Board of Directors (Public session) Further reading Pack

Thursday 9 May 2024

Congratulations to Dorin Willetts who was recently presented with the national Chief Nursing Officer Award for recognising the vital contribution of healthcare support workers in England and her exceptional dedication and commitment, and embodying the values of care, respect, and responsibility.

Within her role in the Professional Development team, Dorin has helped as part of a mass recruitment initiative to recruit and retain support workers. She has really trailblazed her role and is able to work with areas to ensure their new recruits are supported holistically, not just during completing the Care Certificate but beyond this initial three-month period.

Dorin is compassionate, caring, understanding, kind, empathetic, and hardworking. She goes above and beyond her duties to support others and prioritises others needs before her own. She demonstrates an outstanding ongoing commitment and dedication to patient care, through teaching our new recruit's high quality gold standard care that is underpinned by clinical excellence.

aqua

Shape Change Inspire Quality Transform Care

NHS

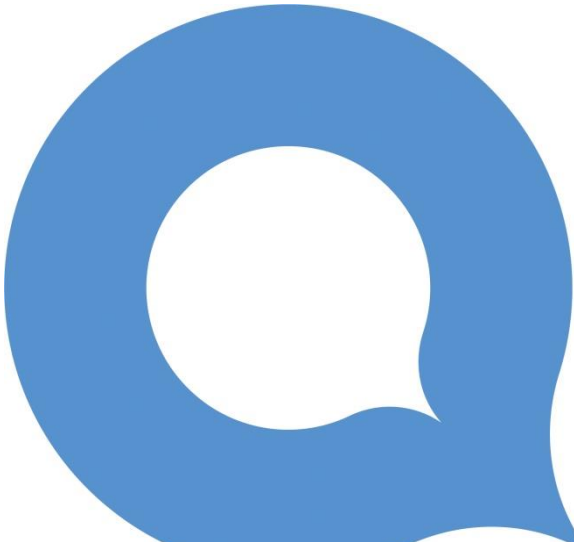
Quarterly Mortality Report

Report No. 43

9th April 2024

Edition prepared for:

The Dudley Group of Hospitals NHS Foundation Trust



Author: Yiinubari Nwigbo

Version: 1.0

Contents

INTRODUCTION *1*

SECTION 1 – The Midlands *2*

1.1 Crude Mortality Rate **2**

1.2 SHMI **3**

1.3 SHMI – proportion of deaths that occur in-hospital **6**

SECTION 2 – Trusts in the Midlands *7*

2.1 Crude Mortality Rate **7**

2.2 SHMI **8**

2.3 Palliative Care coding **9**

2.4 Signs and Symptoms coding **10**

2.5 Co-morbidity **12**

SECTION 3 – Your Trust *13*

3.1 Crude Mortality Rate **13**

3.2 SHMI **14**

3.3 Average Risk of Death **17**

3.4 Palliative Care Coding **19**

3.5 Signs and Symptoms coding **22**

3.6 Co-morbidity **23**

SECTION 4 – Quarterly Focus *25*

4.1 COVID-19 ..... **25**

Appendix A: Differences between HSMR, RAMI and SHMI

Appendix B: Metadata

Appendix C: Midlands Hospital Trust Codes and Names

INTRODUCTION

This is the forty-third quarterly report on Mortality produced by Aqua Analytics for the benefit of its members.

The report provides information on mortality rates, quality of care indicators and system/process measures that may affect the quality of care. The report does focus on the data, however, this is only one part of understanding the issues that may affect a Trust's mortality rate. They are an indicator, a sign-post, a prompt to looking at the wider system issues; these issues and themes are explored in detail in aqua's Mortality Lessons Learned publication (May 2013).

Many of the indicators contained within this report relate to Standardised Mortality Ratios. There are several different methodologies available for the calculation of these ratios – see Appendix A for a summary of the differences between the three main methodologies. Throughout this report, data relating to the Summary Hospital-level Mortality Indicator [SHMI] has been used. This is because this methodology is used and published by the NHS Digital [NHSD].

This report is set out in five sections:

- Section 1 compares the Midlands with other regions of England.
- Section 2 looks at the differences in data for the 20 Trusts in the Midlands for which NHS Digital produces a SHMI.
- Section 3 provides more detailed information for your trust.
- Section 4 focuses on a particular subject. This quarter it is COVID-19.

Some inferences and conclusions have been drawn from the data, however, these need to be set in the context of the wider health-economy. Aqua has a rolling programme of Mortality Reviews in order to support the understanding of issues surrounding mortality and the quality of care provided in a Trust and the health economy that it serves. Detailed trust-level analysis and inferences are best placed within this programme.

This report has been prepared following the publication of the SHMI for the period October 2022 – September 2023; Appendix B details the metadata for the information contained within this report.

Please note: this report uses clinical coding data as it was at the time of production in March 2024. If there are delays in coding, we may see changes to recent months reported here. This is particularly the case with signs and symptoms coding, as the Hospital Episode Statistics algorithm assigns an 'R' code where no codes are recorded.

SECTION 1 – The Midlands

The charts in this section have been updated to reflect the NHS England Regions as at 1st April 2019. This reduces the number of regions from the ten of our previous reports to seven. As a result of this, the West Midlands region has been merged with the East Midlands region. This has had a significant impact on the data so care should be taken when comparing data in this report to previous issues.

1.1 Crude Mortality Rate

The Midlands has the third lowest crude in-hospital mortality rate in England with a rate that is similar to the overall rate for England – see chart 1. The rates for both England and the Midlands have been reducing over the past few years – see chart 2.

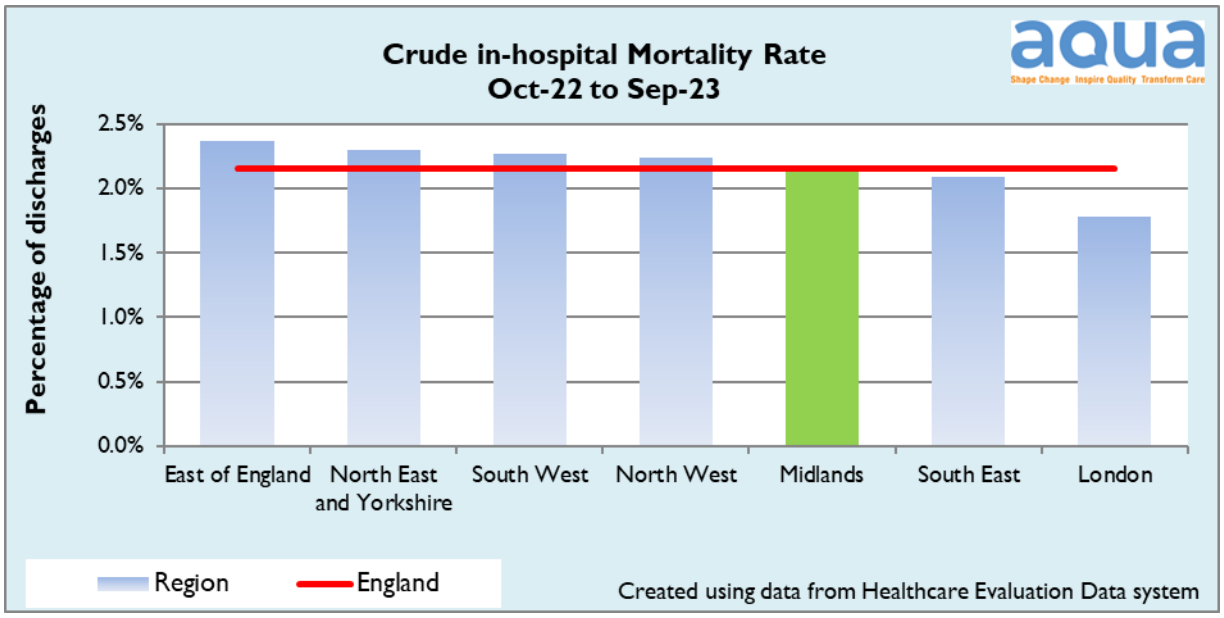


Chart 1 – crude in-hospital mortality rate

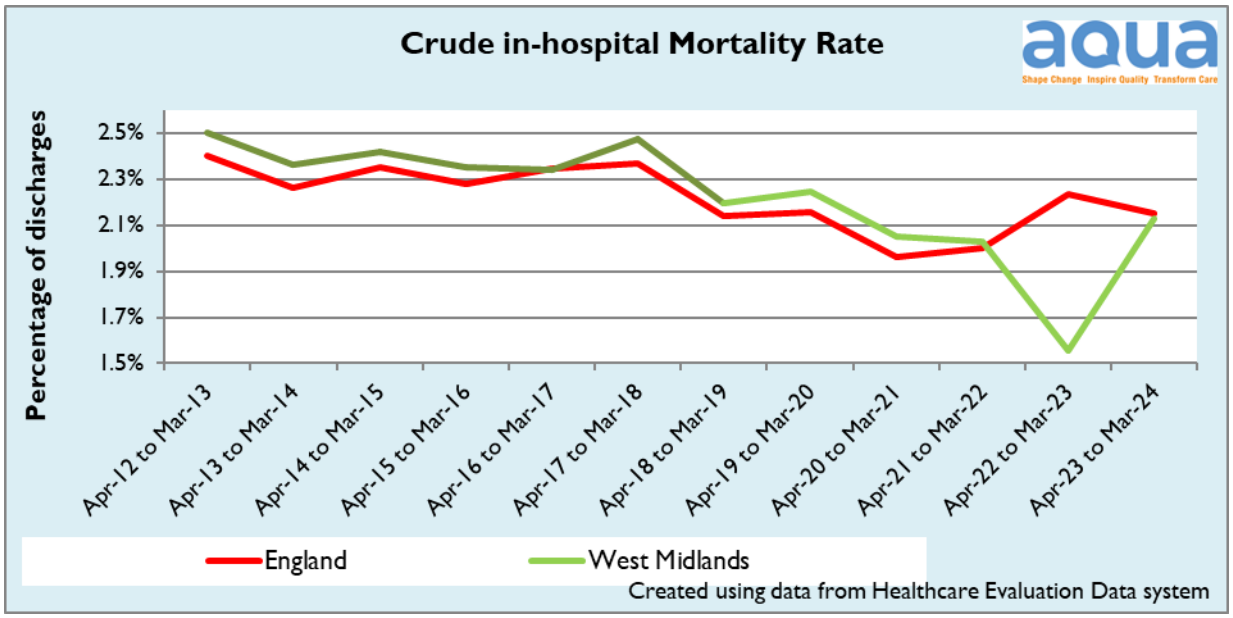


Chart 2 – crude in-hospital mortality rate time-series

Across the regions, crude in-hospital mortality rates for non-elective [NEL] activity are between five and six times higher than for elective [EL] activity; the crude NEL mortality rate for England being 2.4% and the crude EL mortality rate for England being 0.4% (five times higher) – see chart 3. For deaths occurring within 30 days of discharge, there is a five-fold difference between those following a non-elective admission and those following an elective admission [1.0% and 0.2%, respectively] with less regional variation (four to six fold difference). When reviewing the underlying causes of high(er) mortality rates, it would, therefore, be beneficial to explore pathways relating to emergency care.

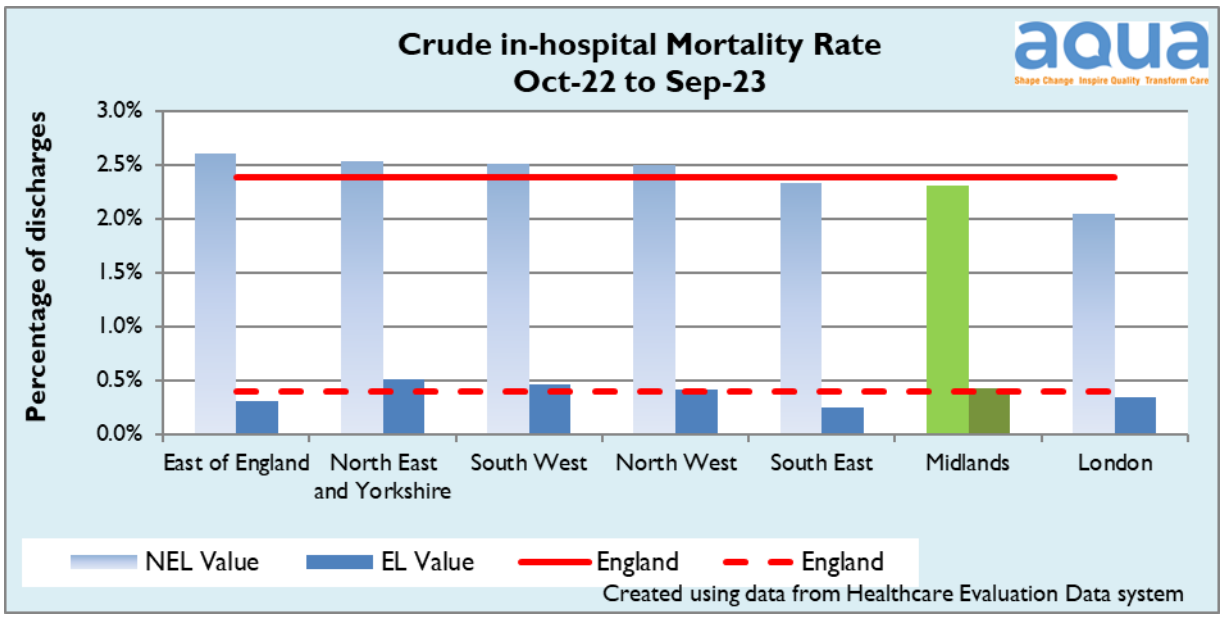


Chart 3 – crude in-hospital mortality rate, NEL & EL split

1.2 SHMI

This report does not aim to describe the SHMI methodology in detail, nor to compare the SHMI methodology to other methodologies e.g. HSMR. Appendix A shows a summary of the differences between the three main methodologies and further information is available from Aqua Analytics.

Although the Midlands has a crude mortality rate that is slightly higher than the England rate, it is still the fourth highest SHMI [1.01] – see chart 4a. In essence, this means that, given the demographic make-up, the case-mix that is treated and the other illnesses that the patients have, it is to be expected that the crude rate would be lower than it is.

A regional SHMI is, of course, constructed from its constituent trusts. Chart 4b is a funnel-plot chart showing the position of each of our trusts alongside all trusts in England. This chart shows the Upper and Lower Dispersal Limits which are used to determine the SHMI band that each trust is in – see Chart 11 for a version showing trust codes.

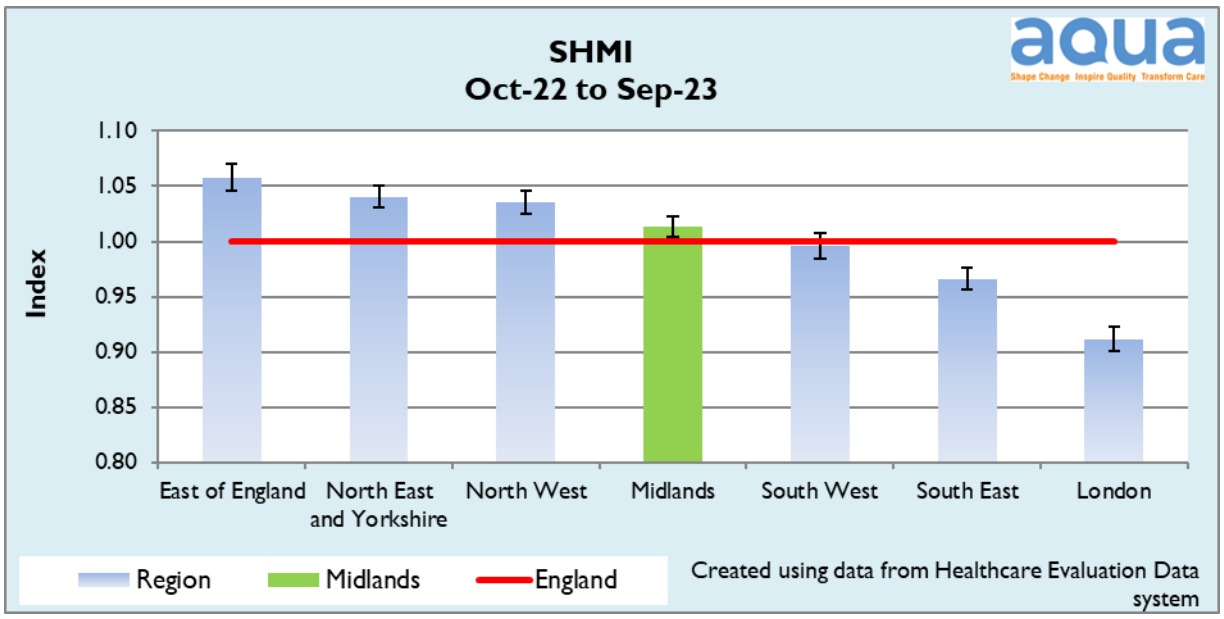


Chart 4a – latest SHMI

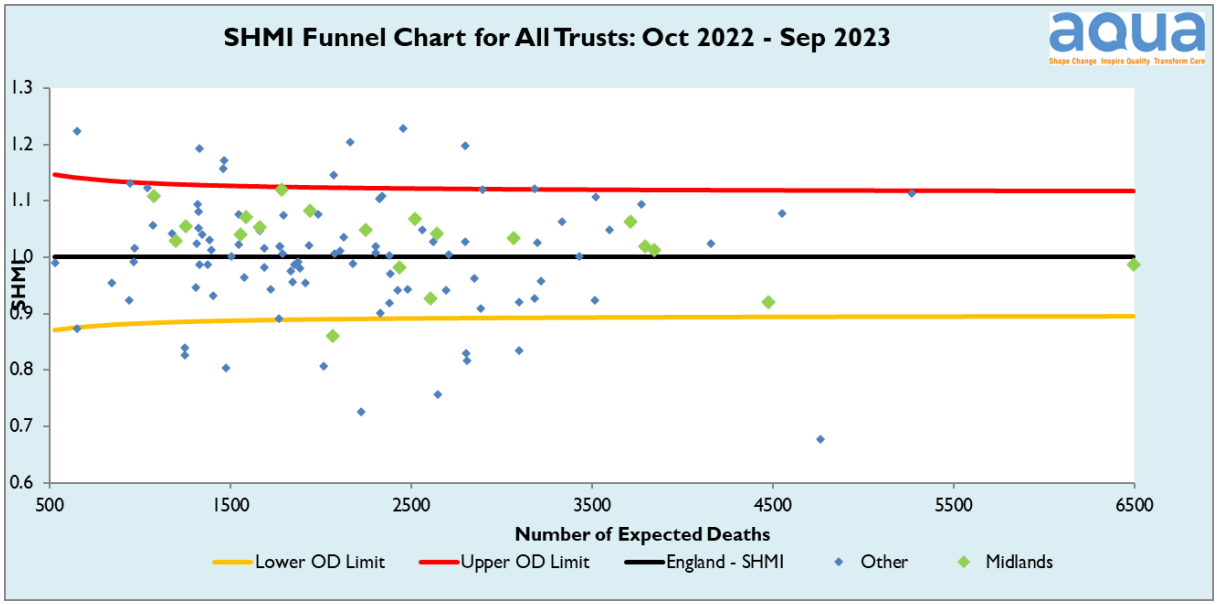


Chart 4b – latest SHMI Funnel Plot

The SHMI for the Midlands had been fairly stable from the period of first release until 2017 when the SHMI started increasing. However, there has been a reduction in the latest six releases which had brought the value back to its historical 'normal' value of c. 1.04. Following the merger of the Midlands and East Midlands, the SHMI reduced to c. 1.02 and current SHMI has once again reduced to c. 1.01 which is now significantly closer to the England average, although is going through a period of continuous increase – see chart 5.

