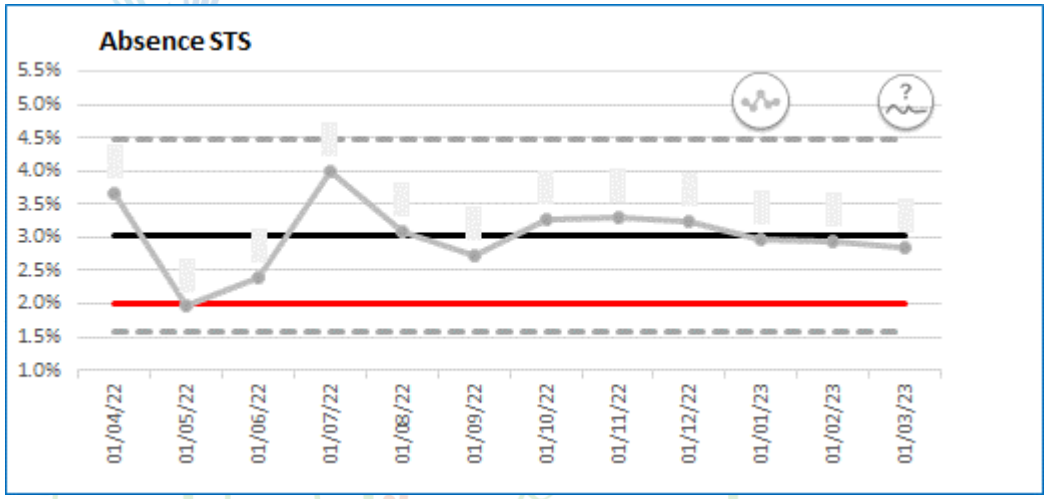


CARE RESPECT RESPONSIBILITY

Long-Term and Short-Term Absence

The Dudley Group NHS Foundation Trust





Long-Term and Short-Term Sickness Absence

In March there has been minimal decrease in long term absence, which is sitting just below 3% and a decrease in short term absence from 2.93% in February to 2.85% in March.

The graphs evidence a continuing decrease in long-term absence. Short-term absence also decreased slightly from November 2022.

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.

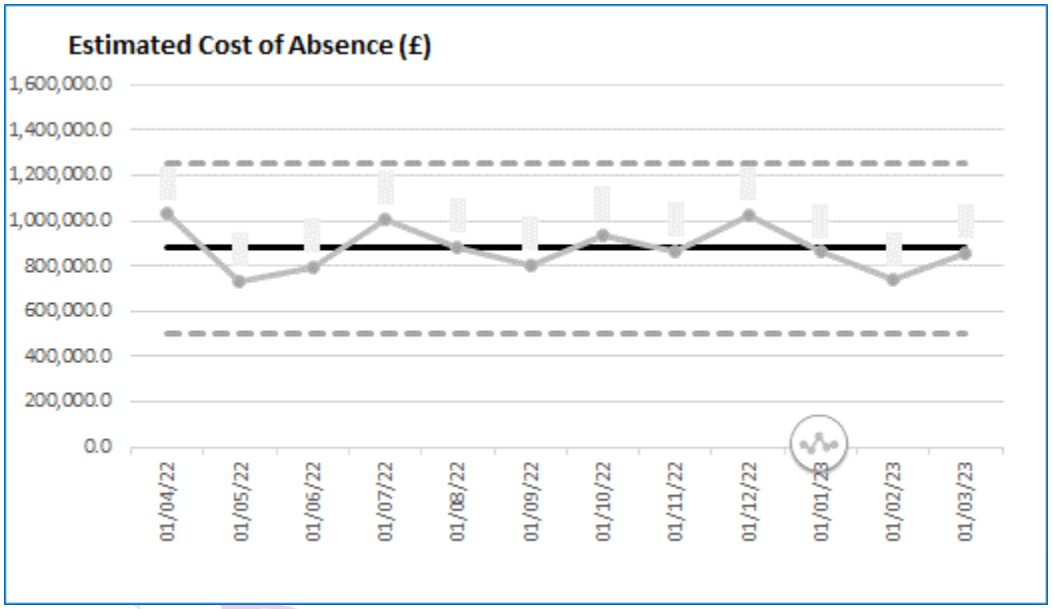
Short-term absence is currently the key focus.

	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
Absence LTS	3.17%	3.12%	3.11%	2.62%	2.97%	2.70%	3.30%	3.20%	3.10%	3.03%	2.97%	2.96%
Absence STS	3.63%	1.96%	2.40%	3.99%	3.08%	2.74%	3.28%	3.30%	3.24%	2.97%	2.93%	2.85%

CARE RESPECT RESPONSIBILITY

Estimated Cost of Absence

The Dudley Group
NHS Foundation Trust



Estimated Cost of Absence

The estimated cost of absence for March 2023 is £858,936 compared to £735,312 in February 2023

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

	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
Estimated Cost of Absence (£)	£ 1,027,706	£ 732,834	£ 793,277	£ 1,006,272	£ 882,113	£ 804,352	£ 935,886	£ 861,583	£ 1,023,406	£ 859,668	£ 735,312	£ 858,936

CARE RESPECT RESPONSIBILITY

Sickness Absence

The Dudley Group NHS Foundation Trust

Top 10 Departments By Time Lost (March)

Department	Abs (FTE)	Avail (FTE)	Absence % (FTE)
253 Maternity Unit Serv	376.49	5,983.77	6.29%
253 Ward EAU Serv	358.04	5,428.28	6.60%
253 Emergency Dept Nursing Serv	333.92	3,807.65	8.77%
253 Critical Care Serv	305.60	4,089.95	7.47%
253 Pathology - Phlebotomy Serv	292.25	1,927.45	15.16%
253 Ward C8 Serv	230.80	2,510.32	9.19%
253 Ward C7 Serv	205.48	2,002.36	10.26%
253 Ward CCU Serv	188.12	1,869.51	10.06%
253 Staff Bank Admin Team Serv	186.00	372.00	50.00%
253 Therapy Department Serv	173.85	4,048.35	4.29%

Top 10 Departments By Absence Rate (March)

Department	Abs (FTE)	Avail (FTE)	Absence % (FTE)
253 Ambulatory Neurology CNS Serv	55.80	86.80	64.29%
253 Staff Bank Admin Team Serv	186.00	372.00	50.00%
253 Acute Oncology Serv	31.00	93.00	33.33%
253 Charitable Funds Fundraising Serv	31.60	99.00	31.92%
253 Respiratory - Lung Cancer Nurse Serv	39.00	148.80	26.21%
253 Contraception & Sexual Health Serv	72.67	311.24	23.35%
253 HR Occupational Health Serv	34.96	153.76	22.74%
253 Imaging - Nuclear Medicine Serv	44.16	210.68	20.96%
253 Treasury Serv	31.00	156.08	19.86%
253 Mgt Team Integrated Care Serv	29.00	155.00	18.71%

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

Absence Reason	Headcount	Abs Occurrences	FTE Days Lost	%
S10 Anxiety/stress/depression/other psychiatric illnesses	743	949	22,988.65	20.9
Other	2003	2,383	14,445.08	13.1
S12 Other musculoskeletal problems	516	630	9,634.54	8.7
S13 Cold, Cough, Flu - Influenza	2173	2,855	9,269.50	8.4
S25 Gastrointestinal problems	1855	2,552	9,053.07	8.2
S99 Unknown causes / Not specified	527	625	5,264.03	4.8
S30 Pregnancy related disorders	230	569	5,019.88	4.6
S28 Injury, fracture	206	224	4,209.23	3.8
S26 Genitourinary & gynaecological disorders	333	413	3,798.75	3.4
S11 Back Problems	243	283	3,789.66	3.4

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

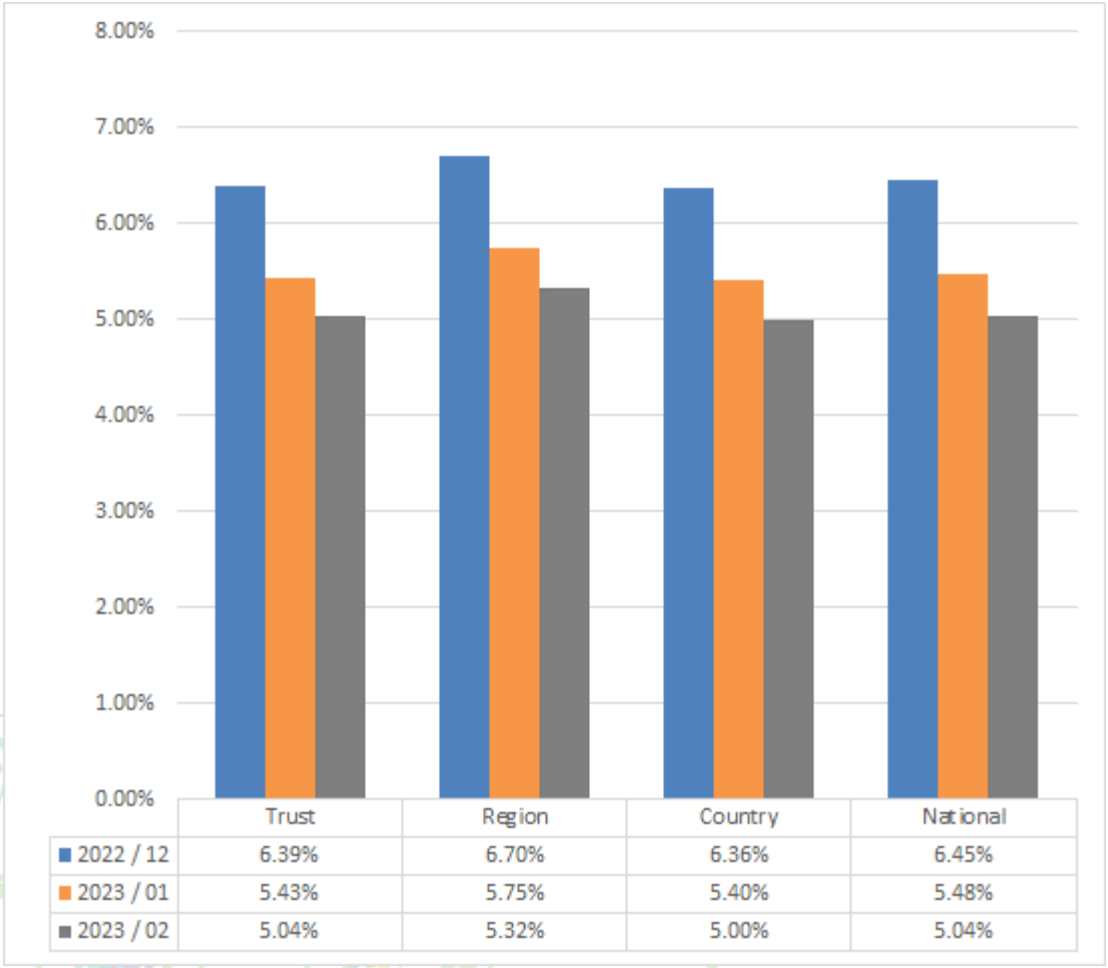
Absence Reason	Headcount	Abs Occurrences	Abs Days	Abs Estimated Cost	%
S10 Anxiety/stress/depression/other psychiatric illnesses	743	949	27,486	£2,055,613.89	21.4
Other	2003	2,383	16,799	£1,521,234.44	13.1
S12 Other musculoskeletal problems	516	630	11,452	£816,912.67	8.9
S13 Cold, Cough, Flu - Influenza	2173	2,855	10,592	£952,752.39	8.2
S25 Gastrointestinal problems	1855	2,552	10,342	£815,307.40	8.1
S99 Unknown causes / Not specified	527	625	5,965	£535,078.59	4.6
S30 Pregnancy related disorders	230	569	5,627	£470,840.79	4.4
S28 Injury, fracture	206	224	4,890	£391,562.62	3.8
S26 Genitourinary & gynaecological disorders	333	413	4,525	£365,167.37	3.5
S11 Back Problems	243	283	4,500	£313,981.13	3.5

Absence Reasons

- Excluding COVID-19 the most common reasons for absence are Anxiety, Stress, and Depression (ASD), musculoskeletal 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 / 12	6.39%	6.70%	6.36%	6.45%
2023 / 01	5.43%	5.75%	5.40%	5.48%
2023 / 02	5.04%	5.32%	5.00%	5.04%

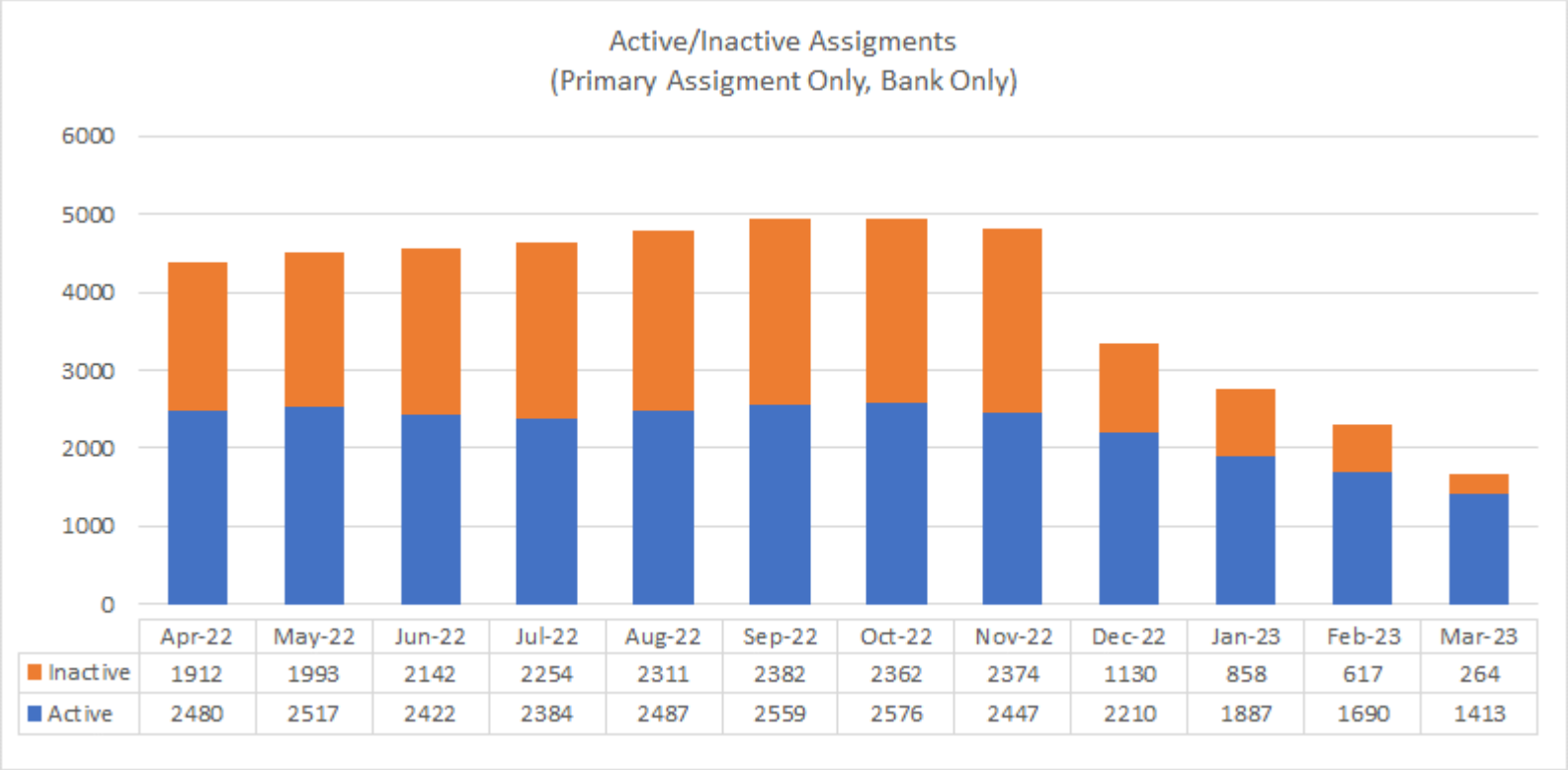
Benchmarking

- National and Regional benchmarking data is only available until end of February.
- 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 February, the Trust's sickness absence rate was slightly lower than the regional position and comparable with the national sickness absence figures.

CARE RESPECT RESPONSIBILITY

Active / Inactive Assignments

The Dudley Group
NHS Foundation Trust



	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
Inactive	1912	1993	2142	2254	2311	2382	2362	2374	1130	858	617	264
Active	2480	2517	2422	2384	2487	2559	2576	2447	2210	1887	1690	1413

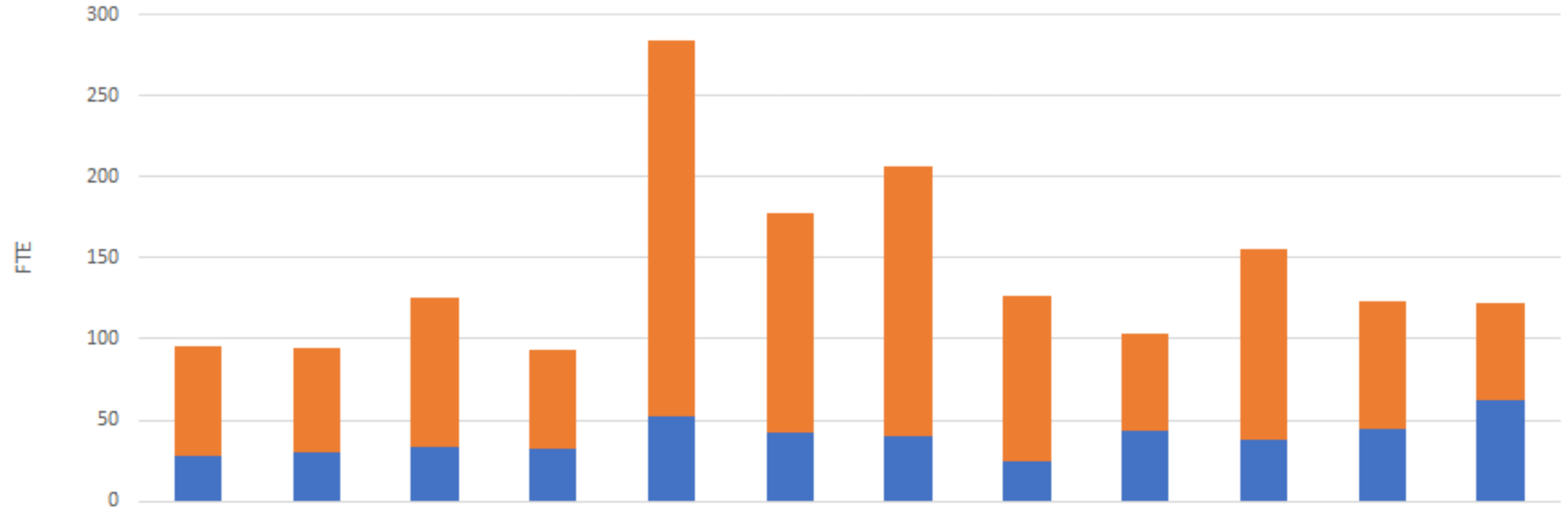
Bank Efficiency

There are 1,677 bank assignments registered on the Trust's Staff Bank, a reduction from 2307 in February 2023. This corresponds with the data cleanse exercise currently taking place in relation to inactive bank staff and the closure of the vaccination workforce bureau. We now have 264 inactive records as opposed to the 617 previously recorded as inactive (not worked in 17-week period).

CARE RESPECT RESPONSIBILITY

Starters and Leavers

The Dudley Group NHS Foundation Trust



	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
Starters FTE	67.42	64.05	92.43	61.12	232.11	135.04	165.91	101.32	59.87	118.15	78.99	60.42
Leavers FTE	27.83	30.04	33.33	32.19	52.26	42.2	40.19	24.91	43.76	37.76	44.49	62.2

Starters vs Leavers

- For the first time since October 2021, leavers have exceeded starters in March 2023.

