Excellent health care, improved health for all

The Dudley Group NHS Foundation Trust

Board of Directors - Further reading pack
Public meeting

Thursday 9 November 2023

October 2023 - New laser surgery technique launched at The Dudley Group
Selective Laser Trabeculoplasty (SLT) is now available as one of many treatments for patients with glaucoma.

Item 8.3 EPRR industrial action appendices

EPRR – Industrial Action debrief Appendices - October 2023

Appendices (for further reading pack)

Appendix 1 – Rescheduled activity due to the October 2023 joint consultant and junior doctor strike.

Elective Inpatient Activity	
Medicine	0
SWC	20
CCCS	0
Total	**20**
Elective Day Case Activity	
Medicine	57
SWC	39
CCCS	0
Total	**96**
New Outpatient Appointments	
Medicine	158
SWC	229
CCCS	0
Total	**387**
Follow-up Outpatient Appointments	
Medicine	376
SWC	616
CCCS	0
Total	**992**
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	30
CCCS	0
Total	**30**
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	78
Total	**78**
CT diagnostic activity	
Medicine	0
SWC	0
CCCS	120
Total	**120**
Ultrasound diagnostic activity	
Medicine	0
SWC	0
CCCS	135
Total	**135**
Other diagnostic activity	
Medicine	0
SWC	0
CCCS	80
Total	**80**

TRUST BOARD FINANCIAL SUMMARY DASHBOARD **SEPTEMBER 2023**

TRUST I&E PERFORMANCE as at SEPTEMBER 2023

	CURRENT			CUMULATIVE YTD		
	PLAN	ACTUAL	VAR	PLAN	ACTUAL	VAR
Pat Care	£41,375	£40,780	-£594	£248,294	£248,925	£631
Other	£1,780	£3,376	£1,596	£10,751	£13,225	£2,474
INCOME	**£43,155**	**£44,156**	**£1,001**	**£259,045**	**£262,150**	**£3,105**
Pay	-£28,834	-£28,113	£721	-£171,742	-£171,350	£392
Non-Pay	-£13,575	-£14,899	-£1,324	-£84,788	-£87,405	-£2,617
Other	-£2,764	-£2,671	£93	-£16,596	-£16,607	-£11
SPEND	**-£45,173**	**-£45,683**	**-£510**	**-£273,126**	**-£275,362**	**-£2,236**
TRUST	**-£2,018**	**-£1,527**	**£491**	**-£14,081**	**-£13,213**	**£868**

Commentary:

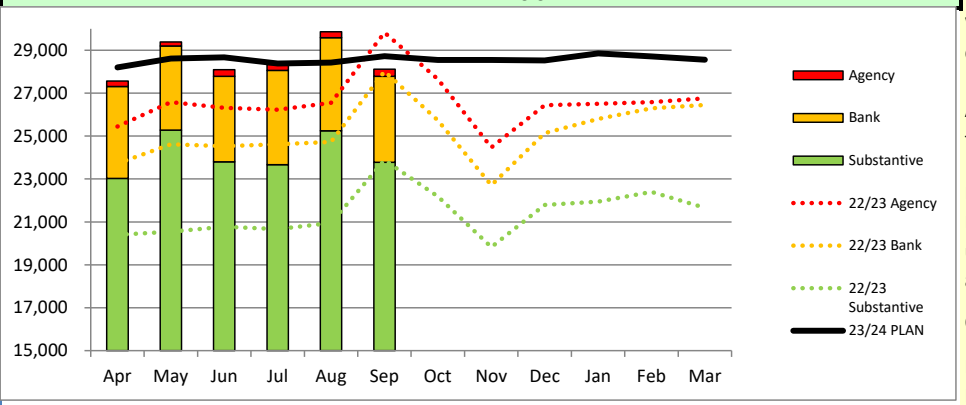
Consolidated deficit to September of £13.213m (£868k ahead of plan). Technical changes of £27k reduce deficit to £13.186m. This is £803k ahead of the phased NHSI plan.

Income includes additional pay award funding and £205k for ERF.

Pay includes £130k pressure for shortfall on 22/23 pay award plus impact of junior doctor strike action. In year pay awards offset by funding.

Non pay pressures of £1.293m for ICB pass through drugs and devices.

PAY ANALYSIS



Commentary:

Within plan to Sep despite 22/23 pay award, junior doctor/consultant strikes and high bank usage.

Additional 2.3% received for in-year pay awards (agenda for changes & medics).

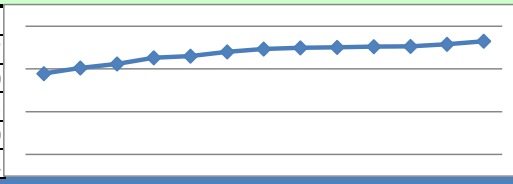
Bank/WLI usage remains high but did reduce in month. Element relates to industrial action but areas with high utilisation rates being challenged to improve and reduce adverse pay variances.

Overtime £100k Apr/May, £60k thereafter.

Reduction in Sep linked to lower Medic bank costs and Medics pay award costs lower than accrued.

WHOLE TIME EQUIVALENT YEAR ON YEAR COMPARISON

	22/23	Plan	Current
Nursing	2,604.28	3,000.85	2,805.47
Doctors	752.06	823.05	820.50
AHPs	880.51	1,006.63	940.35
A&C/Other	1,060.38	1,161.48	1,108.10
Total	**5,297.23**	**5,992.01**	**5,674.42**



Commentary:

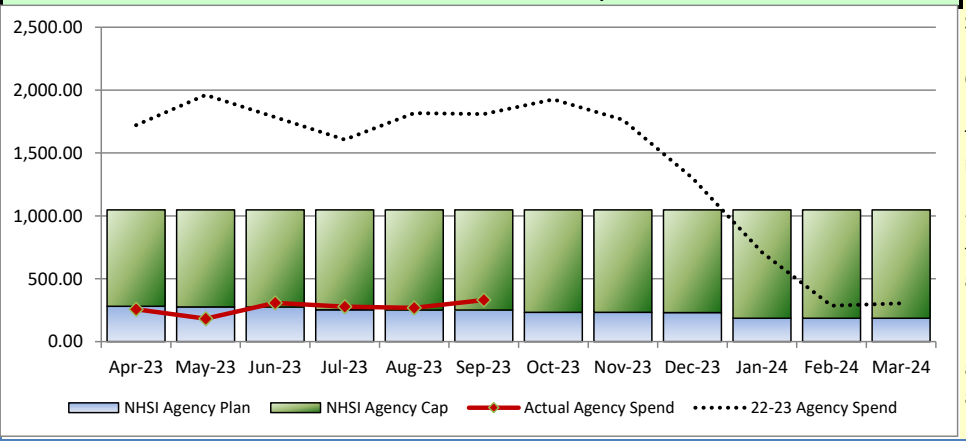
34 WTE increase in Sep (24 AHP/Scientific, 4 Registered Nurses, 6 CSWs).

377 WTE increase on last year.

Vacancies c318 WTE.

Establishment refined to posts that can be recruited.

AGENCY PERFORMANCE 2023/24



Commentary:

System cap of £68m for 23/24.

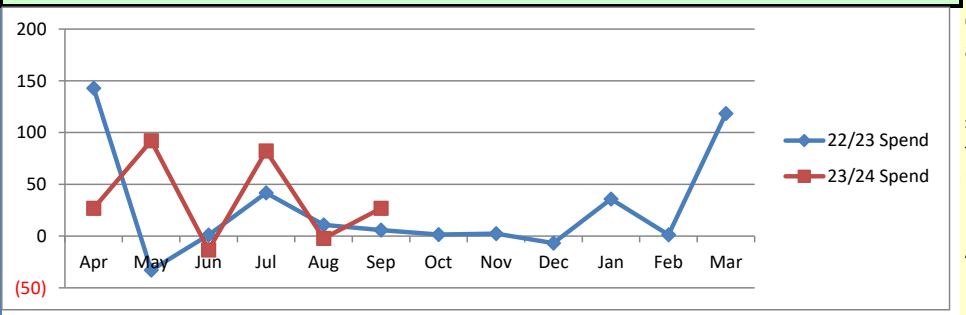
Cap based on limiting agency to 3.7% of paybill.

Trust significantly below cap (1.0% of paybill) but costs increasing.

71% of spend medical staff. Remainder generally relates to agreed time limited exceptions. Last non clinical agency post ended in May.

NHSE letter expressing concern generally at use of agency in excess of targets, non clinical agency use and agency use above price caps.

CONSULTANCY



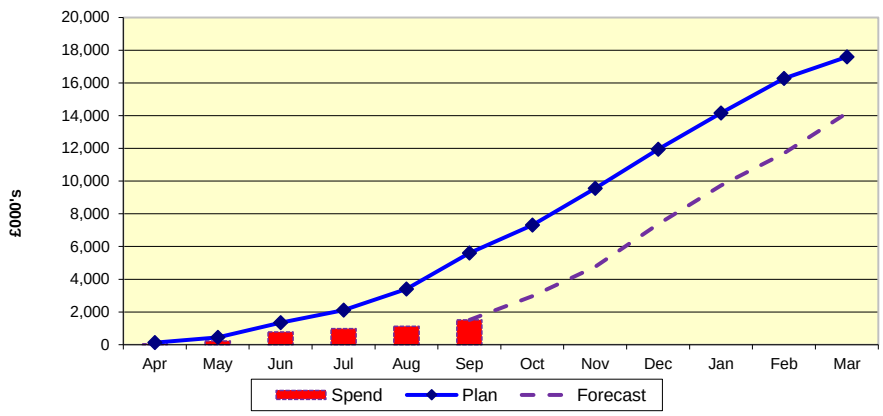
Commentary:

Consultancy in excess of £50k now requires prior approval from NHSE/I.

£175k consultancy spent in May/July within IT for frontline digitisation BC. No prior approval sought from NHSE on basis that NHSE approved initial bid.

Also IT spend of £41.5k on Master Data Mgmt.

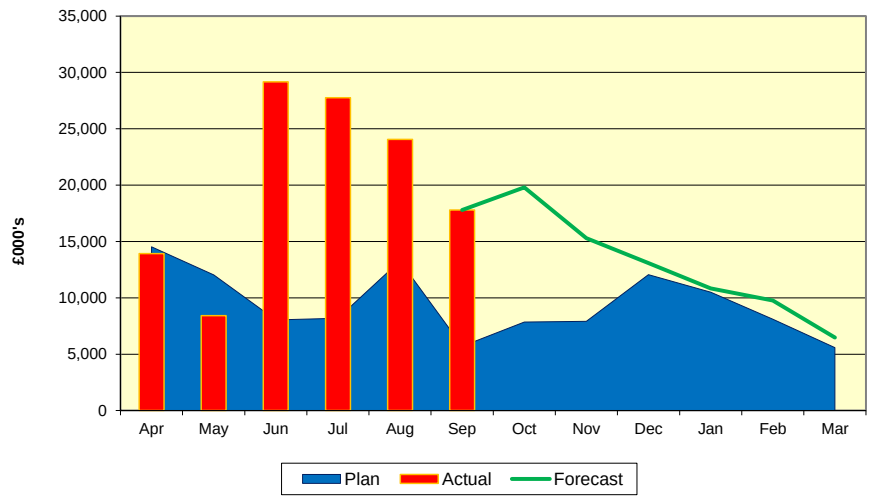
CAPITAL EXPENDITURE 2023/24



Commentary:
Expenditure of £1.511m against the original plan of £5.597m.
Capital forecast has reduced by £3.435m compared to the original plan. Directors have agreed a new forecast following a review. Of the self funded capital the main slippage relates to the North Block Fire scheme which is currently under review and will be subject to a revised business case. All other schemes are reduced as a result of expenditure being lower than plan or expenditure was brought forward into 2022/23. Front line digital PDC funded capital has been reduced to £1.990m.

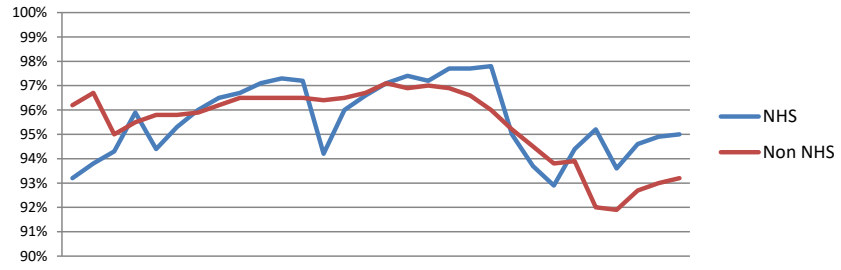
At this stage of the year the Trust is forecasting a capital spend of £14.157m.

CASH FLOW 2023/24



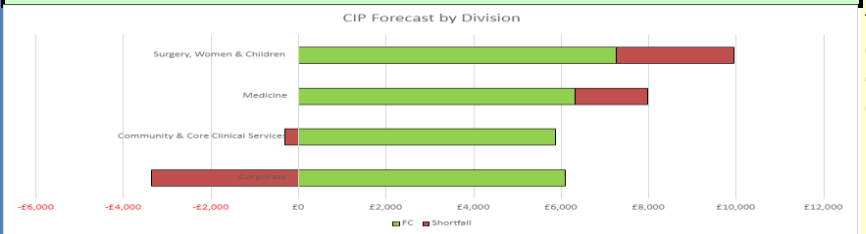
Commentary:
Actual position at the end of September was £1.107m higher than the forecast.
Payments were £1.787m lower than the forecast in September. This was off-set by an under recovery on non-patient income. Both relate to the delay in agerement of P-P charges both payable/receivable.
Current cash forecast has remained the same compared to the previous month. The Trust is forecasting a year end cash balance of £6.476m against the plan of £5.581m. Re-forecast of the capital plan is the main contributor to the movement. Forecast and plan assume £20m of PDC cash support transfers to ensure the Trust remains liquid. £20m on account paid by ICB in June to assist with cash flow for pay award payments. This is to be returned in March.

BETTER PAYMENT PRACTICE CODE (APRIL 2021 TO DATE)



Commentary:
The Trust is required to pay both NHS and Non-NHS suppliers within 30 day terms.
The better payment practice code was achieved for NHS suppliers year to date in September for number of invoices paid. The target of 95% was achieved for all suppliers in terms of the value of invoices paid.

EFFICIENCY PROGRAMME



Commentary:
Total efficiency target of £26.233m
Corporate exceeded plan due to 1-off technical items.
C&CCS forecast to better plan linked to income.
Overall forecast now only £690k short.
ERF potential opportunities included within forecast.
However 50.6% of forecast is non recurrent.

Recurrent schemes needed to address one off items in 23/24.

SYSTEM	YTD	Var
ICB	£2,100	-£400
BCH	-£1,555	-£3,505
DIHC	£501	£29
SWB	-£21,241	-£9,229
DGFT	**-£13,186**	**£803**
RWT	-£28,797	-£4,352
WHT	-£20,800	-£12,980
WMAS	£3,764	£2,580
TOTAL	**-£79,214**	**-£27,054**

DGFT FORECAST	
Most Likely	**-£22,692**
DCSL/Technical	£326
Most Likely Adjusted	**-£22,366**
Agreed Plan	-£19,174
Shortfall	**-£3,192**
Best Case Scenario	**-£17,224**
Worse Case Scenario	**-£32,065**

Commentary:
Most likely forecast falls short of plan by £3.192m
Adverse variance relates to industrial action/excess inflation.
Best case forecast equates to a deficit of £17.224m. Worse case forecast improved to a deficit of £32.065m
Likelihood of additional funding for industrial action.

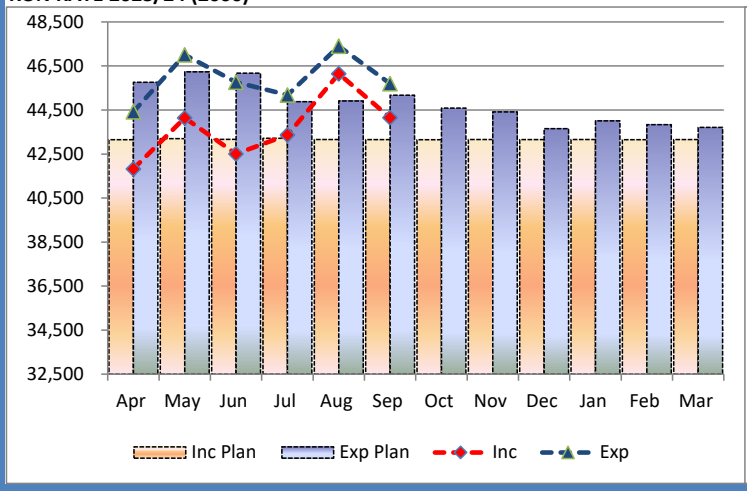
System position shows deficit of £79.2m to September.
This performance is £27m worse than plan.

OVERALL FINANCIAL SUMMARY DASHBOARD **SEPTEMBER 2023**

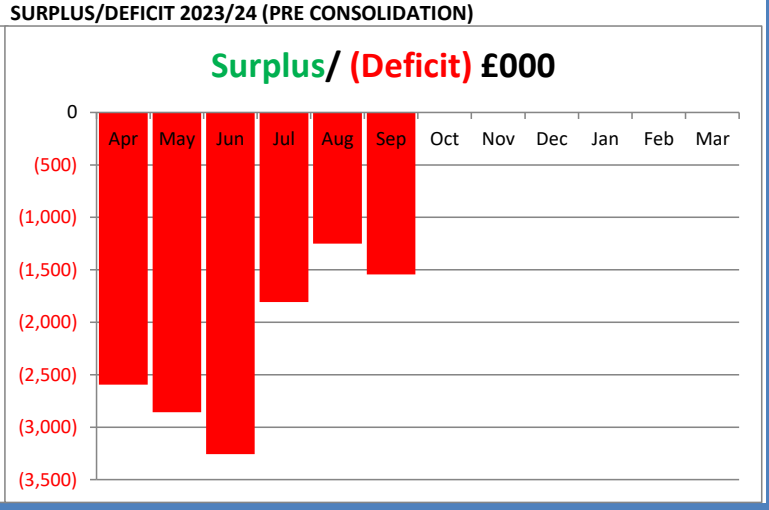
CURRENT MONTH/CUMULATIVE FINANCIAL PERFORMANCE

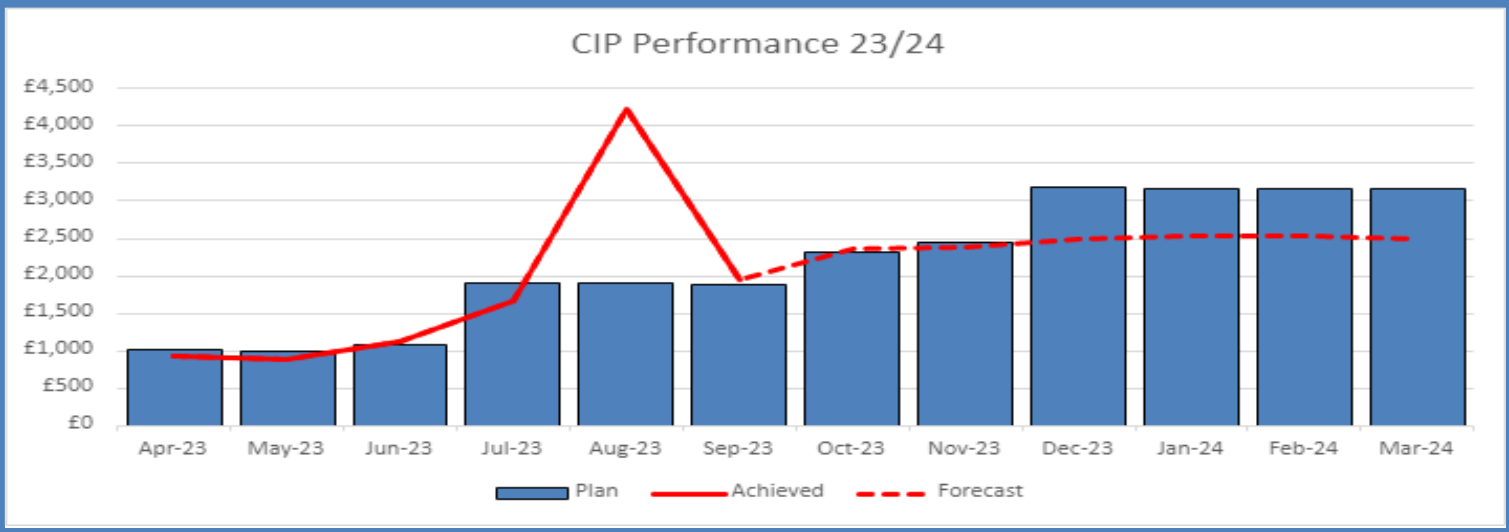
	CURRENT			CUMULATIVE YTD			FORECAST		
	PLAN	ACTUAL	VAR	PLAN	ACTUAL	VAR	PLAN	ACTUAL	VAR
PATIENT CARE INCOME	£41,375	£40,780	-£594	£248,294	£248,925	£631	£496,575	£504,429	£7,854
OTHER INCOME	£1,780	£3,376	£1,596	£10,751	£13,225	£2,474	£21,402	£23,693	£2,291
PAY EXPENDITURE	-£28,834	-£28,113	£721	-£171,742	-£171,350	£392	-£344,148	-£345,997	-£1,849
NON PAY EXPENDITURE	-£13,575	-£14,899	-£1,324	-£84,788	-£87,405	-£2,617	-£159,356	-£170,994	-£11,638
OTHER EXPENDITURE	-£2,764	-£2,688	£76	-£16,596	-£16,705	-£109	-£33,823	-£33,823	£0
PRE CONSOLIDATION	**-£2,018**	**-£1,544**	**£474**	**-£14,081**	**-£13,311**	**£770**	**-£19,350**	**-£22,692**	**-£3,342**
DUDLEY CLINICAL SERVICES LTD		£17	£17		£98	£98		£150	£150
FINAL POSITION	**-£2,018**	**-£1,527**	**£491**	**-£14,081**	**-£13,213**	**£868**	**-£19,350**	**-£22,542**	**-£3,192**

RUN RATE 2023/24 (£000)



SURPLUS/DEFICIT 2023/24 (PRE CONSOLIDATION)





Pre consolidation deficit of £1.544m in September resulting in cumulative deficit of £13.311m.
Post consolidation deficit of £1.527m in September resulting in cumulative deficit of £13.213m.

Adjustments for technical items equating to £0.027m resulting in a **reported M5 deficit of £13.186m.** This is £0.803m better than plan.

It is not expected that the Trust will have any balance sheet flexibility to assist with the position (as per planning assumptions).

The position includes the agenda for change pay award. This was paid in June. The pressure relating to the non-consolidated element for 22/23 is expected to be c£196k (£130k paid to date). The Medics pay award/backpay was paid in September. This has been accrued previous months.

Additional income of £11.877m has been agreed with commissioners for the agenda for change and medical pay awards. This relates to an extra 2.3% plus one-off funding in lieu of other non NHS commissioners. ERF to M5 has been estimated at a benefit of £0.205m (was £0.517m at M5).

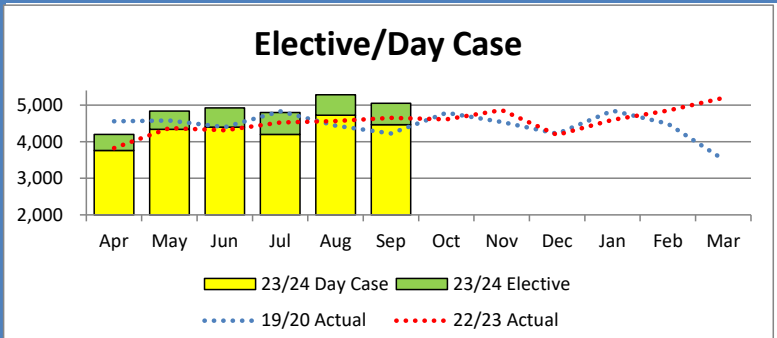
CIP target of £26.233m. Current performance £1.988m better than plan. Latest year end forecast of £25.543m (£690k below plan) split 49.4% recurrent and 50.6% non recurrent. Position bolstered by one-off technical items and assumed additional ERF and other variable contract income. It remains essential to continue to identify and deliver additional recurrent schemes to address non recurrent impact.

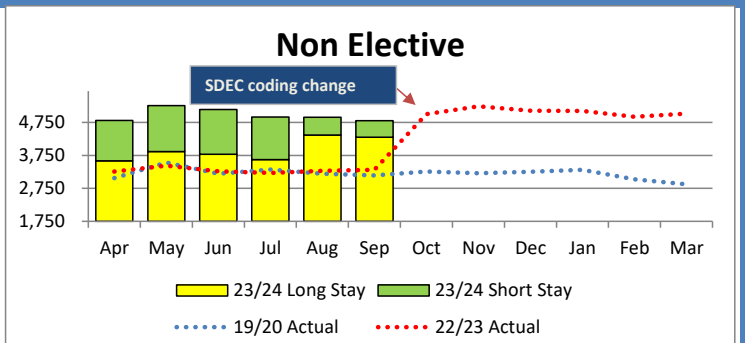
INCOME & ACTIVITY SUMMARY DASHBOARD **SEPTEMBER 2023**

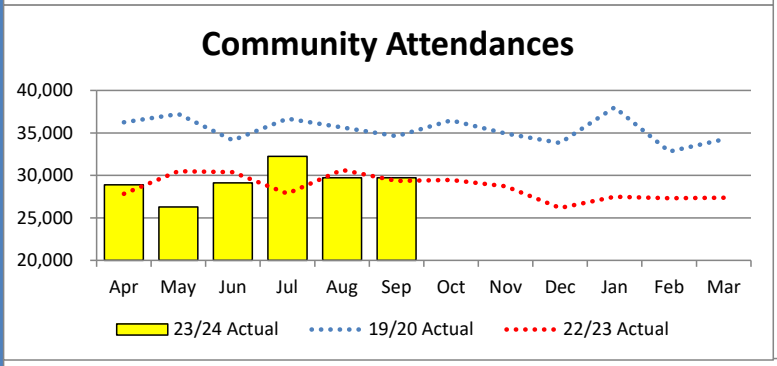
INCOME PERFORMANCE	£000
SEPTEMBER 2023 PLAN	£43,155
SEPTEMBER 2023 ACTUAL	£44,156
SEPTEMBER 2023 VARIANCE	**£1,001**

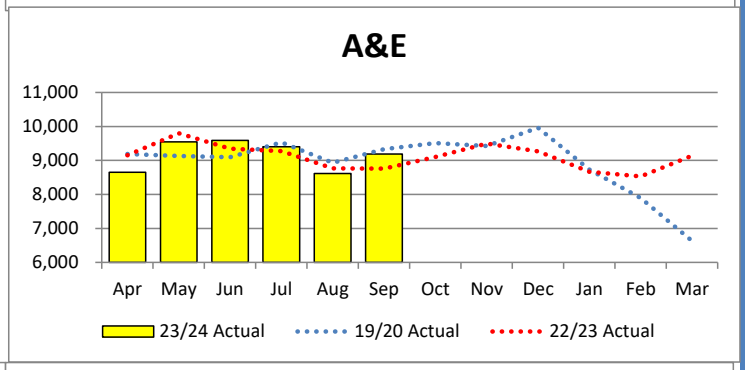
	£000
CUMULATIVE PLAN	£259,045
CUMULATIVE ACTUAL	£262,150
CUMULATIVE VARIANCE	**£3,105**

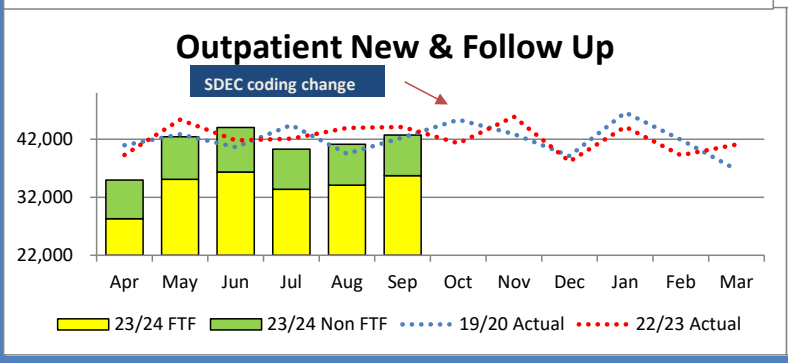
INCOME BREAKDOWN	SEPTEMBER 2023			YEAR TO DATE (£000)		
	PLAN	ACTUAL	VARIANCE	PLAN	ACTUAL	VARIANCE
Patient Care Income	£41,375	£40,780	-£594	£248,294	£248,925	£631
Education	£1,217	£1,966	£750	£7,351	£8,266	£915
Research & Development	£92	£70	-£22	£549	£479	-£70
Non Patient Services	£108	£392	£284	£639	£933	£294
Staff Recharges	£218	£783	£565	£1,301	£2,340	£1,039
Other Income	£146	£165	£20	£911	£1,206	£295
Outside Envelope Funding	£0	£0	£0	£0	£0	£0
GRAND TOTAL INCOME	**£43,155**	**£44,156**	**£1,001**	**£259,045**	**£262,150**	**£3,105**

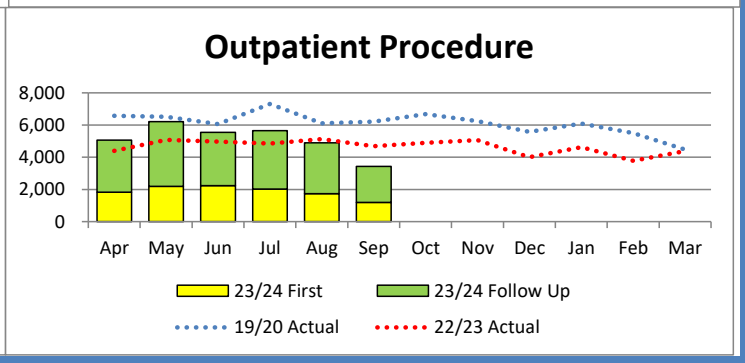












Income performance to September shows an improved performance against plan.

Opening plans have been adjusted by £11.877m relating to funding for the additional pay awards for both agenda for change and medical staff. The adjustment includes inflation from other bodies such as Local Authorities.

The improved performance is linked to ERF, passthrough income from Specialised Services and one-off income relating to 22/23.

Final ERF plans have now been confirmed with adjustments for both pay awards and the 2% reduction in lieu of industrial action. NHSE have sent out estimates for April to June equating to an over-achievement of £1.098m for Dudley Group. However, this value relates to the inflated 19/20 baseline and excludes the additional growth percentage that is required before ERF is payable to the Trust.

There is a requirement to include an estimate for ERF within the M6 position. The latest Trust estimate taking into account the required growth uplift and the 2% deduction for industrial action in April results in an assumed additional £205k.

It has been confirmed that further adjustments are to be agreed in lieu of the continued industrial action. However, it is unclear as to whether this will be actioned via a further reduction to the ERF baseline or an additional allocation to ICBs.

Over-delivery of ERF and the other variable components of the contract will be key to the Trust delivering the required forecast.

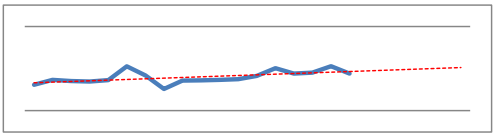
PAY SUMMARY DASHBOARD **SEPTEMBER 2023**

CURRENT MONTH/CUMULATIVE FINANCIAL PERFORMANCE

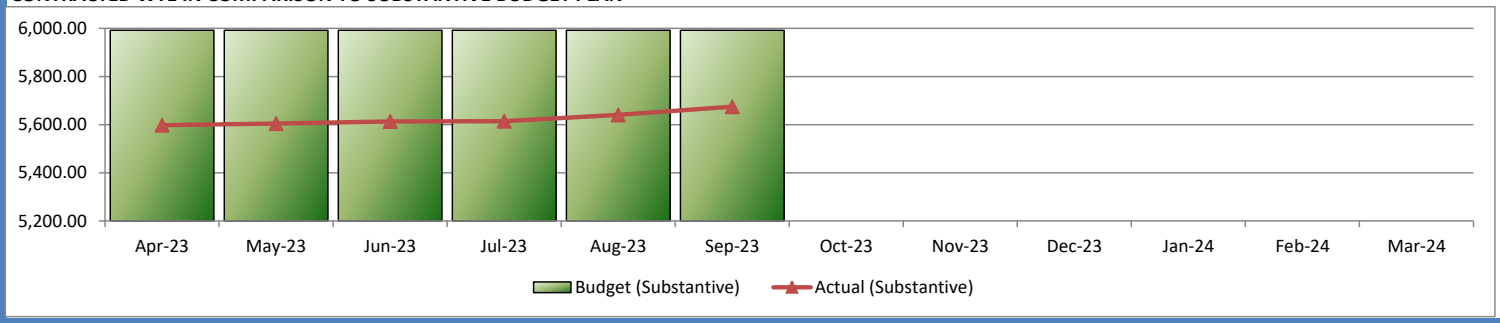
	£000
SEPTEMBER 2023 PLAN	-£28,834
SEPTEMBER 2023 ACTUAL	-£28,113
SEPTEMBER 2023 VARIANCE	**£721**

	£000
CUMULATIVE PLAN	-£171,742
CUMULATIVE ACTUAL	-£171,350
CUMULATIVE VARIANCE	**£392**

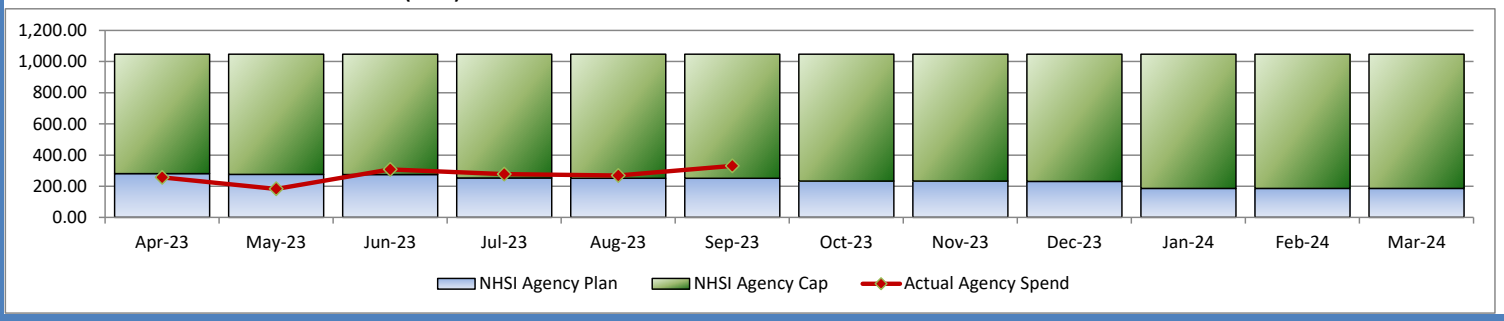
PAY TREND



CONTRACTED WTE IN COMPARISON TO SUBSTANTIVE BUDGET PLAN



AGENCY PERFORMANCE AGAINST NHSI CAP (£000)



AGENCY SPEND BY STAFF GROUP (£000) (EXCLUDES VAX PROG)

	AVERAGE 22/23	AVERAGE 23/24	ACTUAL CURRENT
NURSING QUALIFIED	£1,059	£63	£77
NURSING UNQUALIFIED	-£1	£0	£0
MEDICAL & DENTAL	£207	£191	£240
SCIENTIFIC/THERAPEUT	£63	£13	£14
ADMIN/MGR/OTHER	£87	£4	£0
TOTAL	**£1,416**	**£271**	**£330**

BANK SPEND BY STAFF GROUP (£000) (EXCUDES VAX PROG)

	AVERAGE 22/23	AVERAGE 23/24	ACTUAL CURRENT
NURSING QUALIFIED	£1,128	£1,173	£1,141
NURSING UNQUALIFIED	£674	£611	£642
MEDICAL & DENTAL	£1,007	£1,198	£989
SCIENTIFIC/THERAPEUT	£281	£386	£386
ADMIN/MGR/OTHER	£185	£216	£224
TOTAL	**£3,274**	**£3,585**	**£3,382**

WLI SPEND BY DIVISION (£000) (EXCLUDES VAX PROG)

	AVERAGE 22/23	AVERAGE 23/24	ACTUAL CURRENT
CLINICAL SUPPORT	£12	£12	£15
MEDICINE	£51	£50	£46
SURGERY	£325	£436	£489
CORPORATE	£18	£4	£19
TOTAL	**£407**	**£502**	**£569**

OVERTIME SPEND BY DIVISION (£000) (EXCLUDES VAX PROG)

	AVERAGE 22/23	AVERAGE 23/24	ACTUAL CURRENT
CLINICAL SUPPORT	£54	£20	£7
MEDICINE	£28	£36	£37
SURGERY	£5	£7	£7
CORPORATE	£9	£7	£5
TOTAL	**£97**	**£70**	**£57**

	£000	
Average M1-5	**£28,647**	**Included estimate for medical pay awards**
In-month	**£28,113**	**Reduction in medical bank in September**
Average M1-6	**£28,558**	**Impact of all pay awards now in cumulative position**

