Excellent health care, improved health for all

The Dudley Group NHS Foundation Trust

Board of Directors - Further reading pack
Public meeting
Thursday 14 September 2023

International Nurses attending graduation ceremony at Russells Hall Hospital

To:
- All integrated care boards and NHS trusts:
  - chairs
  - chief executives
  - chief operating officers
  - medical directors
  - chief nurses
  - heads of primary care
  - directors of medical education
- Primary care networks:
  - clinical directors

cc.
- NHS England regions:
  - directors
  - chief nurses
  - medical directors
  - directors of primary care and community services
  - directors of commissioning
  - workforce leads
  - postgraduate deans
  - heads of school
  - regional workforce, training and education directors / regional heads of nursing

NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

18 August 2023

Dear Colleagues,

Verdict in the trial of Lucy Letby

We are writing to you today following the outcome of the trial of Lucy Letby.

Lucy Letby committed appalling crimes that were a terrible betrayal of the trust placed in her, and our thoughts are with all the families affected, who have suffered pain and anguish that few of us can imagine.

Colleagues across the health service have been shocked and sickened by her actions, which are beyond belief for staff working so hard across the NHS to save lives and care for patients and their families.

On behalf of the whole NHS, we welcome the independent inquiry announced by the Department of Health and Social Care into the events at the Countess of Chester and will co-operate fully and transparently to help ensure we learn every possible lesson from this awful case.

NHS England is committed to doing everything possible to prevent anything like this happening again, and we are already taking decisive steps towards strengthening patient safety monitoring.

The national roll-out of medical examiners since 2021 has created additional safeguards by ensuring independent scrutiny of all deaths not investigated by a coroner and improving data quality, making it easier to spot potential problems.

This autumn, the new Patient Safety Incident Response Framework will be implemented across the NHS – representing a significant shift in the way we respond to patient safety incidents, with a sharper focus on data and understanding how incidents happen, engaging with families, and taking effective steps to improve and deliver safer care for patients.

We also wanted to take this opportunity to remind you of the importance of NHS leaders listening to the concerns of patients, families and staff, and following whistleblowing procedures, alongside good governance, particularly at trust level.

We want everyone working in the health service to feel safe to speak up – and confident that it will be followed by a prompt response.

Last year we rolled out a strengthened Freedom to Speak Up (FTSU) policy. All organisations providing NHS services are expected to adopt the updated national policy by January 2024 at the latest.

That alone is not enough. Good governance is essential. NHS leaders and Boards must ensure proper implementation and oversight. Specifically, they must urgently ensure:

1. All staff have easy access to information on how to speak up.
2. Relevant departments, such as Human Resources, and Freedom to Speak Up Guardians are aware of the national Speaking Up Support Scheme and actively refer individuals to the scheme.
3. Approaches or mechanisms are put in place to support those members of staff who may have cultural barriers to speaking up or who are in lower paid roles and may be less confident to do so, and also those who work unsociable hours and may not always be aware of or have access to the policy or processes supporting speaking up. Methods for

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communicating with staff to build healthy and supporting cultures where everyone feels safe to speak up should also be put in place.

4. Boards seek assurance that staff can speak up with confidence and whistleblowers are treated well.
5. Boards are regularly reporting, reviewing and acting upon available data.

While the CQC is primarily responsible for assuring speaking up arrangements, we have also asked integrated care boards to consider how all NHS organisations have accessible and effective speaking up arrangements.

All NHS organisations are reminded of their obligations under the Fit and Proper Person requirements not to appoint any individual as a Board director unless they fully satisfy all FPP requirements – including that they have not been responsible for, been privy to, contributed to, or facilitated any serious misconduct or mismanagement (whether lawful or not). The CQC can take action against any organisation that fails to meet these obligations.

NHS England has recently strengthened the Fit and Proper Person Framework by bringing in additional background checks, including a board member reference template, which also applies to board members taking on a non-board role.

This assessment will be refreshed annually and, for the first time, recorded on Electronic Staff Record so that it is transferable to other NHS organisations as part of their recruitment processes.

Lucy Letby's appalling crimes have shocked not just the NHS, but the nation. We know that you will share our commitment to doing everything we can to prevent anything like this happening again. The actions set out in this letter, along with our full co-operation with the independent inquiry to ensure every possible lesson is learned, will help us all make the NHS a safer place.

Yours sincerely,

Amanda Pritchard
NHS Chief Executive

Sir David Sloman
Chief Operating Officer
NHS England

Dame Ruth May
Chief Nursing Officer, England

Professor Sir Stephen Powis
National Medical Director
NHS England

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Enc 8 Appendices (for further reading pack)

Appendix 1 – Rescheduled activity due to the August 2023 junior doctor strike.

Elective Inpatient Activity	
Medicine	0
SWC	7
CCCS	0
Total	**7**
Elective Day Case Activity	
Medicine	0
SWC	29
CCCS	0
Total	**29**
New Outpatient Appointments	
Medicine	36
SWC	63
CCCS	0
Total	**99**
Follow-up Outpatient Appointments	
Medicine	30
SWC	29
CCCS	0
Total	**59**
78+ week waiters	
Medicine	0
SWC	0
CCCS	0
Total	**0**
104+ week waiters	
Medicine	0
SWC	0
CCCS	0
Total	**0**
2ww cancer activity	
Medicine	0
SWC	0
CCCS	0
Total	**0**
62+ day cancer activity	
Medicine	0
SWC	0
CCCS	0
Total	**0**
104+ day cancer activity	
Medicine	0
SWC	0
CCCS	0
Total	**0**

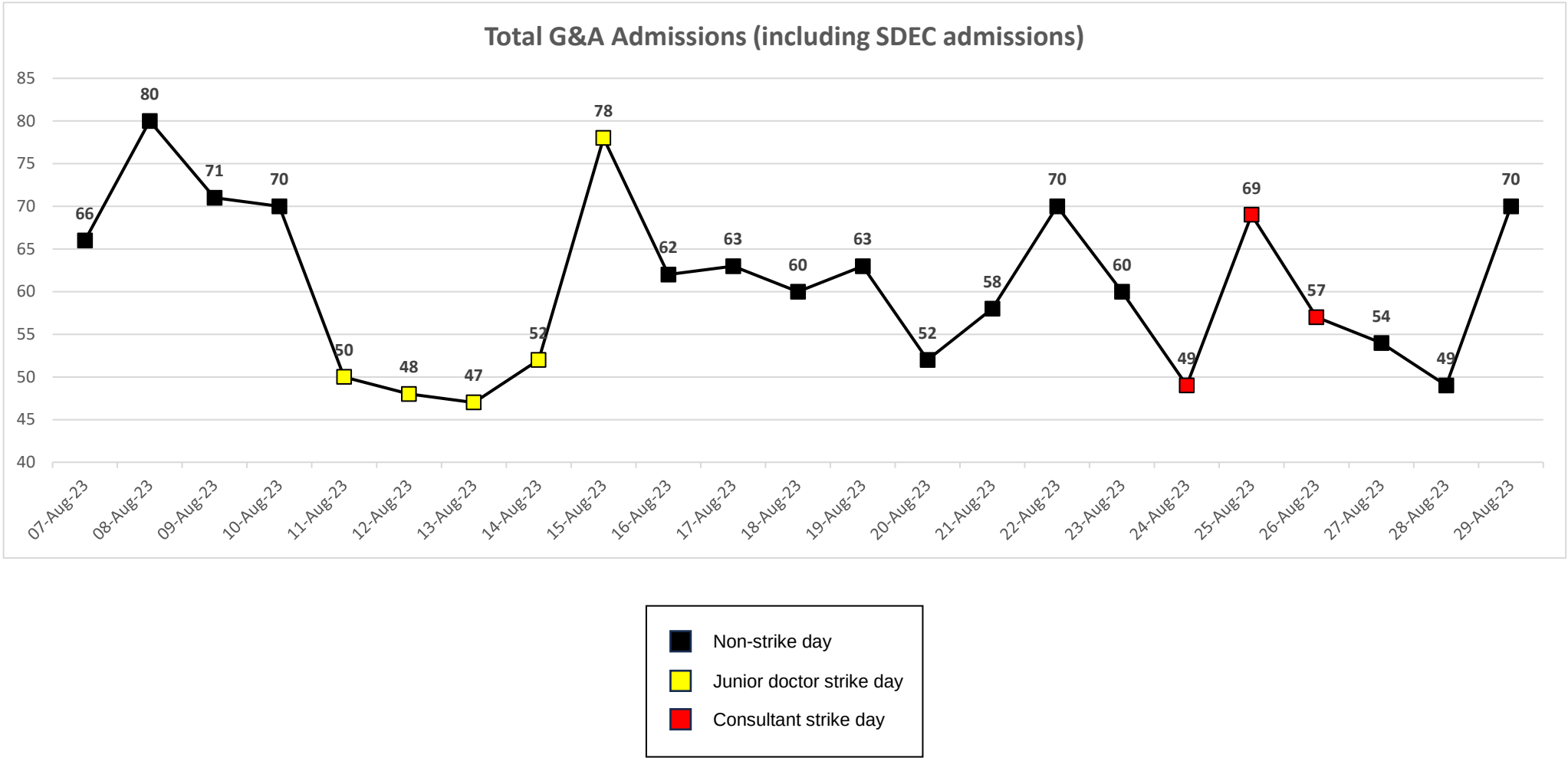
MRI diagnostic activity	
Medicine	0
SWC	0
CCCS	0
Total	**0**
CT diagnostic activity	
Medicine	0
SWC	0
CCCS	0
Total	**0**
Ultrasound diagnostic activity	
Medicine	0
SWC	0
CCCS	0
Total	**0**
Other diagnostic activity	
Medicine	0
SWC	0
CCCS	0
Total	**0**

Appendix 2 – Rescheduled activity due to the August 2023 consultant strike.

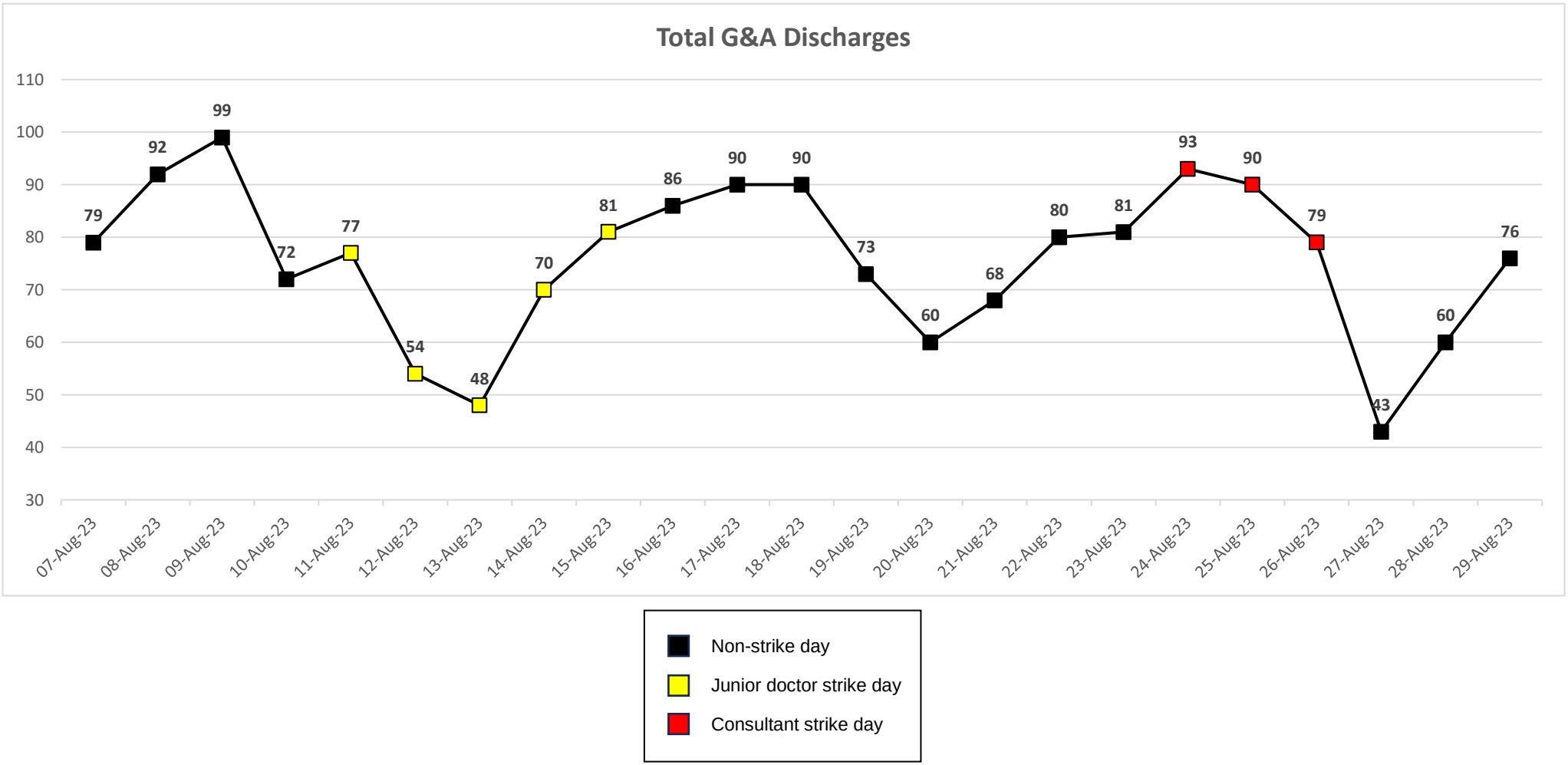
Elective Inpatient Activity	
Medicine	0
SWC	19
CCCS	0
Total	**19**
Elective Day Case Activity	
Medicine	8
SWC	76
CCCS	0
Total	**84**
New Outpatient Appointments	
Medicine	79
SWC	219
CCCS	0
Total	**298**
Follow-up Outpatient Appointments	
Medicine	147
SWC	278
CCCS	0
Total	**425**
78+ week waiters	
Medicine	0
SWC	0
CCCS	0
Total	**0**
104+ week waiters	
Medicine	0
SWC	0
CCCS	0
Total	**0**
2ww cancer activity	
Medicine	0
SWC	6
CCCS	0
Total	**6**
62+ day cancer activity	
Medicine	0
SWC	0
CCCS	0
Total	**0**
104+ day cancer activity	
Medicine	0
SWC	0
CCCS	0
Total	**0**

MRI diagnostic activity	
Medicine	0
SWC	0
CCCS	52
Total	**52**
CT diagnostic activity	
Medicine	0
SWC	0
CCCS	80
Total	**80**
Ultrasound diagnostic activity	
Medicine	0
SWC	0
CCCS	90
Total	**90**
Other diagnostic activity	
Medicine	0
SWC	0
CCCS	40
Total	**40**

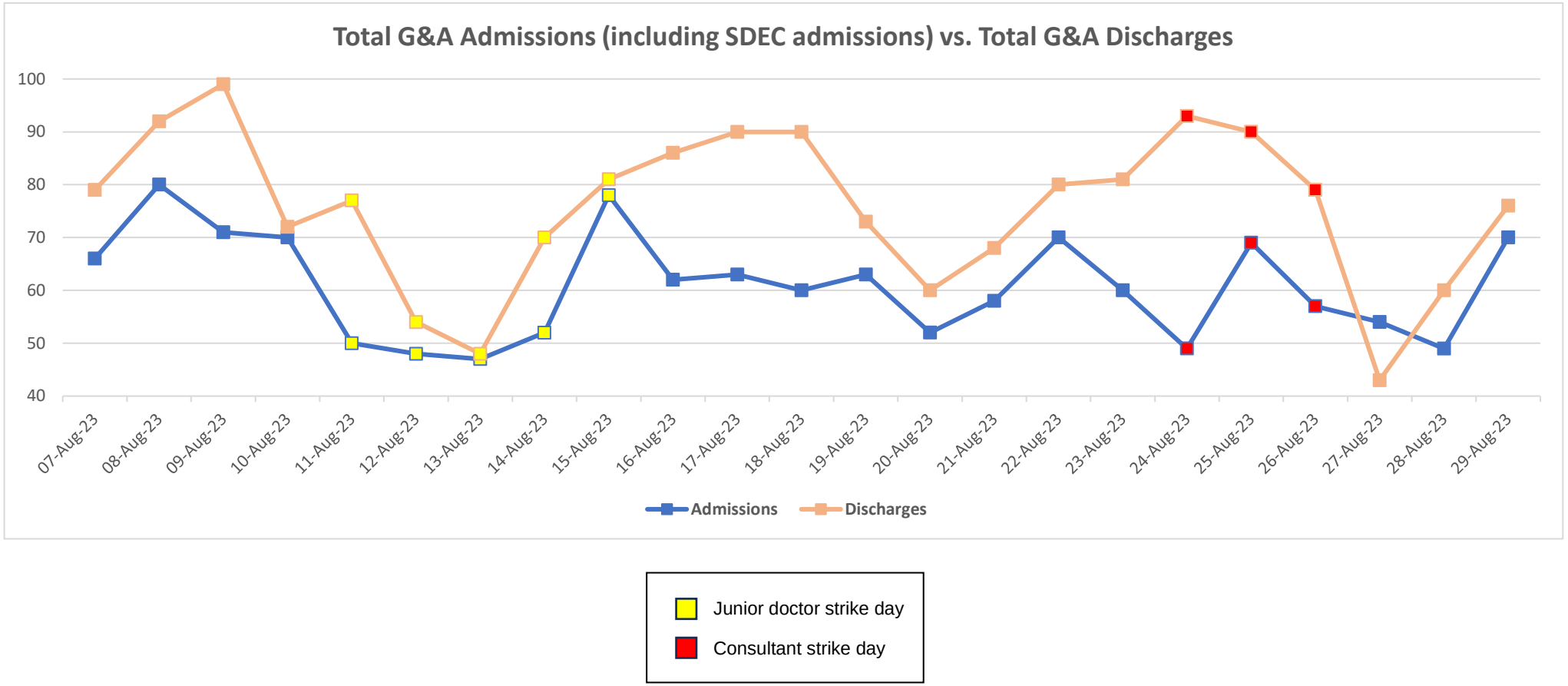
Appendix 3 – Total G&A admissions (including SDEC admissions) per day at The Dudley Group from Monday 7th August to Tuesday 29th August 2023.



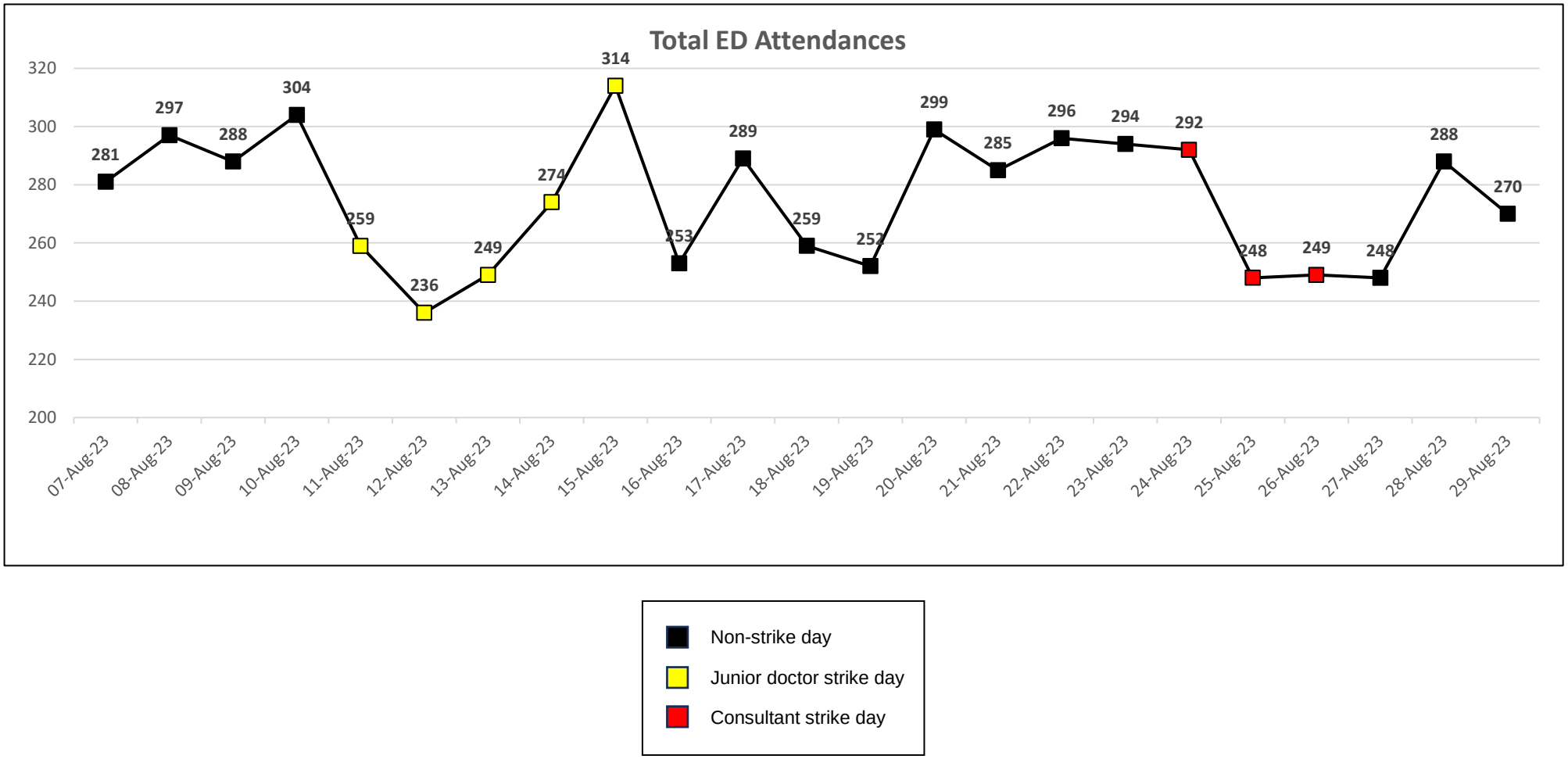
Appendix 4 – Total G&A discharges per day at The Dudley Group from Monday 7th August to Tuesday 29th August 2023.



Appendix 5 – A graph to show the total G&A admissions (including SDEC admissions) per day compared to total G&A discharges per day at The Dudley Group from Monday 7th August to Tuesday 29th August 2023.



Appendix 6 – Total Emergency Department attendances per day at The Dudley Group from Monday 7th August to Tuesday 29th August 2023.



Performance KPIs

August 2023 Report

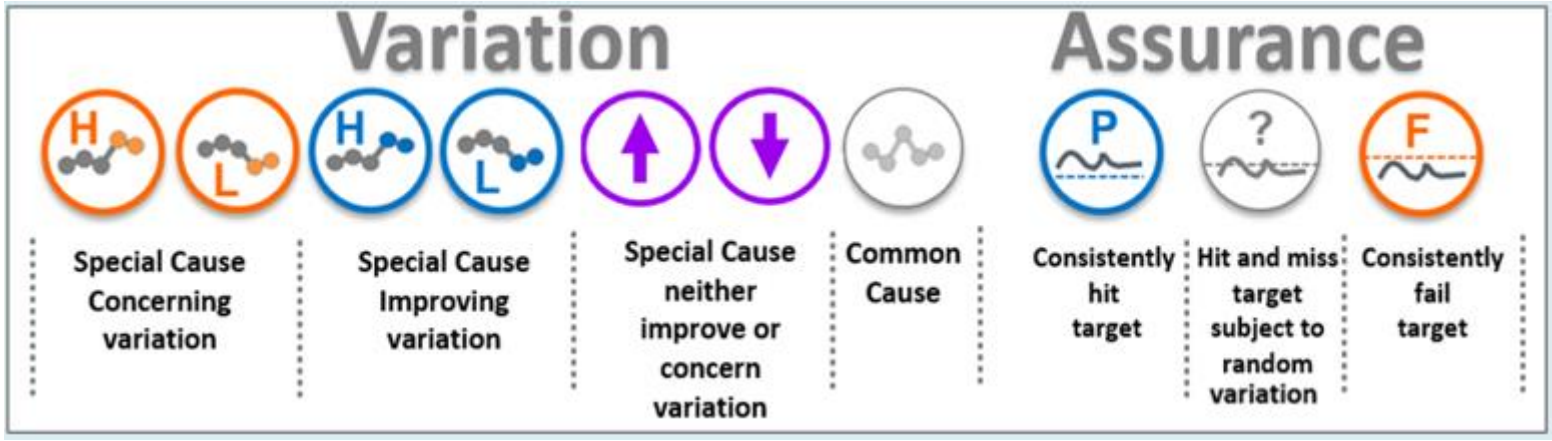
(July 2023 Data, June 2023 Data for Cancer and VTE)

Karen Kelly, Chief Operating Officer

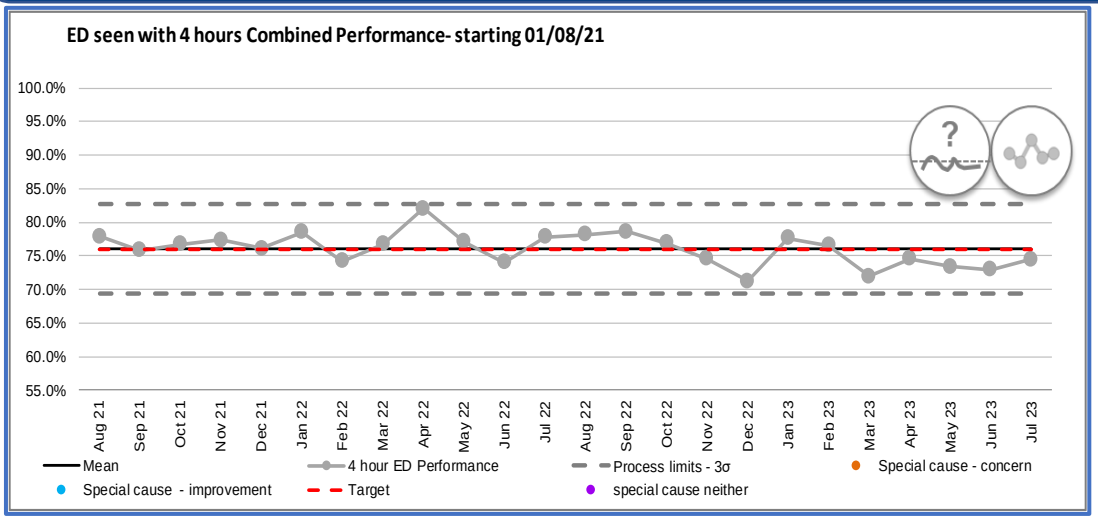
The Dudley Group NHS Foundation Trust

Constitutional Performance

Constitutional Standard and KPI		Target	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Status	
Emergency Access Standard (EAS)	Combined 4hr Performance	95.0%	78.2%	78.7%	76.9%	74.6%	71.3%	77.6%	76.5%	72.0%	74.5%	73.4%	72.9%	74.5%		
Triage	Triage - All	95.0%	85.5%	84.3%	83.8%	80.7%	74.2%	79.5%	71.2%	69.3%	79.5%	77.7%	70.4%	75.2%		
Cancer	Cancer 62 Day - All	85.0%	69.7%	69.7%	69.7%	69.7%	46.6%	41.2%	42.0%	60.0%	59.4%	61.3%	52.9%	N/A		
	Cancer 31 Day -	96.0%	90.1%	84.9%	90.4%	83.2%	92.7%	82.0%	88.4%	86.9%	89.0%	83.3%	85.5%	N/A		
	All Cancer 2 Week Waits	93.0%	78.7%	77.0%	80.6%	86.1%	83.9%	83.5%	93.8%	93.9%	84.7%	75.2%	74.1%	N/A		
Referral to Treatment (RTT)	RTT Incomplete	92%	67.7%	65.5%	64.5%	63.3%	60.3%	59.9%	58.9%	58.2%	57.4%	58.0%	58.3%	56.7%		
Diagnostics	DM01 - Diagnostics achieved within 6 weeks	99%	80.7%	78.1%	76.9%	76.4%	71.0%	70.4%	74.0%	72.1%	68.5%	68.7%	68.7%	67.4%		
VTE	% Assessed on Admission	95%	92.9%	93.2%	93.3%	94.5%	93.4%	93.7%	94.3%	94.3%	94.8%	95.1%	97.4%	N/A		



ED Performance



Latest Month	Latest Month	6th
74.5%	69	For May 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

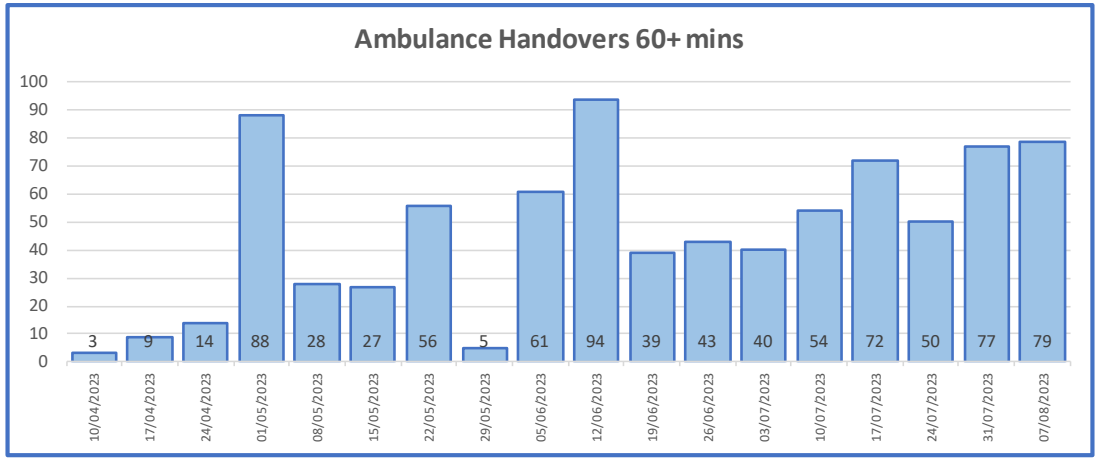
Performance

- 4 hour ED performance during July remained broadly consistent with June and May, attaining 74.5% against the interim target of 76%
- Following record attendances in May and June, July saw a small decrease by circa 200. Total attendance volumes still remain higher than winter months of 22/23
- Average wait time to be admitted fell in July, realising an improvement on both May and June 2023

Action

- Project underway to increase weekend discharge rates with the aim of improving flow from ED to AMU and base wards
- Restructure of Discharge Team through management of change process to improve productivity and complex discharge delivery on going
- Further engagement with the local authority to expand the Discharge to Assess model
- Implementation of TOC on admission via Therapy team to improve discharges and flow

Ambulance Handovers 60+ Mins



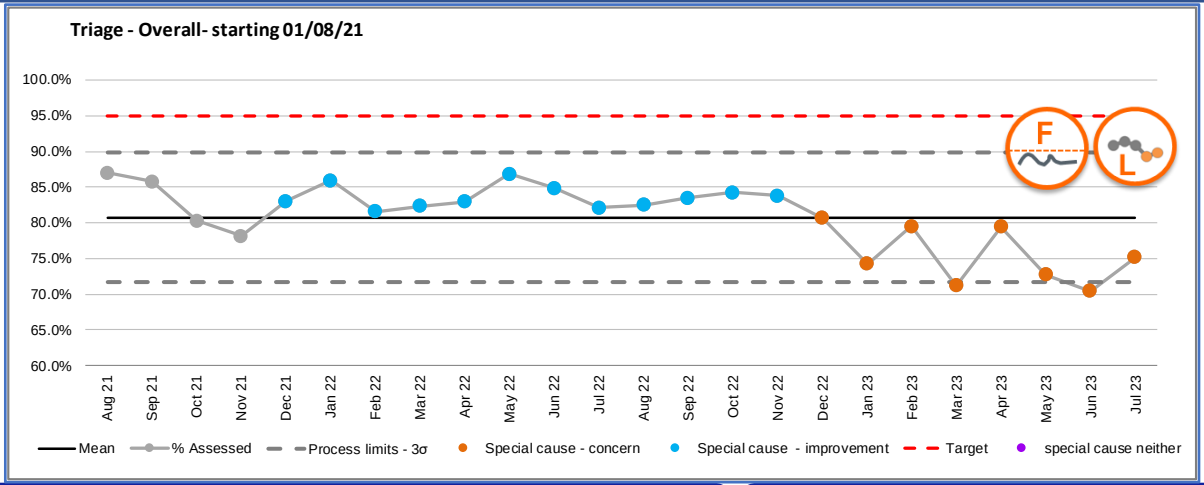
Performance

- Total ambulance handover delays of 60 minutes or more increase in July compared to June
- Having fallen below 3,000 in June, July saw total ambulance conveyances to the Trust exceed 3,000 once more

Action

- The Discharge Improvement Group continues to develop plans through its workstreams, with particular focus on scaling-up Discharge to Assess and Discharge Planning on Admission models
- A ‘right sizing’ project is being undertaken for SDEC areas and is being supported by a national UEC clinical improvement lead with particular focus on the frailty pathway
- The Dudley Improvement practice is engaged with the ED team to deliver improvements in key UEC metrics with an anticipated completed of October 2023

ED Triage



Latest Month

75.2%

Triage – target 95%

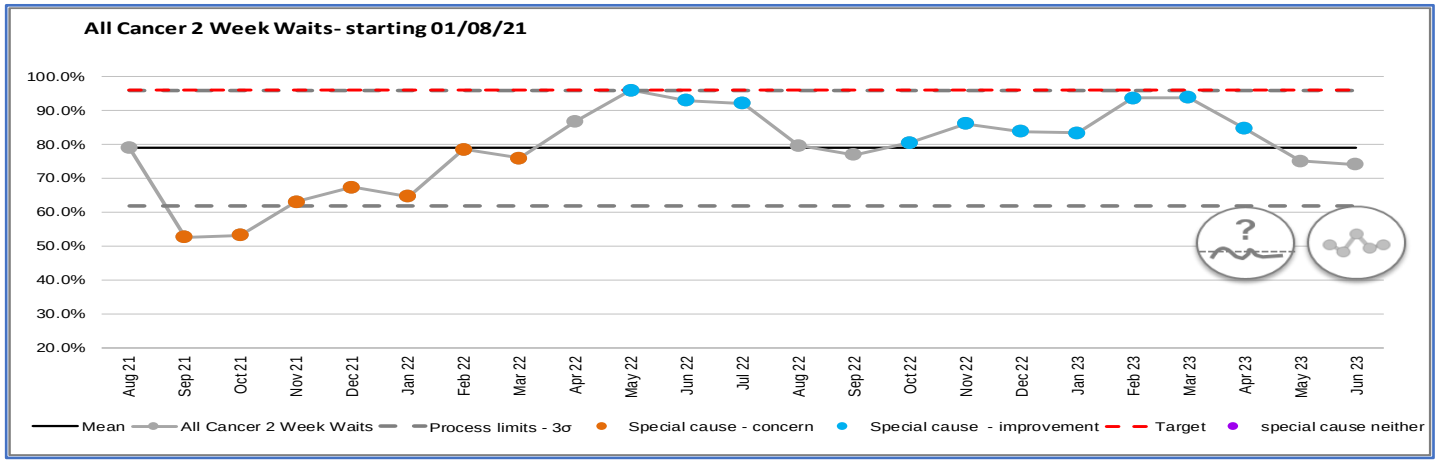
Performance

- Overall triage performance saw a small improvement in performance in July
- Notably, this increase was driven by an increase is performance in all triage areas. See and Treat and Paediatric triage saw the largest gains, with Majors also seeing notable improvement. However, these 3 areas still remain below target with Ambulance triage the only triage function performing above target

Action

- Rostering changes for Paediatric triage will commence from 3rd September which will improve triage flow
- Estates work at costing stage to redefine front triage area to increase capacity

Cancer Performance – 2 Week Wait



Latest Month

74.1%

All cancer 2 week waits – target 93%

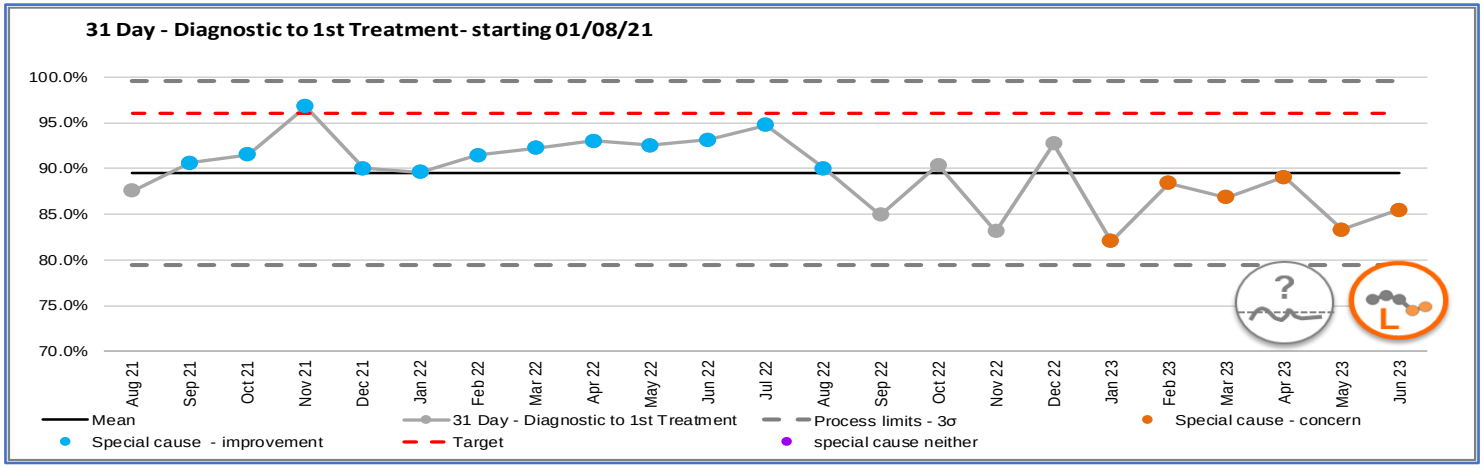
Performance

- All cancer data runs two months behind. Data included within this pack is up to and including June 2023
- Overall 2 week wait performance was below target in June largely due to a fall back in performance within the skin tumour site
- Performance in skin has deteriorated due consultant and junior workforce staffing issues, as well has an increase in suspected skin cancer referrals
- Intense support has been provided to the skin tumour site to recover its position with the speciality now seeing patients at day 5 (at the time of writing in mid-August)
- The measures put in place to support an improvement in skin has resulted in Trust-wide 2 week wait performance for July (which will be reported in September's IPR) attaining the 93% target

Action

- Continue with additional capacity allocated to address immediate capacity shortfalls
- Plastic Surgery substantive vacancy has been recruited to
- Work with system partners to improve the roll-out of Cinapsis service (referrals including images for skin), to reduce the referral demand to sustainable levels
- Enact Trust image clinics for skin to support an increase in virtual 2ww skin clinics, thereby increasing throughput, productivity and improved 2ww performance

Cancer Performance – 31 Day



Latest Month

85.5%

Target 96%

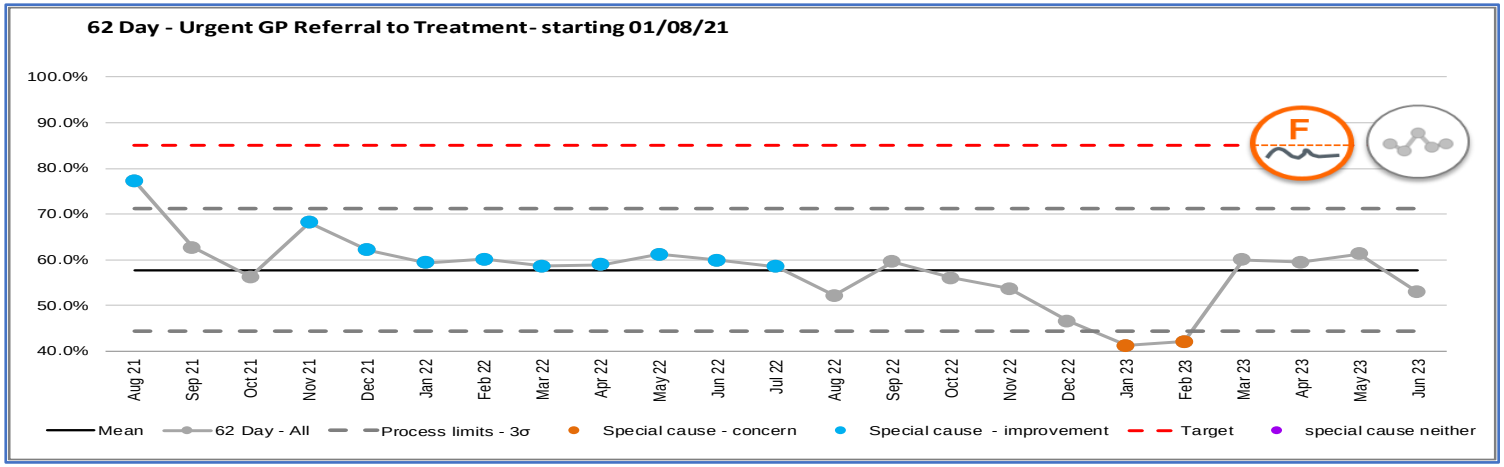
Performance

- 31 day performance improved slightly in June and also saw an increase in the number of treatments in month compared to May
- 4 tumour sites attained the standard in June, compared to 3 in May

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

52.9%

Target 85%

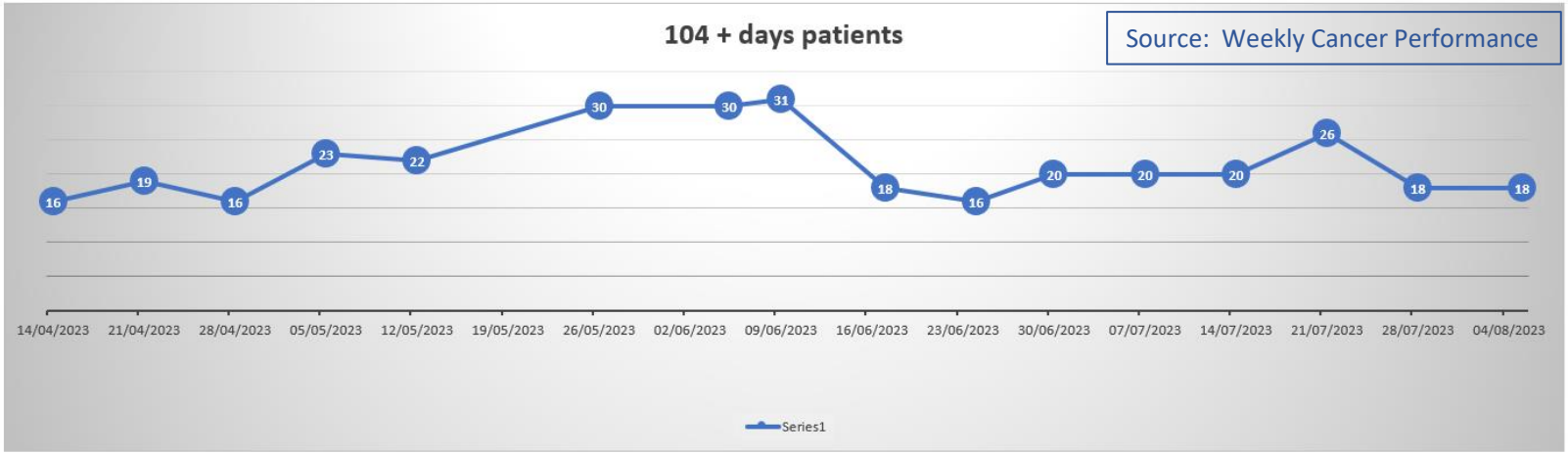
Performance

- Following a steadying of performance in recent months, June saw a slight deterioration to 52.9%
- The number of treatments remained broadly similar but fewer were achieved within target, indicating productivity has not fallen during the initial summer months
- Histology turnaround times remain a significant challenge to cancer targets. 7 day urgent histology turnaround performance in June was 22%
- Despite a fall back in performance, the Trust remains ahead of the submitted 62 day recovery trajectory

Action

- The Trust continues to work with Primary Care providers to scale-up GP usage of digital photography referrals for skin, which will reduce 2ww outpatient clinic demand and reduce waiting times to first appointment, thereby improving 62 day pathway performance
- Continue to prioritise additional theatre sessions for surgical tumour sites
- Ongoing work with BCPS to address urgent histology turnaround times

Cancer Performance – 104 Day



Latest Week

(04/08/23)

18

All 104 week waits, target zero

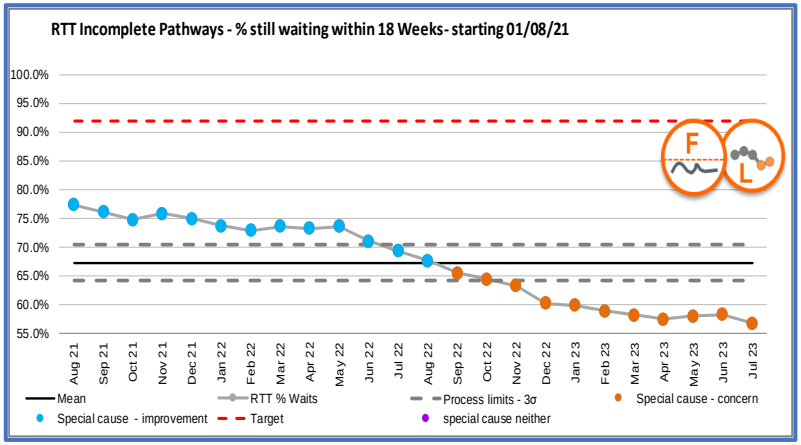
Performance

- Reducing the 104 backlog remains a priority. The backlog has remained steady in recent weeks
- The most challenged tumour sites include colorectal and skin
- 7 of the 20 104+ day patients form a cohort of late tertiary referrals from other Trusts for Urology
- 10 of 18 breaches have treatment plans / treatment dates

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
- Introduction of internal photo clinics in Dermatology to facilitate quicker access and triage and reduced pathway times for 62 day patients

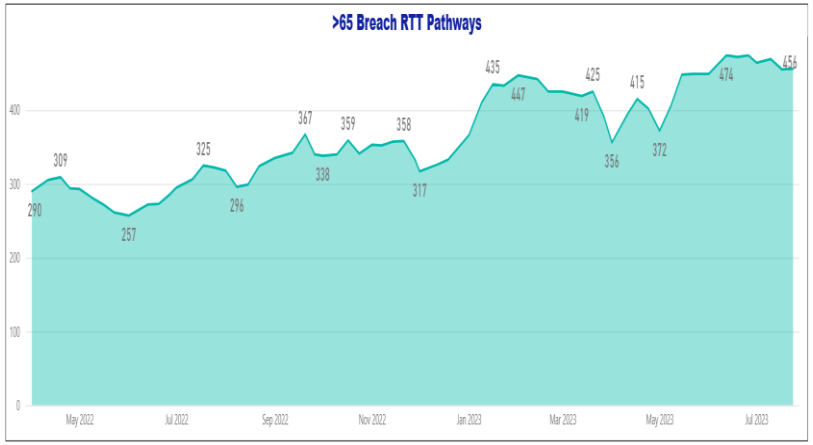
RTT Performance



Latest Month

56.7%

RTT Incomplete pathways target 92%



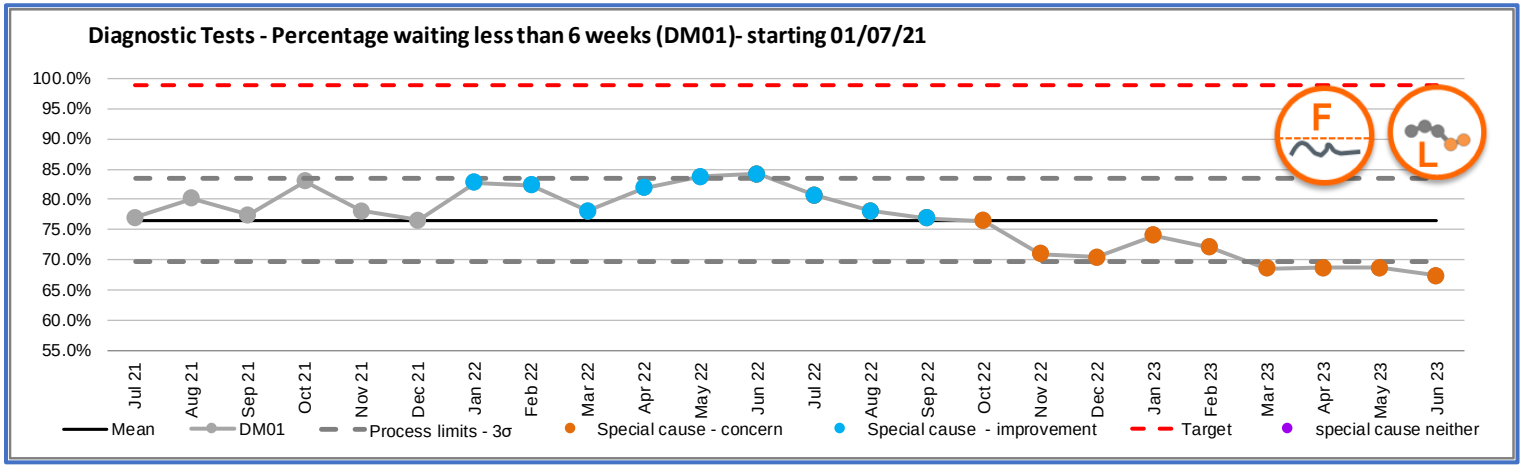
Performance

- 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 the backlog of patients waiting over 78 weeks. The Trust reported 2 78 week breaches in July
- The Trust is focusing on working towards the next national target of reducing long waits over 65 weeks
- 65 week breaches have remained steady for 6 weeks with small reductions week on week
- The Trust is participating the GIRFT-led 'Further Faster' programme which aims to reduce long outpatient waits and consequently, reduce the risk to not attaining the 65 week recovery target

Action

- 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
- Deliver an increase in the number of first/new outpatient appointments delivered
- Increase delivery against initiatives to free up new outpatient appointment capacity – focus through the Outpatient Improvement Group centres on increase PIFU and reducing DNA rate

DM01 Performance



Latest Month

67.4%

DM01 combining 15 modalities - target 99%

Performance

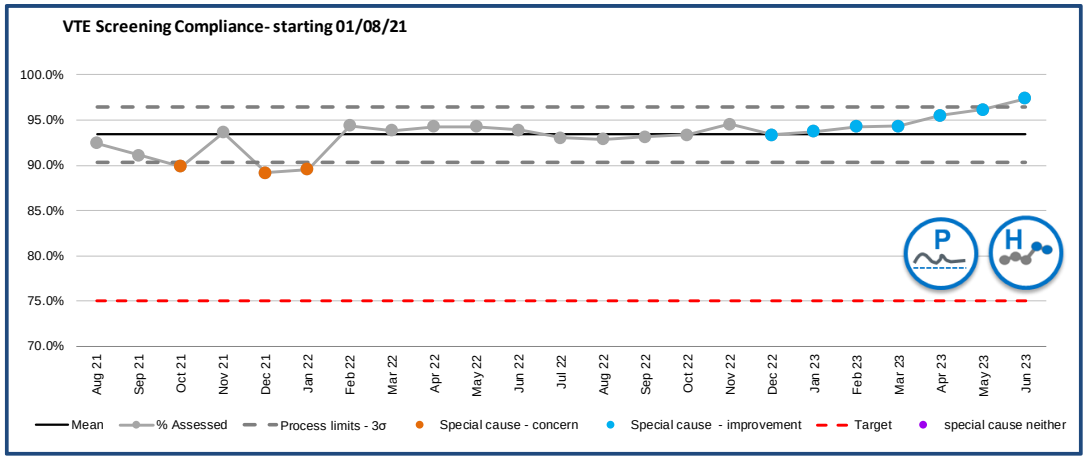
- Performance in July against the DM01 standard is broadly consistent with that delivered since the turn of the calendar year
- Performance is currently consistent with the submitted trajectory. July's performance against recovery plan saw a +0.5% variance
- This marks 4 consecutive months of performance in excess of or in line with the recovery trajectory

Action

- Continue intense monitoring through Diagnostics Performance Group
- The Trust remains on track to deliver this standard by the nationally required target of March 2024

VTE Performance

Please note: VTE figures now run 1 month in arrears



Latest Month	Latest Month	Latest Month
97.4%	98.1%	96.4%
Trust overall Position	**Medicine & IC**	**Surgery, W & C**

Performance

- VTE performance in June continued the steady recovery seen since the back end of the last calendar year

Action

- Specific ward level reporting is now also available – the clinical Divisions are leading on specific ward deep dives and ratification plans

RTT Restoration and Recovery – Trust Comparisons

0-18 Week RTT Performance (Midlands Region): =9th

June 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	16,025	10,691	66.7%
Y60	RK5	SHERWOOD FOREST HOSPITALS NHS FOUNDATION TRUST	51,943	34,269	66.0%
Y60	RNS	NORTHAMPTON GENERAL HOSPITAL NHS TRUST	40,382	26,203	64.9%
Y60	RJC	SOUTH WARWICKSHIRE UNIVERSITY NHS FOUNDATION TRUST	32,604	21,156	64.9%
Y60	RNQ	KETTERING GENERAL HOSPITAL NHS FOUNDATION TRUST	28,246	17,709	62.7%
Y60	RX1	NOTTINGHAM UNIVERSITY HOSPITALS NHS TRUST	80,478	48,776	60.6%
Y60	RFS	CHESTERFIELD ROYAL HOSPITAL NHS FOUNDATION TRUST	25,294	15,177	60.0%
Y60	RLQ	WYE VALLEY NHS TRUST	22,265	13,228	59.4%
Y60	RNA	THE DUDLEY GROUP NHS FOUNDATION TRUST	49,264	28,716	58.3%
Y60	RBK	WALSALL HEALTHCARE NHS TRUST	33,574	19,337	57.6%
Y60	RL4	THE ROYAL WOLVERHAMPTON NHS TRUST	81,208	46,421	57.2%
Y60	RXW	THE SHREWSBURY AND TELFORD HOSPITAL NHS TRUST	35,176	19,267	54.8%
Y60	RJE	UNIVERSITY HOSPITALS OF NORTH MIDLANDS NHS TRUST	78,640	42,620	54.2%
Y60	RWE	UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST	117,494	63,373	53.9%
Y60	RTG	UNIVERSITY HOSPITALS OF DERBY AND BURTON NHS FOUNDATION TRUST	110,690	59,098	53.4%
Y60	RXK	SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST	77,331	40,985	53.0%
Y60	RKB	UNIVERSITY HOSPITALS COVENTRY AND WARWICKSHIRE NHS TRUST	69,727	36,336	52.1%
Y60	RWD	UNITED LINCOLNSHIRE HOSPITALS NHS TRUST	73,313	36,980	50.4%
Y60	RWP	WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST	64,904	32,178	49.6%
Y60	RRK	UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST	139,536	65,224	46.7%

RTT Restoration and Recovery – Trust Comparisons

Number of Patients Waiting 65+ Weeks for Routine Treatment (Midlands Region): 9th

June 2023

Region Code	Provider Code	Provider Name	Total 65 plus weeks
Y60	RLT	GEORGE ELIOT HOSPITAL NHS TRUST	5
Y60	RNQ	KETTERING GENERAL HOSPITAL NHS FOUNDATION TRUST	41
Y60	RK5	SHERWOOD FOREST HOSPITALS NHS FOUNDATION TRUST	203
Y60	RBK	WALSALL HEALTHCARE NHS TRUST	270
Y60	RJC	SOUTH WARWICKSHIRE UNIVERSITY NHS FOUNDATION TRUST	282
Y60	RFS	CHESTERFIELD ROYAL HOSPITAL NHS FOUNDATION TRUST	314
Y60	RLQ	WYE VALLEY NHS TRUST	378
Y60	RNS	NORTHAMPTON GENERAL HOSPITAL NHS TRUST	388
Y60	RNA	THE DUDLEY GROUP NHS FOUNDATION TRUST	463
Y60	RXW	THE SHREWSBURY AND TELFORD HOSPITAL NHS TRUST	654
Y60	RX1	NOTTINGHAM UNIVERSITY HOSPITALS NHS TRUST	741
Y60	RXK	SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST	746
Y60	RL4	THE ROYAL WOLVERHAMPTON NHS TRUST	964
Y60	RWP	WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST	1,418
Y60	RKB	UNIVERSITY HOSPITALS COVENTRY AND WARWICKSHIRE NHS TRUST	1,482
Y60	RJE	UNIVERSITY HOSPITALS OF NORTH MIDLANDS NHS TRUST	1,511
Y60	RTG	UNIVERSITY HOSPITALS OF DERBY AND BURTON NHS FOUNDATION TRUST	1,985
Y60	RWD	UNITED LINCOLNSHIRE HOSPITALS NHS TRUST	2,116
Y60	RWE	UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST	2,535
Y60	RRK	UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST	3,562

RTT Restoration and Recovery – Trust Comparisons

Median Waiting Time (Midlands Region): =9th shortest

June 2023

Region Code	Provider Code	Provider Name	Average (median) waiting time (in weeks)
Y60	RK5	SHERWOOD FOREST HOSPITALS NHS FOUNDATION TRUST	12.3
Y60	RLT	GEORGE ELIOT HOSPITAL NHS TRUST	12.6
Y60	RNQ	KETTERING GENERAL HOSPITAL NHS FOUNDATION TRUST	13.0
Y60	RNS	NORTHAMPTON GENERAL HOSPITAL NHS TRUST	13.0
Y60	RJC	SOUTH WARWICKSHIRE UNIVERSITY NHS FOUNDATION TRUST	13.0
Y60	RX1	NOTTINGHAM UNIVERSITY HOSPITALS NHS TRUST	13.9
Y60	RFS	CHESTERFIELD ROYAL HOSPITAL NHS FOUNDATION TRUST	14.2
Y60	RLQ	WYE VALLEY NHS TRUST	14.3
Y60	RNA	THE DUDLEY GROUP NHS FOUNDATION TRUST	14.7
Y60	RBK	WALSALL HEALTHCARE NHS TRUST	15.0
Y60	RL4	THE ROYAL WOLVERHAMPTON NHS TRUST	15.1
Y60	RXW	THE SHREWSBURY AND TELFORD HOSPITAL NHS TRUST	15.7
Y60	RJE	UNIVERSITY HOSPITALS OF NORTH MIDLANDS NHS TRUST	16.1
Y60	RWE	UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST	16.3
Y60	RTG	UNIVERSITY HOSPITALS OF DERBY AND BURTON NHS FOUNDATION TRUST	16.6
Y60	RXK	SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST	16.9
Y60	RKB	UNIVERSITY HOSPITALS COVENTRY AND WARWICKSHIRE NHS TRUST	17.1
Y60	RWD	UNITED LINCOLNSHIRE HOSPITALS NHS TRUST	17.8
Y60	RWP	WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST	18.2
Y60	RRK	UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST	19.7

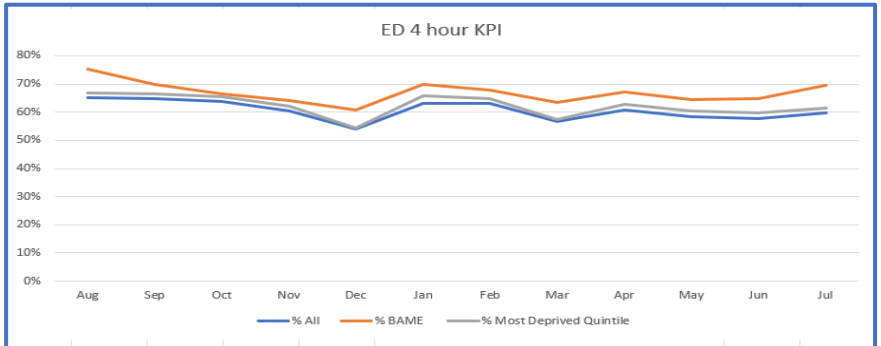
Cancer Restoration and Recovery – Trust Comparisons

2 Week Wait: 4th ICS

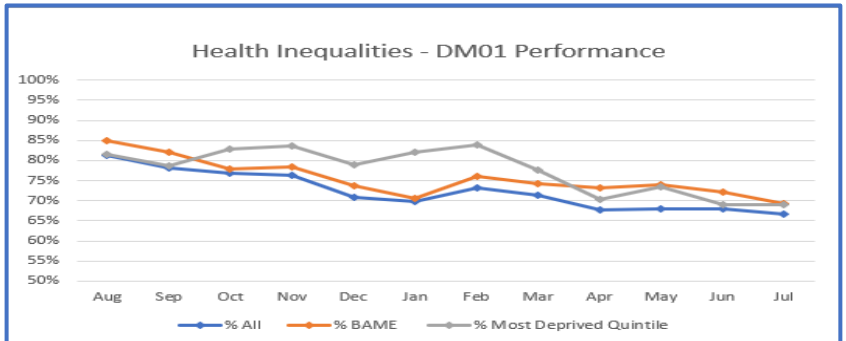
June 2023

ACCOUNTABLE PROVIDER	PERCENTAGE SEEN WITHIN 14 DAYS
SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST	95%
THE ROYAL WOLVERHAMPTON NHS TRUST	79%
WALSALL HEALTHCARE NHS TRUST	78%
THE DUDLEY GROUP NHS FOUNDATION TRUST	74%
ALL ENGLISH PROVIDERS	81%

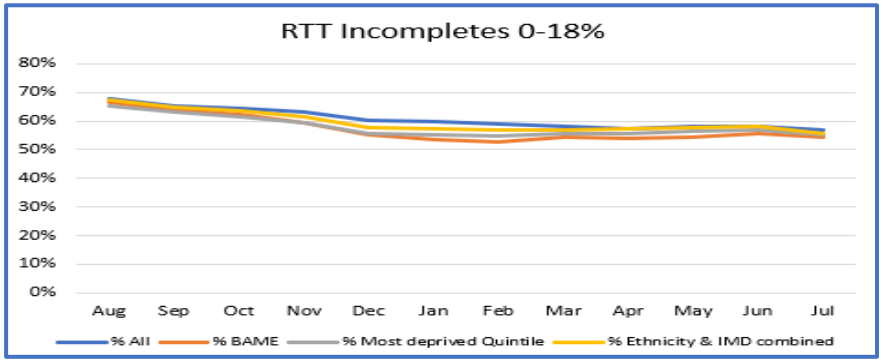
Health Inequalities

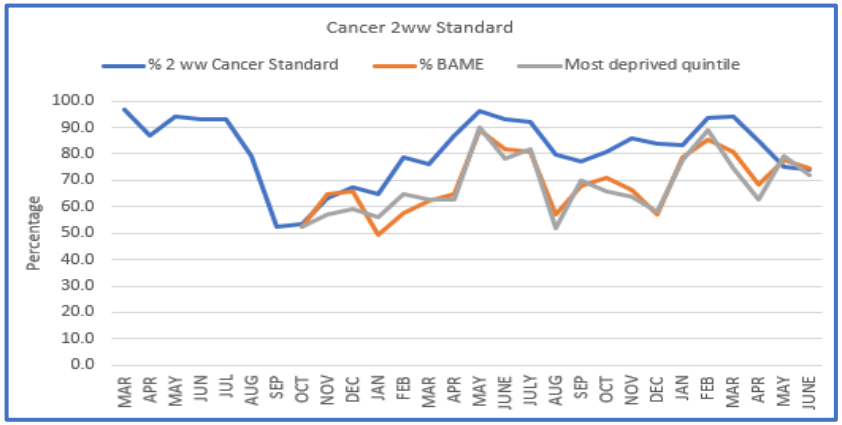


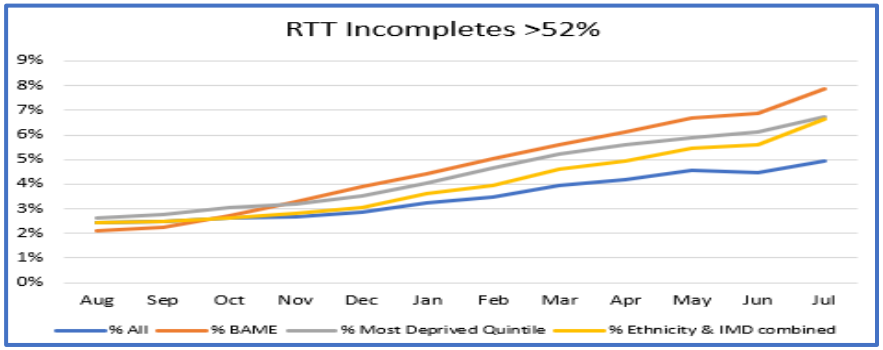
No and % ethnicity is not stated/unknown/not recorded	854	9.08%
No and % IMD postcode is invalid	49	0.52%

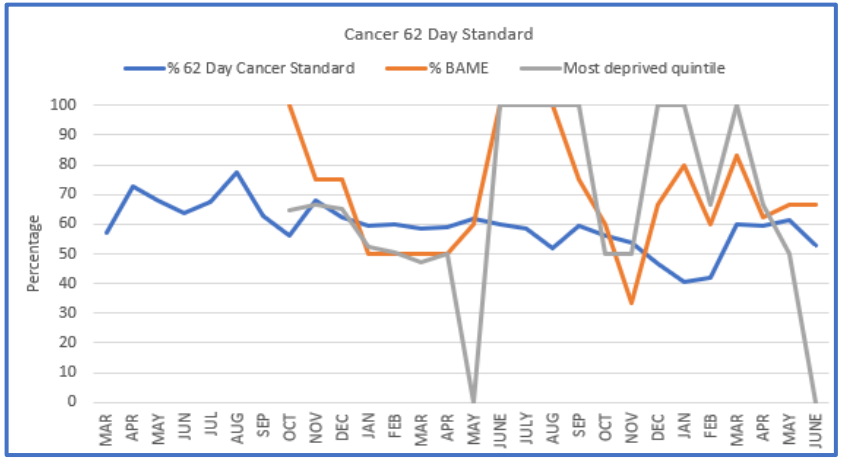


No and % Ethnicity is not stated/unknown/not recorded	1882	15.60%
No and % IDM postcode is invalid	12133	96.13%









No and % ethnicity is not stated/unknown/not recorded	3845	31.7%
No and % IMD postcode is invalid/missing	12661	96.0%

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.