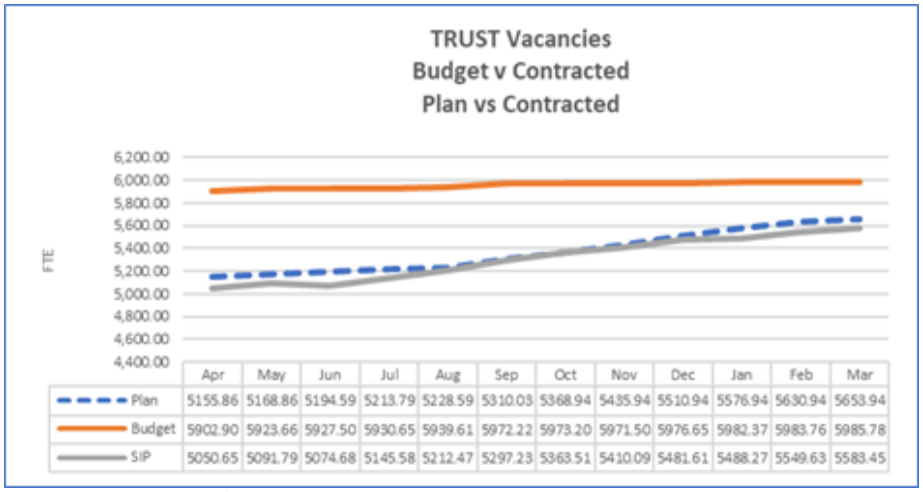
Assurance

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

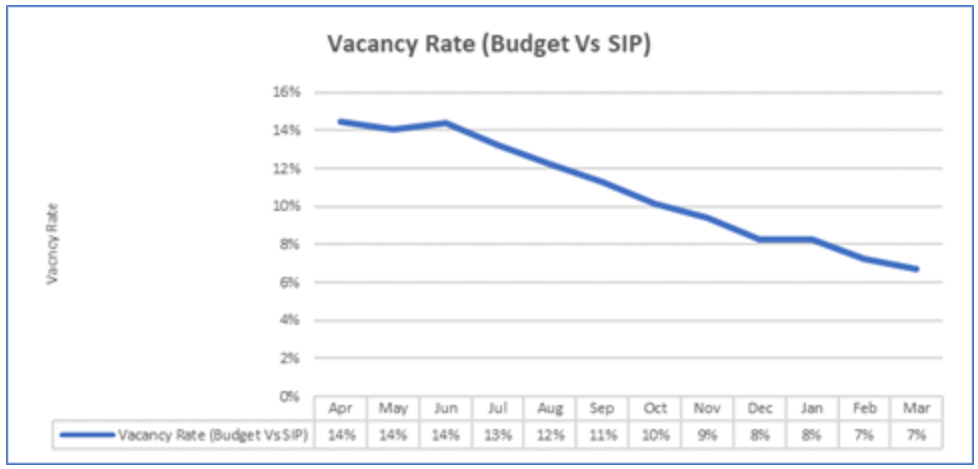
CARE RESPECT RESPONSIBILITY

Recruitment/Vacancies/Turnover - TRUST

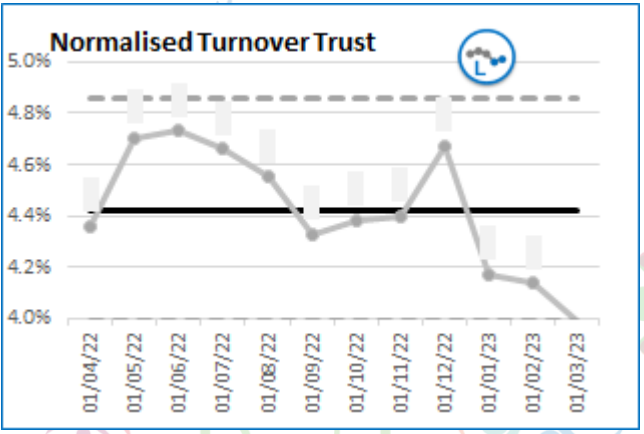
The Dudley Group
NHS Foundation Trust

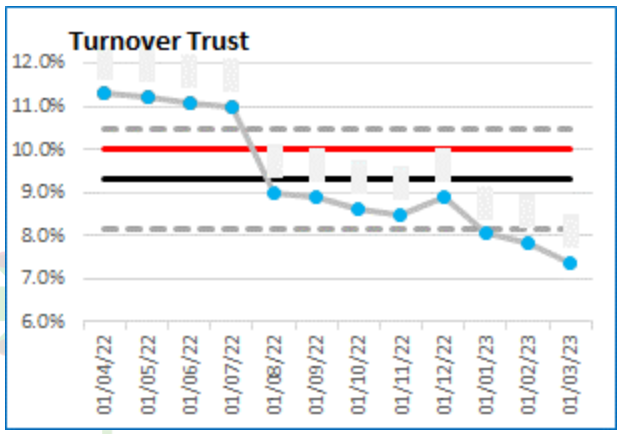


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Plan	5155.86	5168.86	5194.59	5213.79	5228.59	5310.03	5368.94	5435.94	5510.94	5576.94	5630.94	5653.94
Budget	5902.90	5923.66	5927.50	5930.65	5939.61	5972.22	5973.20	5971.50	5976.65	5982.37	5983.76	5985.78
SIP	5050.65	5091.79	5074.68	5145.58	5212.47	5297.23	5363.51	5410.09	5481.61	5488.27	5549.63	5583.45



	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%	7%	7%





	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
Trust Turnover	11.29%	11.20%	11.07%	11.00%	8.99%	8.90%	8.64%	8.50%	8.90%	8.04%	7.84%	7.38%
Trust Normalised Turnover	4.36%	4.70%	4.73%	4.66%	4.55%	4.33%	4.38%	4.40%	4.67%	4.17%	4.14%	3.99%

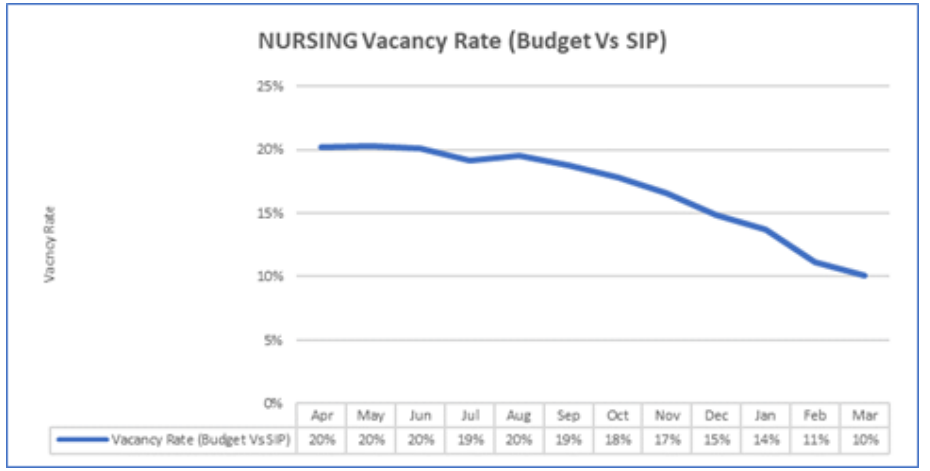
- Contracted WTE staff has increased 5549.63 in February 2023 to 5583.45 in March 2023. This is 70.49 WTE under the workforce plan.
- The total vacancies in March are 402.33 WTE a reduction from 434.13 WTE in February 2023. This equates to a vacancy factor of 7%.
- There are recruitment activity in place for 391.18 WTE of the vacancies.
- Overall staff turnover (rolling twelve months average) is at 7.38%, with normalised turnover at 3.99%.

CARE RESPECT RESPONSIBILITY

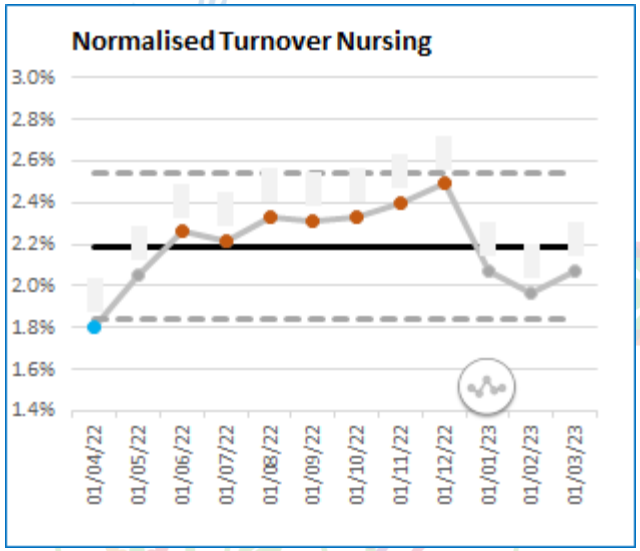
Recruitment/Vacancies/Turnover - Registered Nursing

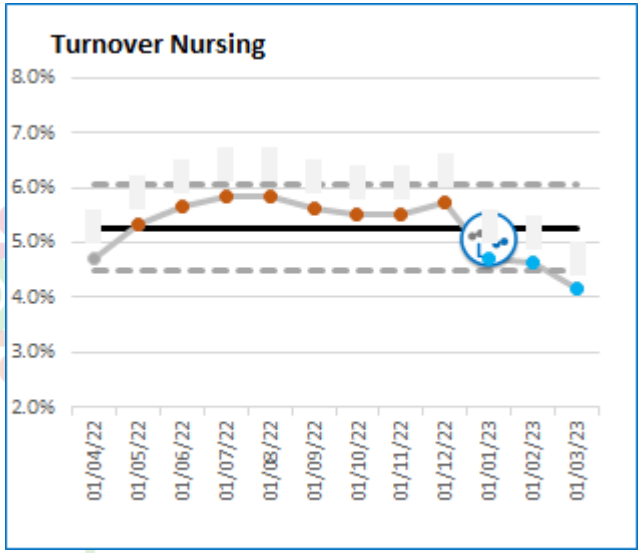
The Dudley Group NHS Foundation Trust

	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	1984.67	1984.66
SIP	1570.65	1576.32	1574.49	1593.63	1590.93	1609.95	1633.29	1655.63	1688.98	1711.3	1762.74	1785.09



	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%	11%	10%



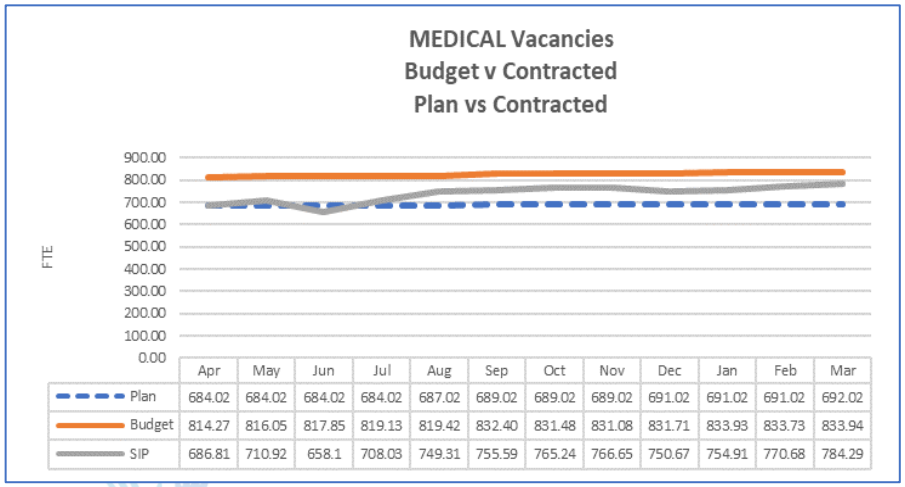


- Contracted WTE for nursing staff has increased from 1762.74 in February 2023 to 1785.09 in March 2023. This is 151.75 WTE under the workforce plan.
- The total nursing vacancies reported stands at 199.57, a reduction from 221.93 WTE in February 2023. This is a reduction from 11% to 10%.
- It should be noted that there are 165 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 34.57 WTE.
- Staff turnover for nursing (rolling 12 months average) is at 4.14%, with normalised turnover at 2.07%.

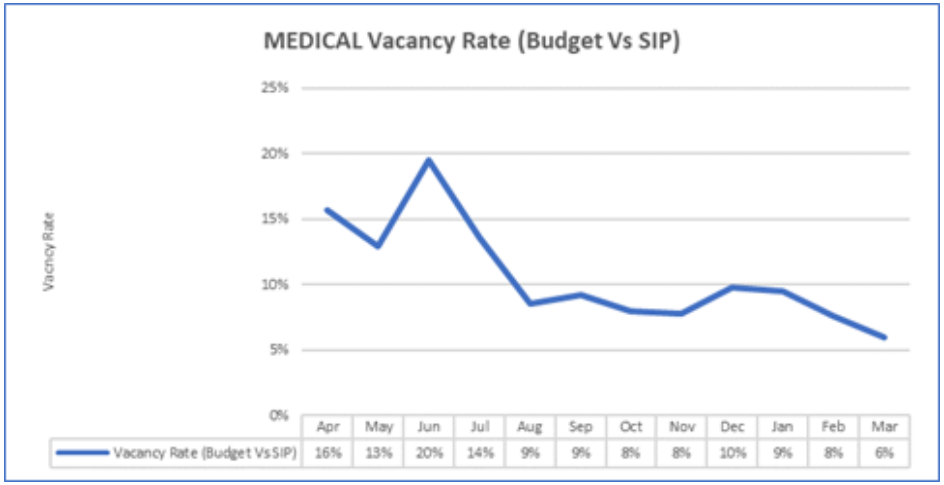
	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
Nursing Turnover	4.70%	5.33%	5.64%	5.84%	5.84%	5.63%	5.50%	5.50%	5.72%	4.72%	4.62%	4.14%
Nursing Normalised Turnover	1.80%	2.05%	2.26%	2.22%	2.33%	2.31%	2.33%	2.40%	2.49%	2.07%	1.97%	2.07%

Recruitment/Vacancies/Turnover - Medical & Dental

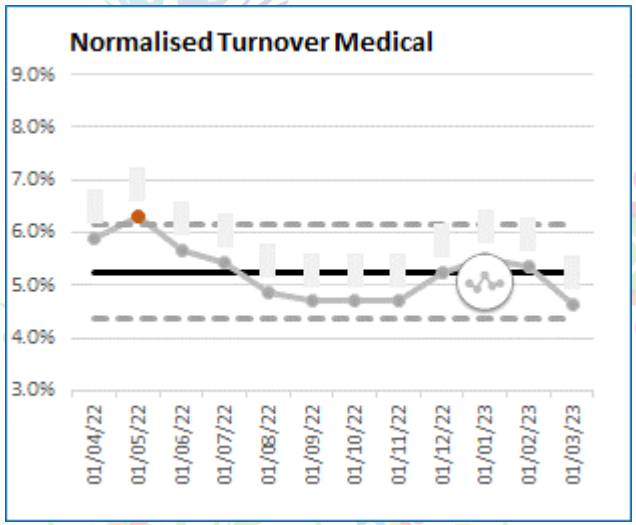
The Dudley Group NHS Foundation Trust

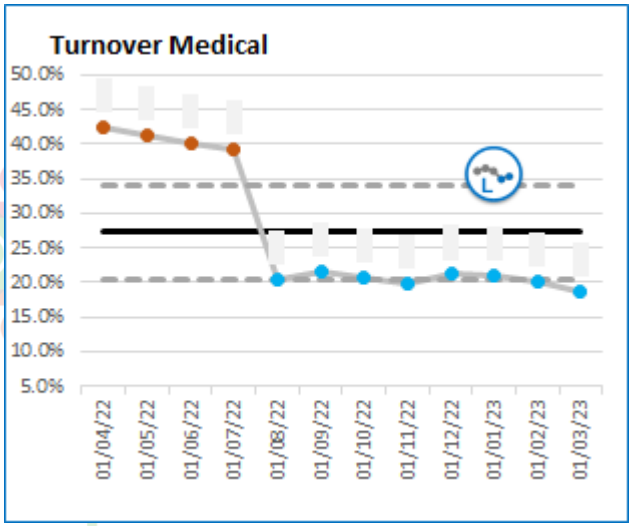


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Plan	684.02	684.02	684.02	684.02	687.02	689.02	689.02	689.02	691.02	691.02	691.02	692.02
Budget	814.27	816.05	817.85	819.13	819.42	832.40	831.48	831.08	831.71	833.93	833.73	833.94
SIP	686.81	710.92	658.1	708.03	749.31	755.59	765.24	766.65	750.67	754.91	770.68	784.29



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Vacancy Rate (Budget Vs SIP)	16%	13%	20%	14%	9%	9%	8%	8%	10%	9%	8%	6%





- Contracted WTE for medical and dental staff has increased from 770.68 WTE in February 2023 to 784.29 WTE in March 2023. This is 92.27 WTE above plan.
- The total medical and dental vacancies stands at 49.65 WTE. The vacancy rate is 6%.
- Staff turnover for medical and dental (rolling 12 months average) has reduced to 18.75%, with normalised turnover reducing to 4.65%.

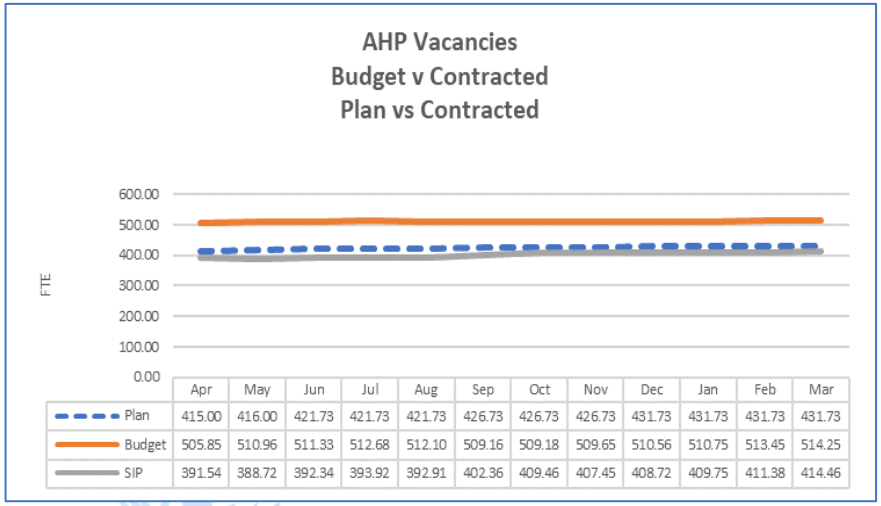
	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
M&D Turnover	42.50%	41.40%	40.21%	39.37%	20.42%	21.52%	20.63%	19.90%	21.18%	21.12%	20.10%	18.75%
M&D Normalised Turnover	5.90%	6.30%	5.66%	5.44%	4.85%	4.69%	4.69%	4.69%	5.24%	5.50%	5.36%	4.65%

RESPECT

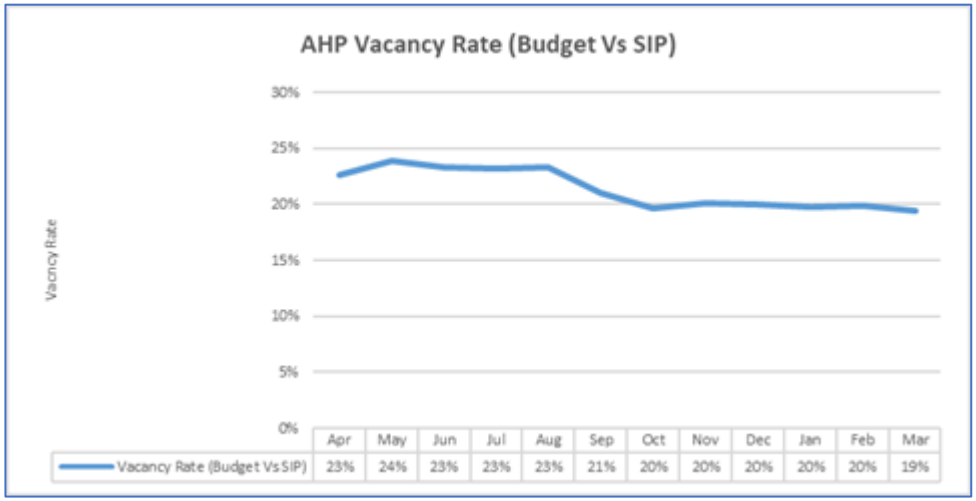
RESPONSIBILITY

Recruitment/Vacancies/Turnover - Allied Health Professional

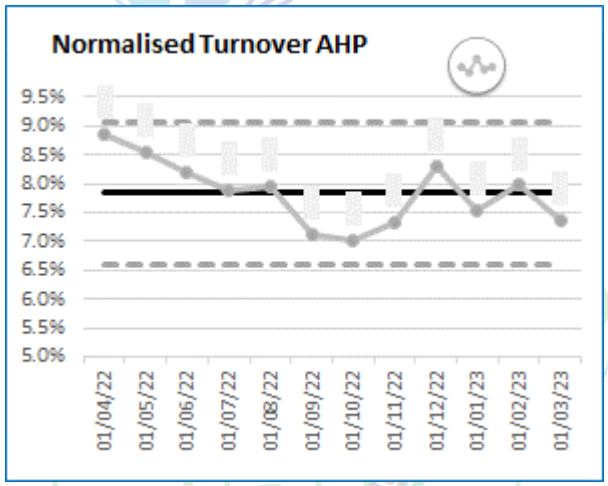
The Dudley Group NHS Foundation Trust

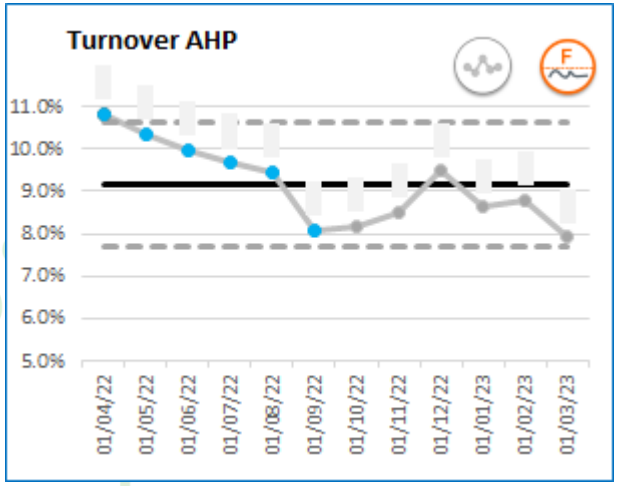


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Plan	415.00	416.00	421.73	421.73	421.73	426.73	426.73	426.73	431.73	431.73	431.73	431.73
Budget	505.85	510.96	511.33	512.68	512.10	509.16	509.18	509.65	510.56	510.75	513.45	514.25
SIP	391.54	388.72	392.34	393.92	392.91	402.36	409.46	407.45	408.72	409.75	411.38	414.46



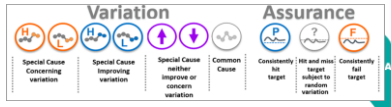
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Vacancy Rate (Budget Vs SIP)	23%	24%	23%	23%	23%	21%	20%	20%	20%	20%	20%	19%





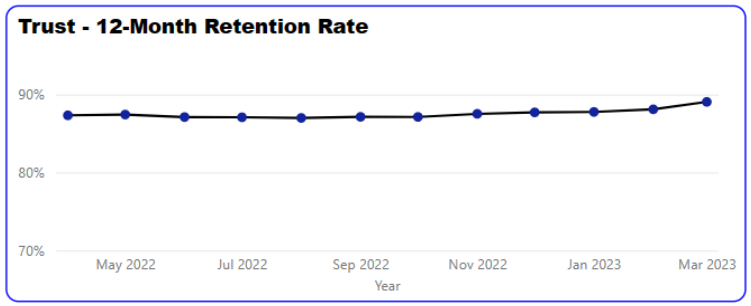
- Contracted WTE for AHP staff has increased from 411.38 in February 2023 to 141.46 in March 2023. This is 17.27 WTE below plan.
- The total AHP vacancies stands at 99.79 WTE. The vacancy rate is 19%.
- Staff turnover for AHP Staff (rolling 12 months average) is 7.91%, with normalised turnover reducing to 7.37%.