PAYBILL £000

	SEPTEMBER 19/20	SEPTEMBER 22/23	SEPTEMBER 23/24		APRIL TO SEPTEMBER 19/20	APRIL TO SEPTEMBER 22/23	APRIL TO SEPTEMBER 23/24	
Employed	**16,950**	**23,878**	**23,774**	0.4% decrease on 22/23	**98,910**	**127,220**	**144,788**	13.8% increase on 22/23
Agency	**837**	**1,810**	**330**	81.7% decrease on 22/23	**6,338**	**10,698**	**1,625**	84.8% decrease on 22/23
Bank	**1,671**	**3,508**	**3,382**	3.6% decrease on 22/23	**10,405**	**19,481**	**21,508**	10.4% increase on 22/23
WLI/OT	**241**	**629**	**626**	0.4% decrease on 22/23	**1,913**	**3,543**	**3,429**	3.2% decrease on 22/23
			28,113				**171,350**	

WTE

	SEPTEMBER 19/20	SEPTEMBER 22/23	SEPTEMBER 23/24		Average APRIL TO SEPTEMBER 19/20	Average APRIL TO SEPTEMBER 22/23	Average APRIL TO SEPTEMBER 23/24	
RNs	**1,477**	**1,614**	**1,854**		**2,222**	**2,392**	**2,751**	
CSWs	**810**	**991**	**951**		**1,180**	**1,426**	**1,461**	
Medics	**595**	**752**	**821**		**875**	**1,071**	**1,204**	
AHP/Sci	**707**	**881**	**940**		**1,050**	**1,276**	**1,362**	
Other	**902**	**1,060**	**1,108**		**1,365**	**1,584**	**1,658**	
	4,491	**5,297**	**5,674**	7.1% increase on 22/23	**6,691**	**7,750**	**8,436**	8.9% increase on 22/23

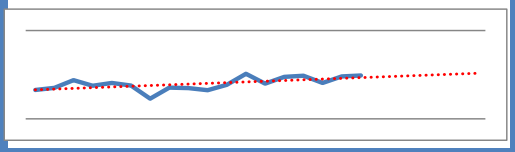
NON PAY SUMMARY DASHBOARD **SEPTEMBER 2023**

CURRENT MONTH/CUMULATIVE FINANCIAL PERFORMANCE

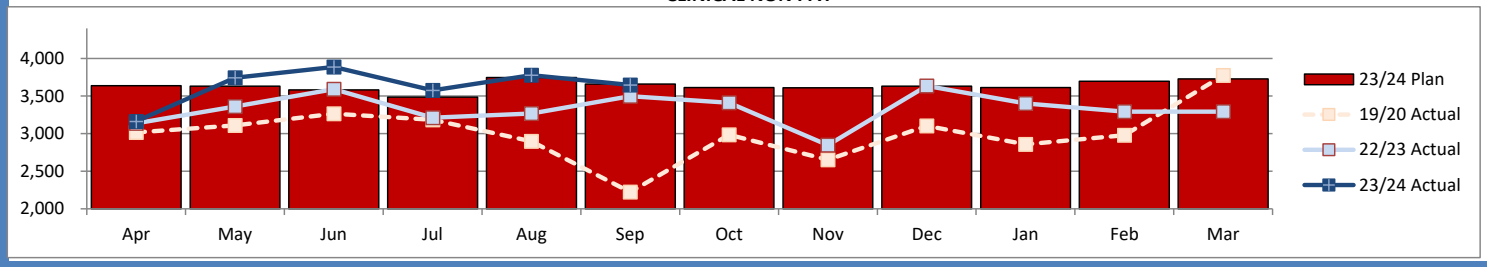
	£000
SEPTEMBER 2023 PLAN	-£13,575
SEPTEMBER 2023 ACTUAL	-£14,899
SEPTEMBER 2023 VARIANCE	**-£1,324**

	£000
CUMULATIVE PLAN	-£84,788
CUMULATIVE ACTUAL	-£87,405
CUMULATIVE VARIANCE	**-£2,617**

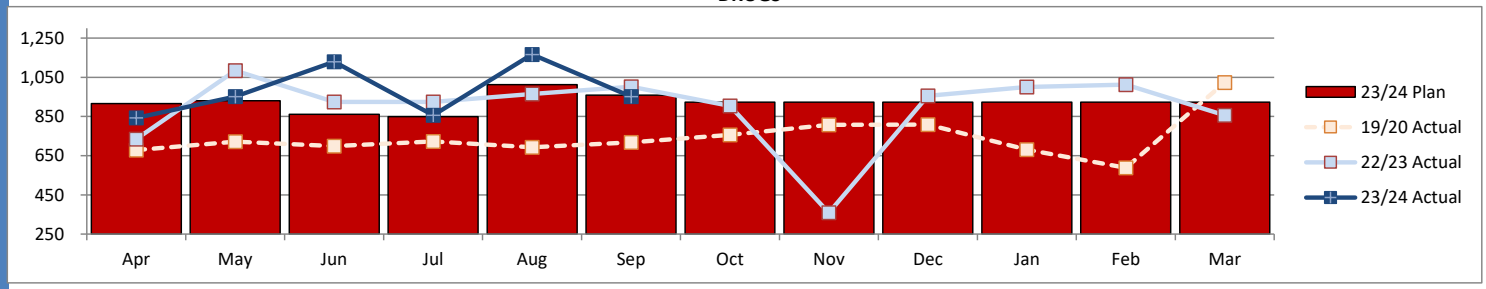
NON PAY TREND FROM APRIL 2022



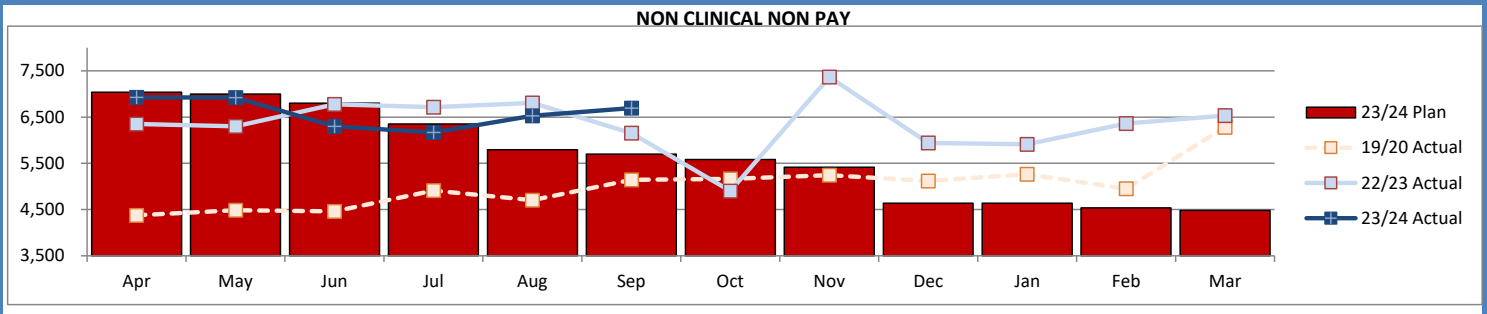
CLINICAL NON PAY



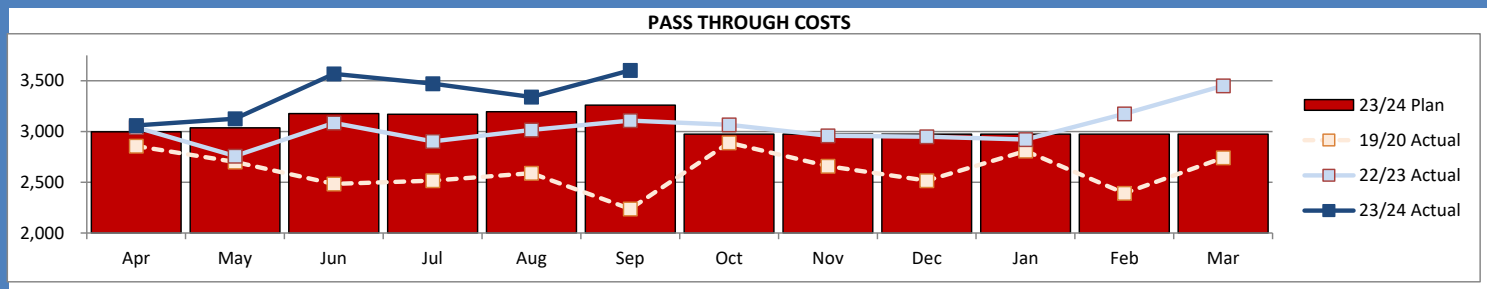
DRUGS



NON CLINICAL NON PAY



PASS THROUGH COSTS



	£000	
Average M1-5	**£14,501**	
In-month	**£14,899**	**September passthrough costs £290k higher than average; Dialysis costs also £75k higher than average**
Average M1-6	**£14,568**	

SEPTEMBER

	19/20	22/23	23/24	PLAN	VARIANCE	
Clinical	**2,223**	**3,499**	**3,648**	**3,661**	**12**	**close to plan**
Drugs	**718**	**1,002**	**952**	**959**	**7**	**close to plan**
Non Clinical	**5,142**	**6,154**	**6,696**	**5,697**	**-999**	**mainly links to Miscellaneous (CIP adjustments)**
Passthrough	**2,238**	**3,107**	**3,603**	**3,258**	**-345**	**ICB Drugs £281k, Infusor Pumps £53k (within block funding)**
			14,899	**13,575**	**-1,324**	

APRIL TO SEPTEMBER

	19/20	22/23	23/24	PLAN	VARIANCE	
Clinical	**17,695**	**20,069**	**21,796**	**21,746**	**-50**	**close to plan**
Drugs	**4,232**	**5,633**	**5,898**	**5,526**	**-371**	**AMU, Chemical Pathology, Obstetrics, Anaesthetics and Outpatients**
Non Clinical	**28,081**	**39,101**	**39,542**	**38,684**	**-858**	**Miscellaneous (CIP), Computers, Consultancy part negated by PFI and Training**
Passthrough	**15,386**	**17,908**	**20,169**	**18,832**	**-1,338**	**ICB drugs £1.012m and Infusor Pumps £281k (within block funding)**
			87,405	**84,788**	**-2,617**	

Appendix 2 – Impacts to mortality rates due to industrial action (Nuala Hadley)

There were 18 deaths during the Junior Doctor strikes with 14 deaths in the same time period prior to the strike and 13 deaths in the same time period post-strike. There are currently no logged incidents requiring a Structured Judgement from Governance and the Medical Examiner did not refer any cases for review for this time period. Review In comparison to the same periods last year the deaths were 31,32,19.

There were 6 deaths during the August consultant strike with 2 deaths in the same time period prior to the strike and 6 in the same time period post-strike. As with the deaths observed during the Junior Doctor strike there have been no logged incidents requiring a Structured Judgement from Governance and the Medical Examiner did not refer any cases for review.

There were 13 deaths during the combined industrial action between 19th September and 23rd September with 23 deaths in the same time period prior to the strike and 20 deaths in the same time period post-strike. There are currently no logged incidents requiring a Structured Judgement from Governance and the Medical Examiner referred 2 cases for review for the period of industrial action but neither related to governance investigations or where there may have been harm. There are also no incidents logged for the dates pre and post-industrial action. The figures for the same periods last year are:

14th ~ 18th September 2022 – 20

19th ~ 23rd September 2022 – 21

24th ~ 28th September 2022 – 19

For the industrial action that took place between 2nd – 5th October there were 11 deaths, for the period prior to the industrial action there were 7 deaths and for the period following the industrial action there were 20 deaths. There was one death reported on Datix and currently registered as a green incident and there were 3 further cases referred by the ME for SJR for learning. There are also no incidents logged for the dates pre and post-industrial action. The figures for the same periods last year are:

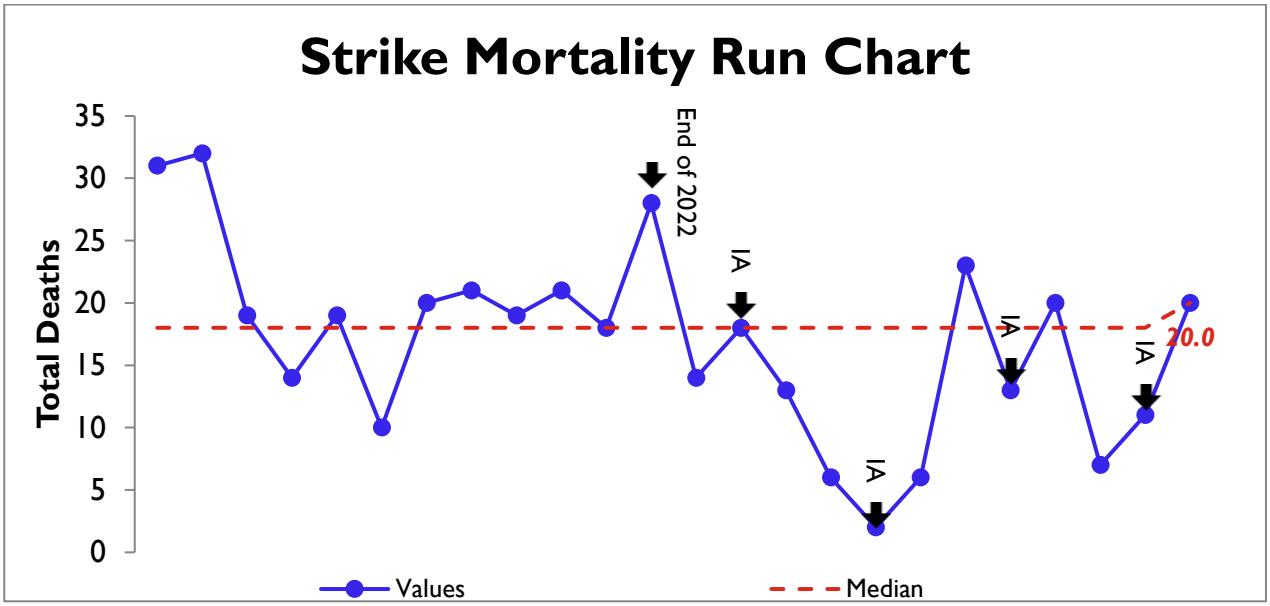
27th September ~ 1st October 2022 – 21

2nd ~ 5th October 2022 – 18

6th ~ 9th October 2022 – 28

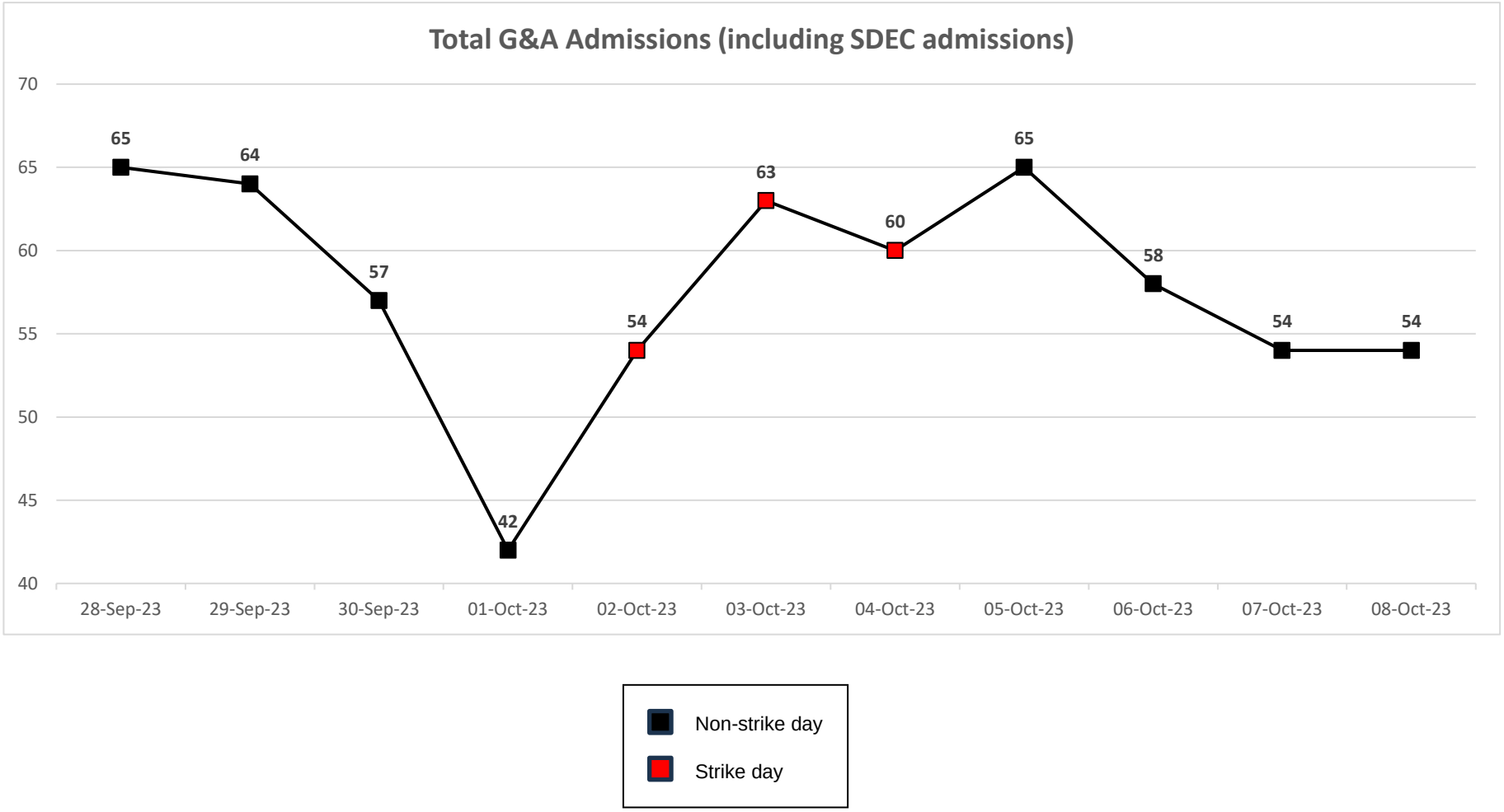
These figures demonstrate that there was no deterioration in patient safety during industrial action.

Appendix 2 continued…

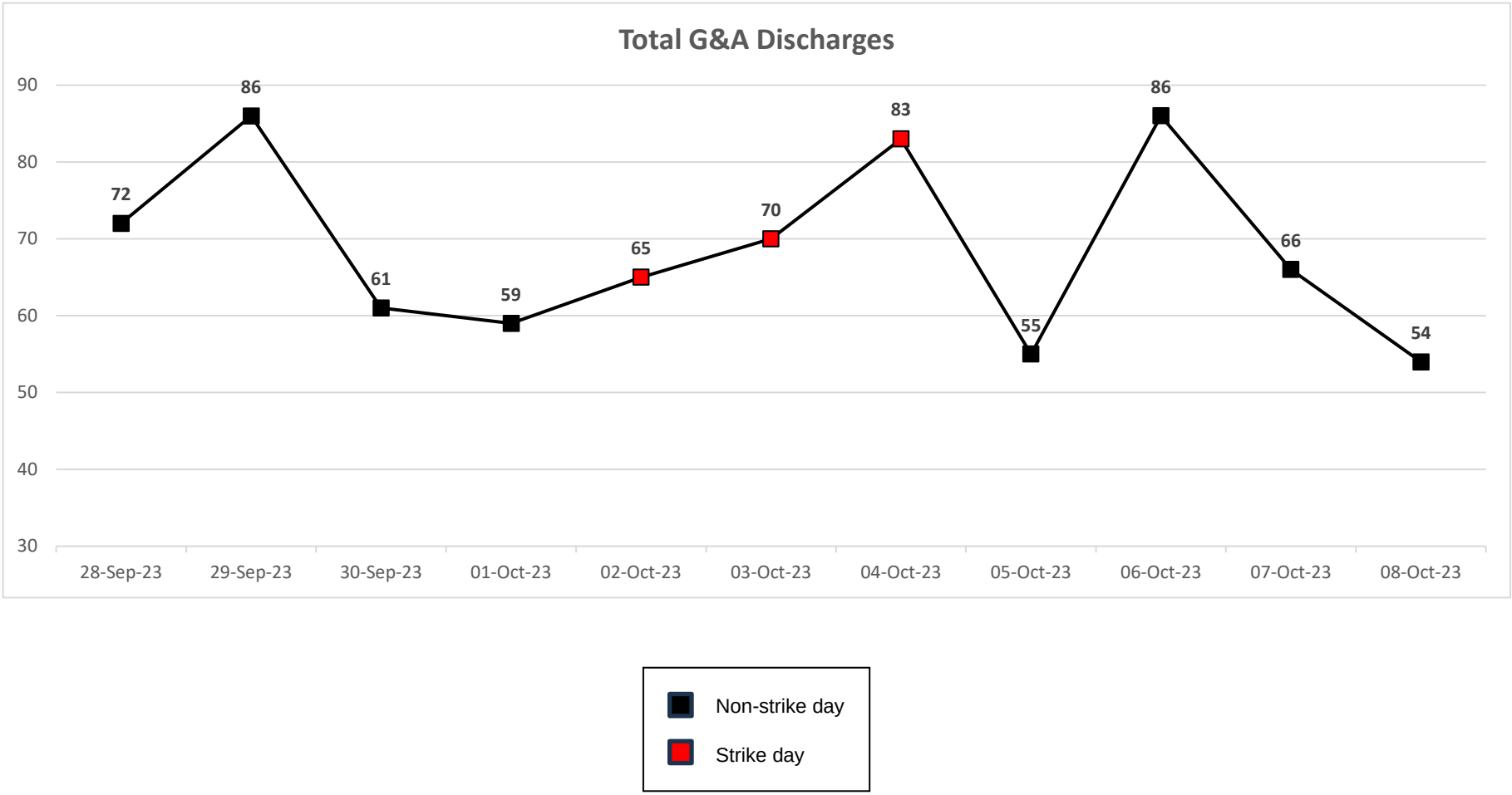


The run chart demonstrates the same periods in 2022 compared to the Industrial Action in 2023, it can be noted that other than the first instance of industrial action there was an increase in deaths following the action, this would need to be triangulated with other data to identify the reasoning for this.

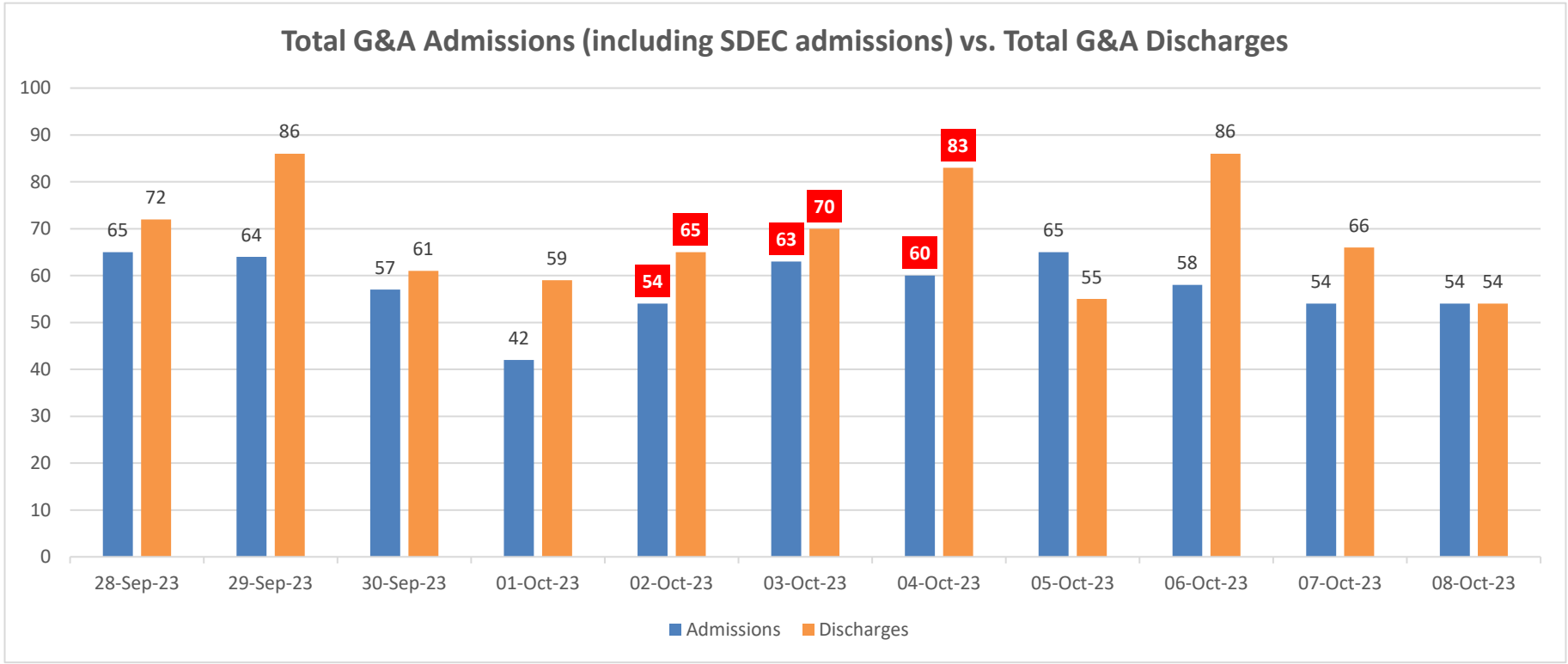
Appendix 3 – Total G&A admissions (including SDEC admissions) per day at The Dudley Group from Thursday 28th September to Sunday 8th October 2023.



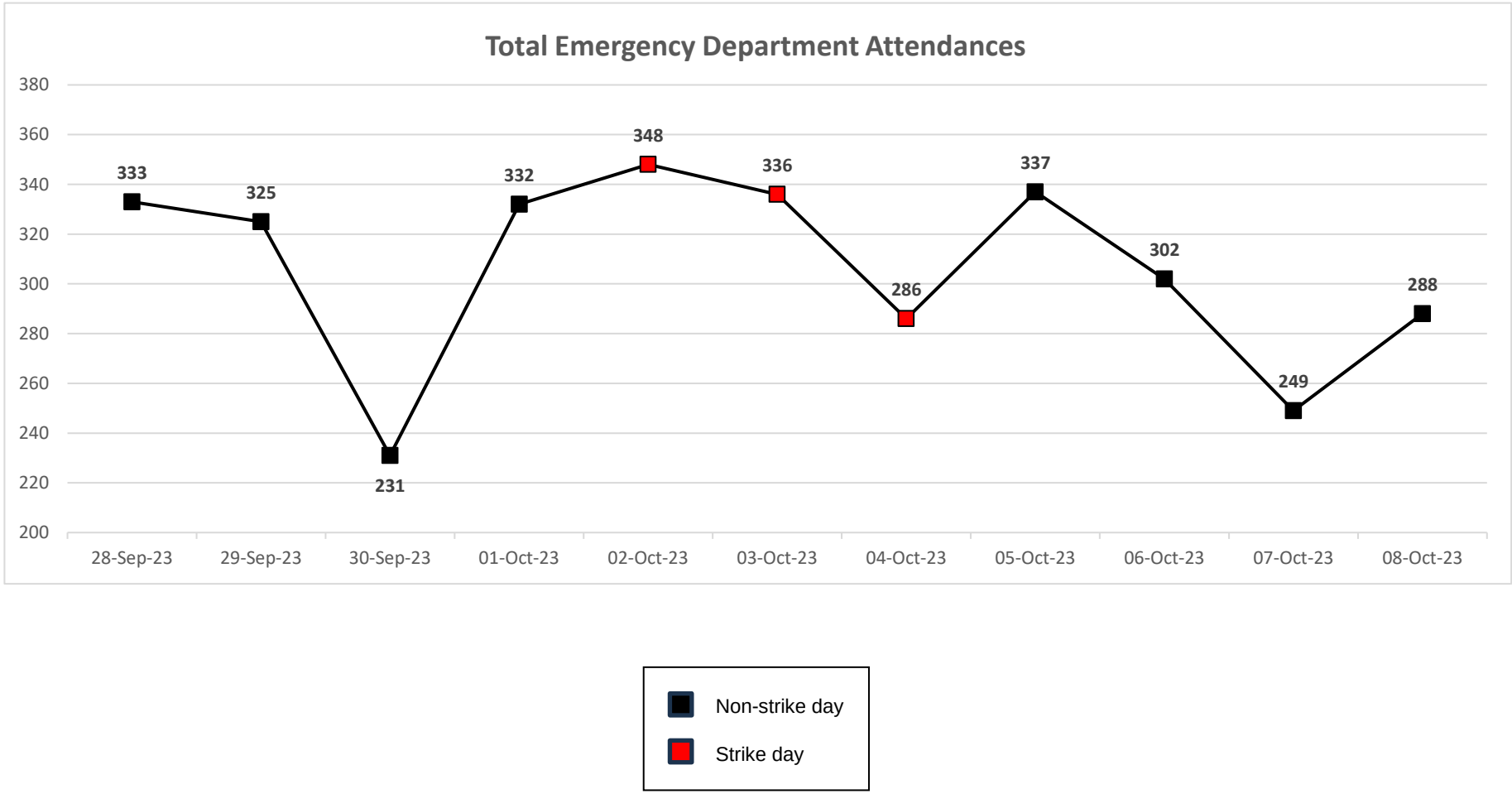
Appendix 4 – Total G&A discharges per day at The Dudley Group from Thursday 28th September to Sunday 8th October 2023.



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 Thursday 28th September to Sunday 8th October 2023.



Appendix 6 – Total Emergency Department attendances per day at The Dudley Group from Thursday 28th September to Sunday 8th October 2023.



Performance KPIs

Item 9.2 IPR data pack

October 2023 Report (September 2023 Data)

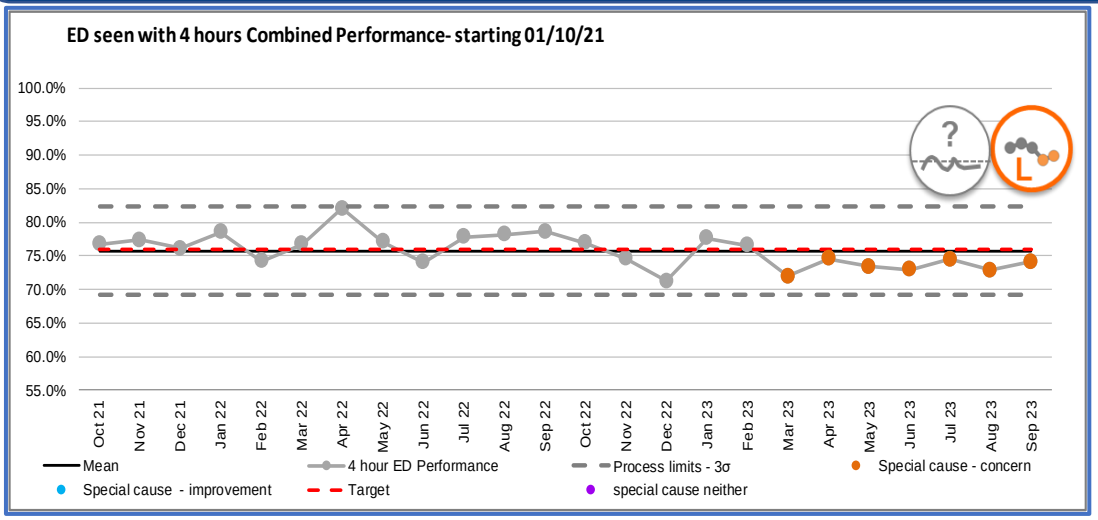
Karen Kelly, Chief Operating Officer

The Dudley Group NHS Foundation Trust

Constitutional Performance

Constitutional Standard and KPI		Target	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Status	
Emergency Access Standard (EAS)	Combined 4hr Performance	75.0%	78.7%	76.9%	74.6%	71.3%	77.6%	76.5%	72.0%	74.5%	73.4%	72.9%	74.5%	72.8%	74.1%	L	?
Triage	Triage - All	95.0%	84.3%	83.8%	80.7%	74.2%	79.5%	71.2%	69.3%	79.5%	77.7%	70.4%	75.2%	78.9%	84.0%		F
Cancer	Cancer 62 Day - All	85.0%	69.7%	69.7%	69.7%	46.6%	41.2%	42.0%	60.0%	59.4%	61.3%	52.9%	64.0%	59.2%	N/A		F
	Cancer 31 Day -	96.0%	84.9%	90.4%	83.2%	92.7%	82.0%	88.4%	86.9%	89.0%	83.3%	85.5%	85.7%	85.4%	N/A	L	?
	All Cancer 2 Week Waits	93.0%	77.0%	80.6%	86.1%	83.9%	83.5%	93.8%	93.9%	84.7%	75.2%	74.1%	93.2%	92.5%	N/A		?
Referral to Treatment (RTT)	RTT Incomplete	92%	65.5%	64.5%	63.3%	60.3%	59.9%	58.9%	58.2%	57.4%	58.0%	58.3%	56.7%	55.6%	55.6%	L	F
Diagnostics	DM01 - Diagnostics achieved within 6 weeks	99%	78.1%	76.9%	76.4%	71.0%	70.4%	74.0%	72.1%	68.5%	68.7%	68.7%	67.4%	64.4%	66.6%	L	F
VTE	% Assessed on Admission	95%	93.2%	93.3%	94.5%	93.4%	93.7%	94.3%	94.3%	94.8%	95.1%	97.4%	98.3%	99.1%	N/A	H	P

ED Performance



Latest Month	Latest Month	5th
74.1%	69	For August 23
EAS 4 hour target 75% for Type 1 & 3 attendances	DTA 12 hour breaches - target zero	DGFT ranking out of 13 West Midlands area Trusts

Performance

September 4 hour position 74.1% vs 75% national target – this is an improvement on August.

4hour performance split into the following:

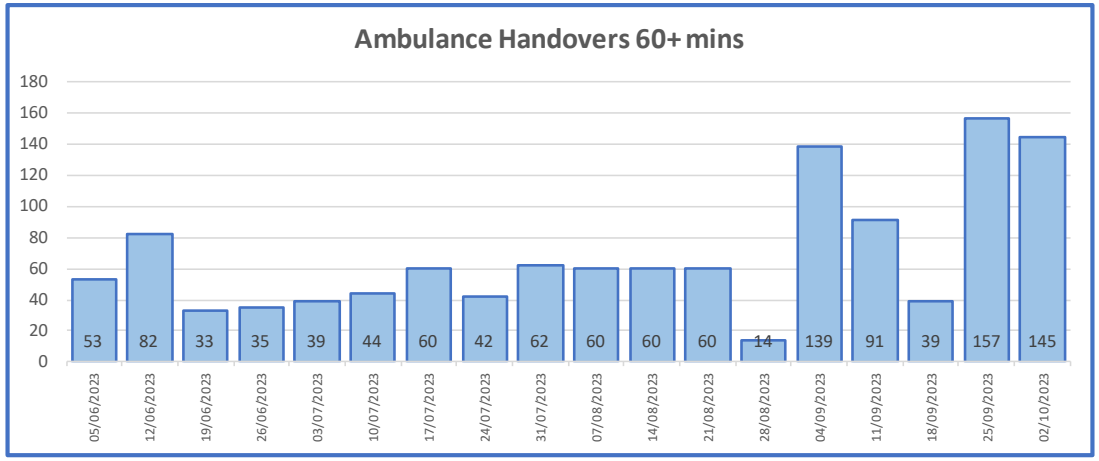
Non Admitted: 215mins Average LoS.
Admitted: 480mins Average LoS.

Delays are occurring with patients waiting an extended period in ED after referral and post-take by speciality waiting for bed capacity in the wider hospital.

Action

- ED Tri working on Roles & Responsibilities in department to ensure that staff groups are aligned in early decision making.
- Communication with wider specialities to ensure that patients are not left stranded in ED Assessment areas limiting ED ability to make prompt decisions.
- Continue to utilise pathways to SDEC/SAEC/UCC for patients who are suitable.
- Ensure when beds are allocated, patients are moved promptly while maintaining safety and dignity.
- Working with DCH & WMAS to increase prehospital utilisation of pathways other than transport to ED.
- Implementation of Rapid Assessment Triage (RAT) at the front door from week of the 23.10.23.
- Joint ED/AMU SOP to support early flow to AMU and thus creating ED capacity.