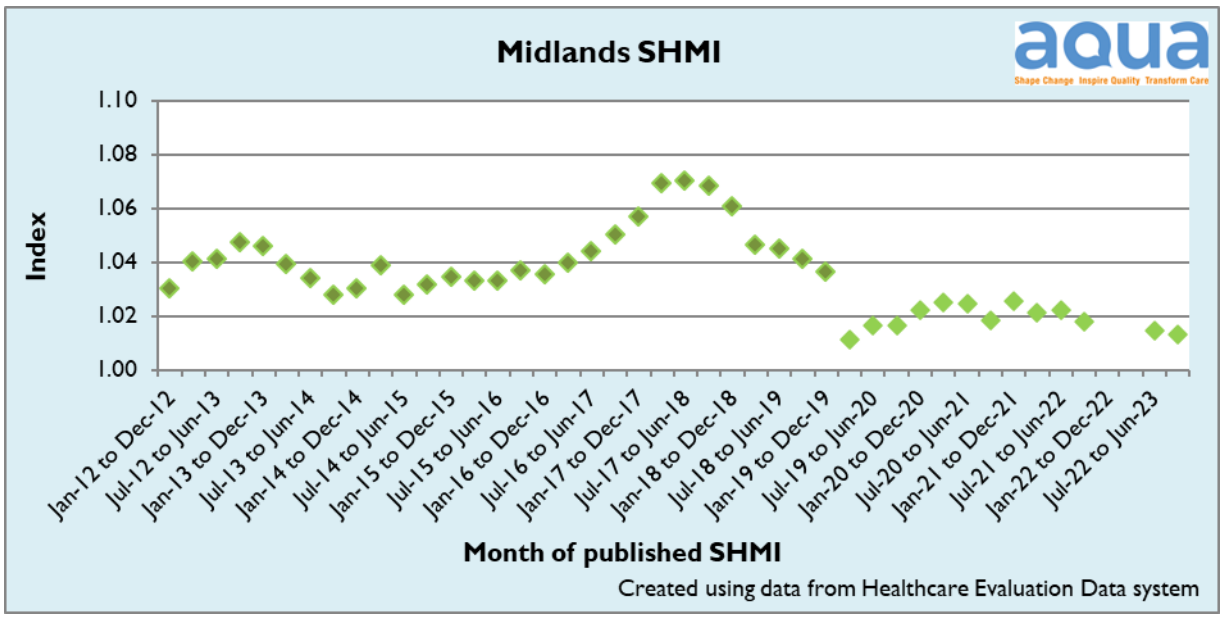


Chart 5 – Midlands SHMI time-series

The SHMI is a relative-risk model centered around England having a value of 1.00 for each publication. Factors that affect this risk model such as Signs and Symptoms coding and levels of co-morbidity are described later in the report.

1.3 SHMI – proportion of deaths that occur in-hospital

SHMI is calculated using deaths that occurred in-hospital and those that occurred within 30 days of discharge. Chart 7 shows the proportion of the total number of deaths that have occurred in-hospital. Low levels of in-hospital deaths could be due to several factors including patients being discharged too early and high levels of nursing, residential and hospice care. The Midlands has a lower rate than the England average. This topic was covered in more detail in Section 4 of Issue 07 and Issue 13.

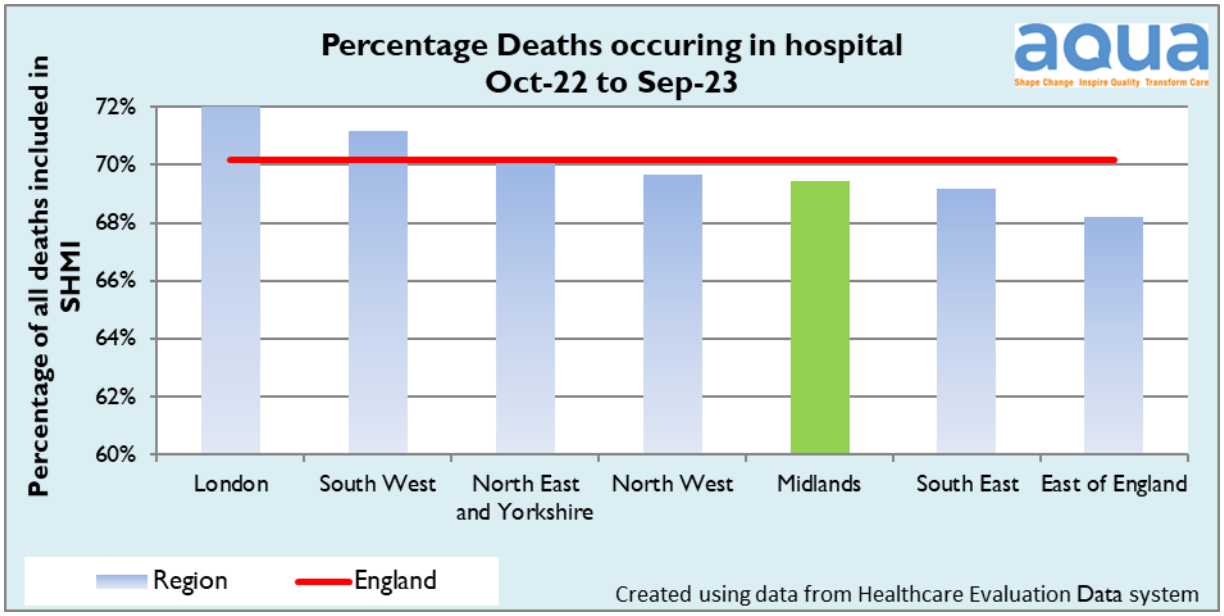


Chart 7 – Percentage of deaths occurring in-hospital

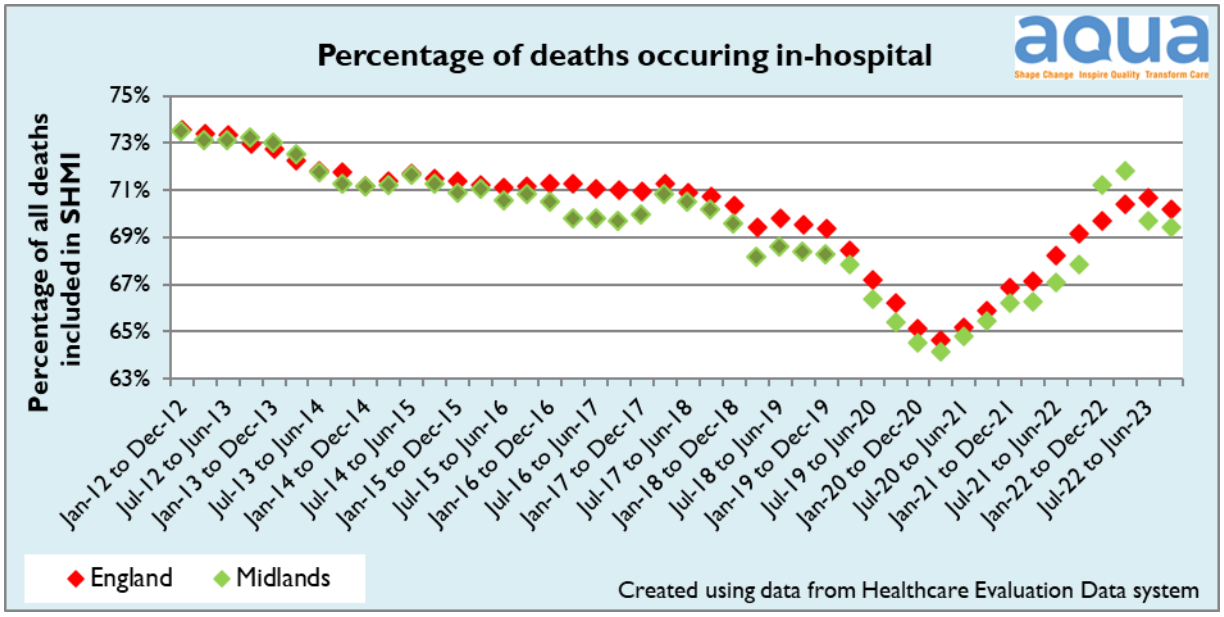


Chart 8 – Percentage of deaths occurring in-hospital time-series

SECTION 2 – Trusts in the Midlands

2.1 Crude Mortality Rate

Based upon the latest published SHMI data, crude in-hospital mortality rates in the Midlands hospitals varies from c.1.5% to c.2.7% - nearly a two-fold difference – see chart 9.

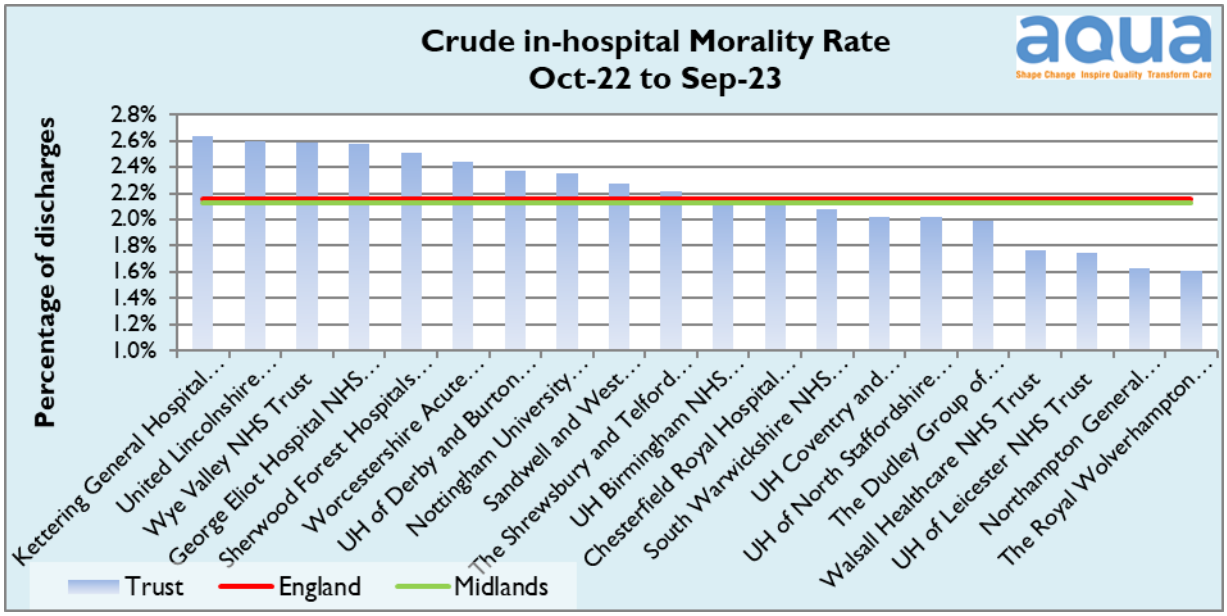


Chart 9 – crude in-hospital mortality rate by trust

There is usually a similar degree of variance for in-hospital deaths for non-elective admissions – from 1.5% to 2.9% - see chart 10. Although crude rates are a useful starting point in understanding the situation regarding a trust's mortality, direct comparisons between trusts should be treated with caution due to potential differences in case-mix and the age-profile of the patients treated. Case-mix variables may be subtle or as fundamental as either not providing a relatively low-risk service [e.g. paediatrics] or of providing a relatively high-risk service [e.g. sub-regional trauma centre] (both examples having the effect of increasing the crude rate). These are, of course, some of the very differences that standardised rates adjust for.

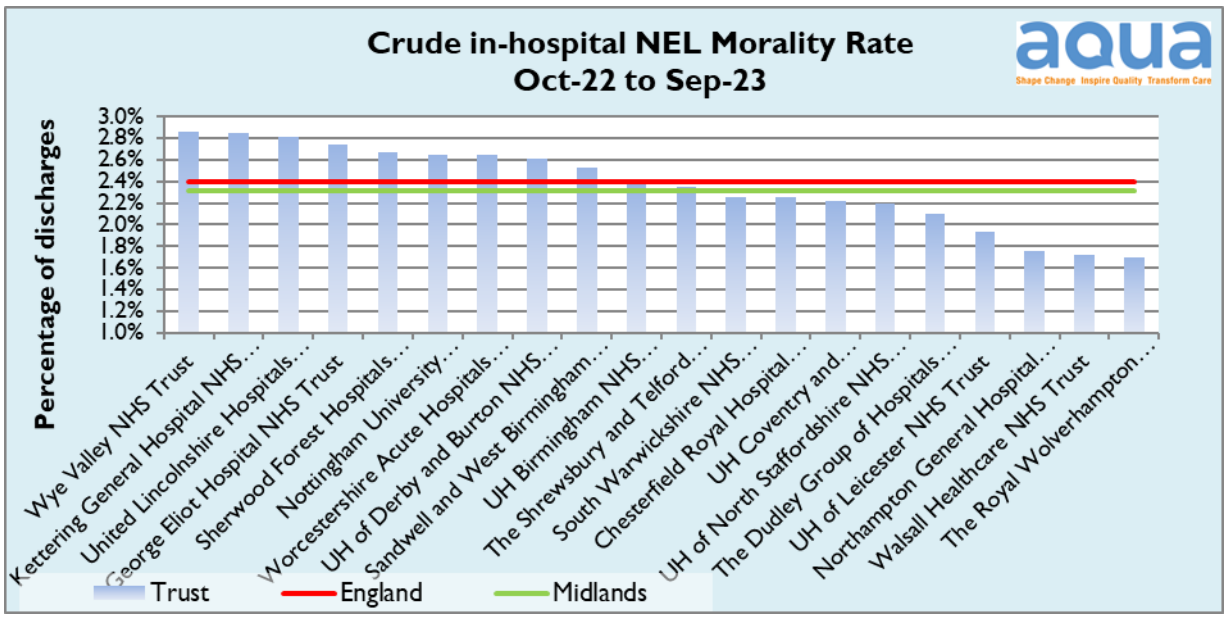


Chart 10 – crude in-hospital NEL mortality rate by trust

2.2 SHMI

Chart 11 shows a funnel-plot chart of the latest SHMI for the 20 Trusts in the Midlands of England. The red (upper) and green (lower) lines show the limits beyond which variance is deemed to be statistically significant and unlikely to be due to random variation [chance]. Trusts within the range of red and green lines / control limits fall within Band 2 – "As expected"; trusts below the lower control limit fall within Band 3 – "Lower than expected" and trusts above the upper control limit fall within Band 1 – "Higher than expected". Beyond the three bandings, there is no inference to be taken from different SHMI values.

A list of Trust codes and names can be found in Appendix C.

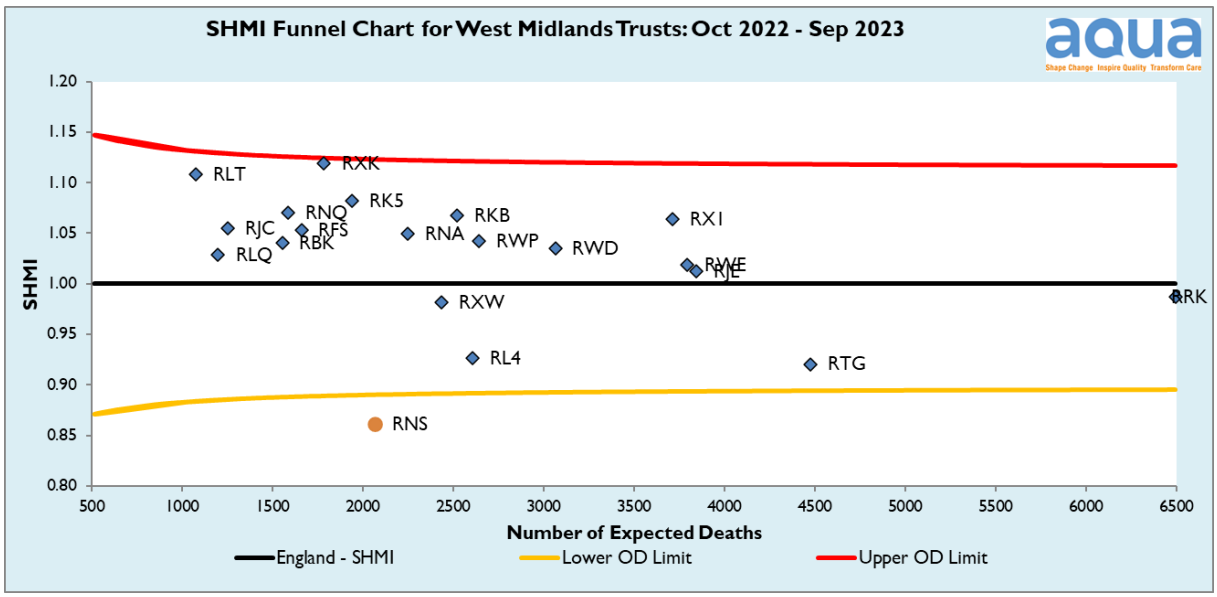


Chart 11 – latest SHMI by trust

2.3 Palliative Care coding

NHS Digital releases contextual information alongside the SHMI – one of these domains is Palliative Care. A patient can be deemed to have received Palliative Care by virtue of Specialty Code 315 being present in any other their episodes or by having ICD10 Code Z515 in any diagnosis in any episode. The charts below [12 and 13] show the rate of coding where either the Specialty Code or the Diagnosis Code is present during the Spell; chart 12 is for all patients and chart 13 is where the patient died.

As can be seen, there is quite a variance in the levels of the recording of Palliative Care. This variance is repeated nationally and is one of the main reasons why Palliative Care is not adjusted for in SHMI.