Director of Infection and Prevention Control Annual Report

2022/2023

NHS
The Dudley Group
NHS Foundation Trust

Contents

i EXECUTIVE INTRODUCTION FROM THE CHIEF NURSE AND DIRECTOR OF INFECTION PREVENTION AND CONTROL

"Dear Staff, Patients, Carers, Service Users and Partners,

Firstly, a huge thank you to you all for all your positive endeavours and in particular in dealing with an unprecedented pandemic.

Special thanks go to our staff, both those in clinical practice facing roles and to those support staff behind the scenes, for their commitment to provide the best possible response to the new challenges and ways of working resulting from these demanding times.

Welcome to The Dudley Group NHS foundation Trust (DGFT) Infection Prevention and Control Annual Report which has been developed in collaboration with the Deputy Director for Infection Prevention and Control and the Infection Prevention and Control Team.

As the Trust's Director of Infection Prevention and Control I am proud to be able to present the Annual Infection Prevention and Control Report for 2022/23. The purpose of this report is to outline the activities relating to infection prevention and control for the year from April 2022 to March 2023 and to discuss the arrangements DGFT have in place to reduce the spread of infections. It reviews our accountability arrangements, policies and procedures relating to infection prevention and control, audit, and the education necessary in order to support the prevention and control of infection.

Our key achievements were:

- 39 *Clostridiodes difficile infections attributable to DGFT against a threshold of no more than 48*
- *Zero Hospital Onset Healthcare Associated (HOHA) MRSA Bacteraemia infections.*
- *Mandatory Infection Prevention and Control training completed by 87.96% of clinical staff.*
- *94.1% of non-clinical staff up to date with Infection Prevention and Control (IPC) e-learning*
- *Response to the challenges arising from SARS CoV-2 (COVID-19)*
- *Upgrading of the laboratory system to the latest version of IC NET*
- *Recruitment to the IPC team under very challenging circumstances*
- *IPC promotional activities included IPC week and World Health Organisation Clean Your Hands Day*
- *An IPC Link worker study day was held in March 2023*
- *Increased surgical site surveillance activity*

The Coronavirus pandemic has significantly impacted on the trust further highlighting the role of infection prevention and control has in keeping our patients and staff safe. I want to formally acknowledge and thank all trust teams for their commitment during the last year.

Looking forward to 2023/24, the IPC team and all DGFT staff will continue to work towards the prevention of all healthcare acquired infections."

Mary Sexton
Chief Nurse and Director of Infection Prevention and Control (DIPC)

TABLE 1: The requirements of the Health and Social Care Act (2008: updated 2022)

Compliance Criterion	What the registered provider will need to demonstrate
1	Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider how susceptible service users are and any risks that their environment and other users may pose to them.
2	Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.
3	Ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.
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.
5	Ensure prompt identification of people who have or are at risk of developing so that they receive timely and appropriate treatment to reduce the risk of transmitting the infection to other people.
6	Systems to ensure that all care workers (including contractors, volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection.
7	Provide or secure adequate isolation facilities.
8	Secure adequate access to laboratory support as appropriate.
9	Have and adhere to policies, designed for the individual's care and provider organisations that will help to prevent and control infections.
10	Providers have a system in place to manage the occupational health needs and obligations in relation to infection.

ii LIST OF ABBREVIATIONS

ACP	Advanced Care Practitioner
AER	Automated Endoscope Reprocessor. A specialised machine for washing and disinfecting endoscopes
AHP	Allied Health Professional
AmpC beta lactamases producing Enterobacteriaceae	Produce enzymes which mediate resistance to a wide variety of B-lactam antibiotics e.g., amoxicillin
AMS	Antimicrobial Stewardship
ASG	Antimicrobial Stewardship Group
Bacteraemia	A bloodstream infection
BBFE	Blood and Bodily Fluids Exposure
BCPS	Black Country Pathology Services
BCWB	Black Country and West Birmingham
BSI	Bloodstream Infection
CCGs	Clinical Commissioning Groups subsumed in to Integrated Care Boards in July 2022

CD	Contact Dermatitis
CDI	*Clostridioides difficile infection.* *Clostridioides difficile* is a bacterium which lives harmlessly in the intestines of many people. *Clostridioides difficile* infection most commonly occurs in people who have recently had a course of antibiotics. Symptoms can range from mild diarrhoea to a life-threatening inflammation of the bowel.
CE	Chief Executive
CMT	Certified Medication Technician
COHA	Community Onset Healthcare Acquired
COIA	Community Onset Indeterminate Association
COVID-19	Coronavirus disease
CPA/ UKAS	Clinical Pathology Accreditation (CPA UK) is a subsidiary of United Kingdom Accreditation Service (UKAS)
CPE	Carbapenemase-producing Enterobacteriaceae. Enterobacteriaceae are a large family of bacteria that usually live harmlessly in the gut of all humans and animals. They are also some of the most common causes of opportunistic urinary tract infections, intra-abdominal and bloodstream infections. Carbapenemases are enzymes that destroy carbapenem antibiotics, conferring resistance.
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation (CQUIN) payment framework
CSSD	Central Sterile Services Division
CSU	Catheter Specimen of Urine
D&V	Diarrhoea and vomiting
Datix	Patient safety organisation that produces web-based incident reporting and risk management software for healthcare and social care organisations.
DDIPC	Deputy Director of Infection Prevention & Control
DGFT	The Dudley Group NHS Foundation Trust
DH	Department of Health
DIPC	Director of Infection Prevention & Control
DMC	Dudley Metropolitan Council
E.coli	*Escherichia coli.* *E. coli* is the name of a type of bacteria that lives in the intestines of humans and animals.
ED	Emergency Department
ENT	Ear, Nose and Throat
EPMA	Electronic Prescribing and Medicines Administration
ESBL	Extended-Spectrum Beta-Lactamases are enzymes that can be produced by bacteria making them resistant to many of the commonly prescribed antibiotics.
ESR	Electronic Staff Record
GNBSI	Gram-negative bacteraemia (GNBSI), including *Escherichia coli*, Klebsiella and Pseudomonas.

GRE/VRE	Glycopeptide-Resistant Enterococci/Vancomycin Resistant Enterococci. Enterococci are bacteria that are commonly found in the bowels/gut of most humans. There are many different species of enterococci but only a few that have the potential to cause infections in humans and have become resistant to a group of antibiotics known as Glycopeptides; these include Vancomycin.
HCAI	Healthcare Associated Infection
HII	High Impact Interventions
HOHA	Hospital Onset Healthcare Associated
HR	Human Resources Department
HSDU	Healthcare Sterilisation Decontamination Unit
HSE	Health and Safety Executive
ICB	Integrated Care Board replaced Clinical commissioning Boards July 2022
IC NET	IPC Surveillance software and database
ICS	Integrated Care System
IPC	Infection Prevention and Control
IPC BAF	Infection Prevention and Control Board Assurance Framework
IPCG	Infection Prevention and Control Group Meeting
IPCT	IPC Team
IPMO PLG	Integrating Pharmacy and Medicines Optimisation Pharmacy Leadership Group
IPS	Infection Prevention Society
IV	Intravenous
KPI	Key Performance Indicator
LFD	Lateral Flow Device
LHE	Local Health Economy
MHRA	Medicines and Healthcare Products Regulatory Agency
MRSA	Meticillin Resistant *Staphylococcus aureus.* Any strain of *Staphylococcus aureus* that has developed resistance to some antibiotics, thus making it more difficult to treat.
MSSA	Meticillin Sensitive *Staphylococcus aureus. Staphylococcus aureus* is a bacterium that commonly colonises human skin and mucosa (e.g., inside the nose) without causing any problems. It most commonly causes skin and wound infections.
NED	Non-Executive Director
NEWS 2	The latest version of the National Early Warning Score (NEWS), which advocates a system to standardise the assessment and response to acute illness.
NHS	National Health Service
NHSE/I	NHS England and NHS Improvement
NICE	National Institute for Health and Care Excellence
NITCAR	National infections team's collaborative for audit and research
NNU	Neonatal Unit

Norovirus	Norovirus is a major cause of acute gastroenteritis and diarrhoea in children and adults.
OH	Occupational Health
Outbreak	One or more persons with the same signs, symptoms in time place and space.
OPAT	Out-patient parenteral antimicrobial therapy
OPD	Outpatients Department
PEG	Patient Experience Group
PFI	Private Finance Initiative
PGD	Patient Group Direction
PHE	Public Health England now UK HSA
PII	Period of Increased Incidence
PIR	Post Infection Review
PLACE	Patient Led Assessment of the Care Environment
PPE	Personal Protective Equipment e.g., gloves, aprons, and goggles
QSC	Quality and Safety Committee
QSG	Quality and Safety Group
RCA	Root Cause Analysis
RCN	Royal College of Nurses
RIDDOR	Reporting of Injuries, Diseases and Dangerous Occurrences Regulations
SARS-CoV-2	COVID-19
SENDS	Safety engineered needleless device systems
SEPSIS	A potentially life-threatening condition caused by the body's response to an infection.
SEQOHS	Safe, Effective, and Quality Occupational Health Service
SHAW	Staff Health and Wellbeing Service
SIGHTED	Suspect, Isolate, Gloves and Aprons, Hand washing, Test for Toxins, Educate, Document
SIP	Service Improvement Plan
SLA	Service Level Agreement
SOP	Standard Operating Procedure
SSI	Surgical Site Surveillance
TDM	Therapeutic Drug Monitoring
The HUB	Staff Intranet Site
TOR	Terms of Reference
UK HSA	UK Health Security Agency formally Public Health England (UK HSA)
UTI	Urinary Tract Infection
WHO	World Health Organisation
WSG	Water Safety Group

SECTION ONE:
INTRODUCTION

The purpose of this report is to provide assurance to The Dudley Group NHS Foundation Trust (DGFT) Board of Directors, Governors and the public for the reporting period 1 April 2022-31 March 2023 regarding the Infection Prevention and Control (IPC) activity including compliance with the Health and Social Care Act 2008: Code of Practice on the prevention and control of infections and related guidance (update December 2022) (commonly known as The Hygiene Code) and with regard to appropriate National Institute for Health and Clinical Excellence (NICE) guidance.

This annual report fulfils the Trusts' statutory requirements under the Health and Social Care Act 2008: Code of Practice on the prevention and control of infections and related guidance (Updated December 2022), which sets out 10 compliance criteria against which a registered provider will be judged on how it complies with the registration requirements for cleanliness and infection prevention and control. This sets the basis of our annual programme which is monitored at the Trust's bimonthly Infection Prevention and Control (IPC) Group meeting. Infection prevention and control is the responsibility of everyone in our healthcare community and is only truly successful when everyone works together. The aim of the IPC team is to increase organisational focus and collaborative working to ensure continued compliance and continuous improvement.

The Trust's is registered with the Care Quality Commission (CQC) and has declared full compliance with the ten compliance criteria as detailed in Table 1.

Compliance criterion	What the registered provider will need to demonstrate
1	Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider how susceptible service users are and any risks that their environment and other users may pose to them.
2	Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.
3	Ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.
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6	Systems to ensure that all care workers (including contractors, volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection.
7	Provide or secure adequate isolation facilities.
8	Secure adequate access to laboratory support as appropriate.
9	Have and adhere to policies, designed for the individual's care and provider organisations that will help to prevent and control infections.
10	Providers have a system in place to manage the occupational health needs and obligations in relation to infection.

Infection Prevention and Control is a scientific approach and practical solution designed to prevent harm caused by infection to patients and health care workers (WHO) it is essential to ensure that the safety and quality of care for our patients can be provided. At The Dudley Group NHS Foundation Trust Infection Prevention and Control (DGFT) is a key priority.

Our Trust is committed to delivering the highest infection prevention and control standards to prevent avoidable harm to patients, visitors and staff from healthcare associated infection. It is a key priority to ensure that a robust infection prevention and control function operates and is embedded within all clinical areas of the organisation. Effective prevention and control of infection is embedded as part of everyday practice and applied consistently by everyone at all times.

The infection prevention and control agenda face many challenges including the ever-increasing threat from emerging diseases, antimicrobial resistant micro-organisms, growing service development in addition to national targets and outcomes. The Trust Infection Prevention and Control Team experienced a number of changes in personnel over the last year and recruitment into the team has been challenging. This has resulted in periods of reduced staffing levels and reduction in the service provided to clinical teams.

The Board of Directors and ultimately the Chief Executive, as the accountable officer, carries responsibility for IPC throughout the Trust and it is a vital component of Quality and Safety. The day-to-day management is delegated to the Director of Infection Prevention and Control (DIPC). All managers and clinicians ensure that the management of IPC risks is one of their fundamental duties. Every clinical member of staff demonstrates commitment to reducing the risk of Healthcare Associated Infections (HCAI) through standard infection prevention and control measures. The IPC team endeavours to provide a comprehensive proactive service, which is responsive to the needs of staff and public alike and is committed to the promotion of excellence within everyday practice of IPC.

As with the previous year, the 2022/23 NHS Outcomes Framework included reducing the incidence of HCAIs, in particular Meticillin Resistant *Staphylococcus aureus* (MRSA) Bacteraemia and *Clostridium difficile* infection (CDI) as areas for improvement. Within Domain 5: Treating and caring for people in a safe environment and protecting them from avoidable harm of the Outcomes Framework reducing all HCAIs remained a priority.

As previously reported, the extension to the mandatory surveillance to include Meticillin Sensitive *Staphylococcus aureus* (MSSA) and *Escherichia coli* (*E.coli*) Bacteraemia infections since 2011 together with the MRSA Bacteraemia and CDI national reduction thresholds set for Acute and Clinical Commissioning Groups (CCGs) reflects the zero-tolerance approach for all avoidable HCAIs.

This report will provide information of the activities and performance of Key Performance Indicators (KPI) for IPC during the period 1 April 2022-31 March 2023 by DGFT. The report is aligned to the 2022/23 IPC Programme, informing progress against the objectives set and outlines performance of DGFT against the MRSA Bacteraemia and CDI reduction thresholds.

In addition, the report aims to reassure the public that reducing the risk of infection through robust infection prevention and control practice is a key priority for DGFT and supports the provision of high-quality services for patients and a safe working environment for staff.

SECTION TWO:
WHO ARE WE, OUR DUTIES, ARRANGEMENTS AND ASSURANCE

2.1 Who are we?

As a Trust, the Dudley Group provides health services to around 450,000 people in Dudley. These include for example three hospital sites, Russell's Hall, Corbet and Guest Hospitals and community nursing services.

In a year we…

- deliver 4,100 babies.
- see around 600,000 outpatients.
- treat almost 173,000 patients in our emergency department.
- We have 450,000 people in our catchment area.

Our PFI partners

- Dispose of 468 tonnes of infectious waste
- sterilise 636,350 clinical instruments.
- undertake 100,000 portering moves.
- recycle approximately 146.78 tonnes of mixed recyclables.

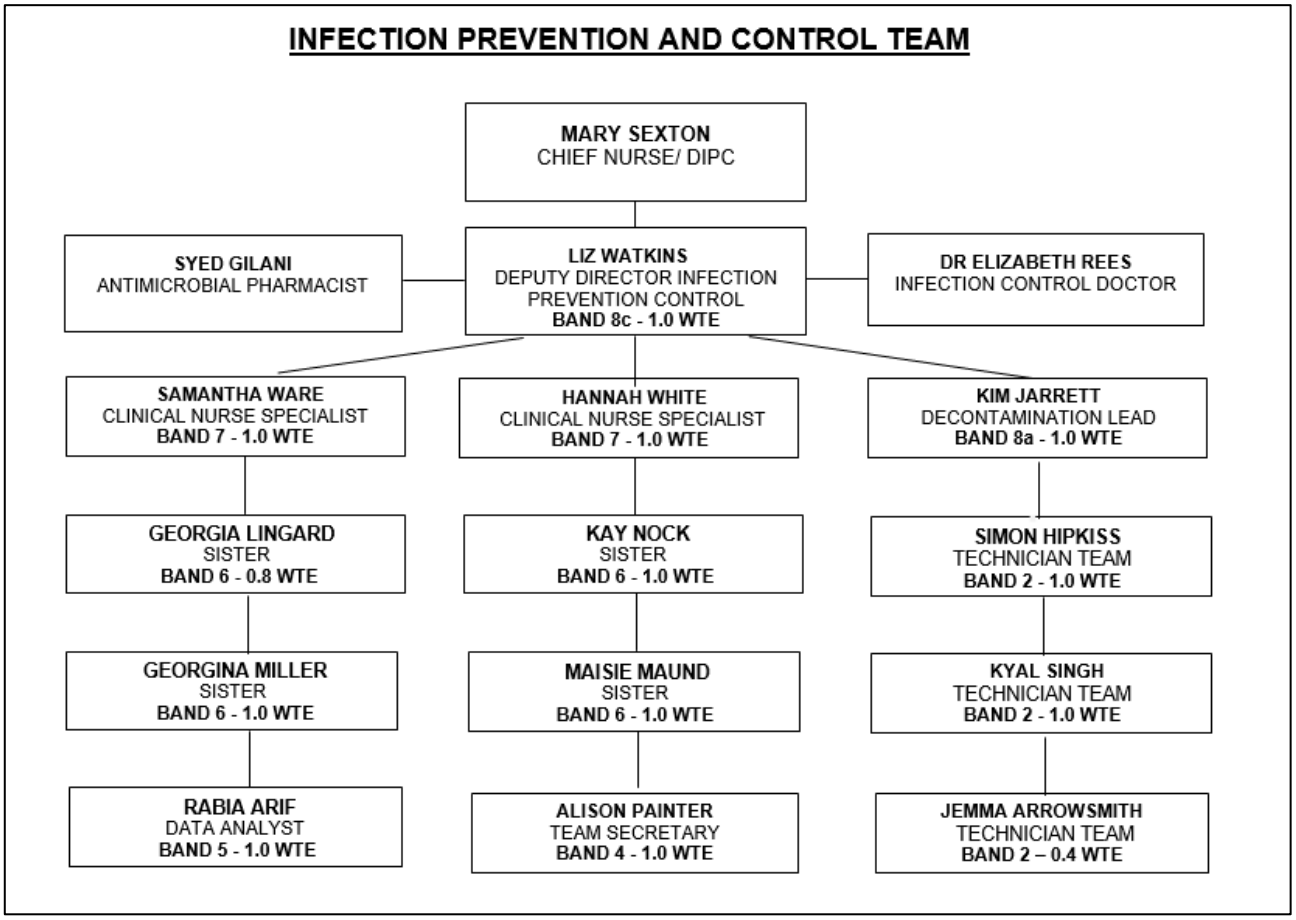
DGFT has a committed IPC team that is very clear on the actions necessary to deliver and maintain patient safety. Equally, it is recognised that infection prevention and control is the responsibility of every member of staff and must remain a high priority for all to ensure the best outcome for patients. The IPC team utilises a both a reactive and proactive approach with the emphasis on being visible so making their accessibility for guidance and advice a priority. This in turn has led to an improved IPC team image i.e., being a regular familiar friendly face rather than only visiting to audit or when there are outbreaks of infections or problems.

Looking forward, it is critical that DGFT maintain this level of commitment. As in previous years, we will continue to work closely with our partner organisations Integrated Care Board (ICB), and the Local Health Economy (LHE) as well as experts in other organisations, UK Health Security Agency (UK HSA) and NHS England.

Our Duties and Arrangements

Infection Prevention and Control Service:

- Director for Infection Prevention and Control (Chief Nurse)
- Deputy Director for Infection Prevention and Control
- Infectious diseases Doctor
- Antimicrobial Pharmacist
- Decontamination Lead
- Infection Prevention and Control Nurse Specialists
- Infection Prevention and Control Nurses
- Data Analyst
- HPV Technicians
- Infection Prevention and Control Team Secretary



2.2 Director of Infection Prevention and Control – **Mary Sexton** (also Chief Nurse)

The Director of Infection Prevention and Control (DIPC) is a role (whether by that name or another) required by all registered NHS care providers under current legislation (The Health and Social Care Act2008, updated 2022). The DIPC will have the executive authority and responsibilities for ensuring strategies are implemented to prevent avoidable HCAIs at all levels within the organisation.

The DIPC will be the public face of IPC and will be responsible for the Trust's annual report, providing details on the organisations IPC programme and publication of HCAI data for the organisation.

The DIPC will lead the commitment to quality and patient safety, good communication and ensure robust reporting channels and access to a group of staff with expert prevention and control knowledge, able to offer advice and support. The role and function of the IPC Service is to provide specialist knowledge, advice and education for staff, service users and visitors. Additional support is provided by the antimicrobial pharmacists and Lead Nurse for Infection Prevention and Control. All work undertaken by the service supports the Trust with the full implementation of and on-going compliance to the Hygiene Code.

At the Dudley Group, the Chief Nurse holds the role of DIPC.

2.3 The Infection Prevention and Control Team

The DIPC has overall responsibility for the IPC Team. The IPC Team works collaboratively alongside clinical leaders at the Trust.

The IPC Team is led day to day by the DDIPC for IPC and is supported by Infection Prevention Nurse Specialists, Infection Prevention Sisters, Data Analyst and Team Secretary.

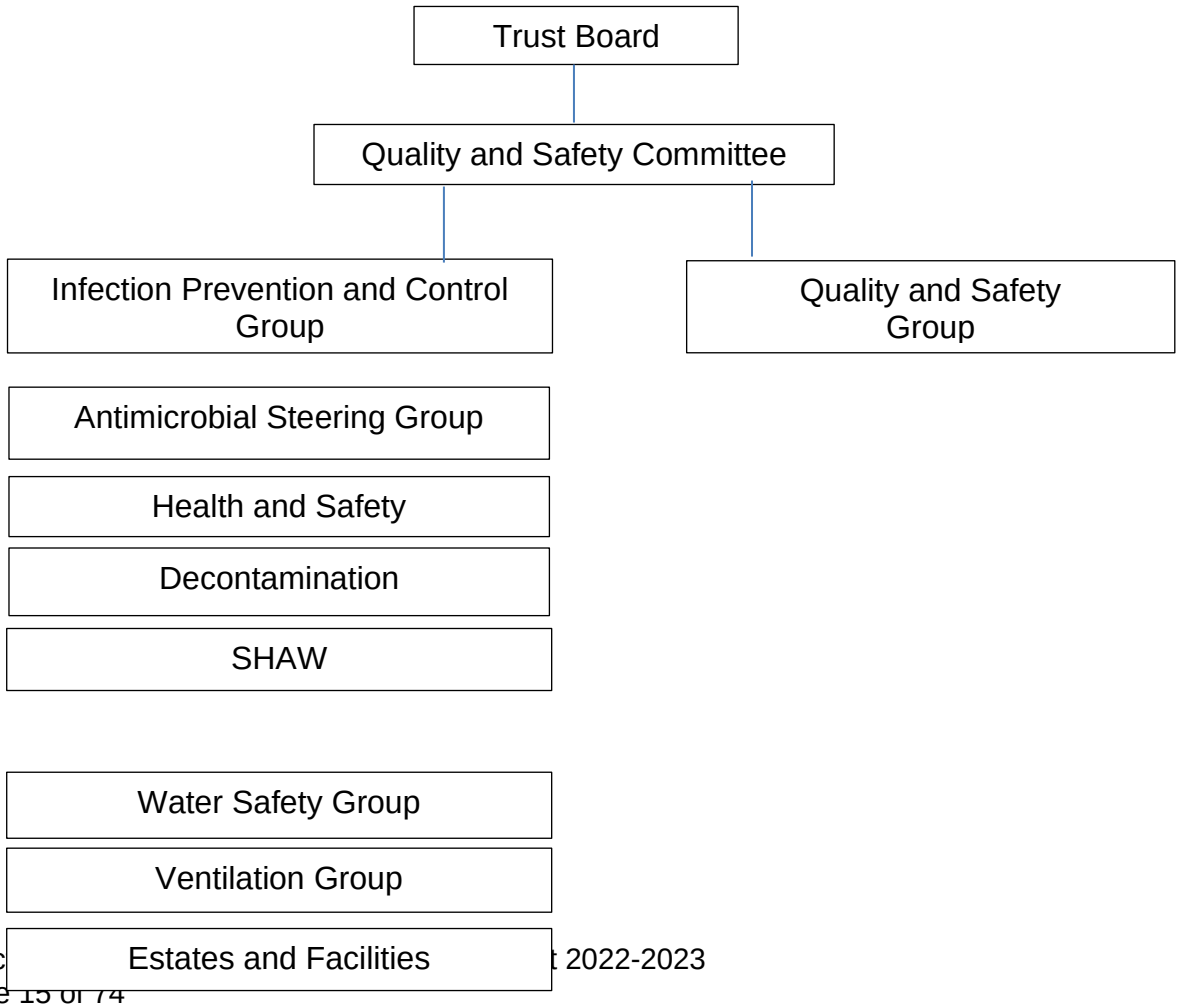
The IPC service is provided through a structured annual programme of works which includes expert advice, education, audit, policy development and review and service development. DGFT has a Service Level Agreement with Royal Wolverhampton Trust for specialist support from a Consultant Microbiologist. Medical microbiology support is provided 24 hours a day, 365 days a year via Black Country Pathology Services.

A workforce review of the IPC Team has been undertaken and an IPC business case has been developed as one of the lessons learnt from the COVID-19 pandemic. This review will be presented to the trust executive team. The review will look at the service being provided over a 7-day period while putting in a sustainable model to future proof the team and the service.

The IPC team devises and implements a robust Annual Programme of Work to reduce HCAIs. This is achieved by working in collaboration with all DGFT services and staff. The IPC team perform a number of activities that minimise the risk of infection to patients, staff and visitors including advice on all aspects of infection prevention and control; education and training; audit; formulating policies and procedures; interpreting and implementing national guidance at local level; alert organisms' surveillance and managing outbreaks of infection.

The IPC Team has re-introduced IPC Link staff which was suspended due to COVID-19. This group now meets on a monthly basis via TEAMS. A Link worker study day was held on in March 2023 for the Trust, 16 staff attended. The overall theme was 'Strengthening the Core' and topics included respiratory infections, sharps safety, hand hygiene, antimicrobial stewardship, and decontamination. The day evaluated very well with lots of positive feedback and comments. There are plans to repeat this annually.

2.4 Committee Structures and Reporting Processes



2.5 Trust Board

The Code of Practice requires that the Trust Board has a collective agreement recognising its responsibilities for IPC. The Chief Executive (CE) has overall accountability for the control of infection at DGFT and any IPC matters across the trust.

DCFT's performance against National and local thresholds are included in Performance Report and Quality and Safety Reports which are presented at DGFT Board meetings.

2.6 Quality and Safety Committee

Bimonthly IPC reports, the IPC Board Assurance Frameworks and the IPC Annual report are presented to the Quality and Safety Committee (QSC) meetings. The QSC is chaired by a Non - Executive Director (NED), it is a delegated committee of the Trust Board which meets monthly. The purpose of the QSC is to provide oversight and scrutiny of infection control standards and practices and seeking assurance that IPC Standards are being met.

The QSC will provide assurance to the Trust Board around the DGFT's arrangements for protecting and improving the quality and safety of patient-centered healthcare, thus improving the experience for all people that come into contact with the services at DGFT.

2.7 Quality and Safety Group

Bimonthly IPC reports are presented to the Quality and Safety Delivery Group meetings. The Quality and Safety Group (QSG), chaired by the Chief Nurse/ DIPC, (until December 2022 now chaired by the Director of Governance), meets monthly and is responsible for ensuring that there are processes in place for ensuring patient safety and continuous monitoring and improvement in relation to key areas including IPC, but also covers subdivisions of the trust as well as other specialties. The QSG receives assurance from the IPC that adequate and effective policies, processes and systems are in place. This assurance is provided through a regular process of reporting.

2.8 Infection Prevention and Control Group (IPCG) Meeting

The membership is multi-disciplinary and includes representation from the divisions, operations and quality directorates, estates department, antimicrobial pharmacists, and Consultant Microbiologist. Additional members are representatives from UK HSA, Dudley Metropolitan Borough Council, ICB and Private finance Initiative (PFI) partners. The meeting is chaired by the DIPC and meets bimonthly. The Terms of Reference (TOR) and membership are reviewed annually to ensure responsibility for IPC continues to be embedded across the organisation. This meeting monitors the progress of the annual IPC programme, approves IPC policies and monitors compliance with them.

The purpose of this meeting is to oversee compliance against the Health and Social Care Act (2008, updated 2022) and to provide assurance that risks are appropriately managed and that appropriate arrangements are in place to provide safe, clinical environments for patients, visitors, and staff.

The IPC Governance Meeting is responsible for:

- Reviewing and monitoring the progress of the annual programme and assisting and affecting implementation.
- Reviewing, developing, and adopting relevant policies, procedures, care pathways and guidelines and standard operating procedures.
- Assessing the impact of all existing and new relevant plans and policies on infection prevention and control and make recommendations for change.
- Ensuring, through the DIPC, the Chief Executive, associated Committees and the Trust Board are informed of any significant infection prevention and control concerns.
- To receive, review and endorse the publication of the Infection Prevention and Control Annual Report.
- To ensure that the wider aspects of maintaining IPC are reported and reviewed within the IPC group these include Health and Safety, Estates, Water Safety, Antimicrobial stewardship and Staff Health and Wellbeing Service (SHAW).
- Effective management of IPC related outbreaks and concerns

2.8.1 DGFT Water Safety Group

The membership is multi-disciplinary and has representatives from PFI Partners and an Authorising Engineer. The Group continues to monitor water risk assessments especially around Legionella, flushing regimens, annual disinfection, Automated Endoscope Reprocessor (AER) and capital developments.

2.8.2 Decontamination Group

This was established in January 2022 by the Trusts new Decontamination lead, the group monitors, challenges, reviews, and where appropriate takes action in response to presented assurances to ensure that the trust is demonstrating compliance against regulatory standards. The aim of the group is to identify any risk factors in relation to decontamination, to identify any trust strategies for the safe decontamination of medical devices in accordance with national and local guidelines with particular reference to HTM 01-01 and 01-06, Decontamination policies, Health, and Social Care Act 2008 (updated 2015), MHRA guidelines, NICE IPG 196 Guidance – replaced with IPG 666 2020 and Care quality commission. The group receives reports from Endoscopy services, Outpatients and Specialist Surgery, Sterile Services (CSSD), theatres and Imaging with the group meeting bimonthly. A Terms of Reference and Governance structure was developed and is reviewed by the Decontamination Group annually. The Group reports to the IPCG Meeting.

2.8.3 Ventilation Group Meeting

The membership is multi-disciplinary and has representatives from PFI Partners and an Authorising Engineer. The Group continues to monitor ventilation risk assessments especially around air handling units, air extraction and capital developments.

2.8.4 DIPC, DDIPC, Consultant Microbiologist and Deputy Chief Nurse

The DIPC, DDIPC, Consultant Microbiologist and deputy Chief Nurse meet weekly to offer a supportive environment within which clinical issues are discussed and a consensus obtained.

2.8.5 Infection Prevention and Control Link Staff –

The aim of our IPC link staff is to enhance the IPC knowledge of healthcare professionals working within DGFT, ensuring the delivery of high standards of quality and patient safety in relation to IPC. Our IPC link staff are responsible for arranging for IPC audits and self-audits to be undertaken where required and for disseminating IPC information to colleagues.

2.8.6 Divisional Leads, Matrons and Ward Managers, Sisters, Charge Nurses, and Team Leaders

Divisional leads, Ward Managers, Sisters, Charge Nurses, and Team Leaders are responsible for ensuring that their work environments are maintained at high levels of cleanliness. Monthly cleanliness audits are undertaken with staff. These audits are reported in the Divisional Leads and Estates reports to the IPCG meeting. The Sisters, Charge Nurses, Ward Managers and Team Leaders are responsible for ensuring the link staff are supported in performing their role and have appropriate time and resources to do this effectively. Self-audit scores and on-going work undertaken by the link staff is also included in Managers reports submitted to the IPCG meeting.

2.8.7 Learning and Development Team

Arrangements are in place for staff to attend corporate induction and complete mandatory training programmes which includes IPC. Due to COVID-19 this has been now delivered virtually. Arrangements are in place for staff training to be effectively recorded and maintained in staff records. Alerts inform managers of their staff's non-compliance with mandatory training. Training compliance is reported monthly to the Quality and Safety Committee.

2.8.8 Roles and Responsibilities of all Staff

All staff in both clinical and non-clinical roles within the Trust are responsible for ensuring that they follow the standard IPC precautions at all times and are familiar with IPC policies, procedures, and guidance relevant to their area of work. All staff have a duty of care to report any non-compliance and act as appropriate. All IPC policies and procedures are available on the staff intranet site, The Hub.

SECTION THREE:
POSITION IN RELATION TO HEALTH CARE ASSOCIATED INFECTIONS

3.1 Surveillance of Healthcare Associated Infection

Surveillance is undertaken within DGFT on a number of alert organisms and mandatory reporting to UK HSA is undertaken via the HealthCare Associated Infection Data Capture System. Performance is monitored by both Dudley Clinical Commissioning Group (CCG) and the Dudley Metropolitan Borough Council (DMC).

3.2 Surgical Site Surveillance

Surgical Site Infection (SSI)

Surgical Site Infections are a particularly important Healthcare-associated Infection (HCAI) because

they can increase a patient's length of stay in hospital and are associated with considerable morbidity. It has been reported that over one-third of postoperative deaths are related, at least in part, to SSI.

However, it is important to recognise that SSIs can range from a relatively trivial wound discharge with no other complications to a life- threatening condition" National Institute for Health and Clinical excellence (NICE) (2008).

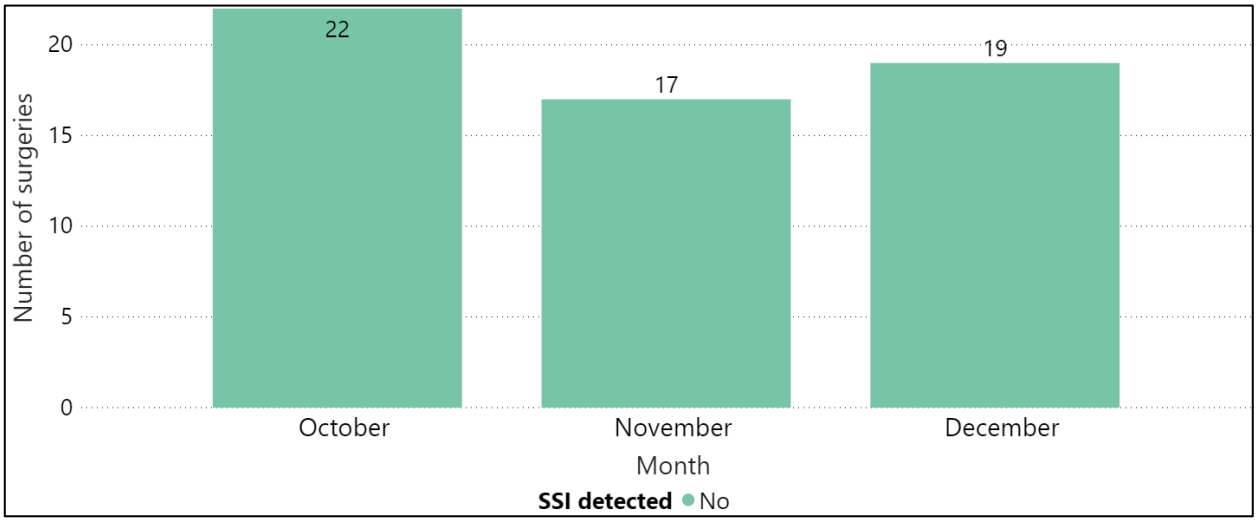
Guidelines for the prevention of SSI were issued by NICE in the UK, updated in 2013, and accompanied by a High Impact Intervention (HII) from the Department of Health.

Mandatory surveillance of infections, in the following procedures, started in April 2004 specifying that each trust should conduct surveillance for at least 1 orthopaedic category for 1 period in the financial year. This surveillance helps hospitals, in England, to review or change practice, as necessary.

- Hip replacement.
- Knee replacement
- Repair of neck of femur
- Reduction of long bone fracture

For the period relating to this report the IPC Team undertook two quarters of mandatory orthopaedic surveillance focusing on hip replacement surgery. In this period there were zero cases of patient reported surgical site infection. Previous surveillance completed did capture a smaller patient group due to pressure related to COVID-19. The surveillance period for this quarter was a larger sample size. 92.7% of all SSIS patients that were seen responded to the phone call and had a completed PDQ. Previously, letters were sent to these patients and in the last four periods 66.3% of patients had a completed PDQ. Moving to phone calls consequently led to a 23.5% increase in PDQ completion.

Figure showing the number of hip replacement patients in quarter three by SSI detection.



2023/2024
The results in the above table show the SSI patients who responded to the questionnaires and whether SSI.

Quarter one 2023/24 Mandatory Surgical Site Infections Surveillance module will change to Knee replacement following a request by the orthopaedic team. The aim is to complete a full 12-month period from the orthopaedic category. Four further members of the IPC team have completed the

Surgical Site Surveillance course (2 clinical, 2 nonclinical), with this in mind the IPC team are hoping to undertake a Voluntary Surgical Site Infection Surveillance module that will focus up on Caesarean Section.

3.3 Meticillin Resistant *Staphylococcus aureus* Blood Stream Infections (MRSA)

Staphylococcus aureus is an organism harmlessly carried on the skin by around 1 in 30 of the healthy population and remains endemic in many UK hospitals. The transmission of MRSA and the risk of MRSA infection (including MRSA Bacteraemia) can only be addressed effectively if measures are taken to identify MRSA carriers as potential sources of infection and treating them to reduce the risk of transmission. Guidance is in place regarding the screening of our patients for MRSA for both emergency and elective admissions at DGFT. In addition, DGFT have processes in place to ensure isolation of patients colonised with MRSA, following the national guidance.

Infection associated with indwelling medical devices, particularly intravascular devices, is a major cause of morbidity and occasionally, mortality.

The Trust comply with national guidance to reduce the risk of blood stream infection and have systems in place for:

- The management and care of devices
- Antimicrobial prophylaxis
- Compliance with national guidance

There have been 2 cases of MRSA bacteraemia identified in total in the local Health Economy. For the cases that were identified as pre-48-hour cases, (Admitted within 48 hours of the positive result being identified), investigations were carried out by the ICB and DMC and actions identified. For the period covered by this annual report there has been two cases of post 48-hour MRSA bacteraemia. Post infection reviews (PIR) were carried out and the investigations concluded that one case was a COHA and the other a Community Onset Indeterminate Association (COIA) with no HOHA being reported. Actions from the PIR were identified and disseminated to staff.

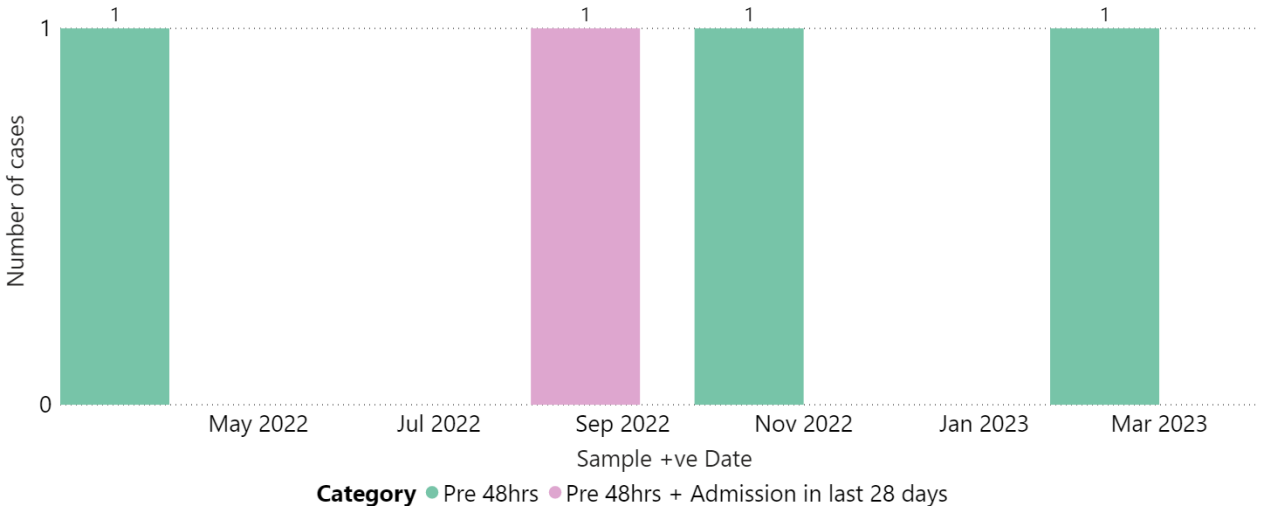
MRSA compliance is monitored against the monthly ward compliance for MRSA in order to identify any missed screening opportunities and investigate reasons for this occurrence. The areas with the lowest screening compliance are identified as areas where a small number of screens have been completed.

Cannulation training continues to be provided via the clinical skills nursing team with competency assessments carried out on ward areas. Saving lives scores are undertaken by link workers on the ward areas with some peer reviews in operation in order to cross reference locally reported scores to ensure assurance.

Actions from the RCA's are completed and monitored through the division and Governance forums.

Epidemiological analyses of *Staphylococcus aureus* bacteraemia data

Figure showing all MRSA cases since April 2022 by category.



	Trust Apportioned > 48 hours	Health Economy Total
April 2022	0	1
May 2022	0	0
June 2022	0	0
July 2022	0	0
August 2022	0	1
September 2022	0	0
October 2022	0	0
November 2022	0	1
December 2022	0	0
January 2023	0	0
February 2023	0	0
March 2023	0	1
Yearly Total to Date	**0**	**4**

The Trust undertook two Post infection reviews for post 48-hour MRSA bacteraemias. One was reported as a COHA and the other a CIOA.

Figure showing Health Economy Total MRSA cases in 2022-2023 compared to 2021-2022

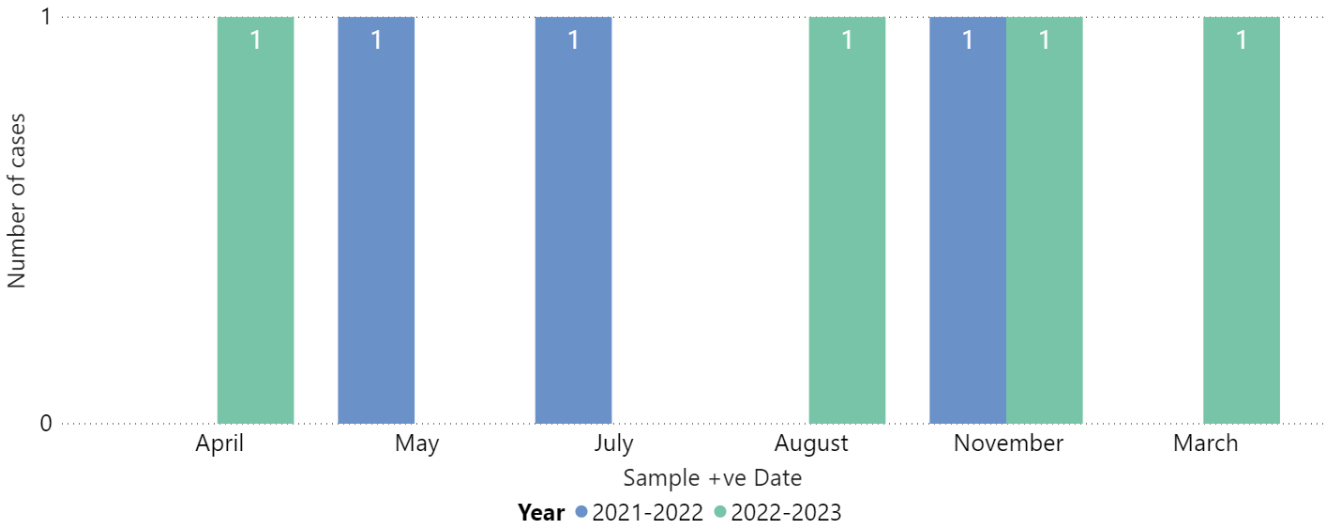


Figure showing quarterly counts of all reported MRSA: April 2007- March 2023

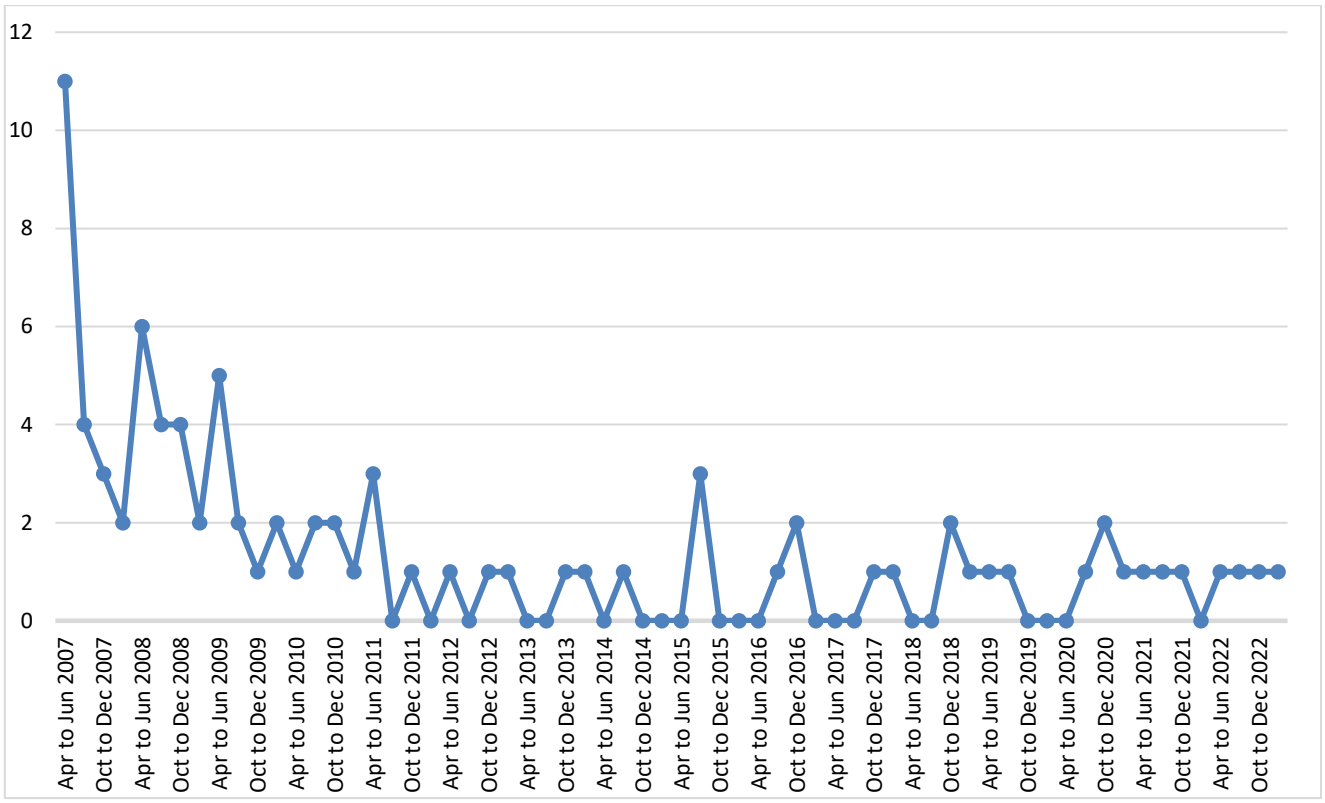
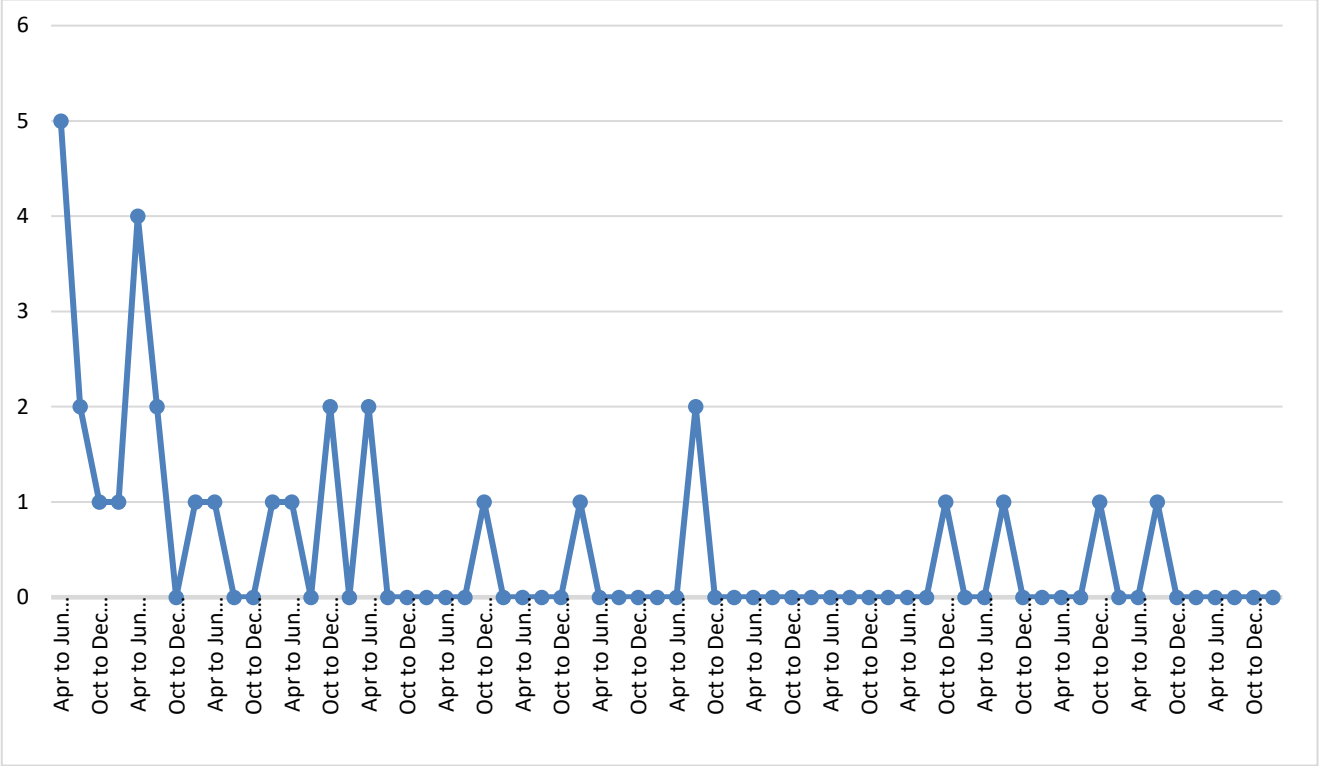


Figure showing quarterly counts of all hospital-onset MRSA: April 2007- March 2023



DGFT is in line with the national performance when compared to peers across England.

There has been a considerable decrease in the incidence rate of all reported MRSA. bacteraemia since the enhanced mandatory surveillance of MRSA bacteraemia began in April 2007.

Rates of MSSA bacteraemia continued to increase moderately from April 2011 to March 2012 when the surveillance was introduced. From April to June 2011 to January to March 2023 there has been a 44% increase from 18 cases to 26 cases.

At its peak (2007/2008) MRSA bacteraemia's accounted for approximately 40% of all *Staphylococcus aureus* bacteraemia cases in England.

The objective to achieve at DGFT is a target of zero cases of post 48-hour MRSA bacteraemia cases.

3.4 Methicillin Sensitive *Staphylococcus aureus* Blood Stream Infections (MSSA)

Meticillin-sensitive *Staphylococcus aureus* (MSSA) is a type of bacterium which lives harmlessly on the skin and in the noses, in one third of people. People who have MSSA on their bodies or in their noses are said to be colonised.

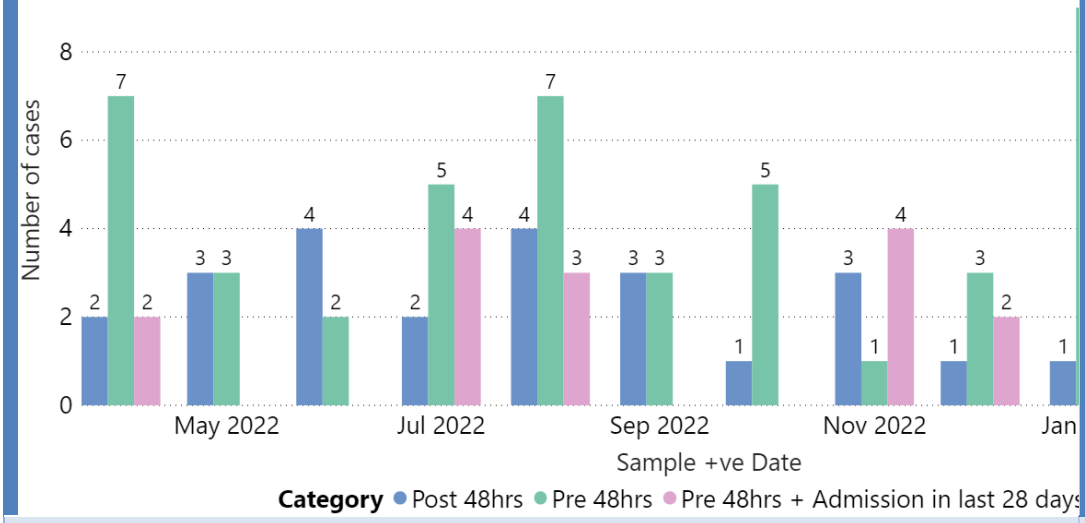
MSSA colonisation usually causes no problems but can cause an infection when it enters into the body. This is more likely to happen in people who are already unwell. MSSA can cause local infections such as abscesses or boils and it can infect any wound that has caused a break in the skin e.g., Grazes, surgical wounds.

MSSA can cause serious infections called septicaemia (blood poisoning) or a blood stream infection where it gets into the bloodstream.

Following a Secretary of State announcement on 5 October 2010, there was a mandatory

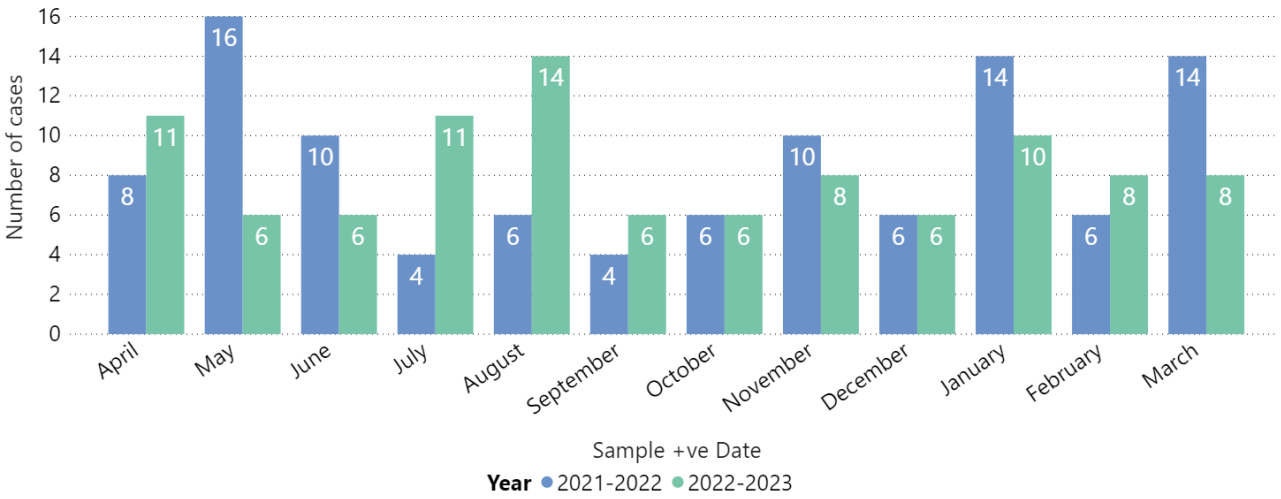
requirement for all NHS acute trusts to report MSSA bacteraemia. This applied to all cases diagnosed after 1 January 2011.