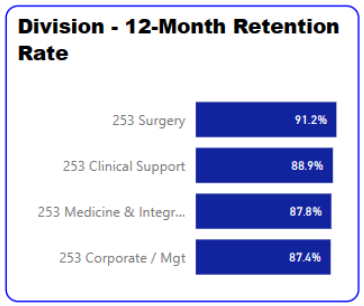
	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
AHP Turnover	10.82%	10.33%	9.98%	9.67%	9.44%	8.07%	8.18%	8.50%	9.47%	8.62%	8.80%	7.91%
AHP Normalised Turnover	8.86%	8.54%	8.19%	7.89%	7.95%	7.13%	7.01%	7.32%	8.29%	7.53%	7.97%	7.37%

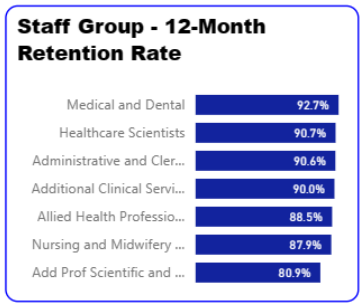


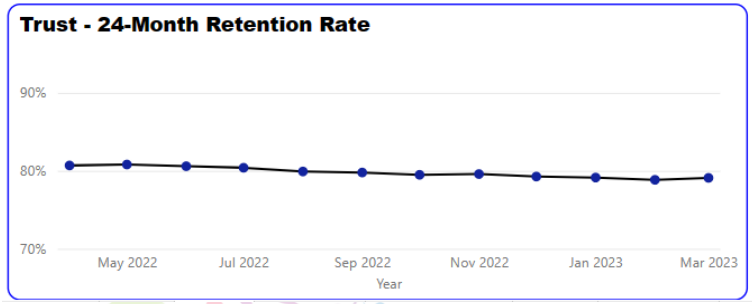
Retention

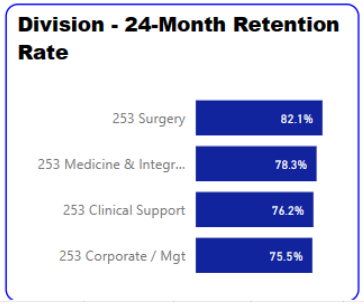
The Dudley Group
NHS Foundation Trust

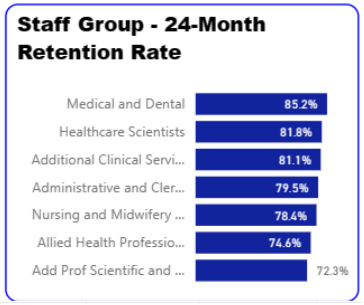












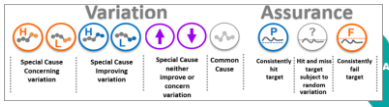
March 2023

12-Month	Trust 89.1%
24-Month	Trust 79.1%

Workforce have developed a retention metric to ensure we are able to retain our workforce. Employee retention improves stability and promotes a better patient experience. In addition, by improving retention we can address employee turnover costs, low staff engagement, poor quality of care with a view to increasing efficiency and developing a positive organisational culture.

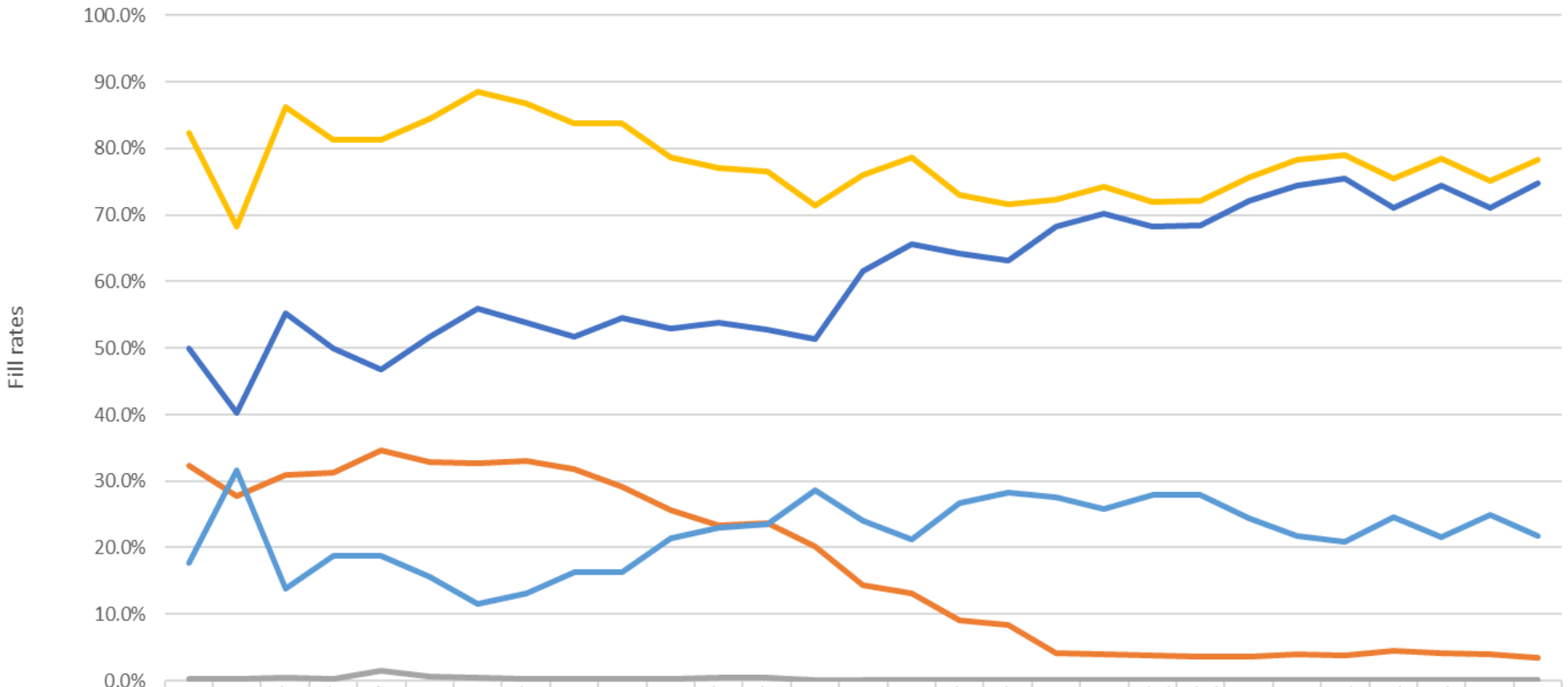
The 12 month retention rate has shown a slight increase from 88.1% in February to 89.10% in March. The 24 month rate has also show slight improvement from 78.8% in February to 79.1% in March

The division with the lowest retention rate is Corporate Services at 75.5% over 24 months; both Additional Professional, Scientific and Technical staff and Allied Health Professionals are two staff groups that show as areas for concern.



Registered Overall Fill Rates

The Dudley Group NHS Foundation Trust



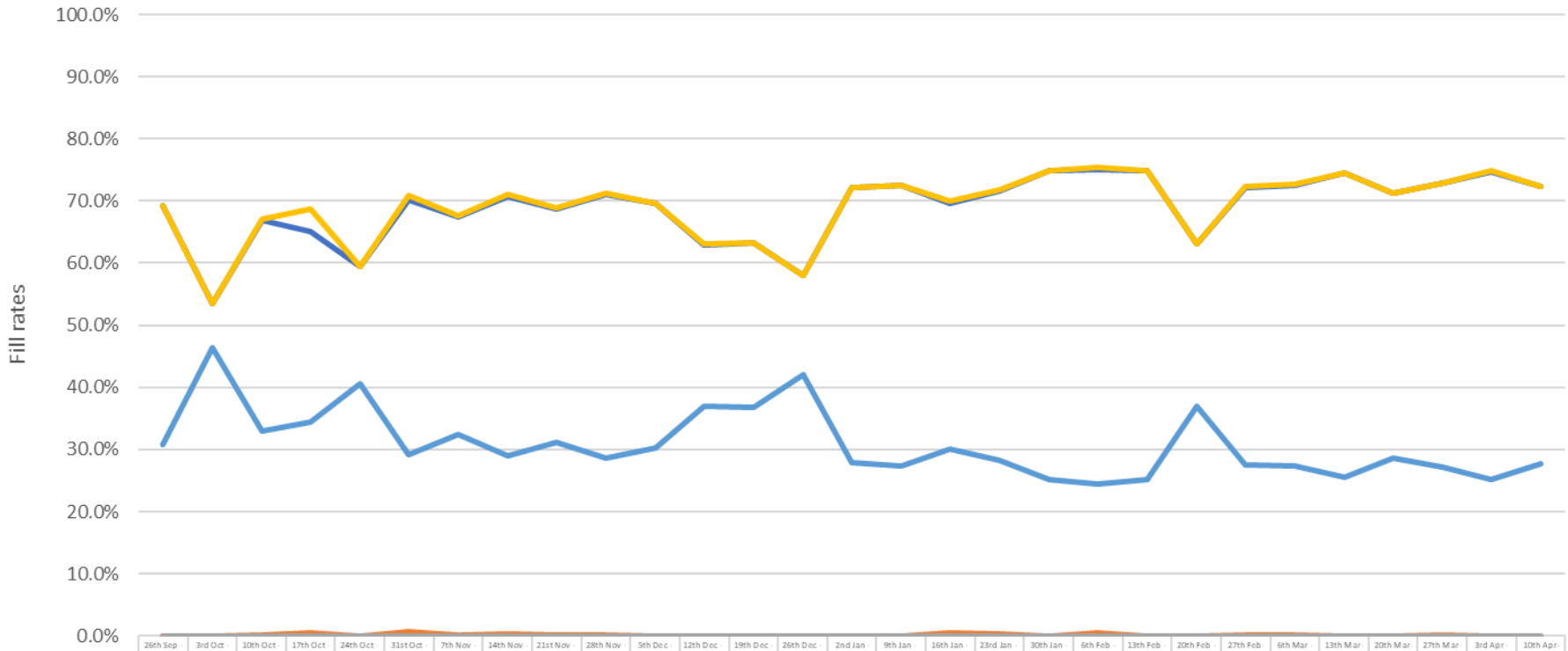
	26th Sep - 2nd Oct	3rd Oct - 9th Oct	10th Oct - 16th Oct	17th Oct - 23rd Oct	24th Oct - 30th Oct	31st Oct - 6th Nov	7th Nov - 13th Nov	14th Nov - 20th Nov	21st Nov - 27th Nov	28th Nov - 4th Dec	5th Dec - 11th Dec	12th Dec - 18th Dec	19th Dec - 25th Dec	26th Dec - 1st Jan	2nd Jan - 8th Jan	9th Jan - 15th Jan	16th Jan - 22nd Jan	23rd Jan - 29th Jan	30th Jan - 5th Feb	6th Feb - 12th Feb	13th Feb - 19th Feb	20th Feb - 26th Feb	27th Feb- 5th Mar	6th Mar - 12th Mar	13th Mar-19th Mar	20th Mar-26th Mar	27th Mar-2nd Apr	3rd Apr - 9th Apr	10th Apr- 16th Apr
Bank Filled	50.0%	40.2%	55.3%	50.0%	46.7%	51.7%	55.9%	53.8%	51.7%	54.5%	52.9%	53.8%	52.8%	51.3%	61.6%	65.6%	64.2%	63.2%	68.2%	70.2%	68.3%	68.5%	72.1%	74.4%	75.5%	71.1%	74.4%	71.1%	74.8%
Agency Filled	32.3%	27.8%	30.9%	31.3%	34.7%	32.8%	32.7%	33.0%	31.8%	29.2%	25.7%	23.3%	23.7%	20.1%	14.4%	13.1%	9.1%	8.4%	4.2%	4.0%	3.7%	3.6%	3.6%	3.9%	3.7%	4.4%	4.1%	4.0%	3.5%
Non-Framework	0.2%	0.2%	0.4%	0.3%	1.5%	0.6%	0.5%	0.3%	0.2%	0.3%	0.3%	0.4%	0.4%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Overall Fill Rate	82.3%	68.3%	86.2%	81.3%	81.3%	84.4%	88.5%	86.8%	83.7%	83.8%	78.6%	77.1%	76.5%	71.4%	76.0%	78.7%	73.1%	71.7%	72.4%	74.2%	72.0%	72.1%	75.6%	78.3%	79.1%	75.5%	78.5%	75.1%	78.3%
Unfilled Duties	17.7%	31.7%	13.8%	18.7%	18.7%	15.6%	11.5%	13.2%	16.3%	16.3%	21.4%	22.9%	23.5%	28.6%	24.0%	21.3%	26.7%	28.3%	27.6%	25.8%	28.0%	27.9%	24.4%	21.7%	20.9%	24.5%	21.5%	24.8%	21.7%

In March (27/02/23 – 02/04/23) 9153 duties were requested compared to 6882 requested in February (30/01/23 – 26/02/23). The overall fill rate for March was 73%, the average bank fill rate in March was 74% compared to 76% in February. This reporting period is 5 weeks as opposed to 4 in February.

CARE RESPECT RESPONSIBILITY

Un-Registered Overall Fill Rates

The Dudley Group
NHS Foundation Trust



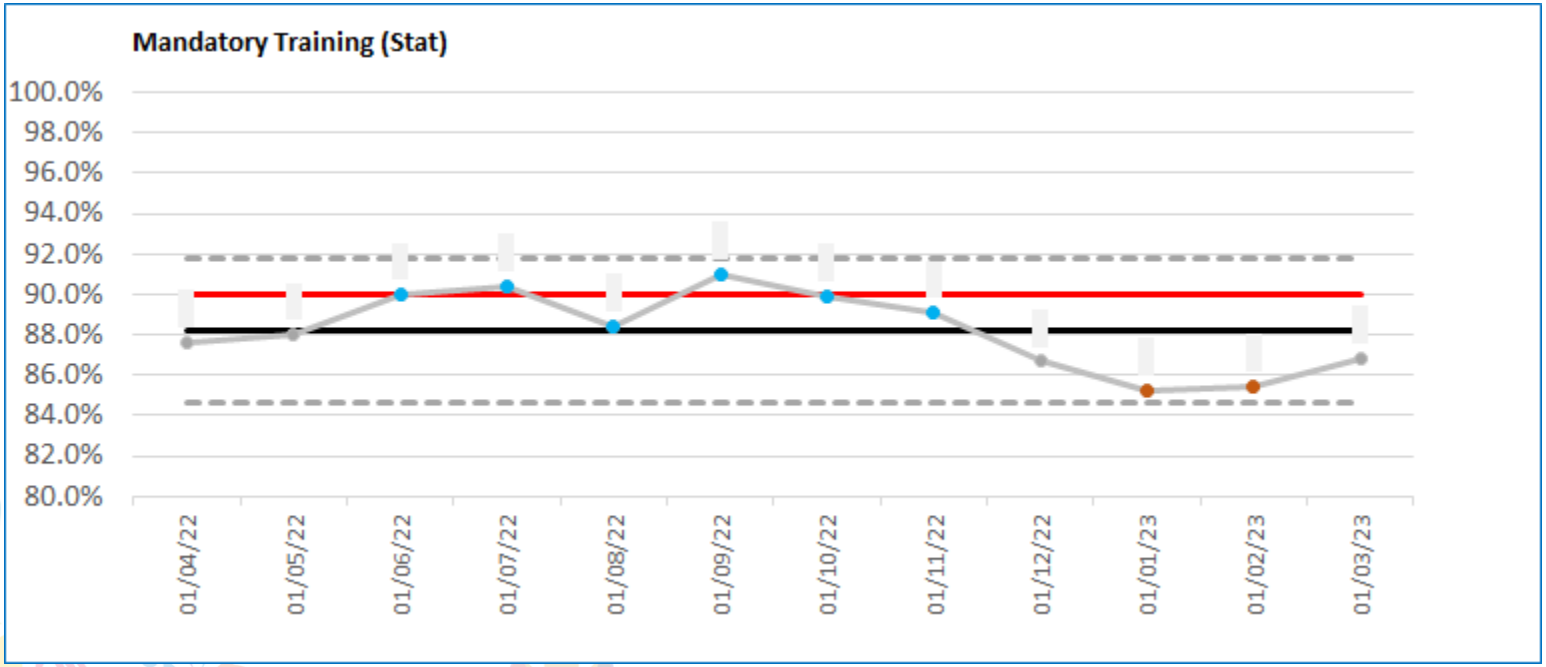
	26th Sep - 2nd Oct	3rd Oct - 9th Oct	10th Oct - 16th Oct	17th Oct - 23rd Oct	24th Oct - 30th Oct	31st Oct - 6th Nov	7th Nov - 13th Nov	14th Nov - 20th Nov	21st Nov - 27th Nov	28th Nov - 4th Dec	5th Dec - 11th Dec	12th Dec - 18th Dec	19th Dec - 25th Dec	26th Dec - 1st Jan	2nd Jan - 8th Jan	9th Jan - 15th Jan	16th Jan - 22nd Jan	23rd Jan - 29th Jan	30th Jan - 5th Feb	6th Feb - 12th Feb	13th Feb - 19th Feb	20th Feb - 26th Feb	27th Feb - 5th Mar	6th Mar - 12th Mar	13th Mar - 19th Mar	20th Mar - 26th Mar	27th Mar - 2nd Apr	3rd Apr - 9th Apr	10th Apr - 16th Apr
Bank Filled	69.3%	53.5%	66.9%	65.0%	59.5%	70.2%	67.5%	70.7%	68.7%	71.1%	69.7%	62.9%	63.2%	58.0%	72.1%	72.6%	69.6%	71.6%	74.8%	75.1%	74.9%	63.1%	72.2%	72.5%	74.5%	71.2%	72.8%	74.8%	72.3%
Agency Filled	0.0%	0.00%	0.20%	0.50%	0.00%	0.60%	0.20%	0.30%	0.20%	0.20%	0.00%	0.01%	0.01%	0.00%	0.0%	0.0%	0.4%	0.3%	0.0%	0.4%	0.0%	0.0%	0.2%	0.2%	0.0%	0.0%	0.2%	0.0%	0.0%
Non Framework	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Overall Fill Rate	69.3%	53.5%	67.1%	68.7%	59.5%	70.8%	67.7%	71.0%	68.9%	71.3%	69.7%	63.0%	63.3%	58.0%	72.1%	72.6%	69.9%	71.8%	74.8%	75.5%	74.9%	63.1%	72.4%	72.7%	74.5%	71.3%	72.9%	74.8%	72.3%
Unfilled Duties	30.7%	46.4%	32.9%	34.5%	40.5%	29.2%	32.4%	29.0%	31.1%	28.7%	30.3%	37.0%	36.7%	42.0%	27.9%	27.4%	30.1%	28.2%	25.2%	24.5%	25.2%	36.9%	27.6%	27.3%	25.5%	28.7%	27.1%	25.2%	27.7%

- In March (27/02/23 – 02/04/23) 5499 duties were requested compared to 4444 in February (30/01/23 – 26/02/23). The overall fill rate in March was 73% compared to 72% in February, with bank fill rates increasing from 72% to 73%. This reporting period is 5 weeks as opposed to 4 in February.