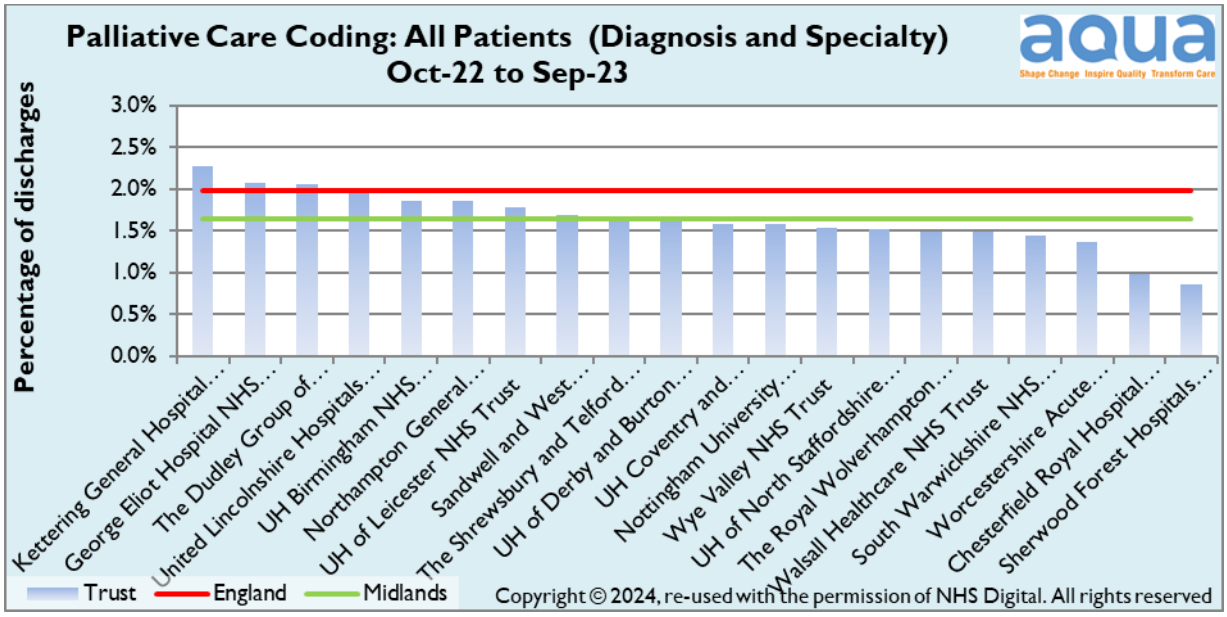


Chart 12 – Palliative Care coding by trust, all patients

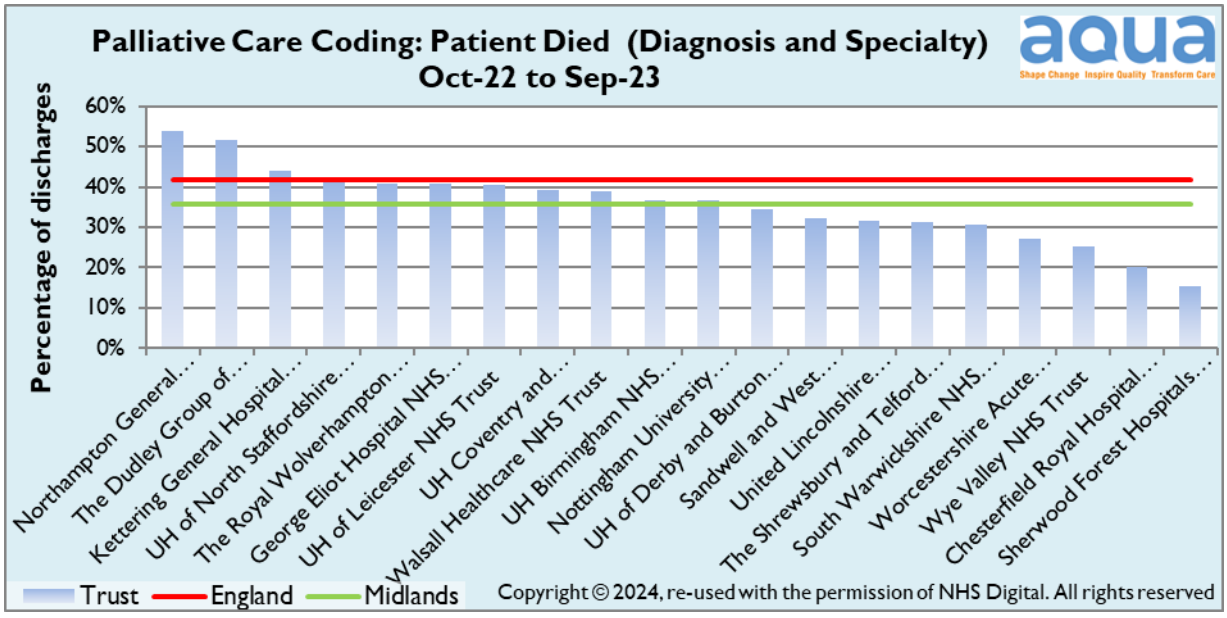


Chart 13 – Palliative Care coding by trust, patient died

2.4 Signs and Symptoms coding

The level of Signs and Symptoms coding [R codes] is important because it has inferences on the quality of care and has an impact on the calculations used to create SHMI.

High levels of R codes may imply lower access to senior medical opinion and later commencement of appropriate treatment. If R codes remain as the primary diagnosis through the first few episodes of a patient's pathway then this could be indicative of multiple hand-overs within a short period of time i.e. during the period of diagnostic investigation.

R codes remaining as the primary diagnosis for the first two episodes affects the calculation of the SHMI, often in an adverse way. SHMI uses the primary diagnosis of the first episode to assign the CCS Group of that admission. If the primary diagnosis of the first episode is an R code then the primary diagnosis of the second episode is used. However, should the diagnosis of the second episode also be an R code then SHMI will revert back to the first episode's primary diagnosis.

The CCS groups that R codes map to have relatively low mortality rates and, therefore, low numbers of expected deaths. If a trust has a high level of R coding then it is more likely to have a higher level of deaths with an R code as the primary diagnosis (first and second episode).

Chart 14 shows the general use of R Codes – there is a four-fold difference between the trust with the highest usage of R codes in the primary diagnosis [49.6%] (all episodes of a Spell where the first episode was non-elective) and the trust with the lowest [11.4%].

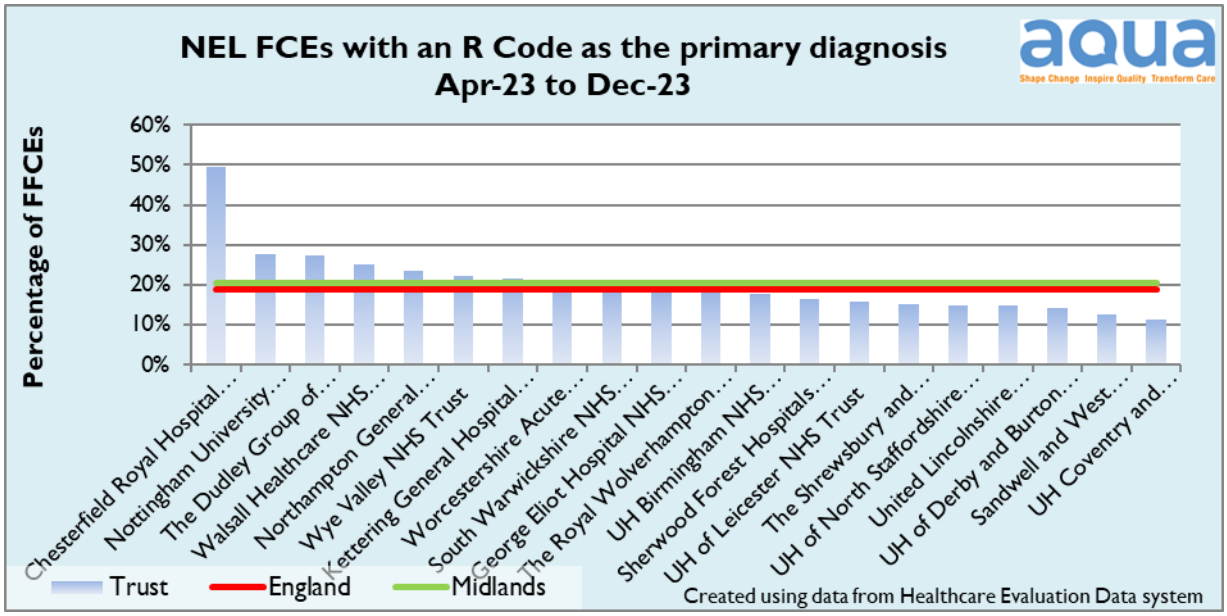


Chart 14 – Signs & Symptoms coding by trust, NEL, all episodes, all patients
*****Take care when interpreting this chart due to smaller time range*****

Chart 15 shows the use of R Codes in the first episode – there is a four-fold difference between the trust with the highest usage of R codes in the primary diagnosis [50.1%] and the trust with the lowest [12.6%].

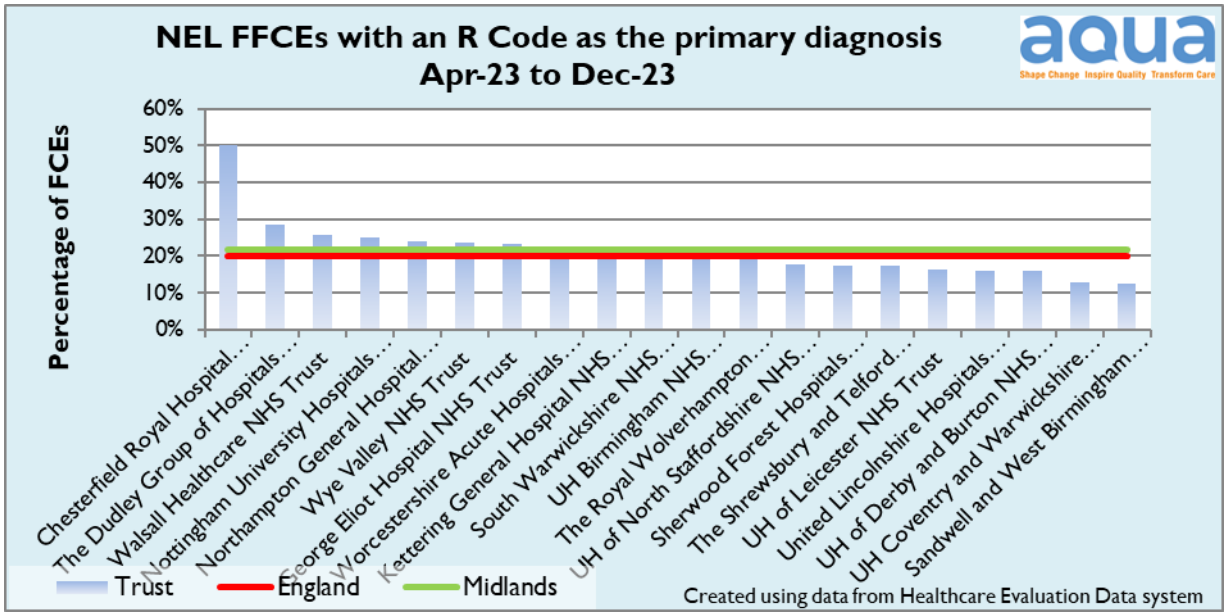


Chart 15 – Signs & Symptoms coding by trust, NEL, first episode, all patients
*****Take care when interpreting this chart due to smaller time range*****

2.5 Co-morbidity

Levels of coding are important for several reasons. Accurate and comprehensive recording of co-morbidities will better reflect the state of health of the patients that the trust is treating. Lower levels may be due to:

- this information not being recorded by the clinician in the patient's notes
- this information not being recorded clearly enough
- this information not being recorded fully on the Trust's PAS
- healthier patients

Levels of co-morbidity are used in both SHMI and HSMR. A relatively high level of co-morbidity increases the expected number of deaths in these calculations and so has the effect of reducing the standardised mortality ratio.

Comparative levels of co-morbidity are arrived at using the Charlson Co-morbidity Index. This Index assigns a weighting to 17 different conditions – the higher the weighting, the higher the perceived impact of that co-morbidity on a patient's risk of dying. A full list of these conditions, their weighting and the underlying ICD10 codes used are available on request from Aqua Analytics.

For non-elective episodes, there is a fair range of average Charlson values per episode* between trusts in the Midlands [from 3.0 to 6.6] – see chart 16. This may be a reflection of the relative health of the population that each trust serves or different case-mixes but it could also reflect more comprehensive coding processes.

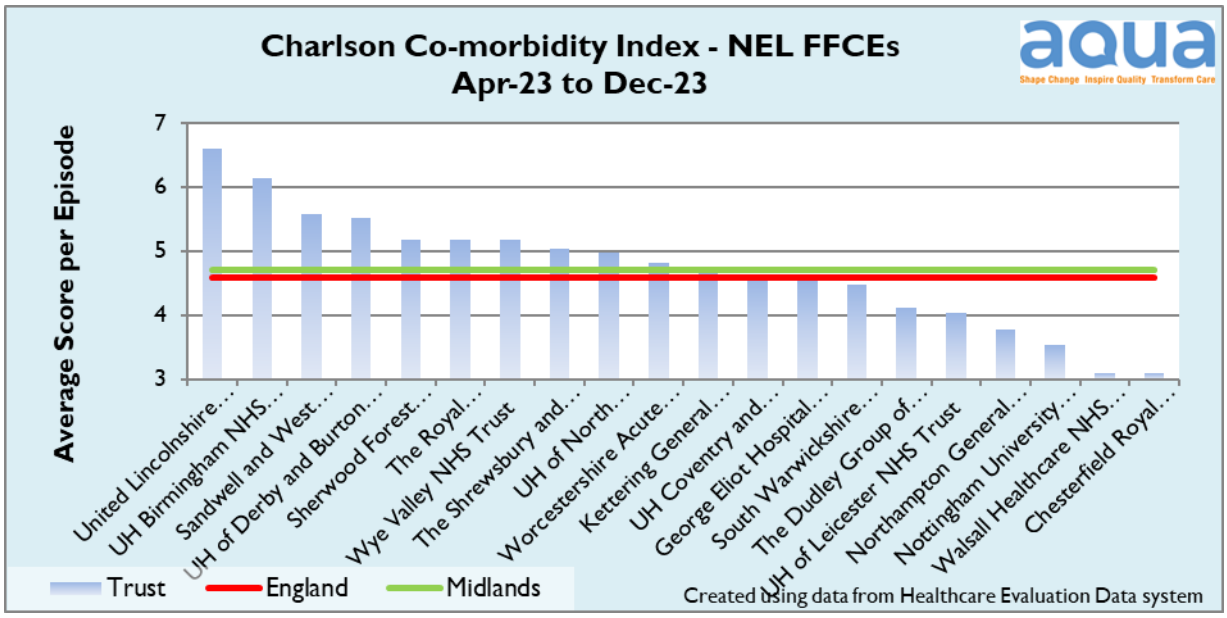


Chart 16 – Co-morbidity score by trust, NEL
*****Take care when interpreting this chart due to smaller time range*****

* This data shows the Index Score for the first episode only as, in the vast majority of cases, it is the score for this episode that is used in the SHMI calculation.

SECTION 3 – Your Trust

This section shows information for your Trust. The data relates to the same domains as in Section 2 but shows a time-series in order to show whether areas are showing improvement or deterioration.

Historic regional information relates to West Midlands; data from 1st April 2019 relates to Midlands.

Trust Name	The Dudley Group of Hospitals NHS Foundation Trust
Trust Code	RNA

3.1 Crude Mortality Rate

Fin. Year	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20
Trust	**2.61%**	**2.4%**	**2.52%**	**2.17%**	**2.18%**	**2.6%**	**2.66%**	**2.74%**
Midlands	2.50%	2.37%	2.42%	2.35%	2.34%	2.48%	2.19%	2.18%
England	2.40%	2.27%	2.35%	2.28%	2.35%	2.37%	2.14%	2.13%

Fin. Year	2020/21	2021/22	2022/23	2023/24
Trust	**2.43%**	**2.31%**	**2.3%**	**1.99%**
Midlands	2.05%	2.03%	1.56%	2.13%
England	1.96%	2.00%	2.24%	2.15%

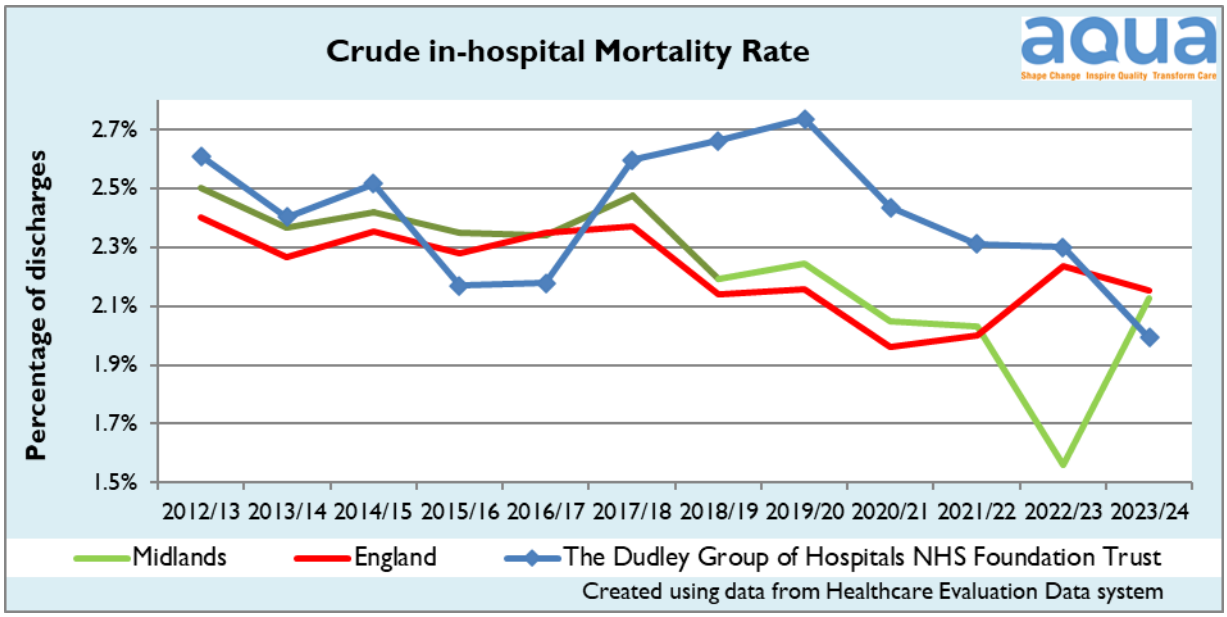


Chart 17 – trust crude in-hospital mortality rate time-series

3.2 SHMI

Period	Jan 14 - Dec 14	Apr 14 - Mar 15	Jul 14 - Jun 15	Oct 14 - Sep 15	Jan 15 - Dec 15	Apr 15 - Mar 16	Jul 15 - Jun 16	Oct 15 - Sep 16
Trust	**1.04**	**1.02**	**1.03**	**1.02**	**1**	**0.98**	**0.96**	**0.98**
Midlands	1.03	1.04	1.03	1.03	1.03	1.03	1.03	1.04