Ambulance Handovers 60+ Mins



Performance

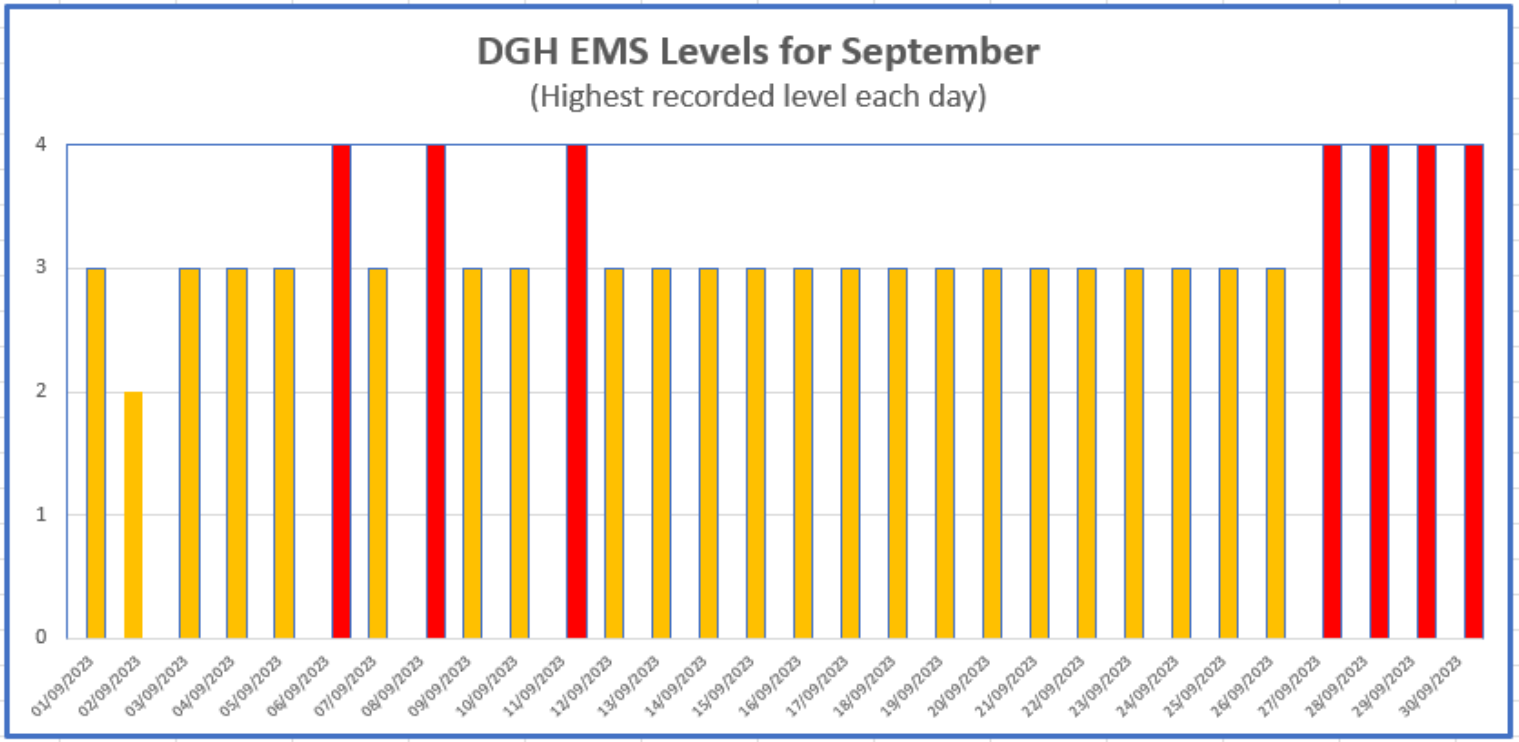
In September, all Trusts within the ICS saw an increase in ambulance handovers of 33%, this took Dudley from 5.64% to just over 9.5% representative of the deterioration across the ICS.

Lack of availability of ambulances led to hi acuity in the waiting room; these patients were unsupervised by paramedics, so in the interest of patient care, waiting room patients were prioritised over ambulance patients. Whilst this has led to an exacerbation in the deterioration in performance it was essential for patient care.

Action

- Electronic transfer sheets developed and being rolled out to aid prompt transfer of patients out of the department.
- Developing offload model to enable WMAS to offload closer to the entrance and under supervision of HALO to prevent unnecessary delays at the bedside or in cleaning trolleys prior to PIN.
- 4 week Rapid Assessment Triage (RAT) pilot beginning 23rd October with increased senior medical resource, as well as, integrated front door team focusing on frailty patients and discharge routes back out to community setting and Virtual Wards.
- Escalation of ambulances without a plan to offload at 30mins to Site Team with additional role cards to link AMU & Site teams based on the Kings College Model.

EMS Level for last month



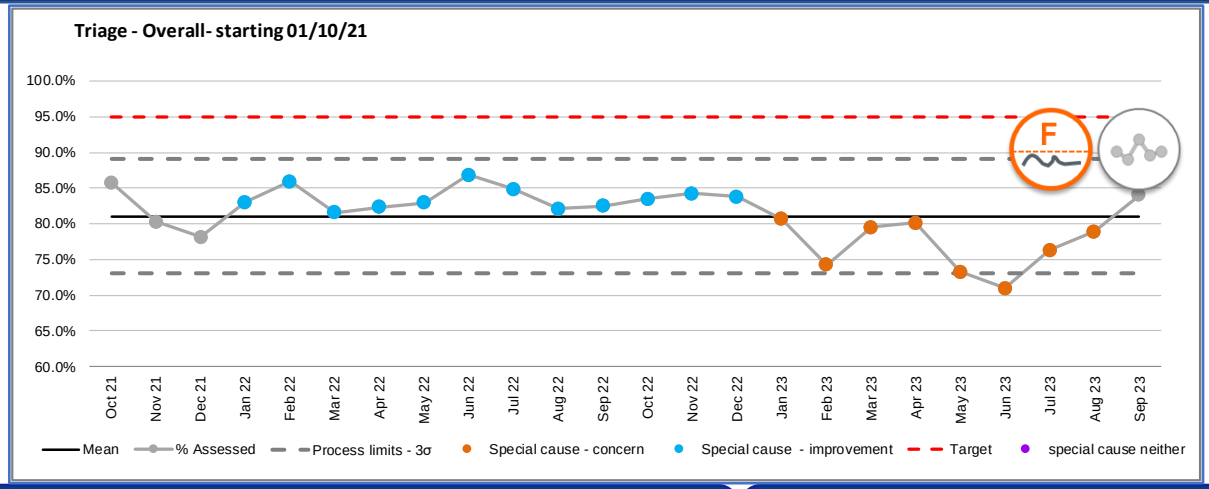
Performance

During September we had almost a 1000 attendances compared to August; bringing us back to our summer peak. This coincides with the number of ICs from Sandwell since the reduction of the bed base to meet the footprint of the new facility at The Midland Met. Hospital. This has been independently modelled by the ICB and it is currently adding 4% of ambulance conveyancing, which is not evenly distributed throughout the day. In terms of capacity the trust has deteriorated to 129 MOFD at the time of writing, which is further exacerbating flow issues and leading to pressure at both the front and back door.

Action

- To continue to utilise non-admitted pathways wherever possible.
- Maintain step downs from acute areas to ensure provision available for the highest acuity patients.

ED Triage



Latest Month

84.0%

Triage – target 95%

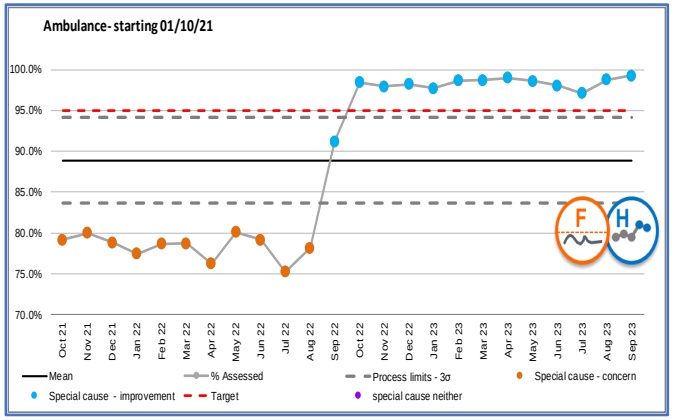
Performance

September Overall Triage position 84% vs 95% national target – this is an improvement on August – contributed by the work undertaken by the DIP team.

Action

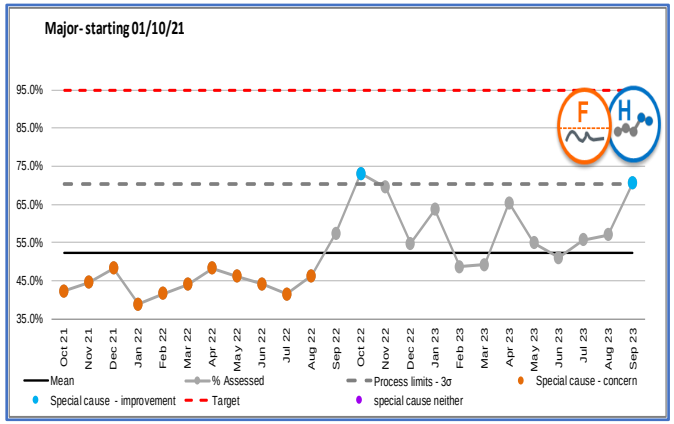
- ECIST currently in supporting with triage process and opportunities for improvement. 2 visits already completed with 3 opportunities identified for focus.
- Deputy Matron now leading on Triage improvement with a target of 31st October set.
- DIP supporting with structured improvement plan and monitoring of actions – weekly meetings to review ongoing.
- ED tri team to present back to the Board on the results of the Triage Project mid-November.

ED Triage



Latest Month

99.3%



Latest Month

70.7%

Performance

Week on week performance of majors triage is beginning to improve over last 4 weeks.

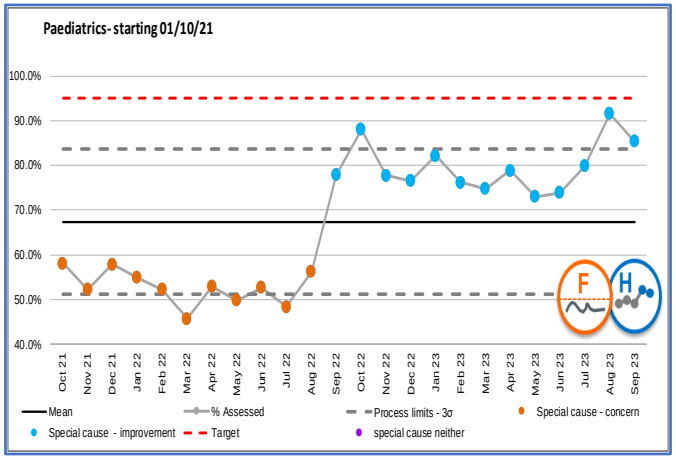
September Ambulance Triage position 99.3% vs 98.7% August.

September Major Triage position 70.7% vs 57% August.

Action

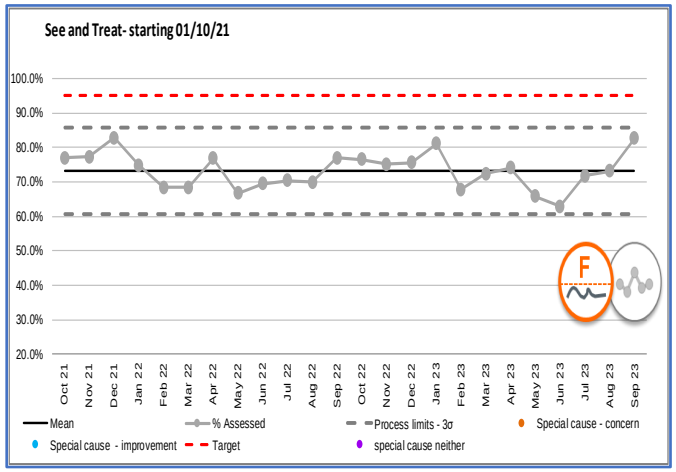
- Reconfiguration of front triage area.
- Roles and responsibilities of triage nurse defined and agreed at Triumvirate to reduce inappropriate tasks and reduce delays calling patients through.
- 1:1 observations by Deputy Matron to identify learning.
- ECIST focusing on registration pathway and staffing of front triage environment.
- Change of upper age limit for minors' triage from 11th September means that less people will need to be seen in majors for a minor injury.
- ED tri team to present back to the Board on the results of the Triage Project mid-November.

ED Triage



Latest Month

85.4%



Latest Month

82.6%

Performance

Redesigning the registration process in conjunction with UCC.

Ensuring that ESI is supported from majors if required.

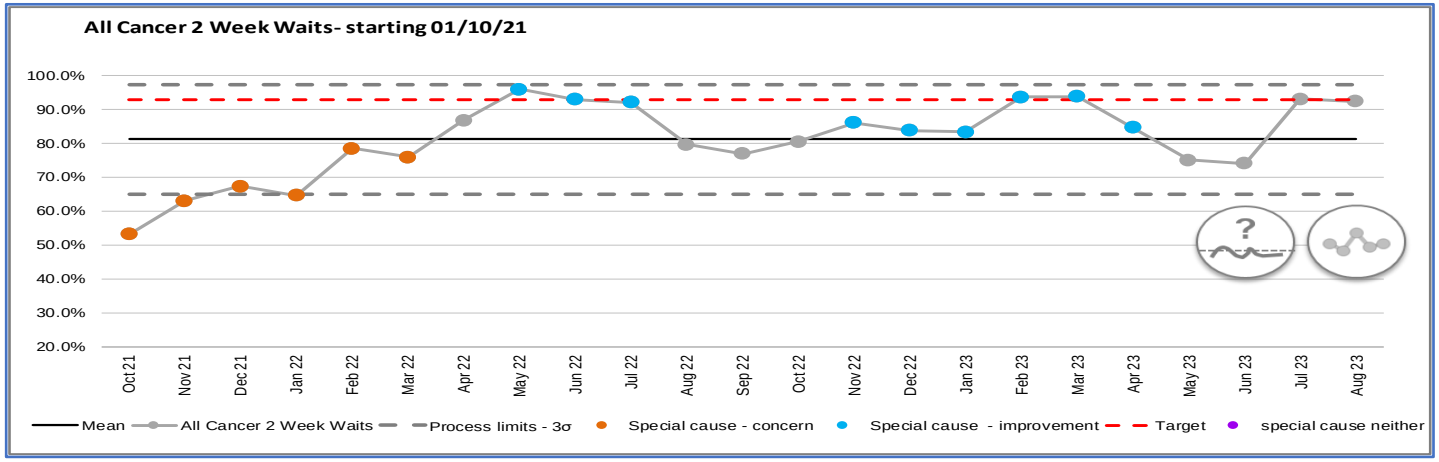
September Paeds Triage position – 85.4% vs 91.6% August – performance slipped through staff sickness; adult ED staff covering paeds area, which has impacted triaging.

September See & Treat Triage position – 82.6% vs 73.1% August.

Action

- Paediatric ward clerk relocated to paeds area for registration of patients.
- Develop process for quickly monitoring and altering when minors patients need to begin having early "eyes on" assessments rather than just seeing and treating patients all in one go – this is being developed and supported by Nurse/ENP/Medical teams.
- ED tri team to present back to the Board on the results of the Triage Project mid-November.

Cancer Performance – 2 Week Wait



Latest Month

92.5%

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 August 2023.

Overall 2 week wait performance achieved target in August.

September unvalidated position shows non-achievement of 93% standard. Challenges with breast and gynae capacity contributed to this, sickness and industrial action did have an impact.

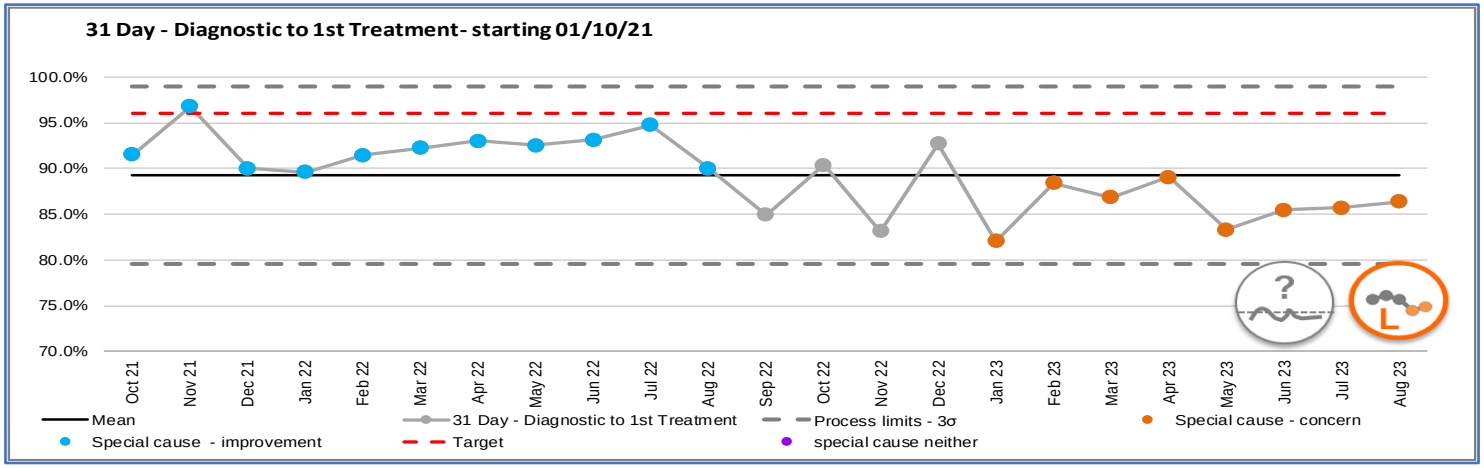
August 2 Week Wait position 92.5% vs 93% national target

*** 93% target was achieved for August, a data error uploading to Cancer Waiting Times to be updated on next upload 31st October.**

Action

- Capacity is challenging for breast, skin and prostate. Extra slots requested. Cancer activity continued during consultant and junior doctor industrial action where possible. Mutual aid for skin provided to Worcester and Sandwell.
- As per NHSE guidance 2 week wait indicator replaced with faster diagnosis standard from October 2023 onwards. Performance against 2 week wait will continue to be monitored locally.

Cancer Performance – 31 Day



Latest Month

86.4%

Target 96%

Performance

31 day performance improved in August and the number of treatments in month remained static compared to July.

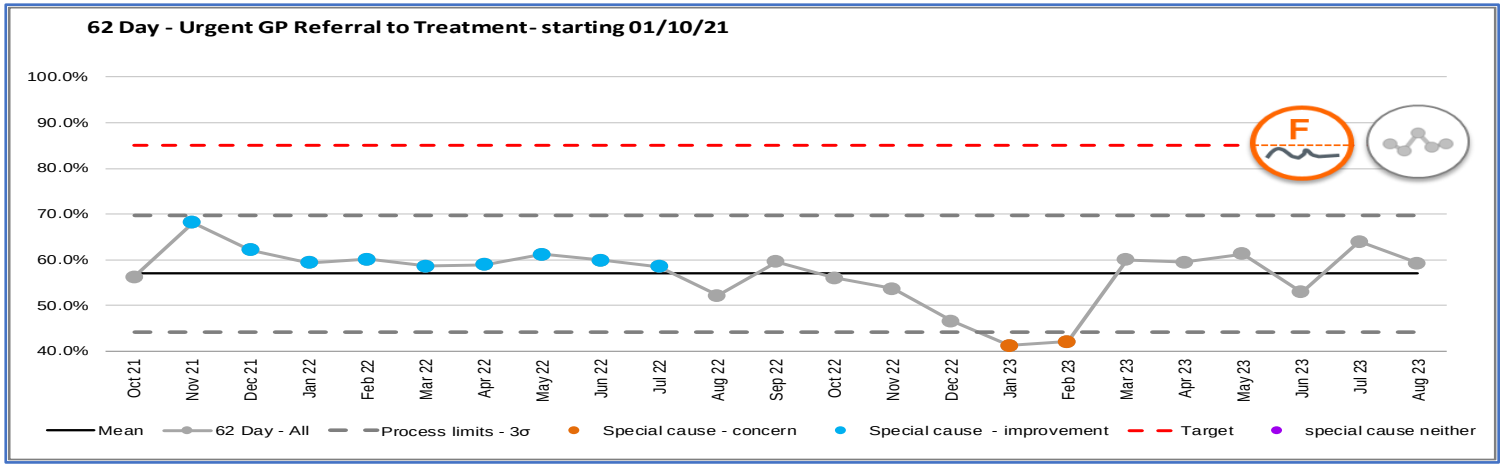
4 tumour sites attained the standard in August, compared to 3 in July.

August 31 day position – 86.4% vs 96% national target.

Action

- Focus remains on reducing the backlog of 62 days with focus on those patients waiting 104 days in order to release treatment capacity.
- Launch of new SOP for Tracking and Escalation to support quicker escalations and prompt response.

Cancer Performance – 62 Day



Latest Month

59.2%

Target 85%

Performance

Performance is below the required operational standard and has declined to 59.2%.

The Trust remains ahead of the submitted 62 day recovery trajectory.

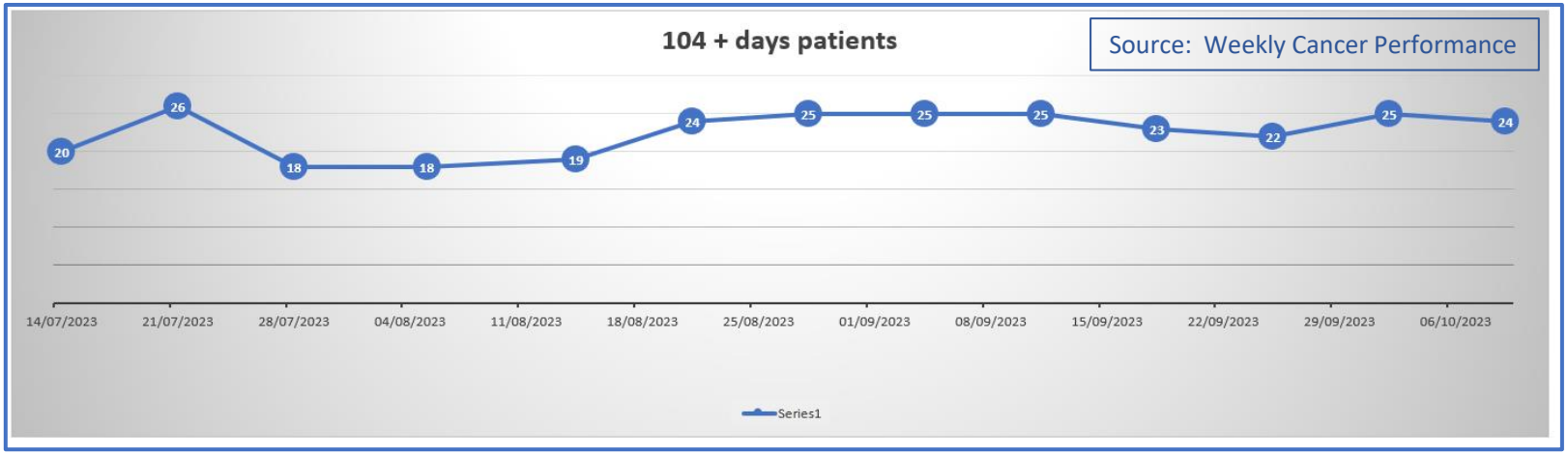
Histology turnaround times remain a significant challenge to cancer targets.

August 62 day position – 59.2% vs 85% national target.

Action

- Improvement in GP usage of digital photography referrals for skin has resulted in a reduction of 2ww outpatient clinic demand and reduced waiting times to first appointment, thereby improving 62 day pathway performance.
- Ongoing work with BCPS to address urgent histology turnaround times.
- Focus remains on reducing the backlog of 62 days with focus on those patients waiting 104 days in order to release treatment capacity. Launch of new SOP for Tracking and Escalation to support quicker escalations and prompt response

Cancer Performance – 104 Day



Latest Week

(13/10/23)

26

All 104 week waits, target 10 Patients

Performance

Reducing the 104 backlog remains a priority. The backlog has remained steady in recent weeks.

The most challenged tumour sites include colorectal, skin, urology, colorectal.

10 of the 26 104+ day patients are tertiary referrals from other Trusts for Urology (Robotic Renal work).

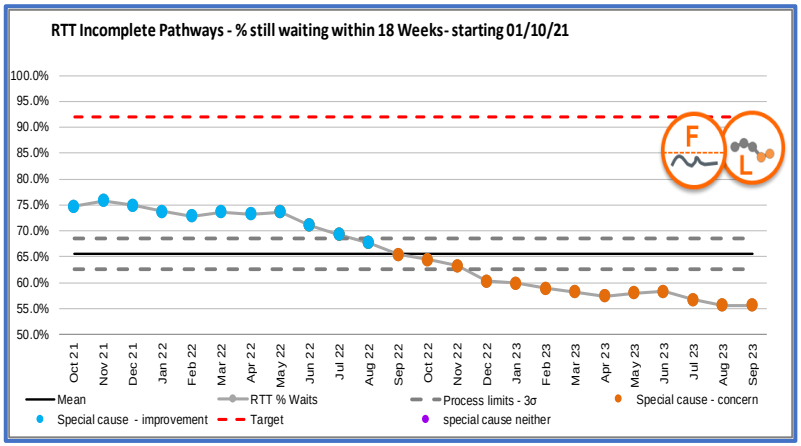
14 of 26 breaches have treatment plans / treatment dates.

October 104 day position – 26 patients

Action

- Focus on reducing the backlog of 104 day waits in order to release treatment capacity for 31 days and 62 day targets continues.
- 10 of the 26 104+ breaches were tertiary urology referrals.
- Reviewing patients at least twice a week over day 80 and formally escalating to the tumours sites for plans. Capacity for Robotic Renal procedures is a challenge. Capacity for excision biopsies for the skin pathway remains a challenge also.

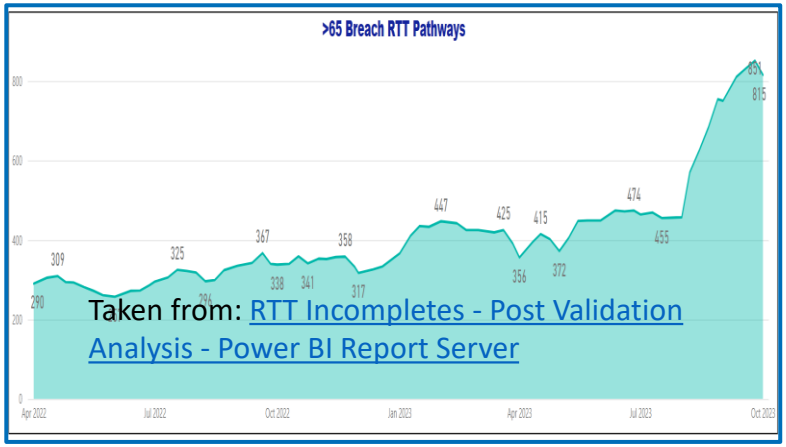
RTT Performance



Latest Month

55.6%

RTT Incomplete pathways target 92%



Performance

Performance against the RTT standard is not routinely monitored nationally with the focus instead being on reducing the backlog of elective patients awaiting treatment.

The trust continues to perform well against both the 78 and 65 week targets for both elective and outpatient procedures, acknowledging some challenges in Neurology and Gynaecology.

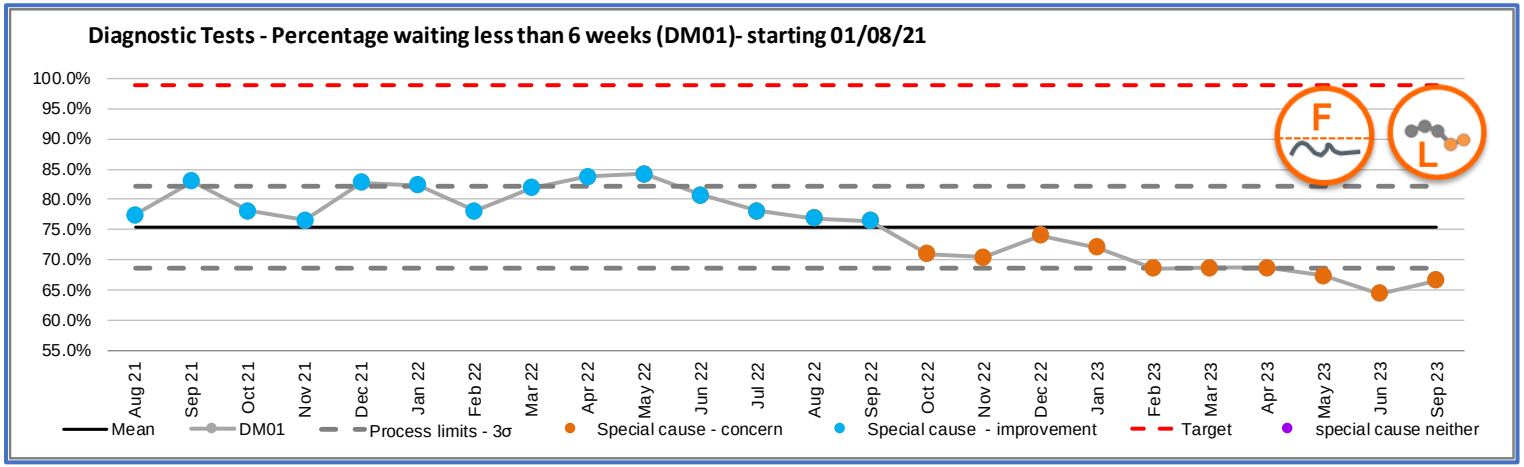
The trust is participating in the GIRFT led Further Faster Programme with all specialities having been issued with the national handbook on how to improve productivity in the outpatient setting.

September RTT position 55.6% vs 92% national target.

Action

- Outsourcing to support Neurology & Gynaecology long waiters.
- Continue to engage with the Further Faster Programme.
- Productivity gains within theatre to increase throughput and attain the 65 week target.
- Increase PIFU and reduce the DNA rate to improve the outpatient throughput.

DM01 Performance



Latest Month

66.6%

DM01 combining 15 modalities - target 99%

Performance

DM01 has underdelivered by 1.66%, achieving 66.56% against a system trajectory of 68.22%. September performance has improved compared to October.

Non achievement was a result of underperformance in Non-Obstetric Ultrasound (NOUS), and continued pressure in Cardiology and Endoscopy. Cardiac MRI saw an increase in patients waiting over 6 weeks and this can be attributed to industrial action.

DM01 position is on track to deliver against the system trajectory from October.

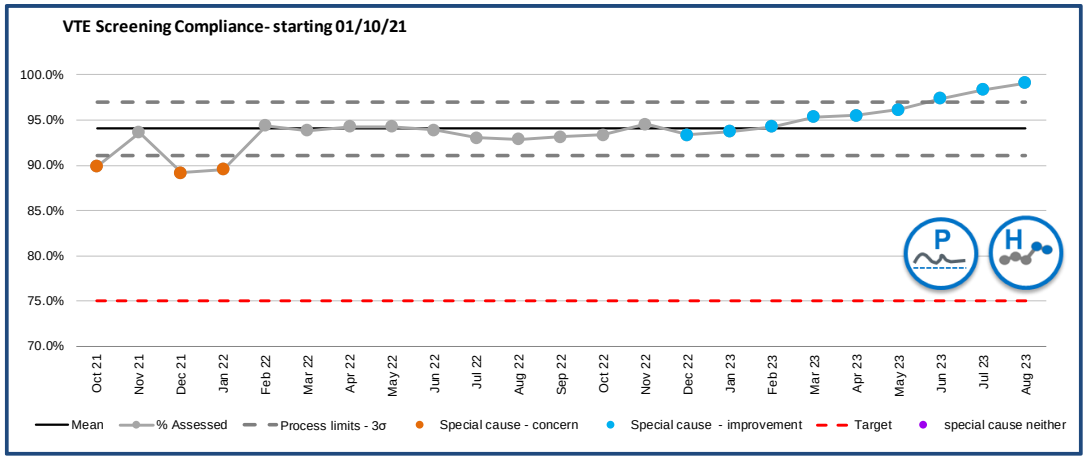
September DM01 position 66.56% vs 68.22% system trajectory

Action

- Patients waiting over 6 weeks for NOUS has reduced during September as planned and will continue to reduce during October as staffing has improved. NOUS mutual aid to be offered to SWBH from November.
- Endoscopy performance is improving, expansion works will provide additional capacity.
- Cardiology is most challenged area. CDC Echo activity to commence by end of 2023. Cardiac MRI recovery plan to address backlog.

VTE Performance

Please note: VTE figures now run 1 month in arrears



Latest Month	Latest Month	Latest Month
99.10%	99.20%	98.98%
Trust overall Position	**Medicine & IC**	**Surgery, W & C**

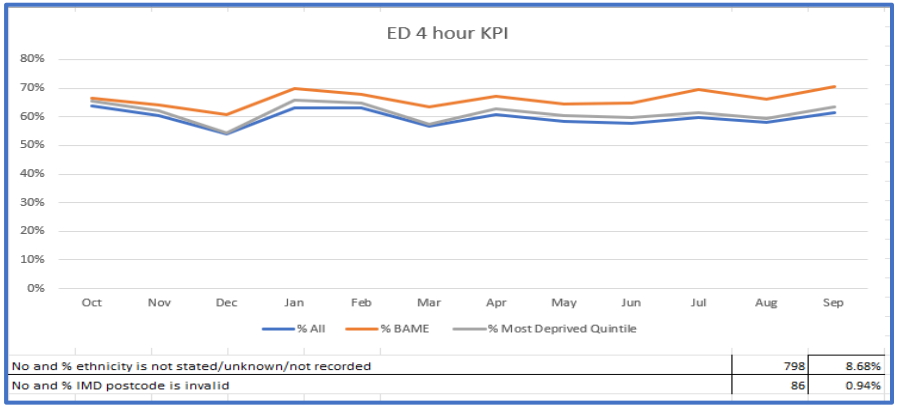
Performance

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

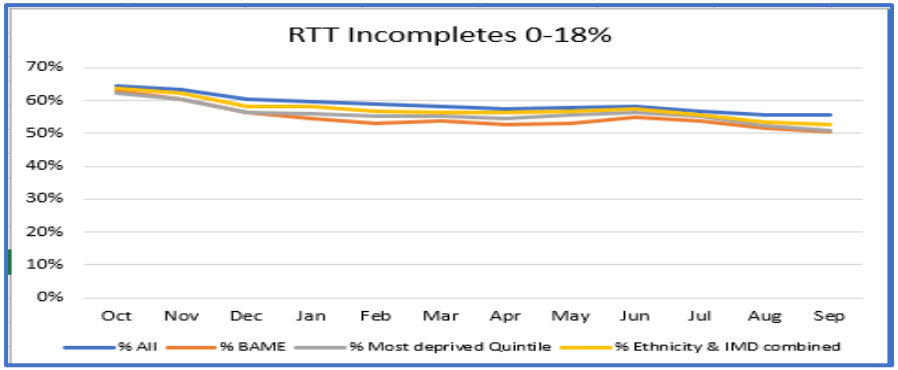
Action

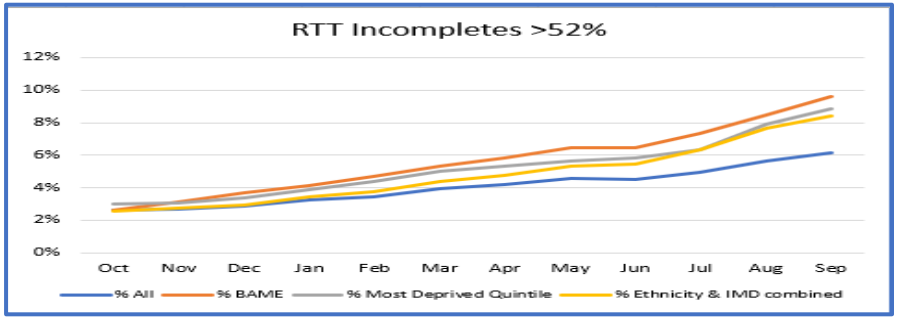
Ward level reporting is available, and this is being monitored as part of the ward performance reviews.