CARE RESPECT RESPONSIBILITY

Mandatory Training

The Dudley Group
NHS Foundation Trust



There appears to be an improving position for statutory training compliance trend from February. However, overall performance remains below target and below comparator performance in the same period in 2022. Work continues across Divisions to focus on areas of challenge across Resus and Safeguarding in particular.
Additional work is in progress to identify divisional actions with Subject Matter Experts in low compliance subjects.
Access to training via the external website is now live.

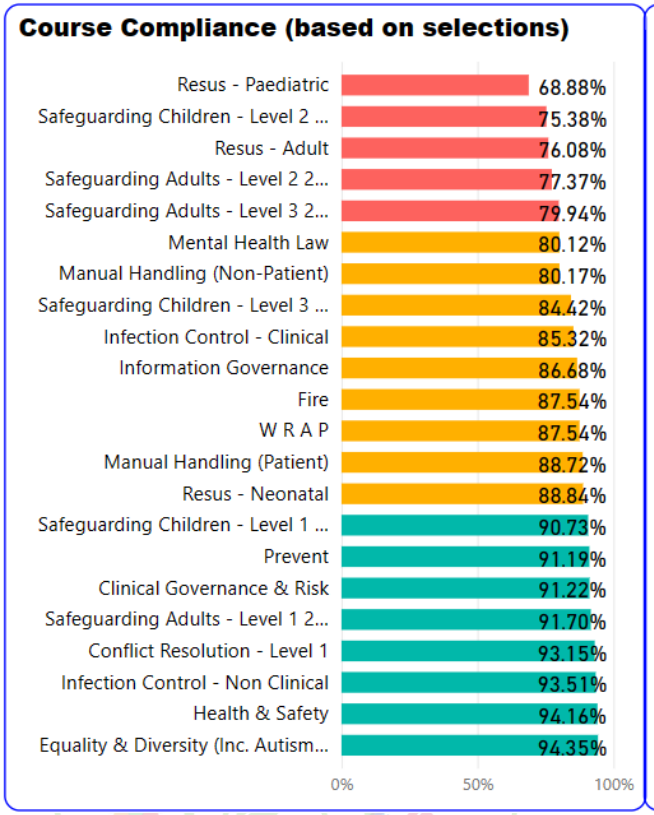
	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
Mandatory Training (Stat)	87.63%	87.98%	89.97%	90.43%	88.44%	91.00%	89.90%	89.10%	86.68%	85.27%	85.45%	86.82%

Mandatory Training – Priority 1

The Dudley Group NHS Foundation Trust

Month: April 2023	Trust	CS	Corporate	MIC	Surgery
	86.82%	90.26%	89.60%	84.67%	86.15%

Course Compliance



Depts by no. required to achieve 90%

Ward/Service (based selections)

Group5Description	Actual	No. >90%	%' tage
253 Medical Staff - Acute Medicine Serv	879	201	73.25%
253 General Surgery Medical Staff Serv	505	149	69.55%
253 Emergency Dept Nursing Serv	1,479	135	82.48%
253 Ward EAU Serv	1,913	107	85.24%
253 Critical Care Serv	1,727	101	85.03%
253 Medical Staff - General Medicine Serv	53	100	31.36%
253 Ward C8 Serv	985	90	82.49%
253 Cardiology Clinical Measurement Serv	409	88	74.09%
253 Medical Staff (Emergency Med) Serv	718	83	80.67%
253 Paediatric Medical Staff Serv	309	82	71.19%
253 Urology Medical Staff Serv	132	82	55.69%
253 Theatres Recovery & Anaesth Serv	671	81	80.35%
253 MOC Medical Staff Serv	449	78	76.75%
253 Theatres T&O Serv	251	77	68.95%
253 Main Theatre Other Specialities Serv	292	73	72.09%
253 Maternity Unit Serv	2,491	73	87.46%
253 GI Unit Serv	718	67	82.33%
253 Ward B4 Serv	951	62	84.53%
253 Medical Staff - Respiratory Serv	229	60	71.33%
Total	**66,020**	**2416**	**86.82%**

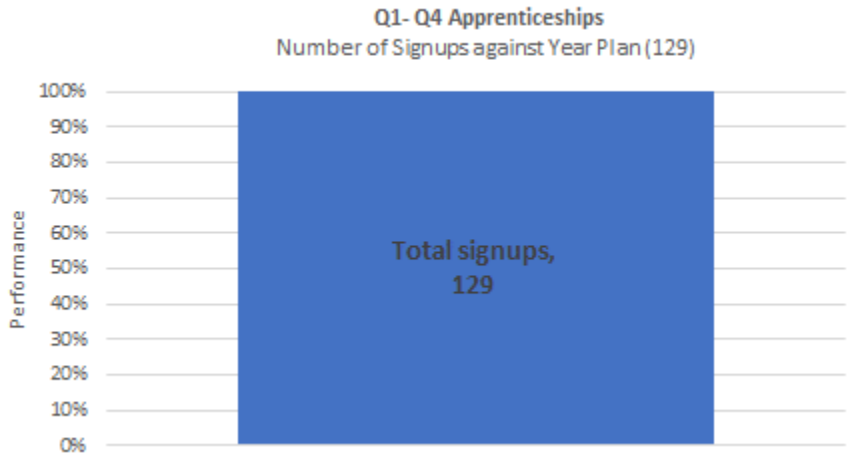
Clinical Support Division is now above Trust target with Corporate Services 0.5% below target.

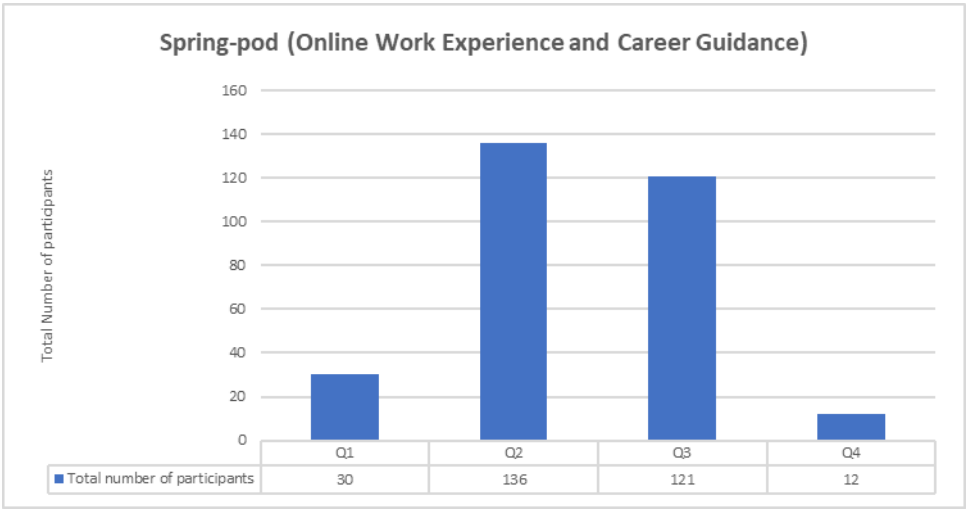
The Medicine Division remains at the lowest position and this is also in relation to the subjects most challenged.
There has been limited improvement in Safeguarding and Neonatal Resus.
Resuscitation Paediatric is the most challenged subject and requires significant work to reach target. Focussed work is ongoing to address this – with Subject matter Experts and departments.

CARE RESPECT RESPONSIBILITY

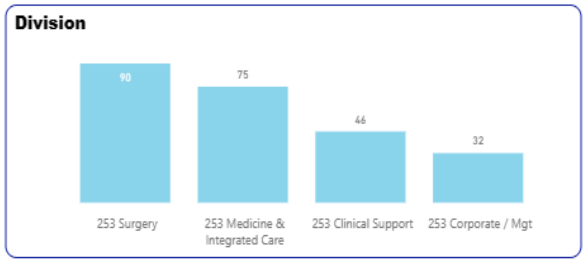
Apprentices and Work Experience

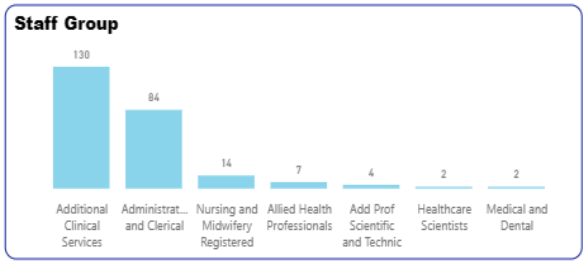
The Dudley Group
NHS Foundation Trust

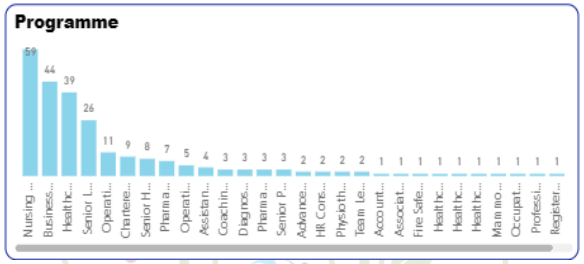


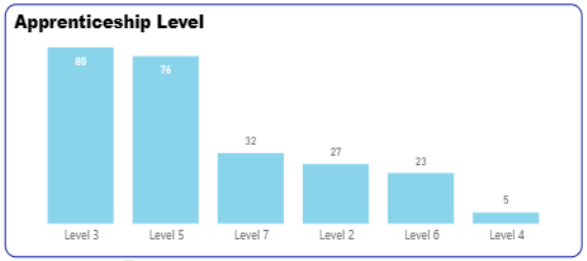


Active Apprenticeships breakdown









Total Active Apprenticeships **243**

Apprentice recruitment has met the target for 2022/23.

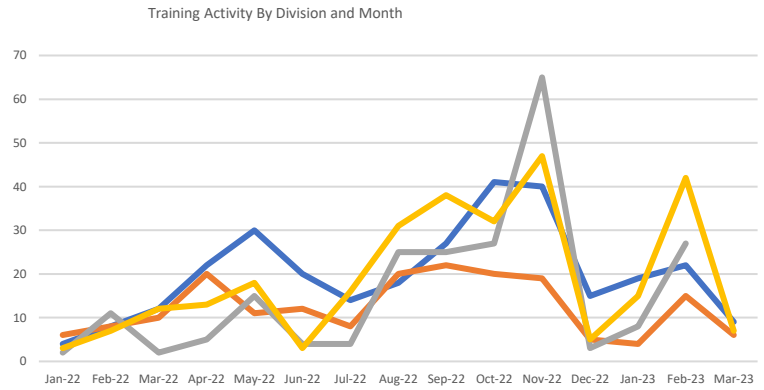
Levy funds are showing a risk of expiry of £7000 in June 2023. Once apprenticeships currently recruited are signed up, it is likely this will be deferred until later in 2023.

We are sponsoring a number of apprentices in other organisations through Levy transfer.

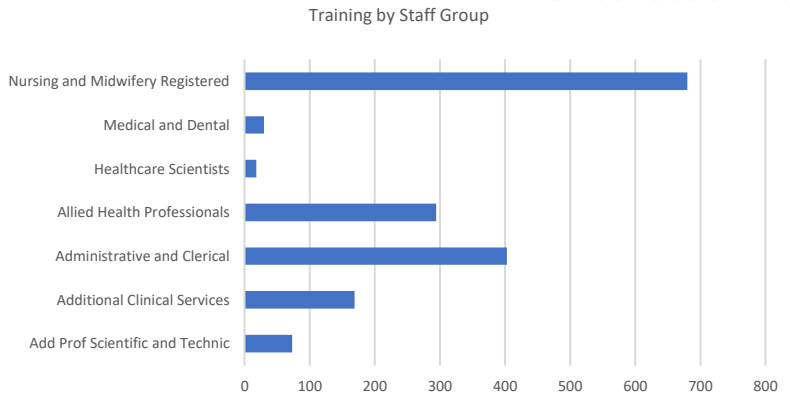
CARE RESPECT RESPONSIBILITY

Organisational Development

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	Feb-23	Mar-23
253 Clinical Support	4	8	12	22	30	20	14	18	27	41	40	15	19	22	9
253 Corporate / Mgt	6	8	10	20	11	12	8	20	22	20	19	5	4	15	6
253 Medicine & Integrated Care	2	11	2	5	15	4	4	25	25	27	65	3	8	27	
253 Surgery	3	7	12	13	18	3	16	31	38	32	47	5	15	42	7



	Add Prof Scientific and Technic	Additional Clinical Services	Administrative and Clerical	Allied Health Professionals	Healthcare Scientists	Medical and Dental	Nursing and Midwifery Registered
Total	73	169	403	294	18	30	680

Course	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	Feb-23	Mar-23	Total
253 Appraisal Training Call													4	7		11
253 Bespoke Training							8		6							14
253 Developing Leaders							6						4	6		16
253 Living The Values				8	19				14	18	14			6		79
253 Managers Essentials	1	5	15	25	28	8	14	13	12	18	11	12	24	21	16	223
253 Welcome 2 Dudley Induction	10	16	16	27		20	5	6	11	18	9	3	8	4	3	156
253 Wellbeing	4	13	5	0	27	11	9	75	69	66	137	13	6	62	3	500
Grand Total	**15**	**34**	**36**	**60**	**74**	**39**	**42**	**94**	**112**	**120**	**171**	**28**	**46**	**106**	**22**	**999**

Training activity continues to increase – with focus on ensuring that Manager's Essentials courses are delivered to capacity and reach all managers. 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: Managers Essentials, Developing Leaders, Living the Values, Wellbeing, Welcome to Dudley. Communication Skills Training (core and advanced) is now available. The trust Learning prospectus has been slightly delayed but will launch during late April. Further programmes being developed include a modular Admin Development programme and a programme of development for Ward Clerks; with plans to relaunch Clinical Leader programmes again in 2023/24.

Appraisal- 22/23

The Dudley Group
NHS Foundation Trust

2022/23 Rate	Trust	CS	Corporate	MIC	SWC
	70.8%	80.5%	84.5%	64.9%	64.8%

Rates by Staff Group

StaffGroup	Total Staff	Valid Appraisal 2022/23 (All Reviews)	Rate
Add Prof Scientific and Technic	200	149	74.5%
Additional Clinical Services	1406	890	63.3%
Administrative and Clerical	1200	949	79.1%
Allied Health Professionals	444	385	86.9%
Healthcare Scientists	49	33	67.3%
Nursing and Midwifery Registered	1928	1292	67.0%
Total	**5227**	**3698**	**70.8%**

Rates by Division

Division	Total Staff	Valid Appraisal 2022/23 (All Reviews)	Rate
253 Clinical Support	1215	970	79.9%
253 Corporate / Mgt	611	519	84.9%
253 Medicine & Integrated Care	1664	1078	64.8%
253 Surgery	1736	1131	65.1%
253 The Dudley Group NHS Foundation Trust	1	0	0.0%
Total	**5227**	**3698**	**70.8%**

The 2022/23 window closed on 31st March at 70.8%, which is below target at 90%. Good progress was made in Clinical Support and Corporate Divisions – both achieving above 80%.

The focus is now on the Appraisal window for 2023 which is live from 1st April until 31st July. Performance is currently 1.9% overall – with expectations this will be at 90% by end July. Ongoing prompts are being undertaken to ensure Divisions are completing appraisals throughout the window.

CARE RESPECT RESPONSIBILITY

Appraisal- 23/24

The Dudley Group
NHS Foundation Trust

2023 Compliance Rate	Trust	CS	Corporate	MIC	SWC
	1.1%	0.4%	0.3%	1.7%	1.4%

Compliance Rate by Division

OrgL2	Total Staff	Appraised	Rate
253 Clinical Support	1215	5	0.4%
253 Corporate / Mgt	611	3	0.5%
253 Medicine & Integrated Care	1664	29	1.7%
253 Surgery	1737	62	3.6%
253 The Dudley Group NHS Foundation Trust	1	0	0.0%
Total	**5228**	**99**	**1.9%**

Compliance Rate by Staff Group

StaffGroup	Total Staff	Appraised	Rate
Add Prof Scientific and Technic	200	0	0.0%
Additional Clinical Services	1407	41	2.9%
Administrative and Clerical	1200	4	0.3%
Allied Health Professionals	444	1	0.2%
Healthcare Scientists	49	0	0.0%
Nursing and Midwifery Registered	1928	53	2.7%
Total	**5228**	**99**	**1.9%**

Reporting has now commenced for 23/24 – however low performance was expected for 1- 17th April due to Easter holidays and Junior Doctor strikes limiting staff availability for non patient activities. Surgery has the highest performance of all Divisions so far at 3.6%.

Weekly reporting will continue throughout the window with targeted support for areas remaining below benchmark position throughout the window. In addition, focus will remain on those areas that were not compliant during the 2022/23 window.

CARE RESPECT RESPONSIBILITY

FURTHER READING PACK

REPORTS FOR ASSURANCE

National Staff Survey 2022 Results and Action Plans for 2023

Report to Board – 11th May 2023

1 EXECUTIVE SUMMARY

1.1 The national annual Staff Survey took place during October and November 2022.

1.2 The purpose of this paper is to:

- Provide a summary of the survey results and enable a comparison between benchmark peers and historical scores.
- Identify areas of progress and areas for further improvement
- Summarise key actions at an organisation and division level.

1.3 The Staff Survey provides an annual report on how staff experience working within the organisation. It is a core metric in measuring the impact of our People Plan and supporting management of risks around staff engagement, recruitment, and retention as well as inclusion and wellbeing.

1.4 The purpose of this paper is to outline performance in the survey and share plans at an organisational and divisional. Areas that perform below expectation are identified for focused action and these are reflected in divisional plans. These are anonymised within the report. The overall goal being to positively influence our staff experience and in doing so improve the future Staff Survey results in those areas and in the overall People Promise areas.

2. BACKGROUND INFORMATION

2.1 The national Staff Survey was held between 3rd October and 25th November 2022. All staff employed on 1st September 2022 (5743 staff members) were invited to complete the survey via an online survey. The Trust has run an online only survey for the last eight years.

2.2 The national survey question set has remained broadly the same for 2022 following major changes undertaken in 2021. This means we will begin to establish historical comparisons for all datasets and are now able to review trend data on the seven people promises plus Engagement and Morale:

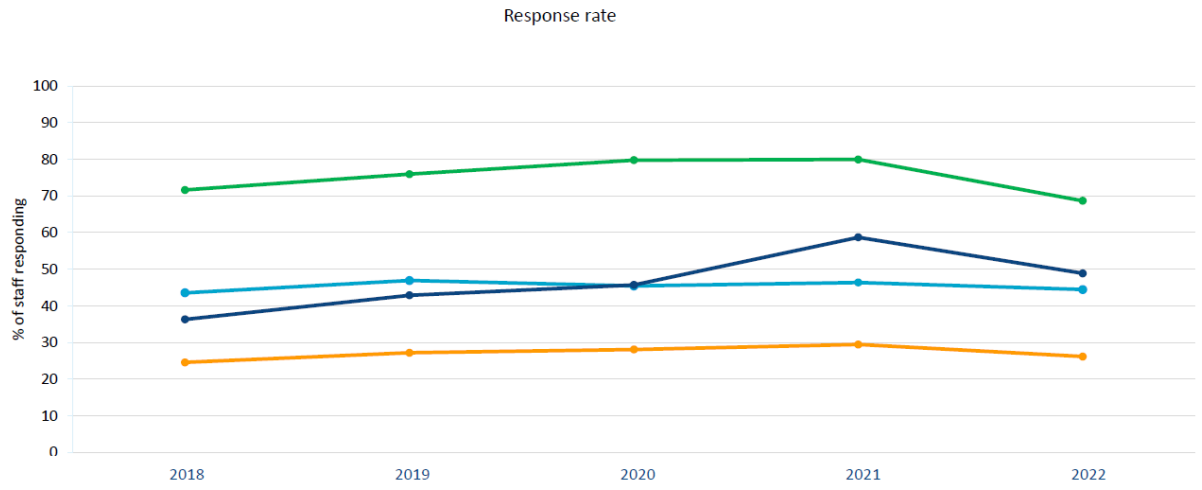
- We are compassionate and inclusive.
- We are recognised and rewarded.
- We have a voice that counts.
- We are safe and healthy.
- We are always learning.
- We work flexibly.
- We are a team.

2.3 Response Rate

The final response rate for 2022 is 49% (2768 members of staff). Although disappointing that this is 10% lower than the previous year (in which we reached our highest ever position of 58.7%), it is above the benchmark average for similar organisations (Acute and Acute & Community Trusts) for 2022 which is 44.5%. All benchmark groups have seen a decline in response rates from 0.9% for the average group to >10% for highest performers.

Achieving higher response rates is related to promotional activity and this year, as for 2021, the Communications team have led the campaign and should be credited for their work to increase the rate. This was supported by additional prompting through divisional prompts, ongoing communications activity, direct mail, screensavers.