Period	Jan 16 - Dec 16	Apr 16 - Mar 17	Jul 16 - Jun 17	Oct 16 - Sep 17	Jan 17 - Dec 17	Apr 17- Mar 18	Jul 17 - Jun 18	Oct 17– Sep 18
Trust	**0.99**	**1**	**1**	**1**	**1.04**	**1.11**	**1.15**	**1.18**
Midlands	1.04	1.04	1.04	1.05	1.06	1.07	1.07	1.07

Period	Jan 18- Dec 18	Apr 18- Mar 19	Jul 18 - Jun 19	Oct 18– Sep 19	Jan 19- Dec 19	Apr 19- Mar 20	Jul 19 - Jun 20	Oct 19– Sep 20
Trust	**1.15**	**1.13**	**1.12**	**1.11**	**1.14**	**1.15**	**1.15**	**1.16**
Midlands	1.06	1.05	1.05	1.04	1.04	1.02	1.02	1.02

Period	Jan 20- Dec 20	Apr 20- Mar 21	Jul 20 – Jun 21	Oct 20– Sep 21	Jan 21- Dec 21	Apr 21- Mar 22	Jul 21 – Jun 22	Oct 21- Sep 22
Trust	**1.18**	**1.15**	**1.13**	**1.12**	**1.1**	**1.11**	**1.14**	**1.15**
Midlands	1.02	1.03	1.02	1.02	1.03	1.02	1.02	1.02

Period	Apr 22 - Mar 23	Jul 22 - Jun 23	Oct 22- Sep 23
Trust	**1.12**	**1.09**	**1.05**
Midlands	0.79	1.01	1.01

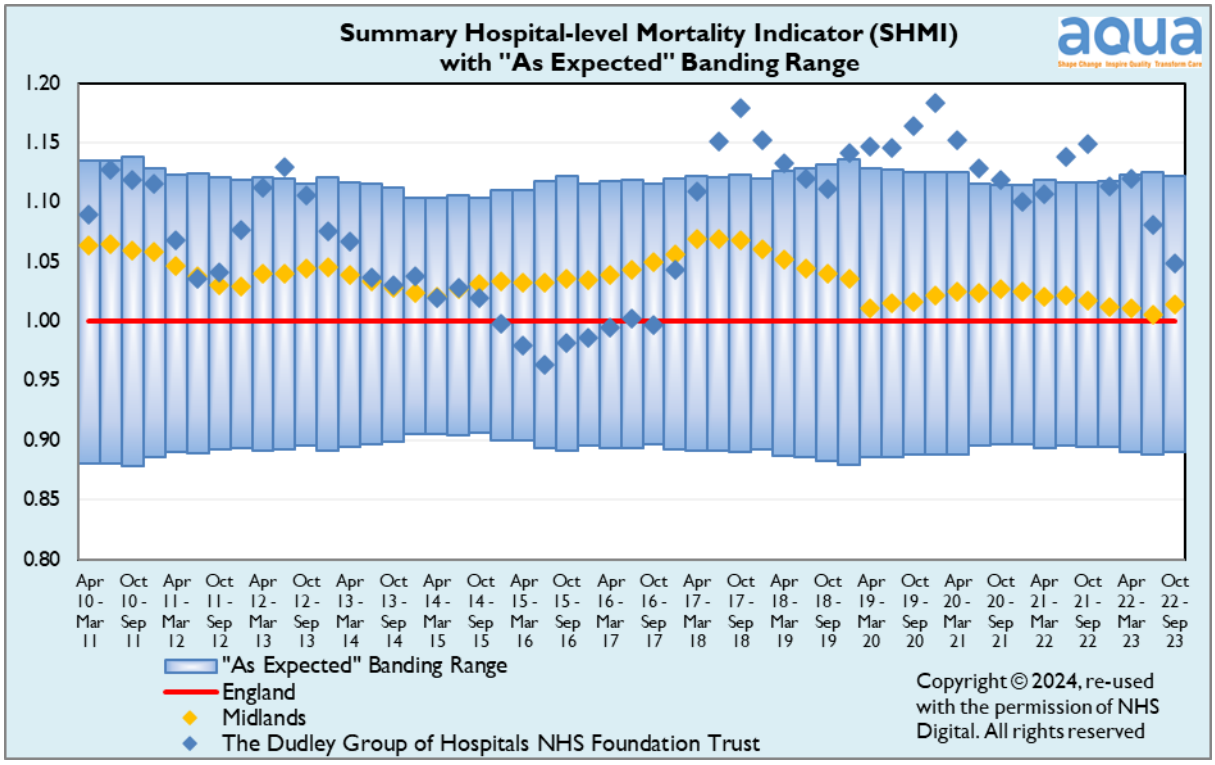


Chart 18 – trust SHMI time-series

The Quarterly Focus of Issue 06 of our report related to the monitoring of the levels of Observed and Expected deaths. The text box below contains the text of Issue 06 which still holds true.

> The SHMI is calculated as a ratio of Observed deaths to Expected deaths. When exploring changes and trends in your SHMI, it is useful to know whether this is being driven by a change in the number of Observed deaths or the number of Expected deaths. Chart 27 shows these figures for your Trust for each of the SHMI releases.
>
> Variation in case-mix and acuity notwithstanding, changes in the Observed number of deaths may indicate a change in the level of care [both during the time in hospital and up to 30 days after discharge].
>
> Changes in the Expected number of deaths will be reflective of the afore-mentioned variation in case-mix together with any changes in coding/recording/classification practice. Some of the main contributing areas that affect the number of Expected deaths have been described in sections 2 and 3 e.g. R codes and co-morbidity. Changes in the number of Expected deaths can occur [relatively] rapidly.
>
> Any unexpected change in the numbers of Observed deaths or Expected deaths or a sudden divergence or convergence of the two numbers should be explored so that the underlying reasons can be understood. One way of undertaking this is to analyse the data to see if any particular CCS Groups are driving the change. Further information and support on this can be provided by AQuA Analytics on request.

Having continued to study this area in detail, we have seen some substantial changes in the number of Expected deaths, often over short periods of time, and this has, in turn, had a substantial effect on the SHMI value for a trust. Gradual changes in the Expected numbers of deaths are often the result of slowly changing case-mixes and improvements in coding; rapid changes are more often associated with a step-change in the number of discharges. For this reason, we have included the number of discharges alongside the Observed and Expected values. When reviewing your trust's chart, ask yourself whether the changes being seen are anticipated consequences of changes in operational, coding or classification practice.

Period	Jan 12 - Dec 12	Apr 12 - Mar 13	Jul 12 - Jun 13	Oct 12 - Sep 13	Jan 13 - Dec 13	Apr 13 - Mar 14	Jul 13 - Jun 14	Oct 13 - Sep 14
Observed	2,182	2,332	2,362	2,304	2,231	2,171	2,107	2,139
Expected	2,026	2,096	2,090	2,083	2,074	2,035	2,032	2,075
Discharged	66,539	65,650	65,947	66,736	67,128	67,578	67,981	68,689

Period	Jan 14 - Dec 14	Apr 14 - Mar 15	Jul 14 - Jun 15	Oct 14 - Sep 15	Jan 15 - Dec 15	Apr 15 - Mar 16	Jul 15 - Jun 16	Oct 15 - Sep 16
Observed	2,273	2,377	2,477	2,451	2,359	2,295	2,262	2,325
Expected	2,190	2,330	2,408	2,403	2,364	2,343	2,347	2,367
Discharged	70,286	71,631	73,833	74,972	75,855	77,421	77,894	78,903

Period	Jan 16- Dec 16	Apr 16 - Mar 17	Jul 16 - Jun 17	Oct 16- Sep 17	Jan 17- Dec 17	Apr 17- Mar 18	Jul 17 - Jun 18	Oct 17– Sep 18
Observed	2,381	2,416	2,435	2,435	2,433	2,533	2,544	2,546
Expected	2,415	2,427	2,428	2,441	2,332	2,283	2,210	2,159
Discharged	79,094	78,805	79,461	78,452	74,252	69,688	64,400	61,076

Period	Jan 18- Dec 18	Apr 18- Mar 19	Jul 18 - Jun 19	Oct 18– Sep 19	Jan 19- Dec 19	Apr 19- Mar 20	Jul 19 - Jun 20	Oct 19– Sep 20
Observed	2,490	2,365	2,370	2,325	2,410	2,430	2,285	2,320
Expected	2,160	2,085	2,115	2,100	2,110	2,120	1,995	1,990
Discharged	61,545	61,625	62,515	63,060	63,005	62,685	58,295	56,965

Period	Jan 20- Dec 20	Apr 20- Mar 21	Jul 20 – Jun 21	Oct 20– Sep 21	Jan 21- Dec 21	Apr 21- Mar 22	Jul 21 – Jun 22	Oct 21- Sep 22
Observed	2,185	1,945	1,980	1,965	2,020	2,045	2,085	2,045
Expected	1,850	1,690	1,755	1,755	1,835	1,845	1,830	1,780
Discharged	54,255	52,160	55,855	55,765	56,730	58,620	58,095	58,110

Period	Apr 22 - Mar 23	Jul 22 - Jun 23	Oct 22- Sep 23
Observed	2,310	2,340	2,360
Expected	2,060	2,145	2,250
Discharged	68,880	74,820	80,325

*Note – From the Jan 18-Dec 18 release NHS Digital began supressing all observed, expected and discharge figures by rounding to the nearest 5.

**Covid-19: data relating to Covid-19 activity is now excluded from SHMI. This will start to have a material impact from the period July 19 – June 20 and you will notice a reduction in Discharges, Observed Deaths and Expected Deaths from this point forward. This is explained in more detail in Section 4.

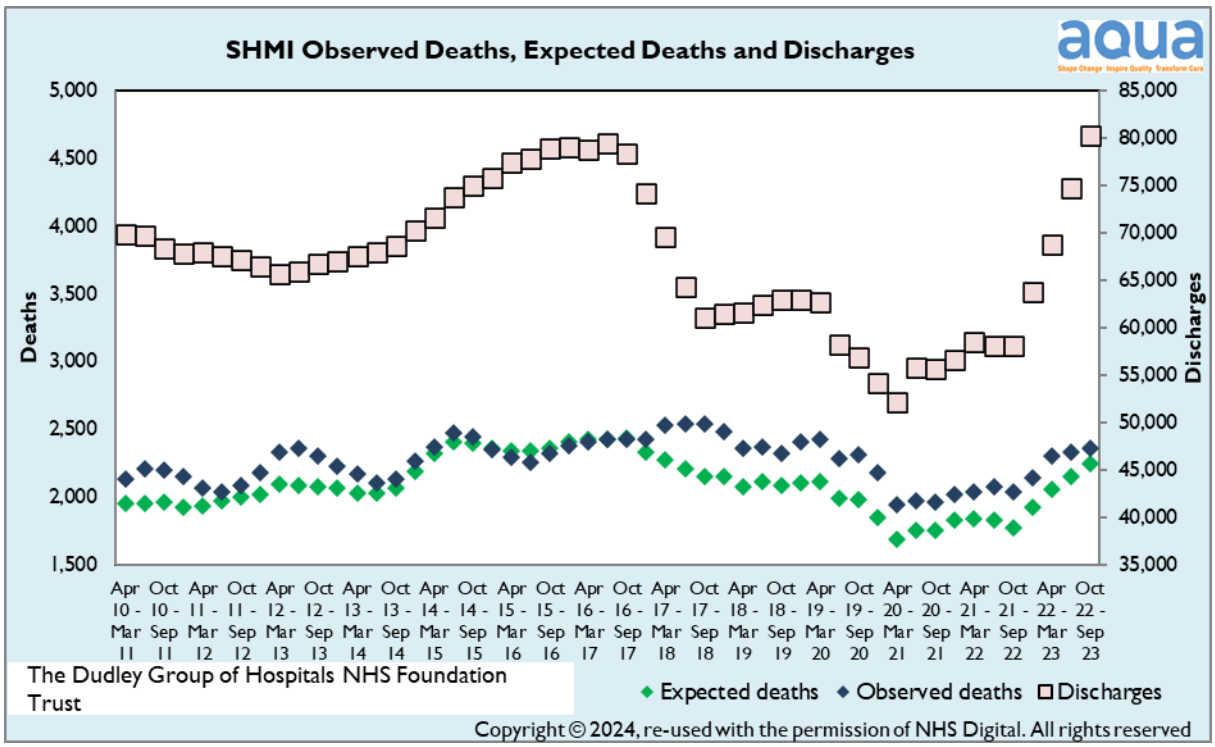


Chart 19 – Observed Deaths, Expected Deaths and Discharges Time Series

3.3 Average Risk of Death

Notwithstanding the aforementioned effect of Covid-19 activity on SHMI data, another measure to keep an eye on is the Average Risk of Death. A full explanation of this measure can be found in Section 4 of this issue but, in short, it is the total number of Expected deaths divided by the total number of discharges. Prima facie, this reflects the average level of acuity of the trust's case-mix – are the reasons for any changes understood and/or planned or are they an unintended consequence of other actions? Further investigation may include looking at this metric for individual CCS Groups.

Period	Jan 12 - Dec 12	Apr 12 - Mar 13	Jul 12 - Jun 13	Oct 12 - Sep 13	Jan 13 - Dec 13	Apr 13 - Mar 14	Jul 13 - Jun 14	Oct 13 - Sep 14
Average risk	3.04%	3.19%	3.17%	3.12%	3.09%	3.01%	2.99%	3.02%

Period	Jan 14 - Dec 14	Apr 14 - Mar 15	Jul 14 - Jun 15	Oct 14 - Sep 15	Jan 15 - Dec 15	Apr 15 - Mar 16	Jul 15 - Jun 16	Oct 15 - Sep 16
Average risk	3.12%	3.25%	3.26%	3.21%	3.12%	3.03%	3.01%	3.00%

Period	Jan 16- Dec 16	Apr 16 - Mar 17	Jul 16 - Jun 17	Oct 16- Sep 17	Jan 17- Dec 17	Apr 17- Mar 18	Jul 17 - Jun 18	Oct 17– Sep 18
Average risk	3.05%	3.08%	3.06%	3.11%	3.14%	3.28%	3.43%	3.53%

Period	Jan 18- Dec 18	Apr 18- Mar 19	Jul 18 - Jun 19	Oct 18– Sep 19	Jan 19- Dec 19	Apr 19- Mar 20	Jul 19 - Jun 20	Oct 19– Sep 20
Average risk	3.51%	3.38%	3.38%	3.33%	3.35%	3.38%	3.42%	3.49%

Period	Jan 20-Dec 20	Apr 20-Mar 21	Jul 20 – Jun 21	Oct 20–Sep 21	Jan 21-Dec 21	Apr 21-Mar 22	Jul 21 – Jun 22	Oct 21-Sep 22
Average risk	3.41%	3.24%	3.14%	3.15%	3.23%	3.15%	3.15%	3.06%

Period	Apr 22 - Mar 23	Jul 22 - Jun 23	Oct 22-Sep 23
Average risk	2.99%	2.87%	2.80%

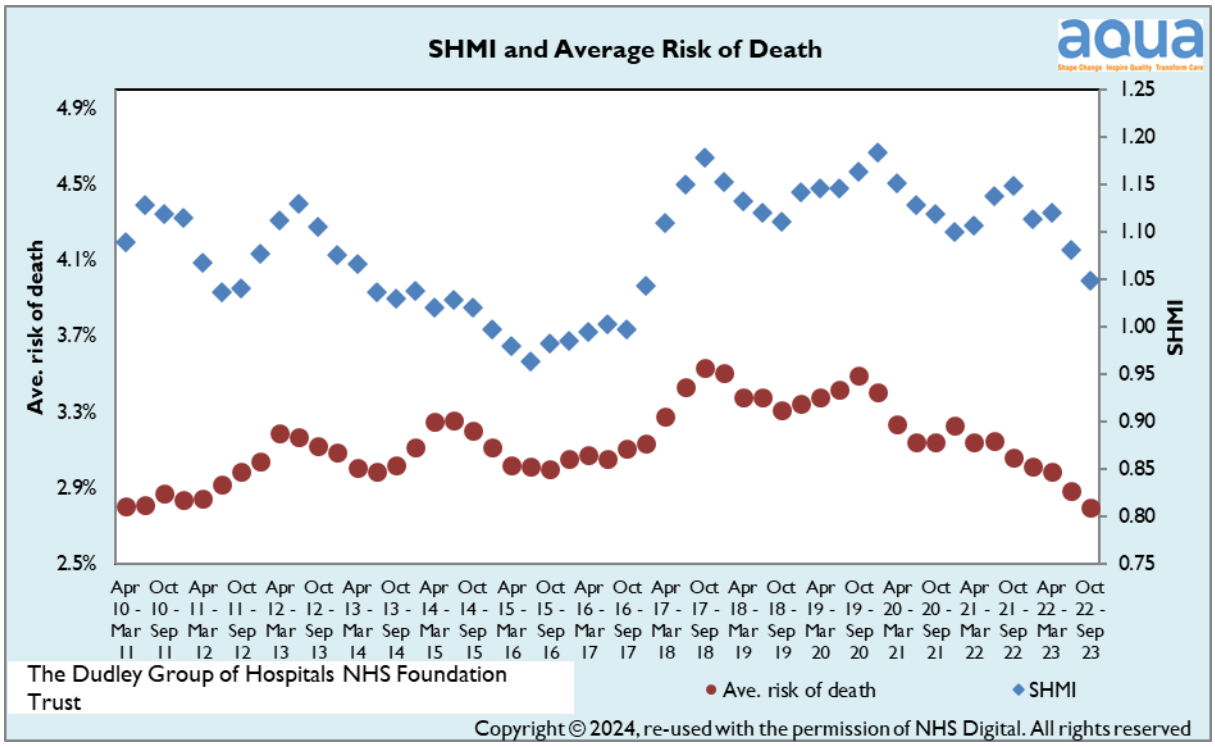


Chart 20 – Average Risk of Death Time Series

3.4 Palliative Care Coding

The first table and chart relate to all patients admitted; the second table and chart relate to patients that died.