Figure showing all MSSA cases since April 2022 by category.



	Trust Apportioned > 48 hours	Health Economy Total
April 2022	2	11
May 2022	3	6
June 2022	4	6
July 2022	2	11
August 2022	4	14
September 2022	3	6
October 2022	1	6
November 2022	3	8
December 2022	1	6
January 2023	1	10
February 2023	1	8
March 2023	2	8
Yearly Total to Date	**26**	**100**

Figure showing Health Economy Total MSSA cases in 2022-2023 compared to 2021-2022.



Common themes identified following patient review include chronic leg ulcers, infective endocarditis. Lower respiratory tract infections and infective dermatitis with many of the cases identified having underlying disease prior to admission. MRSA screening compliance, including wounds is discussed through the divisions monthly in order to review missed screening compliance and identify any gaps in compliance.

3.5 *Clostridiodes difficile* (Previously Referred to as Clostridium difficile) Infection (CDI)

*Clostridioides difficile (*CDI) reporting for 2019/20 year has aligned the UK definitions with international descriptions of disease.

These changes meant that additional patients would be included in the group of patients that the trust is required to investigate. The patients who will be included are categorised in the following groups:

1. Hospital Onset Healthcare Associated (**HOHA**): cases that are detected in the hospital two or more days after admission.

2. Community Onset Healthcare Associated (**COHA**): cases that occur in the community or within two days of hospital admission when the patient has been an inpatient in the Trust reporting the case, within the previous 4 weeks.

For patients in group 2 (COHA), diagnosed in the community or on admission to DGFT but with a previous admission the Infection Prevention and Control Team will lead the RCA.

Patients in group 1 (HOHA) will be investigated by the local clinical team.

During 2022/2023, the number of cases that occurred were:

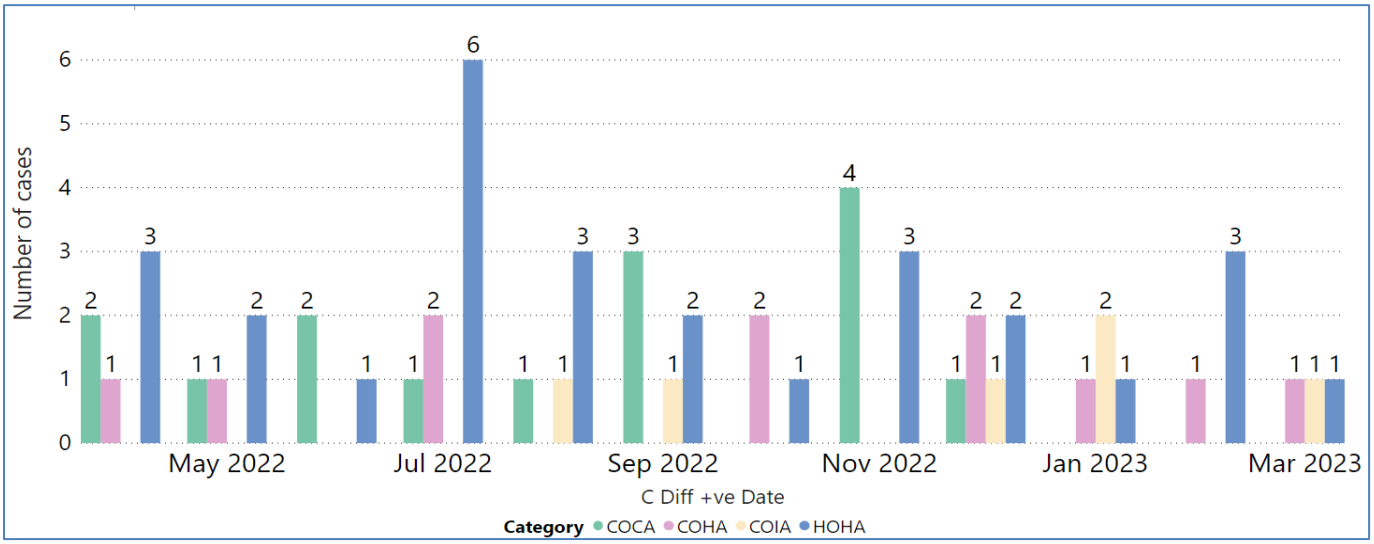
- 28 Hospital Onset Healthcare Associated (HOHA)
- 11 Community Onset Healthcare Associated (COHA)

All cases of CDI were discussed across the health economy using the national apportionment tool. Due to the COVID-19 pandemic several RCA meetings did not go ahead as planned as they were not quorate due to the increased work commitments across the trust by all parties. In order to address issues that were identified, the clinical teams were required to develop action plans which were then monitored locally and via reports submitted by the divisions to the Infection Prevention and Control Group. The RCA meetings involving external partners have now recommenced with the

introduction of a scrutiny panel held internally to review each case prior to the external partner review.

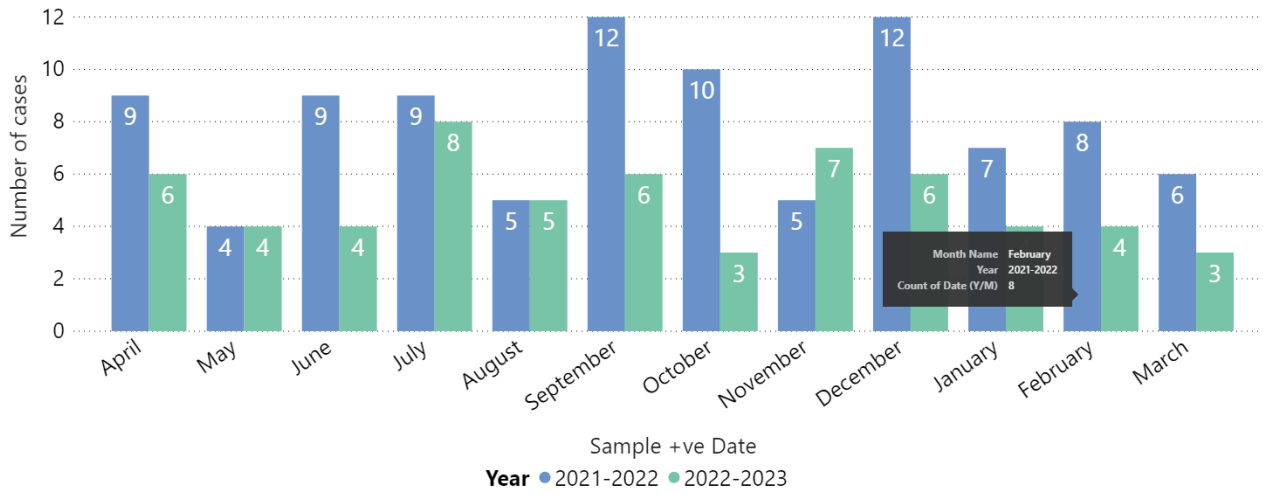
CDI Apportionment Decisions to Date Hospital onset healthcare associated. – April 2022 to March 2023

Figure showing all CDI cases since April 2022 by category.



	Trust Apportioned > 48 hours	Health Economy Total
April 2022	3	6
May 2022	2	4
June 2022	1	4
July 2022	6	8
August 2022	3	5
September 2022	2	6
October 2022	1	3
November 2022	3	7
December 2022	2	6
January 2023	1	4
February 2023	3	4
March 2023	1	3
Yearly Total to Date	**28**	**60**

Figure showing Health Economy Total CDI cases in 2022-2023 compared to 2021-2022



There have been 28 post 48-hour HOHA cases identified in 2022/2023; of these cases 3 have been associated with having a lapse in care. The common themes identified have been antimicrobial stewardship and issues relating to mandatory training compliance and samples not being obtained in a timely manner. To assist with the improvement of antimicrobial prescribing, several actions have been initiated to include:

- Executive level reporting to influence change.
- Antibiotic awareness week campaign supported by IPC and Pharmacy teams.
- Patient safety bulletin published online and sent to all staff.
- Weekly CDI virtual ward round has been introduced with the Trusts Antimicrobial pharmacists to review the medication prescribed and drug interactions.
- Antimicrobial stewardship section in Trust wide Governance newsletter.
- Feedback to the divisions provided via Antimicrobial Stewardship group.
- Quarterly Antimicrobial stewardship report provided monthly to Infection Prevention and Control Group, Drugs and Therapeutics Group & Medicines Management Group.

Further details related to antimicrobial stewardship can be located in the relevant section of this report. Reduced compliance of infection control mandatory training was noted during 2022/2023; the trust was under immense pressure due to COVID-19 and associated workforce challenges. Face to face teaching sessions were suspended due to social distancing measures this impacted on training compliance across the Trust however, IPC induction training for new starters were delivered face to face.

In order to ensure we have systems in place to increase the compliance across the trust there is a direct link to enable staff to complete the training via the DGFT intranet page, making it easier for staff to access e learning.

The face-to-face training sessions for IPC Training have now been re- introduced following the removal of COVID-19 social distancing requirements.

The IPC Team have been involved in a project with NHSE to review and develop new RCA tools to review CDI cases, creation of new literature and resources including CDI pocket cards for nurses and medics detailing the SIGHTED pneumonic and Bristol Stool form chart and CDI severity.

Epidemiological analyses of *Clostridiodes difficile* infection data (England)

Since the initiation of *C. difficile* (CDI) surveillance in April 2007, there has been an overall decrease in the count and incidence rate of both all-reported and hospital-onset cases of CDI.

Since April 2007 there has been a general decrease in the count of all C*. difficile* cases. This trend is also mirrored for all hospital onset *C.difficile* cases. A large part of the decrease in *C.difficile* count occurred between April to June 2007 and January to March 2012, with a 79% decrease in all reported cases of CDI from 149 cases to 32.

Subsequently, between January to March 2012 and January to March 2023, the count of all-reported cases decreased by 66%% from 32 to 11 cases.

For hospital onset CDI cases only there has been a 93% decrease in the number of reported cases between April to June 2007 and January to March 2023, from 71 cases to 5 cases.

Figure showing quarterly counts of all reported CDI: April 2007- March 2023

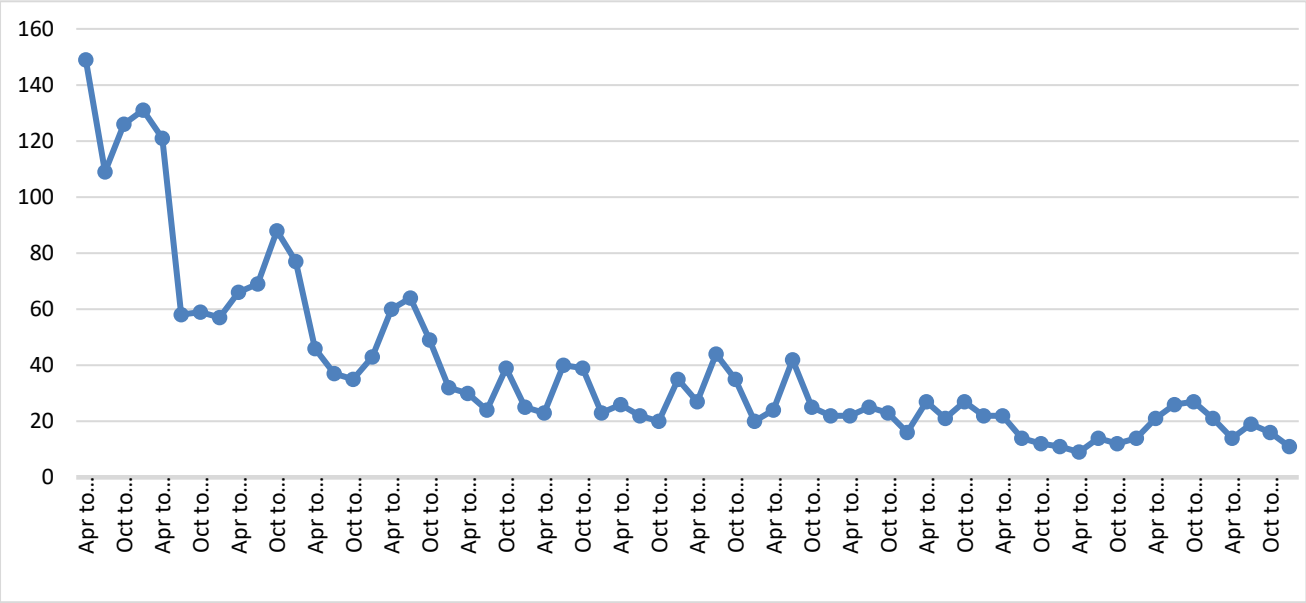
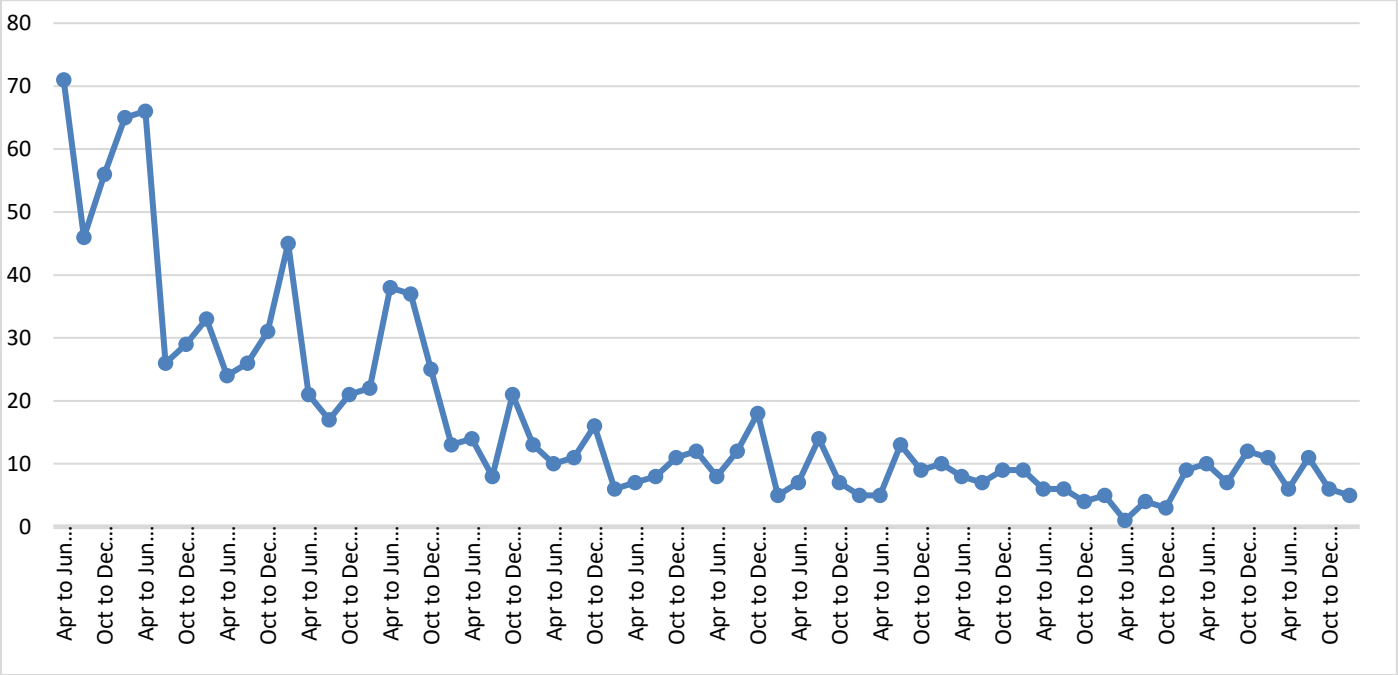


Figure showing quarterly counts of all hospital-onset CDI: April 2007- March 2023



The division of cases into hospital-onset and community-onset cases does not take into account any patient who may have been admitted into healthcare within the previous twenty-eight days leading up to the positive CDI result. Patients who have received previous inpatient care may be at increased risk of developing CDI. For this reason, reporting of information prior to trust exposure to healthcare facilities was introduced in April 2017.

3.6 CDI Root Cause Analysis and Investigation

Preventing and controlling the spread of CDI is a vital part of the Trust's quality and safety agenda by a multifaceted approach and the proactive element of early recognition and isolation of CDI toxin positive cases and of those cases that are CDI carriers (GDH positive).

In all cases control measures are instigated immediately. Each HOHA and COHA CDI's have a Root cause analysis completed.

The HOHA cases undergo an RCA scrutiny panel to establish root cause of the infection and any learning outcomes identified. Following this process and review by the ICB/ Dudley Health Board each case is apportioned to identify if any lapses or no lapses in care can be identified. The lapses in care are then plotted against the trust objective for CDI for that year. This is then feedback via reporting mechanisms to the IPCG. An improvement has been noted throughout this year in comparison to the previous year with a reduction of HOHA cases identified.

Lessons Learnt

Following review of all of the Root Cause analysis completed some common themes have been identified. These include antimicrobial stewardship and appropriateness of antimicrobial prescribing in line with Trust guidelines, Environmental Cleaning scores below an overall compliance of 95% and IPC Mandatory training compliance falling below the Trust objective of 90% compliance. All RCA's have an action plan completed with objectives to achieve and a timeframe for completion with all having a matron sign off to ensure this has senior level review. Many of the actions are addressed through divisional governance meetings or teams' meetings with minutes being taken as well as daily staff reminders on the ward in the form of huddle board meetings. Action plans and compliance are then monitored through the divisions.

DGFT closely monitors periods of increased incidents (PII) of patients with evidence of toxigenic *Clostridioides difficile* in any ward or area. The definition of a PII is 2 or more patients identified with evidence of toxigenic *Clostridioides difficile* within a period of 28 days and associated with stay in the same ward or area, each case is reviewed to establish if they can be linked by time and place and identify any common themes. Should this occur samples are obtained and submitted to UK HSA for ribotyping. This helps to identify wards or areas where patient to patient transmission is likely to have occurred, with enhanced focus on control measures and increased cleaning of the patient areas if necessary.

The terminology of *Clostridioides difficile* is not commonly used, therefore further work in terms of communication of this is required to filter down to the wider organisation.

An additional scrutiny panel has been introduced to discuss all cases of CDI internally with ward representatives, microbiologist, antimicrobial pharmacist, and IPC Team. This allows oversight and challenge against each case identified, to identify any learning and agree action plans prior to the RCA panel discussion with external partners.

3.7 Gram Negative Blood Stream Infections – Escherichia coli (E.coli)

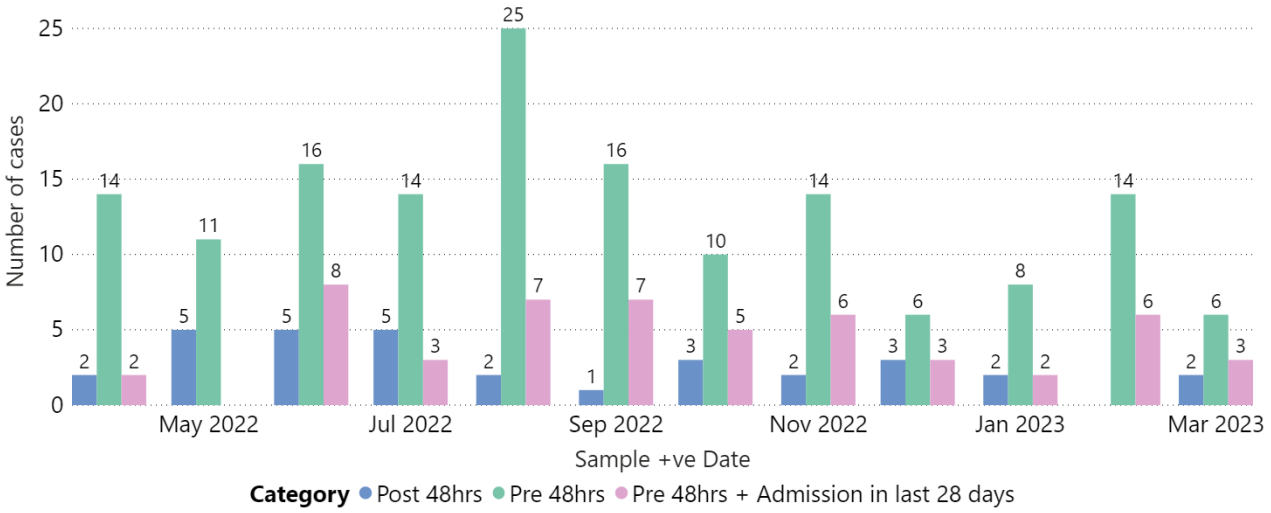
Escherichia coli (E. coli) bacteria are frequently found in the intestines of humans and animals. There are many different types of E. coli, and while some live in the intestine quite harmlessly, others may cause a variety of diseases. The bacterium is found in faeces and can survive in the environment. E. coli bacteria can cause a range of infections including urinary tract infection, cystitis (infection of the bladder), and intestinal infection. E. coli BSI may be caused by primary infections spreading to the blood.

The Secretary of State for Health in 2017 launched an ambition to reduce healthcare associated GN bloodstream infections (BSIs) by 50% by 2021.

Enhanced surveillance of E. coli BSI has been mandatory for NHS acute trusts since June 2011 and is reported monthly to UK HSA. This is to ascertain themes and trends associated with E.coli bacteraemia within the acute Trust to see where lessons may be learnt. There is work ongoing that is part of the national agenda for health and social care economies to reduce the number of Gram-negative bloodstream infections (BSIs) with an initial focus on *Escherichia coli* (E.coli). To date this has focused on the management of patients with long term urinary catheters and a catheter passport was introduced in conjunction with the ICB and used across Birmingham and the Black Country.

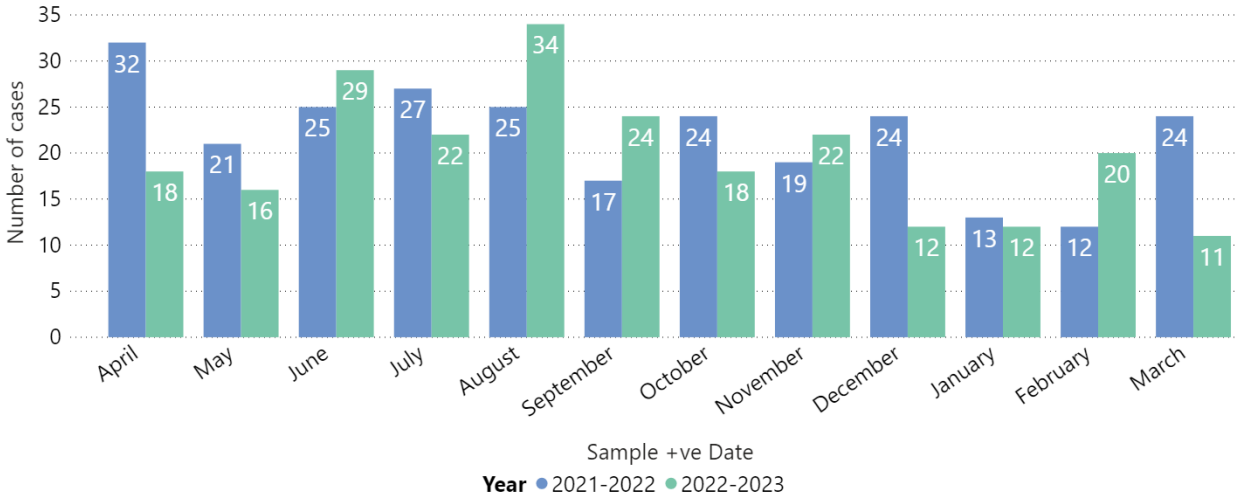
As detailed in the graphs below 238 E. coli infections have been identified with 30 classified as post 48-hour cases. Each post 48-hour case will be reviewed by the IPCT to establish the potential source of the bacteraemia.

Figure showing all E.coli cases since April 2022 by category.



	Trust Apportioned > 48 hours	Health Economy Total
April 2022	2	18
May 2022	5	16
June 2022	5	29
July 2022	5	22
August 2022	2	34
September 2022	1	24
October 2022	3	18
November 2022	2	22
December 2022	3	12
January 2023	2	12
February 2023	0	20
March 2023	2	11
Yearly Total to Date	**32**	**238**

Figure showing Health Economy Total E.coli cases in 2022-2023 compared to 2021-2022.



Epidemiological analyses of Gram- negative bacteraemia data (England)

E. coli bacteraemia

The incidence rate of all reported E. coli bacteraemia increased each year between the initiation of

the mandatory surveillance of E. coli bacteraemia in July 2011 and the start of the COVID-19 pandemic (January to March 2020). This increase was primarily driven by community-onset cases. The number and incidence rates of all reported and community-onset cases declined after the start of the pandemic but remain higher than observed at the start of E. coli surveillance.

In contrast, the count of hospital-onset cases fluctuates during the same period. Between April to June 2011 and January to March 2023, the count all reported cases of E. coli bacteraemia increased by 59% from 27 cases to 43.

Similarly, over the same period, the count of community-onset cases increased by 27% from 22 to 28 cases. Concurrently, the count of hospital-onset cases decreased by 20% from 5 to 4 cases.

Figure showing quarterly counts of all reported E.coli: April 2011- March 2023

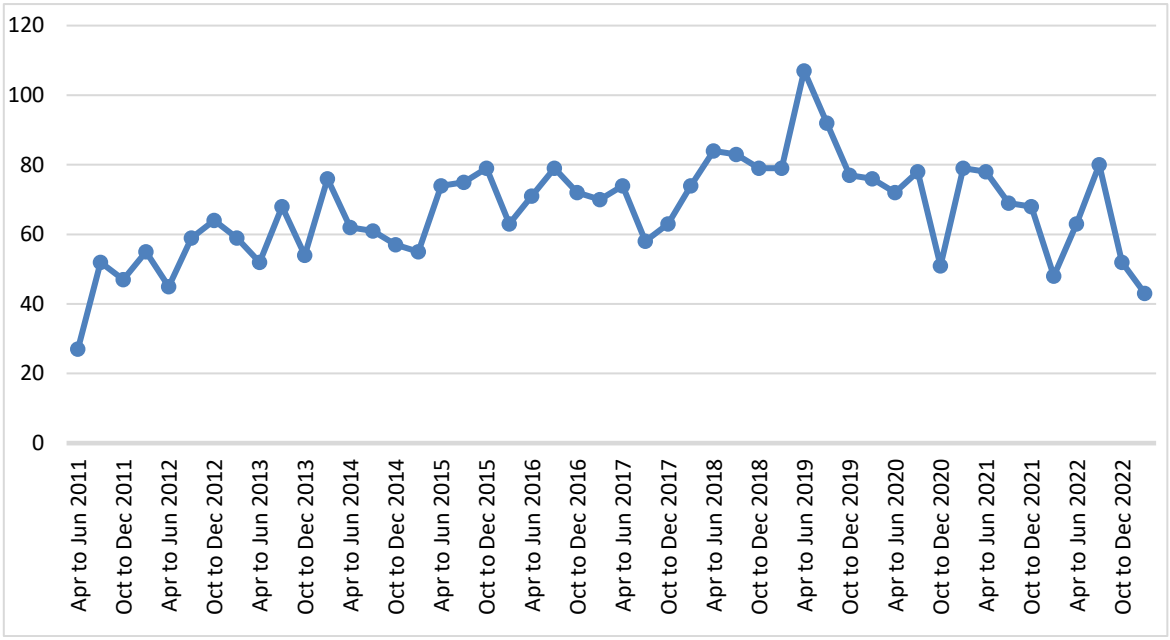
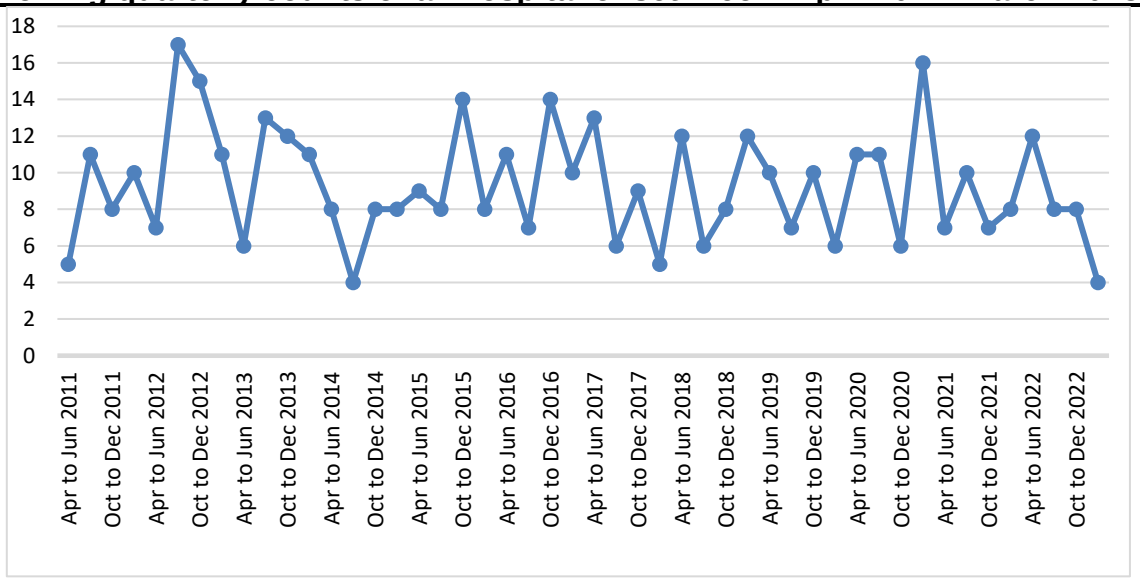


Figure showing quarterly counts of all hospital-onset E.coli: April 2011- March 2023



Further work is needed in order to reduce the number of cases reported within DGFT and examples of these include a catheter passport which was introduced across Birmingham and the Black Country which due to issues associated with the COVID-19 pandemic the embedding of this has been fragmented.

A simplified algorithm was introduced associated with Urinary tract infections in over 65s within ED and in agreement with the ED lead. Teaching sessions completed for all Pharmacists on management of simple Urinary Tract Infections (UTI)s.

3.8 Vancomycin / Glycopeptide Resistant Enterococci (VRE/GRE)

Enterococci are part of the normal bowel flora and can cause urinary tract and blood stream infections.

Vancomycin resistant enterococci (VRE) and Glycopeptide resistant enterococci (GRE) may be found in the healthy population thought to reflect inappropriate use of antibiotics in farming.

Mandatory surveillance was discontinued in 2013.

3.9 Carbapenemase Producing Enterobacteriaceae

The Enterobacteriaceae are a large family of Gram-negative bacteria including species such as E. coli, Klebsiella species, Proteus species, and Enterobacter species. They live usually harmlessly in the guts of both humans and animals. They are opportunistic pathogens, capable of causing urinary tract infections, abdominal infections, and bloodstream infections (UK HSA 2013).

Some of these bacteria develop resistance to antibiotics through various mechanisms, one of them being the ability to produce an enzyme called Carbapenemase which is capable of destroying the β-lactam ring, an essential component of β-lactam antibiotics. The Carbapenemase enzyme makes these organisms resistant to multiple antibiotics, hence the options of treating infections caused by CPE is limited. Antibiotic resistance is a major Public Health concern and stringent Infection Prevention, and Control precautions need to be instigated and maintained to reduce the spread of these organisms.

UK HSA published a toolkit in 2013 to control the spread in healthcare and onwards in the community.

DGFT identified two cases of CPE during the time period covered by the report.

3.10 Norovirus

Norovirus is defined as an abrupt explosive onset of profuse watery diarrhoea which may be accompanied by projectile or violent vomiting. Several cases may occur on the ward within hours. If this occurs the ward must gather information about the patient's affected, this infection is known to be highly infectious. The virus is easily transmitted through contact with infected individuals from one person to another or environmental contamination. In hospital this environmental risk is considerable, and outbreaks are common.

Management relies on prompt recognition of symptoms, robust isolation, and IPC procedures as well as enhanced environmental cleaning within the area affected.

For the period covered in this report DGFT had 50 confirmed cases of Norovirus and 7 outbreaks. Norovirus was prevalent throughout the local community through December to March. All outbreaks are reported to the UK HSA and an internal meeting was held to review. Lessons learned are disseminated throughout the Trust.

Figure showing all Norovirus cases since April 2022 by month.

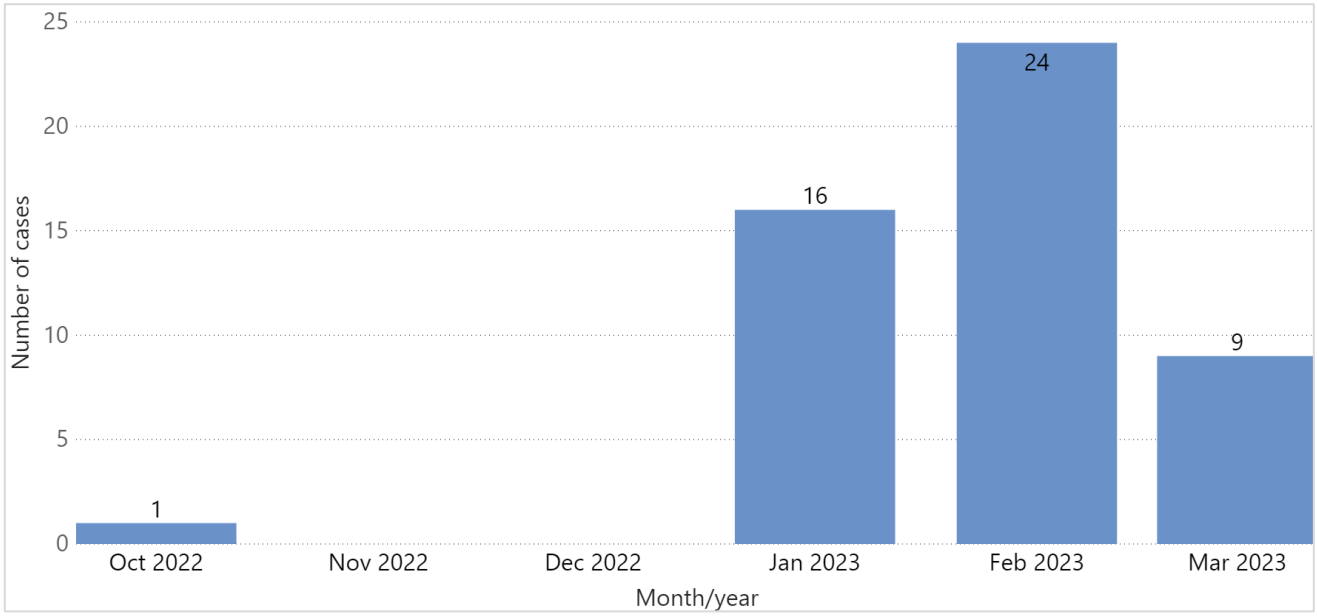
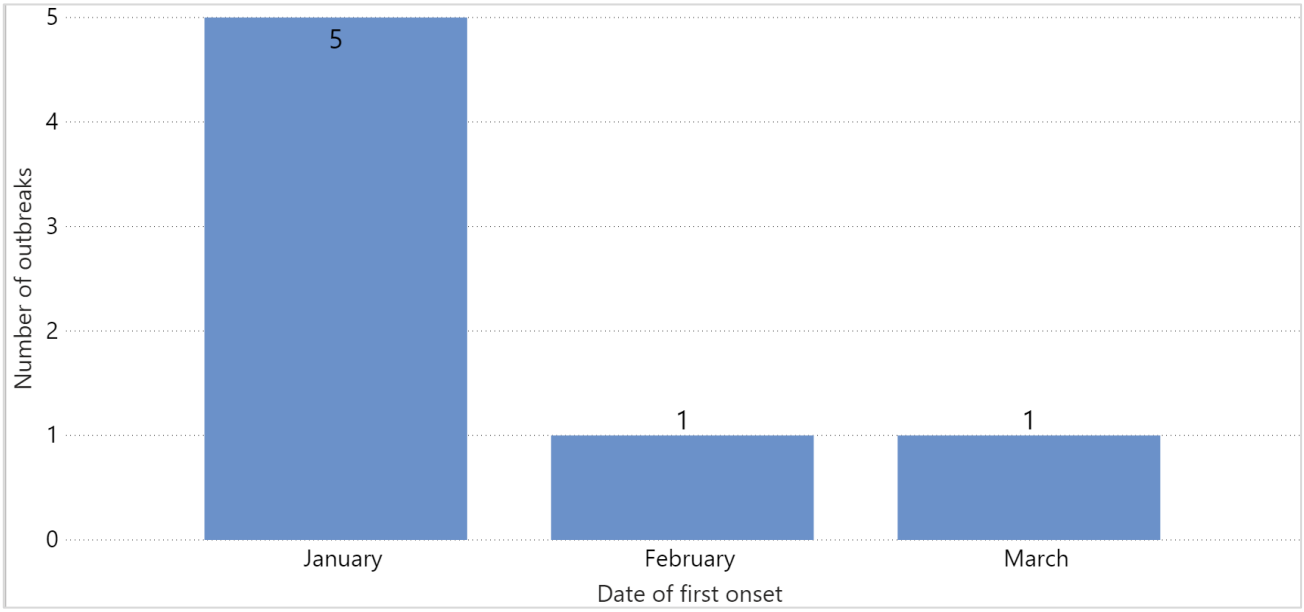


Figure showing all Norovirus outbreaks since April 2022 by month.



3.11 COVID-19

The World Health Organisation (WHO) issued a press release (Thursday 9 January 2020) announcing the discovery of novel virus identified in China and called for more research. In January 2019 Public Health England declared a National Incident following a preliminary determination of a novel (or new) coronavirus by officials in Wuhan, China.

The Department of Health and Social Care also declared an incident and established an incident team. As human-to-human transmission escalated globally numerous countries declared outbreaks with increasing pressures on healthcare systems. On the 12 March 2020 WHO declared a global pandemic of COVID-19.

Background

Coronaviruses are a large family of viruses with some causing less-severe disease, such as the common cold, and others more severe disease such as MERS and SARS. Some transmit easily from person to person, while others do not. A novel coronavirus is a new strain that has not been previously identified in humans. The virus was named as SARS-CoV-2 and the infection caused by the virus named as COVID-19.

The Trust has implemented the requirements as identified by NHS England in order to manage the additional pressures on healthcare systems. A COVID-19 planning team was established and comprises of all key partners that are required within trust to ensure all aspects of COVID-19 are considered and planned for. The Trust is well engaged with all local arrangements and national planning. This work is ongoing and subject to change as national guidance is updated.

Significant changes have been made to how the Trust operates during the COVID-19 pandemic to keep patients' staff and visitors safe; face to face training, consultations and meetings were suspended or held virtually to ensure social distancing.

Hospital Acquired COVID-19 Definitions

- **Admission –** defined as day 0
- **Community-Onset (CO) -** Positive specimen date less than or equal to 2 days after hospital admission or hospital attendance.
- **Hospital-Onset Indeterminate Healthcare-Associated (HOHA)** – defined as positive result within 3-7 days after hospital admission.
- **Hospital-Onset Probable Healthcare-Associated (HOHA) –** defined as positive result within 8-14 days after the hospital admission.
- **Hospital-Onset Definite Healthcare-Associated (HOHA) –** defined as positive result within 15 days or more of the hospital admission.

A **probable** or **definite** hospital-onset healthcare associated COVID-19 infection is a **patient safety incident** and should be reported and responded to according to the trust's existing policies.

A probable or definite hospital-onset healthcare associated COVID-19 infection **death** is defined as.

- The death of a patient who has a positive specimen result where the swab was taken within 28 days of death and/or COVID-19 is cited on either Part 1 or Part 2 of the death certificate (i.e., the death resulted from a COVID-19 clinically compatible illness with no period of complete recovery between the illness and death).
- The COVID-19 infection is linked to the death which meets the definition of 'probable' or 'definite' hospital-onset healthcare associated infection (see above).

In instances where a patient has had a positive test result and the swab date was more than 28 days prior to death, this death would not be considered a COVID-19 death unless COVID-19 is cited in part 1 or part 2 of the death certificate.

Similarly, the death is not considered a COVID-19 death if there is a clear alternative cause of death that cannot be related to COVID-19 disease (e.g., trauma) and so COVID-19 is not cited in part 1 or 2 of the death certificate.

Public Health England / Reporting, reviewing, and investigating hospital-onset COVID-19 cases and COVID-19 deaths (February 2021)

Hospital Acquired COVID-19 Data.

6777 individuals were tested positive for COVID-19 from 1st March 2020 to the 31st of March 2023 at The Dudley Group.

In November 2020 UK HSA / NHSE requested that each acute Trust submit a daily return identifying confirming positive cases and at which point during the patients stay did they become positive. Below is the available data:

Critical Care Data - 1st March 2022 12th April 2023

260 patients were admitted to Critical Care.

There are 37 patients within the Critical Care data set that will require a review as part of a harm review process. NHSE and UK HSA recommend any patient that requires level 2 or level 3 care as part of a hospital acquired COVID-19 positive pathway must be assessed for harm and long-term health needs. A harm review will be completed and will be reported in subsequent report.

Level 2 care is defined as patient who requires support for one organ failure.
Level 3 care is patients who require support for two or more organs that are failing.

Contact Tracing Evidence

Whilst the IPC team and Staff Health and Wellbeing (SHAW) undertook some limited staff contact tracing during the first wave, it was recognised during the second wave that a bespoke team was required to meet the national guidance the Chief Nurse supported resourcing a contact tracing service for staff which came into service in November 2020.

COVID-19 positive staff members have been contact traced (this includes all members of the MDT and PFI staff). This information is fed into the outbreak meetings so that data can be triangulated establishing any potential breaches in the use of Personal Protective Equipment (PPE) or behaviour aspects that may have contributed to the outbreak.

Key themes identified from staff contract tracing have included:

- Breaching PPE – face mask compliance
- Sociaising outside of work areas
- Communial break areas – Doctors Mess, canteen

In line with trust policy all patients who test positive for COVID-19 are informed if appropriate. All cases are investigated and contact tracing undertaken this includes notifying any potential contacts of exposure to isolate as per national guidance.

All patient contact information is stored on a patient database. Information regarding positive patient/s and contacts are detailed within the file and discussed as part of the outbreak meetings held internally andw with external partners. This system provides assurance and oversight for any patient and staff member that recieves a positive result for COVID-19, allowing triangulation of data and the monitoring of any potential outbreaks across the Trust. This early detection and any remedial action taken to prevent further transmission.

COVID-19 Outbreaks

Outbreaks as defined by UK HSA (08.2020) two or more cases linked by time and place where at least one case (if a patient) has been identified as having illness onset after 8 days of admission to hospital. Outbreak meetings were established in line with best practice toolkit from NHSE.

Each outbreak has an individual timeline where all information regarding these patients are collated and reviewed.

These meetings were recorded and minuted, detailing all attendee discusions and findings. Once this information has been signed off by Chief Nurse/DIPC or her deputy, the information is shared with partners via the OTKA NHSE Outbreak System.

Since April 2022 there have been a total of 46 outbreak areas relating to COVID-19 within the Trust where 2 or more cases tested positive on the same ward or area that can be linked by time and place.

Once the outbreak areas have been identified within the trust, reviews are undertaken to find potential themes/issues behind the outbreak occurring. Outbreak meetings are arranged with external partners where necessary, and actions identified. Closure reports are issued after 28 days, and the outbreaks are recorded on the OTKA NHSE database.

The Dudley Group NHS Foundation Trust COVID-19 Outbreak Overview:

DGFT Outbreak Data- 31/03/2023	
Total outbreaks	128
Total COVID-19 Positives	1407
Total Patients	853
Total Staff	554

Figure showing all COVID-19 cases in 2022-2023 compared to 2021-2022.

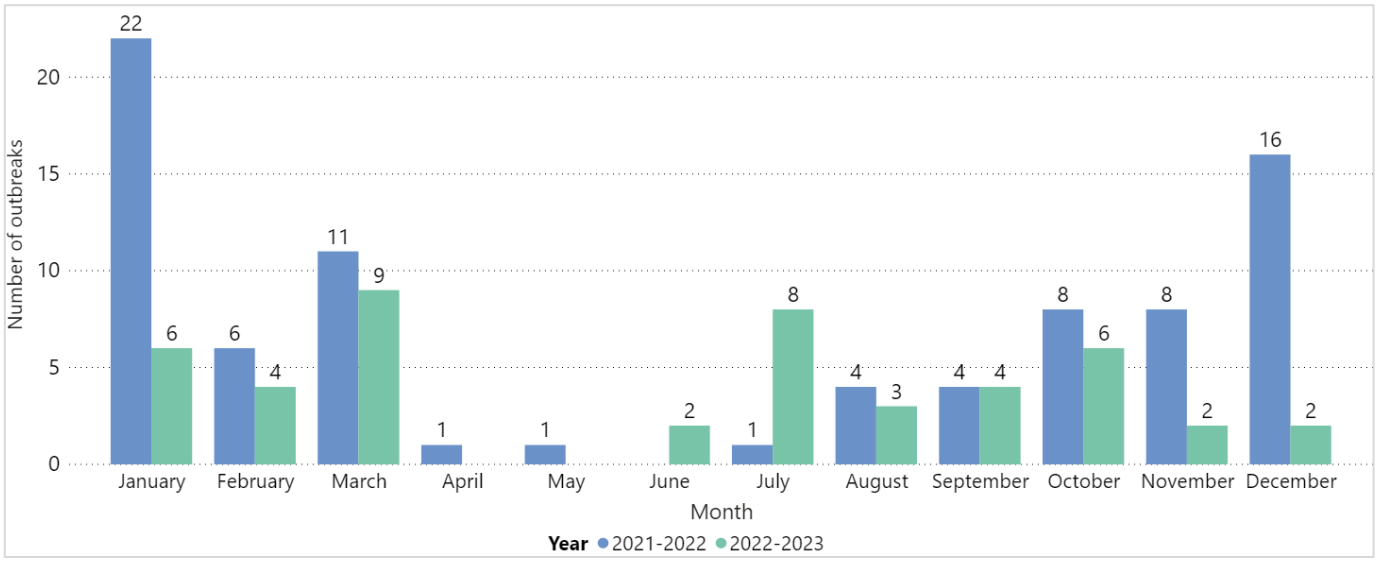
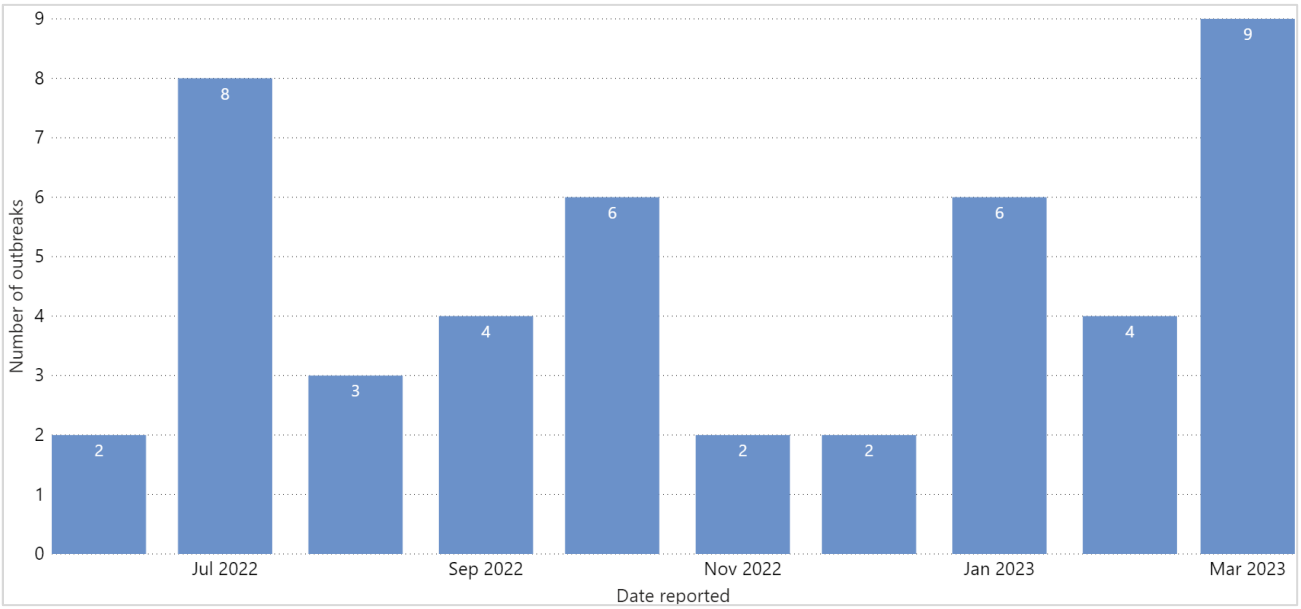


Figure showing all COVID-19 outbreaks since April 2022.



Review of Outbreak Areas – Action Plans

Once outbreak areas have been identified within the trust, reviews are undertaken to find potential themes/issues behind the outbreak occurring. Audits are undertaken by a member of the IPC team to identify compliance and where necessary action plans are devised to prevent any further occurrences. Our Estates departments have been responsive in enabling the zoning of departments within wards in response to demand to enable segregation of patients.

Clinical practice audits including hand hygiene, Matron peer review and Environmental audits are completed and compliance scores for each ward are collated. Where improvements are required, advice is provided by the IPC team to the wards to facilitate an improvement in their overall compliance. By reviewing areas, risks and non-compliance can be identified to limit the potential of outbreaks occurring within the trust.

Specialist audits have been devised and implemented for specific visits to off-site areas such as the vaccination centre at Saltwells Centre, in Dudley.

Recommendations from the COVID-19 Pandemic

- Ensure all patients identified as potential harm via a Structured Judgement Review are referred to the Weekly meeting of harm and a datix completed.
- To set up a harm review panel to discuss level 2 and level 3 patients to review potential harm as a direct consequence of contracting COVID-19 whilst in our care.
- Work with our PFI partners to review the cleaning specification in line with cleaning standards.

Dissemination of the learning is disseminated through the divisions and shared with all Trust teams.

3.12 Audit Programme

The DGFT has a programme of audits in place undertaken on all clinical areas and outpatients' departments. The IPC Team provide assurance against consistent compliance with evidence-based practice and policies. Each audit completed creates an action plan for review and completion by the ward teams. All Environmental audits are recorded on AMaT, and an electronic action plan is generated.

These audits are undertaken quarterly to ensure all wards and departments receive monitoring to provide assurance that improvements are being made.

Where a period of increased incidence (PII) occurs, risks are identified and the IPC Team undertakes additional audits in accordance with risk requirement, this will be daily initially with an increase to weekly once an improvement and consistency in scores has been identified.

Action plans are developed by the clinical areas, and these are managed and monitored within the divisions and escalated to IPCG and upwardly reported through the DGFT Governance structure.

High Impact Interventions

High Impact Interventions relate to key clinical procedures or care processes based on evidence-based approach.

The High Impact Interventions are:

- HII 1 – Ventilator Associated Pneumonia
- HII 2a – Peripheral Vascular Access Devices (Insertion)
- HII 2b – Peripheral Vascular Access Devices (Ongoing Care)
- HII 3a – Central Venous Access Devices (Insertion)
- HII 3b – Central Venous Access Devices (Ongoing Care)
- HII 4a – Surgical Site Infection Prevention (Preoperative)
- HII 4b – Surgical Site Infection Prevention (Intraoperative Actions)
- HII 5 – Infection Prevention in Chronic Wounds
- HII 6a – Urinary Catheter (Insertion)
- HII 6b – Urinary Catheter (Maintenance and Assessment)

The clinical nursing team's complete self-assessment practice audits across each ward area and look at the elements of the high impact interventions applicable to their area. Below is an outline of the performance broken down by month for each of the elements highlighted.

DGFT OVERALL SCORES 2022-2023

Interventions		Quarter 1			Quarter 2			Quarter 3			Quarter 4		
		4-22	5-22	6-22	7-22	8-22	9-22	10-22	11-22	12-22	1-23	2-23	3-23
HII 1:	Ventilator Associated Pneumonia	100.0%	90.0%	90.0%	75.0%	90.0%	90.0%	70.0%	90.0%	100.0%	66.7%	77.8%	80.0%
HII 2a:	Peripheral Vascular Access Devices - Insertion	94.6%	97.0%	96.4%	95.0%	98.7%	97.9%	96.2%	96.6%	99.1%	95.9%	94.9%	95.5%
HII 2b:	Peripheral Vascular Access Devices - Ongoing care	90.2%	98.6%	97.4%	96.6%	95.8%	95.4%	97.0%	97.8%	96.2%	97.2%	92.6%	92.2%
HII 3a:	Central Venous Access Devices - Insertion	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
HII 3b:	Central Venous Access Devices - Ongoing Care	100.0%	100.0%	100.0%	100.0%	100.0%	97.4%	100.0%	97.6%	96.8%	96.0%	94.4%	96.0%
HII 4a:	Surgical Site Infection Prevention - Preoperative	100.0%	92.6%	100.0%	100.0%	100.0%	100.0%	100.0%	89.3%	100.0%	100.0%	86.4%	100.0%
HII 5:	Infection Prevention in Chronic Wounds	94.9%	98.9%	98.7%	98.9%	98.5%	98.6%	100.0%	95.3%	100.0%	100.0%	100.0%	98.4%
HII 6a:	Urinary Catheter - Insertion	97.8%	98.6%	97.9%	97.9%	96.4%	99.2%	99.2%	98.4%	100.0%	99.2%	100.0%	99.0%
HII 6b:	Urinary Catheter - Maintenance & Assessment	94.0%	100.0%	97.0%	98.8%	96.8%	97.6%	98.1%	99.4%	98.6%	95.5%	94.9%	96.0%
High Impact Interventions Monthly Overall		96.8%	97.3%	97.5%	95.8%	97.4%	97.3%	95.6%	96.0%	99.0%	94.5%	93.4%	95.2%
Hand Hygiene		99.4%	99.3%	98.9%	99.3%	98.9%	98.8%	99.7%	99.9%	87.5%	90.0%	99.4%	98.6%
Commode Audits		98.0%	99.1%	98.5%	99.1%	99.1%	99.1%	99.0%	99.4%	98.3%	99.0%	98.8%	99.2%
Cleaning Scores													

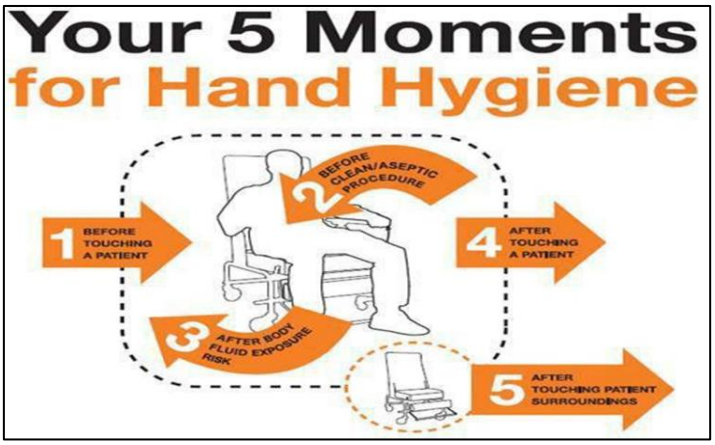
Clinical practice audits have been commenced by the IPC Team to monitor compliance of key infection control issues across the wards and departments such as environmental cleanliness, hand hygiene compliance, equipment monitoring and sharps compliance.

3.13 Hand Hygiene Audits

Hand hygiene continues to be included in the audit programme. An environmental hand hygiene audit was in place throughout a large part of the year which includes environmental elements. Due to the COVID-19 pandemic some of the Hand hygiene scores were not uploaded and there were some gaps in submission, therefore the figures in the chart below indicate compliance based on the data submitted.

The DGFT introduced the 5 moments of hand hygiene tool in March 2021 which focuses on opportunities and performance of hand hygiene across a variety of staff groups on each area. This is completed in conjunction with an environmental hand hygiene audit and the hand hygiene audits completed as part of the ward environmental audit programme.

Hand hygiene continues to be audited across all wards and departments, on a monthly basis, this now includes monthly compliance following the WHO 5 Moments of Hand Hygiene tool and an example of the 5 moments of hand hygiene tool can be found below:



Patients, visitors, and staff are encouraged to challenge staff if they have any concerns about hand

hygiene and in cases of repeated non-compliance, concerns are raised divisionally. This is across all staff groups including nurses, medical staff, AHP's and our PFI partners.

Raising awareness of hand hygiene and the 'Bare below the elbow' are consistently monitored throughout the year.

Individual hand hygiene assessment competencies were introduced on clean your Hands Day in May 2022. These are a peer review set of competencies to be completed by each clinical member of staff as part of their annual appraisal process. Compliance is monitored at the IPCG meeting.

3.14 Mandatory Training

The revised mandatory requirement is to update Infection Control training annually for clinical staff.

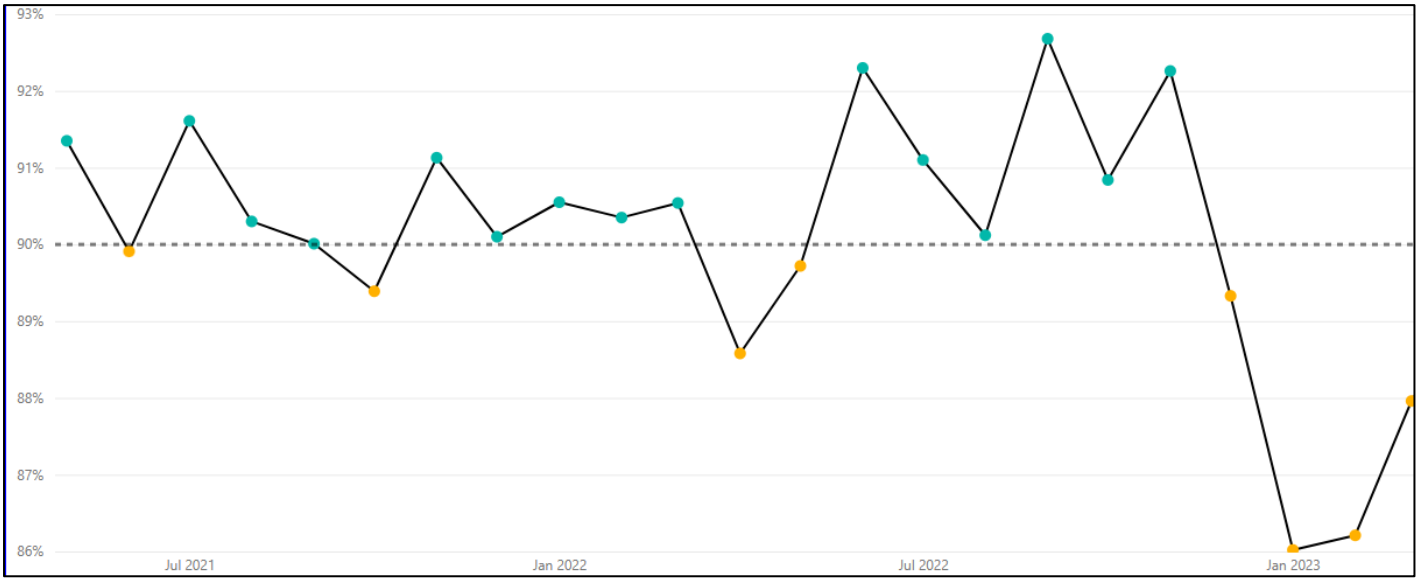
The following measures have been introduced to achieve compliance of 90% of clinical staff.

Reduced compliance of infection control training was noted during COVID-19; the trust was under immense pressure due to COVID-19 and associated workforce challenges. Face to face teaching sessions were suspended due to social distancing measures this has impacted training compliance across the Trust. In order to ensure we have systems in place to increase the compliance across the trust:

- There is a direct link for the mandatory IPC training on the staff intranet (The HUB) making it easier for staff to access e-learning.
- Face to face sessions have now been re-introduced with a reduced capacity to ensure compliance with social distancing requirements.