Table 1 – Response rate

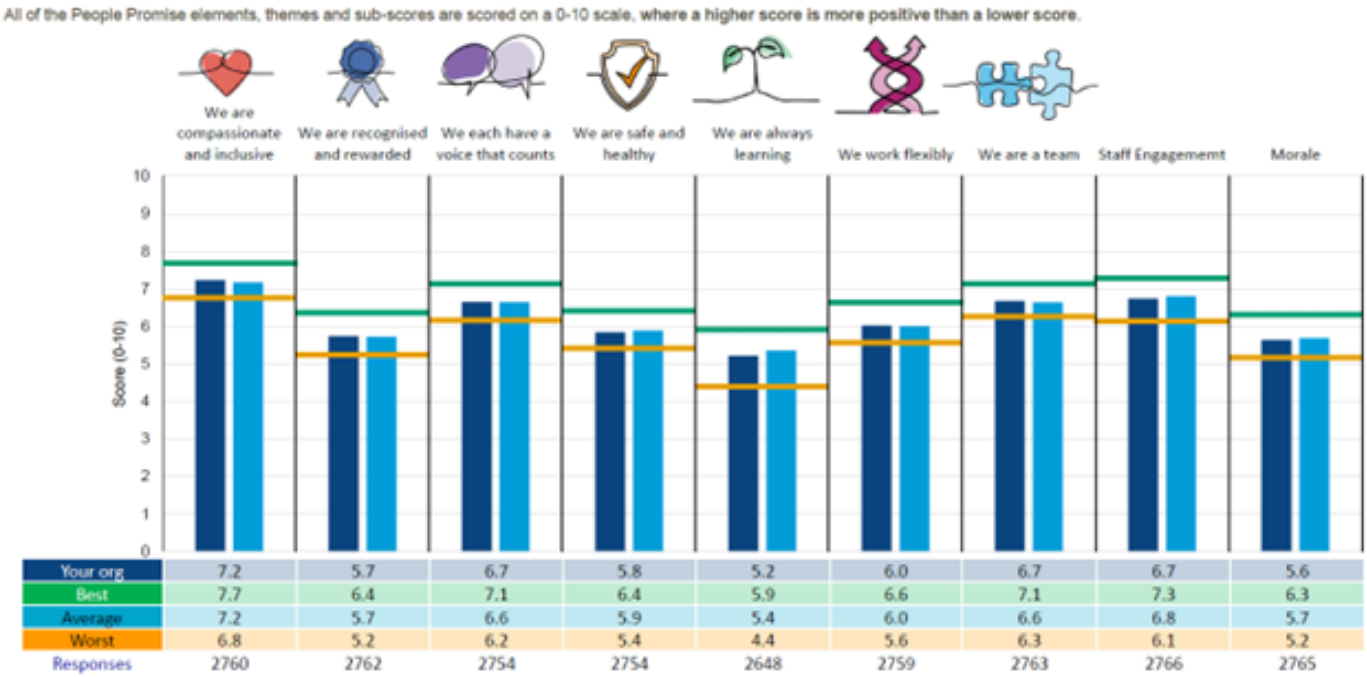


	2018	2019	2020	2021	2022
Your org	36.3%	42.9%	45.7%	58.7%	48.9%
Highest	71.6%	76.0%	79.8%	79.9%	68.7%
Average	43.6%	46.9%	45.4%	46.4%	44.5%
Lowest	24.6%	27.2%	28.1%	29.5%	26.2%
Responses	1657	2049	2322	3185	2768

2.4 **Results Summary**

The table below is an extract from the full benchmark report, showing the overall position of Dudley rated against the people promise and theme results.

Table 2 – Results summary



	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Your org	7.2	5.7	6.7	5.8	5.2	6.0	6.7	6.7	5.6
Best	7.7	6.4	7.1	6.4	5.9	6.6	7.1	7.3	6.3
Average	7.2	5.7	6.6	5.9	5.4	6.0	6.6	6.8	5.7
Worst	6.8	5.2	6.2	5.4	4.4	5.6	6.3	6.1	5.2
Responses	2760	2762	2754	2754	2648	2759	2763	2766	2765

For 2022, the Trust is above or the same for five out of the nine promises/themes, with the remainder being slightly below benchmarked average (0.1-0.2). Between 2021 and 2022, performance across the nine promises and themes has remained the same for six out of the nine indicators. We have improved in two out of the nine and declined in one out of the nine.

As below, this improvement is significant in two areas: we work flexibly, and we are a team.

Table 3 – Significance testing of Promise results.

The table below presents the results of significance testing conducted on the theme scores calculated in both 2021 and 2022*.

People Promise elements	2021 score	2021 respondents	2022 score	2022 respondents	Statistically significant change?
We are compassionate and inclusive	7.2	3119	7.2	2760	Not significant
We are recognised and rewarded	5.7	3155	5.7	2762	Not significant
We each have a voice that counts	6.6	3085	6.7	2754	Not significant
We are safe and healthy	5.8	3109	5.8	2754	Not significant
We are always learning	5.3	3011	5.2	2648	Not significant
We work flexibly	5.9	3143	6.0	2759	Significantly higher
We are a team	6.5	3124	6.7	2763	Significantly higher
Themes					
Staff Engagement	6.7	3159	6.7	2766	Not significant
Morale	5.6	3148	5.6	2765	Not significant

* Statistical significance is tested using a two-tailed t-test with a 95% level of confidence. For more details please see the technical document.

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2.5 Engagement and Morale

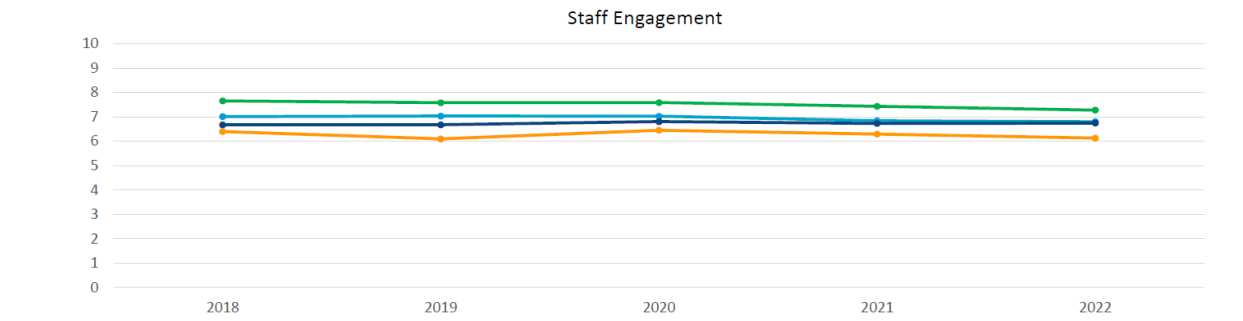
Scores on Staff Engagement have remained consistent over the last five years – with a slight improvement in 2020 to 6.8; the four remaining years in the period have seen a Staff Engagement score of 6.7.

Although it is reassuring that there has not been a decline in this area, we remain 0.1 below average and well below top performance in this area. This is an area for continued focus as an organisation.

Table 4 - Staff Engagement

All of the People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.

Theme: Staff Engagement



	2018	2019	2020	2021	2022
Your org	6.7	6.7	6.8	6.7	6.7
Best	7.7	7.6	7.6	7.4	7.3
Average	7.0	7.0	7.0	6.8	6.8
Worst	6.4	6.1	6.5	6.3	6.1
Responses	1649	2042	2291	3159	2766

There are three sub scores within the engagement theme: with each sub score having three questions. There are improving trends for Dudley responses across all questions within the involvement theme.

The area most challenged within engagement is question 23d: Would recommend as a place for care. This is likely to be related to current staffing experience relating to high operational pressures combined with staffing challenges impacting how staff feel about the care they deliver in those circumstances.

Table 5 – Staff engagement sub themes and peer comparison

	2022	2021	Difference	Peer Benchmark	Difference
Motivation	7.0	7.0	0	7.0	0
Involvement	6.8	6.6	+0.2	6.8	0
Advocacy	6.5	6.6	-0.1	6.6	-0.1
Overall	6.7	6.7	0	6.8	-0.1

Based on the Staff Survey significance testing, the differences above are not considered to be significant differences on both improvement and against peer benchmarks.

Staff Engagement is a measure used to compare organisations as a consistent indicator of Trust performance. National comparisons are published by the HSJ annually on the core engagement question of 'would recommend as a place to work.' For 2022 results, they highlight Dudley as a significant positive outlier in this area – both across the Midlands and nationally. There are 2 trusts within the Midlands to see a positive trend in this area over the last 3 years – Dudley is one of those. Across the UK, there are around 15 trusts who have achieved a positive trend in this question over the last 3 years.

The table below shows scores across the Midlands region for this question.

Table 6 – Peer Comparison for Would recommend as a place to work (Last year and 3-year trend)

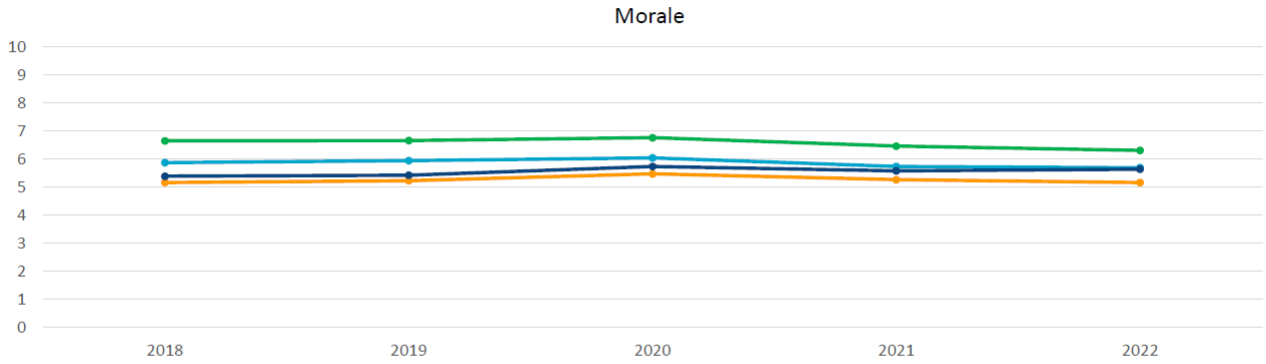
Recommend as a place to work	HSJ Analysis					
Trust Name	2019	2020	2021	2022	2021-22	2019-2022
Sherwood Forest Hospitals NHS Foundation Trust	73%	81%	75%	72%	-3%	-1%
South Warwickshire University Hospitals NHS Trust	77%	79%	70%	71%	1%	-6%
Chesterfield Royal Hospital NHS Trust	70%	75%	70%	68%	-2%	-2%
The Royal Wolverhampton NHS Trust	72%	76%	68%	65%	-3%	-7%
University Hospitals Derby and Burton NHS Trust	68%	71%	64%	61%	-3%	-7%
University Hospitals Coventry and Warwickshire NHS	65%	65%	61%	60%	-1%	-5%
Wye Valley NHS Trust	65%	69%	61%	60%	-1%	-5%
Birmingham Womens and Childrens NHS Trust	64%	70%	58%	57%	-1%	-7%
George Eliot Hospital NHS Trust	59%	62%	61%	56%	-5%	-3%
The Dudley Group NHS Trust	51%	59%	55%	56%	1%	5%
University Hospitals Leicester NHS Trust	63%	56%	66%	55%	-11%	-8%
Nottingham University Hospitals NHS Trust	63%	68%	54%	53%	-1%	-10%
Sandwell and West Birmingham Hospitals NHS Trust	57%	60%	54%	52%	-2%	-5%
Northampton General Hospital NHS Trust	59%	66%	55%	52%	-3%	-7%
Walsall Healthcare NHS Trust	48%	52%	48%	52%	4%	4%
University Hospitals North Midlands NHS Trust	60%	64%	55%	52%	-3%	-8%
Worcestershire Acute Hospitals NHS Trust	57%	63%	55%	50%	-5%	-7%
University Hospitals Birmingham NHS Trust	59%	61%	50%	48%	-2%	-11%
Kettering General Hospital NHS Trust	62%	67%	51%	46%	-5%	-16%
United Lincolnshire Hospital NHS Trust	45%	46%	38%	44%	6%	-1%
Shrewsbury and Telford Hospital NHS Trust	49%	48%	40%	41%	1%	-8%

Staff Morale

Staff Morale is measured through three sub scores of thinking about leaving, work pressure and stressors with a total of 13 questions feeding into those sub scores. Overall, performance in this area has remained the same since 2021 in terms of actual scores and in comparison to benchmark average.

Table 7 - Morale

Theme: Morale



	2018	2019	2020	2021	2022
Your org	5.4	5.4	5.7	5.6	5.6
Best	6.6	6.7	6.8	6.5	6.3
Average	5.9	5.9	6.0	5.7	5.7
Worst	5.2	5.2	5.5	5.3	5.2
Responses	1649	2021	2278	3148	2765

There are some positive sub-questions where the Trust has improved and is rising above benchmark average – these include being involved in changes in work (3e) and my immediate manager encourages me at work (9a).

Morale is an area that has seen challenge at a national level – and although as above, the benchmark average has remained the same, both worst and best performers have seen a decline in this area since 2020.

Table 8 – Morale sub themes and peer comparison

	2022	2021	Difference	Peer Benchmark	Difference
Thinking about leaving	5.8	5.8	0	5.9	-0.1
Work pressure	4.9	4.8	+0.1	5.0	-0.1
Stressors	6.3	6.2	+0.1	6.3	0
Overall	5.6	5.6	0	5.7	-0.1

Based on the Staff Survey significance testing, the differences above are not considered to be significant differences.

2.6 Questions Better Than Benchmark

When reviewing performance for 2022, overall, the Trust position remains in line with benchmark. This is reflected in the question comparison, whereby there have been improvements across a series of questions but these remain below benchmark position. The table below is an extract of those questions where the Trust performance is better than peer benchmark.

It is also important to note that across the whole survey the Trust has seen improved performance across several promises and individual questions when compared with our own performance. Several of the areas relating to teamwork and line manager performance have improved – however, these are not yet in line with benchmark due to starting from a lowest quartile position.

Table 9 – Questions better than benchmark

Areas better than benchmark	Org 2022	Benchmark	Difference
Q23b. My organisation acts on concerns raised by patients/service users	72%	68.3%	+3.7%
q15. Does your organisation act fairly with regard to career progression / promotion, regardless of ethnic background, gender, religion, sexual orientation, disability, or age?	59%	55.6%	+3.4%
Q14a In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from...? Patients / service users **(Lower score better)**	24.8%	28.1%	-3.3%
Q23f If I spoke up about something that concerned me, I am confident my organisation would address my concern.	50%	47.2%	+2.8%
Q9f My immediate manager works together with me to come to an understanding of problems.	69.1%	66.4%	+2.7%
Q9b My immediate manager gives me clear feedback on my work.	64.7%	62.1%	+2.6%

2.7 Questions Worse Than Benchmark

There are still a number of areas where the Trust remains below benchmark performance. Some of these areas have seen improvements over time but are not yet sufficient to achieve benchmark average (Q7f is an example of this).

Two relate to appraisal outcomes and this is already an area of focus due to poor compliance in 2022/23 with appraisal completions. These will remain areas of focus through planned activity until performance improves.

Table 10 – Questions worse than benchmark

Areas worse than benchmark	Org 2022	Benchmark	Difference
Q23d If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation.	58.2%	61.9%	-3.7%
Q22c, I have opportunities to improve my knowledge and skills.	64.7%	67.8%	-3.1%
Q7f My team has enough freedom in how to do its work.	53.9%	57.2%	-3.3%
Q21c It [appraisal] helped me agree clear objectives for my work.	28.6%	31.9%	-3.3%
Q21d It [appraisal] left me feeling that my work is valued by my organisation.	27.6%	31.3%	-3.7%
Q3h, I have adequate materials, supplies and equipment to do my work.	50.5%	53.5%	-3%

2.8 **Areas for Improvement**

Overall, the results for 2022 have illustrated an improving picture across the sub-questions with most People Promises remaining static during a year where external factors are increasing the pressure, morale, and engagement of staff. This should be seen as a positive position.

There is still significant improvement required across all areas in order to achieve top quartile performance.

Given that the focus has been on Wellbeing, Equality, Diversity, and Inclusion alongside Manager performance (which influences team metrics), these remain core priorities in work planning for 2023/24 to ensure that the agreed priorities are met and embedded. This links to the development of Trust People Plan and the People Journeys, which are being developed in these areas.

The areas below are highlighted as requiring specific focus for the next twelve months to target improvement and impact positively on future staff survey performance.

- **We are always learning.**
  Performance in this area has been impacted by the poor appraisal completion this year. There is work already underway to improve this in 2023/24 and is an area that when previous compliance was high, the Trust performed significantly above benchmark average in this question sub-set.

- **We are safe and healthy.**
  Although performance in this area is at benchmark average, there are some areas within this Promise where performance has declined – around the experience of Bullying and harassment – particularly reporting incidents**.**

  Work was planned around this during 2022/23 linked to the 'Be Kind' campaign – this will continue through 2023/24. In addition, to support this a full review of the current behaviour framework has commenced.

- **Staff Engagement**
  This continues to be an area of below benchmark performance and will remain a focus for sustained action during 2023/24. The largest area of decline in this sub-set is around staff reporting their happiness to recommend the care we provide.

  There are links between this indicator and staffing, recruitment, and retention as well as absence. This will continue to have priority through the recruitment and retention workgroup, embedding actions within the recruitment and retention journey – alongside continuing to embed the People Pulse and Staff Survey and engagement forums within divisions.

2.9 **Recognising Improvement**

The overall position as equivalent to benchmark average for the People Promises means that some of the areas of improvement are less obvious, this is because as a Trust we have been below benchmark for a number of years.

However, there are several areas (linked to organisational action) where we are beginning to see improving trends and above benchmark performance on sub-themes or questions. Where improvement is sustained, these will, over time, begin to improve overall Promise scores. Examples include:

- **We are a team.**
  Most questions have a positive upwards trend, and the line management sub-theme score has increased from 6.6 to 6.8 since 2021.

- **We are safe and healthy.**
  The sub-question on the organisation takes positive action on health and wellbeing has increased by 4.7%; both best and average performing benchmark Trusts have declined in performance during this period.

- **We work flexibly.**
  There are positive scores across sub-theme questions including the organisation is committed to flexible working, there are opportunities to discuss flexible working with my line manager.
  There is still significant work to embed this into clinical working practices but indicates an improving awareness of opportunities.

- **We are compassionate and inclusive.**
  Questions around 'my manager' listening, supporting, and resolving problems, being valued by team and fair action on promotion and progression are all showing improving trends. These are areas of work that link directly to our commitment to line manager support over the last two years.

2.10 **Divisional Results**

The divisional overview Appendix 1 provides a summary against people promises and compares to organisational and national benchmark performance.

Point to note – the survey was launched prior to the structure change transferring services across to CCCS. This means the divisional overview is of the old divisional structure with Community Services being included in the Medicine overall results.

The overview highlights that, for 2022, the Corporate Division is performing at or above both the organisation average and benchmark average.

Core Clinical and Community Services has two areas that are worse than organisation and benchmark average – we are always learning, and we work flexibly. These relate to already known issues around the ability to deliver flexible working in some clinical areas and known appraisal performance challenges.

Medicine has one area – we are safe and healthy - below organisation and benchmark average. There are some departments still reporting as lower than organisation average including Emergency and Urgent Care.

The Surgery, Women and Children's Division has the largest number of People Promises that are below organisation and benchmark average – but this is by a small amount in each area. There are challenges across a number of services. Although scores are below average, they have seen significant improvements in 2022.

2.11 **Areas/Departments of Concern in 2021 and 2022**

In the 2021 Survey, a number of areas were reported across three Divisions as having the lowest proportion of positive scores. A review of performance in 2022 has established an improved position in some, with further declines in others. These have been highlighted to divisions for focused action plans to be developed.

Table 11 – Review of areas highlighted in 2021/comparison of 2022.

	Summary of 2022 position
Surgery	
Dept 1	Mixed picture with some significant improvements (value for work, flexible working, positive action on health and wellbeing) alongside areas of decline (able to make suggestions for improvement, shared objectives for team, manager listens and understands). Scores remain below benchmark in most areas. **Requires further support for 2023.**
Dept 2	Further declines in several areas across the department. Also flagged in lowest positive scores below. Significant decline in one sub team. Some positive improvement in medical staff. **Already identified for action through external review.**
Dept 3	Comparisons in 2022 are limited due to changes in reporting and insufficient responses. Scores remain below benchmarked average; scores for the Management team are above benchmark with some exceptions including immediate manager and personal development scores. Comparisons show both improvements and areas of decline. **Requires further support for 2023.**
Dept 4	Significant improvements across department; remains below benchmark but positive scores across most promises/themes. **Team will continue with a local action plan in 2023.**
Dept 5	Responses for 2022 only include department as low response rate in medical staff 4/14. This means a direct comparison is not possible for department as a whole. For the department, scores have declined across several areas including team work and work life balance and remains below benchmark. **Requires further support for 2023.**
Dept 6	Across the seven sub-areas, there have been improvements across five departments. There are two departments that cannot be compared due to response rate. Overall, although in some areas still below benchmark or organisation average, there is significant improvement across most areas – specifically in team, manager, work life balance and wellbeing. **Team will continue with a local action plan in 2023.**

Medicine	
Dept 1	Limited comparison to 2021 data due to low response rates across departments for 2022. Remains below benchmark across most questions although has seen improvements in making suggestions around work, valued by team and positive interest in health and wellbeing. Areas for continued focus include discrimination from patients, recognition for good work and receiving appraisals. **Requires further support for 2023.**

Dept 2	At a directorate level, scores are broadly at benchmark position with a balanced picture for 2022 with improvements and declined areas – with minor changes in most scores (<3%). Meeting conflicting demands, having adequate materials and enough staff are key areas of challenge. Departmental data is not available due to minimum sample size not being met; this is indicative of further support being required. **Requires further support for 2023.**
Dept 3	This is made up of several departments reporting into an overall directorate. Scores remain below benchmark position across the directorate – with both declines and improvements in scores. For medical staff, improvements in teamwork but declines in line manager scores; for nursing staff improvements in effectiveness and working together and recommend as a place to work; declines in experience of harassment from colleagues and ability to show initiative. **Requires further support for 2023.**
Corporate	
Dept 4	Improvements across people promises in particular being valued and recognised and line manager questions. Team have worked on action plan and support and no further support required.