Period	Jan 12 - Dec 12	Apr 12 - Mar 13	Jul 12 - Jun 13	Oct 12 - Sep 13	Jan 13 - Dec 13	Apr 13 - Mar 14	Jul 13 - Jun 14	Oct 13 - Sep 14
Trust	**1.4%**	**1.4%**	**1.5%**	**1.4%**	**1.3%**	**1.3%**	**1.3%**	**1.3%**
Midlands	1.16%	1.23%	1.26%	1.30%	1.35%	1.42%	1.43%	1.46%
England	1.06%	1.12%	1.14%	1.18%	1.22%	1.27%	1.29%	1.31%

Period	Jan 14 - Dec 14	Apr 14 - Mar 15	Jul 14 - Jun 15	Oct 14 - Sep 15	Jan 15 - Dec 15	Apr 15 - Mar 16	Jul 15 - Jun 16	Oct 15 - Sep 16
Trust	**1.3%**	**1.25%**	**1.2%**	**1.18%**	**1.21%**	**1.22%**	**1.25%**	**1.33%**
Midlands	1.48%	1.50%	1.50%	1.51%	1.55%	1.66%	1.71%	1.74%
England	1.34%	1.38%	1.39%	1.42%	1.45%	1.48%	1.51%	1.54%

Period	Jan 16 - Dec 16	Apr 16 - Mar 17	Jul 16 - Jun 17	Oct 16 - Sep 17	Jan 17- Dec 17	Apr 17- Mar 18	Jul 17 - Jun 18	Oct 17- Sep 18
Trust	**1.31%**	**1.37%**	**1.38%**	**1.36%**	**1.41%**	**1.41%**	**1.5%**	**1.54%**
Midlands	1.73%	1.68%	1.61%	1.56%	1.58%	1.52%	1.51%	1.53%
England	1.58%	1.63%	1.64%	1.66%	1.71%	1.75%	1.77%	1.78%

Period	Jan 18 - Dec 18	Apr 18 - Mar 19	Jul 18 - Jun 19	Oct 18- Sep 19	Jan 19 - Dec 19	Apr 19 - Mar 20	Jul 19 - Jun 20	Oct 19 - Sep 20
Trust	**1.5%**	**1.5%**	**1.4%**	**1.3%**	**1.3%**	**1.2%**	**1.3%**	**1.49%**
Midlands	1.54%	1.54%	1.51%	1.51%	1.50%	1.57%	1.60%	1.64%
England	1.80%	1.80%	1.80%	1.80%	1.80%	1.90%	1.89%	1.92%

Period	Jan 20 - Dec 20	Apr 20 - Mar 21	Jul 20 – Jun 21	Oct 20 - Sep 21	Jan 21 - Dec 21	Apr 21 - Mar 22	Jul 21 – Jun 22	Oct 21- Sep 22
Trust	**1.5%**	**1.54%**	**1.55%**	**1.4%**	**1.44%**	**1.34%**	**1.28%**	**1.32%**
Midlands	1.70%	1.66%	1.65%	1.63%	1.63%	1.66%	1.64%	1.61%
England	1.93%	1.91%	1.92%	1.91%	1.94%	1.97%	1.96%	1.93%

Period	Apr 22 - Mar 23	Jul 22 - Jun 23	Oct 22- Sep 23
Trust	**1.77%**	**1.94%**	**2.06%**
Midlands	1.61%	1.59%	1.63%
England	1.94%	1.94%	1.97%

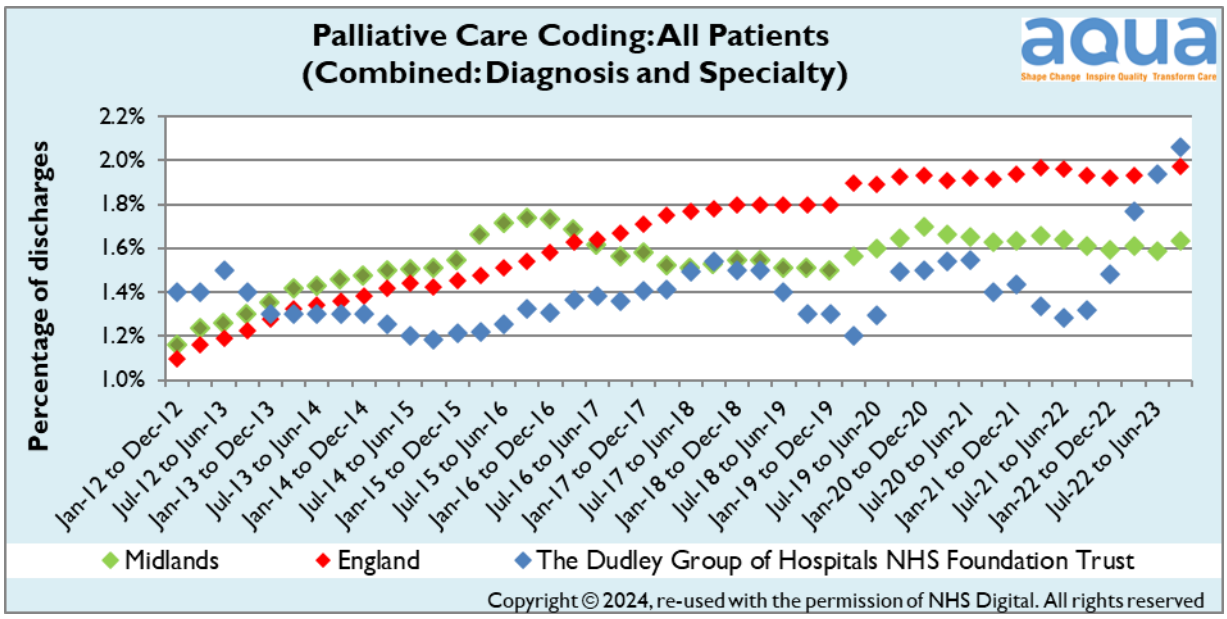


Chart 21 – trust Palliative Care coding time-series, all patients

Period	Jan 12 - Dec 12	Apr 12 - Mar 13	Jul 12 - Jun 13	Oct 12 - Sep 13	Jan 13 - Dec 13	Apr 13 - Mar 14	Jul 13 - Jun 14	Oct 13 - Sep 14
Trust	**27.5%**	**26.4%**	**26%**	**25.3%**	**25.1%**	**26.2%**	**27.1%**	**27.5%**
Midlands	20.1%	21.0%	21.2%	21.7%	23.0%	24.7%	25.9%	26.9%
England	19.1%	19.9%	20.2%	20.9%	22.0%	23.6%	24.6%	25.3%

Period	Jan 14 - Dec 14	Apr 14 - Mar 15	Jul 14 - Jun 15	Oct 14 - Sep 15	Jan 15 - Dec 15	Apr 15 - Mar 16	Jul 15 - Jun 16	Oct 15 - Sep 16
Trust	**27.9%**	**27.2%**	**25.9%**	**26.6%**	**28.1%**	**29.5%**	**31.3%**	**31.5%**
Midlands	26.8%	26.4%	26.2%	26.4%	27.7%	30.3%	31.3%	32.0%
England	25.7%	25.7%	26.0%	26.6%	27.6%	28.5%	29.2%	29.7%

Period	Jan 16 - Dec 16	Apr 16 - Mar 17	Jul 16 - Jun 17	Oct 16 - Sep 17	Jan 17- Dec 17	Apr 17- Mar 18	Jul 17 - Jun 18	Oct 17- Sep 18
Trust	**29.7%**	**29.3%**	**28.5%**	**27.6%**	**27%**	**24.8%**	**24.5%**	**24%**
Midlands	31.5%	30.4%	29.2%	28.0%	27.7%	26.7%	26.5%	27.8%
England	30.1%	30.7%	32.2%	31.5%	32.2%	32.5%	33.1%	33.6%

Period	Jan 18- Dec 18	Apr 18- Mar 19	Jul 18 - Jun 19	Oct 18- Sep 19	Jan 19- Dec 19	Apr 19- Mar 20	Jul 19 - Jun 20	Oct 19 - Sep 20
Trust	**26%**	**26%**	**24%**	**23%**	**22%**	**21%**	**20.8%**	**22.8%**
Midlands	29.2%	29.2%	29.0%	28.8%	28.7%	29.6%	29.7%	29.7%
England	34.3%	35.0%	36.0%	36.0%	36.0%	37.0%	36.3%	36.3%

Period	Jan 20 - Dec 20	Apr 20- Mar 21	Jul 20 – Jun 21	Oct 20- Sep 21	Jan 21- Dec 21	Apr 21 - Mar 22	Jul 21 – Jun 22	Oct 21- Sep 22
Trust	**22.7%**	**24.4%**	**26%**	**23.7%**	**24.5%**	**23%**	**21.8%**	**23.2%**
Midlands	31.0%	31.8%	32.3%	32.6%	32.5%	33.9%	33.9%	33.9%
England	36.6%	37.5%	38.7%	38.8%	39.0%	40.0%	39.9%	39.9%

Period	Apr 22 - Mar 23	Jul 22 - Jun 23	Oct 22- Sep 23
Trust	**37.4%**	**45.1%**	**51.5%**
Midlands	34.5%	34.3%	35.6%
England	40.5%	40.7%	41.8%

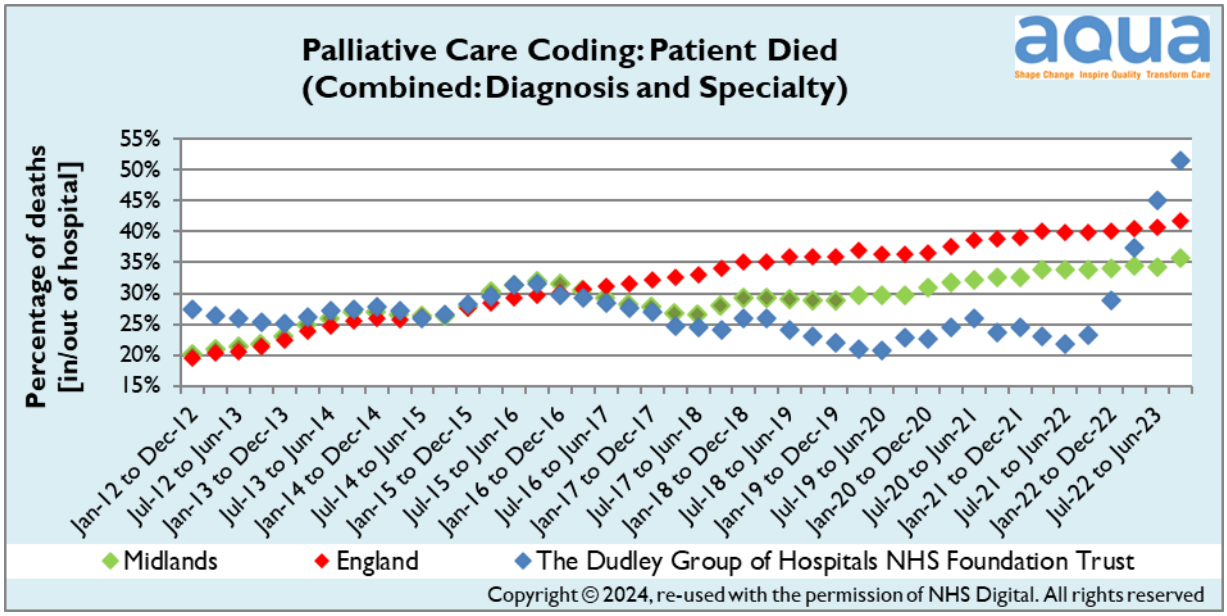


Chart 22 – trust Palliative Care coding time-series, patients died

3.5 Signs and Symptoms coding

All non-elective FCEs.

Fin. Year	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20
Trust	**14.9%**	**15.1%**	**17.3%**	**15%**	**16.1%**	**15%**	**12.1%**	**14%**
Midlands	13.9%	14.6%	14.3%	14.2%	13.4%	16.2%	15.2%	14.8%
England	14.8%	15.1%	14.4%	13.9%	13.5%	13.4%	14.0%	15.0%

Fin. Year	2020/21	2021/22	2022/23	2023/24
Trust	**12.7%**	**14.3%**	**21.5%**	**27.2%**
Midlands	14.6%	15.9%	16.6%	20.3%
England	15.0%	16.0%	16.0%	18.7%

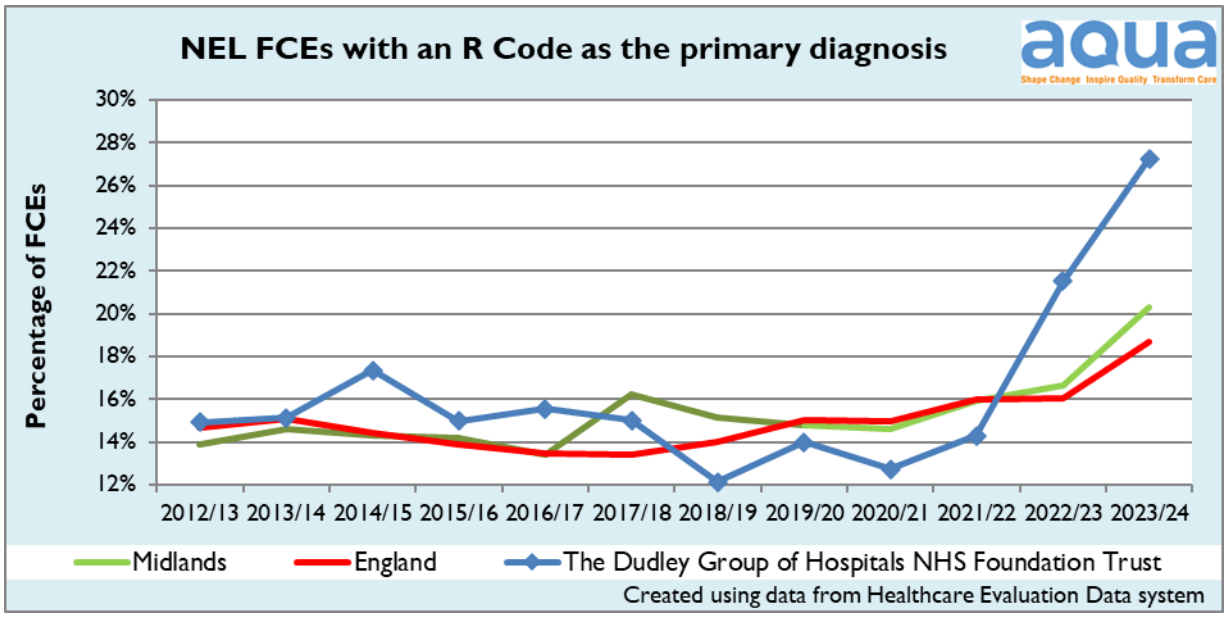


Chart 23 – trust Signs & Symptoms coding time-series, NEL, all patients
*****Take care when interpreting 2023/24 as it is not a complete year*****

First Episode of the non-elective Spell.

Fin. Year	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20
Trust	**15.9%**	**16.3%**	**19.7%**	**16.9%**	**17.3%**	**15.5%**	**13.3%**	**15.2%**
Midlands	15.5%	16.4%	16.1%	16.1%	15.4%	18.0%	17.4%	17.0%
England	15.9%	16.0%	15.6%	15.2%	14.9%	15.0%	16.1%	16.4%

Fin. Year	2020/21	2021/22	2022/23	2023/24
Trust	**13.2%**	**14.5%**	**22.2%**	**28.6%**
Midlands	16.3%	17.6%	18.1%	21.6%
England	16.7%	17.5%	17.3%	20.0%

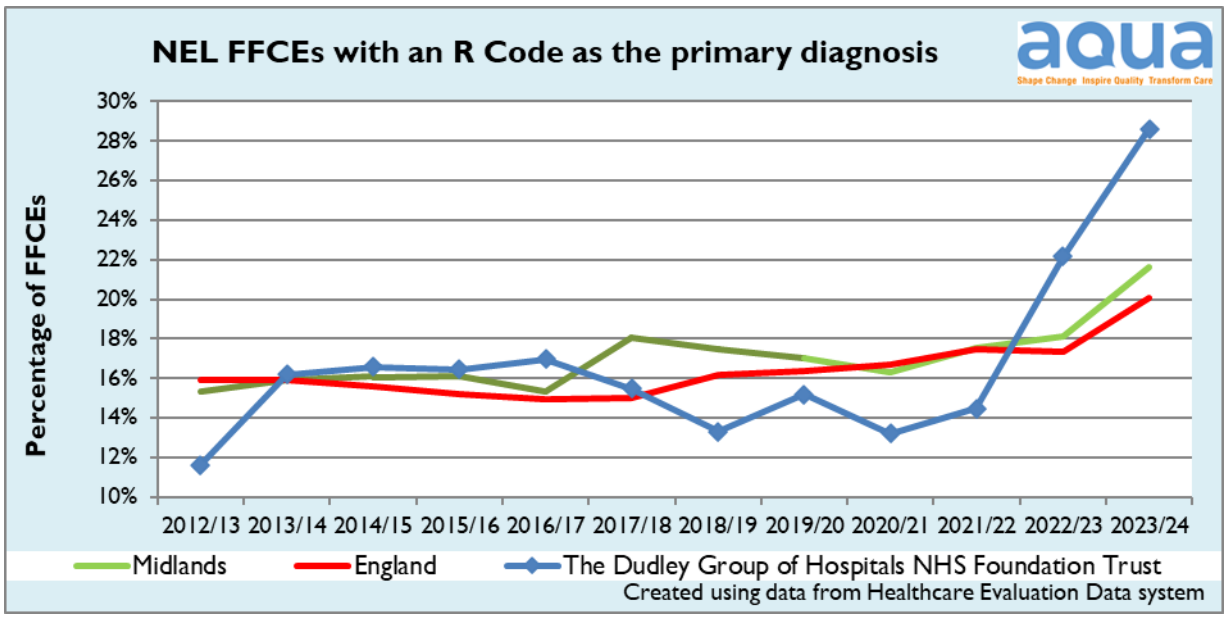


Chart 24 – trust Signs & Symptoms coding time-series, NEL, all patients
*****Take care when interpreting 2023/24 as it is not a complete year*****

3.6 Co-morbidity

Fin. Year	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20
Trust	**3**	**3.2**	**3.9**	**3.5**	**3.6**	**4**	**4.9**	**5.1**
Midlands	3.2	3.5	3.8	4.0	4.1	4.3	4.5	4.8
England	3.0	3.1	3.3	3.8	3.9	4.1	4.2	4.5

Fin. Year	2020/21	2021/22	2022/23	2023/24
Trust	**5.3**	**4.9**	**4.2**	**4.1**
Midlands	5.3	5.0	4.9	4.7
England	4.8	4.7	4.7	4.6

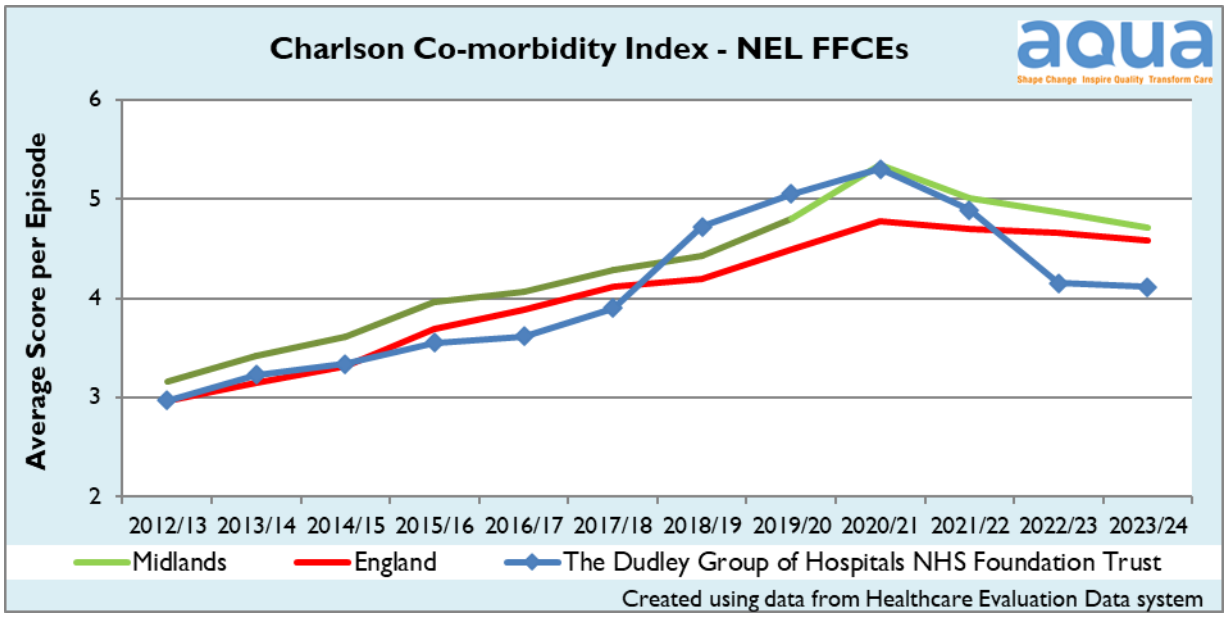


Chart 25 – Charlson Co-Morbidity Index time-series, NEL
*****Take care when interpreting 2023/24 as it is not a complete year*****

SECTION 4 – Quarterly Focus

4.1 COVID-19

As explained in previous issues, Section 4 continues to focus on Covid-19.