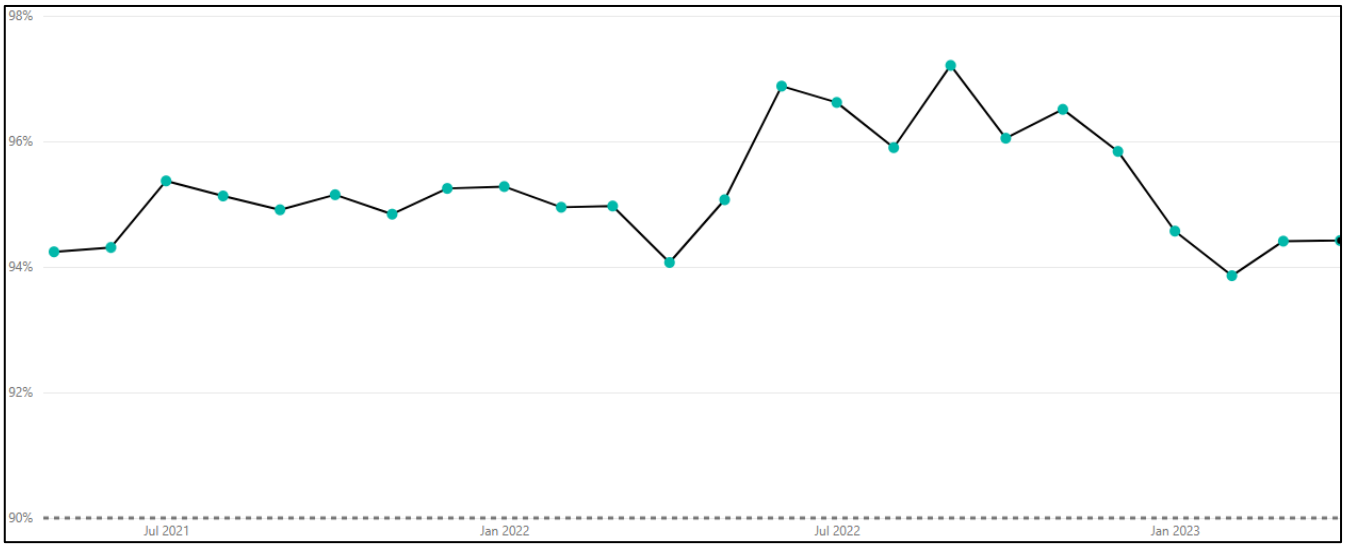
As of March 2023, the trust total is 87.96% (Clinical) & 94.41% (non-Clinical). This data is based upon an annual cycle. The IPC Training compliance is managed by the divisions and is discussed monthly at divisional meetings. This is then fed through the IPC Group with actions being taken to improve compliance and discuss current progress.

Figure showing Infection Control Clinical percentages since May 2021



Infection Control – Clinical %				
Month	**Corporate / Management**	**Medicine/ Integrated Care**	**Surgery**	**Clinical Support**
April 2022	84.66	88.89	88.37	89.33
May 2022	86.66	89.80	89.57	90.98
June 2022	89.17	92.35	91.80	94.91
July 2022	87.70	90.96	91.21	92.54
August 2022	88.82	89.09	90.88	92.35
September 2022	93.83	91.57	93.50	92.83
October 2022	92.50	89.27	90.42	93.67
November 2022	87.19	91.25	92.74	93.84
December 2022	89.08	86.29	90.23	92.69
January 2023	88.82	82.56	87.34	89.00
February 2023	90.90	83.66	85.44	90.78
March 2023	90.85	86.89	86.08	92.17

Figure showing Infection Control Non-Clinical percentages since May 2021



Infection Control – Non-Clinical %				
Month	**Corporate / Management**	**Medicine/ Integrated Care**	**Surgery**	**Clinical Support**
April 2021	91.81	95.09	96.44	94.11
May 2021	92.42	97.04	97.38	94.11
June 2021	94.44	98.28	98.64	98.80
July 2021	95.19	96.98	97.72	98.87
August 2021	94.39	95.73	97.74	97.82

September 2021	95.01	98.27	98.73	98.76
October 2021	93.89	97.85	97.25	97.09
November 2021	94.51	97.83	97.49	98.25
December 2021	94.96	97.42	95.45	96.70
January 2022	93.30	95.76	95.46	94.62
February 2022	92.34	95.31	96.34	91.53
March 2022	92.69	95.78	96.64	93.19

3.15 Influenza Vaccination Programme

There are 4 types of seasonal influenza viruses, types A, B, C and D. Influenza A and B viruses circulate and cause seasonal epidemics of disease.

Seasonal influenza is characterized by a sudden onset of fever, cough, headache, muscle and joint pain, severe malaise, sore throat, and a runny nose. The cough can be severe and can last 2 or more weeks.

Illnesses range from mild to severe and even death. Hospitalization and death occur mainly among high-risk groups. Worldwide, these annual epidemics are estimated to result in about 3 to 5 million cases of severe illness, and about 290 000 to 650 000 respiratory deaths. (WHO, 2018)

The most effective way to prevent the disease is vaccination. Immunity from vaccination wanes over time so annual vaccination is recommended to protect against influenza.
(WHO, 2018)

The Dudley Group held an influenza flu campaign running from August 2022. The campaign included:

- Peer vaccinators across the trust assigned with an online flu competency to be completed.
- Flu posters created and distributed across the trust, via the trust website and on social media.
- New strapline for the year introduced which was added to t shirts and sashes for peer vaccinators to wear and it was used in all communications on the trust intranet and on social media.
- A screensaver was developed prior to the launch to display across trust computers.
- Ward based vaccinators were recruited as well as sessional vaccination sessions at the hospital vaccination hub.
- Staff health and wellbeing provided advice and guidance for staff that had underlying conditions or allergies.

At the end of March 2022 64.1% of the DGFT staff had received their influenzas vaccine. This percentage is a reflection of substantive staff that have been corroborated against Electronic Staff Record (ESR). It was noted that PFI colleagues and volunteers were not included in this percentage in line with the national reporting requirements.

3.16 Link Worker Programme

The IPCT continues to provide the Infection Prevention and Control Link Nurse programme.

Link Worker meetings recommenced in March 2022, and they run every month via TEAMS to provide education support and act as an IPC resource for the link staff to maintain their enthusiasm and commitment to IPC.

The aim of these meetings is to provide updates on any new guidance / policies, an opportunity to share learning outcomes and case studies, and to enhance effective communication across DGFT. There is at least one link worker in every department including inpatient and community areas, they are key in undertaking monthly audits of practice.

A Link worker study day was held on in March 2023 for DGFT, 16 staff attended, topics included respiratory infections, sharps safety, hand hygiene, antimicrobial stewardship, and decontamination. The day evaluated very well with lots of positive feedback and comments. There are plans to repeat this annually.

SECTION FOUR:

PROGRESS AGAINST 2022/2023 INFECTION PREVENTION AND CONTROL PROGRAMME

4.1 CRITERION 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 risk that their environment and other users may pose to them

- Infection Prevention and Control Arrangements and Responsibilities policy reviewed to reflect management and reporting structure of DGFT, outlining its collective responsibility for IPC and demonstrating responsibilities are devolved to all staff/groups in the organisation.
- IPCG meeting Terms of Reference (TOR) and membership reviewed annually.
- Head of IPC has provided quarterly reports to Quality and Safety Committee including thresholds, risks, and progress against objectives.
- Head of IPC has provided bi-monthly reports to Quality and Safety Delivery Group.
- The Annual IPC Report is produced and presented to the public board.
- The Annual IPC Report is made available for public viewing via the DGFT website.
- *Clostridiodes difficile* Improvement plan was developed and is reviewed and monitored at the IPCG meeting.
- IPC Board Assurance Frameworks were developed, updated as required and presented to the Quality and Safety Delivery Groups, quality, and Safety Committees and the DGFT Public Board
- Risks associated with infection have been entered on the DGFT risk register and are reviewed monthly.

- The IPC team continued to identify IPC risks and areas of weakness in policy and practice though audit and surveillance.
- CQC Provider Compliance Assessments completed.
- Information shared with external agencies and partners when requested.
- IPC Team has worked alongside clinical staff in the hospitals as a mechanism to deliver teaching and education to staff.
- New Source and Protective Isolation door signs were introduced.
- All infection outbreaks reviewed, and service improvement plans developed so that relevant learning was appropriately communicated and acted upon.
- RCA/CCRs were completed for all patients who developed a CDI tabled at the IPCG meeting.
- PIRs were completed when required.
- Alerts are added to patients' sunrise records to highlight risk of infection.
- New electronic patient record alerts have been developed to reflect COVID-19, supported by informatics reports to support national reporting requirements.
- The IPC Annual Audit Programme was reduced following an increase in COVID-19, winter pressures and staff sickness and vacancies within the IPC Team
- IPC audit tools adapted in 2011/12 from the Department of Health (DH) /Infection Prevention Society Quality Improvement Tools and DH Saving Lives care bundles have been revised and updated to incorporate new guidance. These are reviewed and updated annually.
- IPC training is delivered via a mixture of face to face, bespoke and via a Heath Education E-learning package.
- IPC Induction training is delivered face to face.

4.2 CRITERION 2

Provide and maintain a clean and appropriate environment in managed premises that facilitates and prevention and control of infections

4.2.1 Estates and Facilities Outbreaks

The section below in italics has been completed by Jannine Dyke, Soft Services contract Manager.

The section below in italics has been completed by Jannine Dyke, Soft Services contract Manager.

Cleaning Audits

The Trust recognises its duty to provide safe and clean environments where patients, staff and visitors can expect to be protected from the risk of infection, cleaning services are in the main provided by Mitie Facilities Management as part of the Trusts PFI contract with Summit Healthcare (Dudley) Ltd (Summit). The contract is managed by the Trust's Estates and Facilities Team. Cleaning audits are undertaken by the Trust Auditors in partnership with Mitie and clinical staff where possible across its sites.

During May 2022 the Trust revised its Cleaning and Disinfection of the Environment Policy to reflect the requirements for implementing The National Standards of Healthcare Cleanliness 2021, with the introduction of a Commitment to Cleanliness Charter, signed by the Chief Nurse & Director for Infection Prevention and Control. Signing up to this charter publicises the Trust's commitment to

achieving a consistently safe and high standard of cleanliness. The Trust continues to work with Mitie on the implementation of the Standards through training and introduction of new technology to drive improvement and efficiencies.

Each Department underwent a review to be given a functional risk (FR) rating (1-6) in line with the guidance provided by NHSE based on clinical activity and risk. Each FR rating has a description to assist the public in understanding why an area is categorised as such. These descriptions are displayed with the cleanliness charter and cleanliness star ratings.

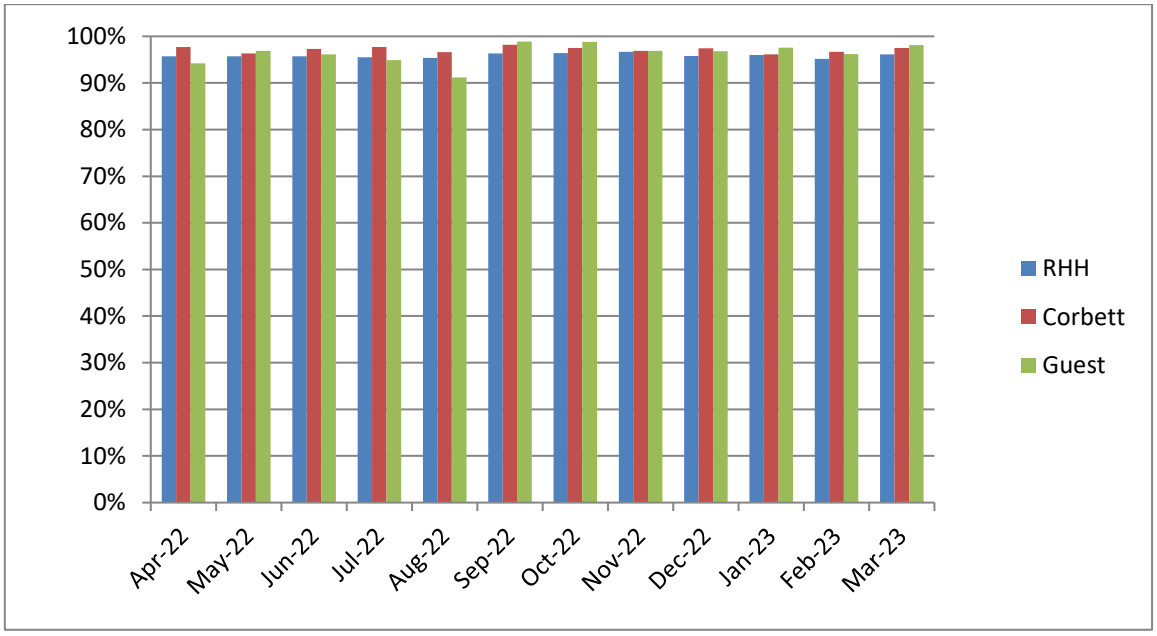
Technical cleanliness audit results are now shown as a star rating (1-5), rather than an audit percentage score. Star ratings are displayed in areas accessed by patients and where they are visible, for example in or near ward and departmental entrances, in circulation areas and/or waiting rooms. The purpose of the star rating is to give patients, staff, and the public an easily understood visual score of the standard of cleanliness being achieved in the area. Star ratings are provided dependent upon the FR rating and the overall cleaning score reviewed against the target score; this includes all cleaning, carried out by the Trust and Mitie. Functional areas rated at 3 stars or fewer are subject to an improvement plan, which is also displayed following the audit. 3 stars is when the overall scores are 4%-6% below the target score, 2 stars is when the overall score is 7%-9% below the target score and 1 star is 10% or more below the target score. Areas that achieve 3 stars or below are reported to the Board via the Infection Prevention and Control Committee (IPCC).

Technical audits are carried out by the Trust's audit team, with Mitie attendance, more frequent attendance by the clinical team continues to be encouraged. Access to rooms can sometimes be denied at the time of the audit but as many rooms as possible are audited at each session. Although the team try to achieve 100%, a minimum of 75% of each area is audited in one session making the audit representative of the whole area. At the end of the audit the auditor liaises with a senior member of the clinical team to advise of the audit outcome and point out any significant areas of concern.

During the technical cleaning audit, items of environmental maintenance are recorded by Mitie and followed through to close out.

Audit results are monitored by the Cleaning Monitoring and Operations Group, which meets monthly to review the scores, as well as other items agreed in the Terms of Reference.

Cleaning scores across the Trust have continued to plateau over the past 12 months. In the main, Russell's Hall Hospital, Guest and Corbett Out-Patient Centres continue to achieve an overall monthly score above the 95% threshold, apart from the Guest OPD where the score was less than this on three occasions. Please see chart below.



An average of 156 audits per month were carried out during the Apr 22-Mar 23 period. Areas were audited in line with the Trust's Cleaning and Disinfection of the Environment Policy and the Trust continued to apply the performance management mechanisms within the PFI contract throughout this period as relevant.

Additional Touchpoint cleaning has continued to take place where the Trust's Infection Prevention and Control (IPC) team have identified a need for this, usually where an infection has been identified. The Trust's Facilities team and IPC team worked closely with Mitie and Summit for this to take place.

Further developments in association with Mitie and Summit are to re-define the contract mechanism so that it aligns to the requirements of the National Standards for Cleanliness and the Trust Policy. The revised specification and contract mechanism will form part of the contract benchmarking in 2025.

Patient Led Assessment of the Care Environment (PLACE)

PLACE is the national system which focuses exclusively on the environment in which care is delivered; it does not cover the clinical care provision.

During 2022 a programme of PLACE-Lite sessions was carried out and an action plan produced to work through the points raised. This is monitored via the Patient Experience Group (PEG), chaired by the Chief Nurse. This programme put the Trust in a good position for the national PLACE assessment. The PLACE-Lite results are recorded on the NHS Digital platform, similar to national PLACE, but this information is not shared with other Trust's and no benchmarking takes place as with national PLACE.

PLACE was carried out in Dudley over two days, this was based on previous feedback by the patient assessors. Assessments took place on Tuesday 25th and Monday 31st October 2022. All PLACE domains were assessed, including Cleanliness, Food, Condition Appearance & Maintenance, Disability, Privacy, Dignity & Wellbeing, as well as Dementia, the results of which were published at the end of March 2023 and are identified below:

Name	Cleaning Score %	Food Domain Score %	Organisation Food Score %	Ward Food Score %	Privacy, Dignity & Wellbeing Score %	Condition, Appearance & Maintenance Score %	Dementia Score %	Disability Score %

Russells Hall Hospital	99.22%	92.91%	92.53%	93.02%	94.31%	97.83%	86.50%	91.52%
National Average	98.01%	90.23%			86.08%	95.79%	80.60%	82.49%

The Trust has achieved above the national average in all domains and is the first time this has been achieved over recent years.

Patient assessors were recruited from both Healthwatch and the Trust's Board of Governors, truly reflecting the patient population. Many of the assessors had taken part in the PLACE-lite programme so required minimal training for national PLACE. A variety of staff assessors also attended the assessments and provided specialist feedback during the assessments this included Matrons, other senior nurses, Deputy DIPC, Head of Dietetics, as well as representatives from the Trust's PFI partner, Mitie, Estates, Catering and Domestic teams.

Over the two days 10 wards were assessed: C3 including FGMN, B3, C7, B4, B6, B5, AMU Ground and First Floors, C1 and Neonatal Unit. The Emergency Department, Communal Areas and External Areas were also assessed. For non-ward areas a minimum of 25% needed to be included and areas visited included GI Unit, Day-Case, Renal Unit, Emergency Surgical Hub, North Block OPD, Main OPD, SDEC, Anti-Coagulant Clinic and Therapies. Assessors were encouraged to speak with patients during the assessments, in addition to making a judgement on what they saw.

In addition, 4 mealtime assessments were also completed on C3, B3, B4 and C1.

Of the clinical areas visited, all areas achieved 'confident' or above when asked 'Having carried out the PLACE assessment on this department, how happy/confident are you that a good level of patient care and experience will be delivered within the environment? This was apart from one clinic area that achieved 'not very confident', and this has been shared with the Matron and Directorate Manager responsible for the area.

An action plan has been generated for the areas not achieving the PLACE requirements and/or where recommendations have been made. The action plan is currently being worked through with the relevant teams to further improve on the environment for our patients.

4.2.2 Water Systems Management

The section below in italics has been completed by Darren Lowe, Estates Compliance Manager.

The Water Safety Group (WSG) oversees all aspects of water safety for the PFI Estate. The Group is normally chaired by Summit Healthcare Limited who are the owners of the PFI Estate, but due to a change in their management, Trust Estates Compliance Manager has been chairing the meetings until the new Managers become established. The members of the group included:

- *General Manager/Assistant General Manager (Summit)*
- *Responsible Person for Water Safety (Mitie)*
- *Deputy Responsible Person for Water Safety (Mitie)*
- *Authorising Engineer for Water Safety (Mitie)*
- *Estates Compliance Manager (Trust)(Interim Chair)*
- *Consultant Microbiologist (Trust)*
- *Infection Prevention and Control (Trust)*

The Trust has recently appointed a new Director of Estates and Facilities who will be the supporting the group and management of water safety in association with Trust IPC and third-party stakeholders.

A regime of regular water quality testing is in place across the PFI estate which has been agreed by the Water Safety Group. The tests include legionella and Pseudomonas Aeruginosa. There were two occasions where concerns were raised from samples results with significant Legionella counts. During December 2022, a large quantity of sample results returned with high Legionella counts, which the water safety group convened and determined as spurious. Precautions were taken (PAL filters installed) and outlets immediately resampled. The results received back were all clear. A Legionella sample result of 14750cfu from North Wing Ophthalmology was received March 2023 and immediately investigated. Issues with flow straighteners on two outlets and a section of pipework were rectified and the system was disinfected. Outlets have been resampled and we await the results.

The Authorising Engineer (AE) for Water Safety did not complete an audit for 2022. An audit has been arranged for May 2023. The outcome of the 2021 audit was described by the AE as site inspections suggest that the system is mostly well managed and maintained with only minor issues identified which are being actioned. One of the actions still outstanding are calorifier internal inspection, which Mitie has advised will be completed during May 2023. Mitie have commissioned a number of Compliance Engineering Technical Audits in 2022/23 and outputs will be shared with the Trust Water Safety Group in July 23.

Flushing of underused outlets has been on agenda of the Water safety Group on many occasions as there are over 400 outlets being flushed twice weekly. During 2022 Mitie carried out temperature monitoring of outlets which were deemed underused. The analysis determined that a significant quantity of outlets serving wash hand basins were in fact being regularly used and following agreement with ward and department leads were removed from the flushing schedule. Following agreement from Mitie, all the wash hand basins currently on the schedule are now being flushed by Domestics Services during their daily cleaning activity, which is also documented.

Pseudomonas risk assessments have been carried out by the Authorising Engineer, which have been ratified the WSG.

Ventilation

The Ventilation Safety Group (VSG) oversees all aspects of Ventilation for the PFI Estate. The Group is normally chaired by Summit Healthcare Limited who are the owners of the PFI Estate, but due to a change in their management, Trust Estates Compliance Manager has been chairing the meetings until the new Managers become established. The members of the group included:

- *General Manager/Assistant General Manager (Summit)*
- *Authorised Person for Ventilation (Mitie)*
- *Authorising Engineer for Ventilation (Mitie)*
- *Estates Compliance Manager (Trust) (Interim Chair)*
- *Consultant Microbiologist (Trust)*
- *Infection Prevention and Control (Trust)*

The new Trust Director of Estates and Facilities has been working with the internal Estates Team to track compliance on outstanding actions following previous AE audit. These are tracked through monthly meetings and use the contract performance mechanism to drive improvement.

As per the latest HTM 03 requirement, critical ventilation systems including ICU, MHDU, Renal, Theatres, CCU, Lung Function, Endoscopy, Mortuary etc (as defined in HTM 03-01 Part B -

4.7) are annually verified for system performance is in accordance with HTM 03-01, design, and room data sheet (RDS) requirements. Although the ventilation systems serving noncritical areas, which were designed and installed to HTM2025 are inspected in accordance with HTM 03, there is currently no requirement for systems to be checked for performance at the grilles.

In January 2023, the Trust became aware that a number of remedial actions from the previous reverifications going back to February 2022 had not been actioned by Mitie. This was escalated to Summit/Mitie via the formal PFI contractual route ad regular weekly meetings are taking place to review progress. Mitie's Authorising Engineer for Ventilation has confirmed that there are no risks to the staff or patients from the remaining remedials.

4.2.3 Management of Decontamination

The section below in italics has been completed by Kim Jarrett the Trusts Decontamination Lead.

DGFT appointed to a 12-month seconded Decontamination Lead post which commenced in September 2021. This role was made permanent in September 2022.

This post is still developing with several key progressions made within the last 12 months.

- *A bespoke decontamination audit tool has been developed. Audits have been undertaken using the newly developed tool tr~~ialled~~ with the plan to roll out as an annual audit programme.*
- *All decontamination policies have been reviewed and incorporated into a new Trust wide Decontamination Policy including neonatal and children's services Standard operating procedures.*
- *This is available for staff to access on the trust's intranet.*
- *The National Standards of Cleanliness 2021 were implemented on 4 May 2022 throughout the trust. The detail was incorporated into the Trusts revised Cleaning and Disinfection of the Environment policy.*

  A commitment to Cleanliness Charter sets out the Trusts commitment to achieve a consistently high standard of cleanliness using the functional Risk (FR) categories, cleaning frequencies and cleaning responsibilities for each functional area. The charters are displayed outside wards and departments, lifts and areas used by the public. All wards and departments have been identified with a functional risk rating between 1 and 6 in line with the new standards. All areas are now audited in line with these categories.

- *Invasive ultrasound probes have been reviewed across the Trust and all areas are now using Tristel three stage wipes for high level disinfection of invasive probes. An initial baseline audit was completed in August 2022 by the Tristel rep and a further follow up audit is scheduled for April 2023.*
- *For short periods over the last 12 months there has been gaps in the Decontamination Group due to no decontamination Lead, this was placed on the risk register for this period. This Group was re launched with the first meeting held in January 2023.*
- *Due to the increased pressure on beds, the Trust sourced a more rapid decontamination approach to assist with capacity. A new Ultraviolet machine has been purchased by the trust which will provide rapid, efficient UV decontamination with a faster turnaround than Hydrogen Peroxide Vapor (HPV). The new UV service was launched in October 2023.*

- *The management and maintenance of the HSDU service is via the Trust PFI Contract with Mitie and is managed against the performance specification in schedule 14 of the contract and payment mechanism as per schedule 16. In 2022, Mitie have appointed a new HSDU manager to lead on their services.*
- *The Trust Endoscopy Washer and Dryer units are maintained through an external contract linked to consumable items from Steris. Performance issues have arisen in year over engineer availability and the Trust EBME team have taken the lead to assign asset information to a central database and manage all validation and call out activities. The service lead for EBME has many years' experience in the sector and funding has been requested to fund his accreditation to Authorised Person Decontamination (appointed by AE) .*

Decontamination Plan for the next 12 months

Over the next 12 months several key things are planned to further strengthen decontamination processes across DGFT:-

- *A further audit led by the decontamination lead and Tristel rep to the use of Tristel wipes and high-level disinfection throughout the Trust is planned to follow up the baseline audit. Particular focus is on invasive probes and devices. A business case continues to be strengthened within Imaging with the focus being on the implementation of an automated decontamination process.*
- *An audit plan has been developed which will cover all areas across all sites of the Trust. This will also include additional ad hoc audits as required.*
- *A proactive decontamination programme using the UV machine is being developed which will include all wards and departments, ensuring all areas receive decontamination on a regular rolling programme. Recruitment to expand the decontamination team has been successful with the addition of two decontamination technicians starting in April. This will provide both proactive and reactive disinfection over a seven-day period throughout the Russell Hall site.*
- *A combined trial between the trust and it's ~~the~~ PFI partners is in progress which will review the use of microfibre products. If the trial is successful consideration will be made to roll out microfibre products out across the wider trust.*
- *Training for EBME lead to be Trust Authorised Person for Decontamination*
- *EBME team to asset manage all HSDU and Endoscopy Equipment so that we have a central register for validation.*
- *Trust Estates and Facilities to engage an external stakeholder for the completion of a condition survey for all assets that are Trust Property to ensure that they are on the forward plan for lifecycle investment/replacement.*

4.3 CRITERION 3

Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance

The section below in italics has been completed by Syed Gilani, Principal Pharmacist Antimicrobial Therapy for the Trust.

Antimicrobial steering Group at The Dudley Group NHS Foundation Trust is the subgroup of Drugs and therapeutics which reports to quality and safety committee via medicines management group.

Antimicrobial Stewardship Annual Report 2022-23

This paper provides an update and an assurance of compliance with standards set out by Health and Social care IPC code of practice for antimicrobial stewardship, Department of Health "Start Smart then Focus" and NICE NG15 (2015) Antimicrobial Stewardship: systems and processes for effective antimicrobial medicines use.

In 2022/2023 The Dudley Group NHS Foundation Trust signed up and achieved the National CQUIN targets on "Management of UTIs in adult patients".

CQUIN: Management of UTIs in patients over 16 years of age.

Achieving 60% of all antibiotic prescriptions for patients aged 16+ years that meet NICE guidance for diagnosis and treatment.

The cases where all the following actions were applied:

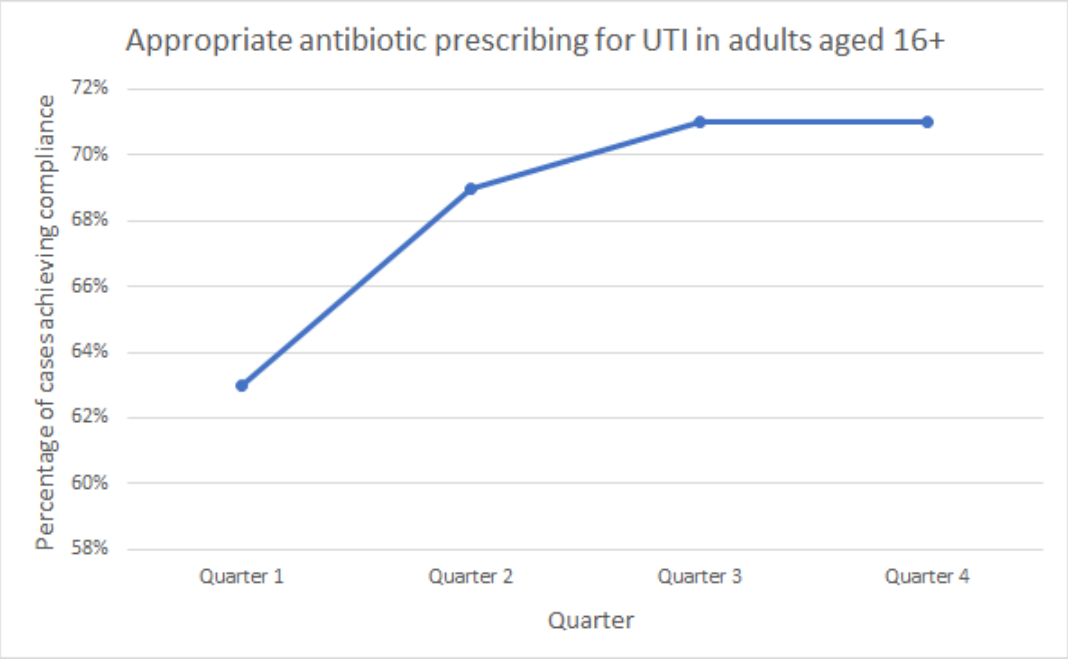
1. *Documented diagnosis of specific UTI based on clinical signs and symptoms.*
2. *Diagnosis excludes use of urine dipstick in people aged 65+ years and in all catheters associated UTI (CAUTI).*
3. *Empirical antibiotic regimen prescribed following NICE/local guidelines.*
4. *Urine sample sent to microbiology as per NICE requirement.*
5. *For diagnosis of CAUTI, documented review of urinary catheter use is made in clinical record.*

Data is submitted quarterly to UKHSA via the online submission portal.

- *The data collection has been completed for quarter 1 (total of one hundred patients' data) and has been submitted. The payment is based on minimum (40% compliance) and maximum (60% compliance).*

The delivery is currently on schedule.

- *Q1 compliance is 63%.*
- *Q2 compliance is 69%.*
- *Q3 compliance is 71%*
- *Q4 compliance 71%.*



National webinar (NHSE/I & AHSN)

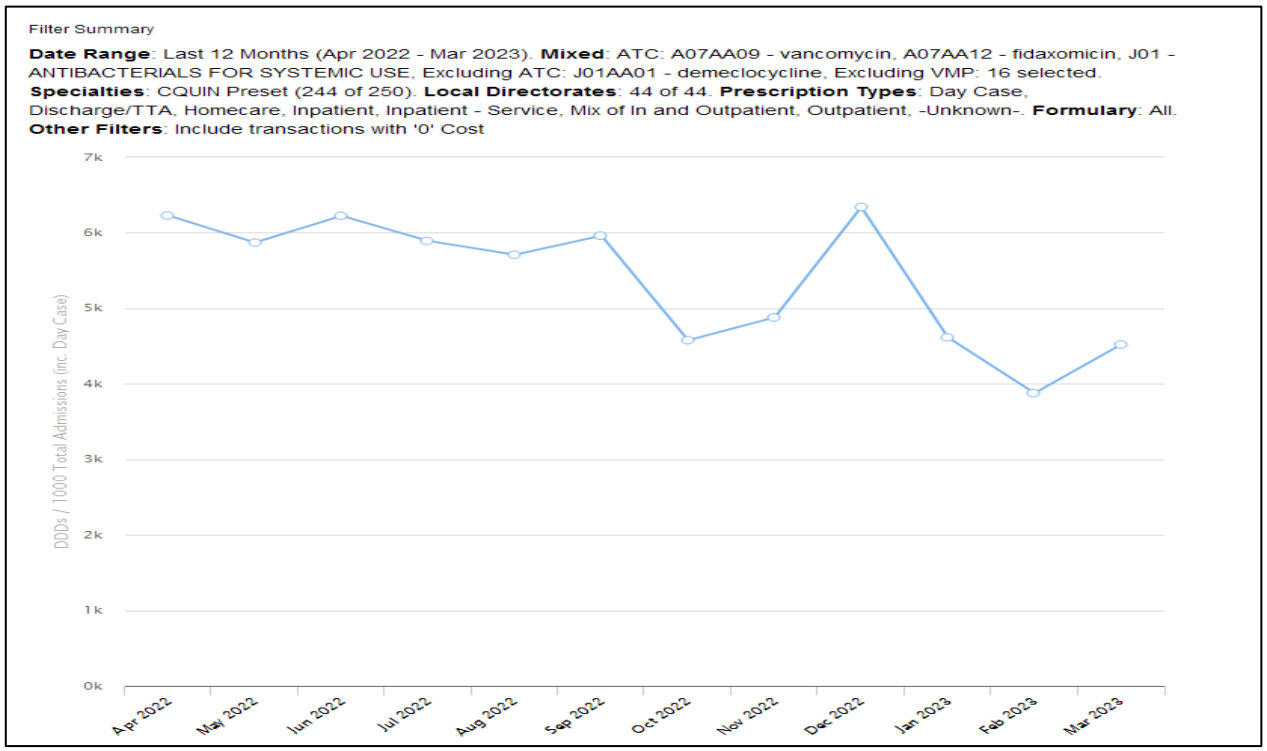
Delivered a national webinar on "Utilising Digital Solutions to Optimise Antimicrobial Stewardship "on 8th June 2022. Shared our good practices and challenges at The Dudley Group , the feedback was positive.

Antimicrobial Consumption

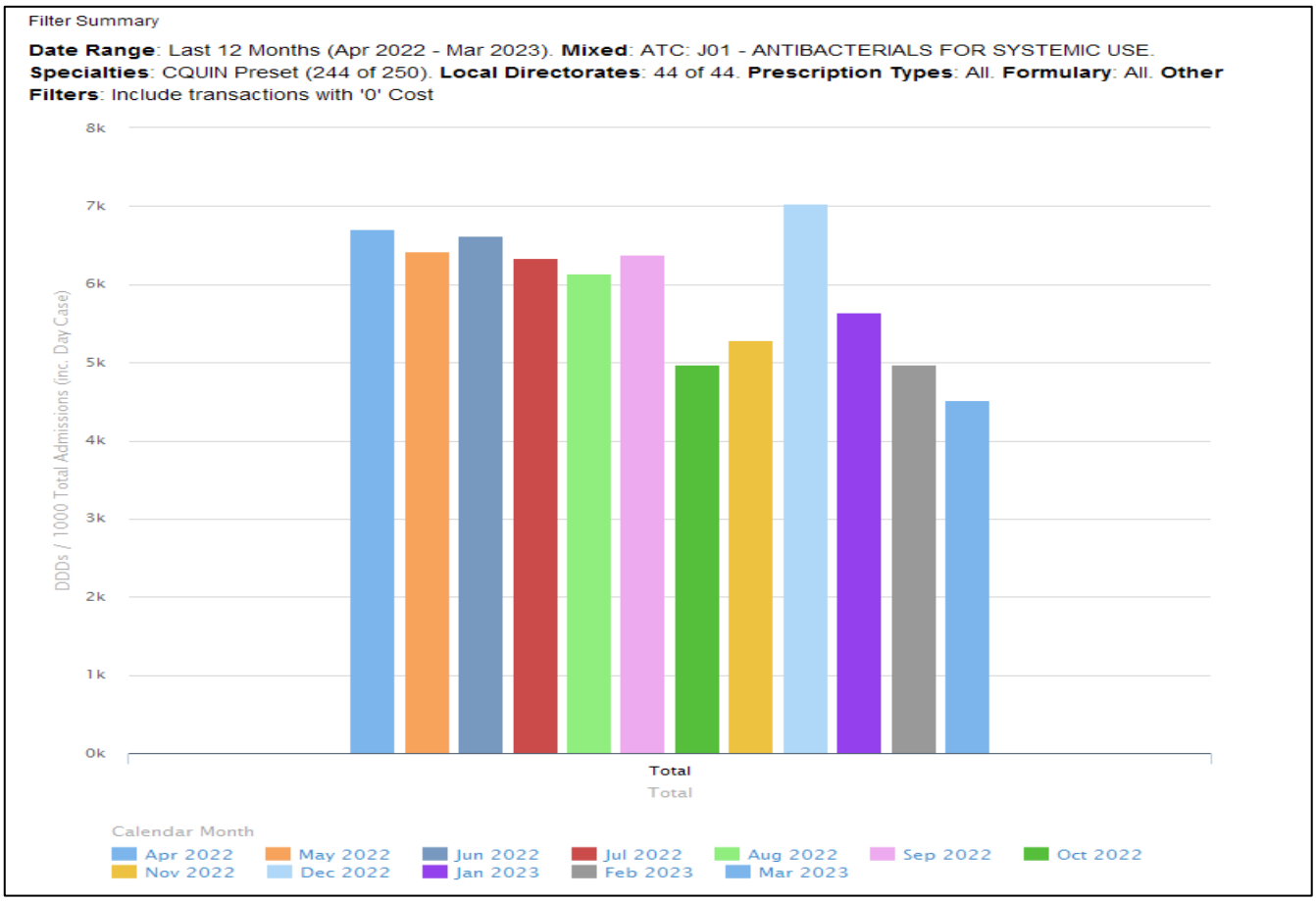
The unprecedented times have fluctuated antimicrobial use significantly.

Total Consumption

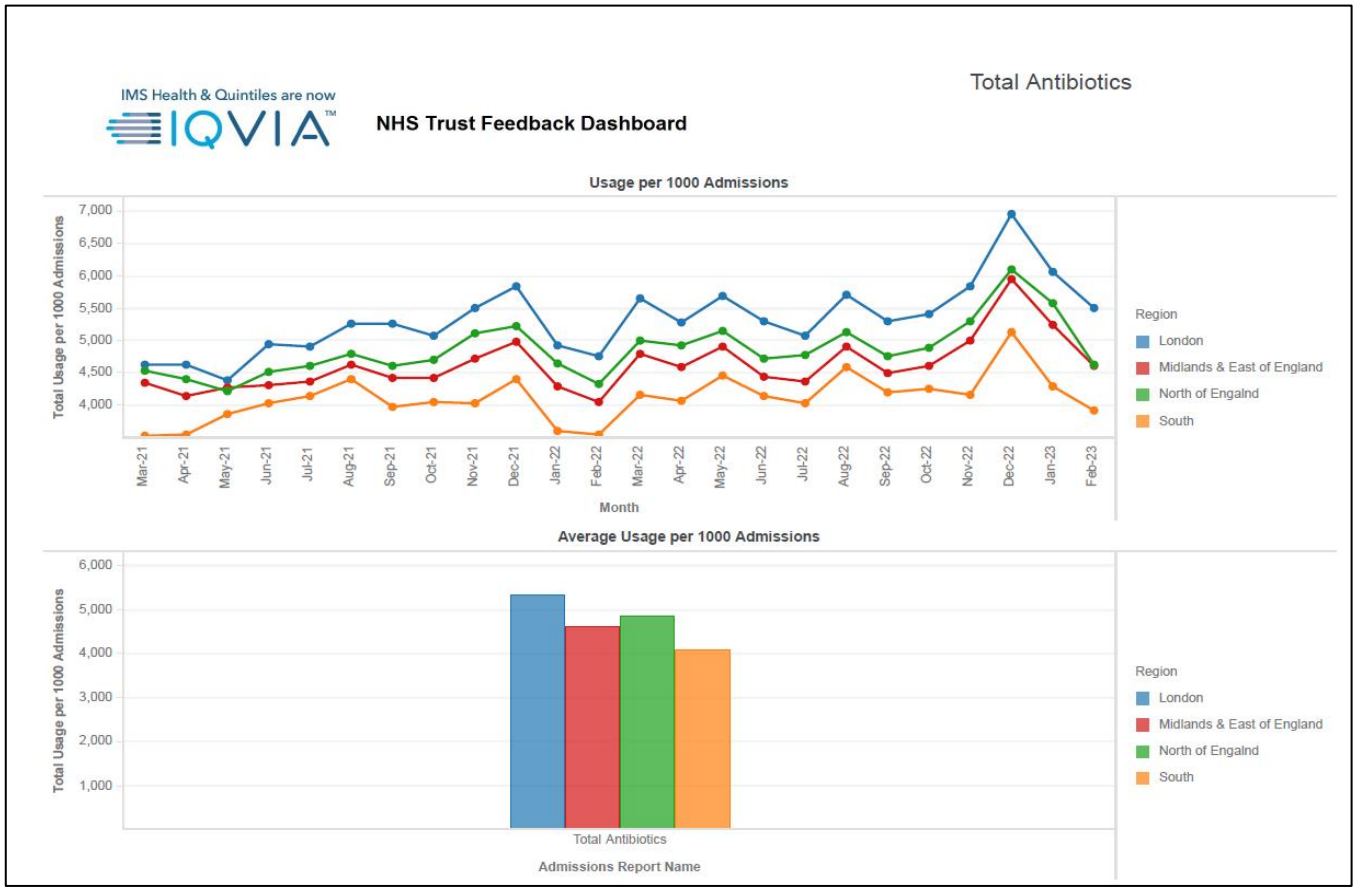
Consumption (2022-2023)



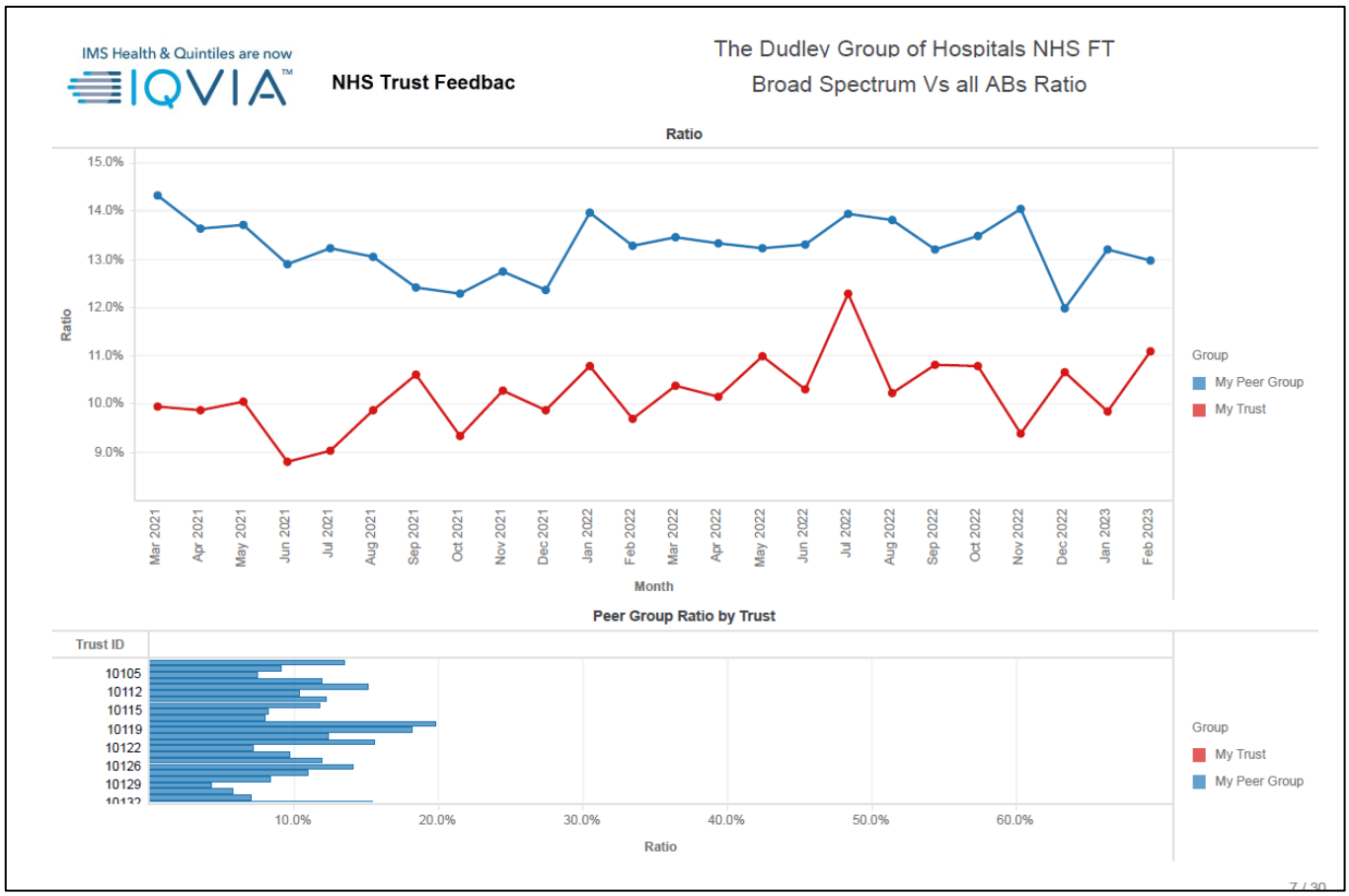
Consumption of antibiotics data excluding day case admission data



National antibiotic consumption per 1000 admissions (March 2021- Feb 2023)

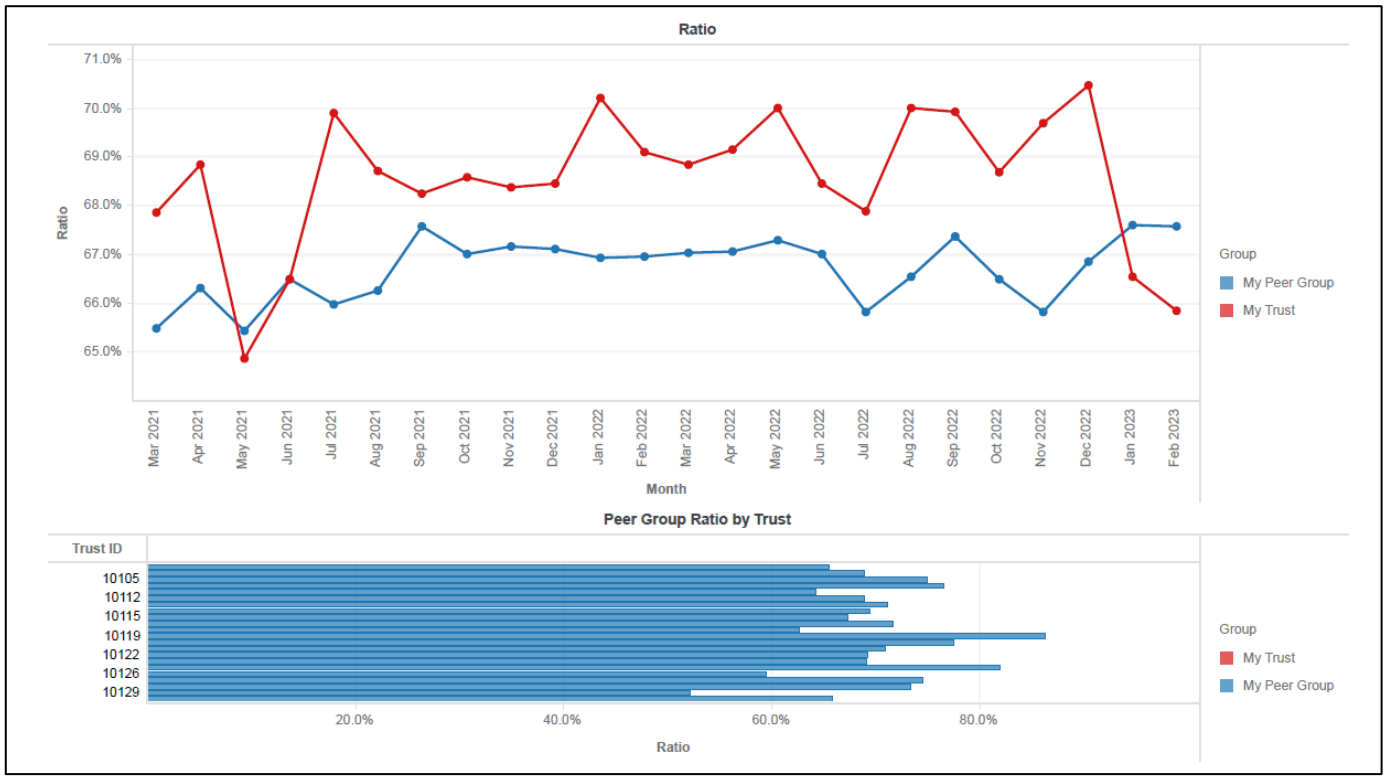


Ratio of Broad-spectrum vs all antibiotics

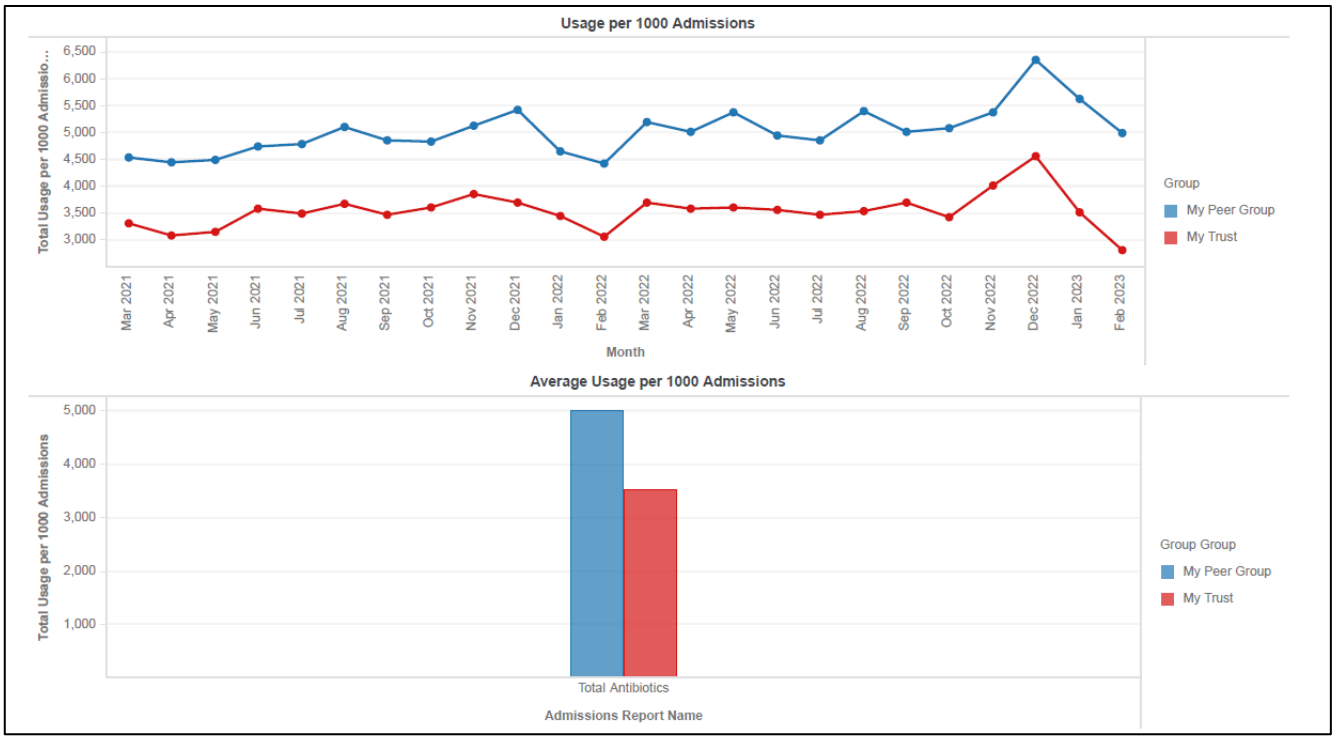


Data suggest Dudley group is performing better compared to its peers.

Oral vs Total antibiotics Ratio of the Dudley Group



Total antibiotics consumption The Dudley Group compared to peers.



The Dudley Group NHS Foundation Trust is among the best quantile in England for using access list antibiotics.

Proportion of Access, Watch and Reserve list of antibiotics (2022/2023)
Access = Narrow spectrum (list provided by NHSE/I and UK HSA)
Watch = Broader spectrum (list provided by NHSE/I and UK HSA)
Reserve = Broader spectrum last line antibiotics (list provided by NHSE/I and UK HSA)

For financial year 2022/2023 the proportion of access list antibiotics used at DGFT was 57% similar to last year.

Antimicrobial Prescribing snapshot audit

Dudley Group NHS Foundation Trust - Snap shot audit			
		Percentage	Regional target
Number of patients audited	534	100.0%	
Allergy Status recorded on chart (NKDA, Yes, No)	530	99.3%	> 98%
Number of patients with an allergy who have the nature of the allergy documented	71	49.7%	> 98%
Number of patients on Antibiotics	208	39.0	
Number of Patients on intravenous antibiotics	110	20.6	
Number of patients on intravenous antibiotics over 48 hours (>72hrs Jan 2013)	47	42.7	
Number of patients where total course over 5 days (>7days Jan 2013)	40	19.2	
Number of patients where stop / review date documented on the prescription chart	208	100.0%	> 70%
Has the indication been documented on the chart/notes?	208	100.0%	> 70%
Is patient on Meropenem/Ertapenem? (Of those patients on an IV abx)	5	4.5%	< 10%

All the results from the snapshot audits carried out over the last year shows significant improvements, the recurrent issue identified is type of allergic reaction documentation, and discussions have been started with EPMA team to explore a potential solution for it.

Medicines Division Data

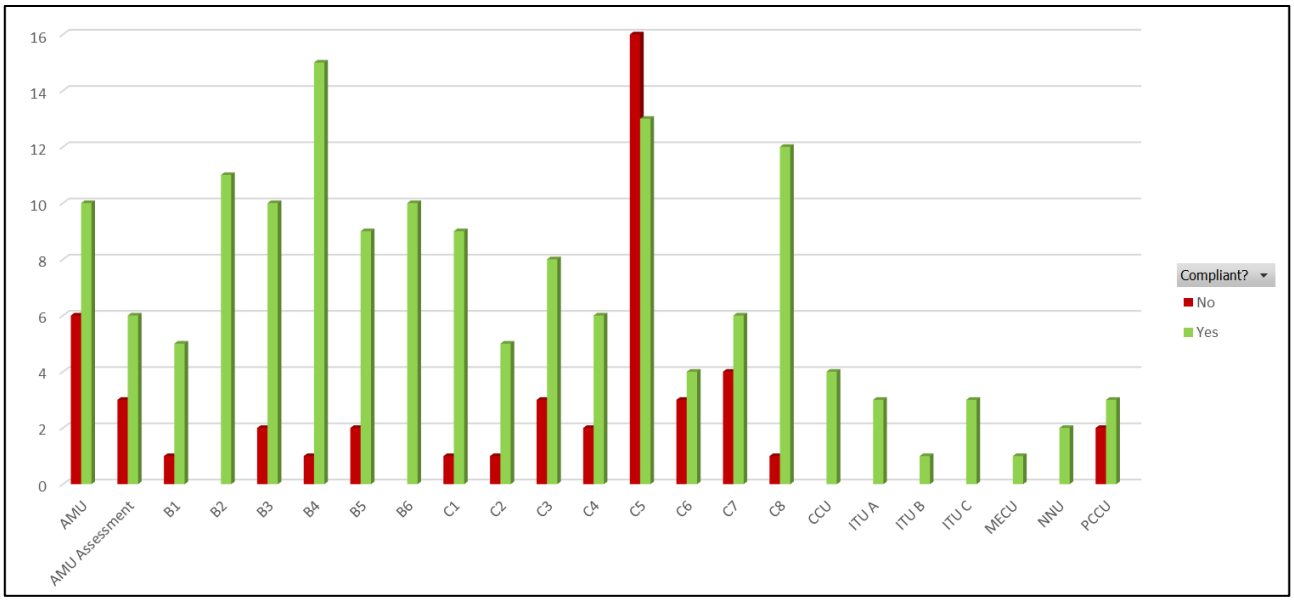
Medicine Divison - Snap shot audit			
		Percentage	Trust target
Number of occupied beds	327	100.0	
Allergy Status recorded on chart (NKDA, Yes, No)	327	100.0%	> 98%
Number of patients with an allergy who have the nature of the allergy documented	45	42%	> 98%
Number of patients on Antibiotics	134	41.0	
Number of Patients on intravenous antibiotics	61	18.7	
Number of patients on intravenous antibiotics over 48 hours (>72hrs Jan 2013)	20	32.8	
Number of patients where total course over 5 days (>7days Jan 2013)	25	18.7	
Number of patients where stop / review date documented on the prescription chart	134	100.0%	> 70%
Has the indication been documented on the chart?	134	100.0%	> 70%
Is patient on Meropenem/Ertapenem? (Out of those on an IV abx)	3	4.9%	< 10%

Surgical Division Data

Surgical Divison - Snap shot audit			
		Percentage	Trust target
Number of occupied beds	207	100.0	
Allergy Status recorded on chart (NKDA, Yes, No)	206	99.5%	> 98%
Number of patients with an allergy who have the nature of the allergy documented	26	61.9%	> 98%
Number of patients on Antibiotics	74	35.7	
Number of Patients on intravenous antibiotics	49	23.7	
Number of patients on intravenous antibiotics over 48 hours (>72hrs Jan 2013)	27	55.1	
Number of patients where total course over 5 days (>7days Jan 2013)	8	10.8	
Number of patients where stop / review date documented on the prescription chart	74	100.0%	> 70%
Has the indication been documented on the chart?	74	100.0%	> 70%
Is patient on Meropenem/Ertapenem? (Out of those on an IV abx)	2	2.7%	< 10%

Compliance by ward

Compliance by ward was fed back to respective directorate Pharmacists who then took the data to respective directorates for reporting and improvement plans.



Current data shows:

- *An increase in the proportion of patients on antibiotics*
- *An improvement in the nature of allergy documentation*
- *An increase in the relative proportion of patients on a carbapenem*
- *Allergy nature documentation is limited, and potential solutions are being looked at with EPMA team.*
- *Currently working on an IT solution for easy data collection moving forward.*

<u>The documentation of stop/review date seems low however, data collected within the</u> snapshot audit is limited to active prescriptions and does not include documentation of stop/review in the medical notes.

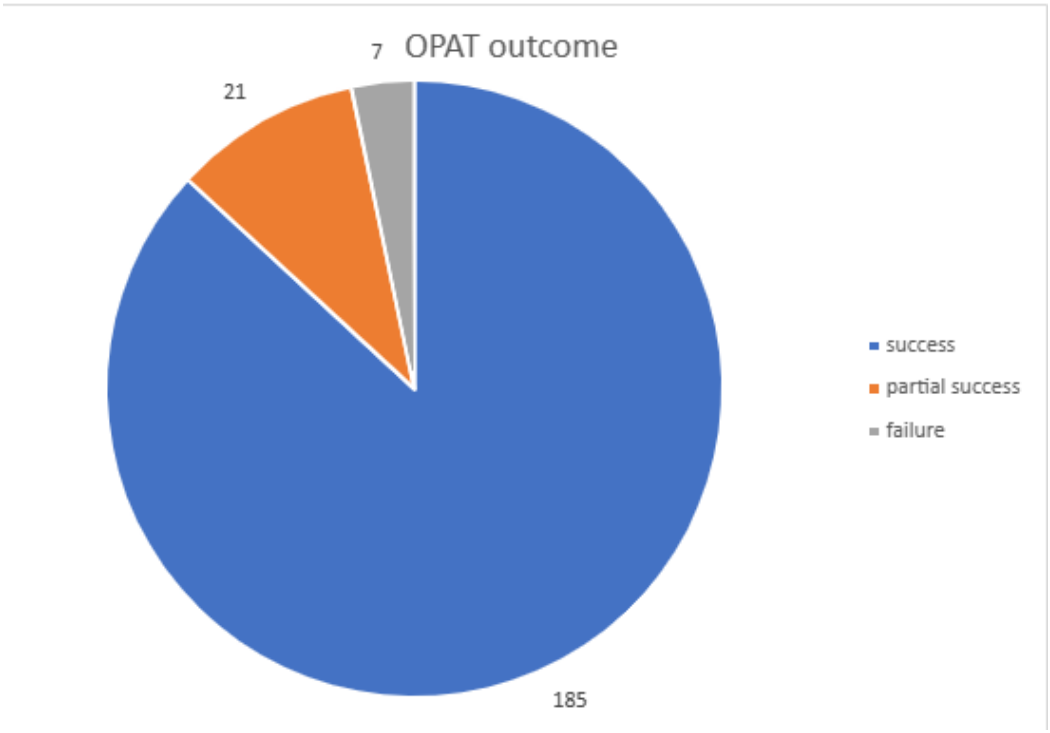
Patients on restricted antibiotics e.g., meropenem & piperacillin/tazobactam (which are not recommended in the Trust guidelines or approved by microbiology) are referred to the antimicrobial pharmacists.

The pharmacy team monitor and raise awareness at ward level on how to correctly document allergy status on prescribing system.