*Will be within CCCS division from 2023 survey onwards

2.12 **Areas for improvement 2022**

As a result of the 2021 survey, teams/departments were highlighted for additional support based on the proportion of lower-than-average responses to questions. This approach has been used again for the 2022 results to identify teams for additional support.

Work in 2021 was provided to areas flagged for concern through the Human Resources, OD and Learning and Improvement teams. The same process will be followed for 2022 to understand the particular challenges in those areas and to develop bespoke action plans to support improvement. This work will link with existing improvement/development activity and any external activity (for example, external reviews).

2.13 **WRES and WDES**

A detailed review of the WRES and WDES indicators to enable a review of the Trust performance on equality, diversity and inclusion will be provided through the Equality, Diversity, and Inclusion (EDI) Steering Group and then reported to Workforce Committee. These will focus on flagging areas of concern and areas of improvement – making links with the existing EDI Action Plans and activity outlined in the EDI Journey.

2.14 **Actions for 2023**

For the last two years, the Trust has identified key strategic actions to support ongoing organisational change and positively impact staff survey results. These areas of focus have been:

- Health and Wellbeing
- Equality, Diversity, and Inclusion
- Manager effectiveness
- Development and career progression

2.15 The above thematic approach was an attempt to embed changes at an organisational level and provide a sustained way of improving staff survey results. This has meant a move away from annual action plans with short-term actions/goals in favour of long-term plans.

2.16 The Trust People Plan and associated People Journeys (currently in development) set out the short, medium, and long-term direction to support the organisation to improve the employee experience. These will directly contribute to improvements across all 7 People Promises and Staff Engagement and Morale themes and set us on the path towards above benchmark average performance across the staff survey indicators.

2.17 In addition, there are three areas that have been identified as requiring focused action. This work continues to be embedded within the People Plan and Journeys but is highlighted as below.

2.18 **Action area 1: We are always learning.**

For 2022, the poor compliance against appraisals across the organisation has directly impacted this Staff Survey measure as both appraisal completion and positive impact of appraisal on an employee is measured in the staff survey question deck which accounts for most of this People Promise.

To improve performance in this promise for 2023, we will need to deliver the Trust target for appraisals between April and July 2023. The revised process and ongoing follow-up on career development should ensure that this element of the survey improves.

2.19 **Action area 2: We are safe and healthy.**

Although performance in this area is at benchmark average, there are some areas within this Promise where performance has declined – around the experience of Bullying and harassment – particularly reporting incidents**.**

Work was planned around this during 2022/23 linked to the 'Be Kind' campaign – this will continue through 2023/24. In addition, to support this a full review of the current behaviour framework has commenced with a specific Culture task group established to support this work.

A detailed action plan will be developed as part of this workstream with the goal of ensuring the enablers of a positive culture are embedded.

2.20 **Action area 3: Staff Engagement**

This continues to be an area of below benchmark performance and will remain a focus for sustained action during 2023/24. The largest area of decline in this sub-set is around staff reporting their happiness to recommend the care we provide. There are links between this indicator and staffing, recruitment, and retention as well as absence.

This will continue to have priority through the recruitment and retention workgroup, embedding actions within the recruitment and retention journey – alongside continuing to embed the People Pulse and Staff Survey and engagement forums within divisions. A key part of the work around the Trust's Culture and behaviour framework will see engagement with staff across the wider organisation.

In addition, to provide further understanding of how to improve staff responses in this areas, local questions on what influences and what improvements are needed to enable staff to recommend [Dudley] as a place for care will be added to the July People Pulse. This will enable a more focused approach to improvements in this area.

2.21 **Divisional Plans and Challenge Areas**

In addition to the pan organisational actions, there are more targeted actions required depending on the division or department within the organisation. In order to address this variation, the Divisional leadership teams have prepared a more detailed outline of planned actions tailored to their divisions in response to the key people promises requiring improvement across each division.

These were outlined in the Divisional Action Plans submitted to Workforce and Staff Engagement Committee on 25th April 2023 (Action slides attached as Appendix 2). Alongside Divisional action plans, each divisional leadership team has outlined the planned activity to support areas key areas/departments of focus within each division. These actions are aligned to the Promises most in need of improvement in those areas and will be supported by Corporate Services through divisional support triumvirates (HR, OD, and Improvement representatives).

2.22 **Community with Core Clinical Services Divisional Plan and Approach to Challenge areas.**

The division has highlighted three People Promise areas for focused action and developed a detailed action plan with target dates and success measures. The areas for focus are:

- We are always learning.
  Actions include ensuring that appraisals are conducted within timescale, leads undertake appraisal training, quarterly reviews of 1-1s following appraisal window, reviewing quarterly People Pulse results.

- We are compassionate and inclusive.
  Bespoke training within the division being designed by HR/OD, micro-aggression training to be rolled out division wide to support action on bullying and harassment, active participation in review of behaviour framework/culture task group.

- We work flexibly.
  Specific departments asked to review flexible working arrangements and requests and to identify opportunities to improve, managers to attend flexible working information sessions.

In addition, the division has highlighted the departments within the division that require tailored support to improve results. These have focused action plans on the specific areas highlighted in department level results. However, there are some standard interventions which include ensuring all managers attend Manager's Essentials training, recruitment and deployment of Wellbeing Champions, Living the Values sessions with teams.

2.23 **Medicine and Integrated Care Divisional Plan and Approach to Challenge areas.**

The division has highlighted three People Promise areas for focused action and developed a detailed action plan with target dates and success measures. The areas for focus are:

- We are always learning.
  Actions include ensuring that appraisals are conducted within timescale, leads undertake appraisal training, promote learning and development prospectus across teams.

- Morale
  Conduct a sample of stay interviews throughout the division, offer/promote living the values sessions for teams to improve relationships, ensure all managers have completed Manager's Essentials during 2023/24

- Engagement
  Promote access to and information on Dudley Improvement Practice to support skill development and focus on ability to demonstrate initiative/improve services, consultation/engagement with staff on how to improve core areas as part of Staff Survey cascade.

In addition, the division has highlighted the departments within the division that require tailored support to improve results. These have focused action plans on the specific areas highlighted in department level results which include a cultural review, a training matrix focused on a specific staff group and engagement work between staff groups.

2.24 **Surgery Women and Children Divisional Plan and Approach to Challenge areas.**

The division has highlighted four People Promise areas for focused action and developed a detailed action plan with target dates and success measures. The areas for focus are:

- We are a team.
  Delivery of Living the Values sessions to key areas, Manager's Essentials targeting areas with historically low take-up and were indicated by line manager questions, appraisal training for managers, team huddles to be introduced or relaunched.

- We are recognised and rewarded.
  Local recognition schemes utilising handovers/huddles, appraisal training for managers, promotion of Greatix and thank you cards,

- We are safe and healthy.
  Local plans to be delivered in core areas, stress audits to be undertaken in areas flagged in survey responses, Wellbeing Champions to be instated in all services, all managers to attend new sickness absence training, promotion of disability staff network.

- We work flexibly.
  Flexible working audit across the division, commitment to advertising all posts with flexible working options highlighted.

In addition, the division has highlighted the departments within the division that require tailored support to improve results. These have focused action plans on the specific areas highlighted in department level results. However, there are some standard interventions which include ensuring all managers attend Manager's Essentials training, recruitment and deployment of Wellbeing Champions, Living the Values sessions with teams.

2.25 **Conclusion and Next Steps**

Considering the current environment, the findings from the 2022 Staff Survey are showing stable performance with a response rate that compares well to the benchmarked position. There is an ongoing commitment to the work already underway and a focus on ensuring that in 2023/24 the focus is on continuing to embed, share and spread the focused work on key

areas that matter to our people of EDI, Wellbeing, Team, and Line Manager effectiveness. This reinforces the work of the planned launch of the Dudley People Plan and associated People Journeys.

The results will be shared more widely to enable a review of action and ongoing improvement. Specifically, this will be via:

- Equality, Diversity and Inclusion Steering Groups
- WSEC Deep Dive - April 2023
- Divisional Performance meetings

The planned communication focuses on:

- Sharing findings across the whole of the organisation through the Staff Survey microsite
- Briefings through In the Know and cascade to managers/teams.
- Divisional Briefings
- Staff Networks

Actions outlined will continue to be monitored through regular reporting to Workforce and Staff Engagement Committee.

3 RISKS AND MITIGATIONS

3.1 Staff engagement, recruitment and retention, EDI and Wellbeing are all identified as Corporate Risks and on the Board Assurance Framework (BAF). The Staff Survey provides the opportunity to review progress to date and identify any further risks as a result.

3.2 The results described above, and actions taken to mitigate known risks, are unlikely to change in risk score or BAF as a result of the Staff Survey results in 2022 as the overall position reported is static. There is an indication of some positive movement in some areas which will be reviewed throughout 2023. There is positive assurance that plans are in place – measures of success will relate to ongoing data collection through quarterly people pulse and national staff survey results.

4. RECOMMENDATION(S)

4.1 The report outlines both areas of improvement and areas of concern – from an organisational and divisional perspective. There are flagged areas for continued focus and existing planned work to improve the employee experience will continue to be embedded.

The Board is asked to note the improving position of the staff survey and positive comparisons with benchmark peers. They are asked to also be aware that there are areas for concern. These are supported by clear organisational and divisional action plans.

4.2 The results will continue to be reviewed and further supported with quarterly data to inform progress or flag risks. Regular reports will be provided through the WSEC on action plans and progress from April 2023 through to September 2023 when the next survey is planned to launch.

Rachel Andrew
Head of OD, Leadership and Culture
27th April 2023

APPENDICES:

Appendix 1 – Divisional Comparison of Promises and Themes

Appendix 2 – Division Action Plans

Appendix 1 – Divisional Comparison of Promises and Themes

People Promises and Staff Engagement and Morale Themes by Division 2022									
	Dudley	National Avg	Lowest benchmark	Highest Benchmark	Corporate Division	CCCS	Medicine	SWC	No of red areas per promise or theme
Response rate	48.9%	44.5%	26.2%	68.7%	72.4%	56.0%	42.0%	47.7%	
People Promise									
We are compassionate and inclusive	7.2	7.2	6.8	7.7	7.5	7.2	7.2	7.2	0
We are recognised and rewarded	5.7	5.7	5.2	6.4	6.4	5.7	5.7	5.6	1
We each have a voice that counts	6.7	6.6	6.2	7.1	6.9	6.6	6.7	6.6	0
We are safe and healthy	5.8	5.9	5.4	6.4	6.4	5.9	5.7	5.6	2
We are always learning	5.2	5.4	4.4	5.9	5.4	5.1	5.3	5.1	2
We work flexibly	6	6	5.6	6.6	6.8	5.9	6	5.9	2
We are a team	6.7	6.6	6.3	7.1	7.2	6.6	6.7	6.6	0
Staff engagement	6.7	6.8	6.1	7.3	7	6.7	6.7	6.7	0
Morale	5.7	5.6	5.2	6.3	6	5.7	5.6	5.5	1
Number worse than national average and worse than organisation average					0	2	1	5	
Worse than national avg/worse than Dudley									
Better or same as national/worse than Dudley									
Worse than national/better or same as Dudley									
Better than national/better or same as Dudley									

Performance KPIs

May 2023 Report

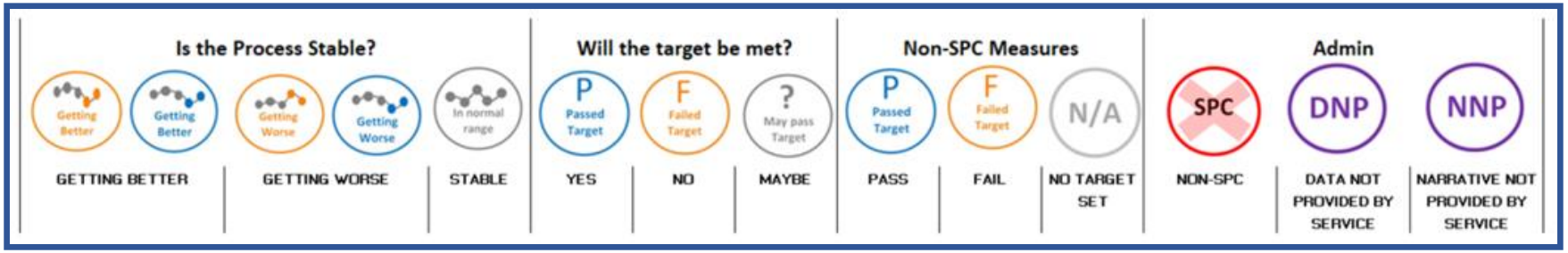
(March 2023 Data, February 2023 Data for Cancer)

The Dudley Group NHS Foundation Trust

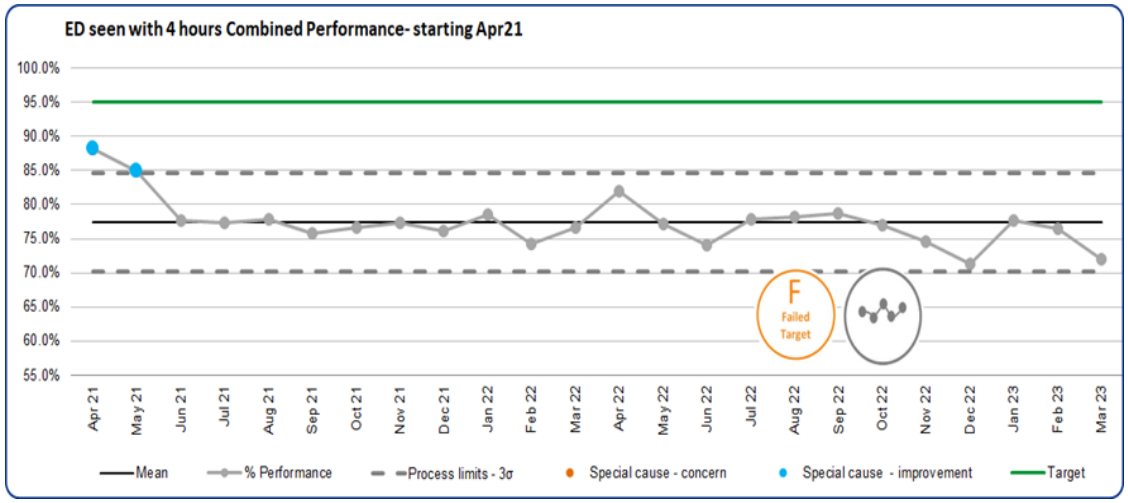
Karen Kelly, Chief Operating Officer

Constitutional Performance

Constitutional Standard and KPI		Target	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Status	
Emergency Access Standard (EAS)	Combined 4hr Performance	95.0%	72.1%	77.1%	74.0%	77.8%	78.2%	78.7%	76.9%	74.6%	71.3%	77.6%	76.5%	72.0%	In normal range	F Failed Target
Triage	Triage - All	95.0%	90.1%	85.4%	84.8%	86.1%	85.5%	84.3%	83.8%	80.7%	74.2%	79.5%	71.2%	69.3%	In normal range	F Failed Target
Cancer	Cancer 62 Day - All	85.0%	56.2%	73.9%	69.3%	69.7%	69.7%	69.7%	69.7%	69.7%	46.6%	41.2%	42.0%	N/A	Getting Worse	F Failed Target
	Cancer 31 Day -	96.0%	93.0%	92.6%	93.2%	94.8%	90.1%	84.9%	90.4%	83.2%	92.7%	82.0%	88.4%	N/A	In normal range	F Failed Target
	All Cancer 2 Week Waits	93.0%	86.9%	96.1%	93.1%	92.3%	78.7%	77.0%	80.6%	86.1%	83.9%	83.5%	93.8%	N/A	In normal range	F Failed Target
Referral to Treatment (RTT)	RTT Incomplete	92%	73.3%	73.6%	71.0%	69.3%	67.7%	65.5%	64.5%	63.3%	60.3%	59.9%	58.9%	58.2%	Getting Worse	F Failed Target
Diagnostics	DM01 - Diagnostics achieved within 6 weeks	99%	78.1%	81.8%	83.1%	84.2%	80.7%	78.1%	76.9%	76.4%	71.0%	70.4%	74.0%	72.1%	Getting Worse	F Failed Target
VTE	% Assessed on Admission	95%	94.3%	94.3%	93.9%	93.0%	92.9%	93.2%	93.3%	94.5%	93.4%	93.7%	94.3%	86.6%	In normal range	F Failed Target



ED Performance



Latest Month	Latest Month	4th
72.0%	30	For February 23
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

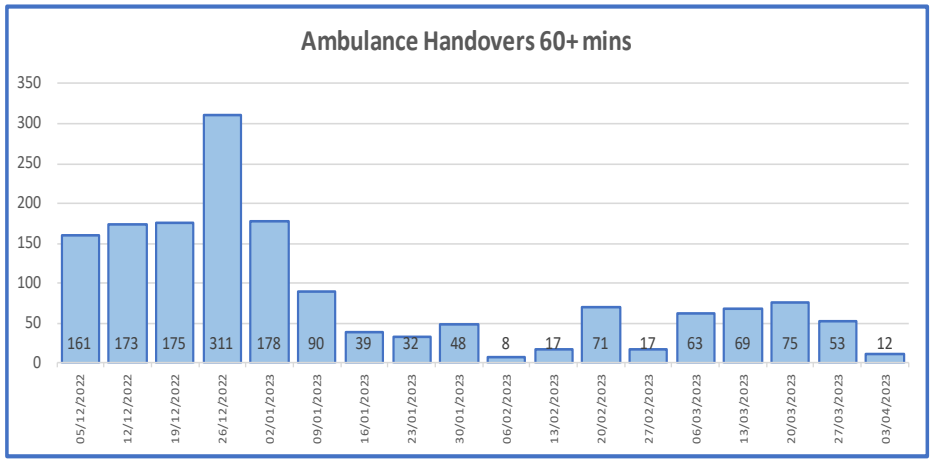
Performance

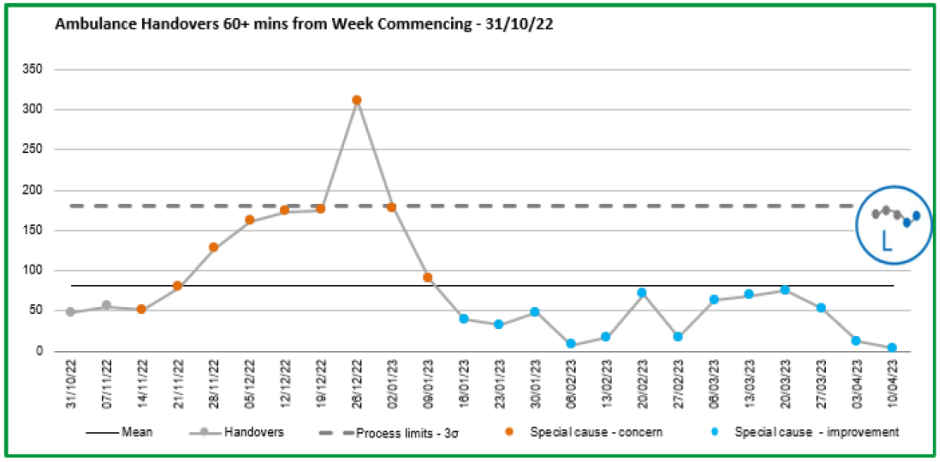
- 4 hour ED performance dipped slightly in March to 72%. An interim target of attaining 76% by March 2024 has been introduced nationally
- March saw a notable increase in Emergency Department attendances compared to recent months; attendances reached over 9,000. March was the busiest month since November 2022, ranking above December and January
- Time to admission saw a slight increase in March compared to February, but remains lower than December and January, reflecting initiatives to improve flow from Urgent and Emergency Care areas to AMU and base wards

Action

- Revised working practices to improve the timeliness of flow between ED, AMU and baseline wards continue to be adapted. Total number of discharges per day over the last 3 months has seen an increasing trend within the Medicine division
- Continue with projects to realise early discharges; during March, the percentage of beds allocated after 1600hrs to patients waiting in the Emergency Department reduced