Health Inequalities



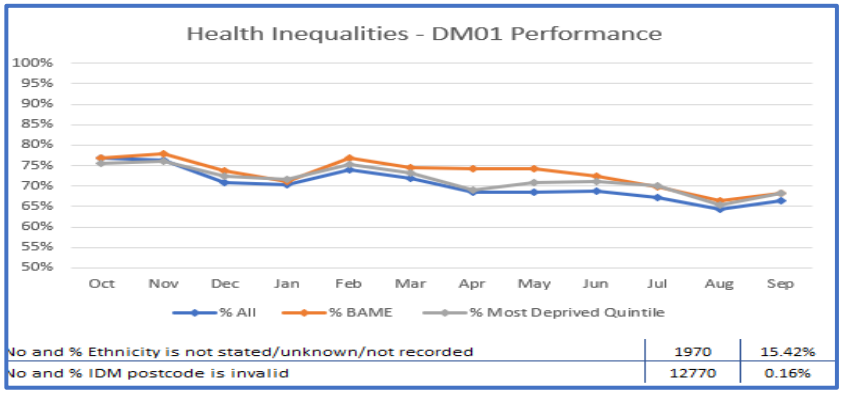
No and % ethnicity is not stated/unknown/not recorded	798	8.68%
No and % IMD postcode is invalid	86	0.94%



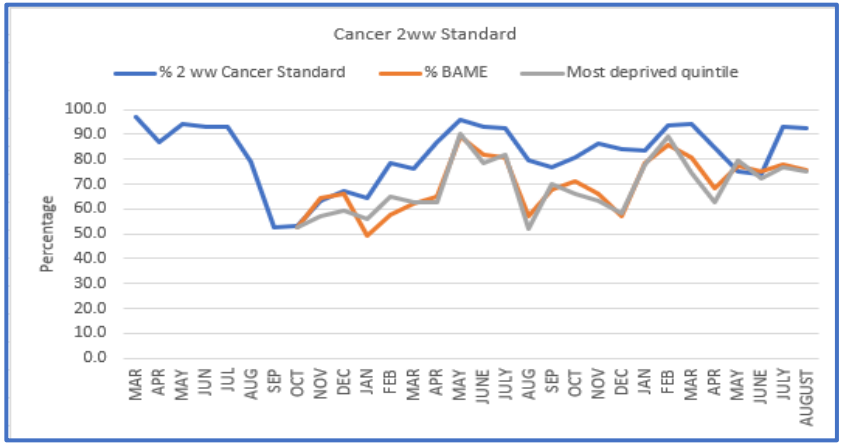


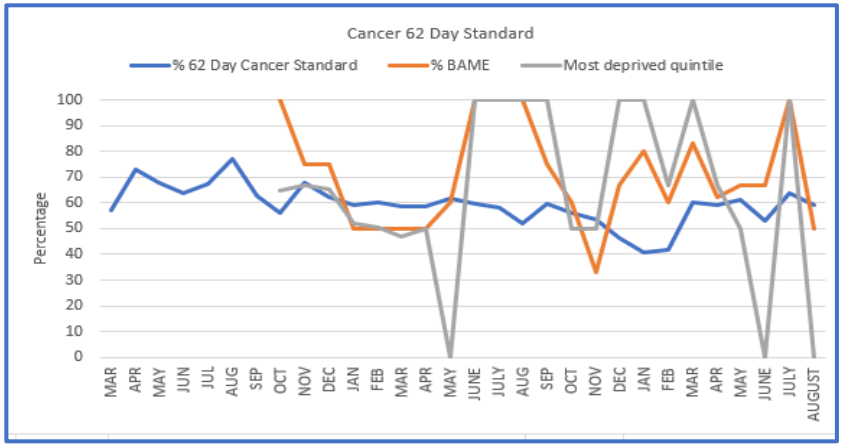
No and % ethnicity is not stated/unknown/not recorded	24371	47.4%
No and % IMD postcode is invalid/missing	18629	36.3%

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



No and % Ethnicity is not stated/unknown/not recorded	1970	15.42%
No and % IDM postcode is invalid	12770	0.16%





Introduction

The National Infection Prevention and Control board assurance framework ('the framework') is issued by NHS England for use by organisations to enable them to respond using an evidence-based approach to maintain the safety of patients, services users, staff and others. The framework is for use by all those involved in care provision in England and can be used to provide assurance in NHS settings or settings where NHS services are delivered. This framework is not compulsory but should be used by organisations to ensure compliance with infection prevention and control (IPC) standards (unless alternative internal assurance mechanisms are in place).

The purpose of the framework is to provide an assurance structure for boards against which the system can effectively self-assess compliance with the measures set out in the National Infection Prevention and Control Manual (NIPCM), the Health and Social Care Act 2008: code of practice on the prevention and control of infections, and other related disease-specific infection prevention and control guidance issued by UK Health Security Agency (UKHSA).

The aim of this document is to identify risks associated with infectious agents and outline a corresponding systematic framework of mitigation measures.

The framework should be used to assure the executive board or equivalent, directors of infection prevention and control, medical directors, and directors of nursing of the assessment of the measures taken in line with the evidence based recommendations of the NIPCM (or whilst the NIPCM is being implemented) including the relevant criterion outlined in the Health and Social Care Act 2008: code of practice on the prevention and control of infections. The outcomes can be used to provide evidence to support improvement and patient safety. The adoption and implementation of this framework remains the responsibility of the **organisation and all registered care providers** must demonstrate compliance with the Health and Social Care Act 2008. This requires demonstration of compliance with the ten criteria outlined.

If the criterion is not applicable within an organisation or setting for example, ambulance services then select not applicable option.

Links

NHS England » National infection prevention and control manual (NIPCM) for England

Health and Social Care Act 2008: code of practice on the prevention and control of infections - GOV.UK (www.gov.uk)

Legislative framework

The legislative framework required to protect patients, service users, staff and others from avoidable harm in a healthcare setting is detailed in the Health and Social Care Act 2008: code of practice on the prevention and control of infections, the duty of care and responsibilities are set out in the Health and Safety at Work Act 1974, and associated regulations for employers and employees.

Local risk assessment processes are central to protecting the health, safety and welfare of patients, service users, staff and others under relevant legislation. This risk assessment process (primary care, community care and outpatient settings, acute inpatient areas, and primary and community care dental settings) has been designed to support services in identifying hazards and risks, and includes guidance on measures that should be maintained to improve and provide safer ways of working by balancing risks appropriately. Where it is not possible to eliminate risk, organisations must assess and mitigate risk and provide safe systems of work using the risk assessment process and the organisation's governance processes.

Links

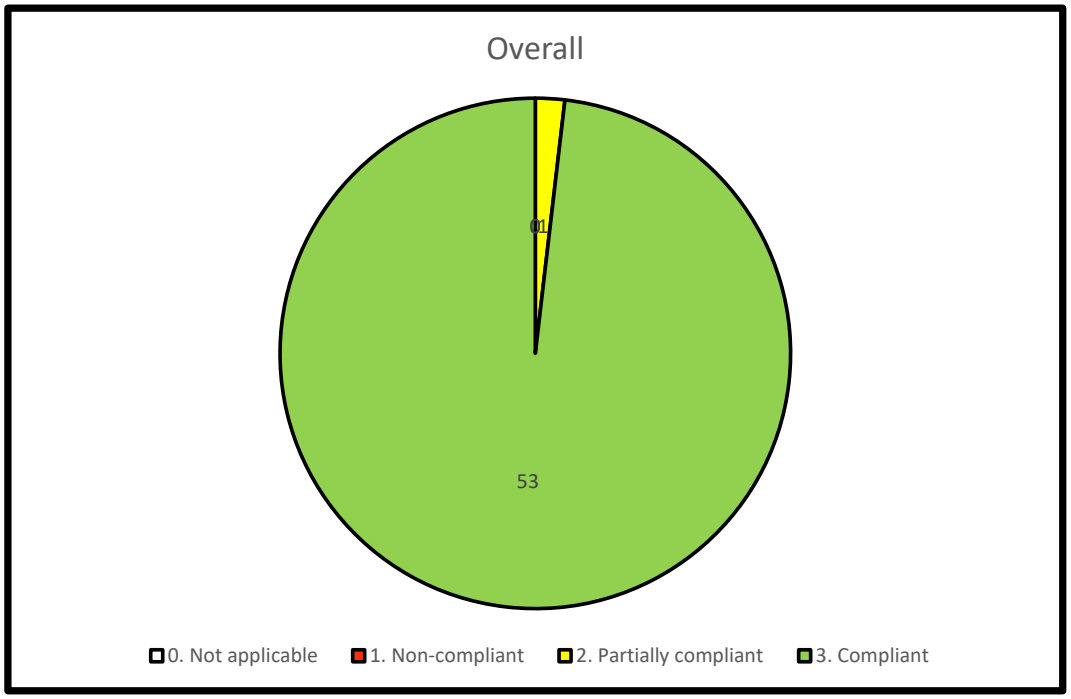
Health and Social Care Act 2008: code of practice on the prevention

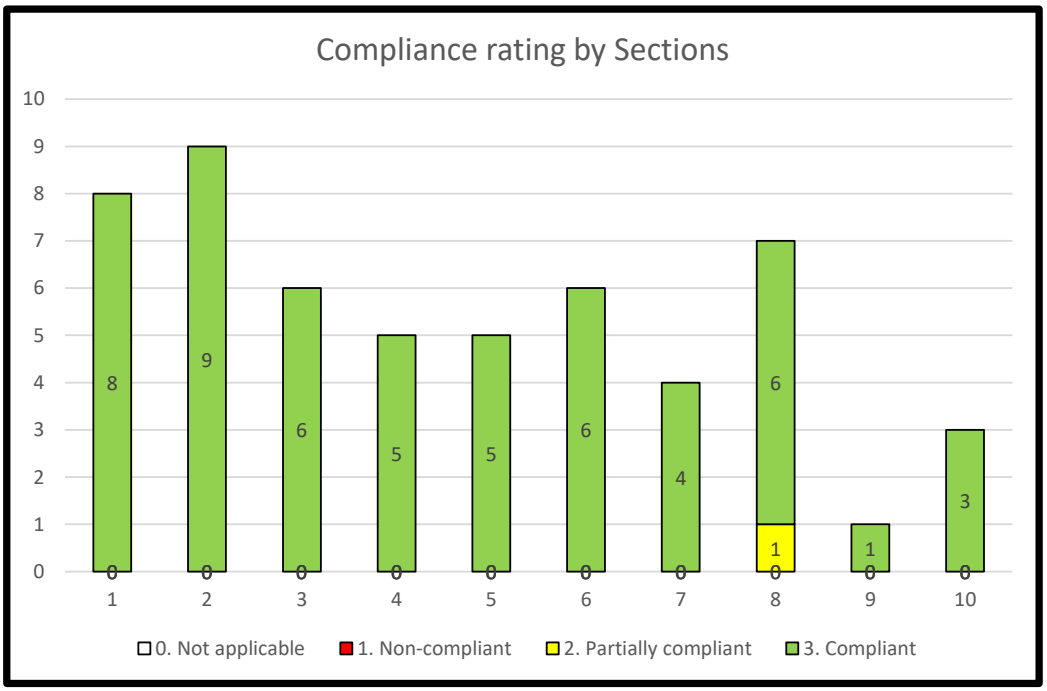
Health and Safety at Work etc. Act 1974

Primary care, community care and outpatient settings

Acute Inpatient areas

Primary and community care dental settings


Overall
1
53
0. Not applicable
1. Non-compliant
2. Partially compliant
3. Compliant


Compliance rating by Sections
10
9
8
7
6
5
4
3
2
1
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9
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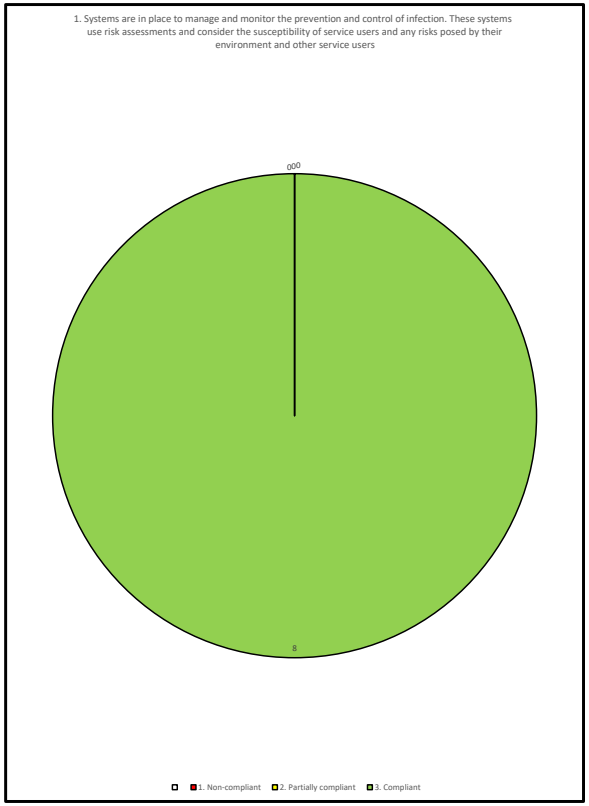
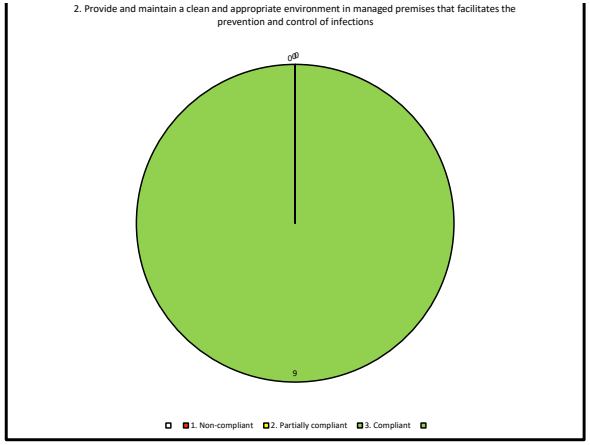
4
6
1
3
1
2
3
4
5
6
7
8
9
10
0. Not applicable
1. Non-compliant
2. Partially compliant
3. Compliant

Infection Prevention and Control board assurance framework v0.1

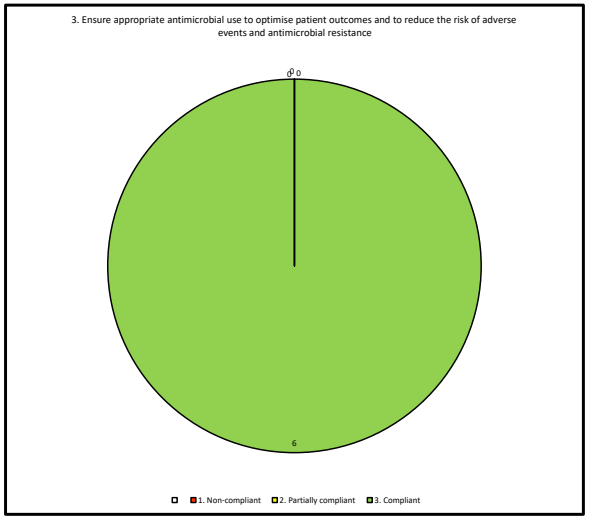
	Key Lines of Enquiry	Evidence	Gaps in Assurance	Mitigating Actions	Comments	Compliance rating
1. Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks their environment and other users may 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:						



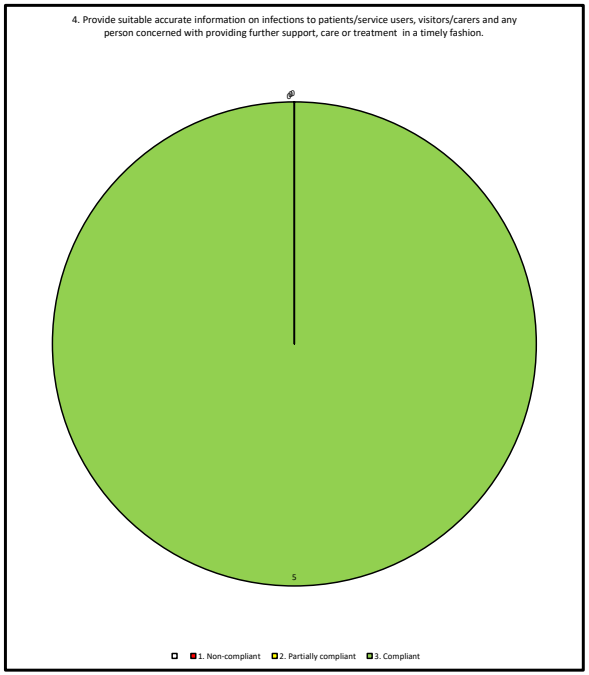
2.1	There is evidence of compliance with National cleanliness standards including monitoring and mitigations (**excludes some settings e.g. ambulance, primary care/dental unless part of the NHS standard contract** these setting will have locally agreed processes in place).	Decontamination of the Environment 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. JE 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



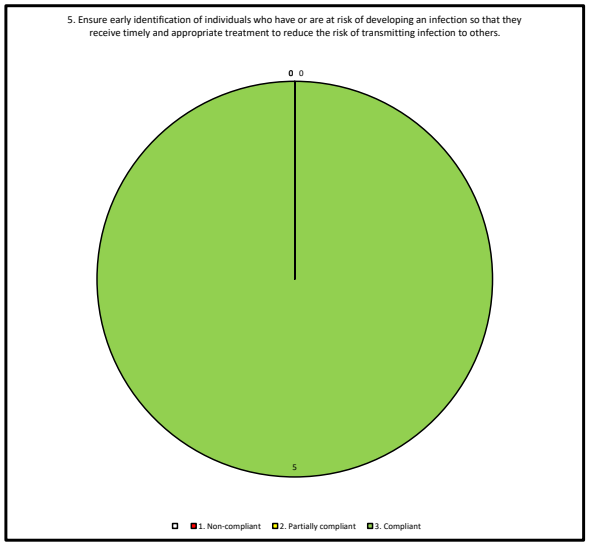
2.7	The classification, segregation, storage etc of healthcare waste is consistent with HTM:07:01 which contains the regulatory waste management guidance for all health and care settings (NHS and non-NHS) in England and Wales including waste classification, segregation, storage, packaging, transport, 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

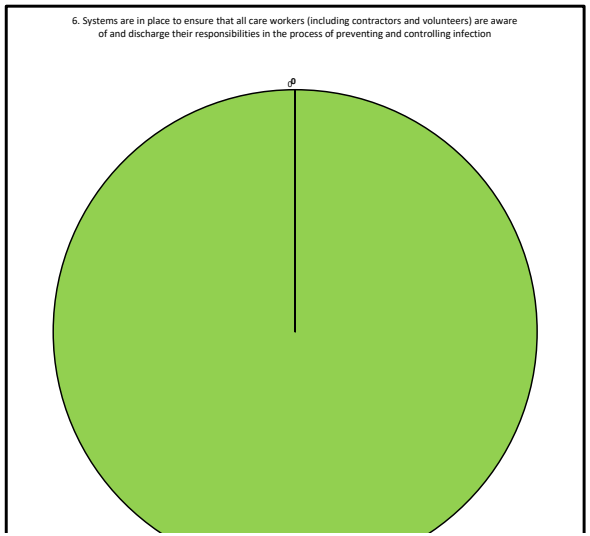


3.6	Resources are in place to support and measure adherence to good practice and quality improvement in AMS. This must include all care areas and staff (permanent, flexible, agency, and external contractors)	AMS team. Electronic prescribing aids (72 hours review) Microguide (Trusts antibiotic guidelines) 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:						

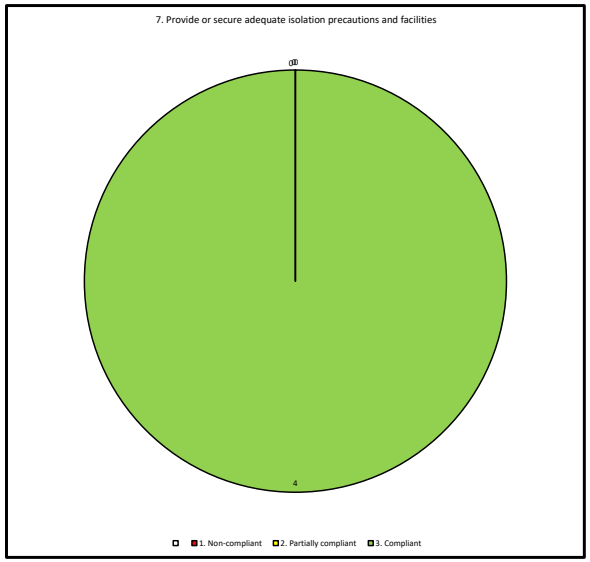


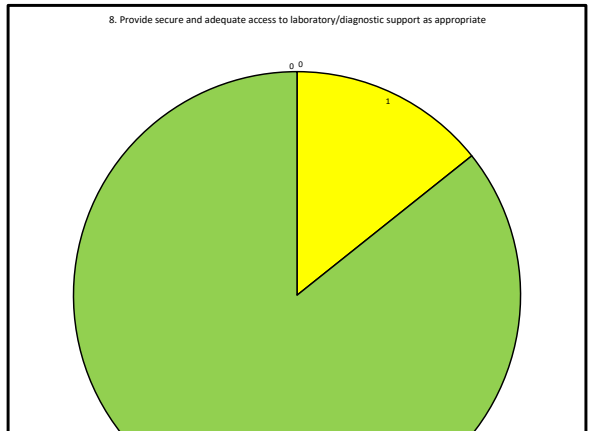
5.1	All patients/individuals are promptly assessed for infection and/or colonisation risk on arrival/transfer at the care area. Those who have, or are at risk of developing, an infection receive timely and appropriate treatment to reduce the risk of infection transmission.	As per policy patients are 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



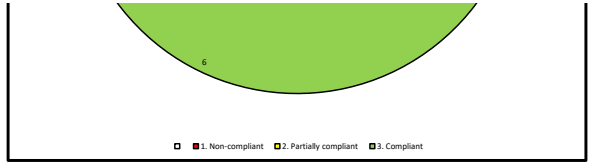


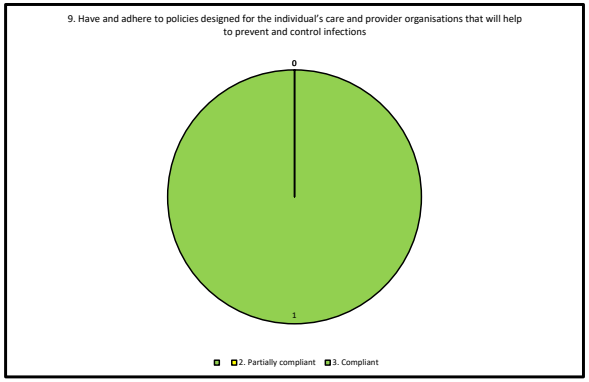
6.6	If clinical staff undertake procedures that require additional clinical skills, for example, medical device insertion, there is evidence staff are trained to an agreed standard and the staff member has completed a competency assessment which is recorded in their records before being allowed to undertake 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

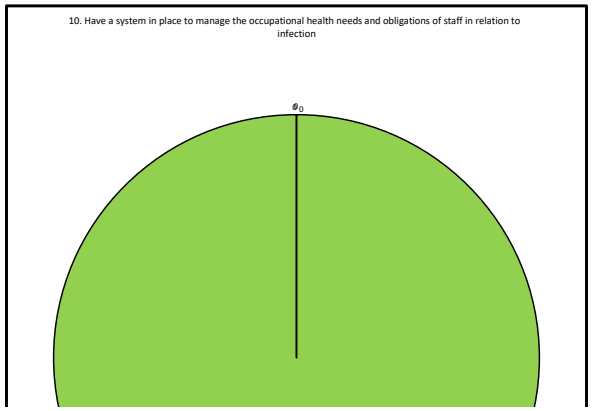




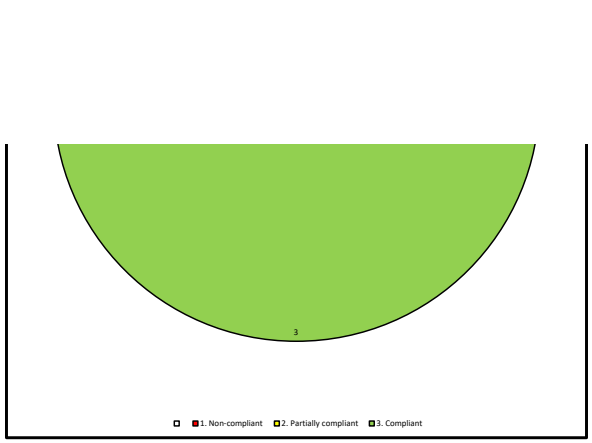
8.4	Patient/service user testing on admission, transfer, and discharge should be in line with national guidance, local protocols and results should be communicated to the relevant organisation.	Polices, procedures and SOPs in place for testing of infections pre admission and on admission. COVID_19 staff 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



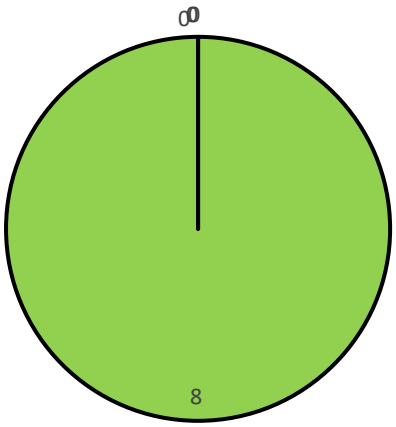




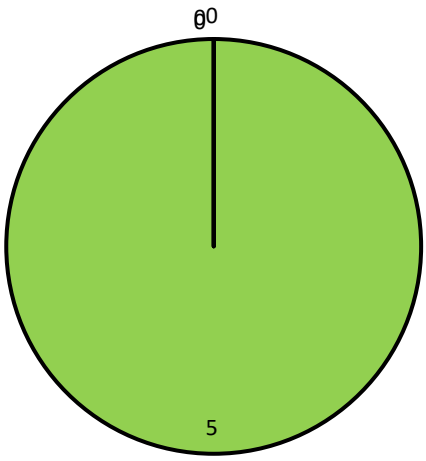
10.3	Staff have had the required health checks, immunisations and clearance undertaken by a competent advisor (including those undertaking exposure prone procedures (EPPs).	Pre employment checks for all staff are completed via the Staff Health and Wellbeing Service.				3. Compliant



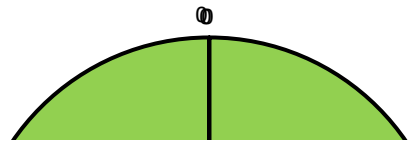
1. Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks posed by their environment and other service users



4. Provide suitable accurate information on infections to patients/service users, visitors/carers and any person concerned with providing further support, care or treatment in a timely fashion.



7. Provide or secure adequate isolation precautions and facilities

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1. Non-compliant
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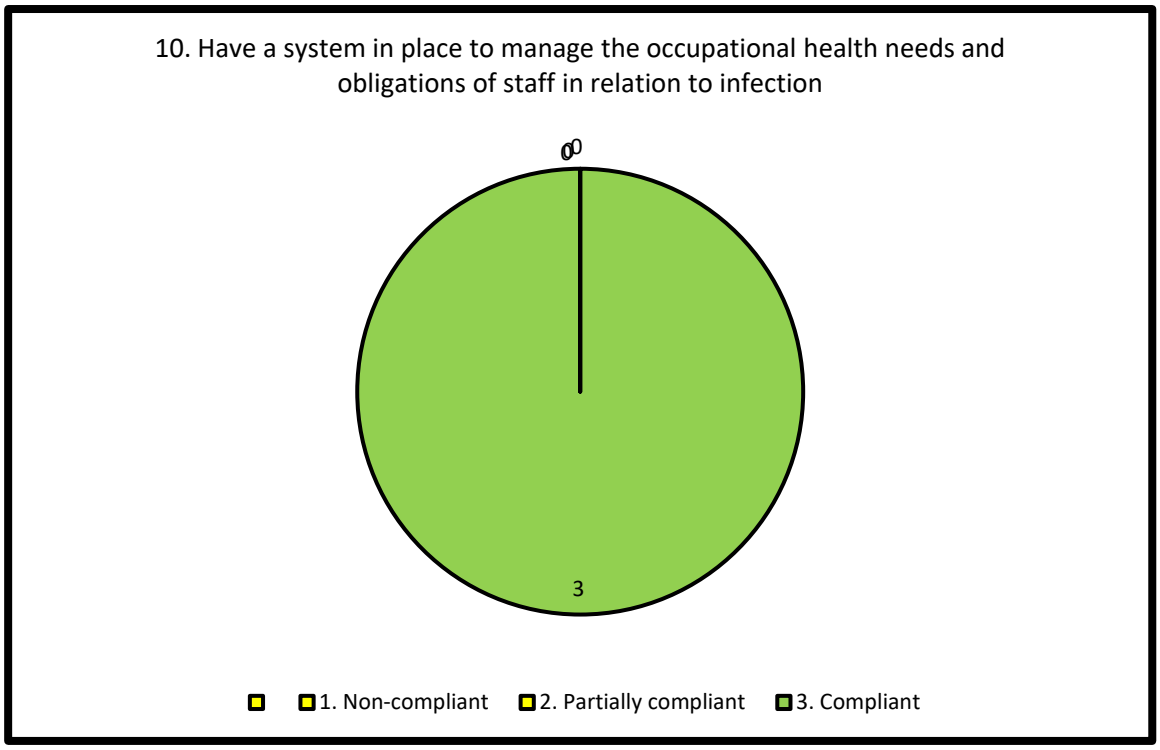
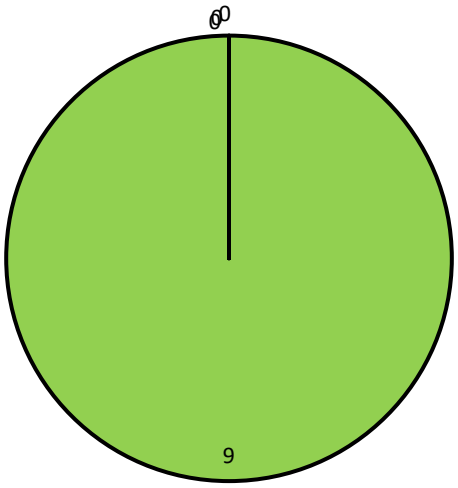
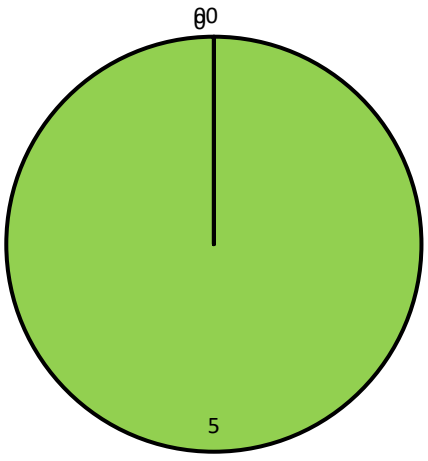

10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection
0
0
3
1. Non-compliant
2. Partially compliant
3. Compliant

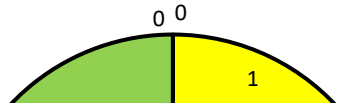
2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections

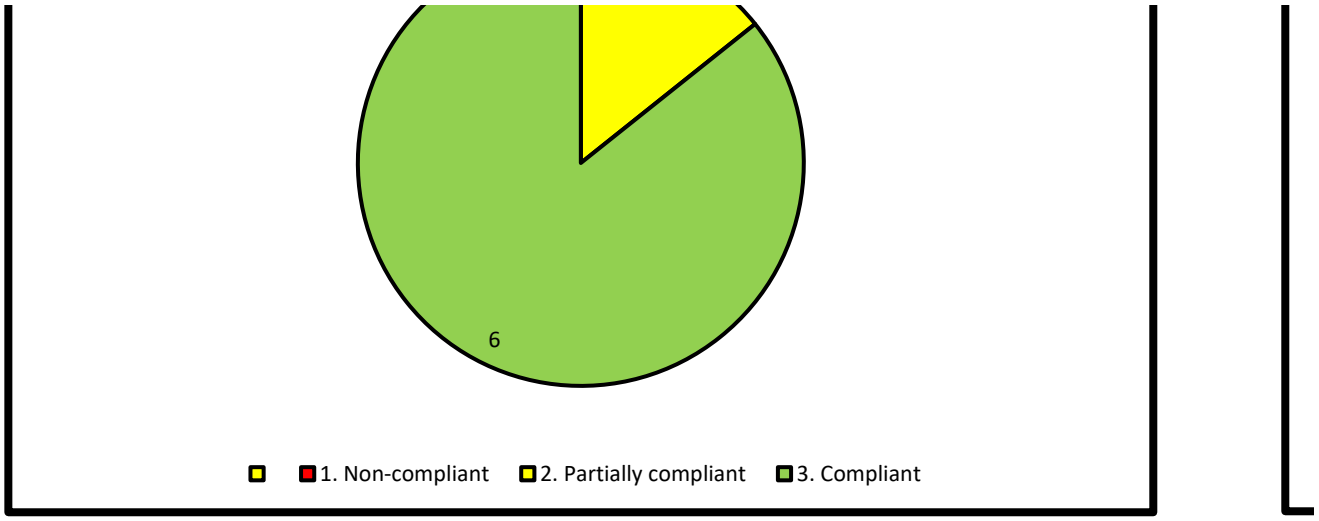


5. Ensure early identification of individuals who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to others.

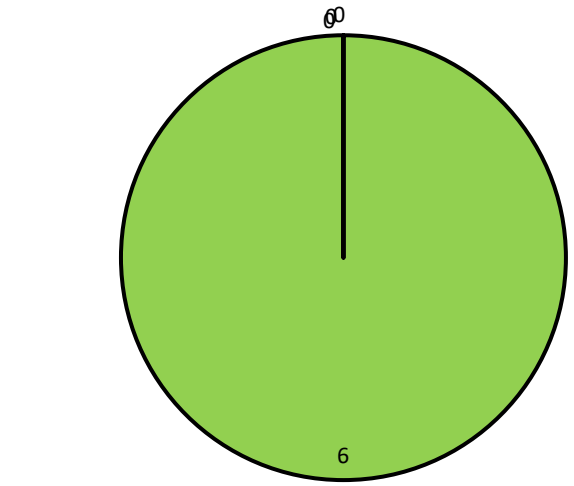


8. Provide secure and adequate access to laboratory/diagnostic support as appropriate

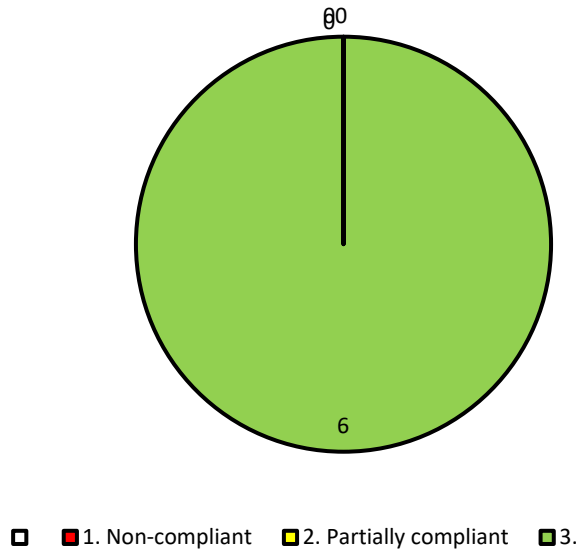



6
1. Non-compliant
2. Partially compliant
3. Compliant

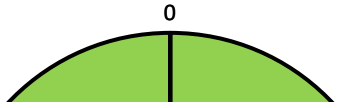
3. Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance



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



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




1
2. Partially compliant
3. Compliant

The Dudley Group NHS Foundation Trust

REPORT FOR ASSURANCE

Maternity and Neonatal Safety and Quality Dashboard

Report to Public Board Thursday November 9th 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 Trust and LMNS board of present or emerging safety concerns or activity to ensure safety with a two-way reflection of ward to board insight across the multidisciplinary multi professional maternity and neonatal service teams. The information within the report will reflect actions in line with Ockendon and progress made in response to any identified concerns at provider level.

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

2. BACKGROUND INFORMATION

2.1 Perinatal Mortality Overview

2.1.1 Stillbirths

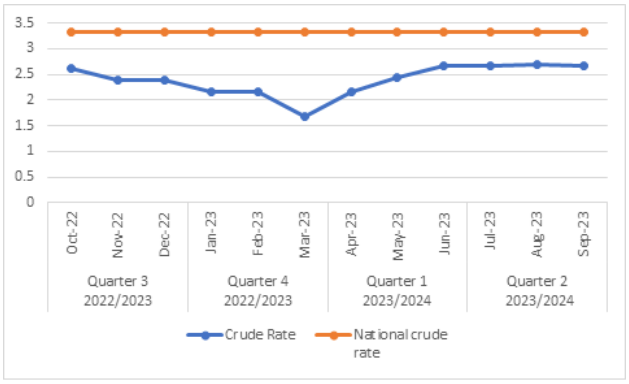
Crude stillbirth rates: Calculated from the total number of stillbirths for the period divided by number of births within the period multiplied by 1,000.

Stillbirth Rates

The National stillbirth rate is 3.33 (MBRRACE 2022) and it can be seen the stillbirth rate for September 2023 at 2.68, this indicates that DGFT are just below the national stillbirth rate.

		Crude Rate	National crude rate	Number of stillbirths
Quarter 3 2022/2023	Oct-22	2.62	3.33	0
	Nov-22	2.39	3.33	0
	Dec-22	2.39	3.33	1
Quarter 4 2022/2023	Jan-23	2.15	3.33	1
	Feb-23	2.15	3.33	0
	Mar-23	1.67	3.33	0
Quarter 1 2023/2024	Apr-23	2.16	3.33	2
	May-23	2.43	3.33	1
	Jun-23	2.67	3.33	2
Quarter 2 2023/2024	Jul-23	2.67	3.33	0
	Aug-23	2.69	3.33	2
	Sep-23	2.68	3.33	2

It should be noted that there were 11 stillbirths from 01.10.22 to 30.09.2023.



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.