NHS Digital publish Contextual Data showing the percentage of Spells with Covid-19 coding. For the period covered in this report [April 2021 to March 2022], there is still only a small amount of activity that has been coded as Covid-19, using ICD-10 codes **U07.1 and U07.2.** Chart 26 shows the proportion of all activity using these codes and that is, therefore, excluded from SHMI.

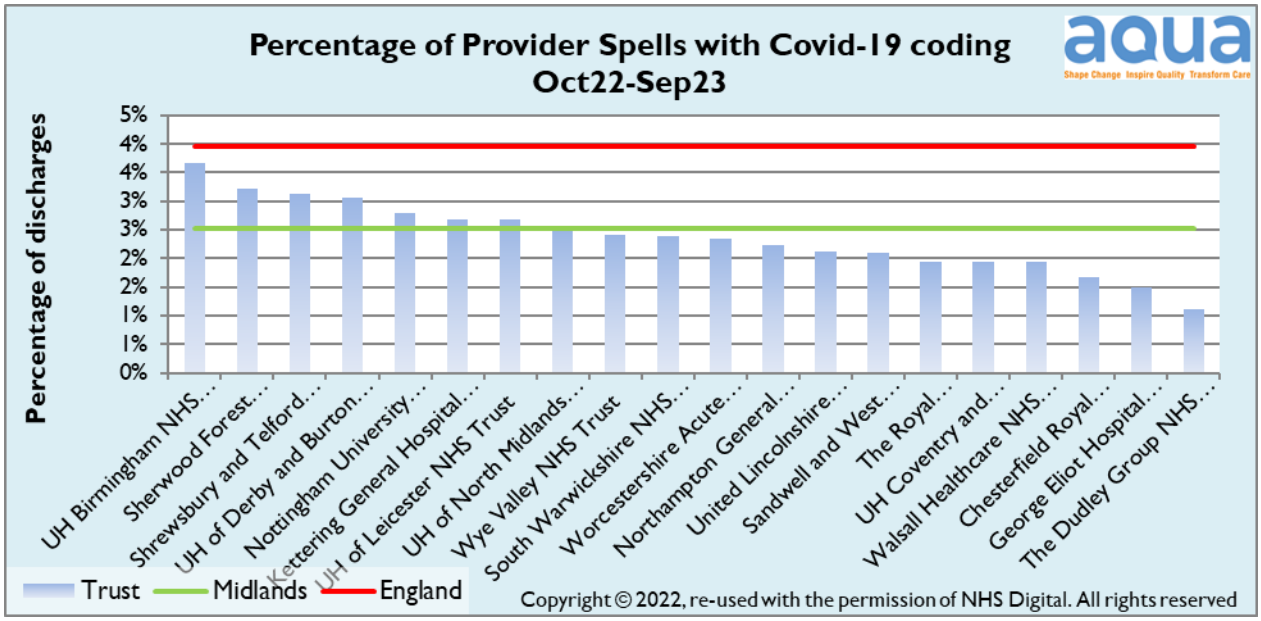


Chart 26 – the proportion of all activity using codes U07.1 and U07.2

The small percentages can no longer be attributed to the time-period covered as 12 months of activity are now included. Given that this includes periods when the majority of elective activity ceased and non-elective activity was much reduced, they do seem to be lower than anticipated.

The Midland average being higher than the England average and reflects the different timing of the prevalence in different regions; two Midland trusts are in the highest 20 trusts in England.

Chart 26 shows the same data as Chart 26, over time for your trust. The rise in percentages for most trusts is the result of:

a) an increasing numerator i.e. more Covid-19 activity being excluded from SHMI as the data period extends to incorporate 12 months of the pandemic, and
b) a decreasing denominator i.e. a reduction in the number of Discharges, as seen in Chart 20.
c) the most recent data point showing a reversal in previous trends due to the resuming of more elective activity.

The scale of this reduction in activity [Discharges] is shown in Chart 27 where data are compared to the last pre-pandemic 12-month period.

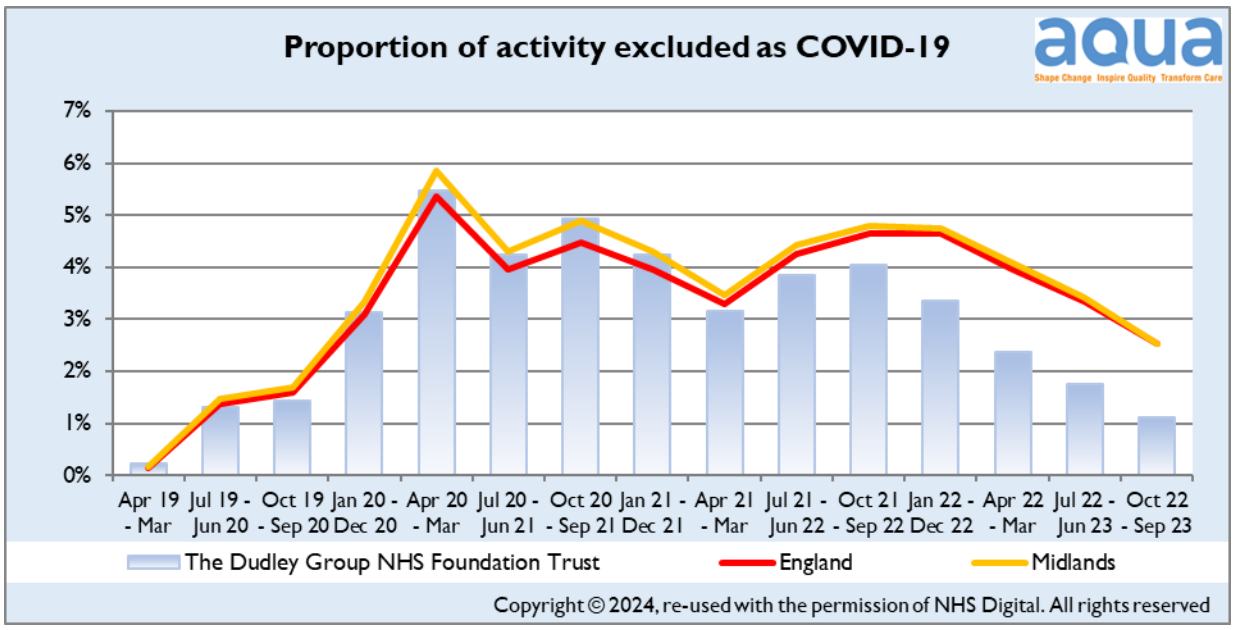


Chart 27 – trust proportion of all activity using codes U07.1 and U07.2

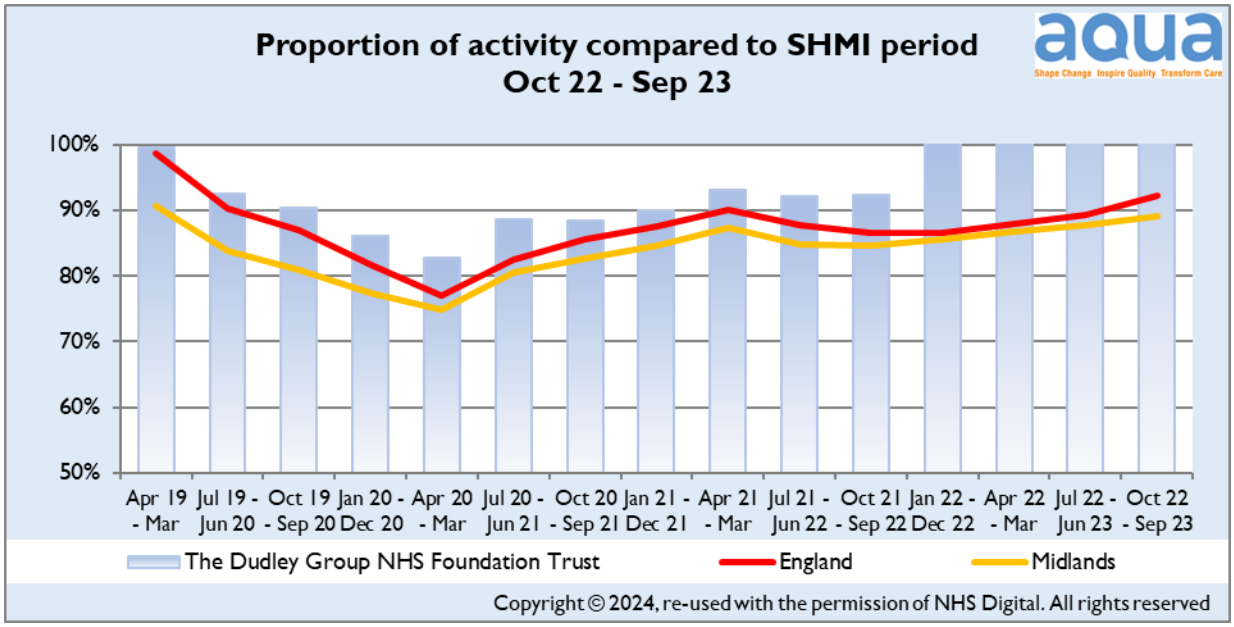


Chart 28 – trust proportion of activity compared to the period Oct 22 - Sep 23

More to explore:

WHO coding guidance: https://www.who.int/classifications/icd/covid19/en/
NHS Digital methodological changes: https://digital.nhs.uk/data-and-information/find-data-and-publications/statement-of-administrative-sources/methodological-changes

Clinical practice guide for improving the management of adult COVID-19 patients in secondary care: A report produced by Getting It Right First Time [GIRFT]
https://www.gettingitrightfirsttime.co.uk/wp-content/uploads/2020/12/Covid19-Clinical-Practice-Guidance-S-FINAL.pdf

Appendix A: Differences between HSMR, RAMI and SHMI

	Hospital Standardised Mortality Rate (HSMR)	**Risk Adjusted Mortality Index (RAMI)**	**Summary Hospital-level Mortality Indicator (SHMI) ****
Observed	All spells culminating in death at the end of the patient pathway, defined by specific diagnosis codes for the primary diagnosis of the spell: uses 56 diagnosis groups which contribute to approx. 80% of in hospital deaths in England*	Total number of observed in-hospital deaths	Number of observed in-hospital deaths plus deaths out of hospital within 30 days of discharge
Expected	Expected number of deaths	Expected number of deaths *Calculated using a 10 year data set (as of 2012) to get the risk estimate*	Expected number of deaths *Calculated using a 36 month data set to get the risk estimate*
Adjustments	▪ Sex ▪ Age in bands of five up to 90+ ▪ Admission method ▪ Source of admission ▪ History of previous emergency admissions in last 12 months ▪ Month of admission ▪ Socio economic deprivation quintile (using Carstairs) ▪ Primary diagnosis based on the clinical classification system ▪ Diagnosis sub-group ▪ Co-morbidities based on Charlson score ▪ Palliative care ▪ Year of discharge	▪ Sex ▪ Age ▪ Clinical grouping (HRG) ▪ Primary and secondary diagnosis ▪ Primary and secondary Procedures ▪ Hospital type ▪ Admission method Further detailed methodology information is included in CHKS products, or specific enquiries to CHKS www.chks.co.uk	▪ Sex ▪ Age group ▪ Admission method ▪ Co-morbidity ▪ Year of dataset ▪ Diagnosis group Details of the categories above can be referenced from the methodology specification document at http://www.ic.nhs.uk/services/summary-hospital-level-mortality-indicator-shmi
Exclusions	Excludes day cases and regular attendees	Excludes mental illness, obstetrics, babies born in or out of hospital, day cases, and patients admitted as emergencies with a zero length of stay discharged alive and spells coded as palliative care (Z515)	▪ Specialist, community, mental health and independent sector hospitals. ▪ Stillbirths ▪ Day cases, regular day and night attenders
Whose data is being compared and how much data is used for comparison e.g. all trusts or certain proportion etc.	All England provider trusts via SUS Data attributed to all Trusts within a 'super-spell' of activity that ends in death	UK database of Trust data and HES Data attributed to Trust in which patient died	All England non-specialist acute trusts except mental health, community and independent sector hospitals. Data attributed to Trust in which patient died or was discharged from

*HSMR does not exclude 20% of deaths, it looks for the diagnosis groups that account for the majority of deaths, and the figure of 80% is quite variable dependent on the case mix of the trust. HSMR

could just as easily cover 100% of activity. It covers 80% of activity mostly for historical reasons and the fact that you get little extra value from the other 20%.

** NHS Digital publishes the SHMI indicator as observed, expected, denominator, value, upper control limits, lower control limits and banding. The term numerator is not used in the publication.

Appendix B: Metadata

Resource type	Title	Description	Coverage	Numerator	Denominator	Date	Source
Mortality	Charts 1 & 9	Crude in-hospital mortality rate	131 SHMI Trusts	Discharge Method = 4	All discharges	Latest published SHMI (12 month period)	HED
Mortality	Charts 2 & 18	Crude in-hospital mortality rate	131 SHMI Trusts (20 in Midlands)	Discharge Method = 4	All discharges	April 2009 – most recent month	HED
Mortality	Charts 3 & 10	Crude in-hospital mortality rate	131 SHMI Trusts	Discharge Method = 4 OR Died within 30 days	All discharges	Latest published SHMI (12 month period)	HED
				Split as per Appendix B.3 of the SHMI Indicator Specification i.e. Elective = Admission Method 11, 12, 13 Acute [NEL] = 21, 22, 23, 24, 28, 31, 32, 81, 82, 83, 84, 89, 98			
Mortality	Chart 4a	SHMI - SHA	131 SHMI Trusts	Observed deaths	Expected deaths	Latest published SHMI (12 month period)	NHS Digital
Mortality	Chart 4b & 11	SHMI – Funnel Plot	131 SHMI Trusts	Observed deaths	Expected deaths	Latest published SHMI (12 month period)	NHS Digital
Mortality	Charts 5 & 19	NW SHMI	20 Trusts in Midlands	Observed deaths	Expected deaths	Latest published SHMI (12 month period)	HED
Mortality	Chart 6	Observed and Expected deaths	20 Trusts in Midlands	N/A	N/A	October 2009 – latest month	HED
Mortality	Chart 7	% Deaths occurring in-hospital	131 SHMI Trusts	Discharge Method = 4	Discharge Method = 4 plus deaths from the HES-ONS linked mortality data file	Latest published SHMI (12 month period)	HED
Mortality	Chart 8	% Deaths occurring in-hospital	131 SHMI Trusts (12 in Midlands)	Discharge Method = 4	Discharge Method = 4 plus deaths from the HES-ONS linked mortality data file	October 2009 – Latest month	HED
Clinical Coding	Chart 12 & 21	Palliative Care coding	20 Trusts in Midlands	Patients with ICD10 Code Z515 in any position of any episode or Specialty Code 315 in any episode	All discharges	Latest published SHMI (12 month period)	NHS Digital

Resource type	Title	Description	Coverage	Numerator	Denominator	Date	Source
Clinical Coding	Chart 13 & 22	Palliative Care coding	20 Trusts in Midlands	Patients with ICD10 Code Z515 in any position of any episode or Specialty Code 315 in any episode (where Discharge Method = 4)	Discharge Method = 4 plus deaths from the HES-ONS linked mortality data file	Latest published SHMI (12 month period)	NHS Digital
Clinical Coding	Charts 14 & 23	Signs & Symptoms coding	20 Trusts in Midlands	ICD10 "R" code in primary diagnosis of any episode. Admission Method = 21 – 28, 31, 32, 81 – 89, 98.	Number of episodes	Latest FY for which data has been published	HED
Clinical Coding	Charts 15 & 24	Signs & Symptoms coding	20 Trusts in Midlands	ICD10 "R" code in primary diagnosis of the first episode. Admission Method = 21 – 28, 31, 32, 81 – 89, 98	Number of first episodes [i.e. Spells]	Latest FY for which data has been published	HED
Clinical Coding	Chart 16 & 25	Charlson Co-morbidity Index	20 Trusts in Midlands	Total co-morbidity score for all relevant codes[1] in Diag02 – Diag20 for the first episode[2]	Number of first episodes [i.e. Spells]	Latest published SHMI (12 month period)	HED
Clinical Coding	Chart 20	Average Risk of Death	20 Trusts in Midlands	Expected Deaths	Total Discharges	January 2012 to latest month	HED
Clinical Coding	Chart 26	Percentage of provider spells with COVID-19 coding	20 Trusts in Midlands	Number of provider spells with COVID-19 coding	Total number of provider spells	Latest published SHMI (12 month period)	NHS Digital
Mortality	Chart 27	Proportion of activity as Covid-19	20 Trusts in Midlands	Number of excluded spells	Number of all spells	Latest data as of September 2023	NHS Digital
Mortality	Chart 28	Proportion of activity compared to SHMI period Jan19 to Dec19	20 Trusts in Midlands	All discharges for a SHMI period post Jan19 to Dec19	All discharges for the SHMI period Jan19 to Dec19	Latest data as of September 2023	NHS Digital

[1] See Appendix D.1 of SHMI Methodology

[2] This most closely reflects the episodes that are used in the SHMI calculation. Only a small proportion of second episodes are used [i.e. where the primary diagnosis of the first episode is an "R" code and the second episode has a primary diagnosis other than an "R" code].