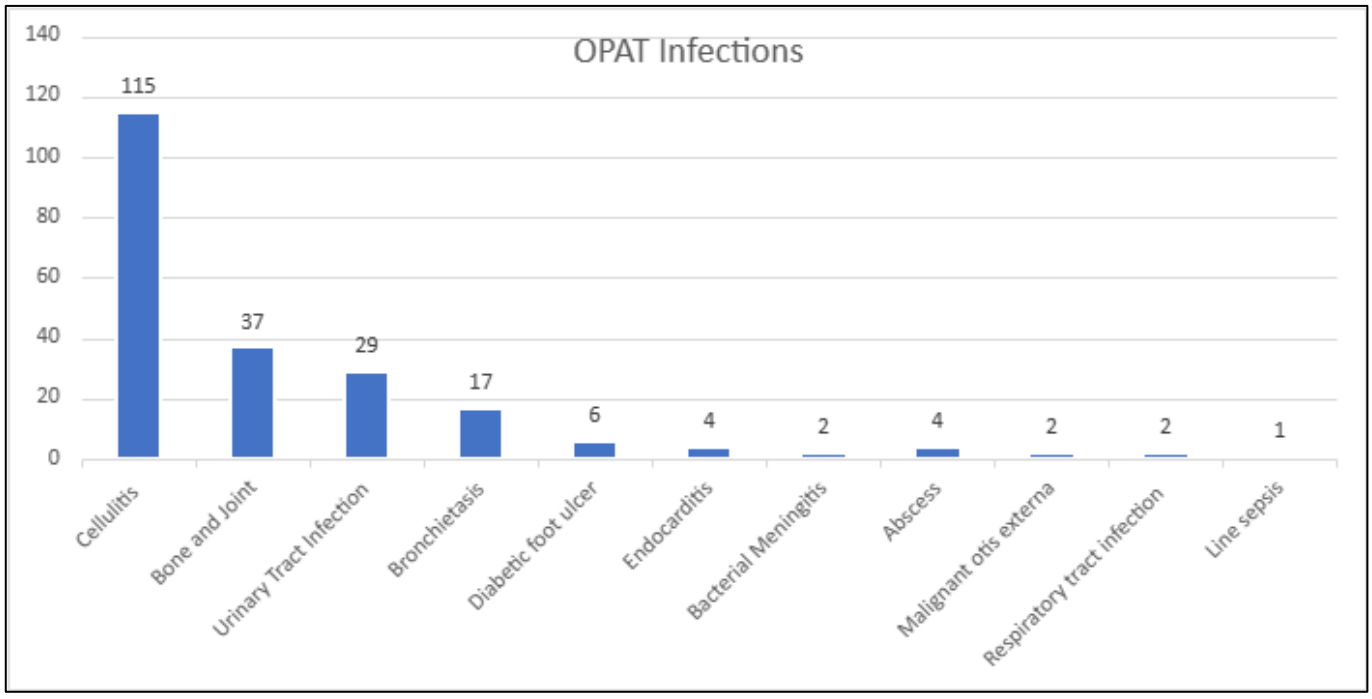
<u>OPAT data for 2022/2023</u>

The Dudley Group NHS Foundation Trust run a successful OPAT (OUTPATIENT ANTIBIOTIC THERAPY) service. An MDT review is carried out for each patient every Tuesday, MDT consists of OPAT nursing team, Antimicrobial stewardship Pharmacist and a Consultant Microbiologist.

A total of 221 patients have been treated as part of the OPAT service which has increased the Trust capacity by 3,199 bed days in the last financial year.



Breakdown of the clinical conditions treated via OPAT service is illustrated in the following figure.



Interventions over past 12 months to improve Antimicrobial Stewardship at DGFT

The targets were achieved with the help of multiple initiatives i.e.

- *Executive level reporting to influence change.*
- *Project group formed including medical director, chief pharmacist, AMS team, Sepsis leads and service improvement.*
- *Established a C diff review ward round (once every week with one AMS pharmacist and one Clinical nurse specialist IPC).*
- *Antibiotic awareness week campaign (completed).*
- *Multiple guidelines updated and published on microguide through the year.*

- *NICE guidance baseline assessment completed.*
- *Audit tool designing for antimicrobial prescribing on EPMA in progress.*
- *Antimicrobial usage during surge is being analysed locally and nationally. Report suggest surge in use (admission data might have affected)*
- *COVID-19 therapeutics guidelines added to Microguide for easy access.*
- *EPMA antimicrobial prescribing module in place so far, no major issues, work being carried out to increase clinicians' awareness on ward level.*
- *CQUIN 2022/23 targets achieved for all 4 quarters.*
- *Patient safety bulletin published online and sent to all staff.*
- *Hub communication/ screen saver produced to raise awareness.*
- *Discussed and shared plans at West midlands Antimicrobial Pharmacists Group.*
- *Junior Dr antimicrobial prescribing teaching sessions completed.*
- *Teaching session completed for all Pharmacists on AMS principles.*
- *Antimicrobial stewardship section in Trust wide Governance newsletter.*
- *Antimicrobial stewardship session delivered to community team.*
- *Feedback to the divisions provided via Antimicrobial Stewardship Group (ASG).*
- *OPAT virtual ward rounds started (Antimicrobial Pharmacist, Microbiologist, and In-charge OPAT Nurse).*
- *Monthly Antimicrobial stewardship report provided monthly to Infection Prevention and Control Group, Drugs and Therapeutics Group &Medicines Management Group.*
- *C diff ward rounds started once a week the team include an antimicrobial Pharmacist and an IPC Nurse.*
- *DGFT (antimicrobial stewardship (AMS)) team has led on the development of COVID-19 therapeutic pathways which were accepted and adapted by the Black Country and West Birmingham (BCWB) system.*
- *DGFT AMS team also heavily contributed to the national COVID-19 vaccination program and provided senior leadership and clinical expertise.*
- *Pelvic inflammatory disease antibiotic guidelines are updated, (awaiting publishing).*
- *Surgical prophylaxis guidelines agreed and updated.*
- *Orbital cellulitis guidelines are agreed.*
- *Bronchiectasis guidelines are agreed after looking at the local antimicrobial resistance trend.*

COVID-19 therapeutics

COVID-19 treatment algorithms are developed by The Dudley Group which were approved and shared across Black Country and West Birmingham (BCWB) Integrated Care system (ICS). AMS team oversees the clinical aspects of Covid-19 therapeutics at the Dudley Group and Dudley DIHC.

ICS AMS Group

The Dudley Group AMS team took the initiative to establish an ICS wide AMS group. The ICS AMS group reports to Clinical leadership group via the IPMO PLG group. The group is looking into all the sectors across the system. The Group has harmonised the Antibiotics formulary across the ICS and is now working on other work streams.

Education and Training

Mandatory training for clinicians in antimicrobial prescribing and stewardship continues to take place. All doctors new to the Trust are provided with antimicrobial training at induction. Better Training Better Care for FY1 and FY2 doctors in Antimicrobial Prescribing received excellent feedback from the participants. Additional training sessions have also been carried out through the year when guideline changes have occurred.

Teaching sessions for CMTs are delivered around antimicrobial stewardship and infection management.

Grand rounds around CQUINs and antimicrobial stewardship is delivered whenever required.

Pharmacists receive regular feedback on antimicrobial prescribing in their clinical areas after the snapshot audits, pharmacist prescribers' complete online modules on antimicrobial prescribing.

Feedback is provided to clinicians after every RCA for C. diff infections.
Teaching/training sessions are delivered to primary care teams of Dudley to improve health economy wide antimicrobial stewardship that include primary care and CCG pharmacists and community/district Nurses and ACPs.

Research

AMS team is always looking for research opportunities and is involved in all the studies carried out in Trust around infection management.

AMS team took part in a regional research piece around IV to Oral switch of antibiotics where survey was conducted. The results are being analysed with the intention of presenting a poster at FIS conference.

An undergraduate final year Pharmacy research project was completed on "Impact of pandemic on antibiotic consumption and C diff rates at Russell's Hall hospital," in collaboration with Birmingham University.

An undergraduate final year Pharmacy research project was completed on "resistance patterns of E coli blood culture isolates at Russell's Hall hospital" in collaboration with Aston University.

The AMS team enrolled and took part in the national quality improvement project around Gentamicin prescribing and monitoring "Co-Gent" which is run by the NITCAR (National infections teams collaborative for audit and research) and are awaiting the publication of results by the study team.

Current Challenges

- *COVID-19 has presented unprecedented challenges currently the national target of reduction in total consumption of antibiotics (Watch and Reserve list) seems unrealistic to achieve within the timeframe specified.*
- *Encouraging already stretched clinicians to represent their areas at ASG meetings.*
- *Capacity of AMS team is limited therefore ward presence is low. Currently 1 x Consultant Microbiologist vacancy with one substantive and one Locum in post. This limits pro-active monitoring through limited ward visits.*
- *Antibiotic shortages are unpredictable and require frequent guidance changes leading to prescriber confusion.*
- *Lack of e-PMA solution for capturing prescribing data at present is making the snapshot audits laborious (IT is developing a solution for it).*

Plans for 2023/2024

- *Deliver National CQUIN for 2023/2024 "Achieving 40% or fewer patients still receiving IV antibiotics past the point at which they meet switching criteria".*

- *Review guidelines in view of new NICE guidance issued in coming months.*
- *Continue working as a part of sepsis work streams: created "Sepsis team" (4x sepsis nurse practitioners' band 7s + 2 x antimicrobial pharmacists+ Consultant Physician)*
- *Focus on drive for IV2PO switch – septic patients flagged to antimicrobial team. Reinforce the need for a high standard antimicrobial stewardship at pharmacist clinical huddles. IV2PO switch has been set as a high priority item on national agenda for AMR.*
- *Training sessions with all pharmacists to highlight the changes and rationale.*
- *Engage clinicians from medical and surgical divisions to attend ASG meetings and feedback to respective directorates.*
- *Regular snapshot audits to assess antimicrobial prescribing.*
- *Increase the frequency of AMS ward rounds currently 3 days a week on critical care, 2 day a week on Medical enhanced care unit and 1 days a week on acute medical wards.*
- *Regular communication in the form of patient safety alerts, screen savers, trust wide communication emails on changes in processes and guidance.*
- *Scope further expansion of antifungal stewardship.*
- *Support postgraduate diploma pharmacists in conducting clinical audits as part of their infectious disease module.*
- *Support 2023/24 trainee pharmacists with antimicrobial audits and teaching if required.*
- *Patient safety bulletins around arising issues over the year.*
- *Organise and promote Antibiotic awareness week 2023.*
- *Identify opportunities for research and development around antimicrobial stewardship.*

4.4 CRITERION 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

- DGFT has a dedicated communication team. In cases of outbreaks where there may be interest from the media, the Communications Team are invited to meetings and their support and guidance on preparing Press statements is sought.
- Communication boards are located across the Trust providing patients and visitors of key communication.
- The IPC Team have a page on the Trust intranet page which provides information to staff.
- The external Trust website also has key messages relating to infection control.
- The Trust Intranet promotes infection prevention issues and guides users to information on specific alert organisms such as MRSA and *Clostridioides difficile* as well as key organisms that may be of particular concern seasonally.

In January 2022, the IPC Team produced a newsletter for staff called "We've gone Viral" which provides updates to staff on current IPC matters. This newsletter will be published on a bi-monthly basis.

- IPC produced an annual report covering the organisation's approach to prevention and control of infections for publication on the DGFT website.
- Hand hygiene included in patient/visitor/volunteer/staff/agency staff and visiting health professionals' information leaflets.
- Strategically placed hand hygiene products available with information on how to use.
- Continued to encourage patient and public involvement in hand hygiene and cleanliness campaigns and services' Quality Review process, satisfaction surveys and PLACE inspections.

- Polices related to specific organisms and care pathways remind staff of the need to give affected patients and relatives leaflets about the infection.
- Information leaflets revised and placed on the DGFT public facing website informing patient/public on specific infections and hygiene measures they can adopt to reduce the risk of infection.
- The IPC team and other members of staff continue to respond to ad hoc requests for information related to IPC under the Freedom of Information Act.
- IPC requirements are included in the health economy transfer/discharge form.
- IPC team share infection rates and outbreak information with appropriate services based upon local, regional, and national surveillance.
- Surgical Site surveillance data is submitted externally.
- Alert organism surveillance by the IPC team.
- IPC polices and procedures are available on the IPC page on the HUB.
- MRSA screening compliance shared.
- IPC team used the Health Hub I main reception to promote Clean your Hands Day and Infection Prevention and Control Week
- A Hand Hygiene game was promoted for wards to compete in a World Cup style game to co-inside with the Football world cup.
- The IPC team promoted AMR in conjunction with the Trusts Pharmacy team.

4.5 CRITERION 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

- The IPC Arrangements and Responsibilities policy reflects the management and reporting structure of SCHT outlining its collective responsibility for IPC and demonstrating responsibilities are disseminated to all staff/groups in the organisation.
- Responsibilities of groups and staff included in IPC policies.
- Support provided by IPC team included visits and telephone contact.
- Continued to develop link staff and support their role.
- Continued to audit compliance with IPC polices and care pathways.
- IPC team access to IC NET Laboratory IT systems allowed enhanced alert organism surveillance. IC NET was updated in September 2022 when the microbiology laboratory transferred from Russells hall to Royal Wolverhampton Trust.
- IPC team reported outbreaks and incidents of infection to the ICB, UK HSA and NHSE Outbreak of infection meeting are held with external partners and agencies to ensure transparency and that any lessons learnt are disseminated throughout the organisation.
- IPC received notification of outbreaks of infection within the local health economy.
- IPC specific organism policies available e.g., MRSA, CDI, VRE/GRE.
- Patients are screened for MRSA on admission.
- Patients are screened for COVID-19 on admission.
- Blue, Amber, Green clinical pathways available to aid correct patient placement.

- Twice weekly COVID-19 Lateral Flow Testing (LFT) was introduced to all patient facing staff in November 2020 this was offered to all staff in February 2021. Routine testing for all staff was discontinued in October 2022.
- Antibiotic policy available to all clinicians.
- PIRs will be undertaken on all MRSA Bacteraemias.
- Use of SIGHTED mnemonic (see images 3 and 4 referred to earlier).
- Ward staff advised to use isolation checklist to ensure compliance with isolation policy.

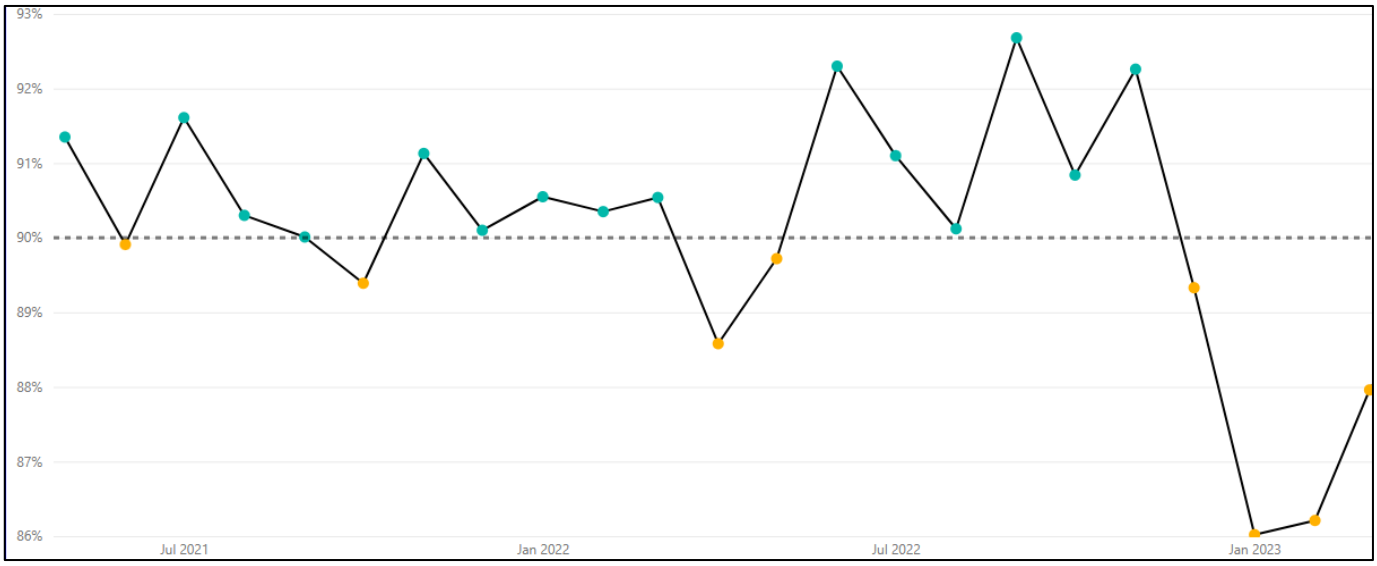
4.6 CRITERION 6

Systems to ensure that all care workers (including contractors and volunteers) are aware of their responsibilities in the process of preventing and controlling infection

At DGFT infection prevention is of paramount importance and everyone's responsibility, it is included in all job descriptions across the Trust.

All clinical staff receive training and education in infection prevention and control practices during their induction and mandatory training sessions. Additional bespoke training is provided to wards and departments as necessary and in response to shared learning.

The graph below identifies the compliance of mandatory IPC Training throughout the year. For each month compliance has been above 80%, however due to the COVID-19 pandemic these scores were not achieving the required objective of 90% compliance. Scores started to improve at the end of the financial year and following divisional escalation IPC Training continues to be a key priority in order to ensure the Trust reaches this objective with improvements in compliance being observed.



- Continued to work with NHS providers and facilitated by the LHE group, to aim to reduce all avoidable infections including MRSA Bacteraemia and CDI.
- Alerts are added to sunrise to highlight risk of infection.
- Compliance with MRSA screening policy audited monthly, and findings shared.
- As appropriate, joint investigations and reviews held between local partners and the acute trust on cases of MRSA Bacteraemia and CDI.
- To assist staff with managing outbreaks,
- Bespoke IPC Training is delivered if need identified.

- IPC team supported the development of DGFT clinical policies/procedures and Standard Operating Procedures (SOPs).
- Infection Prevention and Control Standard Operating Procedure for Building, Construction, Renovation and Refurbishment Projects in available for all contractors working in DGFT.
- IPC in the Built Environment Policy available via the HUB
- A Band 7 IPC nurse has completed the Infection Prevention and Control Course with Highlands and Islands University
- A Band 6 IPC Nurse completed her Professional Practice in IPC Course with Birmingham City University
- A Band 6 IPC Nurse completed the Marion Reed IPC course.
- The IPC team has attended conferences and study days throughout the year.

4.7 CRITERION 7
Provide or secure adequate isolation facilities

Spread of infection in healthcare facilities may be prevented by isolation or other barrier procedures, which may vary, according to the nature of the infection. Isolation may involve either source isolation, whereby infected patients are nursed with precautions necessary to prevent the spread of infection to others, or protective isolation, which is used for patients at special risk of acquiring infection such as haematology or oncology patients.

There is a policy in place which has been updated in 2022 to ensure that patients are isolated appropriately.

The decision to isolate a patient should be based on a risk assessment with regular assessments taking place to ensure the most appropriate use of the isolation facilities. 25% of the inpatient beds at Russell's Hall Hospital take the form of single ensuite rooms which are prioritised for patients with either confirmed or developing signs of infection.

In addition to the Isolation policy a Zoning Standard Operating Procedure (SOP) was developed in March 2020 due to COVID-19 which identified that for the duration of the COVID-19 clinical facilities at DGFT will be segregated into differing zones. Patients will be admitted in to or moved between the different zones dependent on their COVID-19 status. All patients admitted to an inpatient bed will be swabbed for COVID-19 on admissions, day 3, day 5, day 7, day 13 and weekly regardless of whether they display any signs or symptoms of the disease. The zoning introduced was:

- Green zone - proven COVID-19 negative
- Yellow zone - admissions where COVID-19 test results are still awaited.
- Blue zone - confirmed COVID-19 positive or very high clinical suspicion of COVID-19 Infection who has had a negative test, -these patients are to be placed into a side room within a blue area.

This SOP has been updated regularly due to changes in National Guidance.

- IPC Isolation Policy in place to support staff.
- Isolation Policy updated in 2020/21 to include COVID-19.
- Isolation Risk matrix developed to aid patient placement.
- Risk assessments performed by ward staff with support from the IPC team when insufficient isolation facilities were available to meet demand.

- Cohort approach taken as necessary within DGFT during outbreaks of diarrhoea and vomiting.
- All episodes where staff are unable to isolate patients are reported to Risk Management via Datix.
- COVID-19 swabbing has been updated throughout the year in line with National Guidance

4.8 CRITERION 8
Adequate access to laboratory support as appropriate

The IPC Team work closely with the clinical microbiology department which provides comprehensive microbiology advice. The laboratory forms part of the Black Country Pathology Services (BCPS) which covers 4 hospital sites to include The Royal Wolverhampton NHS Trust, The Dudley Group NHS Foundation Trust, Sandwell and West Birmingham NHS Trust and Walsall Healthcare NHS Trust.

The trust has access to a CPA/UKAS accredited laboratory. The clinical microbiology departments provide support to the IPC Team through reporting of results, processing of clinical samples and provision of expert microbiological advice as required. Electronic systems are available for the reporting of alert organisms. Out of hours, the on-call duty microbiologists will provide Infection Prevention and Control advice for the Trust. Funding was secured and the Trust migrated on to the new version of IC NET in September 2022. The microbiology laboratory at Russells Hall Hospital was relocated to Royal Wolverhampton Trust during 2022, this has not led to any changes in service provision.

- Continuation of rapid testing for *Clostridiodes difficile* and use of typing to search for clusters and linked cases.
- Continuation of local test for Norovirus to speed up diagnosis and outbreak management of patients with infection.
- Continuation of local test for influenza to speed up diagnosis and outbreak management of patients with infection.
- Local testing for COVID-19.
- Point of Care testing available in Emergency Department for COVID-19 and Influenza
- Adequate resources available in laboratory for MRSA screening in line with national guidance.
- Mandatory surveillance also included MSSA, *E.coli* , pseudomonas Bacteraemia infections.
- Consultant Microbiologist at DGFT's is DGFT's IPC Doctor.
- Medical microbiology support provided by DGFT 24 hours a day 365 days a year.

4.9 CRITERION 9
Have and adhere to policies, designed for the individual's care and provider organisations that help to prevent and control infections

All IPC policies, guidelines and SOPs are available for staff to view on the Trust Intranet site, the HUB. Access to these are clearly displayed under the documents section and there is a link on the IPC page for ease of use. A formal Governance structure is in place for the development, reviewing and ratifying such documents and is monitored via the IPC Group meeting.

- Rolling programme of policy / SOP review continued.

- Published evidence reviewed whenever policies were developed or reviewed on publication of new national guidance to ensure they reflect up to date, evidence based, best practice national guidance.
- New policies developed as need identified.
- In collaboration with Medicines Management team, commenced work to implement the relevant recommendations of the Tackling Antimicrobial Resistance 2019-2024, the UK's five-year national action plan.

Below is a list of all of the policies which relate to IPC and the date of review:

Carbapenemase producing enterobacteriacea (CPE) screening, management and prevention of the spread policy	July 2024
Cleaning and disinfection of the environment policy	May 2025
Clostridiodes difficile (CDI) – control and management policy	Mar 2025
Control of an outbreak of infection in hospital policy	July 2024
Diarrhoea	
Group a streptococcus management policy	Nov 2024
Healthcare associated infections surveillance policy	May 2025
Gram negative bacteria outbreak in neonatal unit management guideline	March 2024
Decontamination policy	Oct 2025
Infection prevention and control in the built environment policy	May 2025
Infection control precautions for extended spectrum beta lactamase (ESBL) and Amp C producing organisms policy	Nov 2024
Linen procedures for patients personal clothing guideline	Mar 2024
Meticillin-resistant *staphylococcus aureus* (MRSA) screening emergency and elective admissions policy	Dec 2025
Reporting infections to UK Health Security Agency and local authority policy	Nov 2024
Management of scabies policy	Jan 2025
Management of patients with proven or suspected transmissible spongiform encephalopathies (TSE) policy	Apr 2025
Management of influenza in the hospital setting policy	Feb 2026

Compliance with policies was audited locally through the hand hygiene, cleanliness and IPC audit tools/checklists, specific competency tools and peer assessments. Specific audits undertaken by the IPC team as part of their annual programme, clinical incident reporting and root cause analysis of infections including debrief meetings were also used to monitor compliance.

4.10 CRITERION 10

Providers have a system in place to manage the occupational health needs of staff in relation to infection

4.10.1 Staff Health and Wellbeing (SHAW)

The section below in italics has been completed Priyanka Nar, Occupation Health Lead for Occupational Health and Wellbeing Department.

Staff Health and Wellbeing (SHAW) offer a wide range of services and continue to support DGFT by reducing ill health at work and supporting those at work with health problems and disabilities. There is joint work between SHAW and the Health and safety team whereby sharps/splash incidents are discussed to improve the safety of staff when handling sharp devices.

Sharps / Splash incidents

127 incidents in 2022/23

	2022/23
Suture needle	*16*
Vacuette	*14*
Butterfly Needle	*12*

The computer system, Cohort, used within SHAW is being updated internally. Moving forward, SHAW will be able to report data on the below areas:

- *Exact location of incident, breaking it down via department and division*
- *What was the sharps device?*
- *If the injury was sustained from a high-risk patient*
- *When the injury occurred (during or post procedure)*

Health Surveillance

A new health surveillance programme has been devised for SHAW. Moving forward SHAW will work towards the new health surveillance programme and outcomes will be reported to the Health & Safety Steering Group. We will be working with Health & Safety to identify if there are any other areas that require health surveillance, and they will be included into the programme.

Surveillance	**Department involved**	**Screening Required**	**Due Date**	**Comments**
Skin Surveillance	All HCWs who use skin sensitisers	Questionnaire	Jun- 23	N/A
Decontamination sensitiser	GI Unit	Questionnaire and Spirometry	May 2023	In Progress
TB	Respiratory wards, AMU, ED, ICCU, GUM and Respiratory Physiotherapists	Symptom reminder letter	November 2023	N/A

4.10.2 Health and Safety

The section below in italics has been completed by Jodi Griffin, the Trusts Health, and Safety Advisor.

The Health & Safety team have supported the IPC team with a number of projects this year including advising on changes to decontamination substances, provided assistances with risk assessments and took part in the IPC leads training day.

The IPC team have also supported the Health & Safety team with several projects particularly on Sharps incidents.

The health & safety team have carried out a number of audits this year, one of which being IPC related, this being the work around Sharps injuries and splashes.

There was no requirement in this financial year 2022/23 to carry out social distancing audits as all legislation has been removed. However, the Health & Safety team have a Trust overarching "Living with Covid" risk assessment that is updated as and when new IPC guidance is issued, particularly around mask wearing.

Sharps and Cuts injuries

Sharps and Cuts injuries are the most reported incident type under the Health and Safety Category year on year.

Last year (April 1st 2021-March 31st 2022), a total of 125 sharps and cuts injuries were reported on the datix system. Of these, 88% were Needlestick injuries.

An audit was carried out to look at the correlation between the number of needlestick injuries and use of non-safe sharps. The audit found that the departments that were using non-safe needles were reporting more sharps injuries than those areas using safer alternatives.

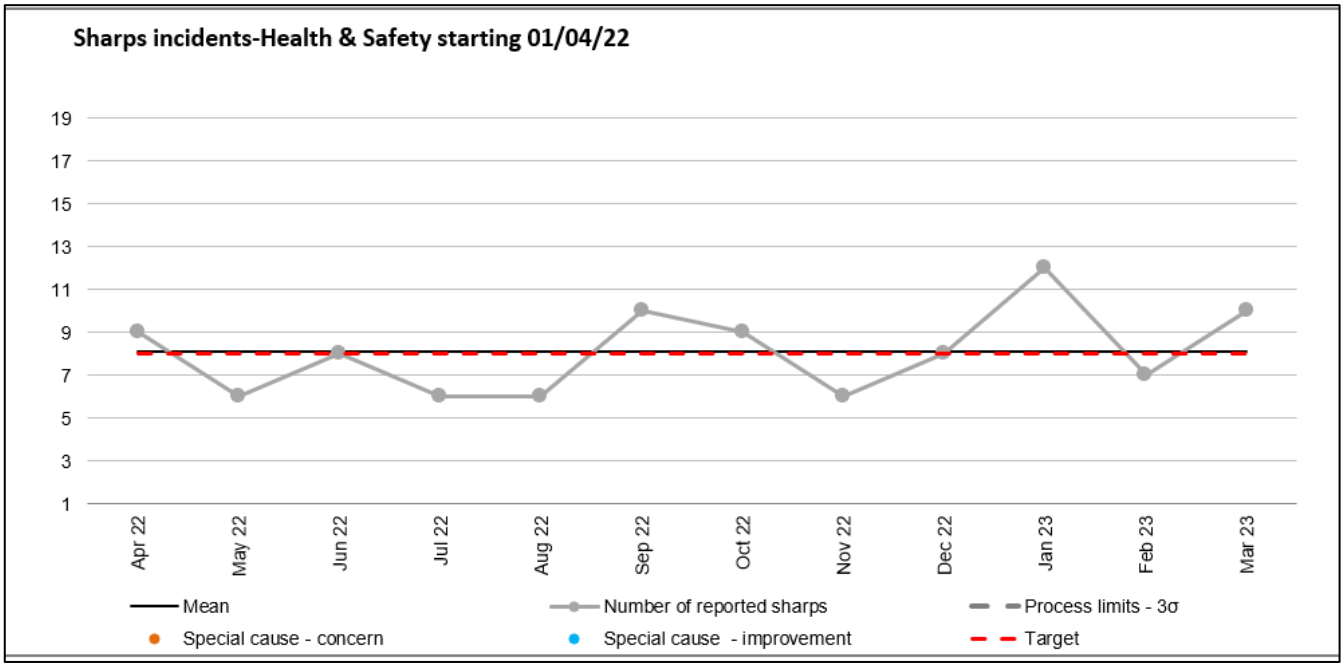
The audit also found that datix reports contained very little information about the type of device involved in the sharps and cuts incident. A new drop-down box where the device involved has to be entered has been made mandatory when completing a sharps and cuts datix report.

A task and finish group has been formed with representation from Health & Safety, deputy Director of Infection Prevention and Control , Deputy Chief Nurse, Clinical Skills , Blood Borne Virus team and Clinical Procurement team. The aim of the group was to look into ways to reduce the number of needlestick injuries and to investigate why some non-safe devices were still being used rather than the safer alternatives and to look at improving the pathways for post Sharps injury/splashes.

IPC related RIDDOR

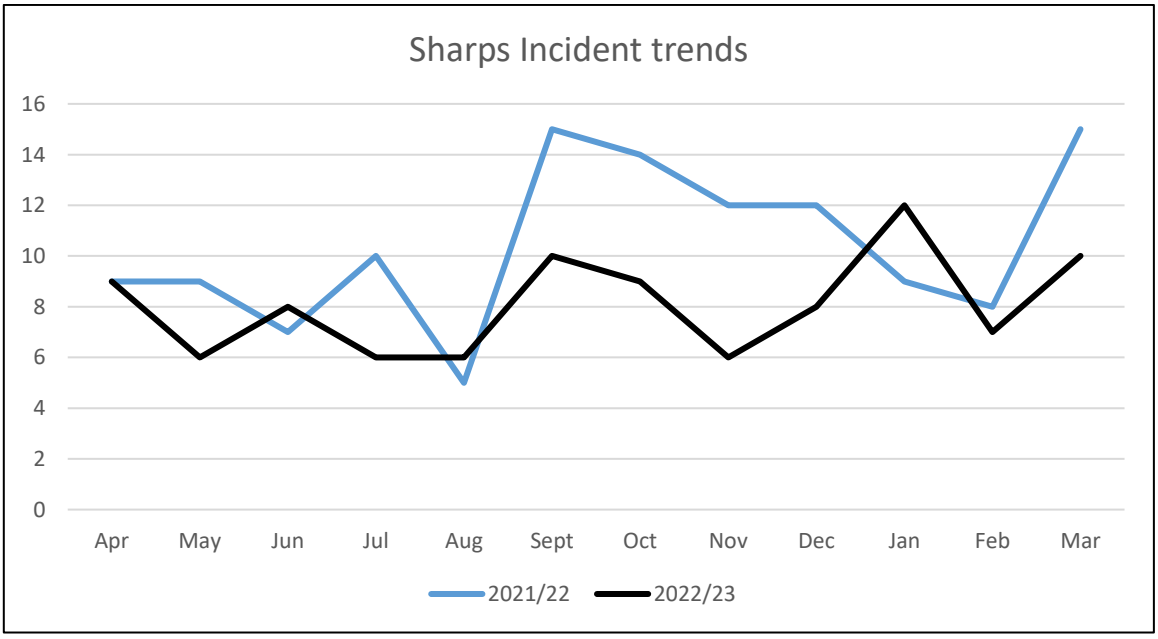
There were 4 IPC related incidents reports to the HSE under RIDDOR (Reporting of Injuries, Disease and Dangerous Occurrences regulations) in the financial year1st April 2022-31st March 2023). These incidents were needlestick injuries involving patients with known Blood Borne Viruses and were reported as Dangerous Occurrences and account for 25% of the reports submitted to RIDDOR in this financial year.

Graph 1: *Graph showing the number of Sharps and cuts incidents per month for year 2022/23*



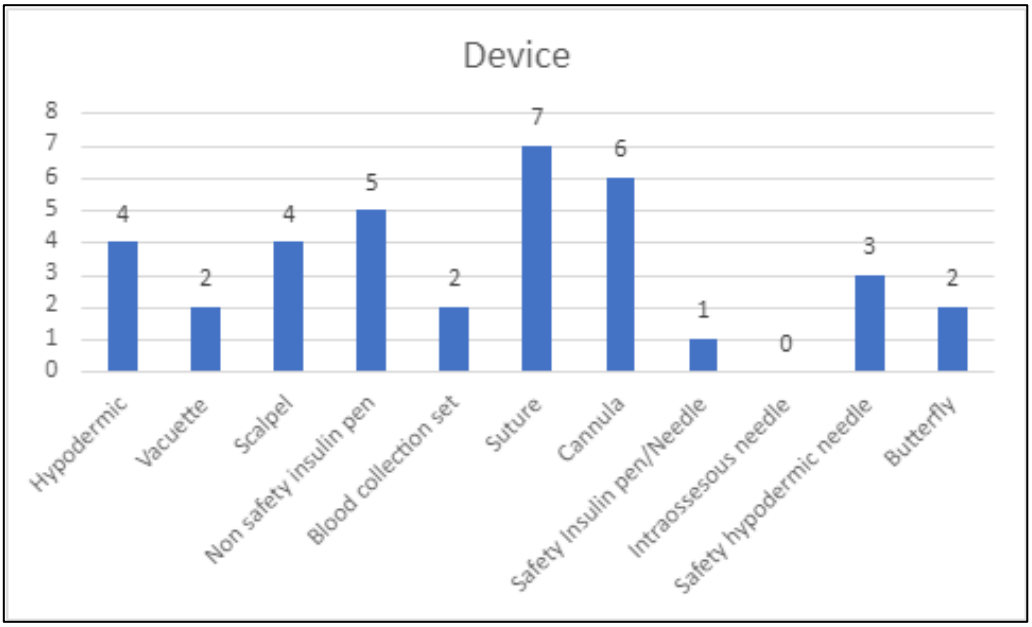
The graph shows spikes in the number of Sharps and Cuts incidents reported in September 2022 and January 2023. There does not appear to be a single caution for these increases.

Graph 2: *Showing the comparison between the number of Sharps and Cuts incidents reported each month for 2021/22 (Blue) and 2022/23 (Orange)*



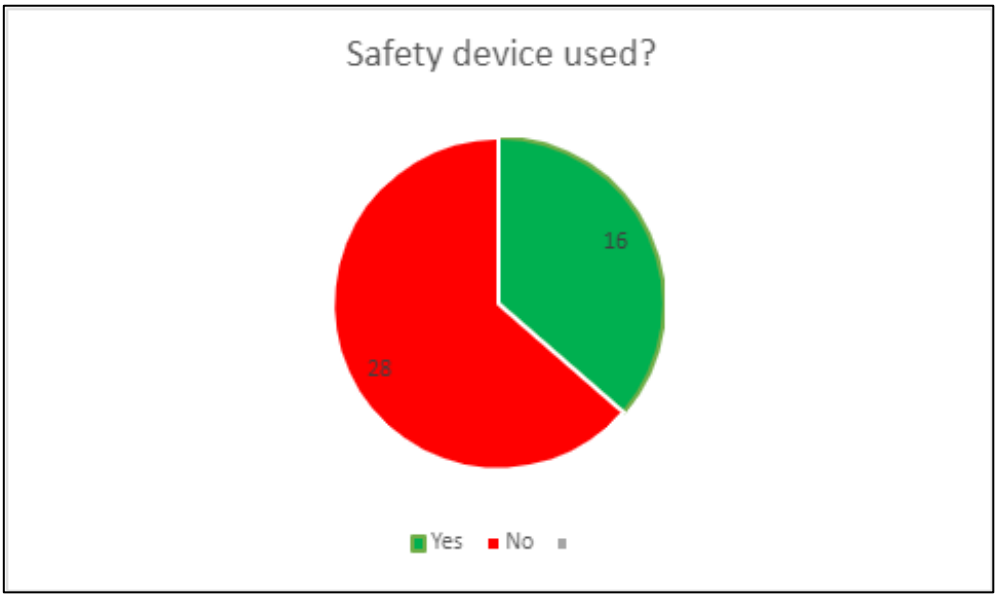
The graph shows that overall, few sharps related incidents were reported in 2022/23 compared to 2021/22. Interesting, in both years a spike in incidents is seen in September in both years and again in March. There does not seem to be a single causation for these spikes in incidents.

Graph 3: *Graph showing the devices/sharps involved in Sharps and Cuts incidents between 1st October 2022 and 31st March 2023 **



*The graph shows the data collated for devices involved in Sharps and Cuts incidents across the Trust between 1st October 2022 and 31st March 2023. Sutures are the most involved sharp device followed by cannulas. *The data collection started in October when the new drop down was added to the datix reports.*

***Graph 4:** Graph showing the number of incidents involving safer sharps versus non-safe sharps for date range 1st October 2022 and 31st March 2023.*



The graph shows that incidents where non-safety devices are involved are more prevalent that those that involve Safety devices.

**The data collection started in October when the new drop down was added to the datix reports. All departments using non-safe sharps have risk assessments in place for their use and rationales for their use are being considered by the Sharps group.*

The group are meeting with Maternity to look at training for use of sutures, as sutures are involved in more incidents than other types of sharps. The learning will then be shared with other departments that use sutures to try to increase awareness and reduce the number of sharps incidents across the Trust.

SECTION FIVE:
LOOKING FORWARD TO 2023 / 2024

5.1 An Overview of Infection Prevention and Control Programme 2023/24

This section gives an oversight of the work planned to prevent and control infections in 2023/24 and to achieve external thresholds and comply with the Code of Practice on the prevention and control of infections. It is designed to reflect DGFT's Quality Strategy to deliver care that is clinically effective; care that is safe; and care that provides as positive an experience for patients as possible.

The key aims in 2023/24 will be to build on the work that has been done in previous years to prevent HCAIs and improve the lives of the people who come into contact with DGFT services. Patient safety is at the heart of IPC, and to ensure our work is sustainable, DGFT promotes that every member of staff takes responsibility for IPC in order that that **no person is harmed by a preventable infection.**

Infection Prevention and Control Strategy focus for the upcoming year are:

- Minimise the risk to patients from healthcare-associated infection and prevent all avoidable HCAI's.
- Maintain compliance with all requirements of the Code of Practice for Health and Adult Social Care on the Prevention and Control of Infections and related guidance 2015.
- Continued commitment to working in partnership with other healthcare providers and the multidisciplinary team.
- Continued delivery of education and training on prevention and control of infection so that staff understands their responsibilities and action to take.
- Review and improve internal processes and systems related to infection control and PFI partners.
- Enhanced surveillance of infections and learning through actions
- Support proactive antimicrobial stewardship within the Trust
- Ensure appropriate information relating to infection risks is communicated to relevant parties.
- Ensure collaborative working within the Trust to ensure the maintenance of a clean and appropriate environment.
- Ensure policies are in place and reviewed to ensure they fully reflect and meet the regulatory standard.
- Continued commitment to an approach whereby prevention and control of infection is viewed as integral to service delivery and development.
- Enhance patient and public involvement in infection prevention and control in order to improve patient experience and reduce risk to the public.
- Develop a programme of quality improvement to underpin the delivery of high-quality infection prevention practice with the potential to foster improvements in experience, safety, and effectiveness of patient care.
- Supporting National Campaigns including Gloves Off
- Introducing Mouth Matters throughout the Trust
- Team members will be supported to develop their skills and knowledge within the field of infection prevention and control ensuring that the quality of service provided by all the members of the team is robust and of high standard.

What are the key challenges?

- Level of hospital activity and service capacity
- Prioritising resources to deliver the Strategy within the current financial climate.
- Emerging infections, resistance patterns and new strains of microorganisms
- Limited isolation facilities
- Ensuring a clean fit for purpose environment
- Meeting regulatory HCAI targets
- Educating workforce, patients and public
- Engaging with key stakeholders and external agencies
- Providing assurance that there is continued compliance with Infection Prevention and Control policy and standards.
- Releasing staff to undertake training.
- Post COVID-19

5.2 2023/24 Local Infection Prevention and Control Objectives as agreed with Commissioners

5.2.1 2023/24 Infection Thresholds

- Zero tolerance MRSA bacteraemia will continue in 2023/24 and reduction targets will be set for *Clostridiodes difficile* infection and Gram-negative bacteraemia (GNBSI), including *Escherichia coli*, Klebsiella and Pseudomonas. 2023/24 NHS Standard Contract
- Financial sanctions relating to MRSA bacteraemia and *Clostridiodes difficile* infection have been removed from the 2022/23 NHS Standard Contract and sanctions will not apply in relation to the new GNBSI targets.

5.2.2 2023/24 IPC Key Performance Indicator (KPI)

DGFT will continue to undertake MRSA screening for all relevant elective and emergency admissions.

5.3 Conclusion

The elimination of avoidable healthcare associated infections continues to be a priority for the Trust, patients and the wider public. In response, a robust annual programme of work has been implemented by the Trust over the last year which has been led by an experienced and highly motivated Infection Prevention and Control Team and supported by colleagues at all levels of the organisation. The successes over the last year have only been possible due to the commitment for infection prevention and control that is demonstrated at all levels within the Trust. High standards of infection prevention and control and antimicrobial stewardship will remain crucial to minimise the risk of infection and limit the emergence and spread of multi-drug resistant organisms.

SECTION SIX:
ACKNOWLEDGEMENTS AND FURTHER INFORMATION

Thank you for reading the IPC Annual Report for 2022/23.

If you require any further information about IPC in DGFT please email the team at dgft.infection.control@nhs.net or visit our webpage at Infection control - The Dudley Group NHS Foundation Trust (dgft.nhs.uk)

This report was prepared by DGFT's IPC team:

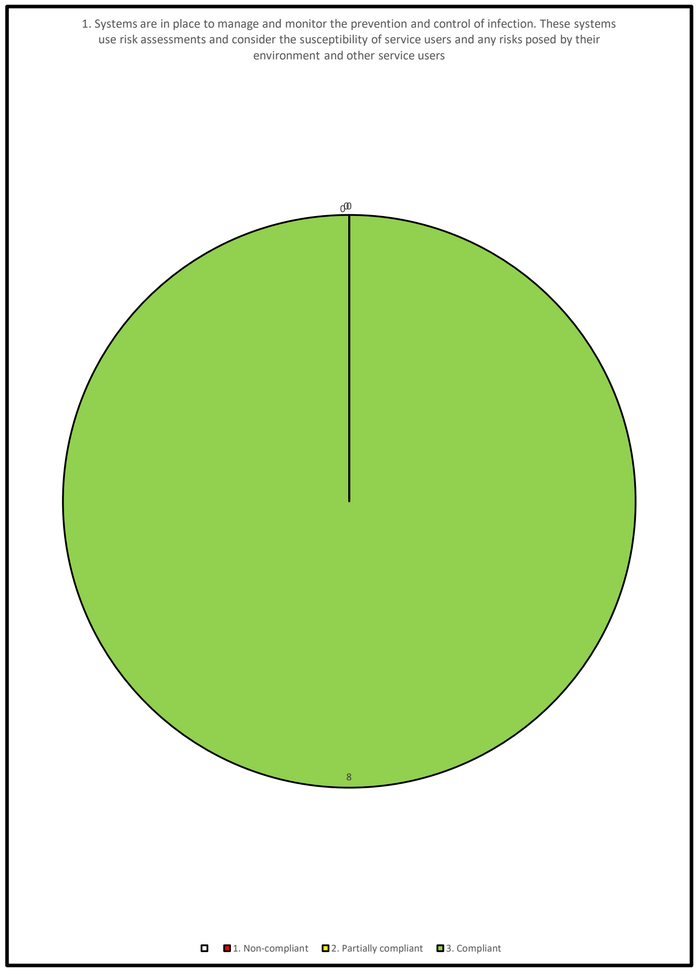
Mary Sexton	- Chief Nurse & Director of Infection Prevention and Control
Liz Watkins	- Deputy Director of Infection Prevention and Control
Kim Jarrett	- Trust Decontamination Lead
Hannah White	- IPC Clinical Nurse Specialist
Samantha Ware	- IPC Clinical Nurse Specialist
Kay Nock	- IPC Nurse
Georgia Lingard	- IPC Nurse (Joined April 2022)
Maisie Maund	- IPC Nurse (Joined April 2022)
Georgina Miller	- IPC Nurse (Joined October 2022)
Diane Garfield	- IPC Nurse (until August 2022)
Sam York	- IPC Data Analyst (until June 2022)
Rabia Aria	- IPC Data Analyst (Joined October 2022)
Simone Burton	- HPV Technician (until August 2022)
Simon Hipkiss	- Ultraviolet Technician
Kyal Singh	- Ultraviolet Technician
Alison Painter	- IPC Team Secretary
Jo Peters	- COVID-19 Bank Nurse Contact Tracer (until July 2022)

In conjunction with:

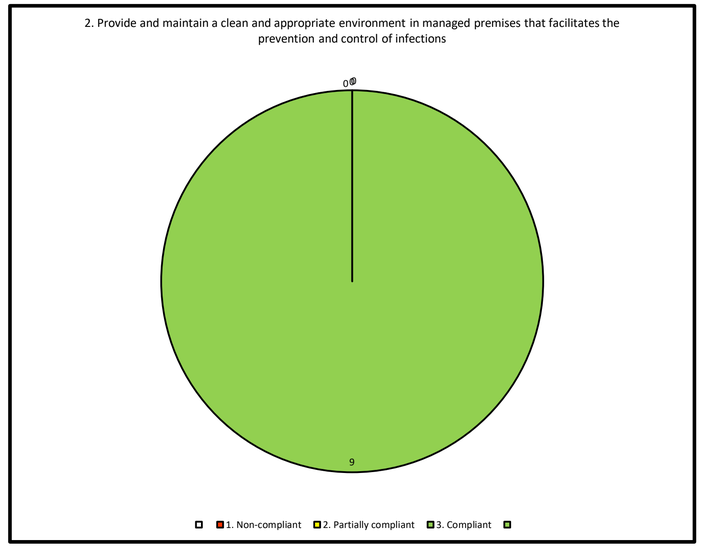
Syed Gilani	- Principal Pharmacist Antimicrobial Therapy
Jodi Griffin	- Health and Safety Advisor
Priyanka Var	- Occupational Health Advisor
Jannine Dyke	- Soft Services Contract Manager
Darren Lowe	- Estates Advisor

Infection Prevention and Control board assurance framework v0.1

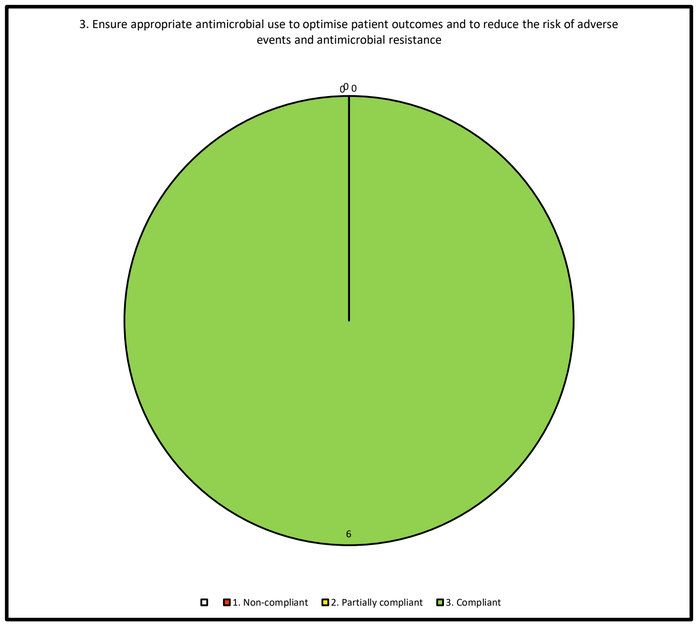
	Key Lines of Enquiry	Evidence	Gaps in Assurance	Mitigating Actions	Comments	Compliance rating
1. Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks their environment and other users may pose to them						
Organisational or board systems and process should be in place to ensure that:						
1.1	There is a governance structure, which as a minimum should include an IPC committee or equivalent, including a Director of Infection Prevention and Control (DIPC) and an IPC lead, ensuring roles and responsibilities are clearly defined with clear lines of accountability to the IPC team.	The Trust has both a DIPC and Deputy DIPC in post. There is an IPC and Decontamination Lead in post. There is a clearly defined structure with clear accountability IPCG meeting meetings quarterly with TOR agreed annually.				3. Compliant
1.2	There is monitoring and reporting of infections with appropriate governance structures to mitigate the risk of infection transmission.	HCAI data is reported to IPCG, CQRM and IPR. Divisions report into IPCG All outbreaks are reported internally and externally to UK HSA and NSHE via the OTKA database. There is an IPC Governance structure in place from IPCG Meeting to Public Board via Quality and Safety Committee. HCAI data is presented to external partners e.g. UK HSA, ICB				3. Compliant
1.3	That there is a culture that promotes incident reporting, including near misses, while focusing on improving systemic failures and encouraging safe working practices, that is, that any workplace risk(s) are mitigated maximally for everyone.	DATIX reporting is encouraged. There is a Freedom to Speak up Guardian in place. There are separate DATIX streams for IPC and Decontamination incidents to be reported and actioned. Decontamination incidents are raised at the Sterile Services and Decontamination Meetings. Meeting minutes available. Incidents are included in IPCG reporting.				3. Compliant
1.4	They implement, monitor, and report adherence to the NIPCM.	An IPC programme of audit is detailed in the IPC Annual Programme. Audits are recorded on AMaT and monitored via the IPCG meeting. IPC Audit tools are fluid documents and are reviewed annually and updated as required. IPCG minutes detail audit scores. Meeting minutes are available				3. Compliant
1.5	They undertake surveillance (mandatory infectious agents as a minimum) to ensure identification, monitoring, and reporting of incidents/outbreaks with an associated action plan agreed at or with oversight at board level.	HCAI data is reported to IPCG, CQRM and IPR. Divisions report into IPCG All outbreaks are reported internally and externally to UK HSA and NSHE via the OTKA database. There is an IPC Governance structure in place from IPCG Meeting to Public Board via Quality and Safety Committee SSI data is recorded and uploaded				3. Compliant
1.6	Systems and resources are available to implement and monitor compliance with infection prevention and control as outlined in the responsibilities section of the NIPCM.	An IPC programme of audit is detailed in the IPC Annual Programme. This is recorded on AMaT and is monitored via the IPCG meeting.				3. Compliant
1.7	All staff receive the required training commensurate with their duties to minimise the risks of infection transmission.	IPC Training for both clinical and non clinical staff is available via e-learning following the Health Education England programme or face to face on induction. Bespoke training is delivered where required. IPC mandatory training data is reported via IPCG meetings and divisional reports.				3. Compliant
1.8	There is support in clinical areas to undertake a local dynamic risk assessment based on the hierarchy of controls to prevent/reduce or control infection transmission and provide mitigations. (primary care, community care and outpatient settings, acute inpatient areas, and primary and community care dental settings)	Risk assessments are available for use. Policies and procedures are developed to facilitate autonomy. IPC Doctor is on call out of ours for advice and support. IPC team attends capacity A weekend plan with IPC is developed and available to site and capacity				3. Compliant



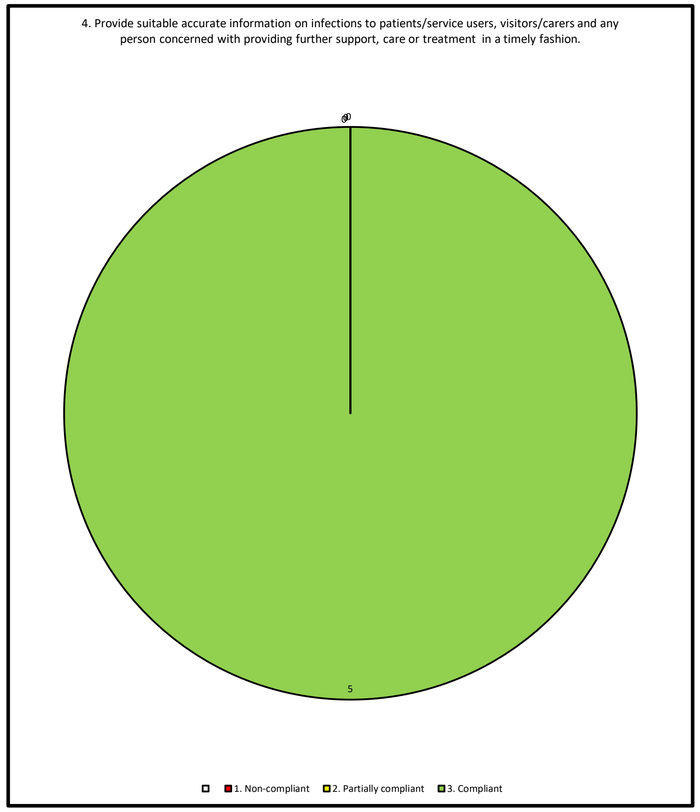
2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections						
System and process are in place to ensure that:						
2.1	There is evidence of compliance with National cleanliness standards including monitoring and mitigations (**excludes some settings e.g. ambulance, primary care/dental unless part of the NHS standard contract** these setting will have locally agreed processes in place).	Decontamination of the Environment Policy incorporating the National standards of Cleanliness adopted April 2022 Cleanliness audits completed and presented at IPCG Stars on the doors are displayed on the entrances to area Minuted Cleaning meeting with PFI partners Touch Point cleaning is increased during an outbreak of infection				3. Compliant
2.2	There is an annual programme of Patient-Led Assessments of the Care Environment (PLACE) visits and completion of action plans monitored by the board.	IPC audits and Quality walk rounds are recorded on AMAT. PLACE visits completed November 2022				3. Compliant
2.3	There are clear guidelines to identify roles and responsibilities for maintaining a clean environment (including patient care equipment) in line with the national cleanliness standards.	Cleaning is outsourced to PFI partners. Cleanliness audits and scores on the doors are produced Mitie follow the Trusts' Decontamination of the Environment policy				3. Compliant
2.4	There is monitoring and reporting of water and ventilation safety, this must include a water and ventilation safety group and plan. **2.4.1** Ventilation systems are appropriate and evidence of regular ventilation assessments in compliance with the regulations set out in HTM:03-01. **2.4.2** Water safety plans are in place for addressing all actions highlighted from water safety risk assessments in compliance with the regulations set out in HTM:04-01.	Ventilation The Trust has a ventilation group with PFI partners Mitie has an appointed authorising engineer for Ventilation Mitie undertake PPM and ventilation audits which are reported to the Ventilation Group Water The Trust has a Water Safety Plan and policies and procedures The Trust has a water safety group with PFI partners Mitie has an appointed authorising engineer for water Flushing, sampling regimes and results are reported to the Water Safety group Both above meetings report to IPCG				3. Compliant
2.5	There is evidence of a programme of planned preventative maintenance for buildings and care environments and IPC involvement in the development new builds or refurbishments to ensure the estate is fit for purpose in compliance with the recommendations set out in HBN:00-09	**Maintenance Controls** 1.1 year and 5 year Maintenance Programme issued annually 2.Asset condition survey 3.Trust Helpdesk for reporting issues 4.Monthly Report to demonstrate compliance 5.Trust Monitoring Team for compliance **Maintenance Improvements** 1.Mitie/Summit to revisit asset lists 2.New CAFM system being implemented 3.Improved self reporting for non performance of PPMs **IPC Capital Schemes Controls** 1.Trust interface for small works and capital projects 2.Trust Policy for IPC in capital schemes 3.Schemes shared with IPC for comment (Larger schemes) **IPC Capital Schemes improvements** 1.Full implementation of IPC policy for capital schemes 2.Trust to gain IPC sign off for designs 3.Trust to develop a Capital Works Policy 4.AE Water and Ventilation to sign off design and commissioning				3. Compliant
2.6	The storage, supply and provision of linen and laundry are appropriate for the level and type of care delivered and compliant with the recommendations set out in HTM:01-04 and the NIPCM.	Linen and laundry are supplied by Mitie via a PFI contract. Laundry is supplied and processed via a contract with Elis and assurance visits are undertaken with the Trust and Mitie. Items are also laundered on site in a laundry ooperated by Mitie with is regularly audited but the Trust. Micrbiological sampling oon the laundry is also undertaken.				3. Compliant



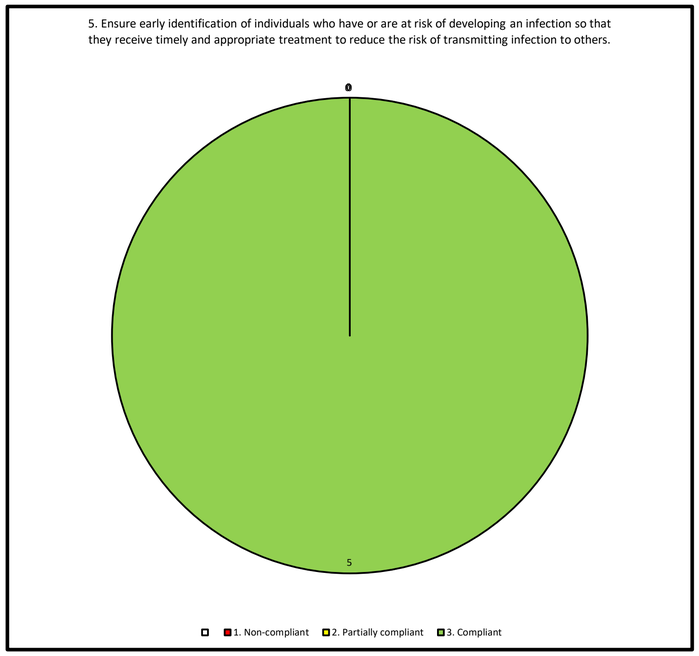
2.7	The classification, segregation, storage etc of healthcare waste is consistent with HTM:07:01 which contains the regulatory waste management guidance for all health and care settings (NHS and non-NHS) in England and Wales including waste classification, segregation, storage, packaging, transport, treatment, and disposal.	Healthcare waste at the segregation of waste is provided by our PFI partner Mitie. A PFI partner waste group meets months. Waste segregation is included on the IPC induction and IPC training programmes. Waste is included on the estates report to IPCG Duty of Care visits are undertaken to outside contractors including Tradebe and Sharpsmart.				3. Compliant
2.8	There is evidence of compliance and monitoring of decontamination processes for reusable devices/surgical instruments as set out in HTM:01-01, HTM:01-05, and HTM:01-06.	Standard infection precautions policy available on the Hub I am clean stickers are in use throughout the Trust Decontamination policy updated September 2022 available on the Hub Reusable non-invasive medical devices are decontaminated using universal wipes or Chlorine releasing agent in line with Trust policy and/or manufactures instructions. Sterile Services follow the HTM 01-01 guidelines. Sterile Services polices and procedures are audited internally and then followed through with our External Approved Body SGS annually. Decontamination programme of audit in place				3. Compliant
2.9	Food hygiene training is commensurate with the duties of staff **as per food hygiene regulations**. If food is brought into the care setting by a patient/service user, family/carer or staff this must be stored in line with food hygiene regulations.	Food hygiene training is undertaken by staff and recorded in ESR. Trust Staff have access to Food Hygiene Basics for Nursing and core staff. Food hygiene regulations.				3. Compliant
3. Ensure appropriate antimicrobial stewardship to optimise service user outcomes and to reduce the risk of adverse events and antimicrobial resistance						
Systems and process are in place to ensure that:						
3.1	If antimicrobial prescribing is indicated, arrangements for antimicrobial stewardship (AMS) are maintained and where appropriate a formal lead for AMS is nominated.	AMS Group in place with AMS lead for the Trust and antimicrobial stewardship principles are implemented throughout the Trust.				3. Compliant
3.2	The board receives a formal report on antimicrobial stewardship activities annually which includes the organisation's progress with achieving the UK AMR National Action Plan goals.	A formal report goes to board via medicines management group which covers AMS activities, achievements and risks. It is also included in annual IPC report to the board.				3. Compliant
3.3	There is an executive on the board with responsibility for antimicrobial stewardship (AMS), as set out in the UK AMR National Action Plan.	Chief Nurse is the executive on the board with responsibility for AMS. Chief Nurse is also the Director of infection prevention and Control.				3. Compliant
3.4	NICE Guideline NG15 'Antimicrobial Stewardship: systems and processes for effective antimicrobial medicine use' or Treat Antibiotics Responsibly, Guidance, Education, Tools (TARGET) are implemented and adherence to the use of antimicrobials is managed and monitored: • to optimise patient outcomes. • to minimise inappropriate prescribing. • to ensure the principles of Start Smart, Then Focus are followed.	The principles of Antimicrobial stewardship are embedded and tools, processes and support is available for effective antimicrobial use. NICE NG15 baseline assessment completed. AMS ward rounds across identified areas for support. AMS teaching sessions to Pharmacists, Drs and Nurses. AMS quality improvement projects. And effective monitoring system around antimicrobial consumption as a whole.				3. Compliant
3.5	Contractual reporting requirements are adhered to, progress with incentive and performance improvement schemes relating to AMR are reported to the board where relevant, and boards continue to maintain oversight of key performance indicators for prescribing, including: • total antimicrobial prescribing. • broad-spectrum prescribing. • intravenous route prescribing. • treatment course length.	All contractual reporting requirements are met and reports sent to Drugs and therapeutics Group, Medicines management Group and IPC Group which are then sent to Quality and safety committee and highlights presented to board.				3. Compliant