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

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

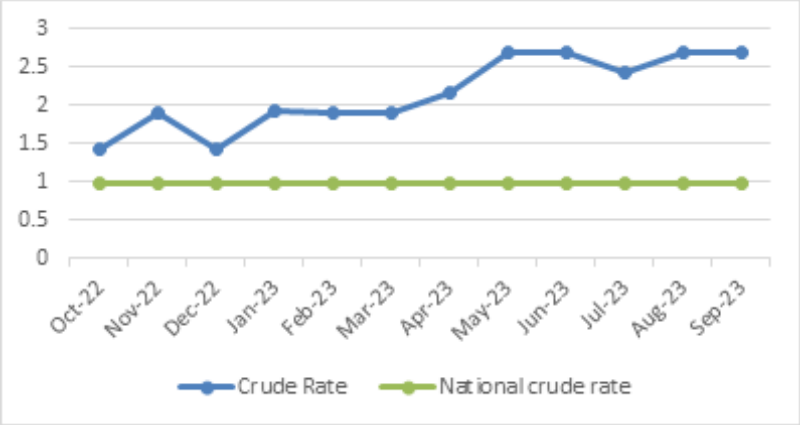
Crude late neonatal death rates – Calculated from the total number of late neonatal deaths divided by number of live births multiplied by 1,000

2.2.1 Early Neonatal Death Rates (ENND)

The National Early Neonatal Death (ENND) rate is 0.98 (MBRRACE 2022) and in Q2 2023/2024 the ENND rate remains higher than the national rate.

		Crude Rate	National crude rate	Number of early NND
Quarter 3 2021/2022	Oct-22	1.43	0.98	0
	Nov-22	1.91	0.98	1
	Dec-22	1.43	0.98	1
Quarter 4 2022/2023	Jan-23	1.92	0.98	3
	Feb-23	1.91	0.98	1
	Mar-23	1.91	0.98	0
Quarter 1 2023/2024	Apr-23	2.17	0.98	1
	May-23	2.68	0.98	2
	Jun-23	2.68	0.98	0
Quarter 2 2023/2024	Jul-23	2.43	0.98	0
	Aug-23	2.69	0.98	1
	Sep-23	2.68	0.98	1

It should be noted that there were11 early neonatal deaths from 01.10.22022 to 30.09.2023.



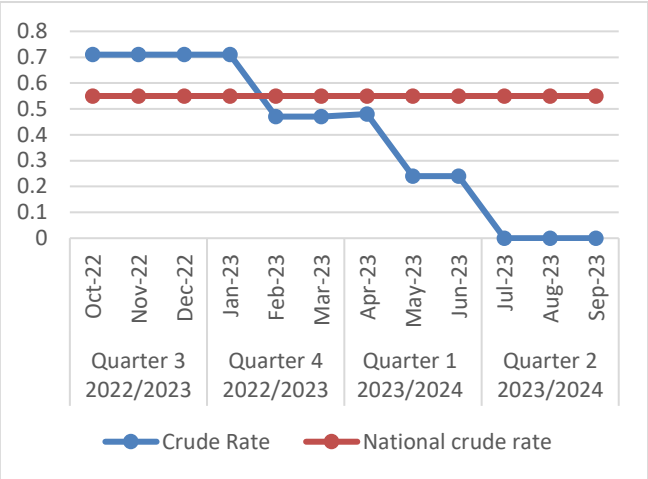
The above chart details how the crude early neonatal death rate has been consistently higher than the National rate of 0.98 (MBRRACE 2021) during the last 12 months.

2.2.2 Late Neonatal Death Rates

The National rate for Late Neonatal Deaths is 0.55 (MBRRACE 2022) and DGFT are below at 0.

		Crude Rate	National crude rate	Number of Late NND
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
	Jul-23	0	0.55	0

Quarter 2 2023/2024	Aug-23	0	0.55	0
	Sep-23	0	0.55	0

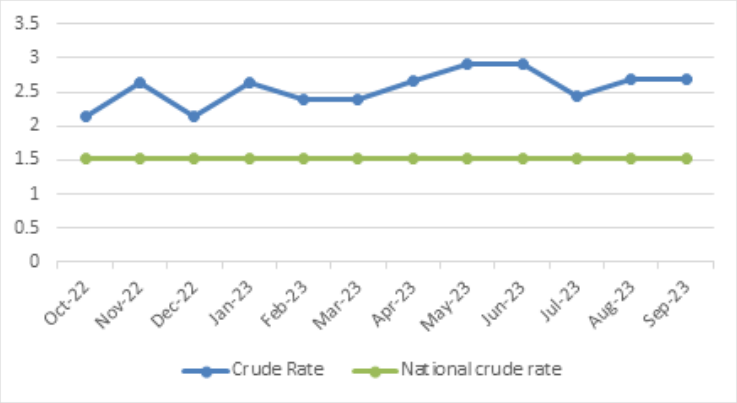


There has been a steady decline in the rate since January 2023 and in Quarter 2 there have been 0 late neonatal deaths.

2.2.3 Combined Neonatal Death Rates

The below chart demonstrates the crude neonatal death rates from 1st October 2022 to 30th September 2023, it can be seen that the combined neonatal death rate is 2.68 continues to be above the national rate of 1.53 (MBRRACE 2022)

		Crude Rate	National Crude Rate
Quarter 3 2021/2022	Oct-22	2.15	1.53
	Nov-22	2.63	1.53
	Dec-22	2.15	1.53
Quarter 4 2022/2023	Jan-23	2.63	1.53
	Feb-23	2.39	1.53
	Mar-23	2.39	1.53
Quarter 1 2023/2024	Apr-23	2.65	1.53
	May-23	2.92	1.53
	Jun-23	2.92	1.53
Quarter 2 2023/2024	Jul-23	2.43	1.53
	Aug-23	2.69	1.53
	Sep-23	2.68	1.53



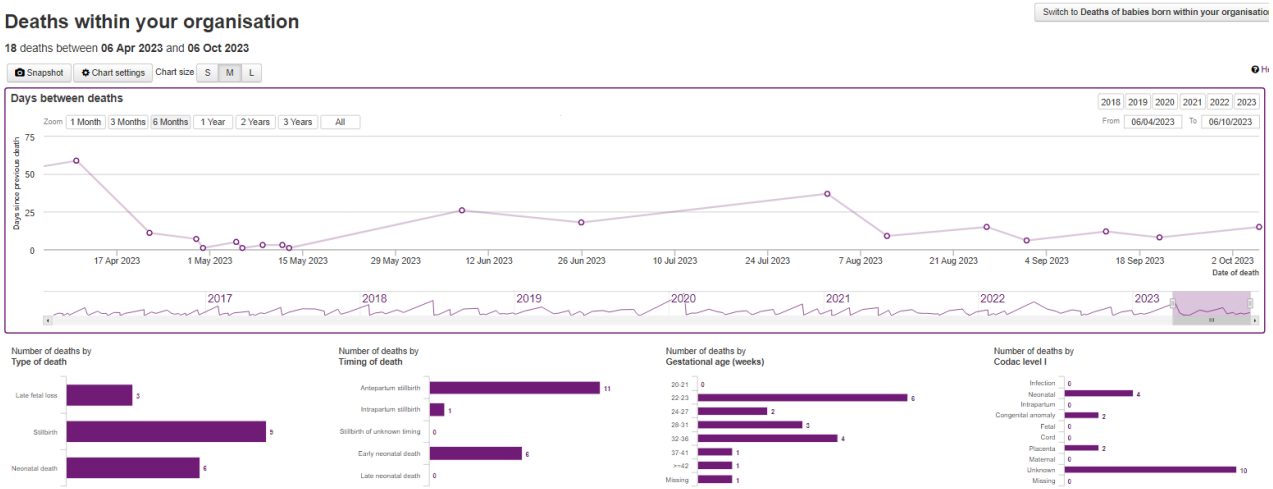
The Women and Children's service continues to report perinatal mortality rates through Divisional Governance each month and into the Trusts Mortality Surveillance Group. A quarterly report of perinatal mortality rates is presented to the Mortality Surveillance group and Maternity safety champion group to ensure that the Trust Board have oversight.

The perinatal quadrumvirate, with support from the medical director, are commencing a thematic review into neonatal mortality cases due to the persistent elevated rates. The group also plans to change the way the data is provided to ensure clearer communication to the committees and boards. This data should be available for future committee/board reports.

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. Appendix one demonstrates full Perinatal mortality data for Q2 (1st July 2023-30th September 2023). **This report forms part of the evidence for MIS year 5 SA1.**

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)/ Maternity and Newborn Safety investigation (MNSI) 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).

As of the 1st of October 2023, Healthcare safety investigation Branch (HSIB) will be known as the **Maternity and Newborn Safety investigations (MNSI)** and will be hosted by the Care quality commission. The new arrangement with the CQC will ensure the continuation of the maternity programme and maintain the independence of maternity investigations within the NHS. This new chapter presents the opportunity for further collaboration within the health and social care sector. It will also allow MNSI to access more resources as part of a larger organisation, including improved analytics capacity and the opportunity to contribute best practice learning through national reporting.

2.4.1 MNSI 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 is 1 active case open with HSIB reported on the 7/9/2023. One further case has been reported, pending their acceptance.

All learning continues are shared across the Black Country and West Birmingham LMNS monthly via the quality and safety workstream. The papers submitted to Quality committee are also shared to the workstream for assurance and learning.

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 August or September 2023

2.6 Maternity Serious Incidents

There was 1 new serious incident reported during August 2023: INC135190

There was 1 new serious incident reported during September 2023. INC136941

Accepted by MNSI.

There are currently 3 open serious incidents within maternity. All are investigated and monitoried via the trusts governance processes as well as the Quality Committee, and any safety concerns are escalated to the maternity safety champions.

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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 there has been two amendments to the details of the scheme. The most recent update was communicated to trust on the 24th October and affect safety action 1 and safety action 8 as outlined below.

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 yet on target
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 made in the Avoiding Term Admissions into Neonatal units Programme?		December 2023
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

Safety action one: Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?

Please see the PMRT Quarterly report attached as **appendix 1.** Currently compliant with all elements of SA1.

Due to potential strike action, NHSR announced the following amendment to the safety action on the 24/10/2023:

Where MDT PMRT review panel meetings (as detailed in standard C) have needed to be rescheduled due to the direct impact of industrial action, and this has an impact on the MIS reporting compliance time scales, this will be accepted provided there is an action plan approved by Trust Boards to reschedule these meetings to take place within a maximum 12-week period from the end of the MIS compliance period.

Safety action two: Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?

Final data being published October 2023 however preliminary results show a pass for all CQIMS therefore fully compliant.

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 made in the Avoiding Term Admissions into Neonatal units Programme?

Appendix 2 shows the Term admissions to neonatal unit report and associated action plan as agreed at Maternity safety champion meeting (September 2023) by the Perinatal quadrumvirate, board level safety champions and associated teams. Also submitted to the LMNS Best starts for discussion.

A review of BAPM Transitional care Framework for practice will be presented to the November Quality committee.

Safety action 4: Can you demonstrate an effective system of clinical workforce planning to the required standard?

This safety action will be demonstrated through the Workforce plan that will be presented in Novembers Quality Committee.

Safety Action 5: Can you demonstrate an effective system of midwifery workforce planning to the required standard?

This safety action will be demonstrated through the Workforce plan that will be presented in Novembers Quality Committee.

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?

Saving babies lives compliance is monitored via the LMNS, by using a national compliance tool within the NHS Futures platform. Self-assessment is undertaken, along with a submission of evidence followed by a touch point assessment with the LMNS. Our first touch point measuring against compliance with Saving babies lives 3 was undertaken in September, results are below:

		Current compliance	Target by Dec 2023
Element 1	Smoking in pregnancy	40%	60%
Element 2	Fetal growth restriction	60%	At target for MIS
Element 3	Reduced fetal movements	20%	60%
Element 4	Fetal Monitoring in labour	20%	60%
Element 5	Preterm birth	33%	60%
Element 6	Diabetes	100%	Above target for MIS
Totals		**47%**	**70%**

***Requires a minimum of 50% to be achieved in each element with an overall 70% compliance.**

Second touch point meeting will be held in December, and we must achieve an overall compliance score of 70% to achieve the MIS year 5, safety action 6.

Current issues requiring action:

- RFM requiring USS changed to 24 hours (used to be 72 hours)
- Guidelines amended to reflect requirement for digital BP monitoring.
- Audit required for stillbirths associated with reduced fetal movement
- Audit of number of IOL under 39 weeks for RFM (as a single factor)
- Review of usage of Tommy leaflet being given/accessed
- Interpretation of leaflets in different languages.

Safety Action 7: Listen to women, parents and families using maternity and neonatal services and coproduce services with users

Maternity and Neonatal voices Partnership (MNVP) workplan being presented to Maternity safety champions and Quality committee in November 2023.

Safety Action 8: **Can you evidence the following 3 elements of local training plans and 'in-house', one day multi professional training (MPET)?**

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

As of 16/10/2023

	Midwives	Obstetricians	Rectification plans
Multi-Professional Emergency Training/Skills Drills	93%	81%	All obstetricians booked onto session and will be over 90% compliant by December 2023
CTG/ fetal Monitoring Training	93%	85%	
Neonatal resuscitation	86%	85%	
Adult resuscitation	90%	96%	

MPET Breakdown by obstetric grade:

Date	Consultants (16)		Registrars (17)	
	No. compliant	Compliance %	No. compliant	Compliance %
As of 16/10	13	81%	14	82%
31/10/2023	13	81%	14	82%
30/11/2023	15	94%	16	94%
31/12/2023	15	94%	17	100%

Please note the due to the recent strike action, this has affected the number of obstetricians that have attended training (MPET day affected 20/9/23). NHSR recognise this risk and therefore have amended the safety action as of 25/10/23 to:

80% compliance at the end of the previously specified 12-month MIS reporting period (December 2022 to December 2023) will be accepted, provided there is an action plan approved by Trust Boards to recover this position to 90% within a maximum 12-week period from the end of the MIS compliance period.

In addition, evidence from rotating obstetric trainees having completed their training in another maternity unit during the reporting period (i.e. within a 12 month period) will be accepted.

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?

Speak up session being held for Maternity and neonatal staff with Board level safety champions scheduled for 19th October 2023. Previous session held in July with FTSU team had no attendance.

These reports as well as board reports form part of the Perinatal quality surveillance model.

SCORE Culture survey of all areas of Maternity and neonatal underway: closes 7th December 2023, feedback in January 2024. Please refer to section 2.8 below for further details of the PCLP.

1st quarterly quadrumvirate quarterly engagement sessions between Maternity safety champions and the quadrumvirate had to be cancelled due to activity within the maternity unit but has been rearranged.

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?

All cases reported to MNSI from December 2022 to December 2023

All relevant cases reported to NHSR early notification scheme for the same timescale

Families involved have received all relevant information (this information was amended following year 4) and duty of candour undertaken for each family.

2.8 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 quad consists of the Clinical directors for both obstetric and neonates, the head of Midwifery and the directorate manager.

Current progress with the program is the launch of the SCORE culture survey on the 16th of October 2023, this runs until the 7rd December 2023. Following closure of the survey- the Quad will be given the opportunity to meet with a nominated Culture coach. The overall

purpose of this phase is to continue the work on team development, to socialise the SCORE results with teams, and start planning for improvement.

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
- Updates on areas for improvement.

Updates on progress continue to be included within future reports.

2.9 Service user feedback- Friends and Family results October 2023

Professional and respectful team, this helped me feel good and in safe hands
The staff in the labour ward were amazing, so kind and gentle, they made my whole labour experience truly wonderful

Very welcoming from the moment I've walked in. I was a bit late and the staff were very understanding

Seen quickly. Well informed and friendly staff

Norma and Laura are so kind and caring! Really what is needed especially with being under the rainbow clinic

A quieter ward would have been nice.

Could have been advised to take painkillers throughout night - was in a lot of pain in the morning

3 RISKS AND MITIGATIONS

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

3.2 The requirements for evidence for Ockenden, Maternity incentive scheme 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(S)

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 and SBLV3.

Name of Authors: Claire Macdiarmid / Hesham Ghoneimy / Raj Uppal
Title of Author Head of Midwifery / Clinical Director for Obstetrics/ Clinical director for Neonates

Date 25/10/2023

Appendix 1

The Dudley Group NHS Foundation Trust

Paper for submission to the Maternity Governance Meeting on 19th October 2023

Title:	Perinatal Mortality Report Quarter Two (Q2) 2023/2024 (1st July 2023 to 30th September 2023)
Author:	Justine Edwards – PMRT Midwife
Presenter:	Justine Edwards – PMRT Midwife

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

Recommendations:

To note the current perinatal mortality rates.

To review the current status of PMRT reviews and identify any concerns.

To note the learning identified through PMRT reviews

Summary of Key Issues:

Perinatal Mortality Rates

This report presents mortality rates for Quarter 2 2023/2024 (1st July 2023 to 30th September 2023), including a rolling 12 months to allow for comparison and identification of increased trends.

Stillbirth Rates

In Quarter 2 2023/2024 in July (2.67), August (2.69) and in September (2.68), the crude rate has remained below the national rate (3.33) but has remained consistent in Q2.

Early Neonatal Deaths Rates

In Quarter 2 2023/2024 in July (2.43), August (2.69) and September (2.68) the crude rate remains higher than the national rate 0.98 (MBRRACE 2022).

Late Neonatal Deaths Rates

In Quarter 2 2023/2024 the crude rates continue to be below the national crude rate of 0.55 per thousand live births (MBRRACE 2022) July (0), August (0) and September (0).

Combined Neonatal Death Rates

In Quarter 2 2023/2024 the combined neonatal death rates are calculated in July (2.43), August (2.69) and September (2.68) is above the national rate of 1.53.

Perinatal Mortality Reviews

During Quarter 2 2022/2023 6 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 reviews undertaken in Quarter 2 2023/2024

A total of 11 cases were reviewed during Quarter 2 2023/2024.

3 cases were reported as Serious incidents. 1 case was graded as a D where the MDT agreed that there were care issues which they considered were likely to have made a difference to the outcome of the baby. 2 cases were graded as a C where the MDT agreed that there were care issues which they considered may have made a difference to the outcome for the baby. Learning has been identified from the cases and has been reflected in the PMRT and actions assigned on the incident reporting system.

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.

Learning has been identified (see in point 4) action plans have been developed and all are assigned as actions in the incident reporting system and monitored through maternity and neonatal governance.

The emerging theme in relation to the PMRT reviews was the management of women in preterm labour and prelabour rupture of membranes. This has led to identified learning which include:

- The need to review the management of women in preterm labour and prelabour rupture of membranes in relation to the administration of steroids and magnesium sulphate. This will be discussed at the LMNS work stream group to benchmark practice across the LMNS.

PMRT – Perinatal Mortality Reviews Summary Report – 01.01.2023 to 31.03.2023

The PMRT – Perinatal Mortality Reviews Summary Report has been generated from the PMRT tool for Quarter 4 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 Q4 2022/2023.

A total of 6 cases met the requirement for PMRT review in Q4 2022/2023. There are 2 cases that the review remains in progress one is a HSIB investigation awaiting ICB approval, and one is a joint case with RWT which has been pre-published and awaiting BWH confirmation of final report.

Of the 4 cases that have been published in Q4 2022/2023 there were no cases that identified issues that may or likely to have made a difference to the outcome of the baby.

In the 3 cases that were published for Q4 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:

- 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.

- 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.
- 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.

An emerging theme from this quarter and in subsequent reviews undertaken in Q2 2023/2024 is the completion of the resuscitation scribe notes, this has led to a review of the newborn record sheet in sunrise to ensure.

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

Implications of the Paper:			
Risk	N	Risk Description: *Inc risk ref number*	
	On Risk Register: N	Risk Score:	
Compliance and/or Lead Requirements	CQC	N	Details:
	NHSE/I	N	Details:
	Other	Y	Details: Safety Action One of the Maternity Incentive Scheme (CNST)

Report Journey/ Destination *(if applicable)*	Working / Exec Group	Y	Date: MGG MSG
	Committee	Y (as part of Mortality Surveillance highlight report	Date:
	Board of Directors	Y by exception	Date:
	Other	N	Date:

Women and Children's Perinatal Mortality Quarter Report Q2
1st July 2023 to 30th September 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.

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 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 22+ weeks gestation or with a birth weight >400grams.

2. DEFINITIONS

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.

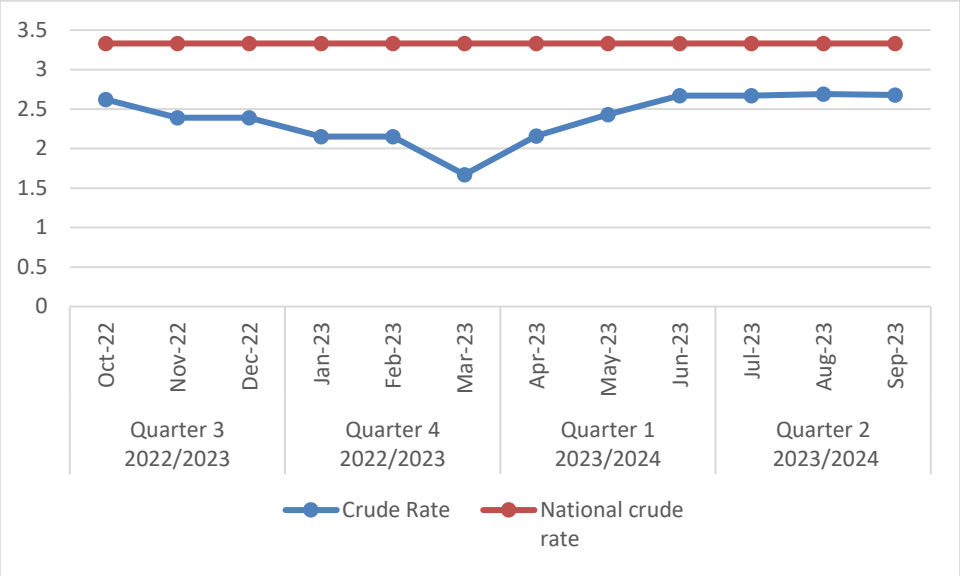
Termination of pregnancy: The deliberate ending of a pregnancy, normally carried out before the embryo or fetus is capable of independent life.

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 2 2023/2024 the rate has remained below the national stillbirth rate over the rolling 12 months.

		Crude Rate	National crude rate	Number of stillbirths
Quarter 3 2022/2023	Oct-22	2.62	3.33	0
	Nov-22	2.39	3.33	0
	Dec-22	2.39	3.33	1
Quarter 4 2022/2023	Jan-23	2.15	3.33	1
	Feb-23	2.15	3.33	0
	Mar-23	1.67	3.33	0
Quarter 1 2023/2024	Apr-23	2.16	3.33	2
	May-23	2.43	3.33	1
	Jun-23	2.67	3.33	2
Quarter 2 2023/2024	Jul-23	2.67	3.33	0
	Aug-23	2.69	3.33	2
	Sep-23	2.68	3.33	2



The above chart provides a comparison of the stillbirth crude rate and national rate. In Quarter 2 2023/2024 in July (2.67), August (2.69) and in September (2.68), the crude rate has remained below the national rate (3.33) despite seeing an increase in rates during Q2 2023/2024.

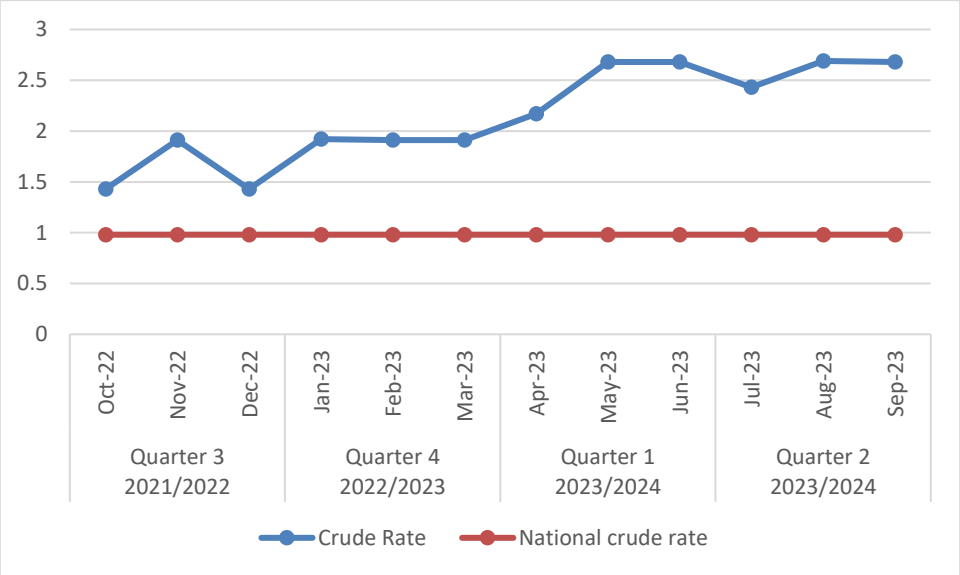
3.2 Early Neonatal deaths

The National Early Neonatal Death (ENND) rate is 0.98 (MBRRACE 2022) and in Q2 2023/2024 the ENND rate remains higher than the national rate.

		Crude Rate	National crude rate	Number of early NND
Quarter 3 2021/2022	Oct-22	1.43	0.98	0
	Nov-22	1.91	0.98	1

	Dec-22	1.43	0.98	1
Quarter 4 2022/2023	Jan-23	1.92	0.98	3
	Feb-23	1.91	0.98	1
	Mar-23	1.91	0.98	0
Quarter 1 2023/2024	Apr-23	2.17	0.98	1
	May-23	2.68	0.98	2
	Jun-23	2.68	0.98	0
Quarter 2 2023/2024	Jul-23	2.43	0.98	0
	Aug-23	2.69	0.98	1
	Sep-23	2.68	0.98	1

In Quarter 2 2023/2024 in July (2.43), August (2.69) and September (2.68) the crude rate is higher than the national rate 0.98 (MBRRACE 2022).



The above Chart allows comparison of the early NND crude and the national crude rate. The rate continues to remain high in Q2 2023/2024 as there were 2 ENND, 1 of these babies was born at <24 weeks gestation and the ENND at Term+14 the mother declined induction of labour and despite extensive counselling.

3.3 Late Neonatal Deaths

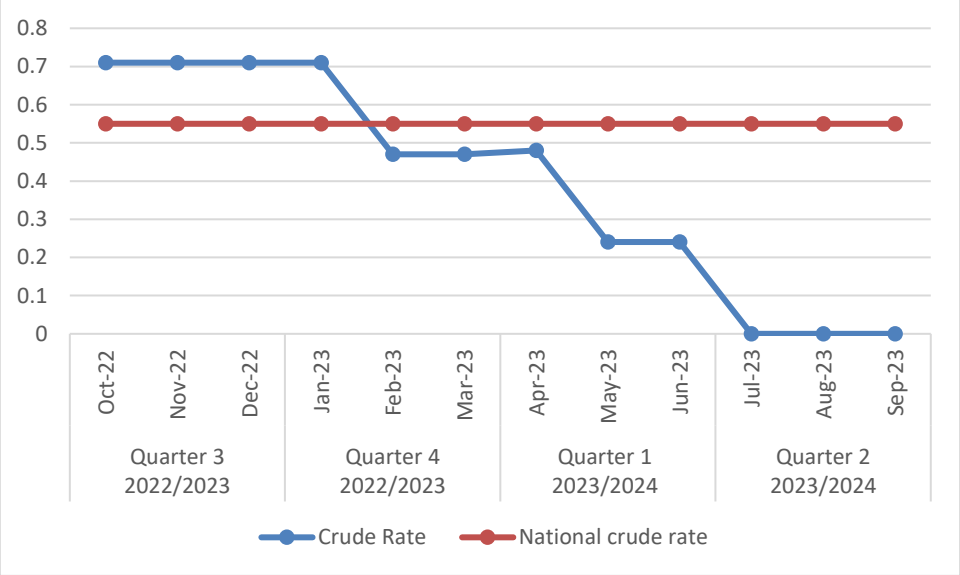
The table below identified the crude late neonatal death rates over the rolling 12 months. The National rate for Late Neonatal Deaths is 0.55 (MBRRACE 2022)

In Quarter 2 2023/2024 the crude rates continue to be below the national crude rate of 0.55 per thousand live births (MBRRACE 2022) July (0), August (0) and September (0).

		Crude Rate	National crude rate	Number of Late NND
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
Quarter 2 2023/2024	Jul-23	0	0.55	0
	Aug-23	0	0.55	0
	Sep-23	0	0.55	0

There has been a steady decline in the rate since January 2023 and in Quarter 2 there have been 0 late neonatal deaths.

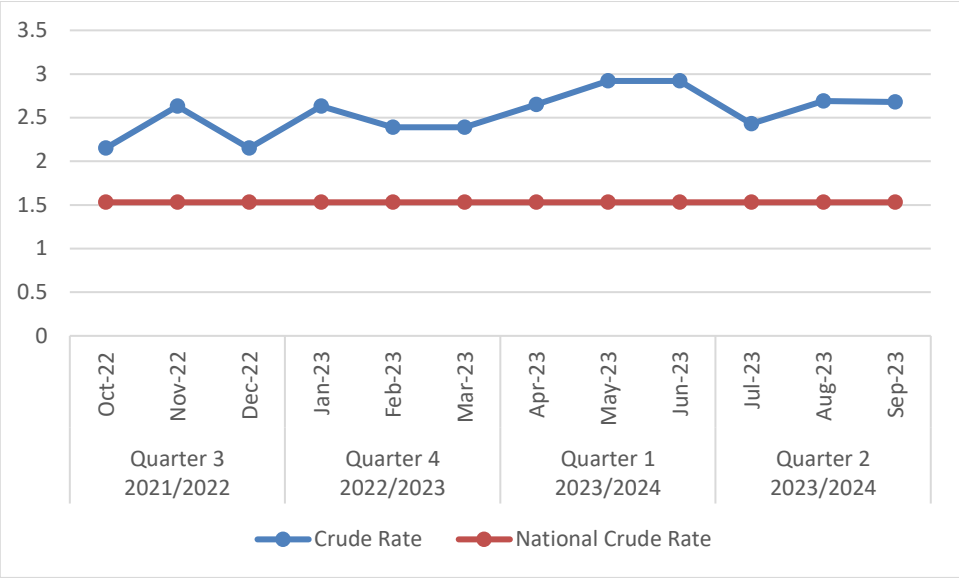


3.4 Combined Neonatal Deaths

In Quarter 2 2023/2024 the combined neonatal death rates are calculated in July (2.43), August (2.69) and September (2.68) is above the national rate of 1.53.

		Crude Rate	National Crude Rate
Quarter 3 2021/2022	Oct-22	2.15	1.53
	Nov-22	2.63	1.53
	Dec-22	2.15	1.53
Quarter 4 2022/2023	Jan-23	2.63	1.53
	Feb-23	2.39	1.53
	Mar-23	2.39	1.53
Quarter 1 2023/2024	Apr-23	2.65	1.53
	May-23	2.92	1.53
	Jun-23	2.92	1.53
	Jul-23	2.43	1.53

Quarter 2 2023/2024	Aug-23	2.69	1.53
	Sep-23	2.68	1.53



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 2 2022/2023 6 perinatal deaths occurred that met the criteria for a perinatal mortality review. These included four stillbirths and two neonatal deaths.

PMRT ID	Overview of Case	Date of Death	Date reported as PMRT (CNST standard to report within 7 days)	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
88749	Stillbirth at 36+2 weeks gestation	02.08.2023	04.08.2023	04.12.2023	04.02.2024	Included	Case to be presented at PMRT Board on 16.10.2023	Yes
88856	NND death at 22 weeks gestation	11.08.2023	11.08.2023	11.12. 2023	11.02.2024	Included	16.09.2023 presented at PMRT Board. Writing report.	Yes
89140	Stillbirth at 31+2 weeks gestation	26.08.2023	29.08.2023	29.12.2023	29.02.2024	Included	To be presented at PMRT Board on 20.11.2023	Yes
89255	Neonatal death at 42 weeks gestation	01.09.2023	05.09.2023	04.01.2024	04.03.2024	Included	To be presented at PMRT Board on 20.11.2023	Yes
89457	Stillbirth at 31+2 weeks gestation	13.09.2023	18.09.2023	18.01.2023	18.03.2024	Included	To be presented at PMRT Board on 18.12.2023	Yes
89533	Stillbirth at 36+2 weeks gestation	21.09.2023	23.09.2023	23.01.2024	23.03.2024	Included	To be presented at PMRT Board on 18.12.2023	Yes

8.2 PMRT reviews undertaken in Quarter 2 2023/2024

A total of 11 cases were reviewed during Quarter 2 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
87114	Late fetal loss	22 weeks gestation	A	N/A	A	Nil learning identified
87300	Stillbirth	25+ weeks gestation	A	N/A	A	Nil learning identified
87366	Late fetal loss	22+5 weeks gestation	A	N/A	A	To add a Risk to the Risk Register in relation to SWB not taking referrals for early onset FGR
87498	NND (declined resuscitation/had planned TOP)	23+2 weeks gestation	B	B	A	To inform community midwives that there is a need to review previous pregnancy notes on sunrise when taking a booking history.
87365	Stillbirth	30+3	C	N/A	B	A meeting to be arranged to look at sonography capacity and acceptance of requests. Case to be presented at CTG Obstetric and Midwifery staff meeting to include human factors. Case to be presented at Audit meeting. Matron to undertake a learning session with the DAU staff.

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
						To include the case in the CTG training day. Case to be included in the Multi Professional Education Training (MPET) day - focusing on escalation and when to call a consultant - Medics and Lead Midwife. Each Baby Count Safe Escalation Strategy to be imbedded into practice (Both Midwives and Medics). Deputy Matron to add an action regarding asking the parents if they want to be in the delivery room when resuscitation is taking place. To inform staff of the need to ensure that partners of women who are under General Anaesthetic are fully informed of progress of the resuscitation. PMRT Lead Consultant to present in Human Factors skill drills. To review the current scribe sheet for neonatal resuscitation and amend to ensure that it allows clear documentation of all aspects of the Resuscitation - Action already identified in PMRT 87303
87499	Stillbirth	23+2 weeks gestation	B	N/A	B	To ensure that community midwives are aware of the need to access EMIS when they book woman to ensure that all risks are identified. To inform staff that when women decline to use interpreting service and wish a relative to translate they need to ensure that the Interpreting and Translation information leaflet is given and that if they still wish to use a relative that they both sign the disclaimer form. To share the learning for this case in relation to the criteria for aspirin at the Maternity Audit meeting.

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
						To amend sunrise risk assessment for aspirin to state that if a woman is = 40/> 40 years of age. To communicate to all staff the need to cancel any external departmental appointments are cancelled when a woman suffers the loss of a baby. To share the learning in the need to screen for lupus when there is a history of abruption at the Maternity Audit meeting. Community midwife to reflect on the fact that she generated a growth chart before the initial USS was undertaken, therefore the incorrect EDD was used.
87860	Stillbirth	Term	A	N/A	A	Nil identified
88142	Stillbirth	40 weeks gestation	B	N/A	A	To remind all staff of the need to record a CO reading at every appointment and to record on the sunrise system. To share the updated smoking guideline which details the need to book for consultant care when a woman has quit, since conception, and/or register a CO reading of 4 or above. To inform medical staff that when a woman is seen following an USS they should ask the woman to see the paper copy of the scan report to ensure any comments made by sonographer were not missed. To share Saving Babies Lives guidance for commencing on aspirin with all midwifery/medical staff.

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
						To remind all medical staff of their responsibility in ensuring a woman is fully informed of that there is no fetal heart and not to await for the 2nd confirmation scan.
86557	Neonatal death at 35 days old (BWH case)	30+6 weeks gestation	B	C	To be graded by BWH	Obstetric tutor to undertake teaching in relation to early decision/administration of steroids and magnesium. All midwives to be informed at the daily huddle of the need to ensure that magnesium and steroids are considered for all women over 22+6/40 admitted with PROM or any threatened preterm delivery. Feeding team to see women in threatened preterm labour to discuss the management of breast feeding before they deliver., utilising the NHS website. To undertake an QI project to improve the completion of the full examination on admission to NNU New process developed to ensure that parents are informed when their baby is transferred to another room by the ward clerk between 0800-1800.
86683	Neonatal death (RWT case)	28 weeks gestation	B	D	To be graded by RWT	To discuss the management of prelabour rupture of membranes women and the administration of steroids and MgSO4 at point of membrane rupture at the LMNS Best Start meeting and to review/update guidelines dependant on outcome. Updated network guideline to be shared with changes - Julie Taylor - new updated book Regular joint NNU and Maternity SIM training on delivery suite and in maternity theatre. KIDZ training arranged for neonatal unit staff

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
						Scribe sheet being amended to document the discussions with the family. Education with Maternity at daily huddle in relation to ongoing support for parents during resuscitation. Hot brief to be undertaken with all staff led by midwifery team. Cold debrief to be undertaken by PMA's Debrief training to be undertaken by Band 7 midwives. Debrief training to be undertaken by Band 7 neonatal nurses. To undertake an QI project to improve the completion of the full examination on admission to NNU. To undertake a re- audit of golden hour. To inform NNU staff that rather than go through NTS to consider discussion individual case with the Level 3 unit.
88856	Neonatal Death	22 weeks gestation	B	A	A	Equality, Diversity & Inclusion Lead Midwife to review the use of interpreting services within Maternity to include assessment at booking and compliance throughout pregnancy and to review the need for staff training To clarify frequency of cervical length and to review all the preterm guidelines to ensure that they all reflect each other and to make relevant changes.