Ambulance Handovers 60+ Mins





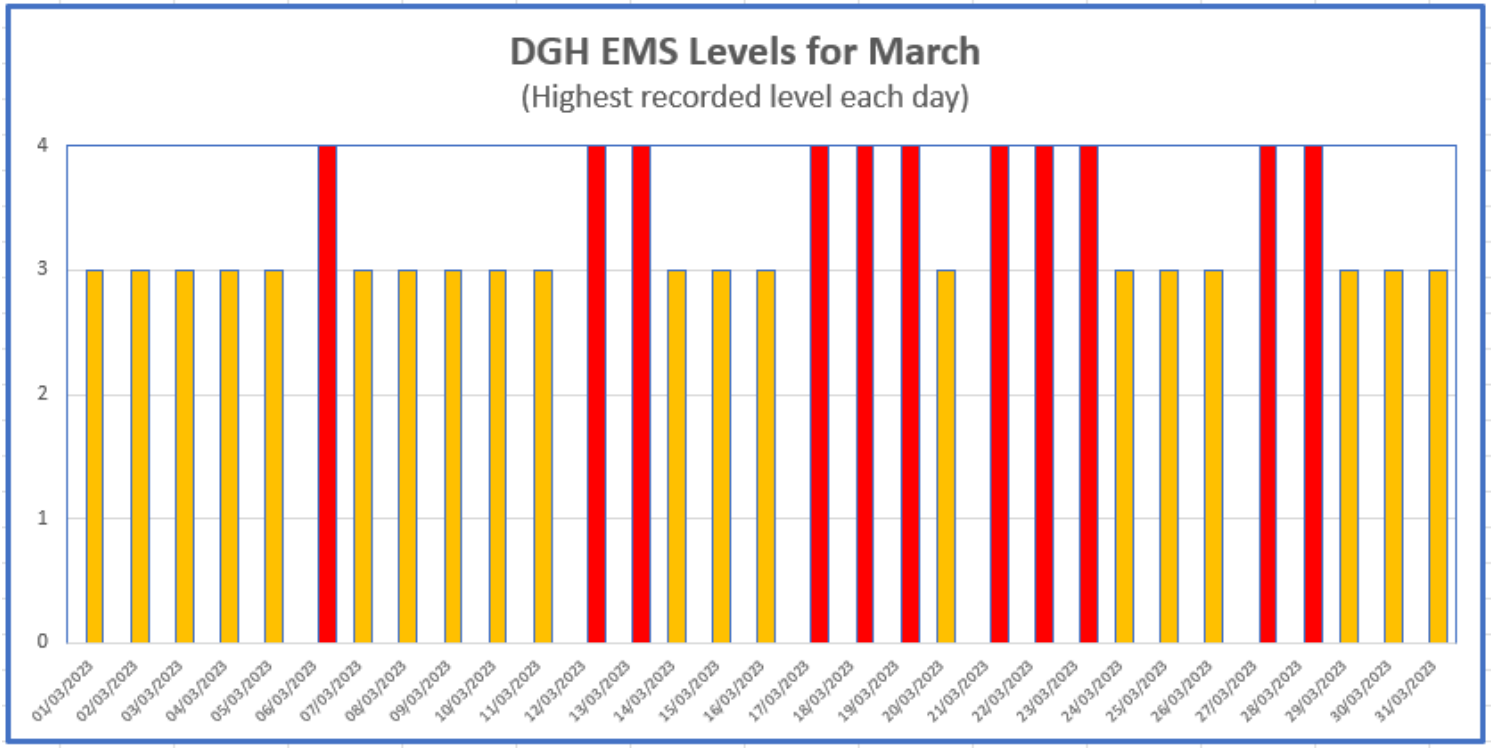
Performance

- March saw a notable increase in ambulance conveyances to the Trust with 3,298 during the month – an increase of 339 on February. Ambulance activity in March eclipsed that seen in December and January during the covid and flu peaks in demand that saw extreme pressure within Urgent and Emergency Care
- Consequently, there was a slight rise in ambulance handover delays during March compared to February, but total delays remained significantly below those experienced in December and early January

Action

- The Discharge Improvement Group continues to develop plans through its workstreams, with particular focus on Discharge to Assess and Discharge Planning on Admission models
- There has been a steady increase in number of discharges per day in the Medicine division over recent month. Continued emphasis on discharge to be a focus

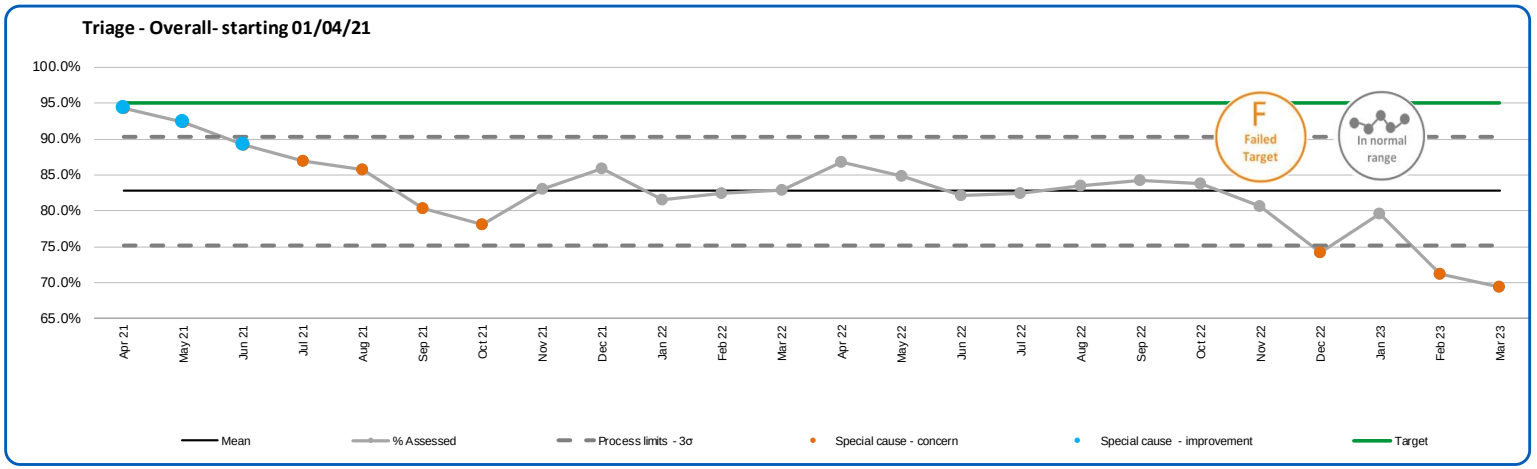
EMS Level for last month



Observations

- The number of days the Trust operated at EMS Level 4 in March increased compared to February. This is reflective of the increase in ambulance arrivals and Emergency Department attendances experienced during the month
- Some surge areas remained in use during March to mitigate urgent and emergency care pressures

ED Triage



Latest Month

69.3%

Triage – target 95%

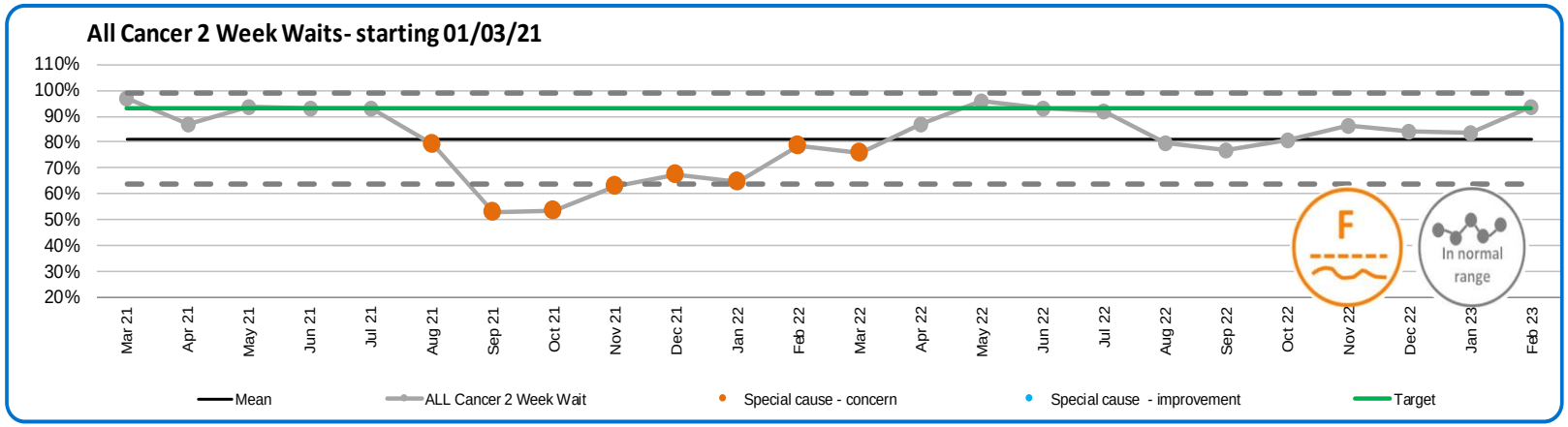
Performance

- Overall, triage performance deteriorated in March, largely driven by Majors and See and Treat
- Ambulance triage remains the only triage measure above target at 98%
- Majors and Peads saw a deterioration in performance. See and Treat remained broadly consistent with February at 68%.

Action

- Additional cohort of training in the ESI triage model for ED nurses has been approved
- Nursing rotas have been amended to provide x4 ESI triage trained nurses per shift. New model commences 30th April

Cancer Performance – 2 Week Wait



Latest Month

93.8%

All cancer 2 week waits – target 93%

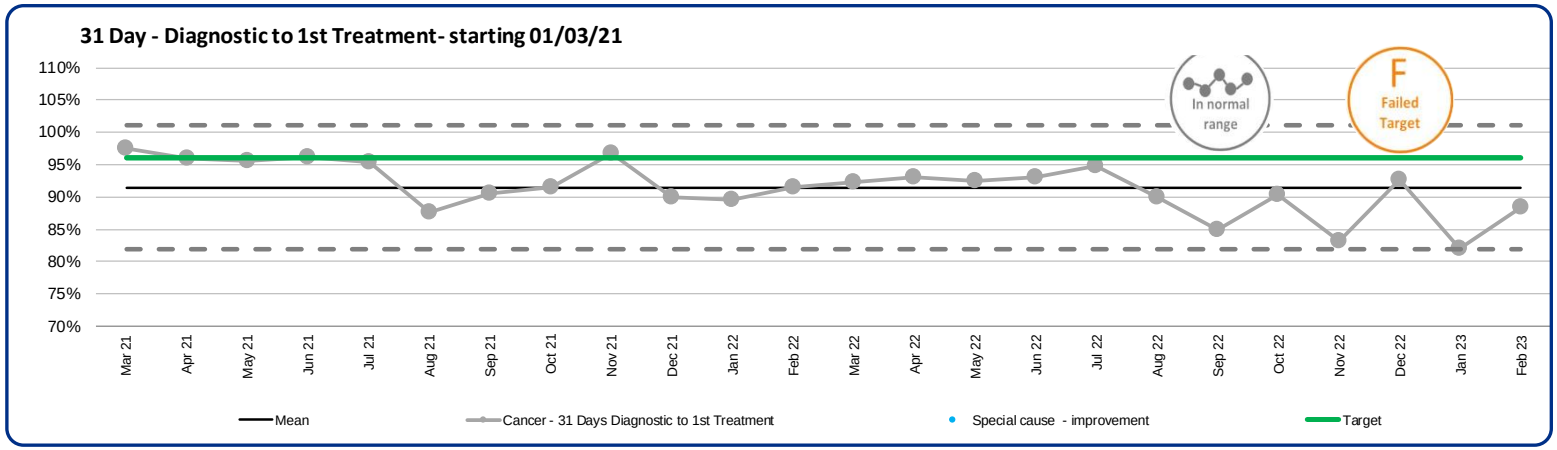
Performance

- All cancer data runs two months behind. Data included within this pack is up to and including February 2023
- 2 week wait performance in February saw a marked improvement compared to previous months, with the Trust attaining the national standard of 93%
- At the time of writing, March performance is to be finalised and is showing performance consistent with that seen in February
- 7 of 9 tumour sites attained the 93% standard in February, up from 2 in January
- The total number of 2ww appointments delivered by the tumour sites in January and February was greater than December and November 2022, equalling improved throughput and productivity

Action

- Continue with additional capacity allocated to address immediate capacity shortfalls
- The skin ‘same day surgery’ pathway trial is to be made permanent, following successful pilot results in reducing pathway length for some patient cohorts
- Workforce challenges in Skin and Gynae are key risks to a fall back in performance. These risks are being mitigated through a detailed workforce recruitment plan in Gynae and potential locum support in Skin while substantive recruitment is on going

Cancer Performance – 31 Day



Latest Month

88.4%

Target 96%

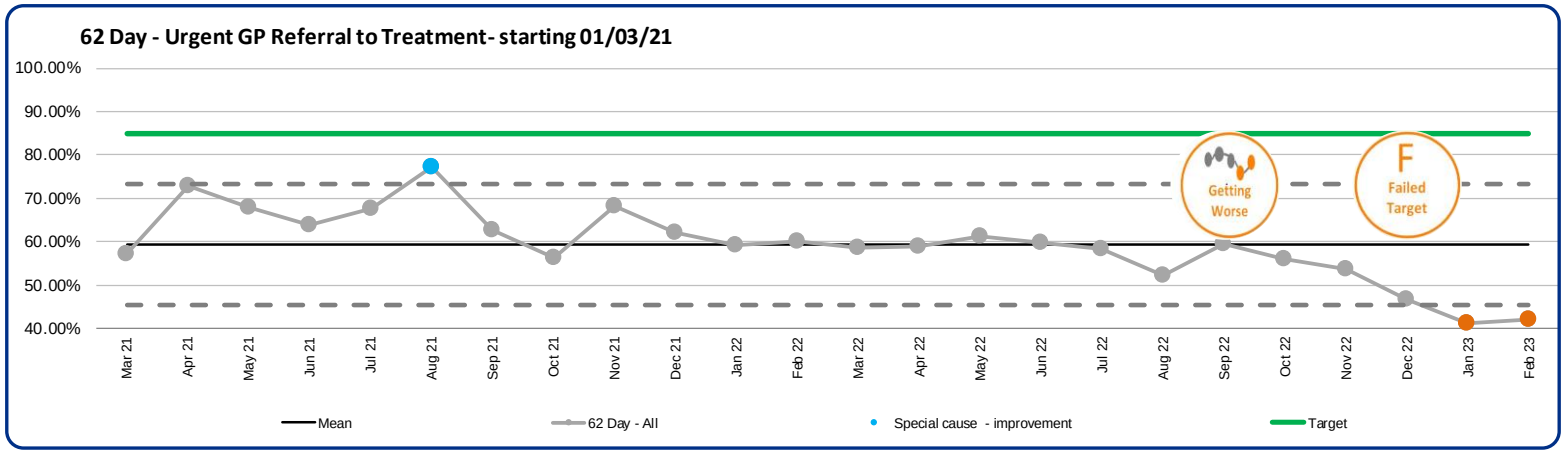
Performance

- Following a decline in performance during January, February saw a partial recovery of this position, to 88.4%
- However, performance remains below target
- 5 of 9 tumour sites realised improvement in performance during February, compared to January

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

42.0%

Target 85%

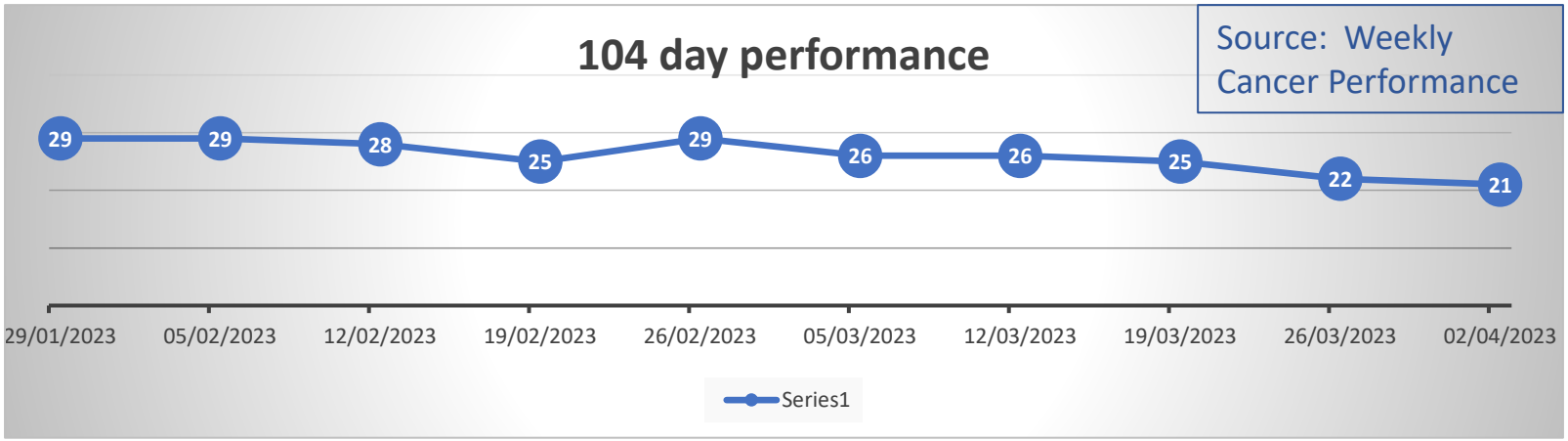
Performance

- Following several months of declining performance against the 62 day standard for patients waiting for first definitive treatment, February saw performance stabilise
- February saw fewer breaches than January, with the high volume tumour sites of Breast and Colorectal delivering a increase in performance

Action

- In collaboration with Primary Care, FIT testing is now being rolled out across the Dudley Place, with the aim of streamlining and reducing pathway times in Colorectal
- The use of an IT system in the skin tumour site, where photographs are included with referrals from Primary Care, has launched but requires further scaling up for an improvement in performance to be realised. The Trust continues to work with Primary Care providers to roll this initiative out further
- Work is ongoing with Black Country Pathology Services to improve cancer turnaround times, which is proving a challenge for the organisation across a number of tumour sites

Cancer Performance – 104 Day



Latest Week

(02/04/23)

21

All 104 week waits, target zero

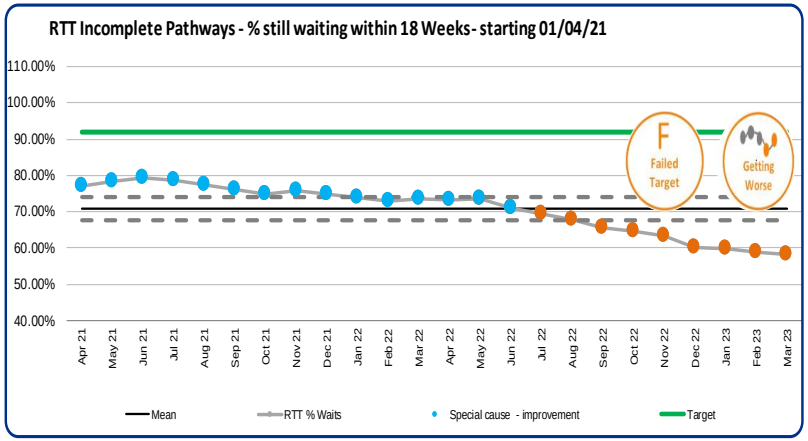
Performance

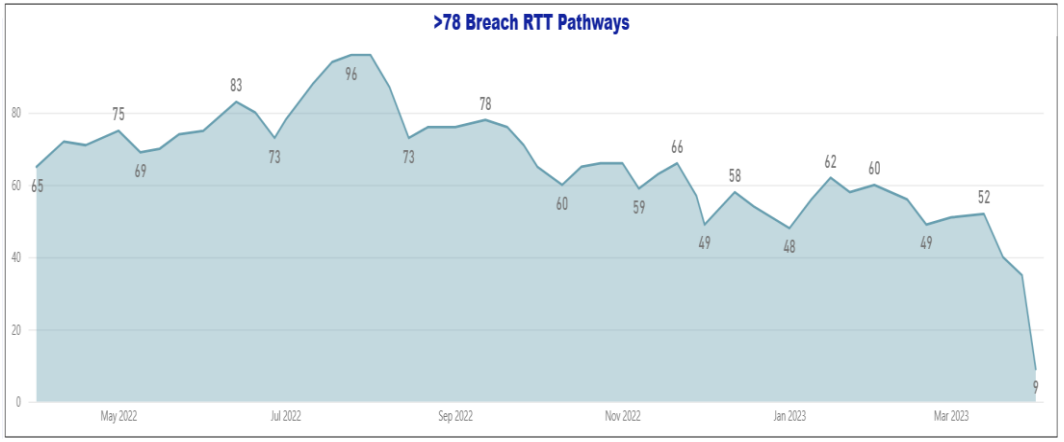
- Reducing the 104 backlog remains a priority, although the backlog has remained stagnant in recent weeks with circa 20-22 patients waiting over 104 days to commence treatment
- The most challenged tumour sites include colorectal and skin. Both tumour sites have sufficient treatment/theatre capacity. Work is focused on reducing the pathway at the referral and diagnostic stages through collaboration with primary care and the introduction of FIT testing (Colorectal) and photography at point of referral (Skin)

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
- Skin have been allocated additional baseline treatment sessions in the Minor Procedure Room facilities