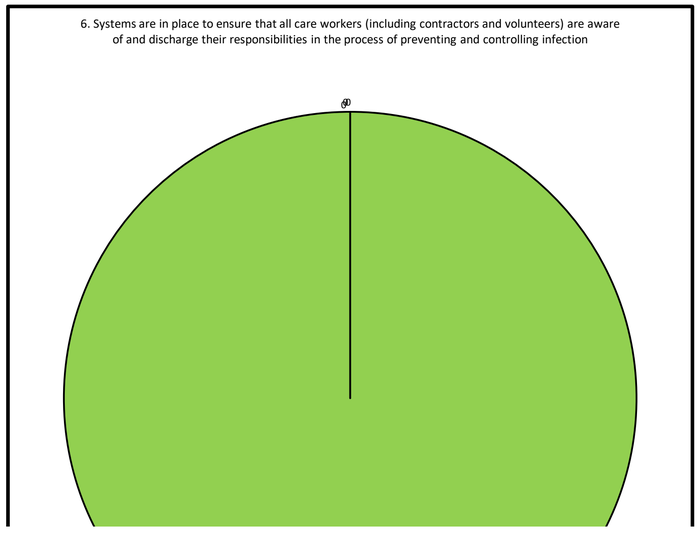


3.6	Resources are in place to support and measure adherence to good practice and quality improvement in AMS. This must include all care areas and staff (permanent, flexible, agency, and external contractors)	AMS team. Electronic prescribing aids (72 hours review) Microguide (Trusts antibiotic guidelines) and induction sessions on antimicrobial stewardship.				3. Compliant
4. Provide suitable accurate information on infections to patients/service users, visitors/carers and any person concerned with providing further support, care or treatment nursing/medical in a timely fashion						
Systems and processes are in place to ensure that:						
4.1	Information is developed with local service-user representative organisations, which should recognise and reflect local population demographics, diversity, inclusion, and health and care needs.	Patient facing information available on the Trust web site Patient leaflets available on the Trust website, different languages aviable Interpreter service available DDIPC attends Dudley Health Board meetings DDIPC attended system health protection and promotion meetings. Updates and alerts received form NHSE, UK HSA are disseminated				3. Compliant
4.2	Information is appropriate to the target audience, remains accurate and up to date, is provided in a timely manner and is easily accessible in a range of formats (e.g. digital and paper) and platforms, taking account of the communication needs of the patient/service user/care giver/visitor/advocate.	Leaflets are reviewed annually and when guidance changes Paper and digital information is aviable Interpreter service is available PALS service available				3. Compliant
4.3	The provision of information includes and supports general principles on the prevention and control of infection and antimicrobial resistance, setting out expectations and key aspects of the registered provider's policies on IPC and AMR.	Information is aviable on IPC and AMR. Information days are held at the Health Hub to promote AMR, Hand Hygiene and IPC weeks. Prescribing information available IPC Policies and procedures available on the Hub CDI ward round held weekly with IPC and Pharmacy External partner CDI meetings held weekly. Antimicrobial pharmacist attends IPCG AMR Systems meetings attended by IPC				3. Compliant
4.4	Roles and responsibilities of specific individuals, carers, visitors, and advocates when attending with or visiting patients/service users in care settings, are clearly outlined to support good standards of IPC and AMR and include: • Hand hygiene, respiratory hygiene, PPE (mask use if applicable) • Supporting patients/service users' awareness and involvement in the safe provision of care in relation to IPC (e.g. cleanliness) • Explanations of infections such as incident/outbreak management and action taken to prevent recurrence. • Provide published materials from national/local public health campaigns (e.g. AMR awareness/vaccination programmes/seasonal and respiratory infections) should be utilised to inform and improve the knowledge of patients/service users, care givers, visitors and advocates to minimise the risk of transmission of infections.	Supporting information available for visitors, patients and relatives, Patient leaflets and information available in paper or digital form. Interpreter available Information available on hand hygiene, specific micro-organisms Hand hygiene provision at the entrance at the hospital and ward entrances, Information banners on entry to the building Information days are held at the Health Hub to promote AMR, Hand Hygiene and IPC weeks. Information aviable on fluid resistant surgical masks Clinical information given to patients documented in the patients notes or Sunrise				3. Compliant
4.5	Relevant information, including infectious status, invasive device passports/care plans, is provided across organisation boundaries to support safe and appropriate management of patients/service users.	Discharge documentation is completed Patients information is given on a need to know basis in line with IG procedures and governance Extenal partners attend CDI and BSI meetings				3. Compliant

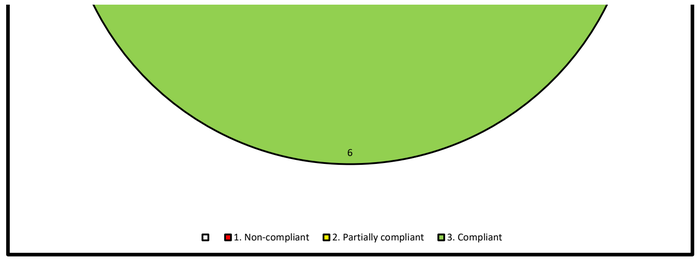


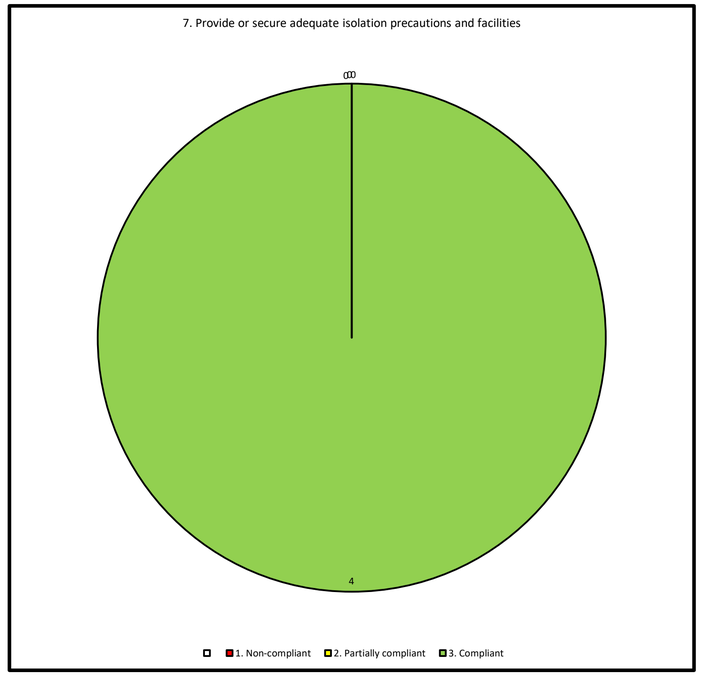
5.	**Ensure early identification of individuals who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to others.**					
Systems and processes are in place to ensure that patient placement decisions are in line with the NIPCM:						
5.1	All patients/individuals are promptly assessed for infection and/or colonisation risk on arrival/transfer at the care area. Those who have, or are at risk of developing, an infection receive timely and appropriate treatment to reduce the risk of infection transmission.	As per policy patients are screened on admission or pre-admission and placed accordingly. Nursing documentation on Sunrise	Trust does not always have side rooms aviable Datix is completed Patient is isolated in the bay until suitable placement can be arranged.	Datix is completed if a patient cannot be isolated with 2 hours.		3. Compliant
5.2	Patients' infectious status should be continuously reviewed throughout their **stay/period of care**. This assessment should influence placement decisions in accordance with clinical/care need(s). If required, the patient is placed /isolated or cohorted accordingly whilst awaiting test results and documented in the patient's notes.	Patient is nursed in most appropriate place. If cannot be nursed in isolation then this is risk assessed and documented on Sunrise Isolation signs are available for protected and Source isolation				3. Compliant
5.3	The infection status of the patient is communicated prior to transfer to the receiving organisation, department, or transferring services ensuring correct management/placement.	Discharge documentation is completed Patients information is given on a need to know basis in line with IG procedures and governance				3. Compliant
5.4	Signage is displayed prior to and on entry to all health and care settings instructing patients with respiratory symptoms to inform receiving reception staff, immediately on their arrival.	Notice and floor length banners are aviable at entrances to educate and remind patients and visitors.				3. Compliant
5.5	Two or more infection cases (or a single case of serious infection) linked by time, place, and person triggers an incident/outbreak investigation and this must be reported via governance reporting structures.	Outbreak policy available on the Hub Outbreak criteria reviewed and all potential outbreaks reviewed All outbreaks reported externally via the OTKA database. Outbreaks reported to external partners including UK HSA and ICB Outbreak meetings held if required External partners invited to outbreak meetings				3. Compliant
6.	**Systems are in place to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection**					
Systems and processes are in place to ensure:						
6.1	Induction and mandatory training on IPC includes the key criteria (SICPs/TBPs) for preventing and controlling infection within the context of the care setting.	IPC induction training is face to face and includes information on HCAI, SIPC, PPE donning and doffing, single use and is community and acute focused.				3. Compliant
6.2	The workforce is competent in IPC commensurate with roles and responsibilities.	Polices and procedures are available on the Hub IPC is included in staff job descriptions IPC training is mandatory				3. Compliant
6.3	Monitoring compliance and update IPC training programs as required.	Training presentation are reviewed and amended at least annually and when information and policies and procedures change IPC competencies are recorded and monitored by the Learning and Development Team.				3. Compliant
6.4	All identified staff are trained in the selection and use of personal protective equipment / respiratory protective equipment (PPE/RPE) appropriate for their place of work including how to safely put on and remove (donning and doffing) PPE and RPE.	PPE and Donning and doffing is included in mandatory face to face induction training. Information is available on the hub including NHSE/ UK HAS Donning and doffing video				3. Compliant

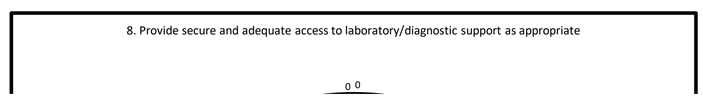




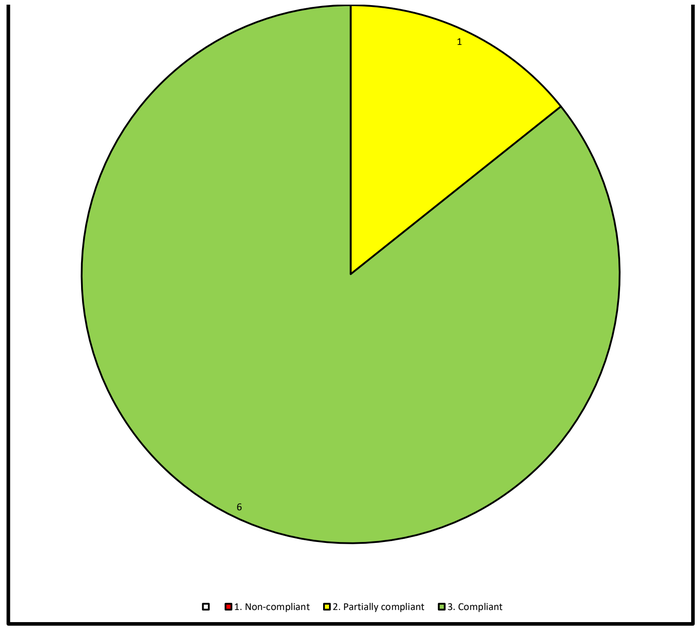
6.5	That all identified staff are fit-tested as per Health and Safety Executive requirements and that a record is kept.	All staff who are required to wear FFP3 masks are fit tested every 2 years or when required if sooner. Records are held by the Health and Safety Department				3. Compliant
6.6	If clinical staff undertake procedures that require additional clinical skills, for example, medical device insertion, there is evidence staff are trained to an agreed standard and the staff member has completed a competency assessment which is recorded in their records before being allowed to undertake the procedures independently.	Competencies and additional training is provided for specific clinical procedures e.g. venepuncture, catheterisation.				3. Compliant
7. Provide or secure adequate isolation precautions and facilities						
Systems and processes are in place in line with the NIPCM to ensure that:						
7.1	Patients that are known or suspected to be infectious as per criterion 5 are individually clinically risk assessed for infectious status when entering a care facility. The result of individual clinical assessments should determine patient placement decisions and the required IPC precautions. Clinical care should not be delayed based on infectious status.	As per policy patients are screened on admission or pre-admission and placed accordingly.	Side rooms are not always available immediately	Datix is completed Patient is isolated in the bay until suitable placement can be arranged.		3. Compliant
7.2	Isolation facilities are prioritised, depending on the known or suspected infectious agent and all decisions made are clearly documented in the patient's notes. Patients can be cohorted together if: • Single rooms are in short supply and if there are two or more patients with the same confirmed infection. • There are situations of service pressure, for example, winter, and patients may have different or multiple infections. In these situations, a preparedness plan must be in place ensuring that organisation/board level assurance on IPC systems and processes are in place to mitigate risk.	Isolation facilities' in side rooms are provided Isolation matrix available to aid clinical placement Patients are cohorted, if appropriate Flu pandemic plan available IPC Business continuity plan available IPC Team attends capacity daily and more frequently when required Weekend plan produced				3. Compliant
7.3	Transmission based precautions (TBPs) in conjunction with SICPs are applied and monitored and there is clear signage where isolation is in progress, outlining the precautions required.	SICP policy available on the Hub PPE readily available Isolation signage available for use source or protective signage available)				3. Compliant
7.4	Infectious patients should only be transferred if clinically necessary. The receiving area (ward, hospital, care home etc.) must be made aware of the required precautions.	All infectious patients are reviewed by the IPC team prior to relocation or transfer. Patients are transferred when clinically appropriate.				3. Compliant
8. Provide secure and adequate access to laboratory/diagnostic support as appropriate						
Systems and processes to ensure that pathogen-specific guidance and testing in line with UKHSA are in place:						
8.1	Patient/service user testing for infectious agents is undertaken by competent and trained individuals and meet the standards required within a nationally recognised accreditation system.	All swabs are sent to BCPS accredited lab at Royal Wolverhampton Hospital. POC testing in ED is undertaken by trained competent staff				3. Compliant

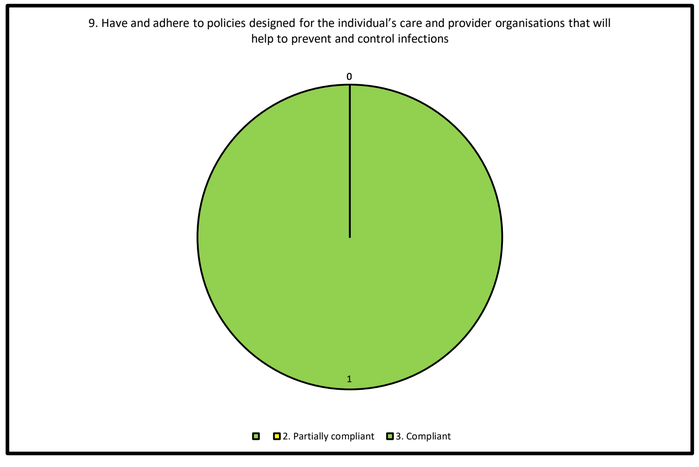




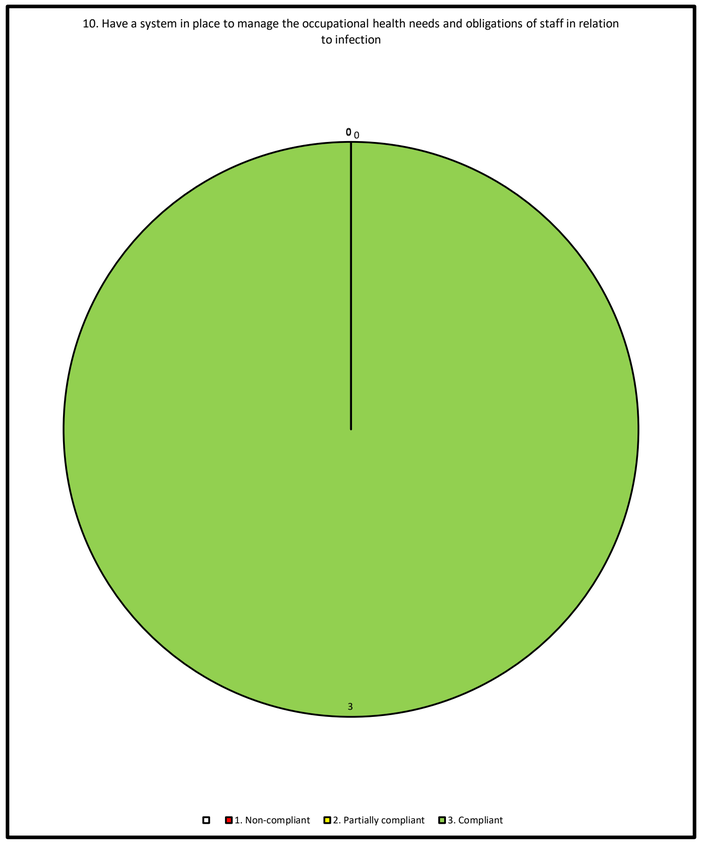


8.2	Early identification and reporting of the infectious agent using the relevant test is required with reporting structures in place to escalate the result if necessary.	Trust has access to IC NET laboratory reporting system	Screening for CPE following the latest guidance. Awaiting outcome of review from ICB and BCPS for funding to meet the new guidance	Trust has an in date CPE policy based on the previous guidance All patients who meet the criteria and are high risk are screened for CPE Rectal and faecal screening for CPE can be provided A new CPE policy following the new guidance has been drafted and approved and is awaiting a decision from BCPS and the ICB This is recorded as a risk on the IPC risk register.		2. Partially compliant
8.3	Protocols/service contracts for testing and reporting laboratory/pathology results, including turnaround times, should be in place. These should be agreed and monitored with relevant service users as part of contract monitoring and laboratory accreditation systems.	Policies and procedures in place. Agreed with Black County Pathology Services.				3. Compliant
8.4	Patient/service user testing on admission, transfer, and discharge should be in line with national guidance, local protocols and results should be communicated to the relevant organisation.	Polices, procedures and SOPs in place for testing of infections pre admission and on admission. COVID_19 staff and screening policy in place Staff have access to LFD patients available from Capacity				3. Compliant
8.5	Patients/service users who develops symptom of infection are tested / retested at the point symptoms arise and in line with national guidance and local protocols.	PCR testing is available for symptomatic in patients for COVID-19 Patients for all other infections are tested at the point symptoms arise. POCT is available in ED				3. Compliant
8.6	There should be protocols agreed between laboratory services and the service user organisations for laboratory support during outbreak investigation and management of known/ emerging/novel and high-risk pathogens.	Polices and procedures are in place with BCPS for outbreak investigation and high risk pathogens				3. Compliant
8.7	There should be protocols agreed between laboratory services and service user organisations for the transportation of specimens including routine/ novel/ emerging/high risk pathogens. This protocol should be regularly tested to ensure compliance.	Policies and procedures are in place for the transportations of specimens to the laboratory in RWT.				3. Compliant
9. Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections						
9.1	Systems and processes are in place to ensure that guidance for the management of specific infectious agents is followed (as per UKHSA, A to Z pathogen resource, and the NIPCM). Policies and procedures are in place for the identification of and management of outbreaks/incidence of infection. This includes monitoring, recording, escalation and reporting of an outbreak/incident by the registered provider.	Polices, procedures and SOPS are in place for specific micro-organisms Outbreak and isolation policies are available All polices, procedures and SOPS are in date and available on the Trusts Hub. There is a CDI Improvement plan in place The Trust has access to IC NET All outbreaks are recorded on the NHSE OTKA database and reported to external partners HCAI data is recorded and reported externally both and nationally. External partners attend BAI and CDI meetings Outbreak meetings are held when required Specimens are sent for Ribotyping when required				3. Compliant
10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection						
Systems and processes are in place to ensure that any workplace risk(s) are mitigated maximally for everyone. This includes access to an occupational health or an equivalent service to ensure:						





10.1	Staff who may be at high risk of complications from infection (including pregnancy) have an individual risk assessment.	risk assessments are completed for staff who are at risk of complications form infection. Risk assessments are kept in staffs' personal file Staff have access to the Staff Health and Wellbeing Service (SHAW)				3. Compliant
10.2	Staff who have had an occupational exposure are referred promptly to the relevant agency, for example, GP, occupational health, or accident and emergency, and understand immediate actions, for example, first aid, following an occupational exposure including process for reporting.	The Trust has a Sharps Injury Policy and have access to a 24 hour Emergency Department on Site. A HIV PEP service is available A Datix system is available to all staff and there is a joined up service between Health and Safety and SHAW for the monitoring and reporting of Sharps Injuries All injuries are reported via the IPCG meeting A sharps flow chart is available for staff to follow in the event of an injury Sharps handing and injuries are covered in IPC mandatory face to face training. The Trust has a sharps safety task and finish group Safer sharps are promoted				3. Compliant
10.3	Staff have had the required health checks, immunisations and clearance undertaken by a competent advisor (including those undertaking exposure prone procedures (EPPs).	Pre employment checks for all staff are completed via the Staff Health and Wellbeing Service.				3. Compliant



The Dudley Group
NHS Foundation Trust

REPORT FOR ASSURANCE

Maternity and Neonatal Safety and Quality Dashboard
Report to Trust Board September 14th, 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, and Trust 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 **June and July 2023**, unless otherwise specified throughout.

2. BACKGROUND INFORMATION

2.1 Perinatal Mortality Overview

2.1.1 Stillbirths

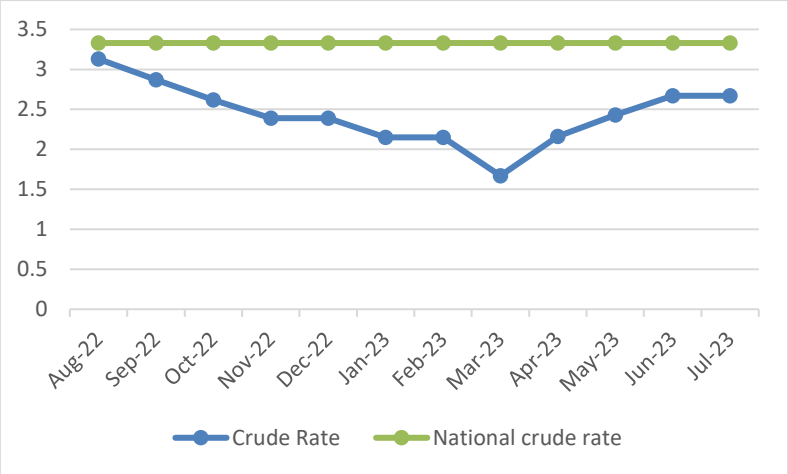
Crude stillbirth rates: Calculated from the total number of stillbirths for the period divided by number of births within the period multiplied by 1,000.

Still birth Rates

The National stillbirth rate is 3.33 (MBRRACE 2022) and it can be seen the stillbirth rate for May 2023 at 2.67, this indicates that DGFT remain below the national stillbirth rate. There were 11 stillbirths between 1/8/2022 and 31/7/2023.

	Crude Rate	National crude rate	Number of stillbirths
Aug-22	3.13	3.33	2
Sep-22	2.87	3.33	2
Oct-22	2.62	3.33	0
Nov-22	2.39	3.33	0
Dec-22	2.39	3.33	1
Jan-23	2.15	3.33	1

Feb-23	2.15	3.33	0
Mar-23	1.67	3.33	0
Apr-23	2.16	3.33	2
May-23	2.43	3.33	1
Jun-23	2.67	3.33	2
Jul-23	2.67	3.33	0



2.2 Neonatal deaths

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

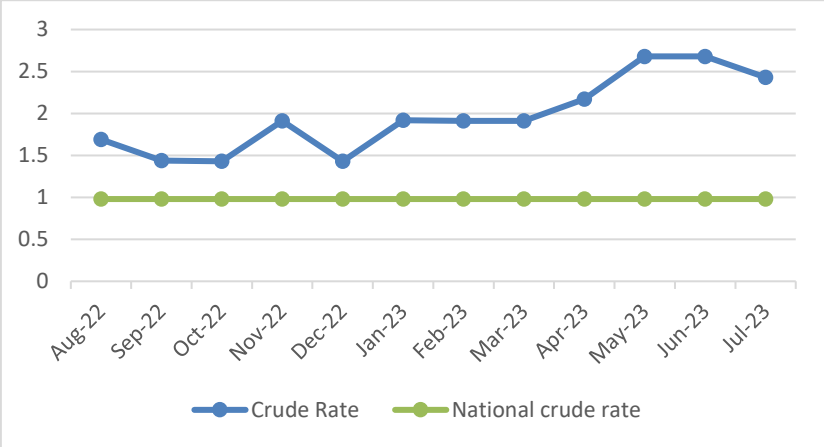
Babies delivered prior to 24 weeks gestation or with known congenital anomalies, then divided by the number of live births for the period and multiplied by 1,000.

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 July 2023 at DGFT the rate is 2.43.

	Crude Rate	National crude rate	Number of early NND
Aug-22	1.69	0.98	0
Sep-22	1.44	0.98	1
Oct-22	1.43	0.98	0
Nov-22	1.91	0.98	1
Dec-22	1.43	0.98	1
Jan-23	1.92	0.98	3
Feb-23	1.91	0.98	1
Mar-23	1.91	0.98	0
Apr-23	2.17	0.98	1
May-23	2.68	0.98	2
Jun-23	2.68	0.98	0
Jul-23	2.43	0.98	0

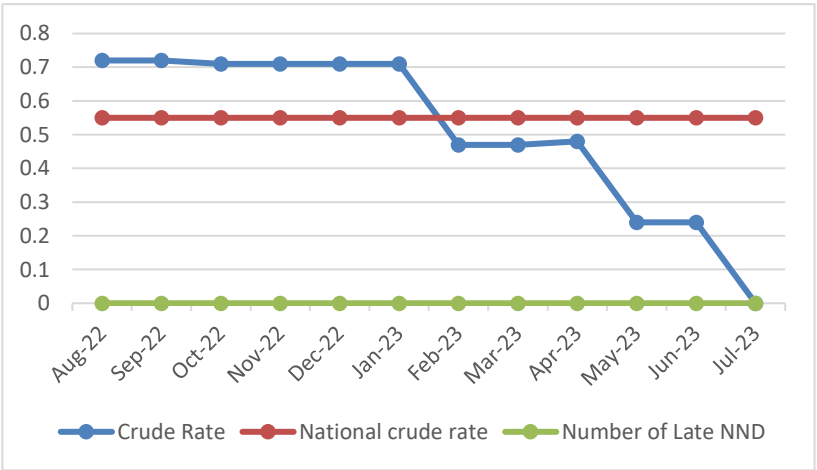


The above charts details how the crude early neonatal death rate has been consistently higher than the National rate of 0.98 (MBRRACE 2021) during the last 12 months. There were10 early neonatal deaths from 01.08.22022 to 31.07.2023.

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.

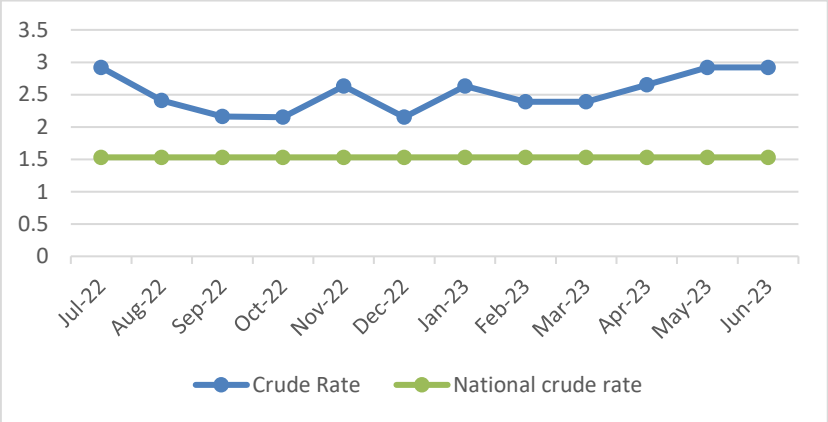
	Crude Rate	National crude rate	Number of Late NND
Aug-22	0.72	0.55	0
Sep-22	0.72	0.55	0
Oct-22	0.71	0.55	0
Nov-22	0.71	0.55	0
Dec-22	0.71	0.55	0
Jan-23	0.71	0.55	0
Feb-23	0.47	0.55	0
Mar-23	0.47	0.55	0
Apr-23	0.48	0.55	0
May-23	0.24	0.55	0
Jun-23	0.24	0.55	0
Jul-23	0	0	0



2.2.3 Combined Neonatal Death Rates

The chart demonstrates the crude combined neonatal death rates from 1st August 2022 to 31st July 2023, it can be seen that the combined neonatal death rate is 2.43 continues to be above the national rate of 1.53 (MBRRACE 2022).

	Crude Rate	National crude rate
Aug-22	2.41	1.53
Sep-22	2.16	1.53
Oct-22	2.15	1.53
Nov-22	2.63	1.53
Dec-22	2.15	1.53
Jan-23	2.63	1.53
Feb-23	2.39	1.53
Mar-23	2.39	1.53
Apr-23	2.65	1.53
May-23	2.92	1.53
Jun-23	2.92	1.53
Jul-23	2.43	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 Maternity safety champion group and included at this Committee to ensure that the Trust Board have oversight.

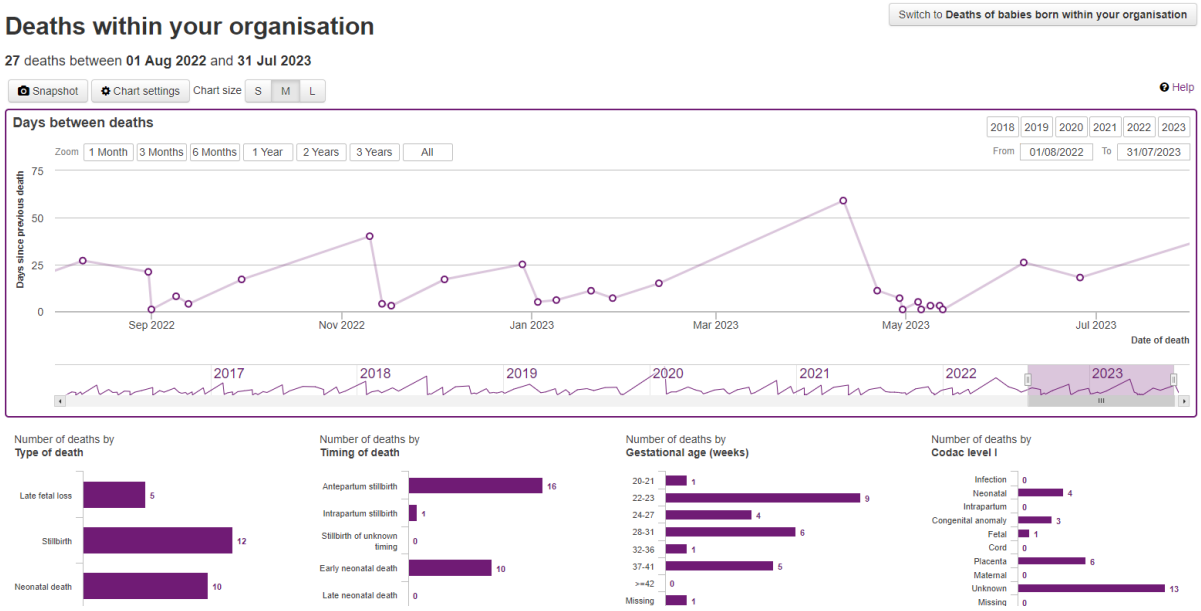
All stillbirths and neonatal deaths are reviewed using the National Perinatal Mortality Review Tool (NPMRT) which includes parent's perspectives and questions as part of the review. The system allows for a report to be produced covering all aspects required as part of the CNST Safety Action 1. A more detailed account of mortality reviews undertaken during quarter 1 (April-June 2023) can be found in Appendix one (Women and Children's Perinatal Mortality Quarter Report Q1 1st April 2023 to 30th June 2023). This summary forms part of the requirements for MIS Year 5 safety action 1.

2.2.4 Learning from Deaths Overdue Actions

There are currently 8 PMRT action plans with overdue actions. 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.

2.3 PMRT real time data monitoring tool

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



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).

2.4.1 Investigation progress update

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.

There are no active cases open with HSIB, and no urgent concerns escalated.

We have received 3 final reports from HSIB in July 2023 and action plans have been developed for all. These will be managed via the trusts governance processes.

HSIB Reference	Date of incident	Overview of case	Learning identified
MI-0200679	January 2023	HIE/Cooling	Due to SBAR not being embedded as the standard method of handover in the maternity unit and closed loop communication being incomplete, the neonatal team's attendance was delayed until the Baby was 10 minutes of age. It is unclear whether this impacted on the outcome for the Baby. 1. The Trust to ensure that the use of a standardised methodology for handover of relevant clinical information, such as SBAR, which encompasses closed loop communication, is embedded across all settings. 2. HSIB recommends that placentas are sent for pathological examination including histology in line with national guidance (Evans et al 2022).
MI-021212	January 2023	Early Neonatal death	No safety recommendations made by HSIB
MI-021805	January 2023	Early Neonatal death	Action plan being finalised- to be presented to Trust executive team. 1. The Trust to ensure that staff are supported to undertake a holistic assessment, including fetal monitoring, if there is any change in the clinical picture during the induction of labour process and to be alert to possible signs of labour progression. 2. The Trust to ensure when a mother reports any uterine activity or pain during an induction of labour that staff listen to the mothers needs and consider the cause of the pain, to support clinical assessment and inform ongoing care in line with local guidance. 3. The Trust to ensure staff consider and are familiar with the insertion and use of an intraosseous needle during neonatal resuscitation when there is difficulty obtaining UVC access. 4. The Trust to ensure resuscitation simulation training includes a clear allocation of roles and responsibilities, including use of an effective helicopter view, leadership, and followership to support the management of neonatal resuscitation.

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 July and August 2023

2.6 Maternity Serious Incidents

There was 1 new serious incident reported in Maternity during June 2023.

INC123352 reported in June 2023, (occurred in May 2023). Taken to weekly meeting of harm (WMOH) in May, advised to complete PMRT to decide on categorisation of harm. PMRT team felt that this was an avoidable death. WMOH deemed to be an SI June 2023. Investigation ongoing including parents perspective. Bereavement support ongoing by Bereavement and chaplaincy team.

There were 0 new serious incidents reported in July 2023.

There are 2 open serious incidents:
INC129662 due to be closed following receipt of the HSIB report (MI021805)

3 submitted to CCG for closure
4 have outstanding actions.

2.7 Maternity action plans

2.7.1 Maternity Incentive Scheme (CNST) Year 5

V1 of Year five of the Maternity incentive scheme launched on the 31st of May 2023. A gap analysis of compliance was completed and presented to relevant groups and committees. Since this time V1.1 has been published with amendments to 7 out of the 10 safety actions which means no safety actions are rated as red, as in previous reports.

MISyear5-update-July-2023.pdf (resolution.nhs.uk)

Current compliance with the safety actions are as below:

	Current RAG rating	Estimated date for completion
Safety action 1: Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?		Ongoing/Completed
Safety action 2: Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?		Completed
Safety action 3: Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies and to support the recommendations		Awaiting update from Neonatal team

made in the Avoiding Term Admissions into Neonatal units Programme?		
Safety action 4: Can you demonstrate an effective system of clinical workforce planning to the required standard?		November 2023
Safety action 5: Can you demonstrate an effective system of midwifery workforce planning to the required standard?		November 2023
Safety action 6: Can you demonstrate that you are on track to compliance with all elements of the Saving Babies' Lives Care Bundle Version Three?		December 2023
Safety action 7: Listen to women, parents and families using maternity and neonatal services and coproduce services with users		October 2023
Safety action 8: Can you evidence the following 3 elements of local training plans and 'in-house', one day multi professional training?		December 2023
Safety action 9: Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues?		Ongoing
Safety action 10: Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB) (known as Maternity and Newborn Safety Investigations Special Health Authority (MNSI) from October 2023) and to NHS Resolution's Early Notification (EN) Scheme?		Ongoing/Completed

Details of each element are being reported monthly to the Quality and safety committee. A deep dive of results will be presented to the December committee meeting.

2.7.2 Perinatal Culture and leadership

The national ambition is to support maternity and neonatal services to create the conditions for a culture of openness, safety and continuous improvement through positive, inclusive and compassionate leadership. NHS England are enabling those with specific responsibility for safety in Maternity and neonatal provider units to understand the relationship between leadership, safety improvement and safety culture to enable change as well as embed a culture of continuous improvement and learning. The Perinatal culture and leadership program (PCLP) has been designed to help the quad to better understand themselves as a team, and the services they lead.

*The perinatal quadrumvirate consists of the Clinical directors for both obstetric and neonates, the head of Midwifery and the directorate manager.

The quadrumvirate attended the first 3 days of the programme in July 2023, and are currently seeking feedback via a 360-style exercise. The programme lasts for 6 months.

Quarterly meetings are being held between the Board level Maternity and neonatal safety champions and the quadrumvirate to discuss:

- Progress and learning from the PCLP.
- Updates on the SCORE culture survey (to be undertaken October 2023)

- Updates on areas for improvement.
- Any support required at Board level to be identified.

Updates on progress will be included within future reports. **PCLP forms part of the requirements of MIS year 5.**

2.7.3 Mandatory and Maternity specific training

Core Competency Framework Version 2
The Maternity transformation Programme have published version 2 of the core competency framework (CCFV2) which sets out clear expectations for all trusts, aiming to address known variation in training and competency assessment across England. The CCFV2 is split into 6 domains with different requirements for all. Updates below outline progress with introduction of each element:

Module 1: Saving babies lives care bundle - Annual: New training day launching October 2023

Module 2: Fetal Monitoring and surveillance- Annual. Currently offering half a day of fetal monitoring training. New full day launching October 2023

Module 3: Maternity Emergencies and multi professional training- Annual: Ongoing- launching with nationally recognised PROMPT faculty October 2023

Module 4: Equality, equity and personalised care- 3 yearly programme of topics - new learning objectives added to all maternity specific training to ensure compliance with CCFV2.

Module 5: Care during labour and immediate postnatal period- 3 yearly programme of topics: Learning objectives added to PROMPT (one day multi-disciplinary emergency training), as well as continuation of existing training: suturing workshops, infant feeding training, and ATTAIN training.

Module 6: Neonatal basic life support- Annual. Ongoing unchanged.

Whilst training for most of these elements have been included in Maternity mandatory training for a number of years, we have changed the learning objectives to ensure compliance and content can be monitored more accurately. This will be reported in future papers.

Current compliance:

	Midwives	Obstetricians	Rectification plans
Multi-Professional Emergency Training/Skills Drills	93%	61%	All obstetricians booked onto session and will be over 90% compliant by December 2023
CTG/ fetal Monitoring Training	94%	91%	
Neonatal resuscitation	91%	96%	
Adult resuscitation	92%	96%	

2.8 Maternity Fill Rates

Community Midwifery	Fill Rate	Maternity Inpatients	Fill Rate	
			Day	Night
November 2022	100%	November 2022	66%	80%
Dec 2022	82%	Dec 2022	62%	73%
Jan 2023	84%	Jan 2023	70%	80%
Feb 2023	83%	Feb 2023	73%	77%
March 2023	88%	March 2023	68%	75%
April 2023	83%	April 2023	70%	82%
May 2023	90%	May	71%	81%
June 2023	90%	June	68%	75%
July 2023	95%	July	70%	80%

*Midwifery fill rates remain stable. A review of requirements for all areas of midwifery are underway which may affect future fill rates. (A detailed review of Maternity staffing is presented twice a year to the board)

2.9 Service user feedback- Friends and Family results July 2023

Staff very friendly and efficient despite clearly being very busy

Prolonged labour followed by emergency C-section. All staff were amazing, I felt safe and involved in all decision making. I cannot thank all the staff enough for the care I received. I will be forever grateful.

The midwives and theatre team were absolutely amazing. Hayley and Priscilla were a pleasure to be with and they were so reassuring and kind. The anaesthetist was also incredibly kind and helpful

Made to feel comfortable, offered drink and food, apologies for the wait often

Information was given in full detail but was very easy to understand. Lady who explained information was very caring and compassionate

I wouldn't know the HPSS lady was here if I didn't already have contact. They are not advertised well and should not be hidden in a corner.

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. A new risk has been added to the risk register to reflect compliance by Obstetricians with multi professional Emergency training.

3.2 The requirements for evidence for Ockenden, Maternity incentive scheme (MIS year 5) and the perinatal quality surveillance model for assurance are very specific, and significant in its amount. The committee is required to receive and minute detailed information particularly in relation to serious incidents, perinatal mortality, and safety champion engagement.

4. RECOMMENDATION

4.1 The Board is invited to accept the assurance provided in this report as current position with mortality data, serious incidents, Maternity incentive scheme year 5, Core competency framework V2 and SBLV2/3.

Claire Macdiarmid / Hesham Ghoneimy
Head of Midwifery / Clinical director for Obstetrics

Date 29/8/2023

Appendix 1

Women and Children's Perinatal Mortality Quarter Report Q1
1st April 2023 to 30th June 2023

1. INTRODUCTION

The NHS Long Term Plan reaffirmed the Department of Health's commitment to halve stillbirth and neonatal mortality by 2025. Whilst giving birth in the UK is largely safe, reports over the past decade have highlighted significant discrepancies in the quality of care provided. The recent MBRRACE-UK confidential enquiries reported that between 60-80% of term deaths might have been prevented. It is therefore critical for services to undertake robust reviews and learn lessons to reduce the number of parents who experience such a tragic loss. This provides the foundation to why Perinatal Mortality Reviews are included as Safety Action One of the Maternity Incentive Scheme (CNST) and that quarterly board reports are integral to that action point.

All stillbirths and neonatal deaths are reported via MBRRACE. 'MBRRACE-UK' is the collaboration appointed by the Healthcare Quality Improvement Partnership (HQIP) to run the national Maternal, Newborn and Infant Clinical Outcome Review Programme (MNI-CORP) which leads the national programme of work conducting surveillance and investigating perinatal and maternal deaths. The cases are reviewed via the National Perinatal Mortality Review Tool (PMRT) which supports high quality standardised perinatal reviews on the principle of 'review once, review well'.

The MBRRACE-UK Perinatal Mortality Surveillance Report – UK Perinatal deaths for births from January to December 2020, published in October 2022 provided an overview of a continued downward trend of the baby deaths in the UK giving a national picture for 2020. Perinatal deaths across the four nations of the UK have reduced over time and this reflects the impact of a range of national initiatives to address safety in maternity and neonatal care.

MBRRACE have released the Dudley MBRRACE-UK perinatal mortality report: 2021 births report in relation to stillbirths and neonatal deaths among 4,076 babies born in the Trust from 01.01.2021 to 31.12.2021. This precedes the National Perinatal Mortality report 2021 which will be launched in September 2023. The report details that the stabilised and adjusted stillbirth rate is average in relation to comparable Trusts, this is also the case when this rate excludes deaths from congenital anomalies. The stabilised and adjusted neonatal mortality rate is more than 5% higher than the average in similar Trusts and the stabilised and adjusted neonatal mortality rate has consistently worsened when compared with similar Trust over the last 3 years. A report has been written in response to the report findings and identifies improvement work that is being driven locally and within the LMNS.

The Trust's PMRT process is complementary to other existing governance processes as appropriate such as: Sudden and Unexpected Deaths in Infancy /Childhood (SUDI/C) multi-agency reviews; safeguarding, HSIB and internal incident investigation processes.

It should be noted for the purposes of comparison that only the perinatal mortality rates for babies born at 24 weeks gestational age or later, excluding termination of pregnancy, are included within

the MBRRACE-UK Perinatal Mortality Surveillance Report. The rates calculated within this report for neonatal deaths is from 20+ weeks gestation or with a birth weight >400grams.

2. DEFINITIONS

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

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

Combined perinatal mortality rates – Calculated by adding the total number of stillbirths and the total number or neonatal deaths for the period, divided by the total number of births within the period multiplied by 1,000.

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.

Late fetal death: A baby delivered between 22+0 and 23+6 weeks gestational age showing no signs of life, irrespective of when the death occurred.

Stillbirths: A baby delivered at or after 24+0 weeks gestational age showing no signs of life, irrespective of when the death occurred.

- ***Antepartum stillbirth***
    - *A baby delivered at or after 24+0 weeks gestational age showing no signs of life and known to have died before the onset of care in labour.*

- ***Intrapartum stillbirth***
    - *A baby delivered at or after 24+0 weeks gestational age showing no signs of life and known to have been alive at the onset of care in labour.*

Neonatal death: A live born baby (born at 20+0 weeks gestational age or later, or with a birth weight of 400g or more where an accurate estimate of gestation is not available who died *before* 28 completed days after birth.

- ***Early neonatal death***
    - *A liveborn baby (born at 20+0 weeks gestational age or later, or with a birth weight of 400g or more where an accurate estimate of gestation is not available) who died before 7 completed days after birth.*

- ***Late neonatal death***
    - *A liveborn baby (born at 20+0 weeks gestational age or later, or with a birth weight of 400g or more where an accurate estimate of gestation is not available) who died after 7 completed days but before 28 completed days after birth.*

Perinatal death: A stillbirth or early neonatal death.

Extended perinatal death: A stillbirth or neonatal death.

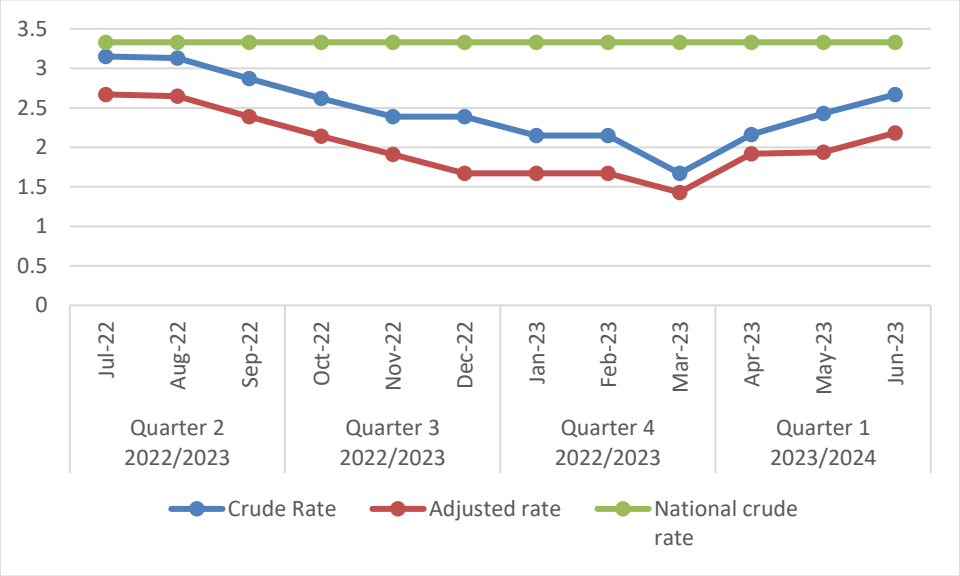
Termination of pregnancy: The deliberate ending of a pregnancy, normally carried out before the embryo or fetus is capable of independent life.

3. PERINATAL MORTALITY RATES

3.1 Stillbirths

The National stillbirth rate is 3.33 (MBRRACE 2022) and it can be seen the crude stillbirth rate for Quarter 1 2023/2024 the rate has remained below the national stillbirth rate over the rolling 12 months.

		Crude Rate	Adjusted rate	National crude rate	Number of stillbirths
Quarter 2 2022/2023	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
Quarter 3 2022/2023	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
Quarter 4 2022/2023	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
Quarter 1 2023/2024	Apr-23	2.16	1.92	3.33	2
	May-23	2.43	1.94	3.33	1
	Jun-23	2.67	2.18	3.33	2



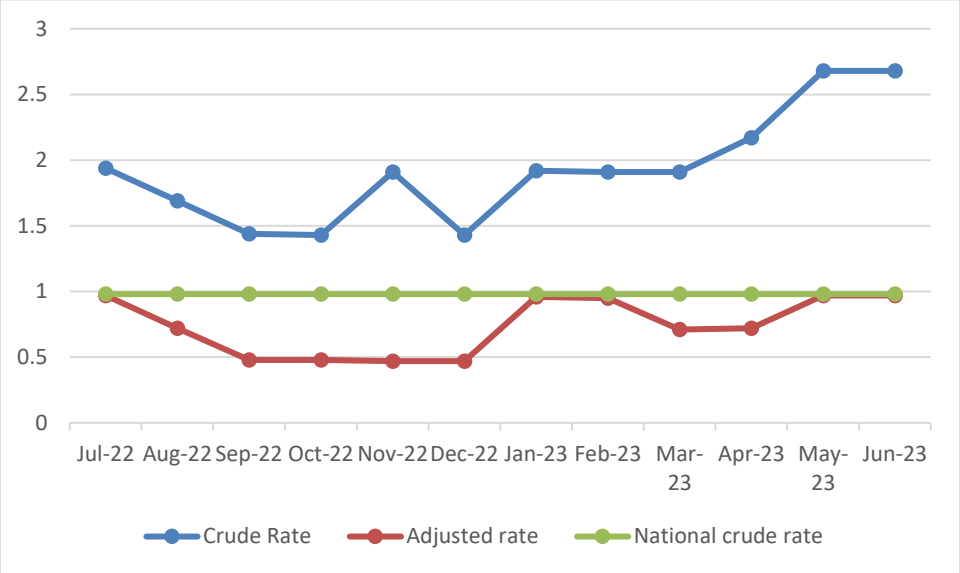
The above chart provides a comparison of the stillbirth crude rate, adjusted rate, and national rate. In Quarter 1 2023/2024 in April (2.16), May (2.43) and in June (2.67), the crude rate has remained below the national rate (3.33) despite seeing an increase in rates during Q1 2023/2024. When the rates are adjusted, the figures are reduced to April (1.92), May (1.94) and June (2.18), there is no national comparable data for when rates are adjusted.

3.2 Early Neonatal deaths

The National Early Neonatal Death (ENND) rate is 0.98 (MBRRACE 2022) and in Q1 2023/2024 the ENND rate remains higher than the national rate.

		Crude Rate	Adjusted rate	National crude rate	Number of early NND
Quarter 2 2022/2023	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
Quarter 3 2021/2022	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
Quarter 4 2022/2023	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
Quarter 1 2023/2024	Apr-23	2.17	0.72	0.98	1
	May-23	2.68	0.97	0.98	2
	Jun-23	2.68	0.97	0.98	0

In Quarter 1 2023/2024 in April (2.17), May (2.67) and June (2.68) the crude rate is higher than the national rate 0.98 (MBRRACE 2022). When the rates are adjusted, the figures are reduced to April (0.72), May (0.97) and June (0.97), there is no national comparable data for when rates are adjusted.



The above Chart allows comparison of the early NND crude and the national crude rate. There has been an increase in the ENND rate in Q1 2023/2024 as there were 3 ENND, 2 of these babies were born at <24 weeks gestation.

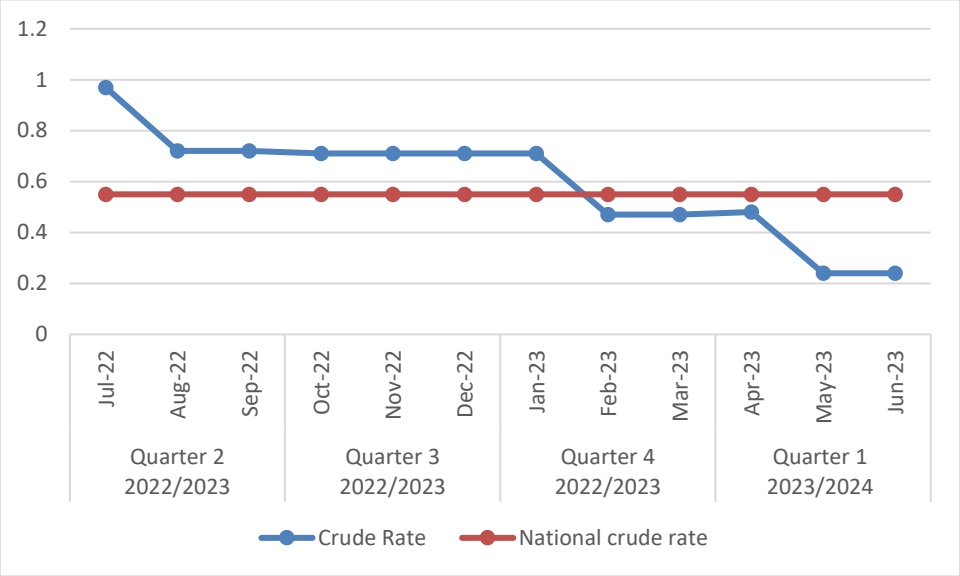
3.3 Late Neonatal Deaths

The table below identified the crude late neonatal death rates over the rolling 12 months. The National rate for Late Neonatal Deaths is 0.55

In Quarter 1 2023/2024 the crude rates continue to be below the national crude rate of 0.55 per thousand live births (MBRRACE 2022) April (0.48), May (0.24) and June (0.24).

		Crude Rate	National crude rate	Number of Late NND
Quarter 2 2022/2023	Jul-22	0.97	0.55	1
	Aug-22	0.72	0.55	0
	Sep-22	0.72	0.55	0
Quarter 3 2022/2023	Oct-22	0.71	0.55	0
	Nov-22	0.71	0.55	0
	Dec-22	0.71	0.55	0
Quarter 4 2022/2023	Jan-23	0.71	0.55	0
	Feb-23	0.47	0.55	0
	Mar-23	0.47	0.55	0
Quarter 1 2023/2024	Apr-23	0.48	0.55	0
	May-23	0.24	0.55	0
	Jun-23	0.24	0.55	0

The chart below demonstrates that the late NND rate peaked in July 2022 as crude rate 0.97. There has been a steady decline in the rate since January 2023, the rate has reduced and is below the national rate of 0.55.

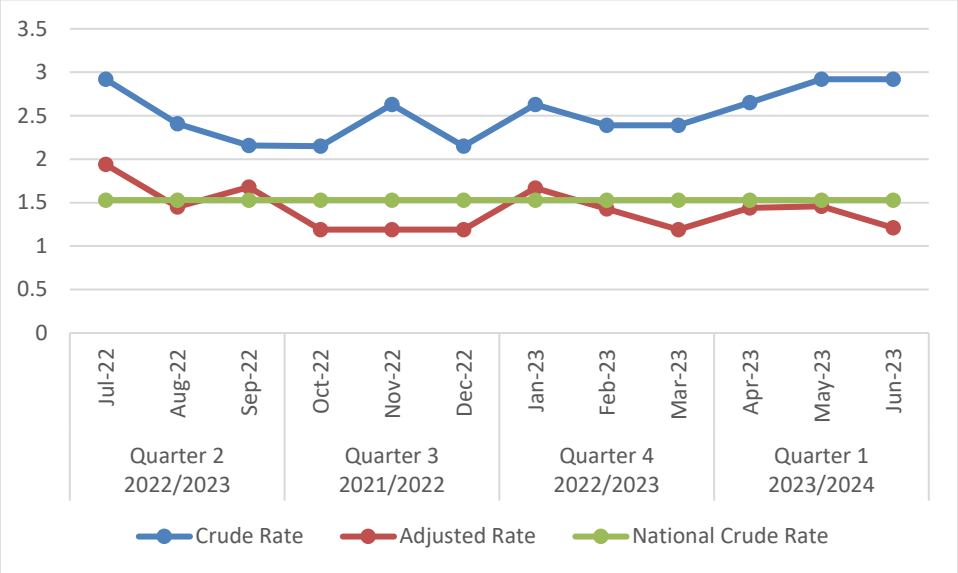


3.4 Combined Neonatal Deaths

In Quarter 1 2023/2024 the combined neonatal death rates are calculated in April (2.65), May (2.92) and June (2.92) is above the national rate of 1.53.

		Crude Rate	Adjusted Rate	National Crude Rate
Quarter 2 2022/2023	Jul-22	2.92	1.94	1.53
	Aug-22	2.41	1.45	1.53
	Sep-22	2.16	1.68	1.53
Quarter 3 2021/2022	Oct-22	2.15	1.19	1.53
	Nov-22	2.63	1.19	1.53
	Dec-22	2.15	1.19	1.53
Quarter 4 2022/2023	Jan-23	2.63	1.67	1.53
	Feb-23	2.39	1.43	1.53
	Mar-23	2.39	1.19	1.53
Quarter 1 2023/2024	Apr-23	2.65	1.44	1.53
	May-23	2.92	1.46	1.53
	Jun-23	2.92	1.21	1.53

When the figures are adjusted the rates are below the national rate in Quarter 1 2023/2024, there is no national comparable data for when rates are adjusted.



4. PERINATAL MORTALITY REVIEW TOOL

The Perinatal Mortality Review Tool (PMRT) is a standardised approach that is utilised by maternity units in England, Wales and Scotland. The tool aims to support a systematic, multidisciplinary, high-quality review of the circumstances and care leading up to and surround each stillbirth and neonatal death, and the deaths of babies who die in the post-neonatal period, having received neonatal care.

The process includes active communication with parents to ensure that they are informed that a review of their care and that of their baby will be carried out and how they can contribute to the process. They will receive a report which includes meaningful, plain language of why their baby died, if possible, and include a grading of care provided.

The following criteria are used by MBRRACE -UK to guide which babies require a perinatal mortality review to be undertaken.

- Terminations of pregnancy - resulting in a pregnancy outcome from 22+0 weeks gestation onwards, plus any terminations of pregnancy from 20+0 weeks which resulted in a live birth ending in neonatal death.
- Stillbirths – the baby is delivered from 24+0 weeks gestation showing no signs of life.
- Early neonatal deaths – death of a live born baby (born at 20 weeks gestation of pregnancy or later or 400g where an accurate estimate of gestation is not available) occurring before 7 completed days after birth.
- Late neonatal deaths – death of a live born baby (born at 20 weeks+0 days gestation of pregnancy or later or 400g where an accurate estimate of gestation is not available) occurring between 7 and 28 completed days after birth

The PMRT has been designed to support the review of the care of the following babies:

- All late fetal losses 22+0 to 23+6
- All antepartum and intrapartum stillbirths
- All neonatal deaths from birth at 22+0 to 28 days after birth

- All post-neonatal deaths where the baby is born alive from 22+0 but dies after 28 following care in a neonatal unit; the baby may be receiving planned palliative care elsewhere (including at home) when they die

During Quarter 1 2022/2023 11 perinatal deaths occurred that met the criteria for a perinatal mortality review. These included five stillbirths, three late fetal losses and three neonatal deaths.