A total of 11 cases have been reviewed at PMRT Board in Quarter 2.

3 cases were reported as Serious incidents. 1 case was graded as a D where the MDT agreed that there were care issues which they considered were likely to have made a difference to the outcome of the baby. 2 cases were graded as a C where the MDT agreed that there were care issues which they considered may have made a difference to the outcome for the baby. Learning has been

identified from the cases and has been reflected in the PMRT and actions assigned on the incident reporting system.

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 management of women in preterm labour and prelabour rupture of membranes. This has led to identified learning which include:

- The need to review the management of women in preterm labour and prelabour rupture of membranes in relation to the administration of steroids and magnesium sulphate. This will be discussed at the LMNS work stream group to benchmark practice across the LMNS.

9. PMRT – Perinatal Mortality Reviews Summary Report – 01.01.2023 to 31.03.2023

The PMRT – Perinatal Mortality Reviews Summary Report has been generated from the PMRT tool for Quarter 4 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 Q4 2022/2023.

A total of 6 cases met the requirement for PMRT review in Q4 2022/2023. There are 2 cases that the review remains in progress one is a HSIB investigation awaiting ICB approval and one is a joint case with RWT which has been pre-published and awaiting BWH confirmation of final report.

Of the 4 cases that have been published in Q4 2022/2023 there were no cases that identified issues that may or likely to have made a difference to the outcome of the baby.

In the 3 cases that were published for Q4 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:

- 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.
- 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.
- 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.

An emerging theme from this quarter and in subsequent reviews undertaken in Q2 2023/2024 is the completion of the resuscitation scribe notes, this has led to a review of the newborn record sheet in sunrise to ensure.

Appendix 2- Reducing term admissions to the neonatal unit

A Retrospective Report of Findings from the Maternity and Neonatal Weekly Incident Review Meetings

Introduction

In 2017 NHS England identified that over 20% of term admissions to the Neonatal unit could be avoided. ATAIN (Avoiding Term Admissions into Neonatal units) is a National programme of work to reduce the harm caused by separation of mother and baby. The aim of this report is to discuss the themes identified from the weekly maternity and neonatal review of term admissions admitted to the Neonatal Unit to promote understanding and development of services which keeps mothers and babies together when it is safe to do so.

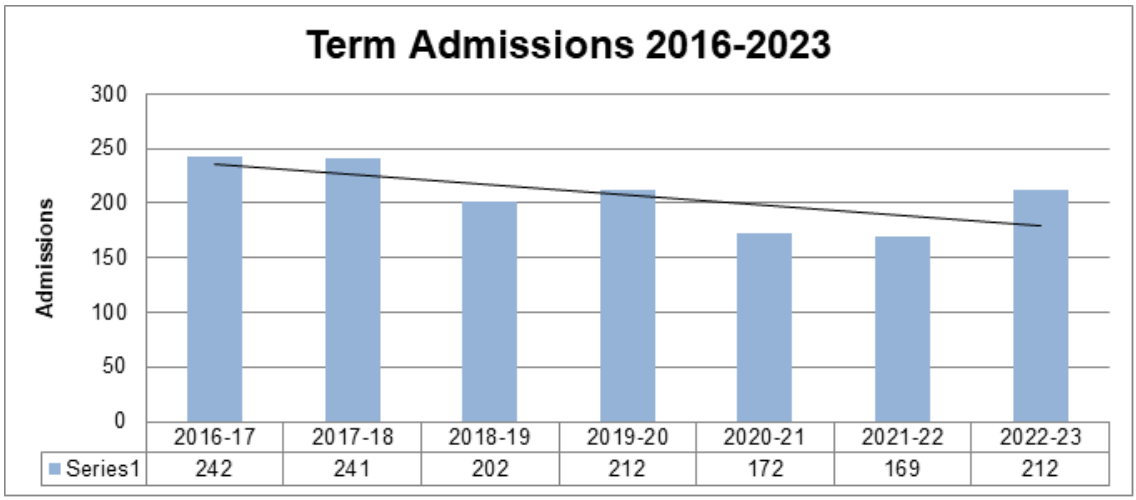
The Maternity Incentive scheme (NHS Resolution) requires an action plan to have been agreed at Trust Board level and with the Local Maternity System (LMS) and Operational Delivery Network (ODN) to address local findings from the review of term admissions. The National ATAIN scheme requires all Trusts to have admission rates of term infants below 5%.

Term Admissions

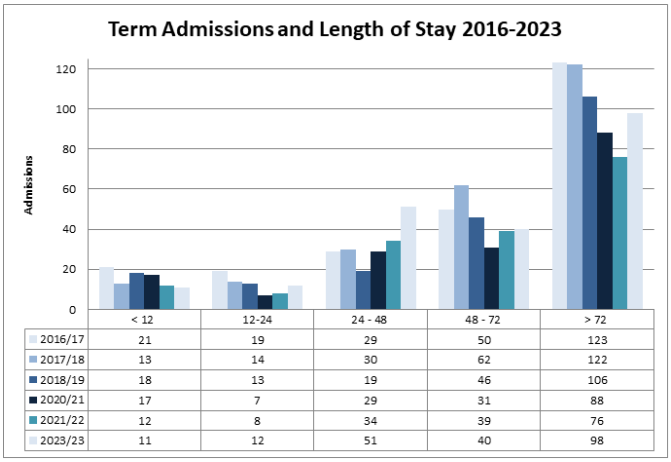
The table below demonstrates the percentage of term babies admitted to the Neonatal unit in the last 5 years. The data from Badgernet is for babies >37 weeks' gestation who stayed in the NNU for at least one day and where the first admission was within the period.

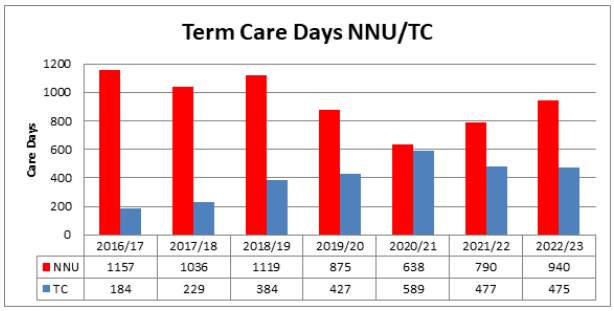
Year	No of Live Births	NNU	%NNU	TC	%TC	Total term admissions (NNU & TC)	%Total term admissions (NNU &TC)
Apr 23-Jun 23	**975**	**48**	**4.9%**	**26**	**2.6%**	**74**	**7.5%**
Jan 23-March 23	**1015**	**68**	**6.69%**	**23**	**2.2%**	**91**	**8.9%**
Oct 22-Dec 22	**1030**	**42**	**4.0%**	**19**	**1.8%**	**61**	**5.9%**
2022-23	4145	212	5.1%	97	2.3%	309	7.4%
2022 – 2022 (Dec)	3122	127	4.1%	70	2.2%	197	6.3%
2020/21	3794	148	4.0%	120	3.2%	268	7.1%

2019/20	4126	204	4.9%	92	2.2%	296	7.2%
2018/19	4300	188	4.4%	98	2.3%	286	6.7%
2017/18	4421	231	5.2%	56	1.3%	287	6.5%

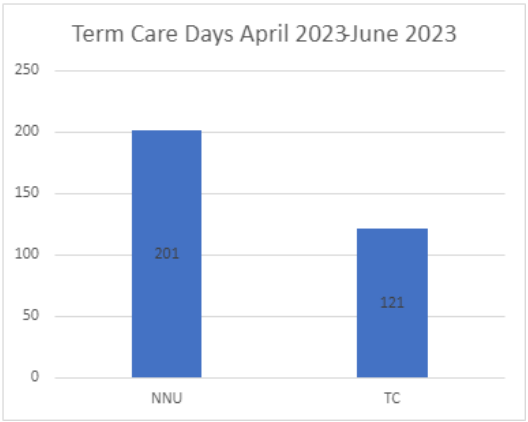


2022/23				Gestation		
Length of stay (hours)	**37**	**38**	**39**	**40**	**41+**	**Total**
No. of babies	**40**	**55**	**65**	**28**	**24**	**212**
< 12	0	2	3	2	4	**11**
12-24	0	3	5	3	1	**12**
24 - 48	7	19	17	4	4	**51**
48 - 72	12	9	9	6	4	**40**
> 72	21	22	31	13	11	**98**





The percentage of term babies admitted to the Neonatal unit in 2022/2023 has increased to 7.4%,and has risen since 2019/10 after a drop. Whilst the number of term babies admitted to the Neonatal unit has increased, the percentage of babies admitted to Transitional care has remained static.



Weekly Incident Review Meeting (WIRMS)

All term admissions except babies with an underlying congenital abnormality and those requiring a place of safety are reported as 'unexpected term admissions to the Neonatal unit". Babies who are admitted in accordance with Network and Trust pathways are also excluded. This includes bilious vomiting and failed pulse oximetry. Each admission is reviewed at a weekly meeting between the obstetric and neonatal team and findings from the review are documented. The WIRMS meetings are held every Wednesday.

Term Admissions

Between Oct 2022- Dec 2022 there were **42** term babies admitted to the Neonatal unit.

Between Jan 2023- March 2023 there were **68** term babies admitted to the Neonatal unit

Only had data for 1st quarter. There are **44** records of babies reviewed at WIRMS during the 1st quarter. ALL **44** were concluded to be unavoidable. **42** had respiratory

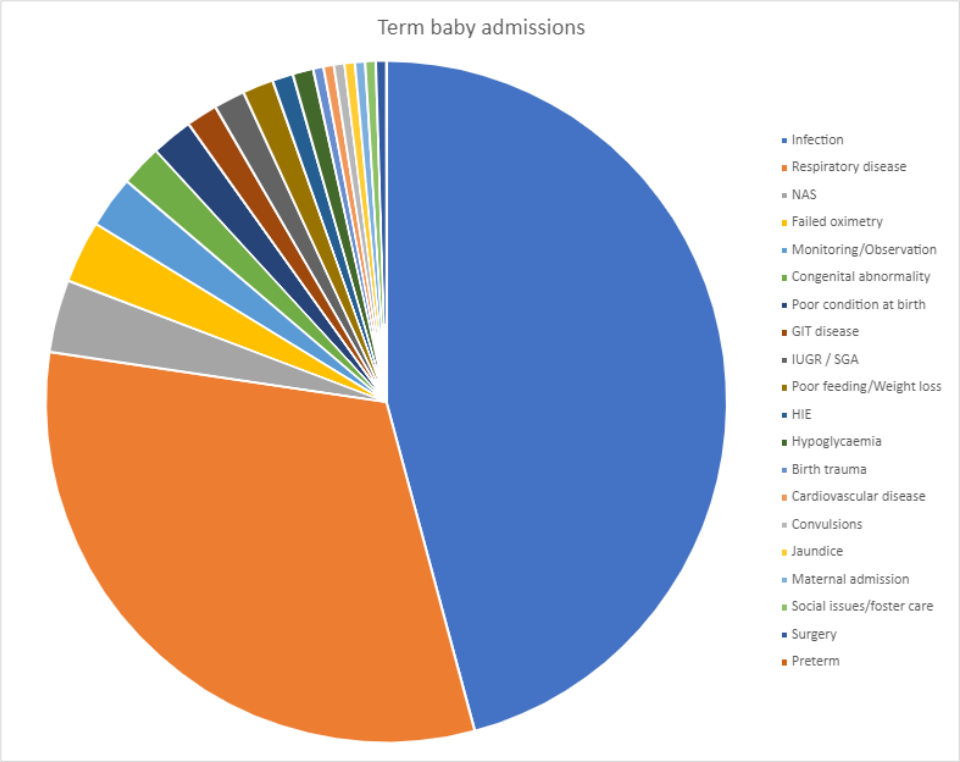
distress and needed respiratory support on NNU. **1** baby had a pre/post ductal discrepancy (should not have needed a Wirms review). **1** baby was a TC baby but there was no capacity on TC (? Need for a wirms review)

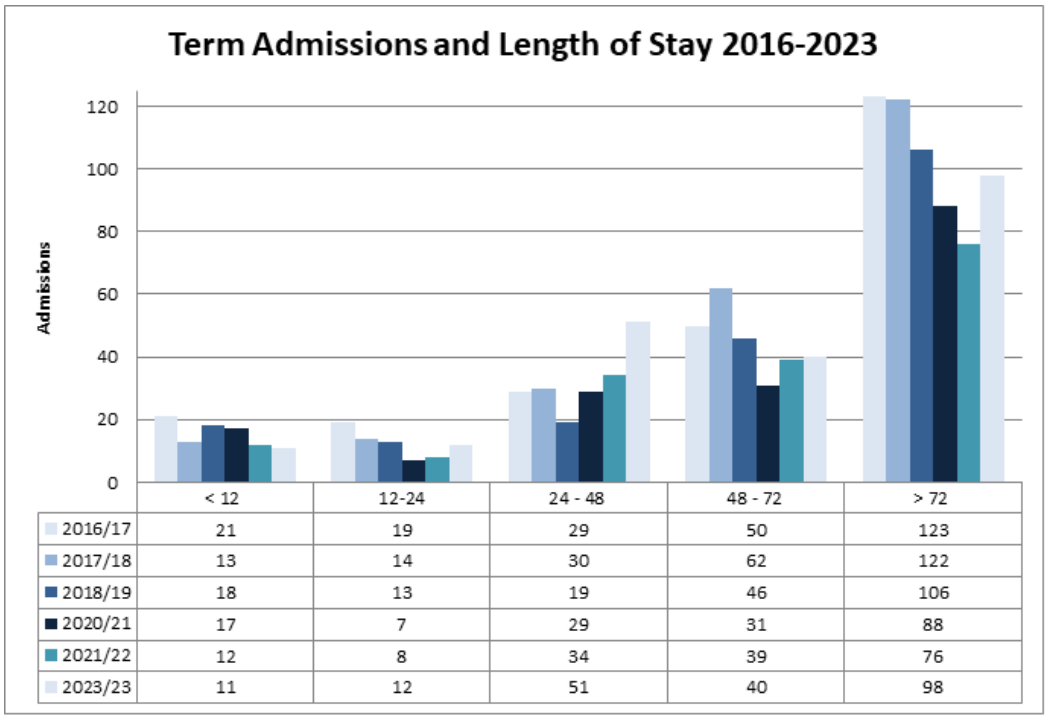
Term Admissions and Interventions

The commonest reason for admission to the Neonatal unit is respiratory distress and this is consistent with previous report findings.

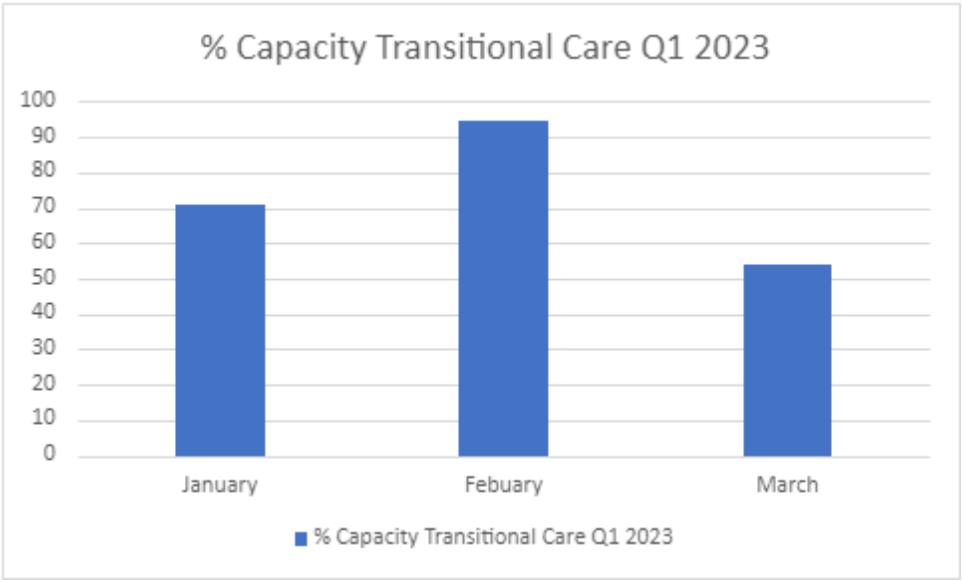
The incidence of respiratory distress and association with mode of delivery by caesarean section or instrumental remains highly evident. In Q1 27 out 44 babies had been born by CS.

The table below shows the gestation and reasons for admission during Oct 22 - March 2023





	< 12	12-24	24 - 48	48 - 72	> 72
2016/17	21	19	29	50	123
2017/18	13	14	30	62	122
2018/19	18	13	19	46	106
2020/21	17	7	29	31	88
2021/22	12	8	34	39	76
2023/23	11	12	51	40	98



% Capacity Transitional Care Q1 2023 shows that in January and March there could have been some cots available to reduce the term babies stays and/ or admissions on the neonatal unit. February 2023 the Transitional care was utilised at over 90% capacity.

Review Findings

- Between January 2023 and March 2023 there were 68 term babies admitted to then neonatal unit. There were 44 records of babies reviewed at WIRMS during the 1st quarter . All 44 were concluded to be unavoidable. This is an improvement on previous quarters as it was reported on previous reports that in Q3 2022 there were 3 babies deemed as unavoidable and in Q4 there were 7 babies deemed unavoidable.

Incidental learning was also identified.

Midwifery

- No handover to neonatal team that MARF submitted due to domestic violence with previous partner, aggressive behaviour and ? cannabis use

Neonatal

- No capacity on Transitional Care on 3 occasions necessitating admission to NNU or delayed transfer to TC
- New born record not in notes
- Badger admission summary not in notes
- Delay in completing Hepatitis B pathway documentation
- Nasal prong oxygen could have been used instead of High flow as blood gas satisfactory
- Earlier review of blood gases

2 of the 3 term admissions which were considered avoidable or potentially avoidable were delivered by emergency or elective caesarean section. It is difficult in a retrospective review to be able to definitely determine in all cases whether an admission is avoidable or unavoidable as clinical judgement and assessment may be influenced by the clinical team's experience and workload. Safe practice may influence the decision to admit to the Neonatal Unit rather than Transitional Care. Whilst the term pathway to standardise practice has yet to be introduced, it would seem unlikely that we will be able to further reduce the number of term admissions considered avoidable. .

Conclusion

The review findings in Q3 have highlighted similar themes to the previous report, in relation to the reasons for admissions deemed avoidable or potentially avoidable. The incidence of babies admitted with abnormal temperature was higher in Q3 compared to Q2 but no associated reasons or service changes could be identified to explain the increase,

In Q3 there has been a reduction in the number of term admissions admitted to the Neonatal unit following caesarean section / instrumental delivery as compared to previous quarters. All babies who were considered to be avoidable or potentially avoidable were identified from the < 12 hrs length of stay group.

Overall progress has continued t reduce the number of term admissions admitted to the Neonatal unit. When comparing data over the last 4 years the percentage of term babies admitted in 2020/21 was < 4%. The Atain programme, changes to the Transitional care criteria and ongoing weekly reviews have all contributed to increased awareness and knowledge to support the unnecessary separation of mother and baby.
.

Learning from the reviews is shared with the team or individual staff via one to one meetings, emails updates huddle meetings and newsletters. The Action plan has been up dated.

Action Plan to Reduce Term Admissions 2023

Problem	Action to achieve Standard	Lead	Timescale	Evidence	Outcome
Lack of staff knowledge about reducing term admissions	Maternity staff to undertake the ATAINe learning package. Aim for 80% compliance	Practice Educator Maternity	Monthly	Training database	78% compliance achieved
	Neonatal staff to undertake the ATAINe learning package. Aim for 80% compliance	Clinical Educator Jemima Saunders	Monthly	Training database	53% compliance achieved- deadline given to staff for completion
	Teaching clinical band 7 nurses TTN pathway to support Drs to ensure Term admissions are appropriate.	ANNP Lisa Gough	30/10/23		TTN pathway being devised by Dr Khurshid and ANNP Gough. Once devised to start teaching and recognition of pathway
No easily accessible database of findings at WIRMS to collate figures for presentation	Excel Database recording number of cases reviewed and findings Review existing data base and fully populate to date Audit on Amat system of WIRMS findings	ANNP team Maternity governance team CCockburn (ANNP)	30/9/2023	Database	Ongoing database but has not been regularly populated. New database commenced which is easier to complete, with shared leaning from maternity and NNU. Completed at WIRMS. 25/10/23
Care days from term admissions to the neonatal unit have increased	Flexible beds on TC Promotion of flexi beds so all staff are aware of process	ANNP Team K Penn (deputy Matron Maternity)	31/10/23	Change in TC SOP	A TC QI event took place on 30/08/2023 which included this initiative. Change

during financial year 2022/3 to the highest since 2018/19. R emain under the 5% required by ATAIN	Update TC SOP to reflect this				has already been implemented. TC SOP to be changed to reflect flexi beds/maternal readmissions. Lisa Gough/K Penn
	Allow mothers to be admitted to TC if babies can be transferred to TC after mother has been discharged from postnatal unit. Update TC SOP to reflect this	ANNP Team K Penn (Deputy Matron Maternity)	30/11/23	Change in TC SOP	A TC QI event took place on 30/08/2023 which included this initiative. This change has already been implemented. 19/10/23 awaiting for introduction of home phototherapy so this can also be included in SOP.
	Introduce TTN pathway for term babies	Dr Khurshid ANNP Lisa Gough	30/11/23		TTN pathway obtained from another NNU (Oct 23) to be adapted to meet our service needs - ongoing
	Education of TTN pathway to medics and Clinical band 7 leads	Dr Khurshid ANNP Gough	30/11/23		
	Introduction of home phototherapy incorporating TC pathway	Dr Iyer NCOT team ANNP Lisa Gough	30/11/23		Pathway (to incorporate TC flexibeds discussed between neonatal/maternity/paediatric teams 24/10/23 Awaiting SOP to be peer reviewed then ratified at Nov GAMe meeting
	Education on home phototherapy to MDT team	NCOT team			
	Regular communication between neonatal and midwifery teams	ANNP Team/Maternity	Ongoing	Meeting minutes	TC QI meeting every 2 weeks between maternity and NNU. K Penn/L Gough meeting 06/10/23
	Present 3 monthly audit findings at Maternity/Childrens Clinical Governance Agenda item on QPD to discuss	ANNP team	3 Monthly	Minutes of meetings	L Gough Presented initial data to best start 28/09/23 Initial data presented at Childrens governance by L Gough 17/10/23

	compliance to reviews and outcome ATTAIN data presented quarterly at LNMS best start				To be presented at ongoing governance meetings.
Delay in delivery and correct interpretation and categorisation of caesarean section	Weekly obstetric training to include interpretation of CTG's One to one feedback and supervision Appropriate escalation in accordance with guidelines	Clinical Governance Lead Maternity	Embedded in practice	Review of notes at WIRMs review	Embedded in practice 06/10/23
Low temperature on admission to TC/Postnatal ward	Ongoing admission to TC temp audit sheet if any babies admitted out of temp range, to identify any common themes. Temp rec-check with 1 hour of admission to TC if out of range. Datix to be completed for any baby with temp below 36 degrees. Heated Mattresses to be used for hypothermic babies ATTAIN training for all staff	Lisa Gough (ANNP) Rebecca Chatterley/Kathleen Kennedy (clinical neonatal leads) Jemima Saunders		Ongoing temp on admission audit	06/10/23 - embedded in practice
	Introduce normothermia toolkit BAPM	Rebecca Chatterley/Kathleen Kennedy			

Item 11.1

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	5.02%	<=5%	↑
Absence - 12m Rolling	5.26%	<=5%	↓
Turnover	8.58%	<=8%	↑
Normalised Turnover	4.34%	<=5%	↑
Retention (12 month)	91%	>=80%	↑
Vacancy Rate	5%	<=7%	↓
Mandatory Training	92.86%	>=90%	↑

Sickness Absence

- In month sickness absence for September is 5.02%, an increase from 4.72% in August. This is just above Trust target.
- The rolling 12-month absence shows a slight decrease from 5.57% in August to 5.26% in September 2023. This remains above target but continues to reduce and show an improving trajectory.

Turnover

- Turnover (all terminations) has increased from 8.50% in August to 8.58% in September 2023.
- Normalised Turnover (voluntary resignation) has increased from 4.28% in August to 4.34% in September 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

- The 12-month retention rate has increased from 90.5% in August to 91% in September 2023.

Vacancy Rate

- The vacancy rate has fallen from 6% to 5% in September 2023 with total vacancies of 320.38 WTE.

Mandatory Training

- Statutory Training has seen a monthly increase – and overall has remained above 90% target for a sustained period. Performance at 26/10/23 is 93.77%.

Exceptions/Improvement/Actions

The Dudley Group
NHS Foundation Trust

METRIC	SUMMARY
Absence	In-month performance for September is above Trust target, both metrics are rated amber and there has been a slight increase in both metrics. Both long-term absence and short-term absence continue to show reductions. In September long-term absence has marginally reduced to 2.80% and there has been a small increase in short-term absence to 2.47%. There is an overall reducing trajectory in both short and long-term absence. In September short-term absence accounted for 87% of all sickness absence episodes, with long-term absence (28 days +) accounting for 13% of absence episodes. However long-term absence accounted for 73% of all days lost, compared to 27% for short term absence.
Mandatory Training	Statutory Training overall compliance has now been above target for six consecutive months. Although there are some monthly increases and decreases, these are small deviations and remain well above target overall. All safeguarding and Resus subjects are now amber rated. Further action on the continued non-compliance on Resus and Safeguarding is being undertaken, including targeted follow-up at both individual and department level.
Appraisals	The appraisal window for 2023/4 was open between April and July, this has now closed. Appraisals for 23/24 are 92.3% overall for the organisation. The area of lowest compliance is the medicine division at 89.2% , with ten appraisals outstanding to achieve target.

CARE RESPECT RESPONSIBILITY

Exceptions/Improvement/Actions

The Dudley Group
NHS Foundation Trust

METRIC	SUMMARY
Leadership and Culture	• Culture #makeithappen was re-launched during September with the first new cycle of face-to-face engagement. These were well received by staff and around 1000 pieces of feedback have been collected. Work to summarise these will be drafted for the end of October and shared back through Divisions, regular communications channels and in the next round of #makeithappen in December. A Culture statement and draft behaviour framework are starting initial consultation. • Leadership Development Development activity continues with a focus on promotion of Manager's Essentials and Developing Leaders. Manager inductions are being developed to launch a session linked to Welcome to Dudley from January 2024, with a programme of work for a new manager in their first year. Shaping Your Future Event was undertaken on 13th October to promote the available learning and development opportunities including sharing the Learning Prospectus. Further events are planned for 2023/24 – with a focus on online and out and about engagement. Staff Survey – launched on 3rd October with a response rate of 25.20%, Work will continue throughout the fieldwork period to ensure we reach an increased rate for 2023.
Vacancies/ Turnover and performance against plan	It is important to triangulate turnover, vacancies and retention to evidence our performance in recruiting and retaining our workforce. Turnover (all terminations) and Normalised Turnover have increased in September, both continue to perform under the national average for the NHS between 10-12%. Retention has seen a marginal increase to 91% in September. The normalised vacancy rate for September is 5% with a vacancy factor of 320.38 WTE .

CARE RESPECT RESPONSIBILITY

Exceptions/Improvement/Actions

The Dudley Group

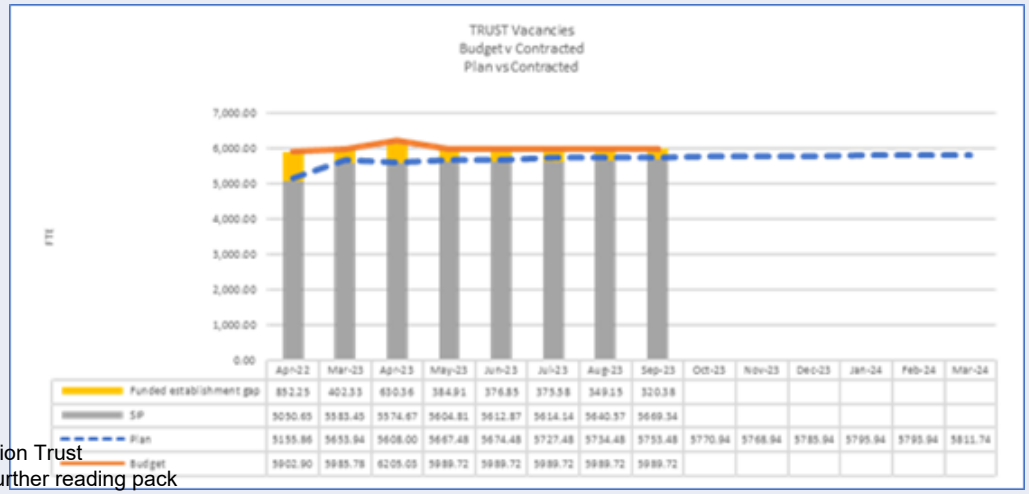
METRIC	SUMMARY
Vacancies/ Turnover and performance against plan	As demonstrated in the table below, the overall workforce growth year to date (April 23 and September 23) in 23/24 (inclusive of bank and agency staffing) is 0.9%, specifically for substantive staff this is 1.38% growth (77.34 WTE), bank staff -4.33% and agency staff 24.57%. Recruitment to substantive posts has been lower than anticipated in plan resulting in higher bank and agency costs.

	Apr-23	Sep-23	Difference	Variance
Total Workforce (WTE)	6271.1	6324.89	53.79	0.86%
Total Substantive	5595.15	5672.49	77.34	1.38%
Total Bank	656.21	627.81	-28.4	-4.33%
Total Agency	19.74	24.59	4.85	24.57%

Principal areas of growth within substantive staff have been seen in Registered Scientific, therapeutic and technical staff (6%)

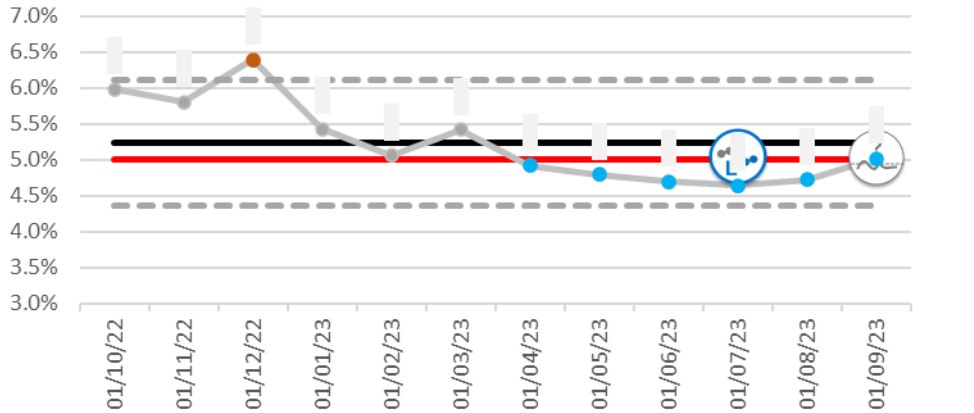
	Apr-23	Sep-23	Difference	Variance
Registered Nursing, Midwifery and Health Visiting Staff (substantive total)	1799.52	1861.83	62.31	3%
Registered Scientific, therapeutic and technical staff (substantive total)	628.72	668.12	39.4	6%
Support to Clinical Staff (substantive total)	1,370.22	1304.23	-65.99	-5%
Total NHS Infrastructure support (substantive total)	1006.38	1022.4	16.02	2%
Medical and Dental (substantive total)	790.31	815.91	25.6	3%
	5595.15	5672.49	77.34	1.4%

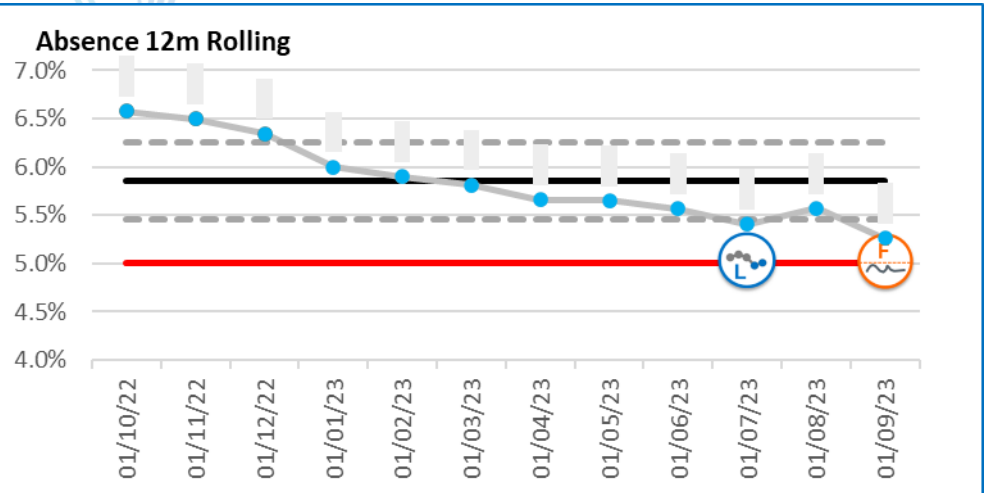
For 2023/24 performance at month 6 (July) Overall workforce is 1.1% below plan with less substantive staff but more bank usage than planned.



Sickness Absence

The Dudley Group
NHS Foundation Trust





In-Month Sickness Absence

In-month sickness absence for September is 5.02%, an increase from 4.72% in August. This is just above Trust target.

Rolling 12 M Sickness Absence

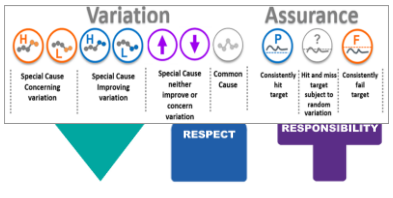
- The rolling 12-month absence shows a slight decrease from 5.57% in August to 5.26% in September 2023. This remains above target but continues to reduce and show an improving trajectory.

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.

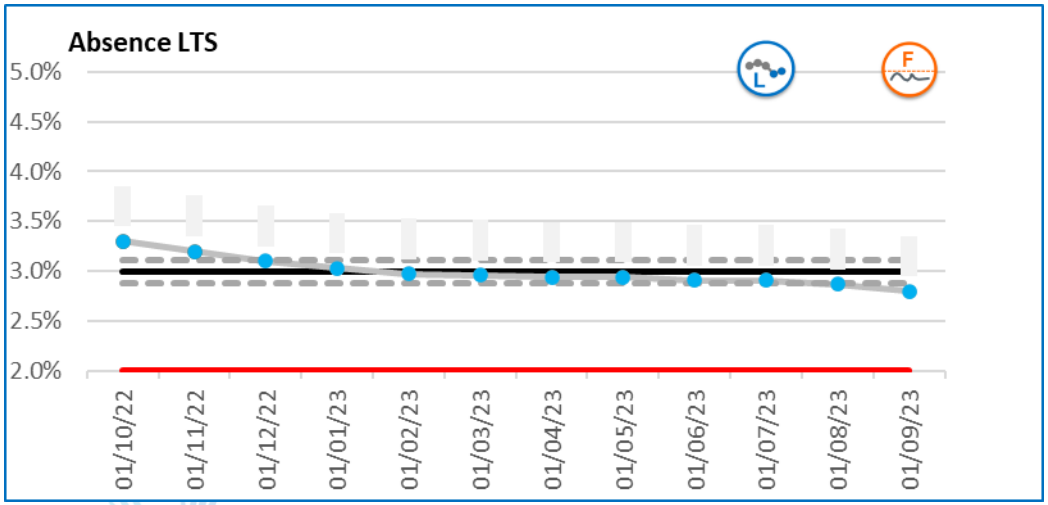
The main objective is to avoid absences and, where absences do occur, reduce their length, so early intervention is key and is supported by the following discrete pieces of work:

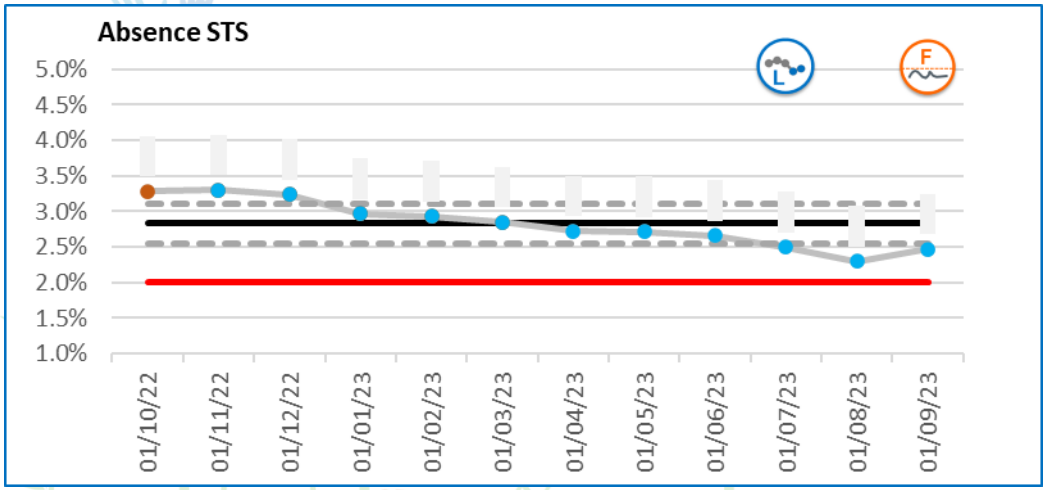
	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23
Absence in Month	5.98%	5.80%	6.39%	5.43%	5.06%	5.42%	4.92%	4.79%	4.69%	4.64%	4.72%	5.02%
Absence 12m Rolling	6.03%	6.00%	6.34%	6.00%	5.90%	5.81%	5.66%	5.65%	5.57%	5.41%	5.57%	5.26%



Long-Term and Short-Term Absence

The Dudley Group NHS Foundation Trust





Long-Term and Short-Term Sickness Absence

In September long-term absence has marginally reduced to 2.80% and there has been a small increase in short-term absence to 2.47%.