Appendix C: Trust Codes and Names

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

Workforce KPI Report

March 2024

Hannah White – Head of People

The Dudley Group
NHS Foundation Trust

CARE
RESPECT
RESPONSIBILITY

Summary

The Dudley Group NHS Foundation Trust

Metric	Rate	Target	Trend	
Absence – In Month	5.16%	<=5%	↓	**Sickness Absence** In month sickness absence for March 2024 is 5.16% a decrease from 5.28% in February 2024. The rolling 12-month absence has decreased to 4.99 % in March 2024 from 5.02% in February 2024.
Absence - 12m Rolling	4.99%	<=5%	↓	
Turnover	8.55%	<=8%	↑	**Turnover** Turnover (all terminations) has increased from 8.46% in February 2024 to 8.55% in March 2024.
Normalised Turnover	3.91%	<=5%	↓	Normalised Turnover has decreased from 3.98% in February 2024 to 3.91% in March 2024. Turnover (all terminations) is all terminations from the organisation. Normalised Turnover focuses on voluntary resignations and excludes dismissals, fixed-term contracts, redundancy, retirement and rotations.
Retention (12 month)	91.5%	>=80%	↑	**Retention** The 12-month retention rate has increased slightly to 91.5% in March 2024 compared to 91% in February 2024.
Vacancy Rate	5%	<=7%	=	**Vacancy Rate** The vacancy rate remains stable at 5% in March 2024 with total vacancies of 315.71 WTE.
Mandatory Training	91.59%	>=90%	↓	**Mandatory Training** Statutory Training has seen a slight monthly decrease to 91.59% - overall it has remained above 90% target for a sustained period.

Exceptions/Improvement/Actions

The Dudley Group
NHS Foundation Trust

METRIC	SUMMARY
Mandatory Training	Performance against target for mandatory training overall remains above 90% for the month. This is an ongoing sustained performance at above target since Q2 23/24. There has been an ongoing decline throughout the winter period although has remained above target each month. There has been increased activity in March and April which indicates that compliance will begin to improve. The Divisional picture is varied and there have been prompts to maintain focus on compliance across the suite of training – with a specific focus on resuscitation and safeguarding training as areas of concern. These remain higher than the same period in 2023 but continue to be a concern where performance is below target.
Leadership and Culture	Work continues on embedding the Induction for new Managers to ensure this provides a strong introduction to expectations. This is linked to continued delivery of Manager's Essentials courses – which are booked to capacity each month. DNA rates remain high – with feedback provided to Divisions and participants contacted. All Divisions are being supported to plan for all line managers to complete during 2024. Plans are underway for the annual Leadership Conference on 26th April focused on Leadership Everyday with invitations having been shared with senior leaders. The leadership programme is currently being reviewed with an additional layer of training for leaders to support confidence and skills being launched in Quarter 2. This will enable leaders to consolidate learning from Manager's Essentials and add to their skills and knowledge through a portfolio approach. Developing Leaders will then re-launch as a stretch programme in Quarter 3. Being a Brilliant Place to Work Divisional Staff Survey Action Plans have been drafted with a focus on a smaller number of targeted actions for 2024. The People Pulse has launched for April with work underway to promote uptake. There are no local questions in April as the focus is on feedback aligned to planned #makeithappen in April/May 2024 with a focus on feedback and promotion of the behaviour framework and People Plan. The annual review window opened on 1st April and compliance after 2 weeks is 4.9% overall. Medicine Division is currently the highest performer at 9.1%.

Exceptions/Improvement/Actions

The Dudley Group
NHS Foundation Trust

METRIC	SUMMARY
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) increased in March 2024 but continues to perform under the national average for the NHS between 10-12%. Normalised Turnover (Voluntary resignations) decreased slightly in March 2024. Retention has remained stable at 91.5% in March 2024. The vacancy rate in March 2024 remains stable at 5% in March 2024 with total vacancies of 315.71 WTE. As demonstrated in the table below, the overall workforce growth year to date (April 23 and March 24) in 23/24 (inclusive of bank and agency staffing) is 0.30%, specifically for substantive staff this is 1.52% growth (85.09 WTE), bank staff -8.96% and agency staff -37.84%

	Apr-23	Mar-24	Difference	Variance
Total Workforce (WTE)	6271.1	6289.95	18.85	0.30%
Total Substantive	5595.15	5680.24	85.09	1.52%
Total Bank	656.21	597.44	-58.77	-8.96%
Total Agency	19.74	12.27	-7.47	-37.84%

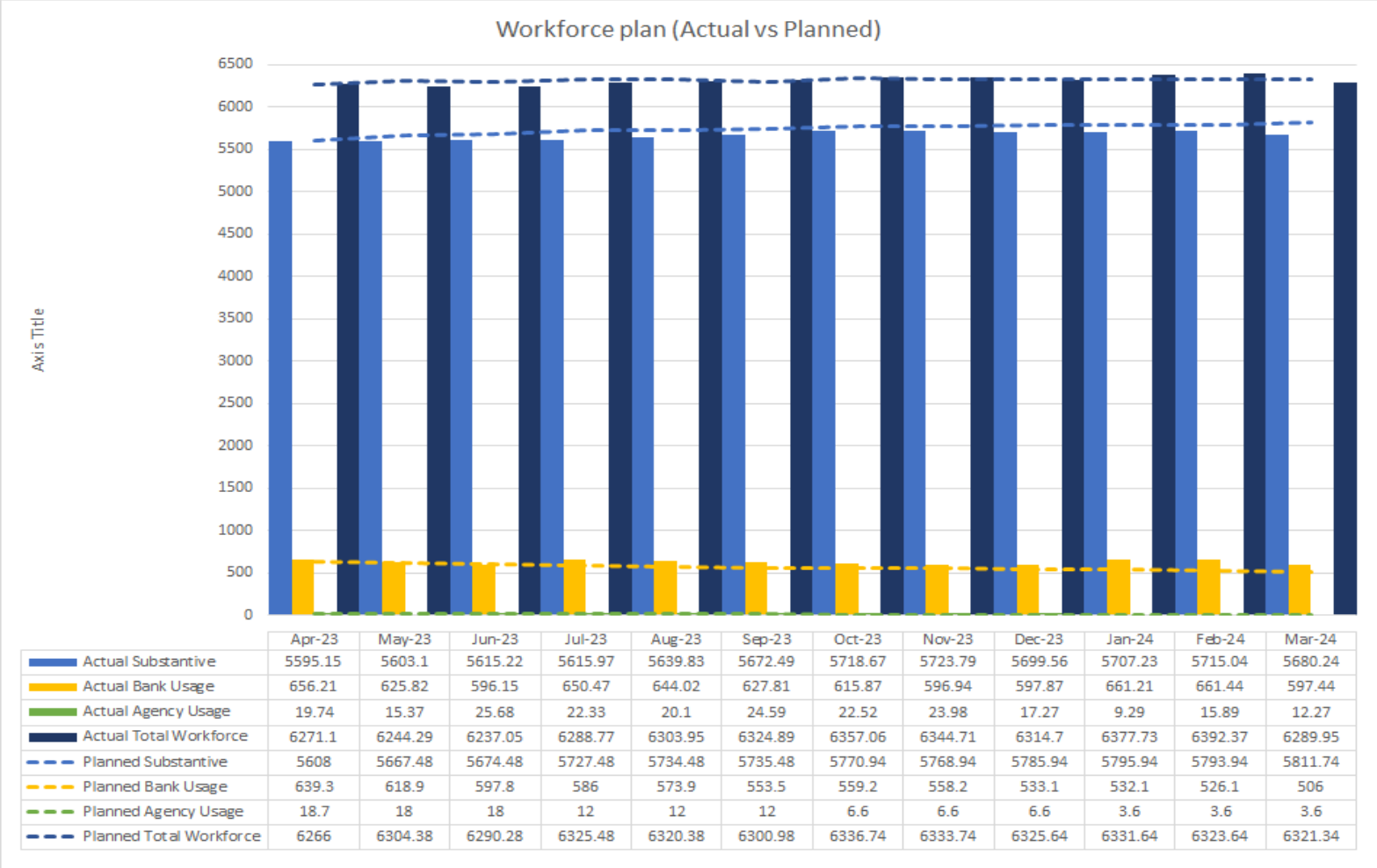
Principal areas of growth within substantive staff have been seen in Registered Scientific, Therapeutic and Technical staff (11%) and NHS Infrastructure (7%).

	Apr-23	Mar-24	Difference	Variance
Registered Nursing, Midwifery and Health Visiting Staff (substantive total)	1799.52	1881.12	81.6	5%
Registered Scientific, therapeutic and technical staff (substantive total)	628.72	697.99	69.27	11%
Support to Clinical Staff (substantive total)	1,370.22	1264.1	-106.12	-8%
Total NHS Infrastructure support (substantive total)	1006.38	1075.01	68.63	7%
Medical and Dental (substantive total)	790.21	762.02	-28.19	-4%

Exceptions/Improvement/Actions

NHS
The Dudley Group

METRIC	SUMMARY
Vacancies/ Turnover and performance against plan	For 2023/24 performance at month 12 (March 2024) overall workforce is slightly below plan (-0.5% variance – 31.39 WTE under plan) with less substantive staff but more bank and agency usage than planned (driven by additional unfunded beds and industrial action)



	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Actual Substantive	5595.15	5603.1	5615.22	5615.97	5639.83	5672.49	5718.67	5723.79	5699.56	5707.23	5715.04	5680.24
Actual Bank Usage	656.21	625.82	596.15	650.47	644.02	627.81	615.87	596.94	597.87	661.21	661.44	597.44
Actual Agency Usage	19.74	15.37	25.68	22.33	20.1	24.59	22.52	23.98	17.27	9.29	15.89	12.27
Actual Total Workforce	6271.1	6244.29	6237.05	6288.77	6303.95	6324.89	6357.06	6344.71	6314.7	6377.73	6392.37	6289.95
Planned Substantive	5608	5667.48	5674.48	5727.48	5734.48	5735.48	5770.94	5768.94	5785.94	5795.94	5793.94	5811.74
Planned Bank Usage	639.3	618.9	597.8	586	573.9	553.5	559.2	558.2	533.1	532.1	526.1	506
Planned Agency Usage	18.7	18	18	12	12	12	6.6	6.6	6.6	3.6	3.6	3.6
Planned Total Workforce	6266	6304.38	6290.28	6325.48	6320.38	6300.98	6336.74	6333.74	6325.64	6331.64	6323.64	6321.34

Exceptions/Improvement/Actions

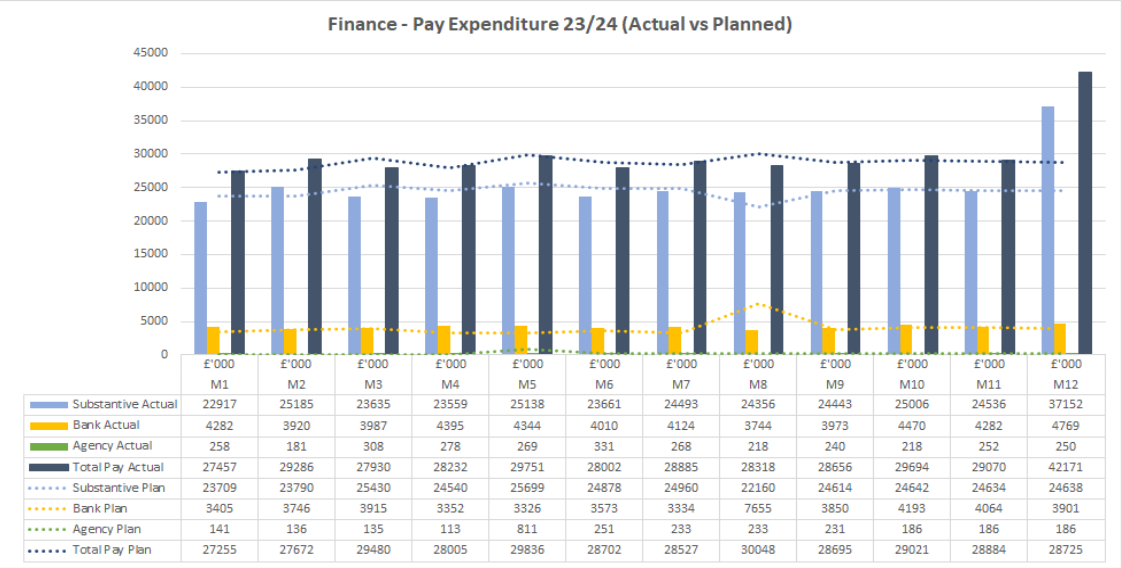
NHS
The Dudley Group

METRIC	SUMMARY
Workforce/ Finance triangulation	March pay costs are distorted by the year end pension adjustment of £12.424m. This one-off year end adjustment is fully funded. Substantive numbers showed a small reduction of 8 WTE. Bank costs were particularly high in March, notably across Nursing (qualified and unqualified) and Scientific/Therapeutic staff. Plans are underway to drive a reduction in bank costs for 2024/25. WLI spend also remained high in March due to the continued drive to improve planned activity performance associated with ERF. Agency costs continue to remain comparatively low at 0.9% of pay bill (versus cap of 3.7%). In March, the spend was slightly lower than average with medical staff responsible for 92% of the spend. The tables and charts on the next two slides provide a summary of the workforce numbers (WTE) and Pay expenditure (Actual vs Forecasted in Plan).

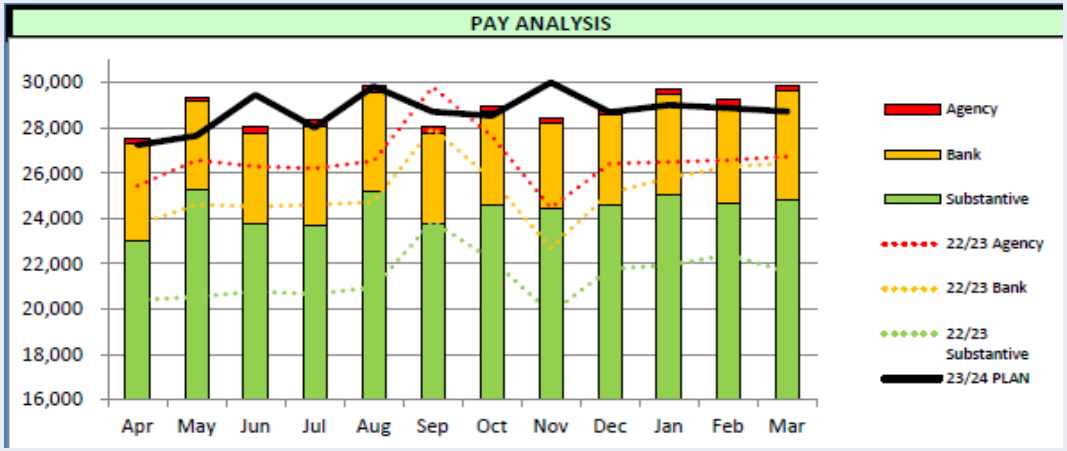
Exceptions/Improvement/Actions

The Dudley Group

METRIC	SUMMARY
Workforce/ Finance triangulation	The chart below provide a summary of the Pay expenditure (Actual vs Forecasted in Plan) - March pay costs are distorted by the year end pension adjustment of £12.424m.



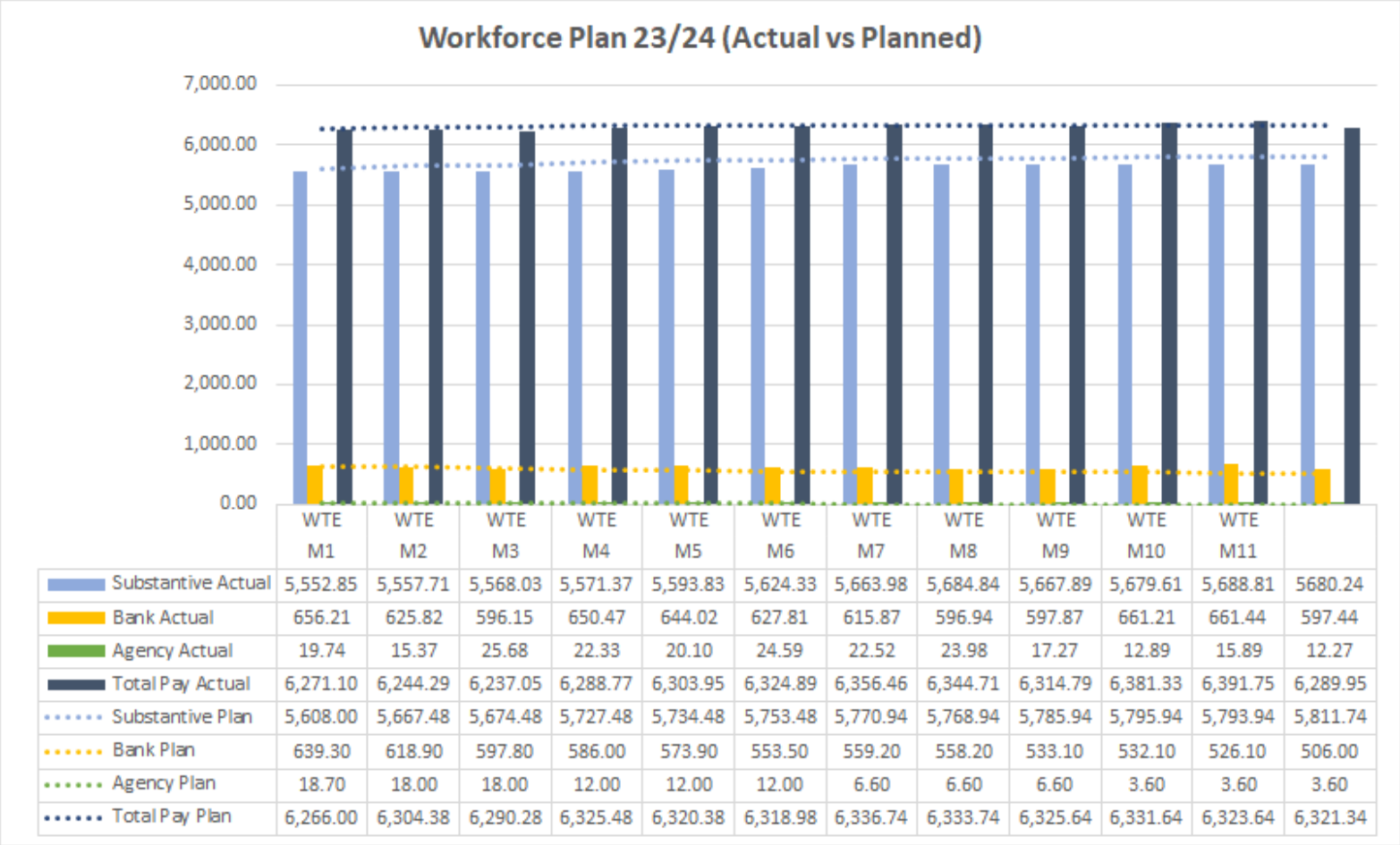
	£'000 M1	£'000 M2	£'000 M3	£'000 M4	£'000 M5	£'000 M6	£'000 M7	£'000 M8	£'000 M9	£'000 M10	£'000 M11	£'000 M12
Substantive Actual	22917	25185	23635	23559	25138	23661	24493	24356	24443	25006	24536	37152
Bank Actual	4282	3920	3987	4395	4344	4010	4124	3744	3973	4470	4282	4769
Agency Actual	258	181	308	278	269	331	268	218	240	218	252	250
Total Pay Actual	27457	29286	27930	28232	29751	28002	28885	28318	28656	29694	29070	42171
Substantive Plan	23709	23790	25430	24540	25699	24878	24960	22160	24614	24642	24634	24638
Bank Plan	3405	3746	3915	3352	3326	3573	3334	7655	3850	4193	4064	3901
Agency Plan	141	136	135	113	811	251	233	233	231	186	186	186
Total Pay Plan	27255	27672	29480	28005	29836	28702	28527	30048	28695	29021	28884	28725



Exceptions/Improvement/Actions

The Dudley Group

METRIC	SUMMARY
Workforce/ Finance triangulation	The chart below provide a summary of WTE (Actual vs Forecasted in Plan).