PMRT ID	Overview of Case	Date of Death	Date reported as PMRT	Date review to be completed	Date report to be published	CNST Safety Action 1 - 6 May 2022 and 5 December 2022.	Status of case	Parents perspectives sought
86937	Stillbirth at 27+3 weeks gestation	11.04.2023	12.04.2023	12.08.2023	27.10.2023	No	21.06.2023 PMRT report published	Yes
87114	Late fetal loss at 22 weeks gestation	22.04.2023	27.04.2023	27.08.2023	27.10.2023	No	PMRT Board on 17.07.2023	Yes
87300	Stillbirth at 25+ weeks gestation (known fetal anomalies)	29.04.2023	04.05.2023	02.09.2023	02.11.2023	No	PMRT Board on 17.07.2023	Yes
87303	NND at 23+4 weeks gestation	30.04.2023	04.05.2023	04.09.2023	04.11.2023	No	19.06.2023 Reviewed at PMRT Board. Local learning identified.	Yes
87365	Stillbirth at 30+3 weeks gestation	05.05.2023	11.05.2023	11.09.2023	11.11.2023	No	Reported as a SI. PMRT Board on 21.08.2023	Yes
87366	Late fetal loss at 22+5 weeks gestation	06.05.2023	11.05.2023	11.09.2023	11.11.2023	No	PMRT Board on 17.07.2023	Yes
87404	NND at 29+4 weeks gestation	09.05.2023	11.05.2023	11.09.2023	11.11.2023	No	12.06.2023 Reviewed at PMRT Board and escalated to WMOH. Reported as a SI.	Yes
87498	NND at 23+2 weeks gestation. (Parental decision for palliative care)	12.05.2023	18.05.2023	18.09.2023	18.11.2023	No	PMRT Board on 17.07.2023	Yes
87499	Early fetal loss at 23+2 weeks gestation	13.05.2023	18.05.2023	18.09.2023	18.11.2023	No	PMRT Board September 2023	Yes
87860	Stillbirth at query Term (unbooked)	08.06.2023	16.06.2023	16.10.2023	16.12.2023	Yes	PMRT Board September 2023	Yes
88142	Stillbirth at 40 weeks gestation	26.06.2023	27.06.2023	27.10.2023	27.12.2023	Yes	PMRT Board September	Yes

8.2 PMRT reviews undertaken in Quarter 1 2023/2024

A total of 5 cases were reviewed during Quarter 1 2023/2024.

Four levels of grading of care are offered for each of the following:

For stillbirths the care considered is:

- The care provided to the mother and baby up to the point that the baby was confirmed as having died.
- The care provided to the mother following confirmation of the death of her baby.

For neonatal deaths and later deaths, the care considered is:

- The care provided to the mother and baby up to the point of the birth of the baby
- The care provided to the baby from birth up to the death of the baby.
- The care provided to the mother following the birth of her baby.

Care Grade	Description
Grade A	No improvements in care identifies
Grade B	Improvements in care identified that would not have changed the outcome
Grade C	Improvements in care identified that may have changed the outcome
Grade D	Improvements in care provided would have changed the outcome

The above table details how the cases are graded within the PMRT tool.

PMRT ID	Case detail	Gestation	Grading of care of the mother and baby to the point of the birth of the baby	Grading of care of the baby from birth up to the death of the baby	Grading of care of the mother following the death of her baby	Learning identified at PMRT Board
85643	Neonatal death	39+2	B	B	A	Reported as a Serious Incident. HSIB investigation made no recommendations in relation to this case. The PMRT review identified local learning: 1.Smoking in pregnancy and Reduced Fetal Movements guideline needs to be reviewed to ensure the referral criteria is comparable. 2.Community Midwife to meet with Deputy Matron to reflect on reasoning for plan for low-risk care. 3.To review practice within the LMNS and at regional hospitals in relation to their guidelines on the management of RFM to assess on what timescale between RFM is adopted

PMRT ID	Case detail	Gestation	Grading of care of the mother and baby to the point of the birth of the baby	Grading of care of the baby from birth up to the death of the baby	Grading of care of the mother following the death of her baby	Learning identified at PMRT Board
						before referring for an USS and to review local guideline as required. 4.There is a need to inform staff that the newborn resuscitation record must be completed by the staff member who commenced the resuscitation. 5.There is a need to inform staff that as per NLS algorithm chest compressions are required if heart rate is less than 60 beats/ minute when chest expansion is achieved with inflation breaths. 6.There is a need to inform staff that the newborn resuscitation record must be completed, and scribe notes can be included and scanned into sunrise. 7.There is a need to inform staff that the newborn resuscitation record must be completed, and scribe notes can be included and scanned into sunrise. 8.There is a need to inform staff that in a resus situation where drugs are indicated preference is for central access UVC or if not able to obtain, IO access. 9.There is a need to provide management of thermal control when commencing Cooling in HIE babies, following Neonatal network guidelines and management of Cooling. 10.All obstetric staff to be informed that when reviewing a woman, they must ensure that the

PMRT ID	Case detail	Gestation	Grading of care of the mother and baby to the point of the birth of the baby	Grading of care of the baby from birth up to the death of the baby	Grading of care of the mother following the death of her baby	Learning identified at PMRT Board
						review is documented on the sunrise system. 11.To review the process for a central storage place for CTG's undertaken on the Maternity unit and DAU. 12.There is a need to remind staff that skin assessment should be made and documented on admission of a baby to the NNU. 13.There is a need to inform staff that they must ensure that umbilical lines are secured before moving the baby from delivery theatre to NNU. 14.Neonatal medical and Maternity staff to be informed that the certification of death needs to be completed as close to the point of death as possible.
85842	Neonatal death	41+1	D	B	A	Reported as a Serious incident. Immediate actions identified: 1.Visiting changes from today IOL/labours – partners can attend 24/7. 2.Shift leads to see all IOL as they would labours 3.Midwife not currently working clinically until further investigation of

PMRT ID	Case detail	Gestation	Grading of care of the mother and baby to the point of the birth of the baby	Grading of care of the baby from birth up to the death of the baby	Grading of care of the mother following the death of her baby	Learning identified at PMRT Board
						knowledge and competence established. 4.Team debrief undertaken 5.Band 7 shift lead extraordinary meeting 2/2/23. 6.Round table for all involved to understand events in greater detail. 1:1 support for team involved.
86091	Neonatal Death – known Mosaic Trisomy 8	33+5	A	A	A	1.To look at the feasibility of flagging when a CTG is not to be undertaken on Sunrise 2.To look at implementing an Advanced Care plan Document for palliative care cases.
86937	Stillbirth	27+3	A	N/A	A	No issues identified
87404	Neonatal death	29+2	B	D	C	1.To re-escalate case to the WMOH. Reported as a Serious Incident. 2. Emergency Scribe sheets to be updated to include who is leading the emergency. 3.To inform all staff of the need to identify a lead during resuscitation via the safety huddle and through communication channels. 4.To inform staff to raise any concerns which require immediate action directly to the Service Consultant, Consultant Governance or Clinical Service Lead. 5.SIM training to be undertaken on 16.06.2023. 6.To arrange joint NNU and Maternity SIM training on

PMRT ID	Case detail	Gestation	Grading of care of the mother and baby to the point of the birth of the baby	Grading of care of the baby from birth up to the death of the baby	Grading of care of the mother following the death of her baby	Learning identified at PMRT Board
						delivery suite and in maternity theatre. 7.To ensure that all medical staff are aware of the requirement to clearly document any discussions with the coroner. 8.To inform all the neonatal medical team that there is a need to undertake an examination of baby and document this clearly in the notes. 9.To request that medical staff review the documentation on the ward round to ensure that an examination has been undertaken. 10.Debrief to be undertaken with the scriber after each emergency to ensure that the documentation reflects an accurate record of events.
87303	Neonatal death	23+4	B	B	A	1.To inform all community midwives if they have a women transferred from another trust to review requirement of the need to be referred to HPSS. 2.To review the current scribe sheet for neonatal resuscitation and amend to ensure that it allows clear documentation of all aspects of the resuscitation 3.Staff to be informed that the guideline states that no more than 2 attempts at intubation and then to consider another clinician attempting.

PMRT ID	Case detail	Gestation	Grading of care of the mother and baby to the point of the birth of the baby	Grading of care of the baby from birth up to the death of the baby	Grading of care of the mother following the death of her baby	Learning identified at PMRT Board
						4.To inform community midwives of the need to ensure that when an OOA transfers to a Dudley GP they need to have a discussion re important symptoms and contact numbers. 5.To add field to sunrise in antenatal documentation to state that important symptoms and contact number. 6.To re-circulate the BAPM guidance in relation to management of baby's less than 24 weeks gestation. 7.To re-iterate in training the BAPM guidance in relation to management of baby's less than 24 weeks gestation. 8.Paediatric Registrar to meet with CSL to reflect on appropriate discussion in relation to PM.

2 cases met the criteria for HSIB investigation, and both these cases were reported as Serious incidents. The one case has been graded as a B as the PMRT MDT identified care issues which they considered would have made no difference to the outcome fort the baby. The second case it was identified that the care of the mother and baby up to the point of birth of baby grading D as the PMRT MDT identified care issues which they considered were likely to have made a difference to the outcome for the baby. Immediate actions were put in place at the time of the incident which included providing support to the staff.

There was one case where the grading of care of the baby from birth up to the death of the baby was D. The review was undertaken with 3 external clinicians supporting the review and it was felt that there were care issues which the MDT considered were likely to have made a difference to the outcome of the baby. This case was re-escalated to the WMOH (previously presented at WMOH and request for urgent PMRT review) and a decision was made to report as a serious incident.

The remaining cases detail that there was either no improvements identified or there was local learning. All learning/actions are assigned with the Datix incident reporting system, and these are monitored for completion and assurance through the Maternity and Neonatal governance groups.

There is a delay in completion of post-mortem, and this is a recognised as a national issue and a risk has been identified on the Trusts Risk Register. MBRRACE has agreed for reports to be published prior to receipt of the post-mortem and the cases are reopened to add this detail.

The emerging theme in relation to the PMRT reviews was the identification of a lead to have helicopter oversight in a neonatal resuscitation. This has led to identified learning which include:

- Review of the Emergency scribe sheets to include who is leading the resuscitation.
- Staff made aware that they are required to identify a lead at the start of a neonatal resuscitation.
- Joint SIM training undertaken with Neonates and Maternity. Further dates to be arranged.

It has been fed back at the PMRT Board that at subsequent neonatal resuscitations the team have seen improvement.

9. PMRT – Perinatal Mortality Reviews Summary Report – 01.10.2022 to 31.12.2022

The PMRT – Perinatal Mortality Reviews Summary Report has been generated from the PMRT tool for Quarter 3 2022/2023. The report only shows a summary of issues and action plans for reviews that have been published, hence the need to generate a report from Q3 2022/2023.

A total of 4 cases met the requirement for PMRT review in Q3 2022/2023. There is 1 case that the review remains in progress as a Serious Incident investigation has been undertaken and is currently with the ICB awaiting confirmation of closure.

There was 1 case where it was identified that there were care issues which may have made a difference to the outcome of the baby. This case was escalated to the Trust Weekly Meeting of Harm and reported as a Serious Incident.

In the 3 cases that were published for Q3 2022/2023 the cause of death has been identified and 1 case the post-mortem results are not yet available.

The report details issues raised and learning identified from reviews, these include:

- To ensure that the pathway for women who present with Preterm Rupture of Membranes (PROM) is part of the LMNS the Best start work stream.
- To review the expectations of coroner in relation to the informing of neonatal deaths.
- There is a need to ensure NNU undertake a hot debrief for all cases of neonatal death and poor outcome.
- To communicate to staff the need to ensure that a kleihauer is undertaken post-delivery of stillbirth, for women with positive and negative blood group.
- To review the feasibility of adding a red flag to soarian to alert that an anomaly has been detected on USS and if feasible to create a list on health issues manager to support staff in identification of anomalies to be alerted.
- All women who are OOA bookings must have a face-to-face booking appointment at RHH. To ensure this is reflected in the OOA SOP.
- The current pathway for women who present with Preterm Rupture of Membranes (PROM) does not depict that the baby needs to be born in a level 3 unit.

An emerging theme from this quarter and previous quarters was the need for Out of Area (OOA) women to be booked face to face by Dudley Midwives. The first OOA booking clinic will start on 01.08.2023 in the Antenatal Clinic.

Appendix 1:

PMRT - Perinatal Mortality Reviews Summary Report

This report has been generated following mortality reviews which were carried out using the national Perinatal Mortality Review Tool

The Dudley Group NHS Foundation Trust

Report of perinatal mortality reviews completed for deaths which occurred in the period:

1/10/2022 to 31/12/2022

Summary of perinatal deaths*

Total perinatal* deaths reported to the MBRRACE-UK perinatal mortality surveillance in this period: *5*

Summary of reviews**

Stillbirths and late fetal losses				
Number of stillbirths and late fetal losses reported	Not supported for Review	Reviews in progress	Reviews completed ***	Grading of care: number of stillbirths and late fetal losses with issues with care likely to have made a difference to the outcome for the baby
4	1	1	2	0

Neonatal and post-neonatal deaths				
Number of neonatal and post-neonatal deaths reported	Not supported for Review	Reviews in progress	Reviews completed ***	Grading of care: number of neonatal and post-neonatal deaths with issues with care likely to have made a difference to the outcome for the baby
2	1	0	1	0

*Late fetal losses, stillbirths and neonatal deaths (does not include post-neonatal deaths which are not eligible for MBRRACE-UK surveillance) – these are the total deaths reported and may not be all deaths which occurred in the reporting period if notification to MBRRACE-UK is delayed. Deaths following termination of pregnancy are excluded.

** Post-neonatal deaths can also be reviewed using the PMRT

*** Reviews completed and have report published

Table 1: Summary information for the babies who died in this period and for whom a review of care has been completed – number of babies (N = 3)

Perinatal deaths reviewed	Gestational age at birth						
	Ukn	22-23	24-27	28-31	32-36	37+	Total
Late Fetal Losses (<24 weeks)	0	1	--	--	--	--	1
Stillbirths total (24+ weeks)	0	0	1	0	0	0	1
Antepartum stillbirths	*0*	*1*	*1*	*0*	*0*	*0*	*2*
Intrapartum stillbirths	*0*	*0*	*0*	*0*	*0*	*0*	*0*
Timing of stillbirth unknown	*0*	*0*	*0*	*0*	*0*	*0*	*0*
Early neonatal deaths (1-7 days)*	0	1	0	0	0	0	1
Late neonatal deaths (8-28 days)*	0	0	0	0	0	0	0
Post-neonatal deaths (29 days +)*	0	0	0	0	0	0	0
Total deaths reviewed	0	2	1	0	0	0	3
Small for gestational age at birth:							
IUGR identified prenatally and management was appropriate	0	0	0	0	0	0	0
IUGR identified prenatally but not managed appropriately	0	0	0	0	0	0	0
IUGR not identified prenatally	0	0	0	0	0	0	0
Not Applicable	0	2	1	0	0	0	3
Mother gave birth in a setting appropriate to her and/or her baby's clinical needs:							
Yes	0	2	1	0	0	0	3
No	0	0	0	0	0	0	0
Missing	0	0	0	0	0	0	0
Parental perspective of care sought and considered in the review process:							
Yes	0	2	1	0	0	0	3
No	0	0	0	0	0	0	0
Missing	0	0	0	0	0	0	0
Booked for care in-house	0	1	0	0	0	0	1
Mother transferred before birth	0	0	0	0	0	0	0
Baby transferred after birth	0	0	0	0	0	0	0
Neonatal palliative care planned prenatally	0	0	0	0	0	0	0
Neonatal care re-orientated	0	1	0	0	0	0	1

*Neonatal deaths are defined as the death within the first 28 days of birth of a baby born alive at any gestational age; early neonatal deaths are those where death occurs when the baby is 1-7 days old and late neonatal death are those where the baby dies on days 8-28 after birth. Post-neonatal deaths are those deaths occurring from 28 days up to one year after birth

Table 2: Placental histology and post-mortems conducted for the babies who died in this period and for whom a review of care has been completed – number of babies (N = 3)

Perinatal deaths reviewed	Gestational age at birth						
	Ukn	22-23	24-27	28-31	32-36	37+	Total
Late fetal losses and stillbirths							
Placental histology carried out							
Yes	0	1	1	0	0	0	2
No	0	0	0	0	0	0	0
Hospital post-mortem offered	0	1	1	0	0	0	2
Hospital post-mortem declined	0	1	0	0	0	0	1
Hospital post-mortem carried out:							
Full post-mortem	0	0	1	0	0	0	1
Limited and targeted post-mortem	0	0	0	0	0	0	0
Minimally invasive post-mortem	0	0	0	0	0	0	0
External review	0	0	0	0	0	0	0
Virtual post-mortem using CT/MR	0	0	0	0	0	0	0
Neonatal and post-neonatal deaths:							
Placental histology carried out							
Yes	0	1	0	0	0	0	1
No	0	0	0	0	0	0	0
Death discussed with the coroner/procurator fiscal	0	0	0	0	0	0	0
Coroner/procurator fiscal PM performed	0	0	0	0	0	0	0
Hospital post-mortem offered	0	1	0	0	0	0	1
Hospital post-mortem declined	0	1	0	0	0	0	1
Hospital post-mortem carried out:							
Full post-mortem	0	0	0	0	0	0	0
Limited and targeted post-mortem	0	0	0	0	0	0	0
Minimally invasive PMpost-mortem	0	0	0	0	0	0	0
External review	0	0	0	0	0	0	0
Virtual post-mortem using CT/MR	0	0	0	0	0	0	0
All deaths:							
Post-mortem performed by paediatric/perinatal pathologist*							
Yes	0	0	1	0	0	0	1
No	0	0	0	0	0	0	0
Placental histology carried out by paediatric/perinatal pathologist*:							
Yes	0	1	1	0	0	0	2
No	0	0	0	0	0	0	0

*Includes coronial/procurator fiscal post-mortems

Table 3: Number of participants involved in the reviews of late fetal losses and stillbirths without resuscitation

Role	Total Review sessions	Reviews with at least one
Chair	0	0%
Vice Chair	0	0%
Admin/Clerical	0	0%
Bereavement Team	2	100% (2)
Community Midwife	0	0%
External	0	0%
Management Team	10	100% (2)
Midwife	17	100% (2)
Neonatal Nurse	5	100% (2)
Neonatologist	4	100% (2)
Obstetrician	6	100% (2)
Other	0	0%
Risk Manager or Governance Team	0	0%
Safety Champion	0	0%

Table 4: Number of participants involved in the reviews of stillbirths with resuscitation and neonatal deaths

Role	Total Review sessions	Reviews with at least one
Chair	0	0%
Vice Chair	0	0%
Admin/Clerical	0	0%
Bereavement Team	1	100% (1)
Community Midwife	0	0%
External	0	0%
Management Team	3	100% (1)
Midwife	10	100% (1)
Neonatal Nurse	4	100% (1)
Neonatologist	2	100% (1)
Obstetrician	2	100% (1)
Other	2	100% (1)
Risk Manager or Governance Team	0	0%
Safety Champion	0	0%

Table 5: Grading of care relating to the babies who died in this period and for whom a review of care has been completed – number of babies (N = 3)

Perinatal deaths reviewed	Gestational age at birth						
	Ukn	22-23	24-27	28-31	32-36	37+	Total
STILLBIRTHS & LATE FETAL LOSSES							
Grading of care of the mother and baby up to the point that the baby was confirmed as having died:							
A - The review group concluded that there were no issues with care identified up the point that the baby was confirmed as having died	0	1	1	0	0	0	2
B - The review group identified care issues which they considered would have made no difference to the outcome for the baby	0	0	0	0	0	0	0
C - The review group identified care issues which they considered may have made a difference to the outcome for the baby	0	0	0	0	0	0	0
D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the baby	0	0	0	0	0	0	0
Not graded	0	0	0	0	0	0	0
Grading of care of the mother following confirmation of the death of her baby:							
A - The review group concluded that there were no issues with care identified for the mother following confirmation of the death of her baby	0	1	1	0	0	0	2
B - The review group identified care issues which they considered would have made no difference to the outcome for the mother	0	0	0	0	0	0	0
C - The review group identified care issues which they considered may have made a difference to the outcome for the mother	0	0	0	0	0	0	0
D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the mother	0	0	0	0	0	0	0
Not graded	0	0	0	0	0	0	0

NEONATAL AND POST-NEONATAL DEATHS							
Grading of care of the mother and baby up to the point of birth of the baby:							
A - The review group concluded that there were no issues with care identified up the point that the baby was born	0	0	0	0	0	0	0
B - The review group identified care issues which they considered would have made no difference to the outcome for the baby	0	0	0	0	0	0	0
C - The review group identified care issues which they considered may have made a difference to the outcome for the baby	0	1	0	0	0	0	1
D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the baby	0	0	0	0	0	0	0
Not graded	0	0	0	0	0	0	0
Grading of care of the baby from birth up to the death of the baby:							
A - The review group concluded that there were no issues with care identified from birth up the point that the baby died	0	1	0	0	0	0	1
B - The review group identified care issues which they considered would have made no difference to the outcome for the baby	0	0	0	0	0	0	0
C - The review group identified care issues which they considered may have made a difference to the outcome for the baby	0	0	0	0	0	0	0
D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the baby	0	0	0	0	0	0	0
Not graded	0	0	0	0	0	0	0

Grading of care of the mother following the death of her baby:							
A - The review group concluded that there were no issues with care identified for the mother following the death of her baby	0	1	0	0	0	0	1
B - The review group identified care issues which they considered would have made no difference to the outcome for the mother	0	0	0	0	0	0	0
C - The review group identified care issues which they considered may have made a difference to the outcome for the mother	0	0	0	0	0	0	0
D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the mother	0	0	0	0	0	0	0
Not graded	0	0	0	0	0	0	0

Table 6: Cause of death of the babies who died in this period and for whom a review of care has been completed – number of babies (N = 3)

Timing of death	Cause of death
Late fetal losses	**1 causes of death out of 1 reviews**
	Cause of death unknown, but underlying multiple congenital anomalies and possible restricted growth may have contributed to fetal demise
Stillbirths	**1 causes of death out of 1 reviews**
	Awaiting post mortem results
Neonatal deaths	**1 causes of death out of 1 reviews**
	Extreme Prematurity Maternal Sepsis Prolonged Rupture of Membranes longer than 24 hours
Post-neonatal deaths	**0 causes of death out of 0 reviews**

Table 7:Issues raised by the reviews identified as relevant to the deaths reviewed, by the number of deaths affected by each issue* and the actions planned

Issues raised which were identified as relevant to the deaths	Number of deaths	Actions planned
The current pathway for women who present with Preterm Rupture of Membranes (PROM) does not depict that the baby needs to be born in a level 3 unit.	1	To ensure that the pathway for women who present with Preterm Rupture of Membranes (PROM) is part of the LMNS the Best start work stream.

*Note - depending upon the circumstances in individual cases the same issue can be raised as relevant to the deaths reviewed and also not relevant to the deaths reviewed.

Table 8: Issues raised by the reviews which are of concern but not directly relevant to the deaths reviewed, by the number of deaths in which this issue was identified* and the actions planned

Issues raised which were identified as not relevant to the deaths	Number of deaths	Actions planned
This mother booked late. Are there any organisations to consider in relation to her booking late?	2	No action entered
		No action entered
This mother booked late. Did this affect her care?	2	No action entered
		No action entered
Although indicated this mother was not offered a Kleihauer test	1	No action entered
During the resuscitation of the baby surfactant was indicated but was not given	1	No action entered
It is best practice to discuss neonatal deaths with the coroners	1	To review the expectations of coroner in relation to the informing of neonatal deaths
It is not possible to assess from the notes whether following the resuscitation of the baby a rapid safety focused resus de-brief with the staff involved was carried out	1	There is a need to ensure NNU undertake a hot debrief for all cases of neonatal death and poor outcome.
It was not possible to ask this mother about was not asked about domestic abuse at booking as she was seen remotely and was not alone	1	No action entered
Keilhauer not taken following delivery as per guidelines	1	To communicate to staff the need to ensure that a keilhauer is undertaken post delivery of stillbirth, for women with positive and negative blood group
There is no alert on the IT system to alert staff that there is an anomaly on a woman's USS	1	To review the feasibility of adding a red flag to soarian to alert that an anomaly has been detected on USS and if feasible to create a list on health issues manager to support staff in identification of anomalies to be alerted.
There needs to be a face to face booking appointments for Out of Area women	1	All women who are OOA bookings must have a face to face booking appointment at RHH. To ensure this is reflected in the OOA SOP.

*Note - depending upon the circumstances in individual cases the same issue can be raised as relevant to the deaths reviewed and also not relevant to the deaths reviewed.

Table 9: Top 5 contributory factors related to issues identified as relevant to the deaths reviewed, by the frequency of the contributory factor and the issues to which the contributory factors related

Issue Factor	Number of deaths	Issues raised for which these were the contributory factors
Task Factors - Decision making aids	1	The current pathway for women who present with Preterm Rupture of Membranes (PROM) does not depict that the baby needs to be born in a level 3 unit.

NHS
The Dudley Group
NHS Foundation Trust

The Dudley People Plan

Shaping #OurFuture

Foreword

We are pleased to introduce the Dudley People Plan which sets our overall direction for how we recruit and support our staff in delivering the Trust strategy shaping #OurFuture and meets our goal of being a brilliant place to work and thrive.

Our plan describes our ambition to support the people who choose to collaborate with us. It recognises that our staff are our most important asset, who through dedication and commitment provide excellent care for our patients.

Our People Plan helps our staff to understand what is on offer for them and creates a clear picture of where we are and where we want to be in three years' time.

Our goals through this plan are for us to provide a place where we look after our staff, be clear on how we support and develop them whilst they collaborate with us and create a workplace culture where we treat each other with respect, ensuring equal opportunities and celebrating diversity.

Our values are core to supporting our staff and we embed these within all elements of our people journeys – through positive engagement, strong collective leadership and accountability and an inclusive culture that encourages and enables colleagues to be their best every day.

Diane Wake
Chief Executive

Alan Duffell
Chief People Officer

A brilliant place to work and thrive

Shaping #OurFuture

attract recruit welcome develop & support

Contents

Introduction

The Trust published its strategy - Shaping #OurFuture in 2021, developed through engagement with our staff, patients, and partner organisations. With a clear vision, a set of strategic priorities and values, it places people at the heart of what we do as they are central to the success of the organisation. The successful delivery of the Trust's vision "**Excellent health care, improved health for all**" requires a motivated and skilled workforce.

Our key people goal is "**To be a brilliant place to work and thrive**", The Dudley People Plan recognises the achievements made so far, including significant achievements across Equality, Diversity and Inclusion, Wellbeing and our performance against our strategic measures of success - to reduce the vacancy rate, which is now at 7% (2023) and to improve the staff survey results. We know from our National NHS staff survey, satisfaction scores that despite high operational pressures combined with staffing challenges we are improving the experience at our Trust, being particularly proud that our staff are telling us that 'we work flexibly' and 'we are a team.'

We know there is more to do and the Dudley People Plan describes our ambition to support the people who collaborate with us, recognising the contribution made by every person and the important role they play, each and every day, in delivering safe, effective, high quality patient care, whilst role modelling our values. The Dudley People Plan recognises the value of our staff and the link that exists between a valued, engaged, happy workforce and the quality and effectiveness of the care they are able to provide.

This Plan should be read in conjunction with the organisational strategy **Shaping #OurFuture** and the five key people journeys as they reflect what matters to our staff in its delivery. It is recognised that not all staff provide direct patient care but that we all have a key role in the patient journey. All staff should feel supported and valued in their development to ensure they are able to progress as far as possible in their careers.

The plan covers a three-year period from 2023-2026 and summarises what our people can expect embedded in our five People Journeys:

- **Equality, inclusion and diversity**
- **Organisational development**
- **Wellbeing**
- **Recruitment and retention**
- **Continuous improvement**

To develop our journeys, we have used the employee lifecycle to illustrate and plan for each stage of our employees' interactions with our Trust; providing us with the insight necessary to develop our journeys by providing a framework for employee engagement and development allowing us to maximise the value of our workforce, their talent, and their contribution.

> **"We all have a key role in the patient journey."**

Introduction

A positive employee experience is at the heart of our plan, and the employee lifecycle is pivotal in the development of our journeys. It provides a model for managing every interaction between the employee and employer through a timeline of employment and brings many advantages, including:

- **Engages with staff at each level:**
  Adopting the employment lifecycle model and working towards improving each stage of employee experience helps deepen staff engagement. This, in turn, helps increase productivity with a happier and more engaged workforce.
- **Optimises employee experience:**
  The model also helps in maximising employee experience, which helps in the building of happier and stronger teams with better cohesion.
- **Lowers turnover and increases retention rates:**
  Employees find themselves more appreciated and tend to remain with the organisation for longer periods. This helps make savings on hiring costs in the longer term.

To support the development and implementation of the Dudley People Plan, it is essential to understand and use strategic enablers, these are capabilities, capacities, and resources that contribute to the effective delivery of the plan. The success of the Dudley People Plan is supported by the following strategic enablers:

- **Digital**
  Using digital tools to support us to deliver our goals and to innovate.
- **Communication**
  Communicate well by listening and learning from our staff to inform what we do.
- **Engagement**
  Engage with our staff to ensure they participate in our work to deliver our plans.
- **Culture**
  Develop a culture that supports our goals through values and beliefs that guide activity through a shared vision.

We have a strong ambition to create a place where people choose to work and, whilst they are with us, they experience Dudley to be a brilliant place to work and thrive.

Our goals for each aspect of the employee experience are outlined in five individual People Journeys, with some of the work crossing over into more than one journey. These outline our main priorities in how we recruit, support, and develop staff, embed the elements of inclusive, compassionate leadership in our culture and meet the strategic goal "**to be a brilliant place to work and thrive.**"

"We have a strong ambition to create a place where people choose to work."

About our Trust

The Dudley Group NHS Foundation Trust (DGFT) provides acute and community services to the population of Dudley and to other parts of the Black Country, West Birmingham, South Staffordshire, and North Worcestershire.

Our staff are our greatest asset. We have a workforce of around 6,600 whole time equivalent (WTE) staff making us the second largest employer in Dudley.

We offer services from three main hospital sites and through our community-based teams who work around the whole of Dudley delivering care to around 450,000 local people.

Our People

- **Age** – we have people from all age groups working for us – from under 20 years to over 70 years old. This means that we have four generations in our working population bringing different perspectives, needs and expectations.
- **Disability** – in our last Staff Survey (2022), 23% of our staff have declared that they have a disability. This increases our responsibility to ensure we offer reasonable adjustments and for these staff to remain well whilst at work.
- **Gender** – 81% of our staff are female.
- **Ethnicity** – Black and Minority ethic staff make up 21% of our workforce. Although they are not equally represented in our leadership roles.
- **Local Community** – we employ 65% of our staff from our local community.

Our Challenges

Analysis by the King's Fund, the Health Foundation, and the Nuffield Trust (2018) [1] suggests the health service could be short of up to 350,000 staff if it continues with current practices. We continue to face challenges in attracting, recruiting, and retaining staff – partly as a result of local competition and national shortages of clinical staff, however we have reduced our vacancy rates in 2022 - due primarily to international nurse recruitment.

Those who leave us soon after starting (within the first year or two years) tend to leave due to work life balance. Those who stay with us longer tend to leave due to retirement.

We know that we need to increase diversity in leadership roles. We also need to ensure development is available for all to support growth.

The current working environment is challenging for our staff, and this means they are not always well at work. Good work has been done, but there remains more to do.

To deliver these challenges we need to continue to work effectively and collaboratively with local and national partners. We need to redesign and shape the workforce, develop new and existing roles to meet workforce constraints and current and future service needs, whilst supporting staff with the knowledge, skills, and confidence to operate in a dynamic environment. We need to work across the Black Country Integrated Care System to redefine how we plan, recruit, and retain people across all services.

> **"We have four generations in our working population bringing different perspectives, needs and expectations."**

National context

People's expectations of work are changing. What people value in a job is changing. They also want to be able to balance their work more easily with other areas of their lives. These factors may become as important to individuals as levels of pay, reward and potential for career progression.

Demographics within the workforce are changing. Working lives are becoming longer as the UK population ages. As the UK state pension age rises, more older people will be in employment. By 2030, the number of economically active people aged 65 and over is expected to increase by one third.

There is more competition for the workforce, as the UK faces a labour shortage, linked to the ageing population, which results in more people leaving the jobs market than entering it. Alongside this, demand for health and care services is growing, also due to the ageing population, so a larger workforce will be needed.

The work supporting our people is influenced by a number of external drivers that have set a clear direction for how we create brilliant people services, these are summarised below and visualised in appendix 1.

- **NHS Long-Term Plan**
  Published in 2019 it recognised concern about funding, staffing, increasing inequalities and pressures from a growing and ageing population. Recognising we must tackle head-on the pressures our staff face, while making our extra funding go as far as possible. And as we do so, we must accelerate the redesign of patient care to future-proof the NHS for the decade ahead.
- **NHS People Plan**
  Published in 2021 it outlined a clear direction in delivering better support to our NHS staff to ensure the NHS is a modern, supportive, and inclusive employer. The focus is on 4 themes: Looking after our people, belonging in the NHS, Growing for the future and new ways of working.
- **NHS People Promises**
  Which embeds the detailed 'what we must do' to provide a supportive work environment for our staff. 7 People Promises to set clear expectations on how we support our staff.
- **NHS Future of HR and OD**
  This review of how people function provide the support needed to enable the delivery of the People Plan and People Promises sets clear expectations of how we should deliver our support services to our staff. It includes how we remain forward thinking, professional and embed the values and behaviours within the People Plan in how we deliver our people services.
- **The Health and Social Care Review: Leadership for a collaborative and inclusive culture (Messenger Review)**
  Completed in June 2022, provides a renewed commitment to leadership development within health and social care with a focus on seven key deliverables. These are included throughout our journeys and are focused on leadership behaviours, action on equality diversity and inclusion, consistency in management, high quality appraisals, career development and supporting potential.
- **NHS Impact**
  A new NHS Improvement approach which creates a single vision and a shared approach to improvement.

> **"By 2030, the number of economically active people aged 65 and over is expected to increase by one third."**

Local context

Healthier Futures
Black Country Integrated Care System

Integrated Care System (ICS)

The Black Country has 1.26 million residents and is made up of four distinct places: Dudley, Sandwell, Walsall, and Wolverhampton. The Black Country is a hugely diverse system and there is no "one size fits all" approach to working with local people or partners. The Black Country Integrated Care System (ICS) is made up of several partners including the Integrated Care Board (ICB), Provider Collaborative and Black Country Places.

Our People Strategy, aligned to the People Plan and People Promise articulates our actions and aims to achieving our strategic priority of making the Black Country the best place to work.

Working under two key themes – 'Workforce Optimisation' and 'Inclusive Culture' – workforce leaders from across the system are driving improvements to deliver the principles of 'one workforce'; enabling a culture of belonging where all colleagues in the Black Country can thrive and continue to deliver high quality patient care.

Black Country Provider Collaborative

The implementation of Integrated Care Systems in 2022 and ongoing development of the Black Country Provider Collaborative means that we are looking to operate as 'one hospital' across multiple sites if we are to be successful in achieving the vision of **'One healthcare system, across multiple sites, working in partnership to provide better, faster and safer care to the population of the Black Country and beyond**.' We need our staff to develop the skills to be able to work differently. In addition, there are further opportunities in how we collaborate with other non-NHS Partners such as schools, universities, and local authorities to meet the requirements of the NHS workforce plan and the national goals within the People Plan and Promises.

Collaborative working between providers/within the Integrated Care System and place-based partnerships means the movement of our staff across organisations should be easier and less organisation focused. Over time, we may develop ways to deliver this together.

Dudley Health and Care Partnership

The direction set out in the White Paper (Health and social care integration: joining up care for people, places and populations) [2] and the NHS Long-Term Plan requires all parts of the NHS to work towards better integration of services: integrating primary, community, secondary health care, physical and mental health, and social care. Within the Black Country there are four 'places' where models of integration are being developed. Within Dudley there is the Dudley Health and Care Partnership, of which we are a member, whose mission is '**community where possible; hospital when necessary**.' One of the areas of focus that we want to collaborate on with our partners chis to identify new ways of growing and nurturing our own staff. Staffing shortages in other partners has a direct impact on our services and staff so it is an issue we can collectively work on to resolve. There will be increased opportunities to share resources, good practice and implement more joint initiatives across the partnership.

Five People Journeys

Employee life cycle model

We have developed 5 People Journeys to outline our ambitions for each element of our people functions and these are all modelled around the employee lifecycle. There are cross-cutting themes and actions across those journeys where our teams work together to deliver activities and meet our goals. All of the journeys embed our commitment to a workplace culture that demonstrates the People Promises with a dedicated focus on being inclusive, compassionate and where staff feel they belong.

Each journey outlines the key ambitions, steps to achieve goals and the measures of success along the 3-year journey. Delivering these will ensure that we have a culture which supports the organisation to achieve its strategic priorities; have outstanding leaders at every level; ensure a motivated and engaged workforce delivering better patient outcomes; have integrated workforce plans and models across the health and care system which are fit for the future.

Within each journey are a number of priorities including Workforce Transformation, Recruitment and Retention, Health and Wellbeing, Equality, Diversity and Inclusion, Education, Training and Innovation, Engagement and Involvement and Management and Leadership development. All objectives will have a focus of compassionate, collective leadership running throughout.

Designing and developing an employee experience that leads to retention, success, and great employee engagement is a key focus of the Dudley People Plan and rather than looking at staff engagement as a one-time endeavour, it needs to be fully embedded to develop a positive organisational culture. The employee life cycle model frames engagement as a designed experience embedded into the trajectory of every employee within our Trust.

The employee life cycle model helps to describe and plan for each stage of our employee's interactions with our Trust, providing us with the insight necessary to develop our journeys by providing a framework for staff engagement and development, allowing us to maximise the value of workforce, their talent, and their contribution.

> "All objectives will have a focus of compassionate collective leadership running throughout."

Five People Journeys

Organisational Culture

It is recognised that developing and sustaining a compassionate and supportive organisational culture is not something than can be delivered across a whole organisation in a short timeframe. Changing and embedding positive behaviours is a long-term commitment that begins with a shared vision, provided by the Dudley People Plan and actions that will influence the development of an organisational culture that delivers the People Promises are set out across our five journeys.

There is a clear vision of developing a compassionate organisational culture, in which we develop a diverse and inclusive workforce who are fully engaged and committed to '**Excellent health care, improved health for all**.'

We fully recognise that in transforming our culture there are key programmes of work (through our journeys) that will need to be delivered, these include a revision of the behavioural framework to fully embed our values, leadership, and development programmes for our staff. To be successful we will develop a culture of psychological safety, just culture and civility.

Journey — Equality, Diversity and Inclusion

The Equality, Diversity & Inclusion Journey identifies six core workforce priorities with key actions anchored in the employee life cycle, whilst reflecting on national and regional workforce equality and inclusion strategies and priorities, including The Race Equality Code.

The EDI Journey is aligned to compliance requirements under the Public Sector Equality Duty (PSED) under the Equality Act 2010, taking into account national compliance drivers.

The Equality, Diversity & Inclusion Journey demonstrates our intention to build on and uphold our pledge to become a more inclusive Trust and provides a framework to support the delivery of this vision. Our journey sets out our aims over the next 3 years to support the organisation in becoming a brilliant place to work and thrive for all. The Equality Delivery System Assessment tools will support the Trust over the coming years to have active conversations with our workforce, patients, and key stakeholders to improve staff experience.

Our aim is to be a more inclusive organisation, where people matter most and Equality, Diversity and Inclusion is a '**golden thread**' evidenced throughout our work. These overall objectives over the next three years will help reduce vacancy rates, increase diverse recruitment to create a representative workforce and improve the experience of staff from across diverse communities. We will report progress against these objectives in the Trust's annual report and use this opportunity to review our targets each year.

> "To be successful we will develop a culture of psychological safety, just culture and civility."

Five People Journeys

Journey — Organisational Development

Our Organisational Development Journey describes our ambition to support those who choose to work with us. It helps our staff to understand what is on offer for them and creates a clear picture of where we are and where we want to be in three years' time.

It is integral to our organisational Shaping **#OurFuture** Strategy, six core workforce priorities with key actions anchored in the employee life cycle. We reflect on national and regional leadership strategies and priorities, including Our Leadership Way and NHS People Promise.

Our Leadership Way sets out the compassionate and inclusive behaviours we want all our leaders at every level to show towards us as individuals and colleagues.

The Health and Social Care (Messenger) review, completed in June 2022, provides a renewed commitment to leadership development within health and social care with a focus on seven key deliverables. These are included throughout our journey.

Leading across and within our place and through our Integrated Care System is a core duty and our work on leading and learning is connected to our local ICB People Board and priorities.

We have connected the dots between our own internal plans including Dudley Improvement Practice, Equality, Diversity and Inclusion, Health and Wellbeing, Recruitment and Retention, Career Development Guidelines, and the Dudley Behaviour Framework.

Our Leadership Journey will support our people to be the best leaders in their role and therefore contribute to all 5 strategic goals to shaping **#OurFuture**, our particular emphasis is on how we ensure that Dudley is the best place to work and thrive. Our leadership offer is a significant driver of that objective.

Journey — Wellbeing

Our Trust vision statement is Excellent healthcare, improved health for all and the Wellbeing Journey complements that vision to better support and influence the wellbeing of our workforce. The Wellbeing Journey provides a framework to support delivery of this vision, to include establishing a comprehensive and diverse health and wellbeing journey for all our staff which sits at the heart of the Trust's strategic goal of being a brilliant place to work and thrive. The emphasis on supporting our staff to stay safe and well has never been more important, given the significant pressures faced throughout the pandemic.

The Wellbeing Journey addresses key priority areas aligned to the NHS Health and Wellbeing framework, with tangible actions identified within each area. The journey also considers feedback from workforce engagement sessions, key stakeholders within the organisation, completion of the NHS health and wellbeing diagnostic tool, regional and national health, and wellbeing priorities for workforce wellbeing in the NHS, and consideration of the wider workplace wellbeing lens. We also consider local population health data to inform the journey, through a health inequality lens.

We want our workforce to feel assured that their wellbeing is taken seriously, and we are aiming for excellence in this area, no matter what their position is within the Trust. We acknowledge that there is no one size fits all approach to workforce wellbeing and a holistic view has been taken in developing this journey, to sit across the whole organisation. We recognise the importance of the wellbeing of our workforce and how it contributes to a variety of factors to include a better organisational culture, healthier and more engaged employees, higher performance, and productivity, leading to better patient care and better relationships and experience across the whole Trust.

Five People Journeys

Journey — Recruitment & Retention

For the first time ever, we have four generations in the working population with differing expectations and personal values around what they expect from employment and their employer and our local population is growing increasingly diverse, where a 'one size fits all approach to recruitment, selection and retention will no longer be enough. We can no longer afford to have a complacent approach to recruiting and retaining our staff, as our people will select the Trust in the future rather than the other way around. There are more opportunities than ever before to move around to different Trusts given the labour market supply and demand pressures and increasingly, we will see a trend of staff moving across the system or their work being realigned towards 'place' rather than within an organisational boundary.

Whilst this presents challenges in recruiting and retaining our people; it is also a unique opportunity for The Dudley Group NHS Foundation Trust to begin its journey to approaching recruitment and retention differently. A standardised approach to recruitment and retention that favours convenience, with processes designed around software and systems is not enough for our people (both prospective and current). This recruitment and retention journey starts us along the road to changing the way we do things and to being more people centred in our approach and to become more progressive, modern, flexible, and adaptable and tailor our approaches to the diverse needs of our people.

> "... being more people centred in our approach and to become more progressive, modern, flexible and adaptable..."

Journey — Continuous Improvement

As with all five, the Continuous Improvement Journey is integrated and woven through all our People Plan Journeys. The Dudley Improvement Practice approach is a method which can support the application and delivery of the values, behaviours, culture, and leadership aspirations stated throughout this document. It is accessible to every employee through their everyday work, and it leverages all three enablers: digital, communication and engagement.

The vision and purpose of the Dudley Improvement Practice is to develop 'a culture of continuous improvement, delivering safe, high-quality, compassionate care.'

The DIP method consists of a range of training, events, facilitated workshops and improvement capability development plans which together support individuals, teams and services by providing a structured approach to their improvement journeys. This is underpinned by joint-working with Organisational Development to develop changes in leadership behaviours that promote an improvement culture and by a management system that links improvement activities to the Trust's strategic goals.

DIP believes in three essential elements of continuous improvement.

- **Engagement** - the power of collaboration is maximised by engaging the people who do the work every day and therefore have the most insight about how to improve it.
- **Equality** - harnessing the great diversity in our staff by treating everyone as thinking equals drives innovation and creativity.
- **Empowerment** - developing a coaching style of leadership to make our staff feel valued and psychologically safe to propose new ways of working, to contribute and to learn together.

To measure progress towards our vision, we use a subset of nine questions from the national NHS Staff Survey which together are indicative of a culture of continuous improvement. These questions encompass staff engagement, empowerment, inclusion, psychological safety, team effectiveness, leadership, wellbeing, and staff development. Primarily used as measures for improvement, we can also identify teams and departments that can be learnt from and others that may need focused support.

Aligned with the NHS England 'National Improvement Approach' which will be released later in 2023, the Dudley Improvement Practice approach will also play a key role in facilitating the collaboration between organisations across the Black Country towards common, patient-centred goals.

> "The vision and purpose of The Dudley improvement Practice is to develop a culture of continuous improvement."

Strategic enablers

To support the development and implementation of the Dudley People Plan, it is essential to understand and use strategic enablers, these are capabilities, capacities, and resources that contribute to the effective delivery of the plan, the success of the Dudley People Plan is supported by the following strategic enablers:

Digital

We recognise the need to use digital tools to support how we deliver our plans, this means that we will make use of existing digital tools and when developing new work, will ensure that digital is a part of our design and implementation to ensure continuous improvement and innovation.

Communication

We recognise communicating well is central to the successful delivery of our People Plan. It is critical that we listen and learn from our staff to inform what we do. This means that we have clear plans on how we share information with our staff and ask for their views, including using routine engagement tools like the Staff Survey and People Pulse to inform what we do.

Engagement

Engagement is key to designing, implementing, and delivering our plans. It is essential that we involve our staff in our work to deliver our plans, create opportunities for staff to provide feedback and to use that feedback to inform the services we develop and deliver.

> “It is critical that we listen and learn from our staff to inform what we do.”

Implementing The Dudley People Plan

Organisational culture

The owner and lead responsible for delivering the 'Dudley People Plan' is the Chief People Officer, supported by the Director of Operational HR who will ensure it is implemented across the organisation. The delivery of our People Plan will be overseen by the Trust's Workforce and Staff Engagement Committee, and assurance will be given to the Board via committee updates alongside an annual Board progress update.

To implement the Dudley People Plan we will have five clear People Journeys, each journey has clear yearly deliverables and will have a senior lead responsible for its delivery. Each journey describes a number of areas and measures that will enable success to be captured. We have selected 2 key breakthrough measures for each Journey.

People Journeys				
Equality, diversity & inclusions	**Organisational Development**	**Wellbeing**	**Recruit & Retain**	**ContinuousImprovement**
We will create an inclusive organisation that ensures equal opportunity and celebrates diversity.	We offer support and growth for you to develop your potential. There are opportunities for everyone.	We support staff to be safe and healthy and have access to professional support when needed.	Dudley is the place people want to work. We make it easy to work at Dudley.	We engage, empower and enable everyone to continuously improve their work.
Measures of success				
1. Sustain and expand membership of individual diversity networks. **2.** Improve reported position on WRES and WDES metrics around progression, development and leadership representation.	**1.** 100% of managers have completed Managers Essentials **2.** 90% compliance for Annual Reviews to be achieved from 2023 onwards, with quality audits demonstrating reviews meet standards.	**1.** Wellbeing Staff Survey scores improve annually with the goal of achieving the top quartile by 2025. **2.** Fully embed Wellbeing champions with a goal of one active champion for each team/service.	**1.** Vacancy rate below 7% **2.** Turnover Rate below 8%.	**1.** The proportion of employees engaged in improvement activity is above 50%. **2.** DGFT's culture of continuous improvement as measured by a subset of staff survey questions is in the top quartie of Acute and Community Trusts.

Enablers		
Digital	**Communication**	**Engagement**
We use digital tools to deliver our plans	We listen and learn from our people to inform what we do	We involve people in our work

Implementing The Dudley People Plan

Every member of staff should come to work with a clear understanding of what is expected of them, receive feedback on how well they are doing against those expectations and feel supported to be able to successfully achieve them. Living our values in every aspect of our roles, especially when short of time, under pressure or busy, is vitally important to ensuring safe, high quality effective care for our patients.

The Workforce and Staff Engagement sub-committee (WSEC) of the Trust Board will maintain governance oversight and scrutiny to its delivery of the Dudley People Plan and its associated Journeys by:

- **Reviewing the delivery of the People Plan twice a year.**
- **Reviewing progress against the EDI and Wellbeing Journeys. These journeys will be reported through to WSEC via the EDI and Wellbeing Steering Groups on a bi-monthly basis.**
- **Monitor progress against the Continuous Improvement, Leadership and Learning and Retention Journeys on a quarterly basis.**

In addition, an annual review for Board will be undertaken for the People Plan and respective journeys, ensuring that the work is connected to identify and manage risks.

Divisional and Corporate leadership teams will contribute to the success of this plan through local delivery plans and implementation of the associated key work streams.

We measure performance in delivery of the People Plan through our embedded Key Performance Indicators and insight metrics such as the Staff Survey, Workforce Race Equality Standards (WRES) and Workforce Disability Equality Standards (WDES) and recruitment measures, including:

- **Absence**
- **Turnover**
- **Vacancies**
- **Staff Survey**
- **Time to Hire**
- **Mandatory Training**
- **Employee Relations Casework**

This will feed through into the overall Trust Strategy quarterly update to Trust Board.

Conclusion

We know that our services face significant challenges and opportunities in the coming years over the life of this plan, whether these are from how we provide services, the cost of services or who provides them. Achieving our stated goal **"to be a brilliant place to work and thrive"** will not be easy or straightforward. However, the Dudley People Plan will help make working for The Dudley Group NHS Foundation Trust a positive experience for everyone, at every level of the organisation.

Our plan aims to deliver our goal by identifying the key areas of focus and action in areas we know will help us to make a positive difference and achieve our wider Trust vision, aims, and objectives.

We appreciate that the plan will need to remain dynamically under review and will be subject to changes over the coming years. To this end we will review the strategy annually alongside the five people journeys. We also very much appreciate that new issues, new opportunities, and new technologies will arise over the life cycle of the plan. In responding to these our intentionis to ensure we continue to engage and involve our colleagues and our partners in producing fresh ideas and solutions.

Appendix 1 - Summary of NHS People Goals

References

[1] The health care workforce in England: make or break? (kingsfund.org.uk)

[2] Health and social care integration: joining up care for people, places and populations - GOV.UK (www.gov.uk)

Excellent health care, improved health for all

Supported by our values of Care, Respect and Responsibility

Workforce KPI Report

Alan Duffell

Chief People Officer

The Dudley Group
NHS Foundation Trust

CARE

RESPECT

RESPONSIBILITY

Summary

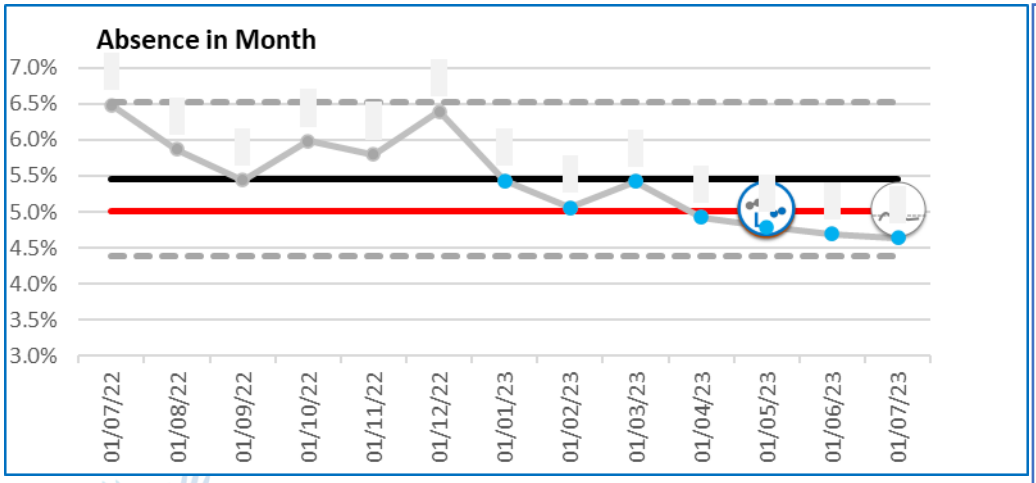
The Dudley Group NHS Foundation Trust

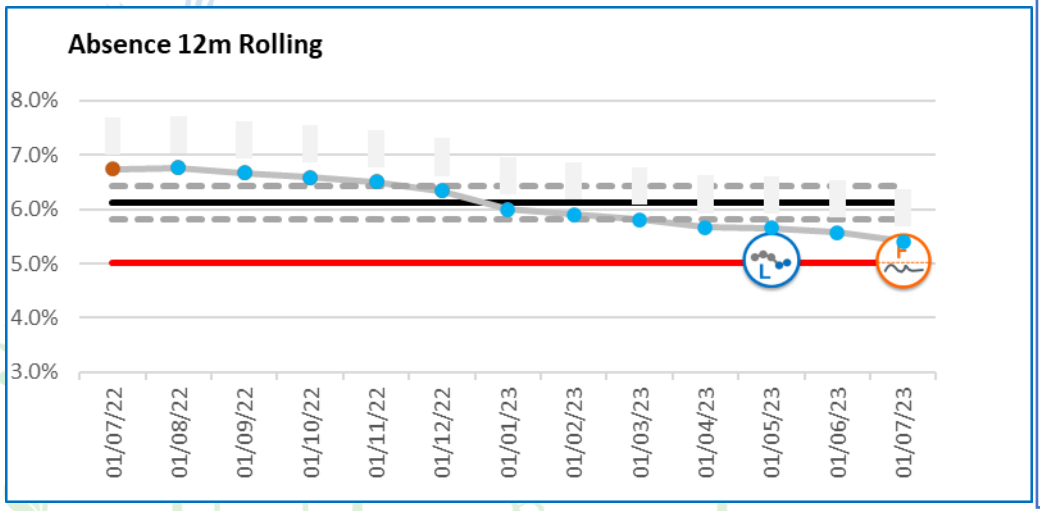
Metric	Rate	Target	Trend	
Absence – In Month	4.64%	<=5%	↓	**Sickness Absence** • In month sickness absence for July is 4.64% a small reduction from June at 4.69%.
Absence - 12m Rolling	5.41%	<=5%	↓	• The rolling 12-month absence shows a reduction from 5.57% in June 2023 to 5.41% in July 2023.
Turnover	7.55%	<=8%	↑	**Turnover** • Turnover (all terminations) has increased from 7.40% in June to 7.55% in July 2023
Normalised Turnover	3.98%	<=5%	↑	• Normalised Turnover (voluntary resignation) has increased from 3.78% in June to 3.98% in July 2023. • Turnover (all terminations) is all terminations from the organisation. Normalised Turnover focuses on voluntary resignations and excludes dismissals, fixed term contracts, redundancy, retirement and rotations.
Retention (12 month)	90%	>=80%	↑	**Retention** • The 12-month retention rate has increased from 89.3% in June to 90% in July 2023
Vacancy Rate	6%	<=7%	=	**Vacancy Rate** • The vacancy rate has remained stable at 6% with total vacancies of 375.58 WTE
Mandatory Training	91.63%	>=90%	↓	**Mandatory Training** • Statutory Training has decreased from 91.84% as of 21st June 2023 to 91.63%. Please note – as of 24/08/2023 this was 91.89%
Appraisals	92.3%	>=90%	↑	**Appraisals** • The appraisal window has now closed for 2023/24 at 92.3% compliance

CARE RESPECT RESPONSIBILITY

Sickness Absence

The Dudley Group NHS Foundation Trust





In-Month Sickness Absence

In month sickness absence for July is 4.64% a small reduction from June at 4.69%. You will note that absence has continued to decline since March 2023.

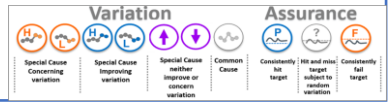
Rolling 12 M Sickness Absence

The rolling 12-month absence shows a reduction from 5.57% in June 2023 to 5.41% in July 2023. This is now amber against target.

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:

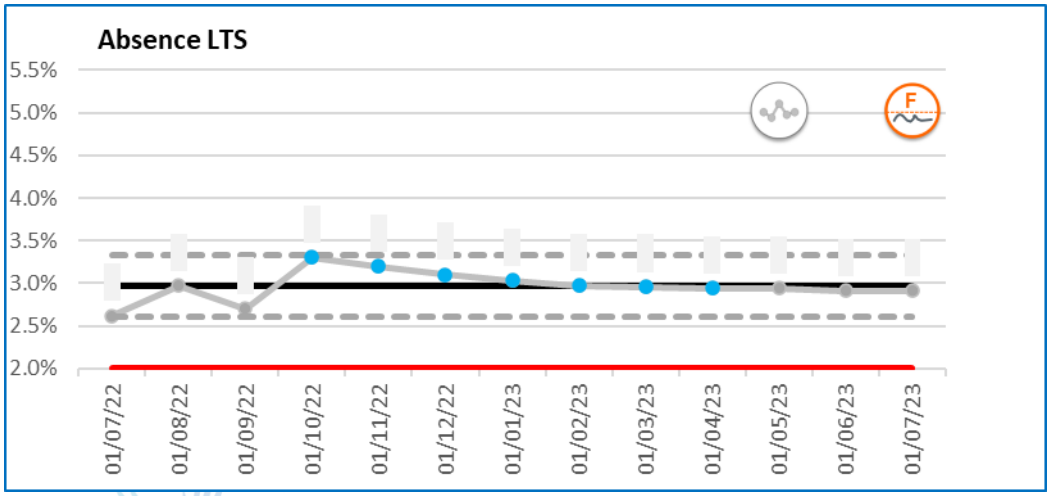


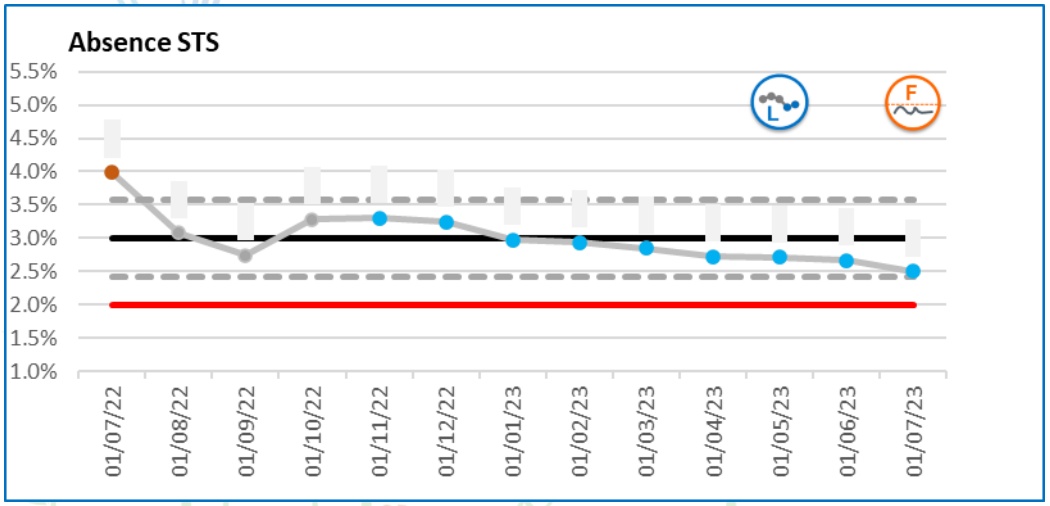
	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23
Absence in Month	5.87%	5.44%	5.98%	5.80%	6.39%	5.43%	5.06%	5.42%	4.92%	4.79%	4.69%	4.64%
Absence 12m Rolling	6.76%	6.66%	6.58%	6.50%	6.34%	6.00%	5.90%	5.81%	5.66%	5.65%	5.57%	5.41%

CARE RESPECT RESPONSIBILITY

Long-Term and Short-Term Absence

The Dudley Group NHS Foundation Trust





Long-Term and Short-Term Sickness Absence

Long-term absence has shown a decreasing trend since October 2022 and is now at 2.91%

Short-term absence has also shown a decreasing trend since November 2022 and is now at 2.50%.

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.