The graphs evidence an overall reducing trajectory in both short and long-term absence.

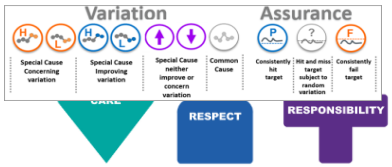
In September short-term absence accounted for 87% of all sickness absence episodes, with long-term absence (28 days +) accounting for 13%% of absence episodes. However long-term absence accounted for 73% of all days lost, compared to 27% for short-term absence.

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 6 months+ and for all short-term persistent absence is being managed robustly.

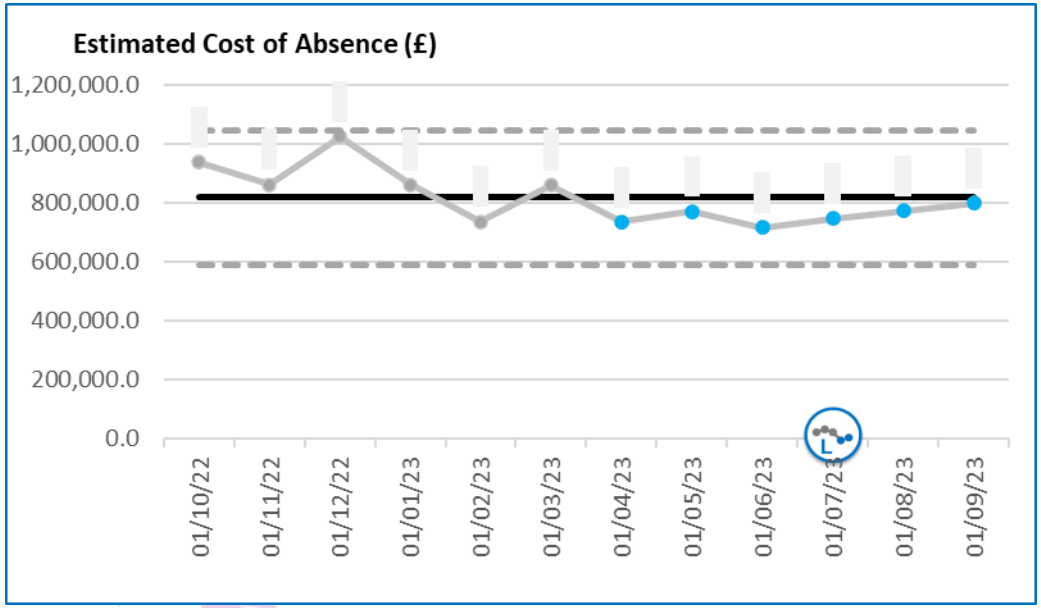
Short-term absence is currently the key focus.

	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23
Absence LTS	3.30%	3.20%	3.10%	3.03%	2.97%	2.96%	2.94%	2.94%	2.91%	2.91%	2.87%	2.80%
Absence STS	3.28%	3.39%	3.24%	2.97%	2.93%	2.85%	2.72%	2.71%	2.66%	2.50%	2.30%	2.47%



Estimated Cost of Absence

The Dudley Group
NHS Foundation Trust



Estimated Cost of Absence

The estimated cost of absence for September is £798,619 compared to £770,785 in August 2023.

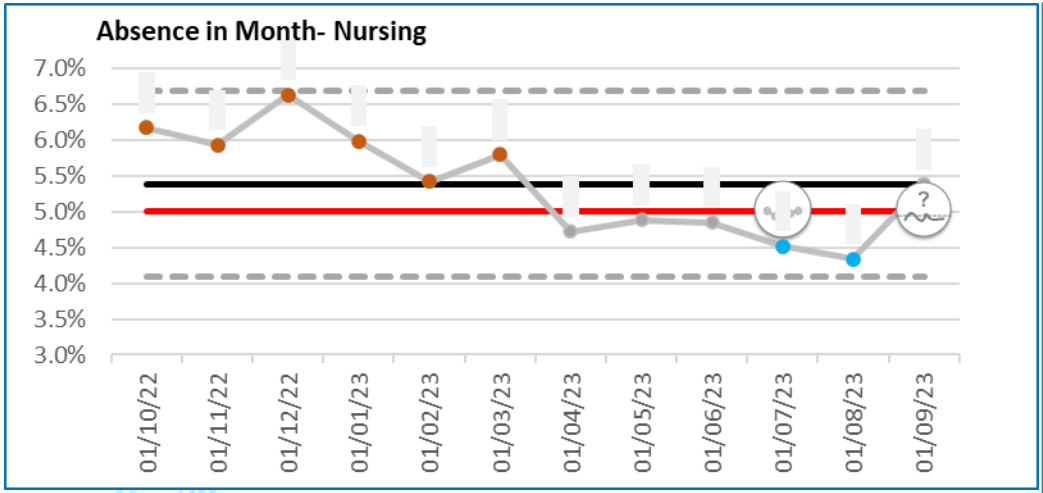
It should be noted that the estimated cost of absence refers only to sick pay and does not include any cover arrangements.

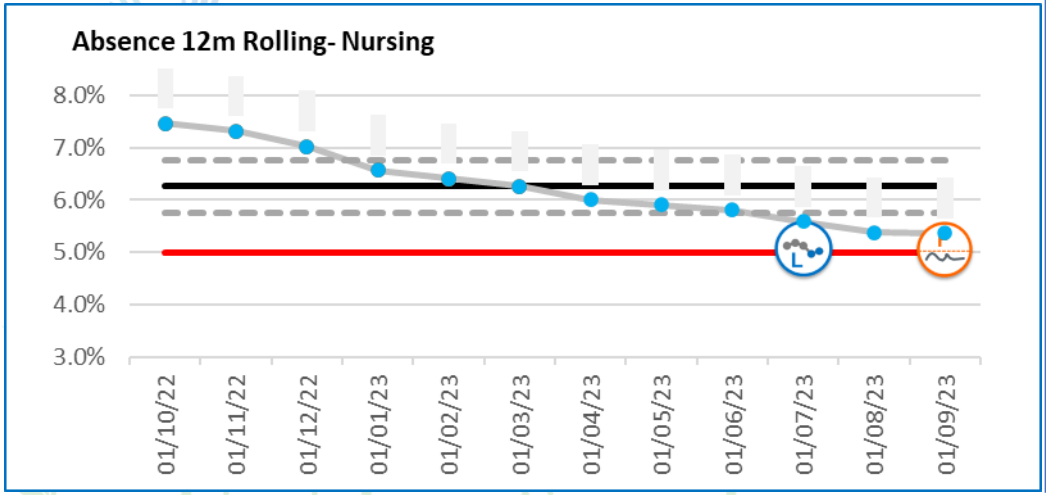
	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23
Estimated Cost of Absence (£)	£ 935,886	£ 861,583	£ 1,023,406	£ 859,668	£ 735,312	£ 858,936	£ 733,729	£ 769,327	£ 715,978	£ 746,460	£ 770,785	£ 798,619

CARE RESPECT RESPONSIBILITY

Sickness Absence- Nursing

The Dudley Group NHS Foundation Trust





In-Month Sickness Absence

In month sickness absence in nursing for September is 5.39%, an increase from 4.34% in August. This is above Trust target.

Rolling 12 M Sickness Absence

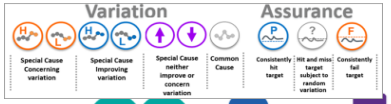
The rolling 12-month absence for nursing shows a reduction to 5.36% in September 2023. This is now amber against target and has shown a reducing trajectory over the last twelve months.

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:

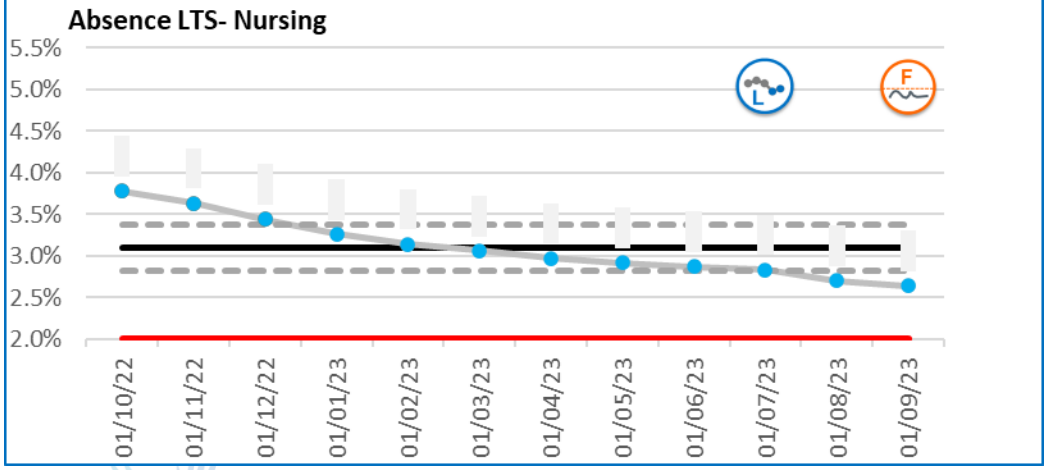
	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23
Absence in Month- Nursing	6.17%	5.93%	6.63%	5.99%	5.43%	5.80%	4.72%	4.89%	4.85%	4.52%	4.34%	5.39%
Absence 12m Rolling- Nursing	7.46%	7.31%	7.03%	6.57%	6.41%	6.26%	6.00%	5.91%	5.81%	5.58%	5.38%	5.36%

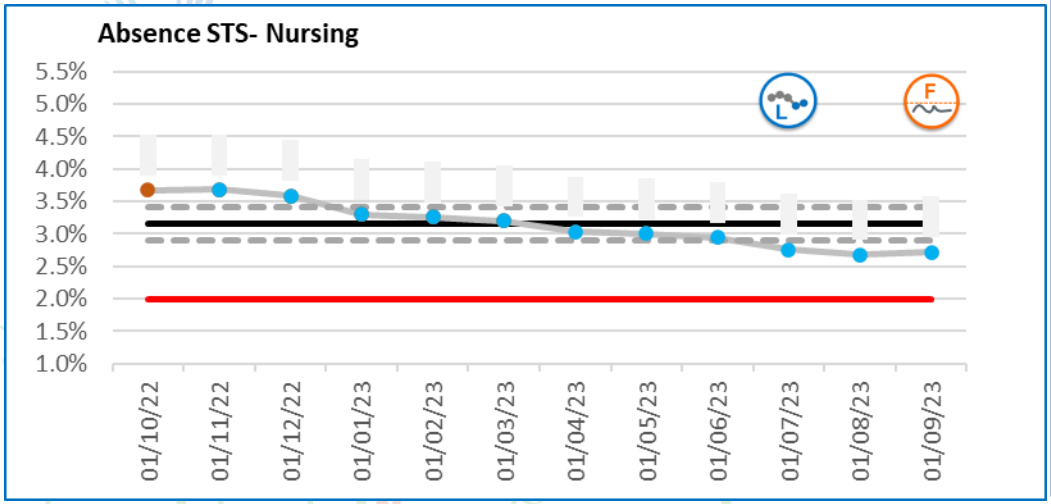


CARE RESPECT RESPONSIBILITY

Long-Term and Short-Term Absence – Nursing

The Dudley Group NHS Foundation Trust





Long-Term and Short-Term Sickness Absence

Long-term absence in nursing and midwifery has shown a decreasing trend since October 2022 and is now at 2.64%.

Short-term absence had also shown a decreasing trend since September 2022, however in September 2023 we have seen a slight increase to 2.72%.

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.

	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23
Absence LTS- Nursing	3.78%	3.63%	3.44%	3.26%	3.14%	3.06%	2.97%	2.92%	2.87%	2.83%	2.70%	2.64%
Absence STS- Nursing	3.67%	3.68%	3.59%	3.30%	3.26%	3.20%	3.03%	3.00%	2.94%	2.76%	2.68%	2.72%

CARE RESPECT RESPONSIBILITY

Sickness Absence

The Dudley Group
NHS Foundation Trust

Top 10 Departments By Time Lost (September)

Department	Absence FTE	Available FTE	Absence FTE %
253 Maternity Unit Serv	351.65	5,802.68	6.06%
253 Pharmacy Department Serv	337.36	4,911.80	6.87%
253 Critical Care Serv	283.08	3,911.60	7.24%
253 Ward B4 Serv	280.24	2,525.32	11.10%
253 Ward EAU Serv	275.72	5,595.56	4.93%
253 Emergency Dept Nursing Serv	272.00	3,668.72	7.41%
253 Pathology - Phlebotomy Serv	256.21	1,880.64	13.62%
253 Therapy Department Serv	198.13	4,119.69	4.81%
253 RHH Day Case Theatre Wd Serv	168.69	899.76	18.75%
253 Ward C8 Serv	156.44	2,399.12	6.52%

Top 10 Departments By Absence Rate (September)

Department	Absence FTE	Available FTE	Absence FTE %
253 Ambulatory Neurology CNS Serv	41.20	71.20	57.87%
253 Mgt Team Specialist Surgery Serv	30.00	90.00	33.33%
253 Acute Oncology Serv	22.00	90.00	24.44%
253 Med Secs - Cardiology Serv	64.43	279.60	23.04%
253 Macmillan Specialist Team Community Serv	63.60	295.24	21.54%
253 Med Secs - Renal Serv	30.00	144.00	20.83%
253 Treasury Serv	30.00	150.00	20.00%
253 RHH Day Case Theatre Wd Serv	168.69	899.76	18.75%
253 Renal Unit Serv	151.92	831.20	18.28%
253 Leg Ulcer Service Adult DN Serv	48.12	270.00	17.82%

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

Absence Reason	Headcount	Abs Occurrences	FTE Days Lost	%
S10 Anxiety/stress/depression/other psychiatric illnesses	737	946	22,795.79	21.9
S13 Cold, Cough, Flu - Influenza	2259	2,999	9,856.16	9.5
S12 Other musculoskeletal problems	515	641	9,309.01	8.9
S25 Gastrointestinal problems	1948	2,665	9,032.73	8.7
Other	894	985	5,587.46	5.4
S99 Unknown causes / Not specified	545	654	5,361.68	5.1
S30 Pregnancy related disorders	252	590	5,048.61	4.8
S28 Injury, fracture	224	243	4,543.68	4.4
S26 Genitourinary & gynaecological disorders	326	422	4,382.70	4.2
S11 Back Problems	265	302	3,723.87	3.6

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	737	946	27,819	£2,108,839.03	22.8
S13 Cold, Cough, Flu - Influenza	2259	2,999	11,149	£1,015,053.13	9.1
S12 Other musculoskeletal problems	515	641	10,978	£776,949.55	9.0
S25 Gastrointestinal problems	1948	2,665	10,431	£828,029.43	8.5
Other	894	985	6,432	£580,012.96	5.3
S99 Unknown causes / Not specified	545	654	6,262	£542,169.18	5.1
S30 Pregnancy related disorders	252	590	5,705	£483,657.06	4.7
S28 Injury, fracture	224	243	5,434	£462,923.56	4.4
S26 Genitourinary & gynaecological disorders	326	422	5,136	£421,211.84	4.2
S11 Back Problems	265	302	4,320	£308,690.40	3.5

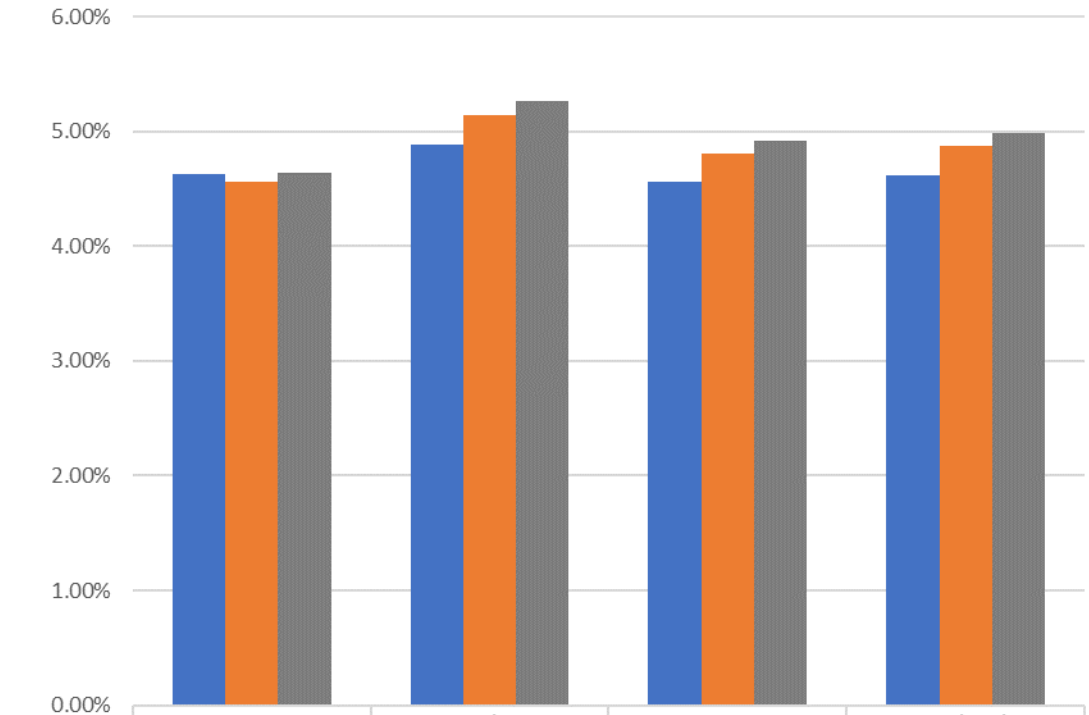
Absence Reasons

- 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

Absence Benchmarking

The Dudley Group NHS Foundation Trust



	Trust	Region	Country	National
2023 / 06	4.63%	4.89%	4.56%	4.62%
2023 / 07	4.56%	5.14%	4.81%	4.88%
2023 / 08	4.64%	5.27%	4.92%	4.99%

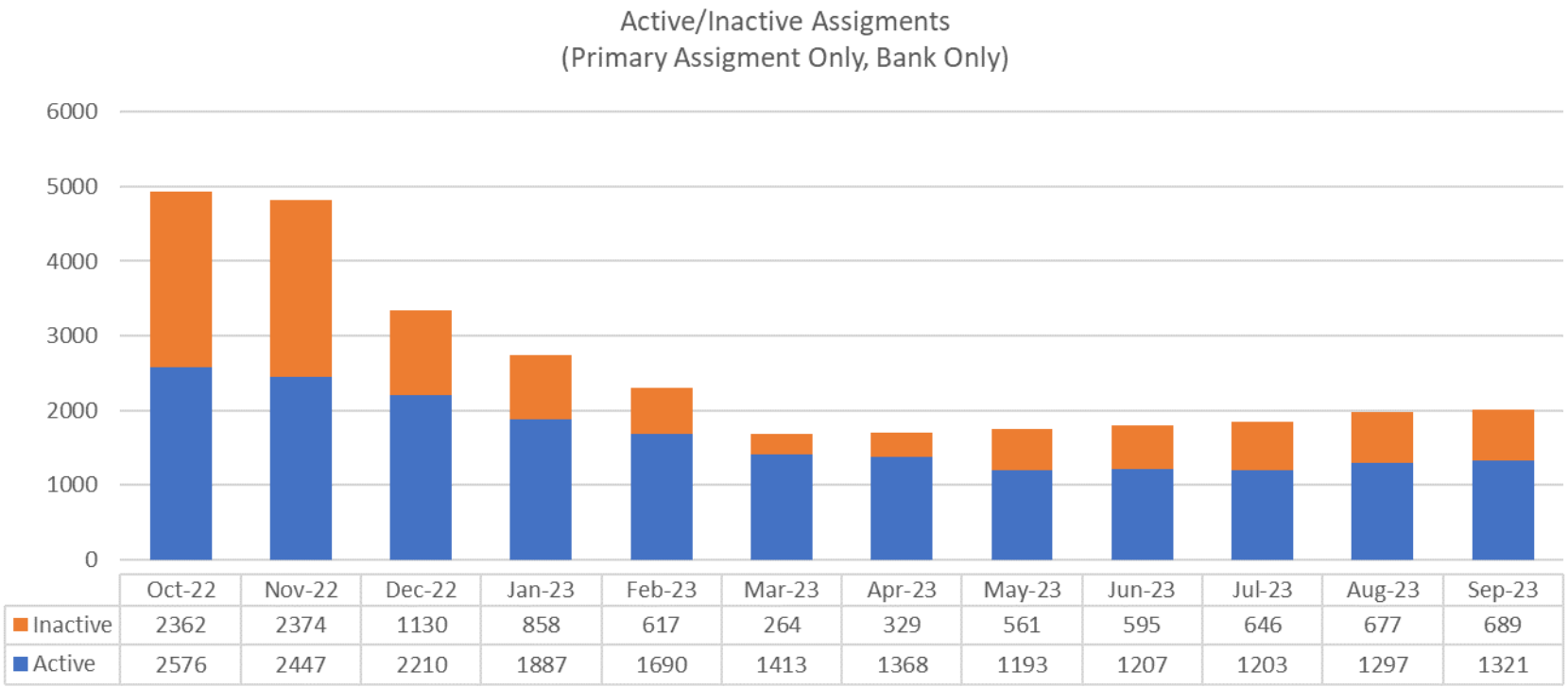
Benchmarking

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

CARE RESPECT RESPONSIBILITY

Active / Inactive Assignments

The Dudley Group NHS Foundation Trust



	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23
Inactive	2362	2374	1130	858	617	264	329	561	595	646	677	689
Active	2576	2447	2210	1887	1690	1413	1368	1193	1207	1203	1297	1321

Bank Efficiency

There are 2,010 bank assignments registered on the Trust's Staff Bank, an increase from 1974 in August 2023

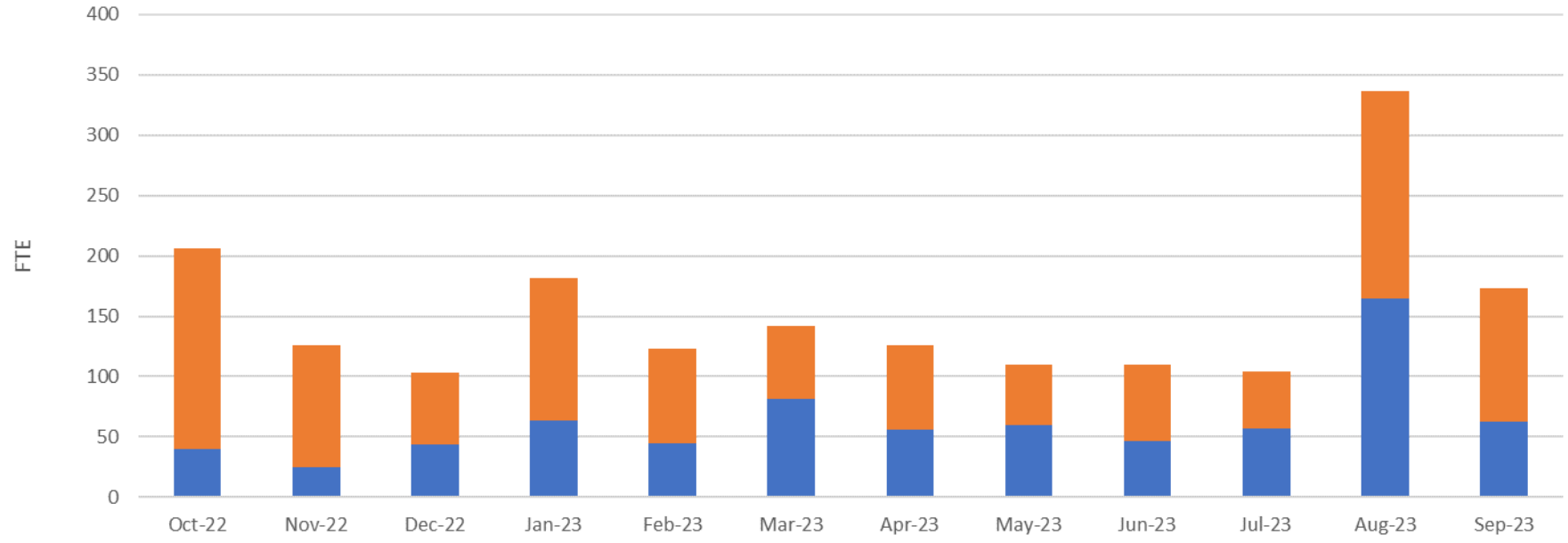
We now have 689 active records as opposed to the 677 previously recorded as inactive (not worked in 17-week period). This month has also seen an increase in active workers.

Currently 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



	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23
Starters FTE	165.91	101.32	59.87	118.15	78.99	60.42	70.64	50.29	63.5	47.56	172.18	109.84
Leavers FTE	40.19	24.91	43.76	63.95	44.49	82	55.66	59.79	46.58	56.66	164.49	62.96

Starters vs Leavers

- This month we have seen more starters than leavers, in September there were 62.96 WTE leavers compared to 109.84 WTE starters.

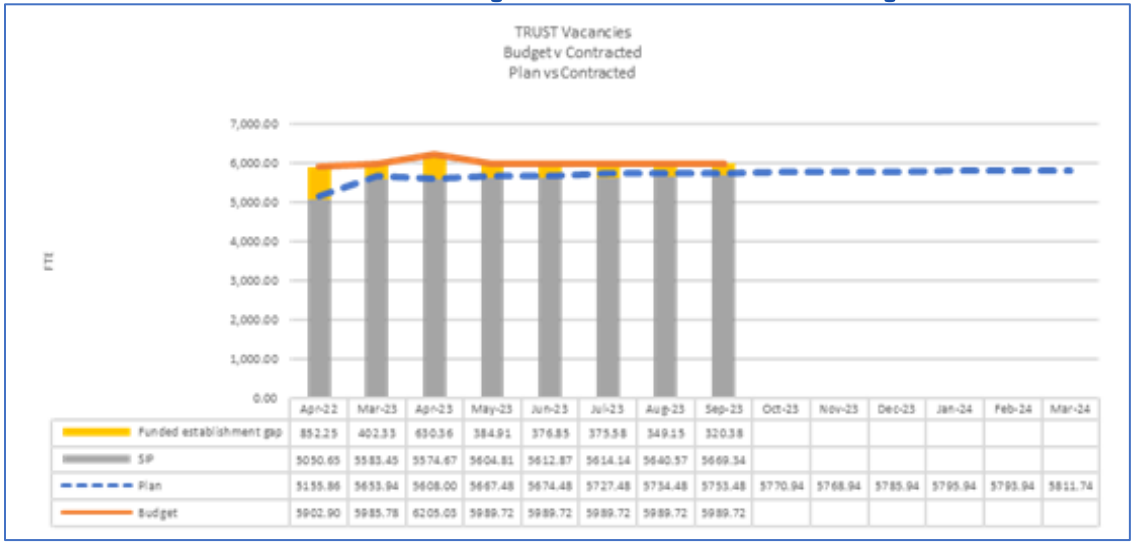
Assurance

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

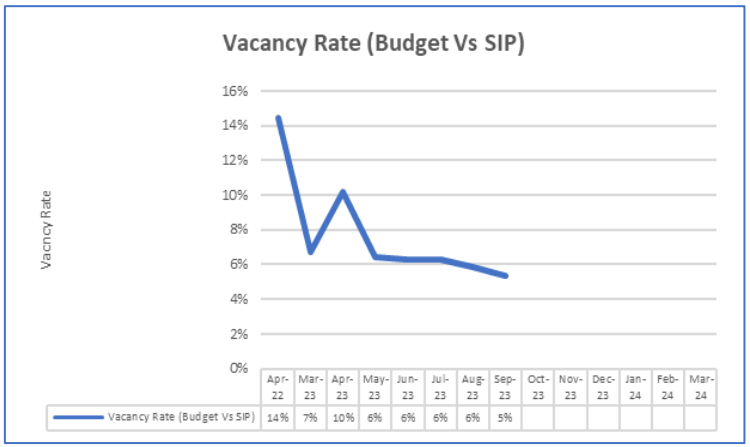
CARE RESPECT RESPONSIBILITY

Recruitment/Vacancies/Turnover - TRUST

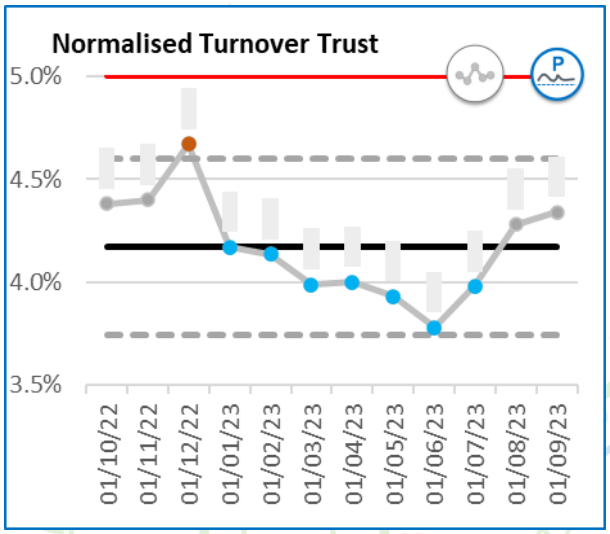
The Dudley Group
NHS Foundation Trust

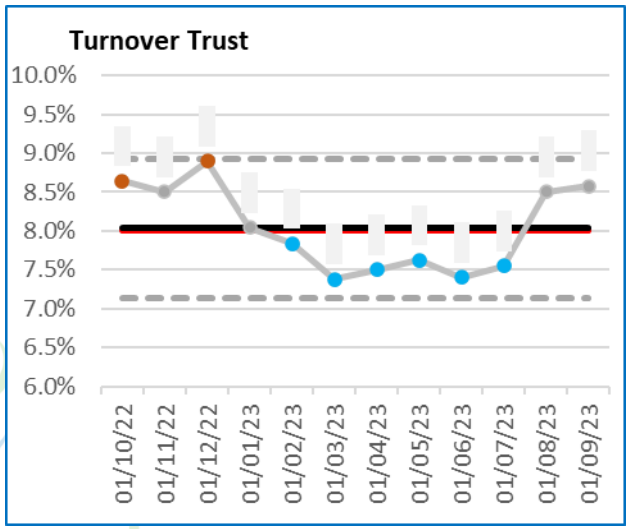


	Apr-22	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Funded establishment gap	852.25	402.33	630.36	384.91	376.85	375.58	349.15	320.38						
SIP	5050.65	5583.45	5574.67	5604.81	5612.87	5614.14	5640.57	5669.34						
Plan	5155.86	5653.94	5608.00	5667.48	5674.48	5727.48	5734.48	5753.48	5770.94	5768.94	5785.94	5795.94	5795.94	5811.74
Budget	5902.90	5985.78	6205.03	5989.72	5989.72	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%	6%	5%						





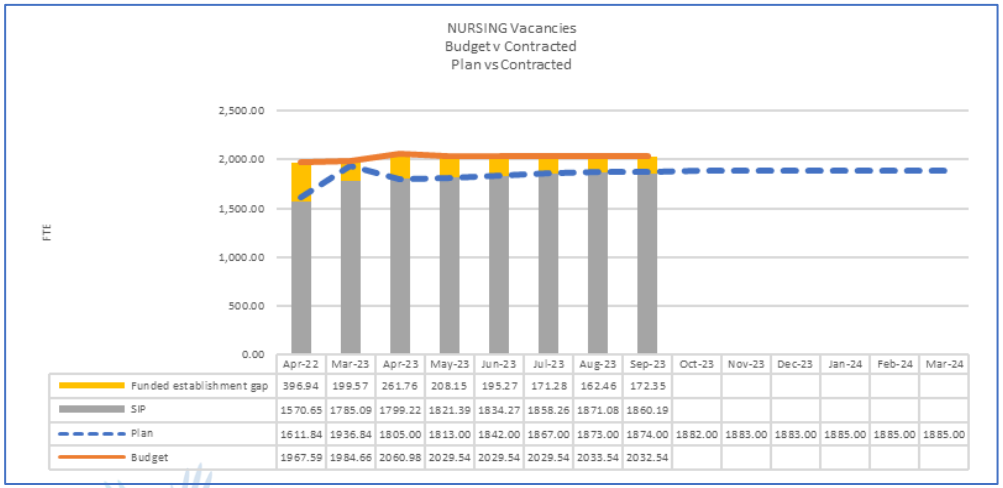
- Contracted WTE staff has increased from 5640.57 WTE in August to 5669.34 in September 2023.
- This is 84.14 WTE under the workforce plan.
- The total vacancies stands at 320.38 WTE in September 2023. This equates to a vacancy factor of 5%.
- Overall staff turnover (rolling twelve months average) is at 8.58%, with normalised turnover at 4.34%.

	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23
Trust Turnover	8.64%	8.50%	8.90%	8.04%	7.84%	7.38%	7.50%	7.62%	7.40%	7.55%	8.50%	8.58%
Trust Normalised Turnover	4.38%	4.40%	4.67%	4.17%	4.14%	3.99%	4.00%	3.93%	3.78%	3.98%	4.28%	4.34%

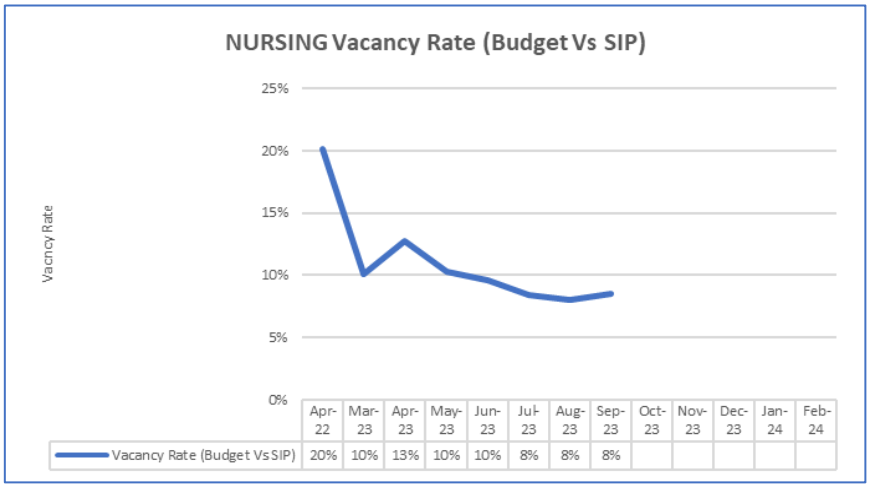
CARE RESPECT RESPONSIBILITY

Recruitment/Vacancies/Turnover - Registered Nursing & Midwifery

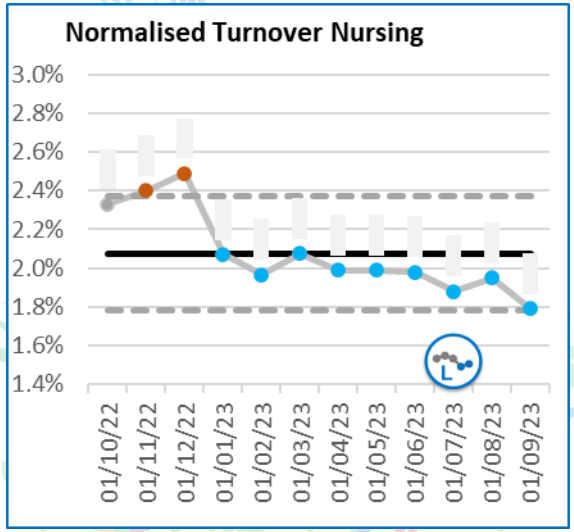
The Dudley Group NHS Foundation Trust

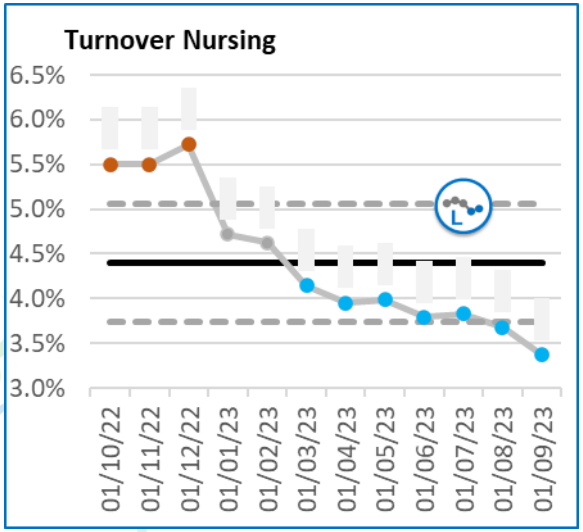


	Apr-22	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Funded establishment gap	396.94	199.57	261.76	208.15	195.27	171.28	162.46	172.35						
SIP	1570.65	1785.09	1799.22	1821.39	1834.27	1858.26	1871.08	1860.19						
Plan	1611.84	1936.84	1805.00	1813.00	1842.00	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	2033.54	2032.54						



	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%	8%	8%					



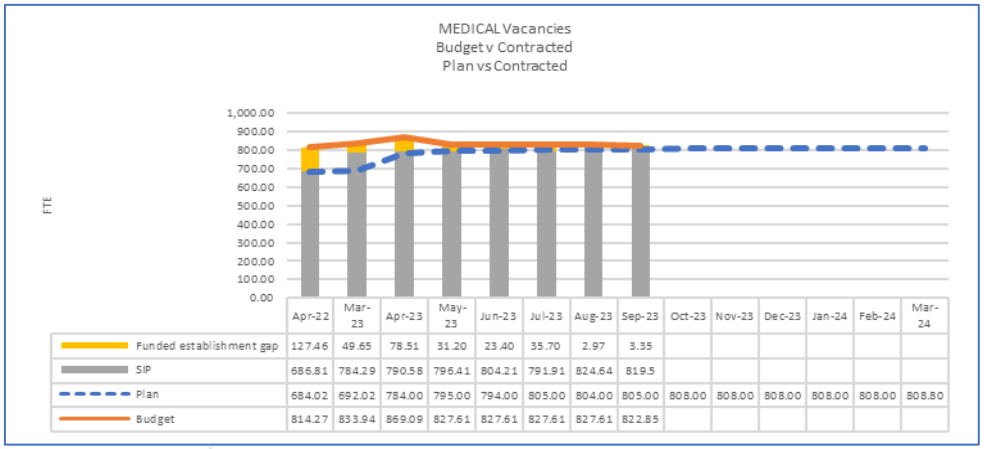


- Contracted WTE for nursing and midwifery staff has increased from 1871.08 WTE in August to 1860.19 in September 2023.
- This is 13.81 WTE below the workforce plan.
- The total nursing and midwifery vacancies reported stands at 172.35 WTE, which equates to a vacancy rate of 8%.
- Staff turnover for nursing (rolling 12 months average) is at 3.37%, with normalised turnover at 1.79%.