RTT Performance





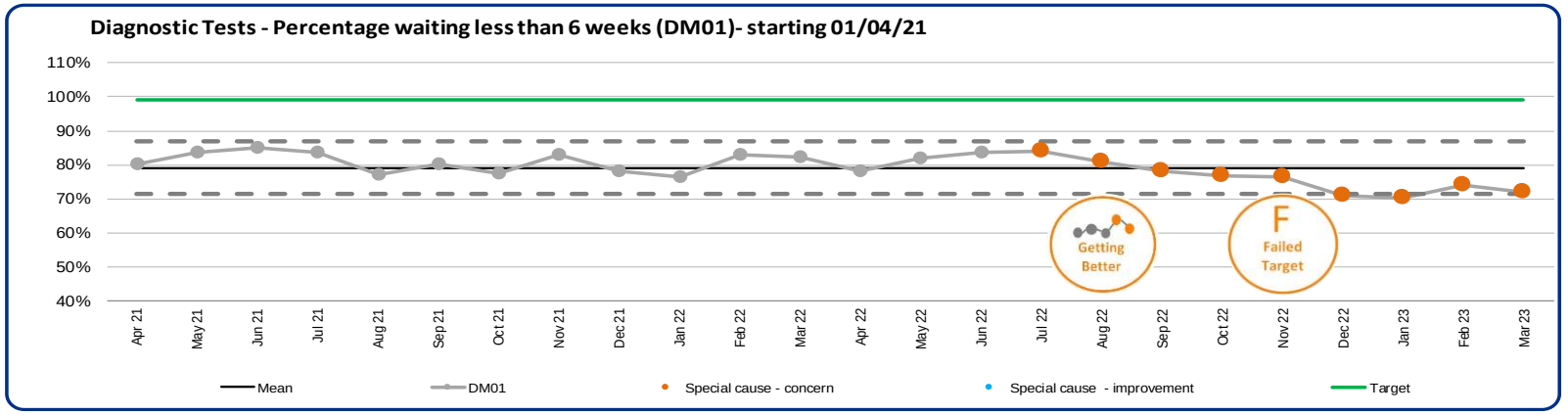
Performance

- Performance against the RTT standard is not routinely monitored nationally, with the national focus instead being centred on reducing the backlog of patients waiting to commence elective treatment
- The Trust has made good progress over recent months in reducing clearing the backlog of patients waiting over 78 weeks. The Trust ended March with 9 patients unable to commence treatment within the month
- The Trust is focusing on working towards the next national target of reducing long waits over 65 weeks
- The Trust is placed joint 1st of 20 Midlands acute Trusts for the number of 104 week breaches with 0

Action

- Plans and trajectories have been developed with regards to delivering against the next national target of reducing 65 week + cohort
- Productivity gains will be key to attaining the 65 week target. Reducing late starts and increasing throughput through theatre lists is being driven through the Theatre Improvement Group
- The Surgical Division is developing plans for further high volume, low complexity theatre lists to improve theatre productivity, with particular focus on ENT (grommet procedures) and Urology (circumcision lists)

DM01 Performance



Latest Month

72.1%

DM01 combining 15 modalities - target 99%

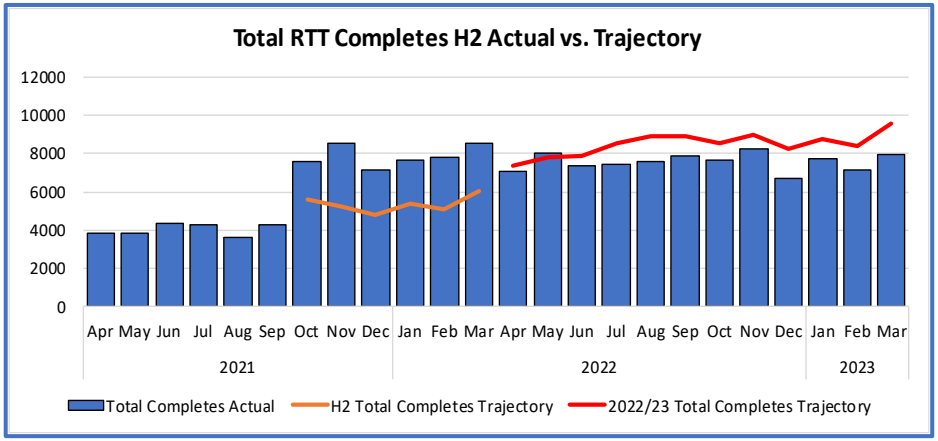
Performance

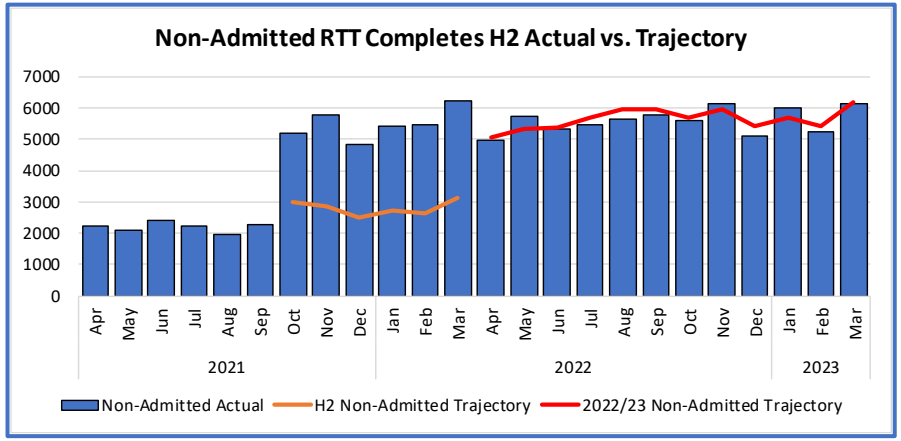
- Performance in March against the DM01 standard is broadly consistent with that delivered in February
- At a modality level, notable improvements have been realised in Audiology, MRI, Cystoscopy and Gastro
- Performance is currently ahead of the submitted recovery trajectory

Action

- System level project underway to devise system-wide solutions in Cardiology
- The Trust remains on track to deliver this standard by the nationally required target of March 2024

Recovery and Restoration – RTT Completes





Performance

- The Trust continues to have x0 104 week breaches and continues to reduce the number of patients waiting over 78 weeks - the Trust reduced the backlog over 78 weeks to 9 patients at the end of March
- Mutual aid has been provided to other Black Country Trusts to support a system-wide reduction of the 78 week cohort, with a particular focus on supporting Royal Wolverhampton and Walsall

Action

- The clinical Divisions are devising plans and trajectories to work towards the next national target of reducing the backlog over patients waiting over 65 weeks
- Productivity gains are a key component of further recovery, with projects being driven via the Theatre Improvement Group.

RTT Restoration and Recovery – Trust Comparisons

0-18 Week RTT Performance (Midlands Region): =8th

February 2023

Region Code	Provider Code	Provider Name	Total number of incomplete pathways	Total within 18 weeks	% within 18 weeks
Y60	RLT	GEORGE ELIOT HOSPITAL NHS TRUST	15,504	10,955	70.7%
Y60	RJC	SOUTH WARWICKSHIRE UNIVERSITY NHS FOUNDATION TRUST	30,808	20,880	67.8%
Y60	RK5	SHERWOOD FOREST HOSPITALS NHS FOUNDATION TRUST	46,999	31,514	67.1%
Y60	RNQ	KETTERING GENERAL HOSPITAL NHS FOUNDATION TRUST	26,767	16,954	63.3%
Y60	RNS	NORTHAMPTON GENERAL HOSPITAL NHS TRUST	39,012	24,487	62.8%
Y60	RFS	CHESTERFIELD ROYAL HOSPITAL NHS FOUNDATION TRUST	23,761	14,612	61.5%
Y60	RLQ	WYE VALLEY NHS TRUST	21,181	12,490	59.0%
Y60	RNA	THE DUDLEY GROUP NHS FOUNDATION TRUST	45,965	27,081	58.9%
Y60	RX1	NOTTINGHAM UNIVERSITY HOSPITALS NHS TRUST	76,872	45,000	58.5%
Y60	RBK	WALSALL HEALTHCARE NHS TRUST	33,929	19,332	57.0%
Y60	RL4	THE ROYAL WOLVERHAMPTON NHS TRUST	73,041	41,376	56.6%
Y60	RXK	SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST	70,768	38,184	54.0%
Y60	RJE	UNIVERSITY HOSPITALS OF NORTH MIDLANDS NHS TRUST	76,374	40,791	53.4%
Y60	RTG	UNIVERSITY HOSPITALS OF DERBY AND BURTON NHS FOUNDATION TRUST	111,196	58,162	52.3%
Y60	RXW	THE SHREWSBURY AND TELFORD HOSPITAL NHS TRUST	36,090	18,810	52.1%
Y60	RKB	UNIVERSITY HOSPITALS COVENTRY AND WARWICKSHIRE NHS TRUST	64,604	33,271	51.5%
Y60	RWD	UNITED LINCOLNSHIRE HOSPITALS NHS TRUST	72,047	35,709	49.6%
Y60	RWE	UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST	118,475	57,644	48.7%
Y60	RWP	WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST	67,148	30,718	45.7%
Y60	RRK	UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST	144,711	62,199	43.0%

RTT Restoration and Recovery – Trust Comparisons

Number of Patients Waiting 78+ Weeks for Routine Treatment (Midlands Region): 6th February 2023

Region Code	Provider Code	Provider Name	Total 78 plus weeks
Y60	RLT	GEORGE ELIOT HOSPITAL NHS TRUST	0
Y60	RNQ	KETTERING GENERAL HOSPITAL NHS FOUNDATION TRUST	0
Y60	RNS	NORTHAMPTON GENERAL HOSPITAL NHS TRUST	1
Y60	RK5	SHERWOOD FOREST HOSPITALS NHS FOUNDATION TRUST	21
Y60	RLQ	WYE VALLEY NHS TRUST	47
Y60	RNA	THE DUDLEY GROUP NHS FOUNDATION TRUST	50
Y60	RJC	SOUTH WARWICKSHIRE UNIVERSITY NHS FOUNDATION TRUST	52
Y60	RFS	CHESTERFIELD ROYAL HOSPITAL NHS FOUNDATION TRUST	71
Y60	RBK	WALSALL HEALTHCARE NHS TRUST	89
Y60	RL4	THE ROYAL WOLVERHAMPTON NHS TRUST	164
Y60	RXK	SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST	188
Y60	RKB	UNIVERSITY HOSPITALS COVENTRY AND WARWICKSHIRE NHS TRUST	212
Y60	RXW	THE SHREWSBURY AND TELFORD HOSPITAL NHS TRUST	252
Y60	RX1	NOTTINGHAM UNIVERSITY HOSPITALS NHS TRUST	290
Y60	RWD	UNITED LINCOLNSHIRE HOSPITALS NHS TRUST	612
Y60	RWP	WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST	708
Y60	RTG	UNIVERSITY HOSPITALS OF DERBY AND BURTON NHS FOUNDATION TRUST	725
Y60	RJE	UNIVERSITY HOSPITALS OF NORTH MIDLANDS NHS TRUST	769
Y60	RRK	UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST	1,642
Y60	RWE	UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST	1,914

RTT Restoration and Recovery – Trust Comparisons

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

February 2023

Region Code	Provider Code	Provider Name	104 plus
Y60	RLT	GEORGE ELIOT HOSPITAL NHS TRUST	-
Y60	RNQ	KETTERING GENERAL HOSPITAL NHS FOUNDATION TRUST	-
Y60	RNS	NORTHAMPTON GENERAL HOSPITAL NHS TRUST	-
Y60	RK5	SHERWOOD FOREST HOSPITALS NHS FOUNDATION TRUST	-
Y60	RLQ	WYE VALLEY NHS TRUST	-
Y60	RNA	THE DUDLEY GROUP NHS FOUNDATION TRUST	-
Y60	RJC	SOUTH WARWICKSHIRE UNIVERSITY NHS FOUNDATION TRUST	-
Y60	RBK	WALSALL HEALTHCARE NHS TRUST	-
Y60	RL4	THE ROYAL WOLVERHAMPTON NHS TRUST	-
Y60	RWP	WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST	-
Y60	RFS	CHESTERFIELD ROYAL HOSPITAL NHS FOUNDATION TRUST	1
Y60	RXK	SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST	1
Y60	RXW	THE SHREWSBURY AND TELFORD HOSPITAL NHS TRUST	1
Y60	RKB	UNIVERSITY HOSPITALS COVENTRY AND WARWICKSHIRE NHS TRUST	2
Y60	RRK	UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST	2
Y60	RX1	NOTTINGHAM UNIVERSITY HOSPITALS NHS TRUST	4
Y60	RWD	UNITED LINCOLNSHIRE HOSPITALS NHS TRUST	4
Y60	RWE	UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST	53
Y60	RJE	UNIVERSITY HOSPITALS OF NORTH MIDLANDS NHS TRUST	73
Y60	RTG	UNIVERSITY HOSPITALS OF DERBY AND BURTON NHS FOUNDATION TRUST	78

RTT Restoration and Recovery – Trust Comparisons

Median Waiting Time (Midlands Region): =8th shortest

February 2023

Region Code	Provider Code	Provider Name	Average (median) waiting time (in weeks)
Y60	RK5	SHERWOOD FOREST HOSPITALS NHS FOUNDATION TRUST	11.8
Y60	RLT	GEORGE ELIOT HOSPITAL NHS TRUST	12.1
Y60	RJC	SOUTH WARWICKSHIRE UNIVERSITY NHS FOUNDATION TRUST	12.3
Y60	RNQ	KETTERING GENERAL HOSPITAL NHS FOUNDATION TRUST	12.9
Y60	RNS	NORTHAMPTON GENERAL HOSPITAL NHS TRUST	13.7
Y60	RFS	CHESTERFIELD ROYAL HOSPITAL NHS FOUNDATION TRUST	13.9
Y60	RX1	NOTTINGHAM UNIVERSITY HOSPITALS NHS TRUST	14.5
Y60	RLQ	WYE VALLEY NHS TRUST	14.6
Y60	RNA	THE DUDLEY GROUP NHS FOUNDATION TRUST	14.6
Y60	RL4	THE ROYAL WOLVERHAMPTON NHS TRUST	14.9
Y60	RBK	WALSALL HEALTHCARE NHS TRUST	15.0
Y60	RJE	UNIVERSITY HOSPITALS OF NORTH MIDLANDS NHS TRUST	16.4
Y60	RXK	SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST	16.7
Y60	RTG	UNIVERSITY HOSPITALS OF DERBY AND BURTON NHS FOUNDATION TRUST	16.9
Y60	RXW	THE SHREWSBURY AND TELFORD HOSPITAL NHS TRUST	17.0
Y60	RKB	UNIVERSITY HOSPITALS COVENTRY AND WARWICKSHIRE NHS TRUST	17.3
Y60	RWD	UNITED LINCOLNSHIRE HOSPITALS NHS TRUST	18.2
Y60	RWE	UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST	18.8
Y60	RWP	WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST	20.0
Y60	RRK	UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST	21.8

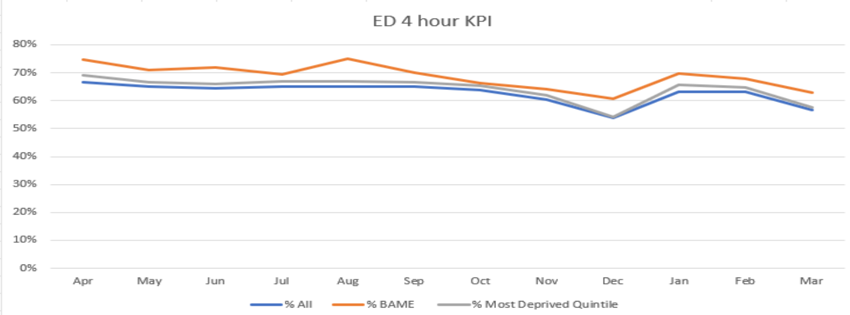
Cancer Restoration and Recovery – Trust Comparisons

2 Week Wait: 2nd ICS

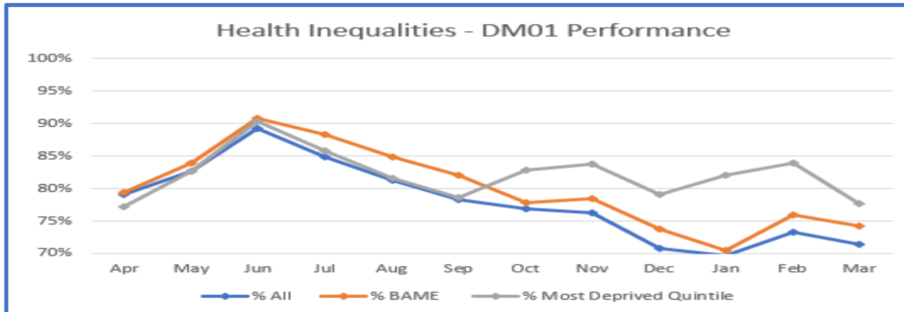
February 2023

	PERCENTAGE
ACCOUNTABLE PROVIDER	SEEN WITHIN 14 DAYS
SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST	98.2%
THE DUDLEY GROUP NHS FOUNDATION TRUST	93.8%
THE ROYAL WOLVERHAMPTON NHS TRUST	86.9%
WALSALL HEALTHCARE NHS TRUST	65.2%
ALL ENGLISH PROVIDERS	86.1%

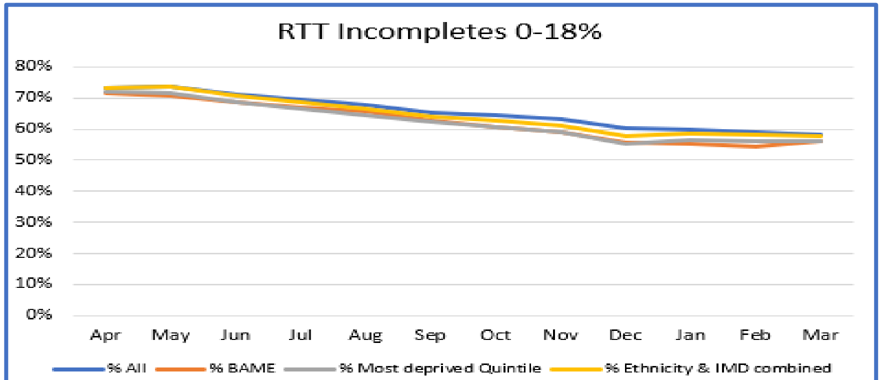
Health Inequalities

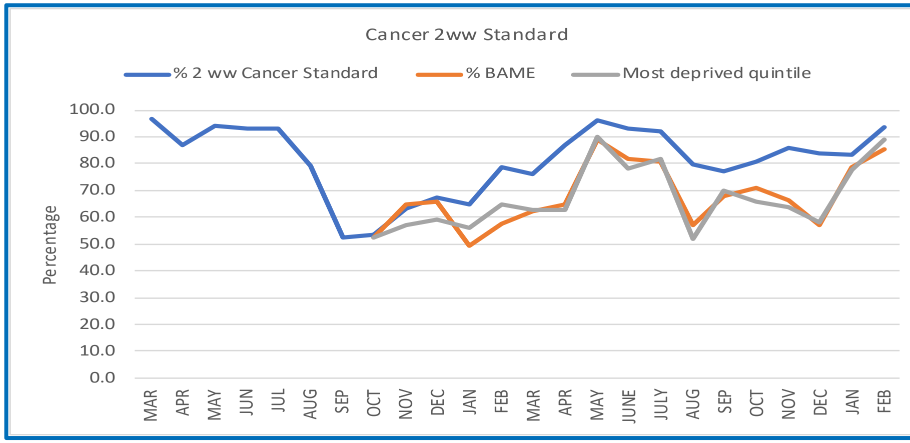


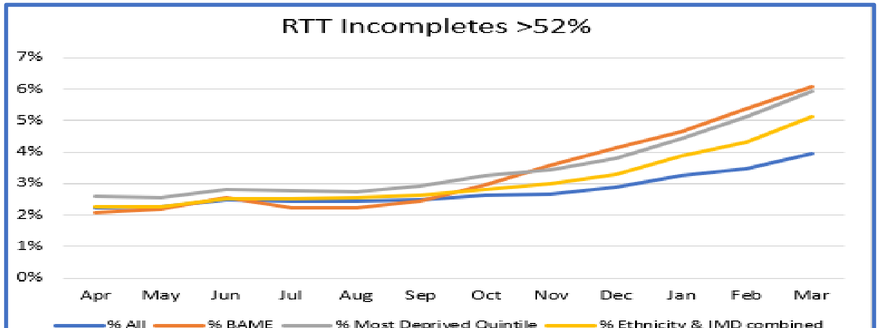
No and % ethnicity is not stated/unknown/not recorded	970	10.60%
No and % IMD postcode is invalid	41	0.44%



No and % Ethnicity is not stated/unknown/not recorded	1811	14.98%
No and % IDM postcode is invalid	12149	96.18%







No and % IMD postcode is invalid/missing	15047	32.2%
No and % ethnicity is not stated/unknown/not recorded	20485	43.6%

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.