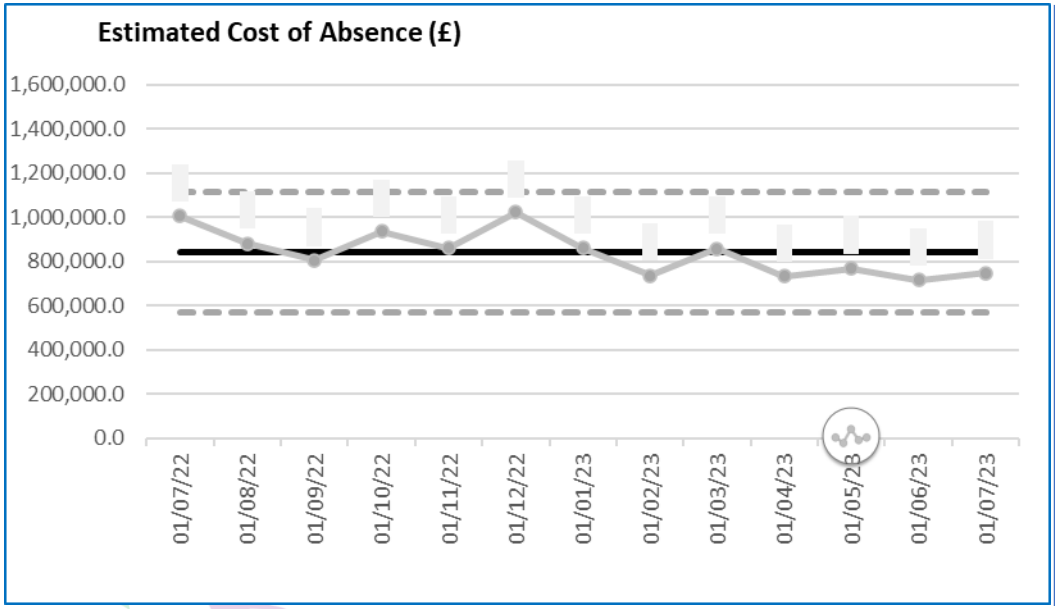
Short-term absence is currently the key focus.

	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23
Absence LTS	2.97%	2.70%	3.30%	3.20%	3.10%	3.03%	2.97%	2.96%	2.94%	2.94%	2.91%	2.91%
Absence STS	3.08%	2.74%	3.28%	3.30%	3.24%	2.97%	2.93%	2.85%	2.72%	2.71%	2.66%	2.50%

CARE RESPECT RESPONSIBILITY

Estimated Cost of Absence

The Dudley Group NHS Foundation Trust



Estimated Cost of Absence

The estimated cost of absence for July is £746,460 compared to £715,978 in June 2023.

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

	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23
Estimated Cost of Absence (£)	£ 882,113	£ 804,352	£ 935,886	£ 861,583	£ 1,023,406	£ 859,668	£ 735,312	£ 858,936	£ 733,729	£ 769,327	£ 715,978	£ 746,460

CARE RESPECT RESPONSIBILITY

Sickness Absence

The Dudley Group NHS Foundation Trust

Top 10 Departments By Time Lost (July)

Department	Abs (FTE)	Avail (FTE)	Absence % (FTE)
253 Ward EAU Serv	456.32	5,631.92	8.10%
253 Emergency Dept Nursing Serv	349.40	3,886.09	8.99%
253 Maternity Unit Serv	283.96	5,986.99	4.74%
253 Critical Care Serv	264.49	4,107.49	6.44%
253 Pharmacy Department Serv	228.55	4,884.86	4.68%
253 Therapy Department Serv	209.13	3,932.09	5.32%
253 Ward B4 Serv	208.48	2,693.16	7.74%
253 Pathology - Phlebotomy Serv	183.49	1,948.00	9.42%
253 OPD Surgery & Plastics Team Serv	172.48	1,081.33	15.95%
253 Ward B3 Serv	158.64	2,110.52	7.52%

Top 10 Departments By Absence Rate (July)

Department	Absence FTE	Available FTE	Absence FTE %
253 Ambulatory Neurology CNS Serv	56.80	86.80	65.44%
253 Eye Dept Serv	136.07	623.35	21.83%
253 Gynaecology Ambulatory Serv	89.76	430.69	20.84%
253 Respiratory - Lung Cancer Nurse Serv	31.00	148.80	20.83%
253 Leg Ulcer Service Adult DN Serv	51.20	279.41	18.32%
253 Treasury Management Serv	21.00	124.00	16.94%
253 Dudley Integrated Liver Service Serv	21.00	130.20	16.13%
253 OPD Surgery & Plastics Team Serv	172.48	1,081.33	15.95%
253 Renal CAPD Uni Serv	44.04	298.28	14.76%
253 Health In Pregnancy Support Serv	31.00	227.33	13.64%

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

Absence Reason	Headcount	Abs Occurrences	FTE Days Lost	%
S10 Anxiety/stress/depression/other psychiatric illnesses	735	949	23,057.62	21.8
S12 Other musculoskeletal problems	512	625	9,664.74	9.1
S13 Cold, Cough, Flu - Influenza	2199	2,875	9,347.83	8.8
S25 Gastrointestinal problems	1914	2,615	9,221.73	8.7
Other	1157	1,314	7,537.93	7.1
S99 Unknown causes / Not specified	545	649	5,230.26	4.9
S30 Pregnancy related disorders	246	581	5,224.49	4.9
S28 Injury, fracture	218	238	4,383.01	4.1
S26 Genitourinary & gynaecological disorders	343	431	4,279.91	4.0
S11 Back Problems	258	296	3,674.92	3.5

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	735	949	28,093	£2,068,869.33	22.7
S12 Other musculoskeletal problems	512	625	11,393	£819,016.95	9.2
S13 Cold, Cough, Flu - Influenza	2199	2,875	10,584	£959,484.26	8.6
S25 Gastrointestinal problems	1914	2,615	10,573	£839,681.58	8.5
Other	1157	1,314	8,699	£778,964.23	7.0
S99 Unknown causes / Not specified	545	649	5,980	£539,951.25	4.8
S30 Pregnancy related disorders	246	581	5,853	£499,539.54	4.7
S28 Injury, fracture	218	238	5,122	£439,917.71	4.1
S26 Genitourinary & gynaecological disorders	343	431	5,076	£417,298.21	4.1
S11 Back Problems	258	296	4,368	£313,795.59	3.5

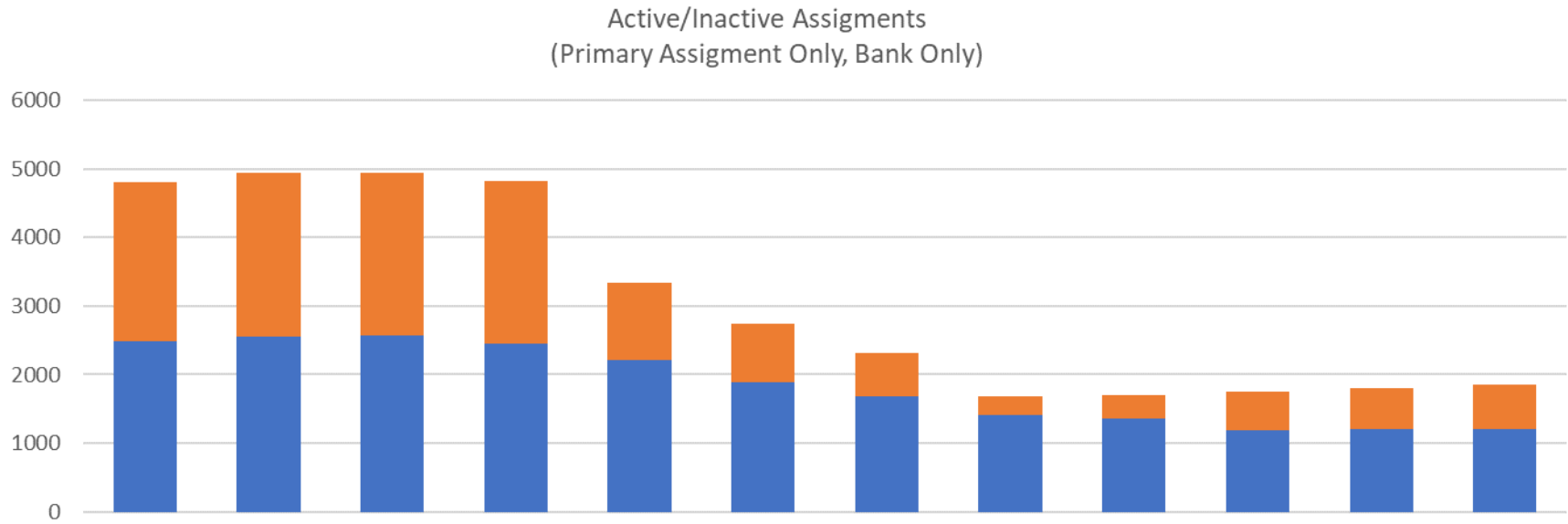
Absence Reasons

- 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.

CARE RESPECT RESPONSIBILITY

Active / Inactive Assignments

The Dudley Group NHS Foundation Trust



	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23
Inactive	2311	2382	2362	2374	1130	858	617	264	329	561	595	646
Active	2487	2559	2576	2447	2210	1887	1690	1413	1368	1193	1207	1203

Bank Efficiency

There are 18049 bank assignments registered on the Trust's Staff Bank, an increase from 1807 in June 2023

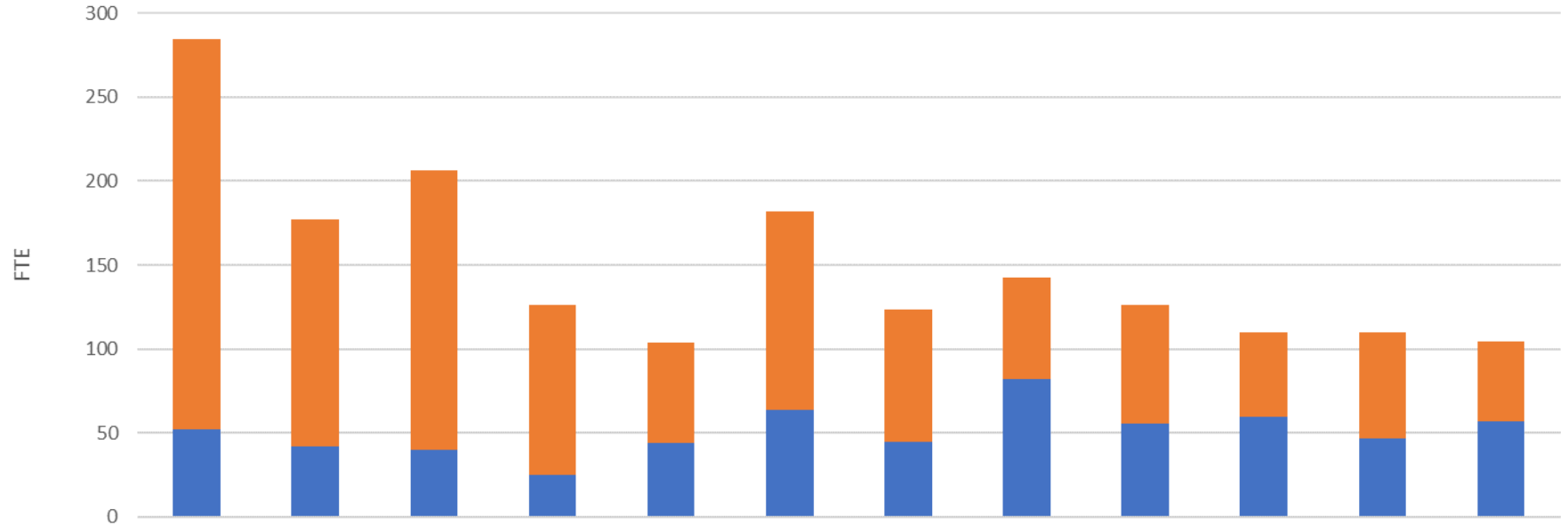
We now have 646 inactive records as opposed to the 595 previously recorded as inactive (not worked in 17-week period).

Currently on 15% of bank workers are bank only 85% are substantive staff with a bank contract.

RESPECT RESPONSIBILITY

Starters and Leavers

The Dudley Group NHS Foundation Trust



	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23
Starters FTE	232.11	135.04	165.91	101.32	59.87	118.15	78.99	60.42	70.64	50.29	63.5	47.56
Leavers FTE	52.26	42.2	40.19	24.91	43.76	63.95	44.49	82	55.66	59.79	46.58	56.66

Starters vs Leavers

- This month we have seen more leavers than starters, in July there were 56.66 WTE leavers compared to 47.56 WTE starters.

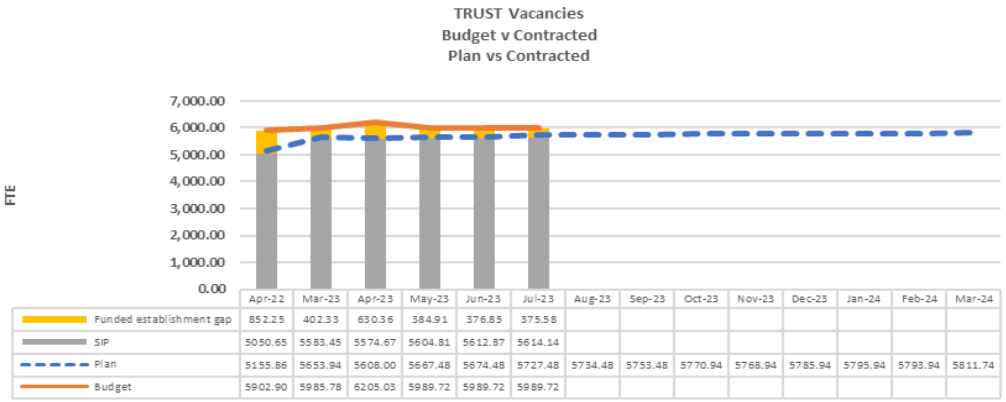
Assurance

- Work is continuing on both recruitment and retention and this forms part of NHSE's Long-Term Workforce Plan.

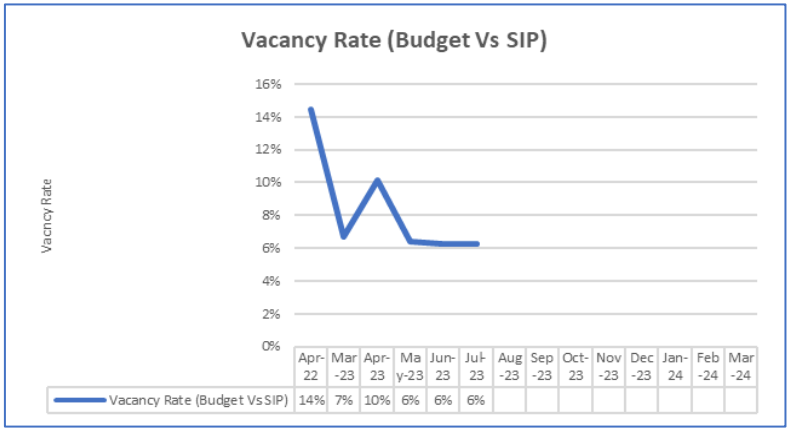
CARE RESPECT RESPONSIBILITY

Recruitment/Vacancies/Turnover - TRUST

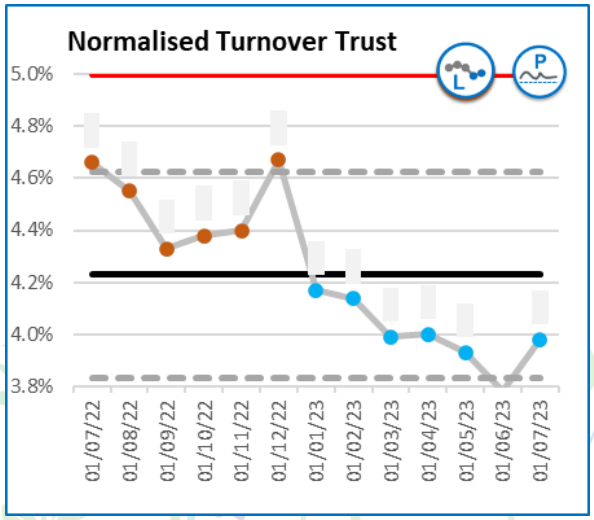
The Dudley Group NHS Foundation Trust

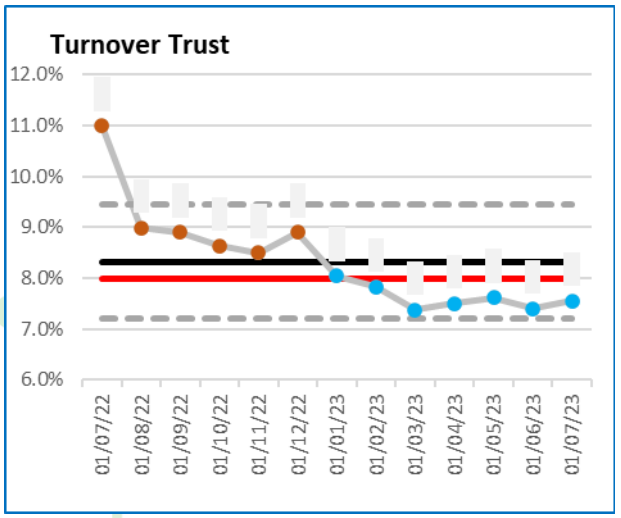


	Apr-22	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Funded establishment gap	852.25	402.33	630.36	384.91	376.85	375.58								
SIP	5050.65	5583.45	5574.67	5604.81	5612.87	5614.14								
Plan	5155.86	5653.94	5608.00	5667.48	5674.48	5727.48	5734.48	5753.48	5770.94	5768.94	5785.94	5795.94	5793.94	5811.74
Budget	5902.90	5985.78	6205.03	5989.72	5989.72	5989.72								



	Apr-22	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Vacancy Rate (Budget Vs SIP)	14%	7%	10%	6%	6%	6%								





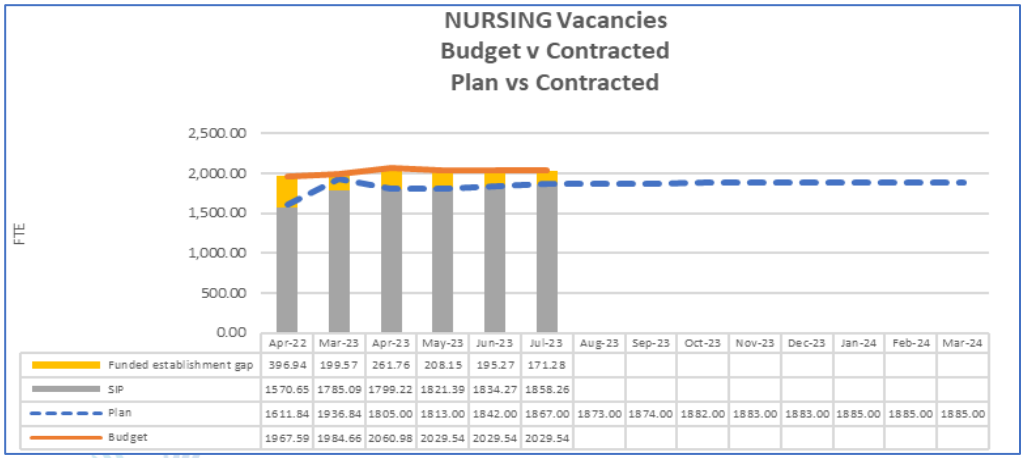
- Contracted WTE staff has increased from 5612.87 WTE in June to 5614.14 WTE in July 2023, This is 113.34 WTE under the workforce plan.
- The total vacancies stands at 375.58 WTE in July 2023. This equates to a vacancy factor of 6%.
- Overall staff turnover (rolling twelve months average) is at 7.55%, with normalised turnover at 3.98%.

	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23
Trust Turnover	8.99%	8.90%	8.64%	8.50%	8.90%	8.04%	7.84%	7.38%	7.50%	7.62%	7.40%	7.55%
Trust Normalised Turnover	4.55%	4.33%	4.38%	4.40%	4.67%	4.17%	4.14%	3.99%	4.00%	3.93%	3.78%	3.98%

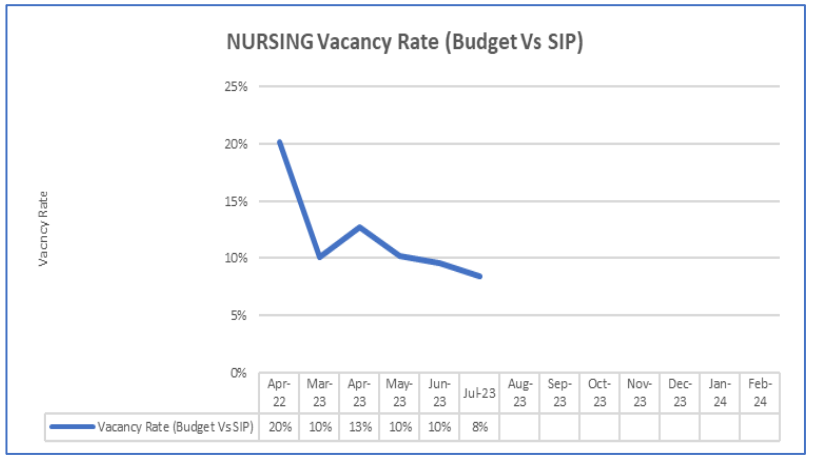
CARE RESPECT RESPONSIBILITY

Recruitment/Vacancies/Turnover - Registered Nursing

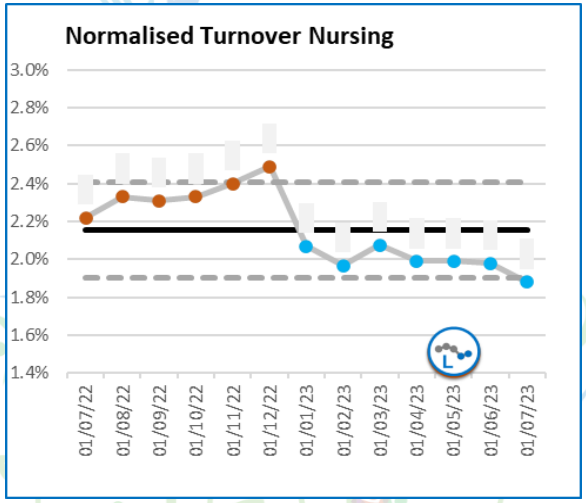
The Dudley Group NHS Foundation Trust

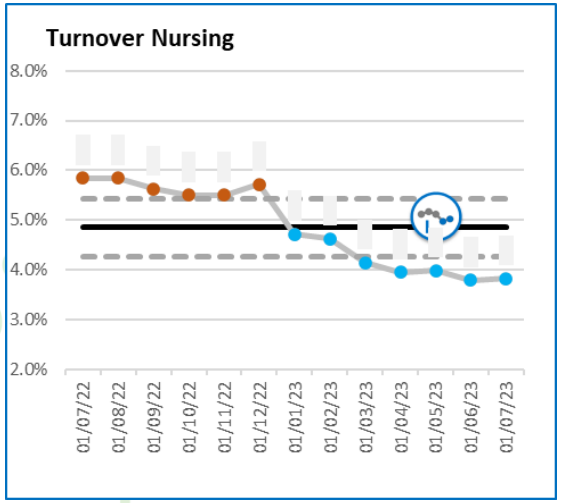


	Apr-22	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Funded establishment gap	396.94	199.57	261.76	208.15	195.27	171.28								
SIP	1570.65	1785.09	1799.22	1821.39	1834.27	1858.26								
Plan	1611.84	1936.84	1805.00	1813.00	1842.00	1867.00	1873.00	1874.00	1882.00	1883.00	1883.00	1885.00	1885.00	1885.00
Budget	1967.59	1984.66	2060.98	2029.54	2029.54	2029.54								



	Apr-22	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24
Vacancy Rate (Budget Vs SIP)	20%	10%	13%	10%	10%	8%							





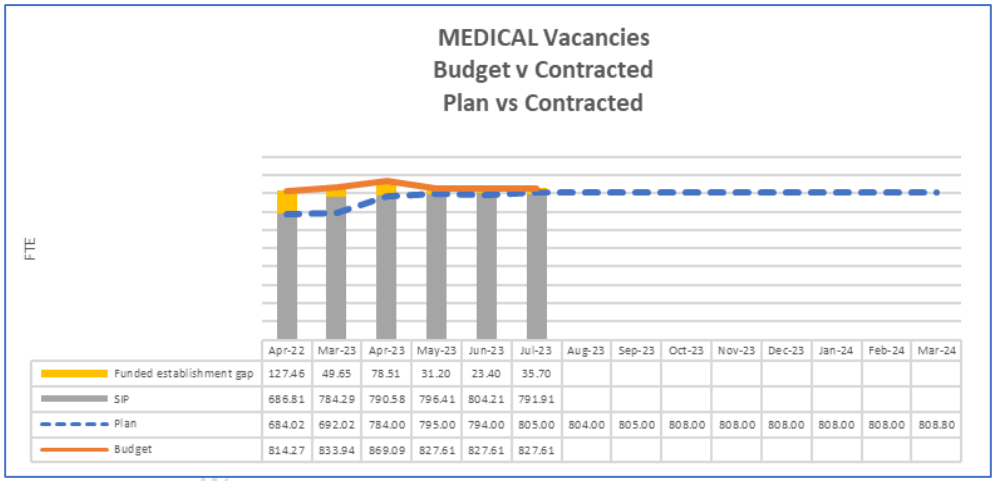
	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23
Nursing Turnover	5.84%	5.63%	5.50%	5.50%	5.72%	4.72%	4.62%	4.14%	3.95%	3.99%	3.79%	3.83%
Nursing Normalised Turnover	2.33%	2.31%	2.33%	2.40%	2.49%	2.07%	1.97%	2.07%	1.99%	1.99%	1.98%	1.88%

- Contracted WTE for nursing staff has increased from 1834.17 WTE in June to 1858.26 in July 2023 . This is 8.74 WTE below the workforce plan.
- The total nursing vacancies reported stands at 171.28 WTE, which equates to a vacancy rate of 8%.
- Following conversion of nurses waiting either their registration or completion of their OSCE, this will be 100.28 WTE.
- Staff turnover for nursing (rolling 12 months average) is at 3.83%, with normalised turnover at 1.88%.

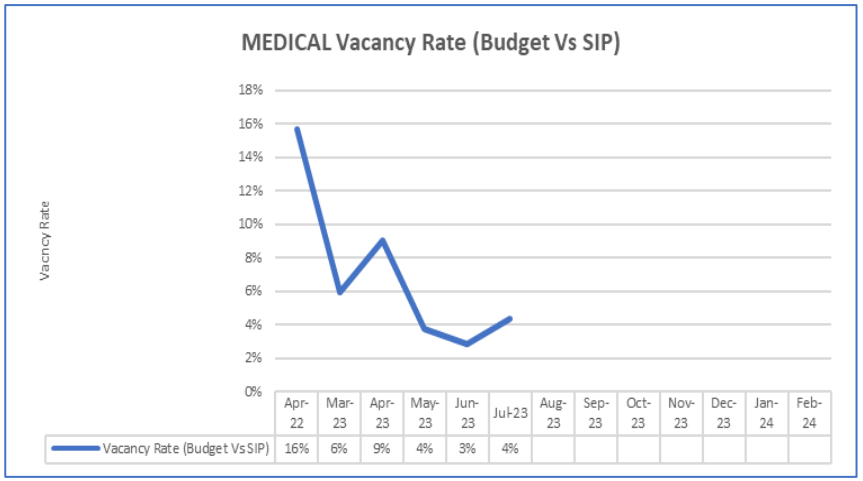
CARE RESPECT RESPONSIBILITY

Recruitment/Vacancies/Turnover - Medical & Dental

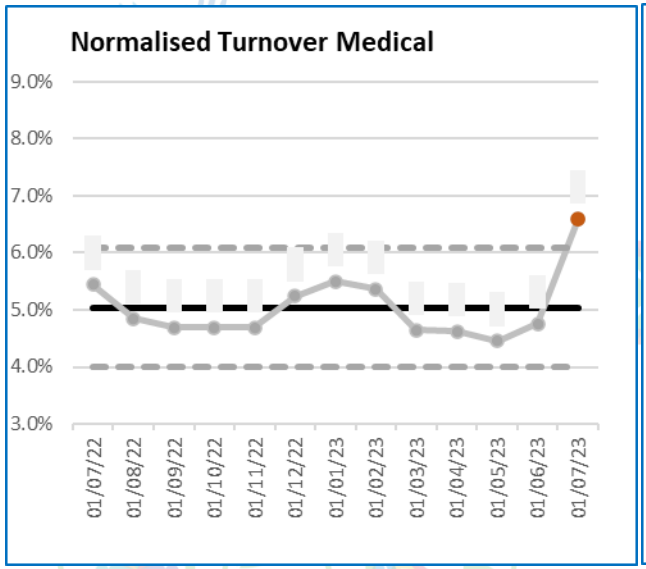
The Dudley Group NHS Foundation Trust

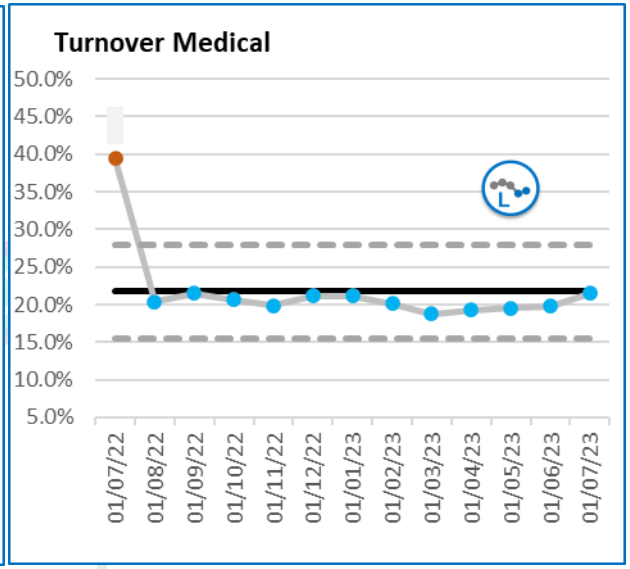


	Apr-22	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Funded establishment gap	127.46	49.65	78.51	31.20	23.40	35.70								
SIP	686.81	784.29	790.58	796.41	804.21	791.91								
Plan	684.02	692.02	784.00	795.00	794.00	805.00	804.00	805.00	808.00	808.00	808.00	808.00	808.00	808.80
Budget	814.27	833.94	869.09	827.61	827.61	827.61								



	Apr-22	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24
Vacancy Rate (Budget Vs SIP)	16%	6%	9%	4%	3%	4%							





- Contracted WTE for medical and dental staff has increased from 804.21 wte in June 2023 to 791.91 wte in July 2023. This is still 13.09 WTE below plan.
- The total medical and dental vacancies stands at 35.70 WTE. The vacancy rate is 4%.
- Staff turnover for medical and dental (rolling 12 months average) has increased to 21.45% (mainly due to rotation), with normalised turnover increasing to 6.60%.

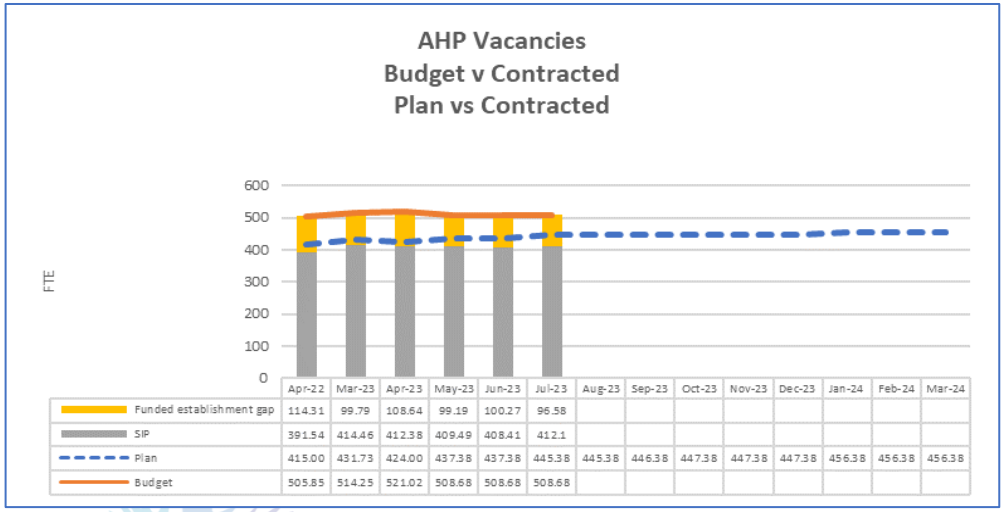
	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23
M&D Turnover	20.42%	21.52%	20.63%	19.90%	21.18%	21.12%	20.10%	18.75%	19.28%	19.52%	19.82%	21.45%
M&D Normalised Turnover	4.85%	4.69%	4.69%	4.69%	5.24%	5.50%	5.36%	4.65%	4.62%	4.46%	4.76%	6.60%

RESPECT

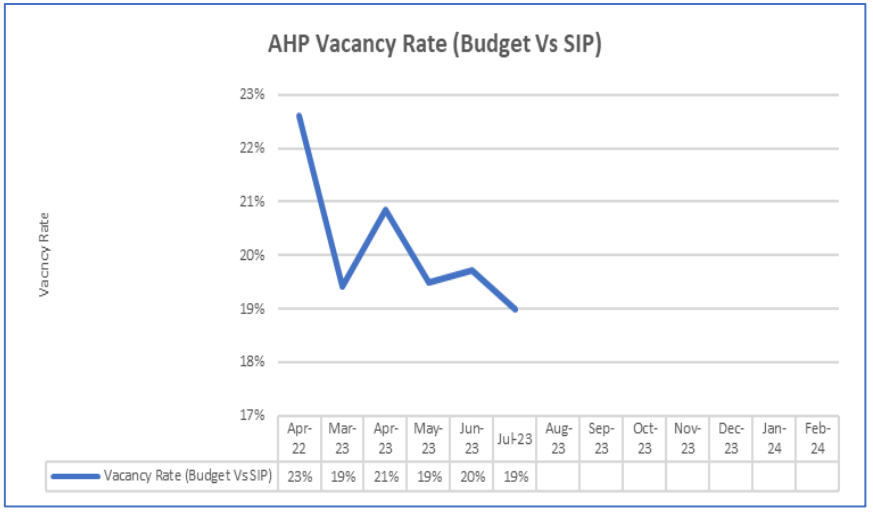
RESPONSIBILITY

Recruitment/Vacancies/Turnover - Allied Health Professional

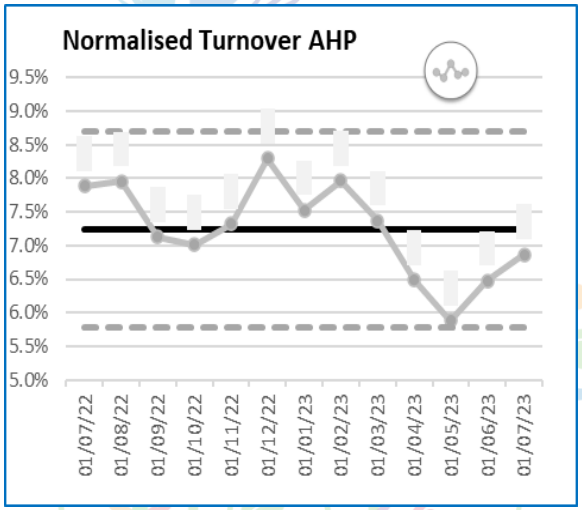
The Dudley Group NHS Foundation Trust

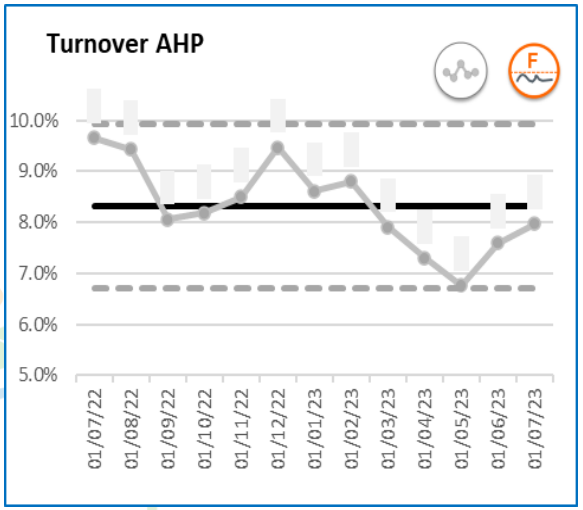


	Apr-22	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Funded establishment gap	114.31	99.79	108.64	99.19	100.27	96.58								
SIP	391.54	414.46	412.38	409.49	408.41	412.1								
Plan	415.00	431.73	424.00	437.38	437.38	445.38	445.38	446.38	447.38	447.38	447.38	456.38	456.38	456.38
Budget	505.85	514.25	521.02	508.68	508.68	508.68								



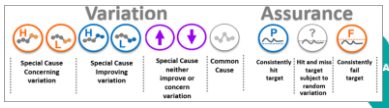
	Apr-22	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24
Vacancy Rate (Budget Vs SIP)	23%	19%	21%	19%	20%	19%							





- Contracted WTE for AHP's has increased from 408.41 WTE in June to 412.10 in July 2023. This is 33.28 WTE under the workforce plan.
- The total AHP vacancies in July 2023 are 96.58 WTE, this equates to a vacancy factor of 19%.
- It should be noted that there are 10 WTE AHP's in post awaiting their registration.
- Staff turnover for AHP's (rolling 12 months average) is at 7.97%, with normalised turnover at 6.87%.

	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23
AHP Turnover	9.44%	8.07%	8.18%	8.50%	9.47%	8.62%	8.80%	7.91%	7.30%	6.77%	7.59%	7.97%
AHP Normalised Turnover	7.95%	7.13%	7.01%	7.32%	8.29%	7.53%	7.97%	7.37%	6.49%	5.88%	6.48%	6.87%

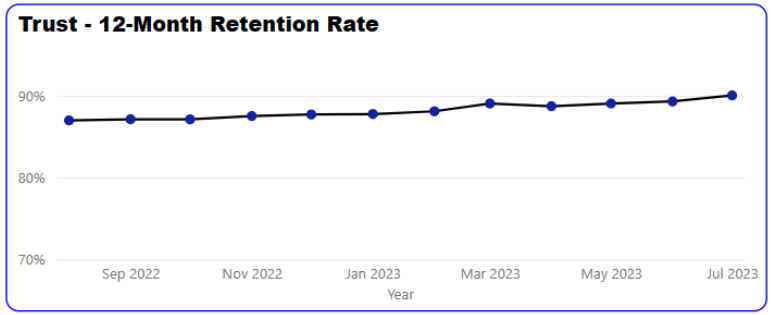


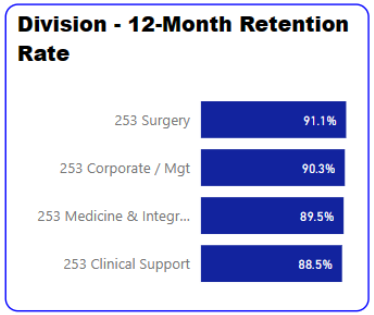
RESPECT

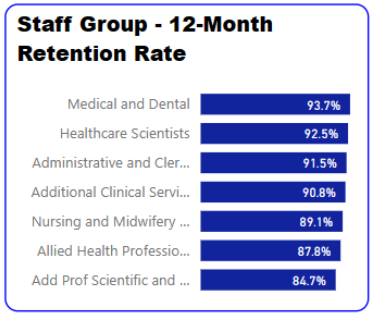
RESPONSIBILITY

Retention

The Dudley Group
NHS Foundation Trust

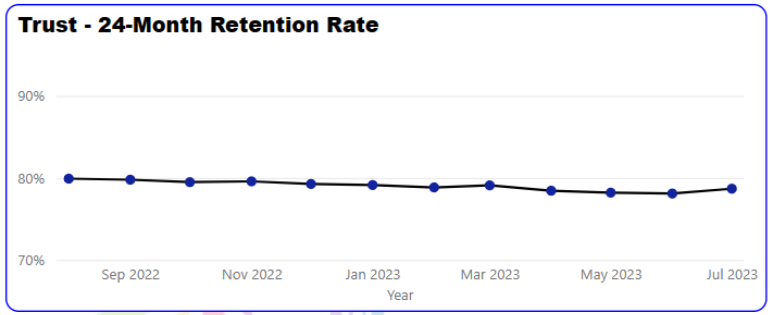


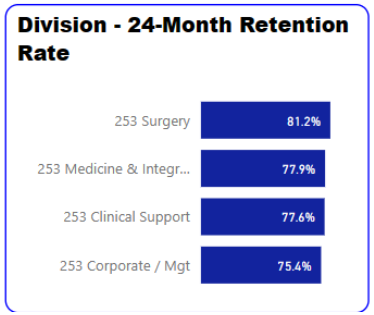


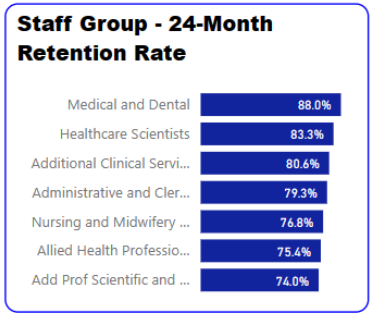


July 2023

12-Month	Trust 90.0%
24-Month	Trust 78.7%



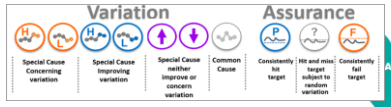




Workforce have developed a retention metric to ensure we are able to retain our workforce. Employee retention improves stability and promotes a better patient experience. In addition, by improving retention we can address employee turnover costs, low staff engagement, poor quality of care with a view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

The 12-month retention rate is relatively stable and increasing, the 24-month rate was showing a steady decline since March 2022 but this month has seen an increase.

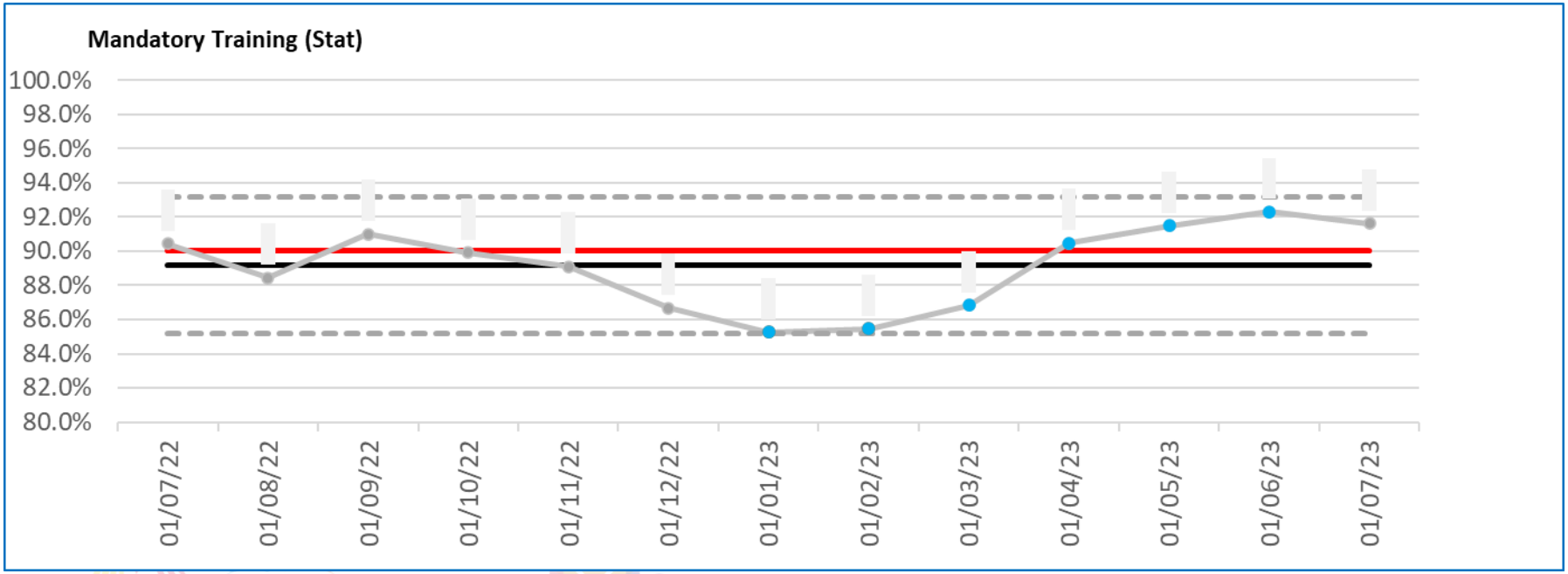
The division with the lowest retention rate is Corporate Services at 75.4% over 24 months; both Additional Professional, Scientific and Technical staff and Allied Health Professionals are two staff groups that show as areas for concern.



CARE RESPECT RESPONSIBILITY

Mandatory Training

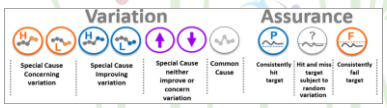
The Dudley Group
NHS Foundation Trust



Quarter 1 saw an increasing statutory training compliance trend and this continues to remain above Trust target, although we have seen an expected slight decline, this reflects a seasonal trend for improvement – likely linked to annual appraisals and expiry dates for annual training. This follows by a fall in the main holiday period.

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.

	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23
Mandatory Training (Stat)	88.44%	91.00%	89.90%	89.10%	86.68%	85.27%	85.45%	86.82%	90.48%	91.48%	92.30%	91.63%



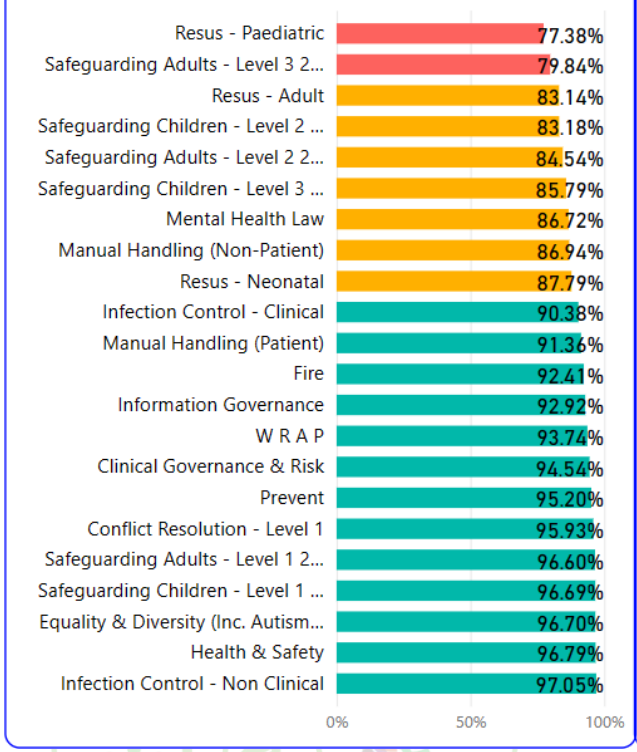
CARE RESPECT RESPONSIBILITY

Mandatory Training – Priority 1

The Dudley Group
NHS Foundation Trust

Month: August 2023	Trust	CS	Corporate	MIC	Surgery
	91.63%	93.21%	93.33%	90.78%	91.06%

Course Compliance



Depts by no. required to achieve 90%

Ward/Service (based selections)

Group5Description	Actual	No. >90%	%' tage
253 Emergency Dept Nursing Serv	1,691	112	84.42%
253 Medical Staff - Acute Medicine Serv	794	112	78.92%
253 General Surgery Medical Staff Serv	493	73	78.50%
253 Medical Staff - General Medicine Serv	108	57	59.01%
253 Medical Staff GP Medicine Serv	63	51	50.00%
253 Medical Staff Renal Serv	63	51	50.00%
253 Obs.and Gynae. Medical Staff Serv	449	50	81.04%
253 Medical Staff - GI Serv	218	46	74.40%
253 Cardiology Clinical Measurement Serv	506	43	82.95%
253 ENT Medical Staff Serv	151	43	70.23%
253 Medical Staff (Older People) Serv	223	42	75.85%
253 MOC Medical Staff Serv	424	41	82.17%
253 Medical Staff Cardiology Serv	150	39	71.42%
253 Medical Staff Stroke Serv	120	33	71.00%
253 Pharmacy Department Serv	1,695	33	88.28%
253 Medical Staff - Respiratory Serv	232	32	79.18%
253 Med Staff (Clin Haematology) Serv	158	31	75.23%
253 Medical Staff (Emergency Med) Serv	731	31	86.40%
253 Medical Staff Endocrin/Diab Serv	96	30	68.57%
253 Main Theatre Other Specialities	438	27	84.88%
Total	**70,157**	**-1250**	**91.63%**

Statutory Training has continued to remain above target.

All divisions are above the organisation target of 90% - with the Medicine Division at the lowest position.

The five subjects requiring most improvement are Resuscitation Paediatric, Safeguarding Children Level 2, Safeguarding Adults Level 2 & 3 and Resuscitation Adult.

Targeted work is underway for challenge subjects (resus and safeguarding).

CARE RESPECT RESPONSIBILITY

Apprenticeships

The Dudley Group NHS Foundation Trust

Q1 Apprenticeships

Number of Signups against year plan (142)

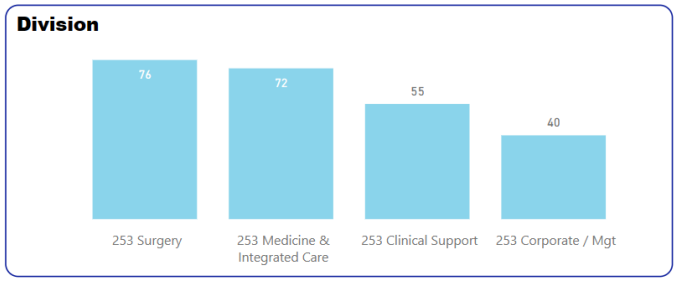
	Number of signups
Remaining signups	117
New Apprentices	1
Existing staff	24

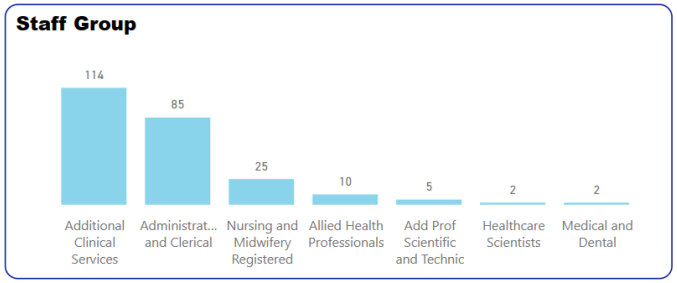
Total Active Apprenticeships **288**

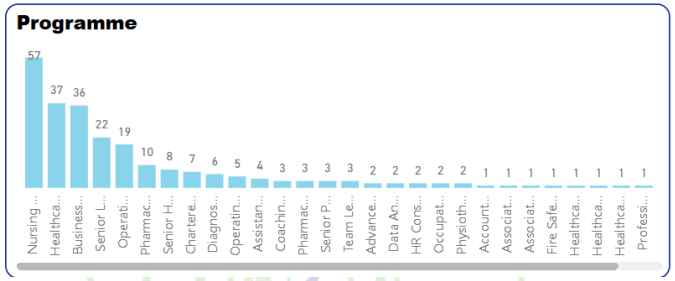
Apprenticeship Levy	£
Expired Levy April 23	£0
Expired Levy May 23	£0
Expired Levy June 23	£1,134.04
Expired Levy July 23	£14,555

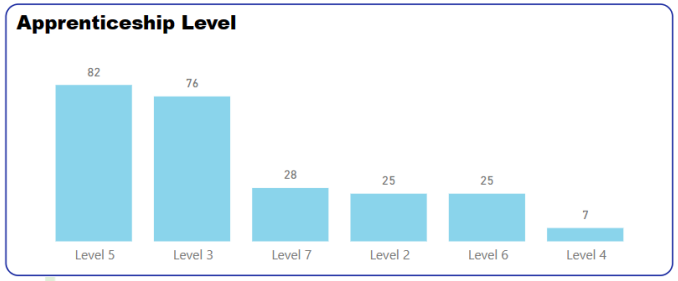
Activity continues to sign up existing members of staff as well as a new with an intake of 21 Senior Healthcare Support Worker level 3. Expired levy will be partly due to overdue completion payments beyond our control.

Active Apprenticeships breakdown









Activity continues to expand the sign-ups to existing programmes and exploring new areas of work, including Doctor Apprenticeships planning for 2024.

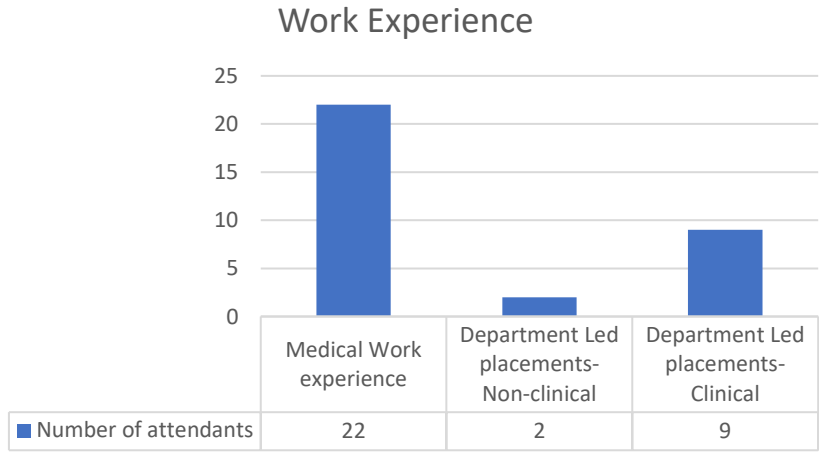
We remain on track against target for 2022/23 with recruitment processes underway.

The Trust is currently not facing any Levy expiry until August 2024. We are sponsoring a number of apprentices in other organisations through Levy transfer.

CARE RESPECT RESPONSIBILITY

Work Experience and Widening Participation

The Dudley Group NHS Foundation Trust



Work Related Learning	July
Behind the Scenes- Events	0
Spring pod 2nd year virtual programme- Registered	49
Spring pod 2nd year virtual programme- Places available	201

Work related Learning:
Behind the scenes- no events in July 2 have been scheduled for Q2 and Q3
Spring pod data available quarterly.

Careers Education Information Advice and Guidance (CEIAG)
This data will report on Ambassadors activity and Meet the Expert events.

New process of collating Ambassadors data launched early August.

Meet the expert July event was cancelled due to teachers strikes, These events are currently as and when requested by local schools.

Ambassadors			
Breakdown	Total number of active ambassadors on record	New active (following In the Know)	Number requested to be removed due to time commitments, retirement and leaving the trust
Q1	71	9	10

We currently have 71 Ambassadors in total. Activities range from events to career talks with local schools. This is generally unplanned/ad-hoc activity.

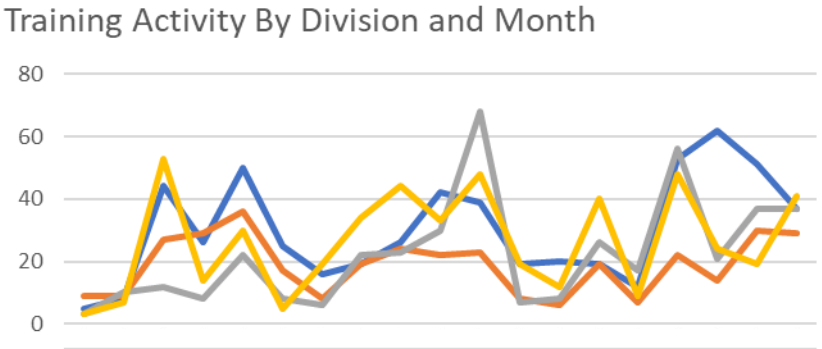
Employability Programmes (Sector-based Work academy programmes)		Attendances
DWP SWAP		12
Breakdown		
Gender	9 Female	3 Male
Disability	3 Disability declared	
Ethnicity	9 White British	3 African

Employability Programmes (Sector-based Work academy programmes)	Attendances
EGSALT SWAP	11
Breakdown	
Offered Interview	9
Attended Interview	7
Offered CSW Novice Posts	4

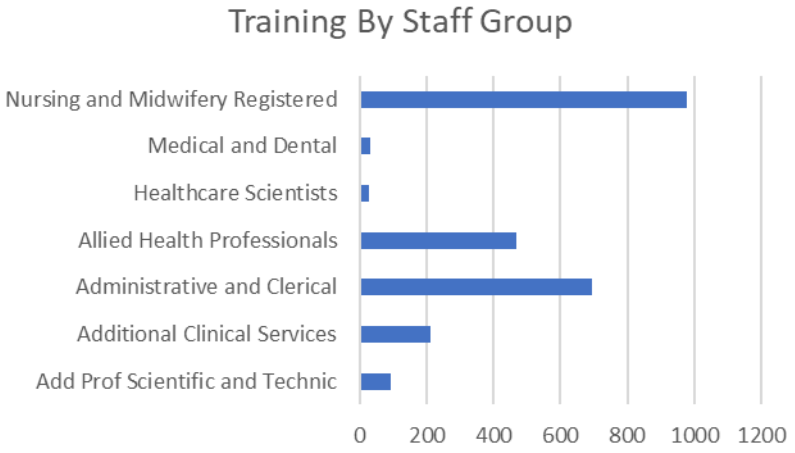
CARE RESPECT RESPONSIBILITY

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	Apr-23	May-23	Jun-23	Jul-23
253 Clinical Support	5	8	44	26	50	25	16	19	26	42	39	19	20	19	12	53	62	51	37
253 Corporate / Mgt	9	9	27	29	36	17	8	19	24	22	23	8	6	19	7	22	14	30	29
253 Medicine & Integrated Care	3	10	12	8	22	8	6	22	23	30	68	7	8	26	17	56	21	37	37
253 Surgery	3	7	53	14	30	5	19	34	44	33	48	19	12	40	9	48	24	19	41



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	Apr-23	May-23	Jun-23	Jul-23	Grand Total
253 Appraisal Training (Non-medical)			99	20	54	13				3	2		4	7	6	85	70	35	1	399
253 Bespoke Training							8		6			6					18			38
253 Coaching																	2		7	9
253 Communications																	5	3	13	21
253 Developing Leaders	5						6					4		6					8	29
253 Leadership For All		1	1		10	4	6	7		8	7	9	5							58
253 Living The Values				6	19				20	18	13	6		6	15	3	4	22	13	145
253 Local Induction Training																		32		32
253 Managers Essentials	1	5	15	24	28	8	15	13	12	18	11	12	24	21	16	20	9	22	22	296
253 Welcome 2 Dudley Induction	10	16	16	27		19	5	4	11	16	8	3	7	4	3		2	11	11	173
253 Wellbeing	4	12	5	0	27	11	9	70	68	64	137	13	6	60	5	71	11	12	69	654
Grand Total	**20**	**34**	**136**	**77**	**138**	**55**	**49**	**94**	**117**	**127**	**178**	**53**	**46**	**104**	**45**	**179**	**121**	**137**	**144**	**1854**

Training activity continues to increase – with a focus on ensuring that Manager's Essentials courses are delivered to capacity and reach all managers. 520 participants have attended in total to the end of June 2023. Course bookings are consistently high, but non-attendance continues to be challenging. July, August and September courses are booked to capacity (overbooked) and additional courses have been added in September to increase capacity for those months. This will be reviewed monthly for the Autumn.

Core programmes now running include Manager's Essentials, Developing Leaders, Living the Values, Wellbeing, Welcome to Dudley, and Being Brilliant at Communication, with An Introduction to Coaching; launched in May. Still receiving increased requests for the team based 'Living the Values' sessions – across all divisions.

Appraisal- 23/24

NHS
The Dudley Group
NHS Foundation Trust

2023 Compliance Rate	Trust	CS	Corporate	MIC	SWC
	92.1%	95.6%	94.6%	89.2%	91.5%

Compliance Rate by Division

OrgL2	Total Staff	Appraised	Rate
253 Clinical Support	1237	1182	95.6%
253 Corporate / Mgt	614	581	94.6%
253 Medicine & Integrated Care	1691	1509	89.2%
253 Surgery	1768	1618	91.5%
Total	**5310**	**4890**	**92.1%**

Compliance Rate by Staff Group

StaffGroup	Total Staff	Appraised	Rate
Add Prof Scientific and Technic	202	191	94.6%
Additional Clinical Services	1376	1248	90.7%
Administrative and Clerical	1215	1133	93.3%
Allied Health Professionals	444	421	94.8%
Healthcare Scientists	55	49	89.1%
Nursing and Midwifery Registered	2018	1848	91.6%
Total	**5310**	**4890**	**92.1%**

The appraisal window has now closed for 2023/24 at 92.3% compliance. Medicine is the area with lowest compliance at 89.2% just under target.

CARE RESPECT RESPONSIBILITY