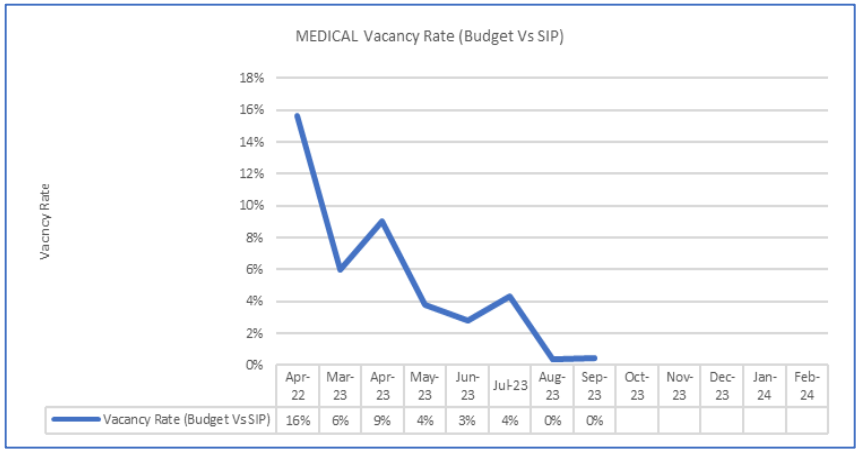
	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23
Nursing Turnover	5.50%	5.50%	5.72%	4.72%	4.62%	4.14%	3.95%	3.99%	3.79%	3.83%	3.68%	3.37%
Nursing Normalised Turnover	2.35%	2.40%	2.49%	2.07%	1.97%	2.07%	1.99%	1.99%	1.98%	1.88%	1.95%	1.79%

Recruitment/Vacancies/Turnover - Medical & Dental

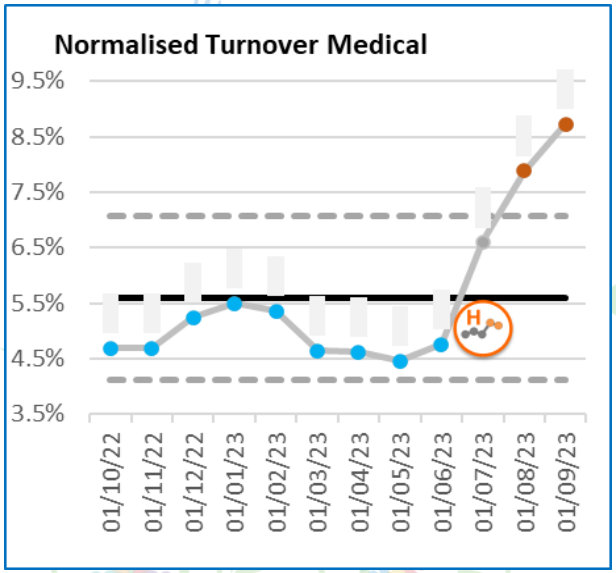
The Dudley Group NHS Foundation Trust

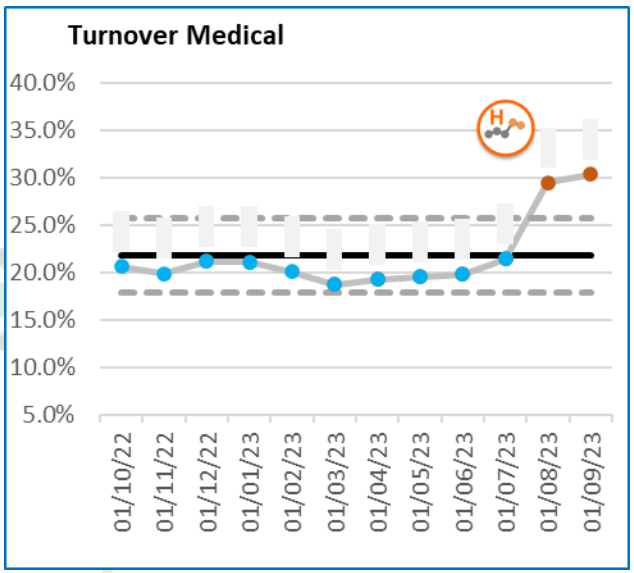


	Apr-22	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Funded establishment gap	127.46	49.65	78.51	31.20	23.40	35.70	2.97	3.35						
SIP	686.81	784.29	790.58	796.41	804.21	791.91	824.64	819.5						
Plan	684.02	692.02	784.00	795.00	794.00	805.00	804.00	805.00	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	827.61	822.85						



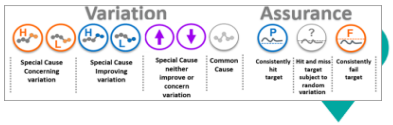
	Apr-22	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24
Vacancy Rate (Budget Vs SIP)	16%	6%	9%	4%	3%	4%	0%	0%					





- Contracted WTE for medical and dental staff has reduced from 824.64 WTE in August 2023 to 819.5 in September 2023
- The total medical and dental vacancies stands at 3.35 WTE. The vacancy rate is 0%.
- Staff turnover for medical and dental (rolling 12 months average) has increased to 30.34% (mainly due to rotation), with normalised turnover increasing to 8.73%.

	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23
M&D Turnover	20.63%	19.90%	21.18%	21.12%	20.10%	18.75%	19.28%	19.52%	19.82%	21.45%	29.45%	30.34%
M&D Normalised Turnover	4.69%	4.69%	5.24%	5.56%	5.36%	4.65%	4.62%	4.46%	4.76%	6.60%	7.89%	8.73%

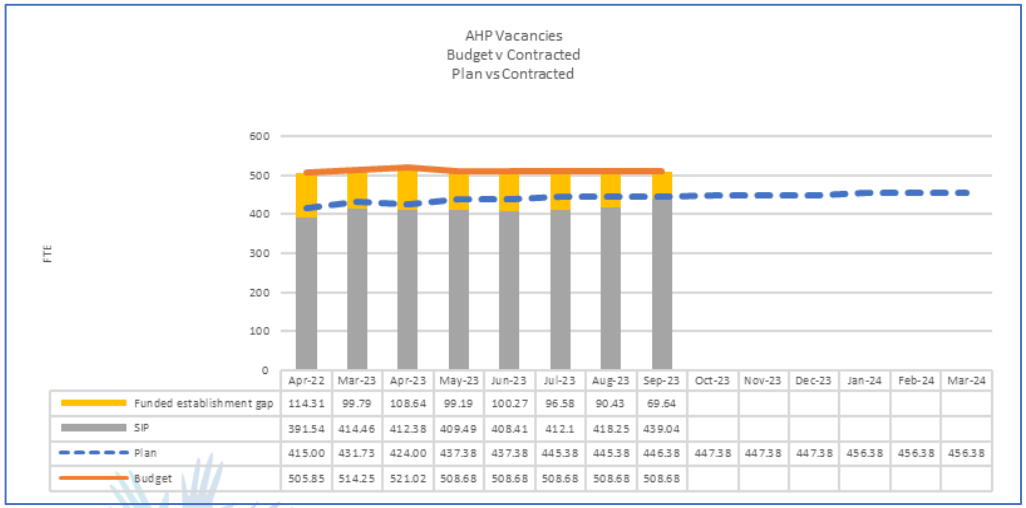


RESPECT

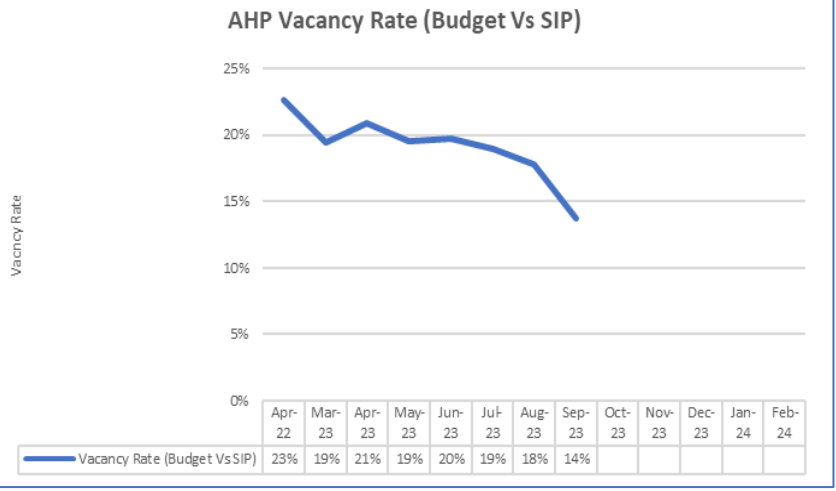
RESPONSIBILITY

Recruitment/Vacancies/Turnover - Allied Health Professional

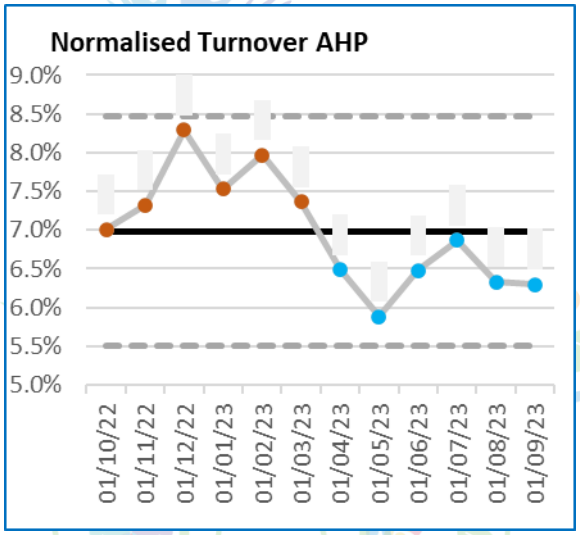
The Dudley Group NHS Foundation Trust

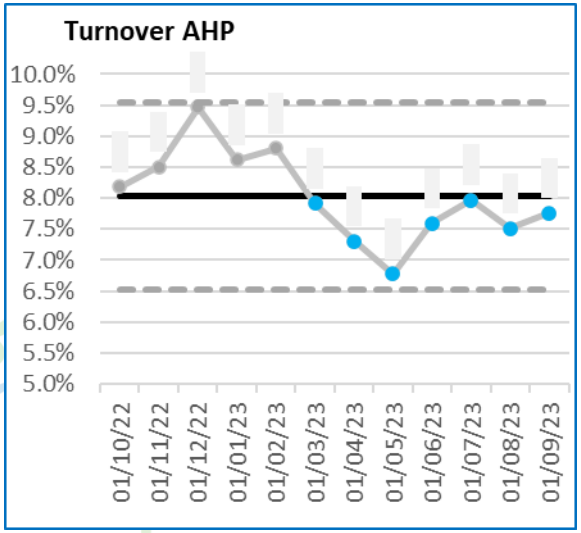


	Apr-22	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Funded establishment gap	114.31	99.79	108.64	99.19	100.27	96.58	90.43	69.64						
SIP	391.54	414.46	412.38	409.49	408.41	412.1	418.25	439.04						
Plan	415.00	431.73	424.00	437.38	437.38	445.38	445.38	446.38	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	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%	18%	14%					



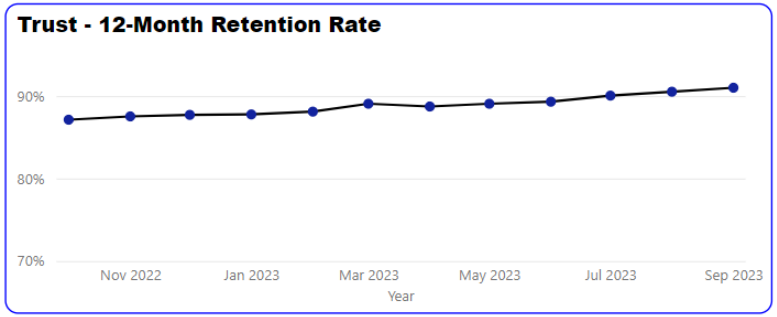


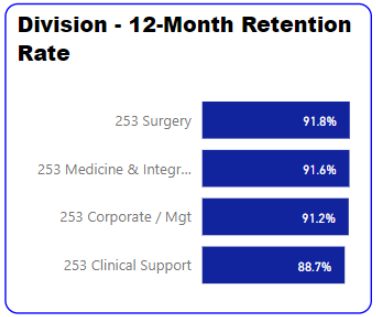
- Contracted WTE for AHP's has increased from 418.25 in August to 439.04 in September 2023.
- This is 7.34 WTE under the workforce plan.
- The total AHP vacancies in September 2023 are 69.64 WTE, this equates to a vacancy factor of 14%.
- Staff turnover for AHP's (rolling 12 months average) is at 7.76%, with normalised turnover at 6.30%.

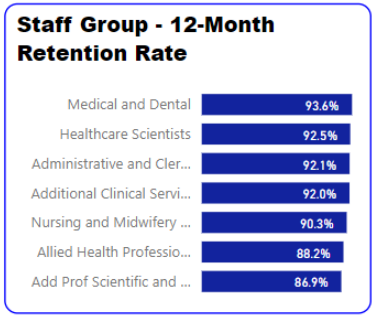
	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23
AHP Turnover	9.18%	8.50%	8.47%	8.62%	8.80%	7.91%	7.30%	6.77%	7.59%	7.97%	7.51%	7.76%
AHP Normalised Turnover	7.01%	7.32%	8.29%	7.53%	7.97%	7.37%	6.49%	5.88%	6.48%	6.87%	6.33%	6.30%

Retention

The Dudley Group
NHS Foundation Trust



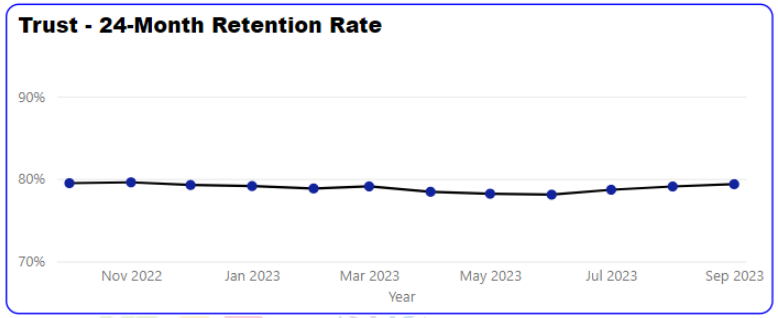


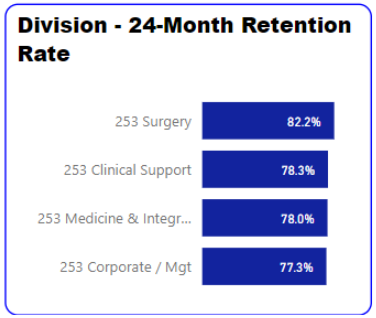


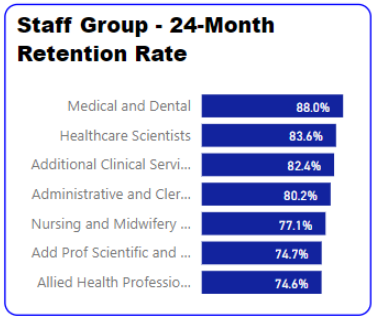
September 2023

12-Month: Trust 91.0%

24-Month: Trust 79.4%



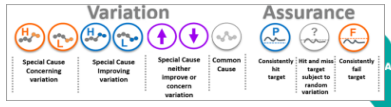




Workforce have developed a retention metric to ensure we are able to retain our workforce. Employee retention improves stability and promotes a better patient experience. In addition, by improving retention we can address employee turnover costs, low staff engagement, poor quality of care with a view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

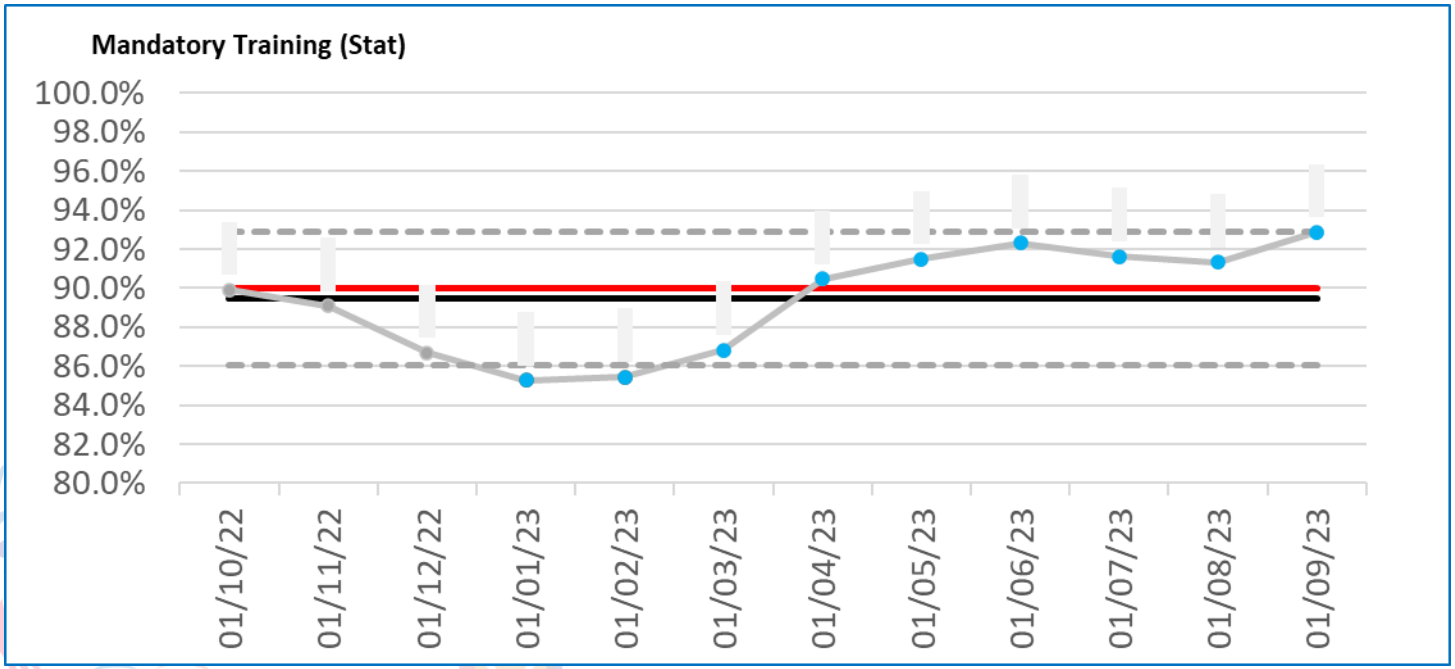
The 12-month retention rate is relatively stable and increasing, the 24-month rate was showing a steady decline since March 2023 but is now showing an increasing trajectory.

The division with the lowest retention rate is Corporate Services at 77.3% over 24 months; both Additional Professional, Scientific and Technical staff and Allied Health Professionals are two staff groups that show as areas for concern.



Mandatory Training

The Dudley Group
NHS Foundation Trust



Performance against target for mandatory training overall shows a positive sustained performance at above target. There is some limited monthly variation with minor decreases and then increases – with the latest month showing an increase from last reported figures. This provides an overall positive position approaching winter months where operational pressures can impact on the ability of staff to be released to complete training. Improvements in the information available on the hub page and external web links have seen a decrease in queries.

	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23
Mandatory Training (Stat)	89.90%	89.10%	86.68%	85.27%	85.45%	86.82%	90.48%	91.48%	92.30%	91.63%	91.32%	92.86%

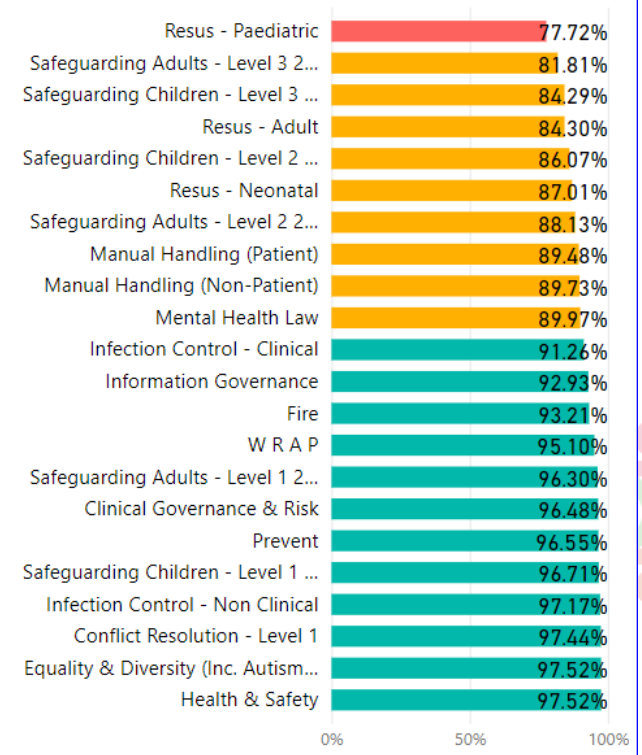
Mandatory Training – Priority 1

The Dudley Group
NHS Foundation Trust

Month: October 2023	Trust	CS	Corporate	MIC	Surgery
	92.86%	93.83%	95.68%	91.93%	92.43%

Course Compliance

Course Compliance (based on selections)



Depts by no. required to achieve 90%

Ward/Service (based selections)

Group5Description	Actual	No. >90%	%' tage
253 Emergency Dept Nursing Serv	1,675	88	85.54%
253 Cardiology Clinical Measurement Serv	486	45	82.37%
253 General Surgery Medical Staff Serv	406	34	83.19%
253 Medical Staff - General Medicine Serv	131	34	71.58%
253 Ward C8 Serv	1,008	30	87.42%
253 Medical Staff - Respiratory Serv	236	28	80.54%
253 Medical Staff Stroke Serv	115	25	74.19%
253 Dudley Nursing (Adult DN) Serv	322	24	83.85%
253 Medical Staff Renal Serv	53	23	63.09%
253 Ambulatory-Medics Dermatology Serv	94	20	74.60%
253 ENT Medical Staff Serv	136	20	78.61%
253 Maxillofacial Surgery Medical Staff Serv	56	20	66.66%
253 Medical Staff Endocrin/Diab Serv	96	18	76.19%
253 West Midlands Imaging Network Serv	26	18	54.16%
253 Medical Staff Cardiology Serv	98	16	77.77%
253 Emergency Minor Injuries Area Serv	202	14	84.16%
253 HR Occupational Health Serv	86	11	80.37%
Total	**68,976**	**-2127**	**92.86%**

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).

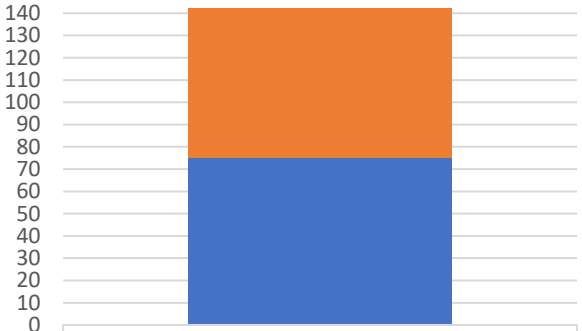
CARE RESPECT RESPONSIBILITY

Apprenticeships

The Dudley Group NHS Foundation Trust

Apprenticeships - as of Sep 23

Number of Signups against year plan (142)



	Number of signups
Remaining signups	67
Sign ups	75

Total Active Apprenticeships **167**

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
Expired Levy Aug 23	£10,052.31
Expired Levy Sep 23	£6,478.73

Q2 has been a productive quarter with the addition of 58 sign ups, to include cohorts from the Nursing pathways as well as AHP's, introducing our first Physiotherapy Msc level 7 apprenticeship (the learner for which completed the Kickstart Programme with us).

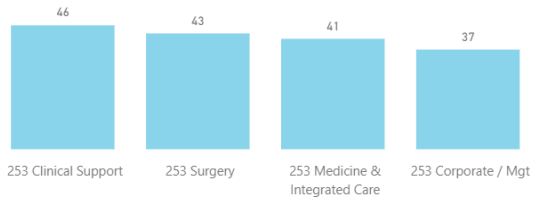
Opportunities to develop a pathway are currently being explored to incorporate AHP and Maternity Support worker development into the novice level 2 and level 3 Healthcare Support worker programmes.

Promotion of levels 5 to 7 has also taken place to build a support worker development pathway.

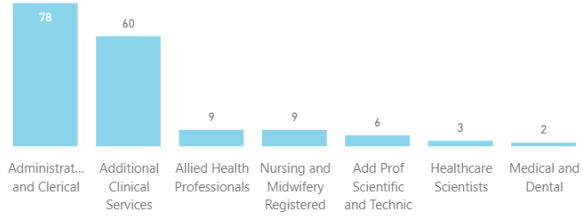
Levy predictions tell us that we are not due to lose Levy funding until January 2024. Recent deductions have been as a result of unavoidable delays in completion.

Active Apprenticeships breakdown

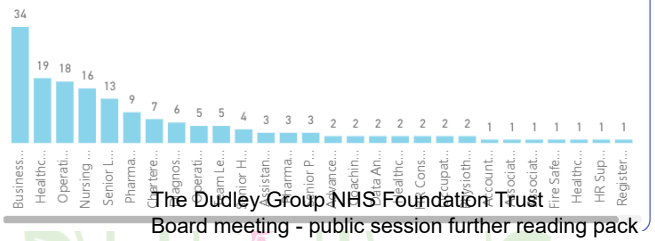
Division



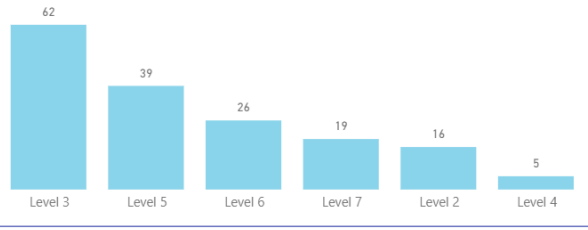
Staff Group



Programme



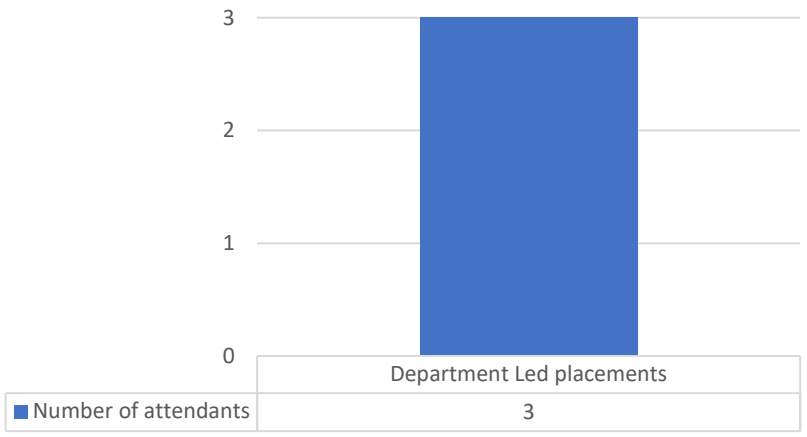
Apprenticeship Level



CARE RESPECT RESPONSIBILITY

Work Experience and Widening Participation

The Dudley Group NHS Foundation Trust



Department led placements- All of which were clinical – two of these to gain access to higher education, and one as part of organised college work experience.

Careers Education Information Advice and Guidance (CEIAG)

This data will report on Ambassadors activity and Meet the Expert events.

Ambassador activity:

250 x CEIAG contacts delivered during September (all face to face from various careers events – including Mike Woods Jobs and Skills Fair)

Meet the expert - no meet the expert sessions were delivered in September. These events are currently as and when requested by local schools.

Ambassadors- September			
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
Q2	74	1	N/A

We currently have 74 Ambassadors in total. Activities range from events to career talks with local schools. This is generally unplanned/ad-hoc activity.

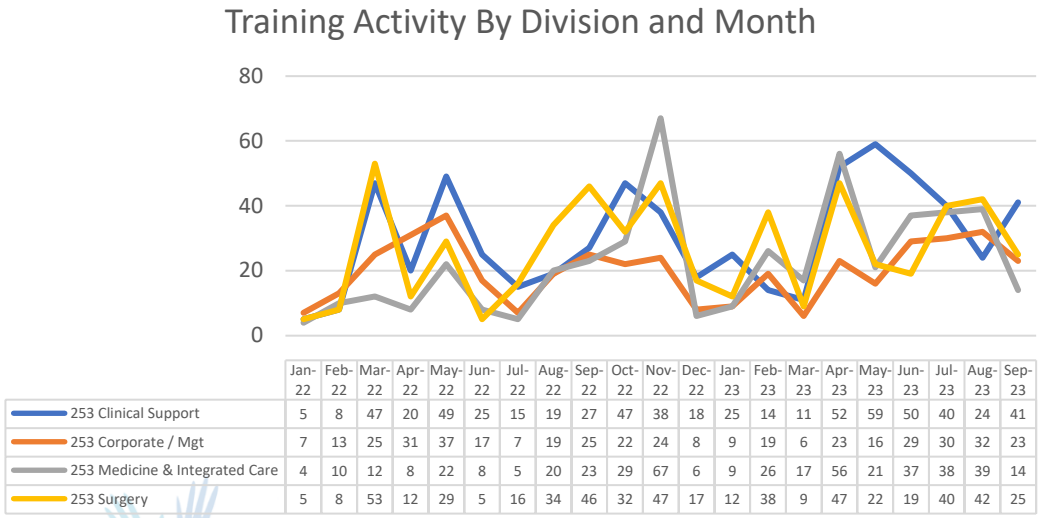
Employability Programmes (Sector-based Work academy programmes)
No Sector-based Work Academy Programmes delivered during September (Project in Pilot Phase). Work is underway to develop pathways and target recruitment.

Work Related Learning	**September**
Behind the Scenes- Events	One scheduled but postponed until November due to Doctor's strikes.
Spring pod 2nd year virtual programme	From July to end of Sept - 100 students have enrolled, out of which 29 have started and four have completed.

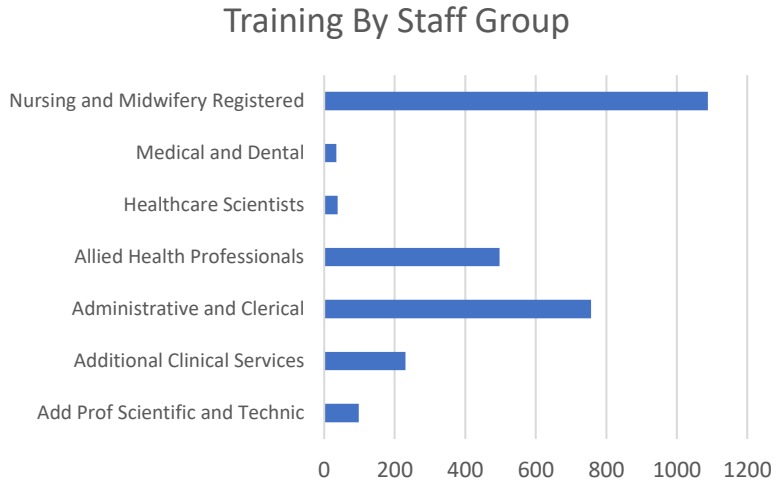
CARE RESPECT RESPONSIBILITY

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	Aug-23	Sep-23
253 Clinical Support	5	8	47	20	49	25	15	19	27	47	38	18	25	14	11	52	59	50	40	24	41
253 Corporate / Mgt	7	13	25	31	37	17	7	19	25	22	24	8	9	19	6	23	16	29	30	32	23
253 Medicine & Integrated Care	4	10	12	8	22	8	5	20	23	29	67	6	9	26	17	56	21	37	38	39	14
253 Surgery	5	8	53	12	29	5	16	34	46	32	47	17	12	38	9	47	22	19	40	42	25



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	Aug-23	Sep-23	Grand Total
253 Appraisal Training (Non-medical)			98	20	54	13				3	2		4	7	6	84	69	34	1			395
253 Bespoke Training							8		6			6					17					37
253 Coaching																	2		7			9
253 Communications																	5	3	13	12	8	41
253 Developing Leaders	6								4	6			8									24
253 Leadership For All		1	1		10	4	6	6		8	7	9	5									57
253 Living The Values				6	19				20	17	13	6		6	15	3	3	22	13	5	10	158
253 Local Induction Training																		31	13	7	8	59
253 Managers Essentials	1	10	17	18	27	8	15	13	12	18	11	12	25	20	15	20	9	22	21	19	26	339
253 Welcome 2 Dudley Induction	10	16	16	27		19	5	4	11	13	8	3	7	4	2		2	11	11	12	12	193
253 Wellbeing	4	12	5	0	27	11	9	69	68	65	135	13	6	60	5	71	11	12	69	82	39	773
Grand Total	**21**	**39**	**137**	**71**	**137**	**55**	**43**	**92**	**121**	**130**	**176**	**49**	**55**	**97**	**43**	**178**	**118**	**135**	**148**	**137**	**103**	**2085**

Training activity remains steady – with a continuing focus on ensuring that Manager's Essentials courses are delivered to capacity and reach all managers. 600 participants have attended in total to the end of September 2023. Course bookings are consistently high, but non-attendance continues to be challenging with around 35% of short notice cancellations or DNAs. There are 64 places booked to the end of December.

Core programmes now running include Manager's Essentials, Developing Leaders, Living the Values, Wellbeing, Welcome to Dudley, and Being Brilliant at Communication and An Introduction to Coaching. Communication Skills 2 and Manager's Induction will launch in January. We are seeing an increase in requests for the team based 'Living the Values' sessions – across all divisions.

Appraisal- 23/24

The Dudley Group
NHS Foundation Trust

2023 Compliance Rate	Trust	CS	Corporate	MIC	SWC
	92.7%	95.9%	95.1%	90.2%	92.2%

Compliance Rate by Division

OrgL2	Total Staff	Appraised	Rate
253 Clinical Support	1237	1186	95.9%
253 Corporate / Mgt	614	584	95.1%
253 Medicine & Integrated Care	1691	1525	90.2%
253 Surgery	1768	1630	92.2%
Total	**5310**	**4925**	**92.7%**

Compliance Rate by Staff Group

StaffGroup	Total Staff	Appraised	Rate
Add Prof Scientific and Technic	202	192	95.0%
Additional Clinical Services	1376	1260	91.6%
Administrative and Clerical	1215	1137	93.6%
Allied Health Professionals	444	424	95.5%
Healthcare Scientists	55	49	89.1%
Nursing and Midwifery Registered	2018	1863	92.3%
Total	**5310**	**4925**	**92.7%**

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