	WTE M1	WTE M2	WTE M3	WTE M4	WTE M5	WTE M6	WTE M7	WTE M8	WTE M9	WTE M10	WTE M11	
Substantive Actual	5,552.85	5,557.71	5,568.03	5,571.37	5,593.83	5,624.33	5,663.98	5,684.84	5,667.89	5,679.61	5,688.81	5680.24
Bank Actual	656.21	625.82	596.15	650.47	644.02	627.81	615.87	596.94	597.87	661.21	661.44	597.44
Agency Actual	19.74	15.37	25.68	22.33	20.10	24.59	22.52	23.98	17.27	12.89	15.89	12.27
Total Pay Actual	6,271.10	6,244.29	6,237.05	6,288.77	6,303.95	6,324.89	6,356.46	6,344.71	6,314.79	6,381.33	6,391.75	6,289.95
Substantive Plan	5,608.00	5,667.48	5,674.48	5,727.48	5,734.48	5,753.48	5,770.94	5,768.94	5,785.94	5,795.94	5,793.94	5,811.74
Bank Plan	639.30	618.90	597.80	586.00	573.90	553.50	559.20	558.20	533.10	532.10	526.10	506.00
Agency Plan	18.70	18.00	18.00	12.00	12.00	12.00	6.60	6.60	6.60	3.60	3.60	3.60
Total Pay Plan	6,266.00	6,304.38	6,290.28	6,325.48	6,320.38	6,318.98	6,336.74	6,333.74	6,325.64	6,331.64	6,323.64	6,321.34

Exceptions/Improvement/Actions

NHS
The Dudley Group

METRIC	SUMMARY
Workforce/ Finance triangulation	The chart below provide a summary of WTE (Actual vs Forecasted in Plan).

Finance - Pay Expenditure 23/24 (Actual vs Planned):

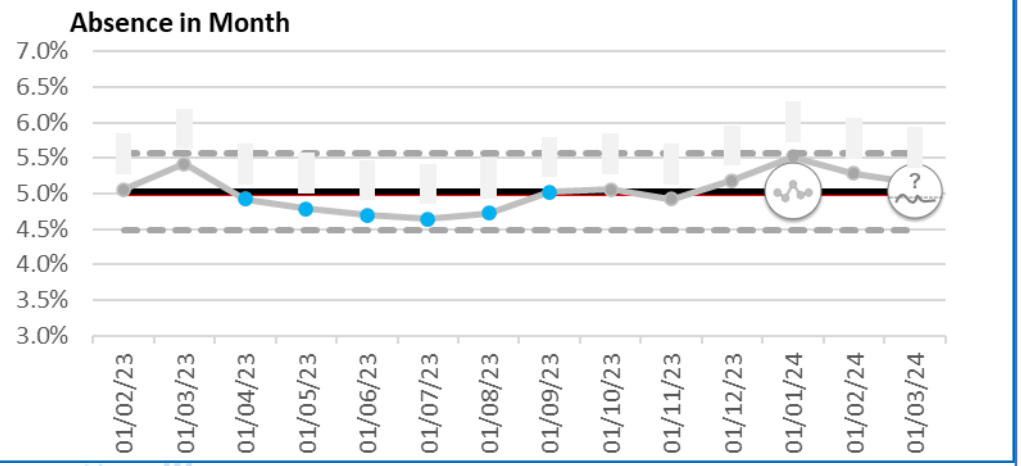
Item Description	M1 £'000	M2 £'000	M3 £'000	M4 £'000	M5 £'000	M6 £'000	M7 £'000	M8 £'000	M9 £'000	M10 £'000	M11 £'000	M12 £'000	YTD £'000	Variance YTD
Substantive Plan	23709	23790	25430	24540	25699	24878	24960	22160	24614	24642	24634	24638	293694	
Substantive Actual	22917	25185	23635	23559	25138	23661	24493	24356	24443	25006	24536	37152	304081	10387
Bank Plan	3405	3746	3915	3352	3326	3573	3334	7655	3850	4193	4064	3901	48314	
Bank Actual	4282	3920	3987	4395	4344	4010	4124	3744	3973	4470	4282	4769	50300	1986
Agency Plan	141	136	135	113	811	251	233	233	231	186	186	186	2842	
Agency Actual	258	181	308	278	269	331	268	218	240	218	252	250	3071	229
Total Pay Plan	27255	27672	29480	28005	29836	28702	28527	30048	28695	29021	28884	4	316129	
Total Pay Actual	27457	29286	27930	28232	29751	28002	28885	28318	28656	29694	29070	42171	357452	41323

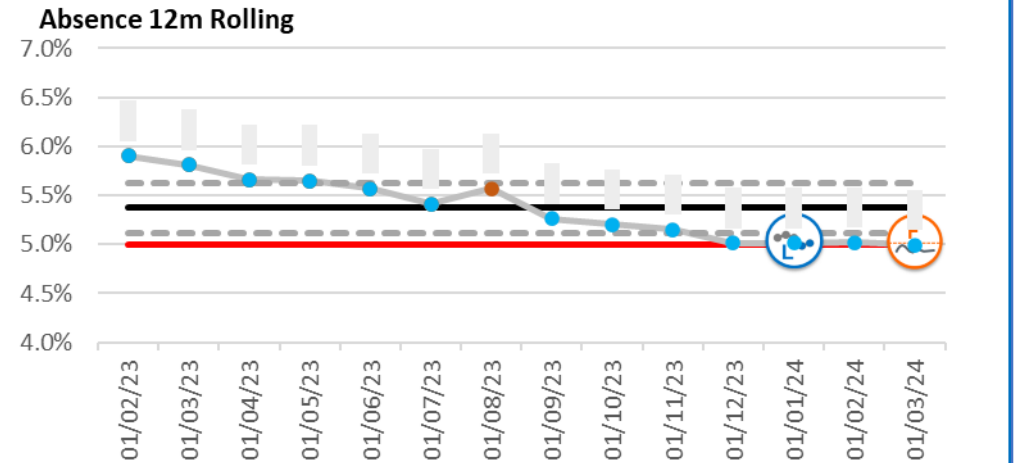
Workforce Plan 23/24 (Actual vs Planned):

Item Description	M1 WTE	M2 WTE	M3 WTE	M4 WTE	M5 WTE	M6 WTE	M7 WTE	M8 WTE	M9 WTE	M10 WTE	M11 WTE	M12 WTE
Substantive Plan	5,608.00	5,667.48	5,674.48	5,727.48	5,734.48	5,753.48	5,770.94	5,768.94	5,785.94	5,795.94	5,793.94	5,811.74
Substantive Actual	5,552.85	5,557.71	5,568.03	5,571.37	5,593.83	5,624.33	5,663.98	5,684.84	5,667.89	5,679.61	5,688.81	5680.24
Bank Plan	639.30	618.90	597.80	586.00	573.90	553.50	559.20	558.20	533.10	532.10	526.10	506.00
Bank Actual	656.21	625.82	596.15	650.47	644.02	627.81	615.87	596.94	597.87	661.21	661.44	597.44
Agency Plan	18.70	18.00	18.00	12.00	12.00	12.00	6.60	6.60	6.60	3.60	3.60	3.60
Agency Actual	19.74	15.37	25.68	22.33	20.10	24.59	22.52	23.98	17.27	12.89	15.89	12.27
Total Pay Plan	6,266.00	6,304.38	6,290.28	6,325.48	6,320.38	6,318.98	6,336.74	6,333.74	6,325.64	6,331.64	6,323.64	6,321.34
Total Pay Actual	6,271.10	6,244.29	6,237.05	6,288.77	6,303.95	6,324.89	6,356.46	6,344.71	6,314.79	6,381.33	6,391.75	6,289.95

Sickness Absence

The Dudley Group NHS Foundation Trust





In-Month Sickness Absence

In-month sickness absence for March 2024 is 5.16%, a decrease from 5.28% in February 2024.

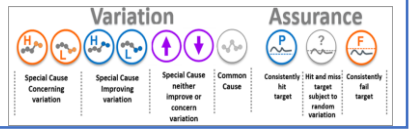
Rolling 12 M Sickness Absence

The rolling 12-month absence has decreased slightly to 4.99% in March 2024 from 5.02% in February 2024. Across the last 12 months this has been reducing but has levelled out over the last 3 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:

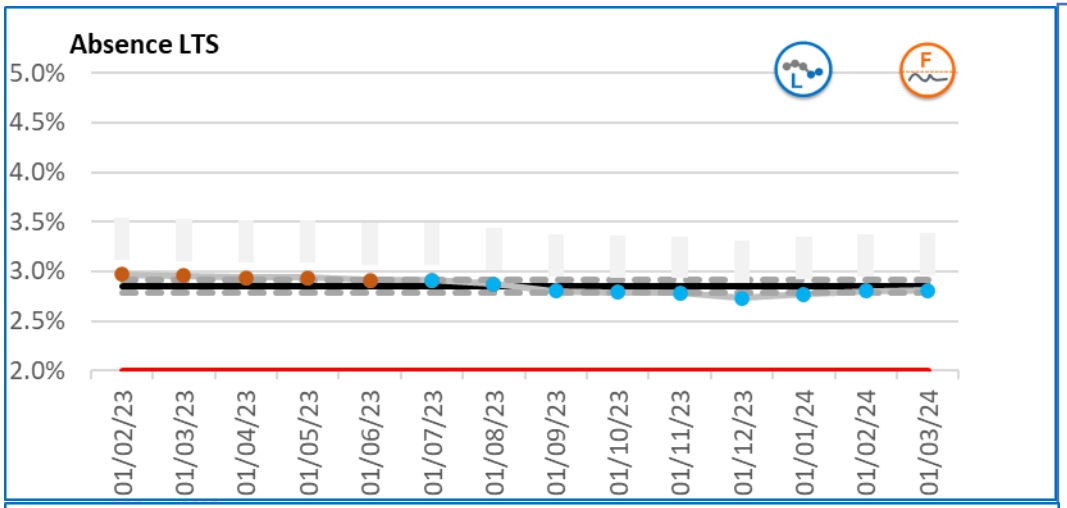


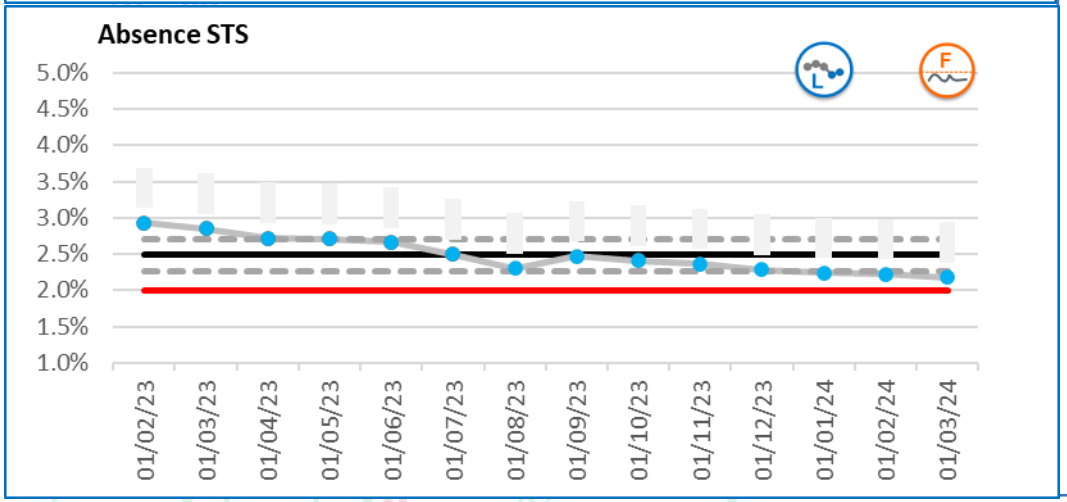
	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Absence in Month	4.92%	4.79%	4.69%	4.64%	4.72%	5.02%	5.06%	4.92%	5.18%	5.52%	5.28%	5.16%
Absence 12m Rolling	5.66%	5.65%	5.57%	5.41%	5.57%	5.26%	5.20%	5.15%	5.01%	5.01%	5.02%	4.99%

CARE RESPECT RESPONSIBILITY

Long-Term and Short-Term Absence

The Dudley Group NHS Foundation Trust





Long-Term and Short-Term Sickness Absence

In March 2024 long-term absence has marginally increased to 2.81% from 2.80% in February 2024. There has been a small decrease in short-term absence from 2.22% in February 2024 to 2.18% in March 2024.

In March 2024 short-term absence accounted for 84% of all sickness absence episodes, with long-term absence (28 days +) accounting for 16% of absence episodes. Long-term absence accounted for 51% of all FTE days lost, compared to 49% for short-term absence.

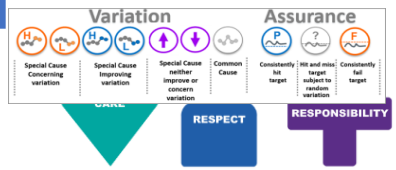
As at 31 March 2024 there were 94 long-term absences open across the Trust.
81 cases are between 28 days and 6 months
9 cases between 6 months and 12 months
4 cases over 12 months in length

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.

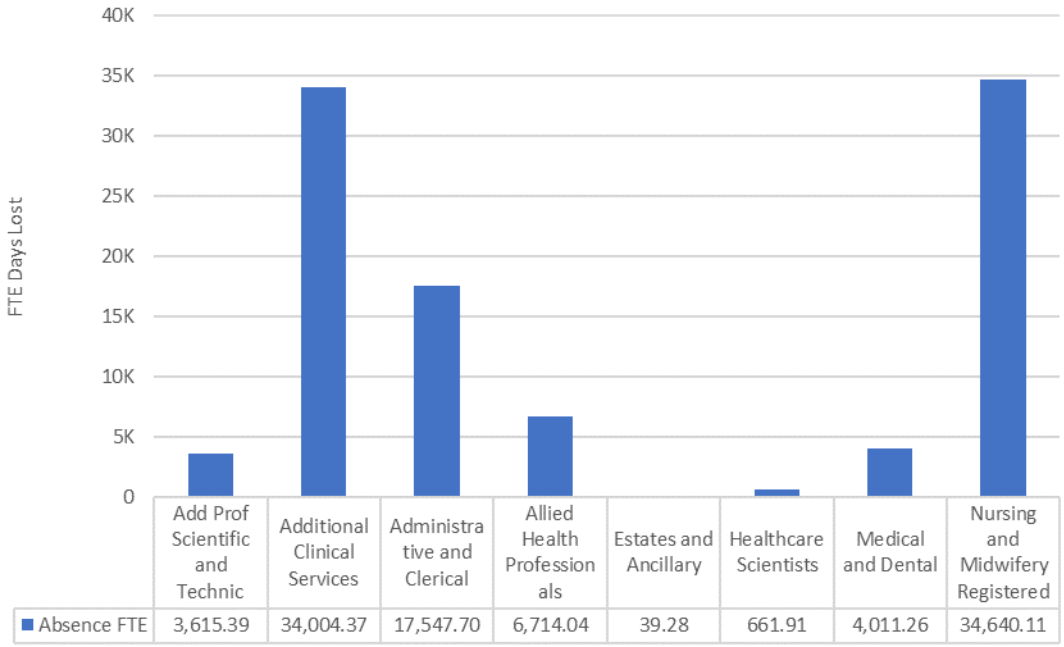
Short-term absence is currently the key focus.

	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Absence LTS	2.94%	2.94%	2.91%	2.91%	2.87%	2.80%	2.79%	2.78%	2.73%	2.77%	2.80%	2.81%
Absence STS	2.72%	2.71%	2.66%	2.50%	2.30%	2.47%	2.41%	2.36%	2.28%	2.24%	2.22%	2.18%



Sickness Absence - Staff Groups

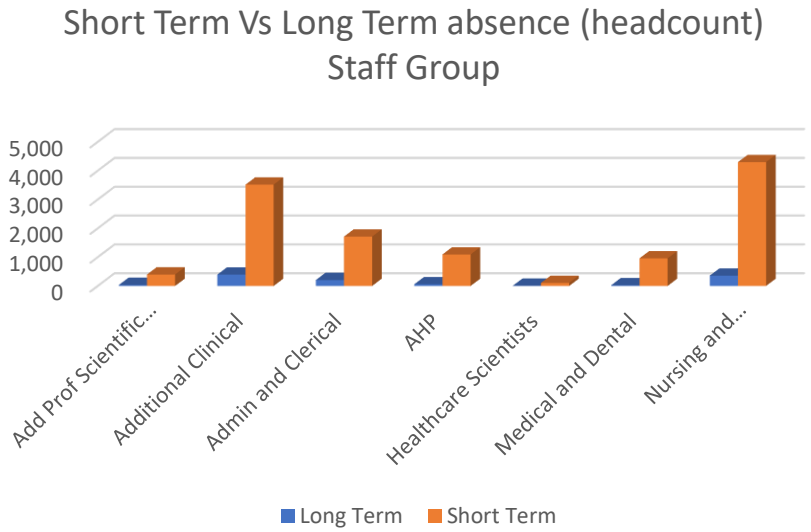
The Dudley Group NHS Foundation Trust



Year-to-date Nursing and Midwifery and Additional Clinical Services have lost the most FTE days as a result of sickness absence.

Nursing and Midwifery and Additional Clinical services lost the most FTE days to both long-term and short-term sickness absence.

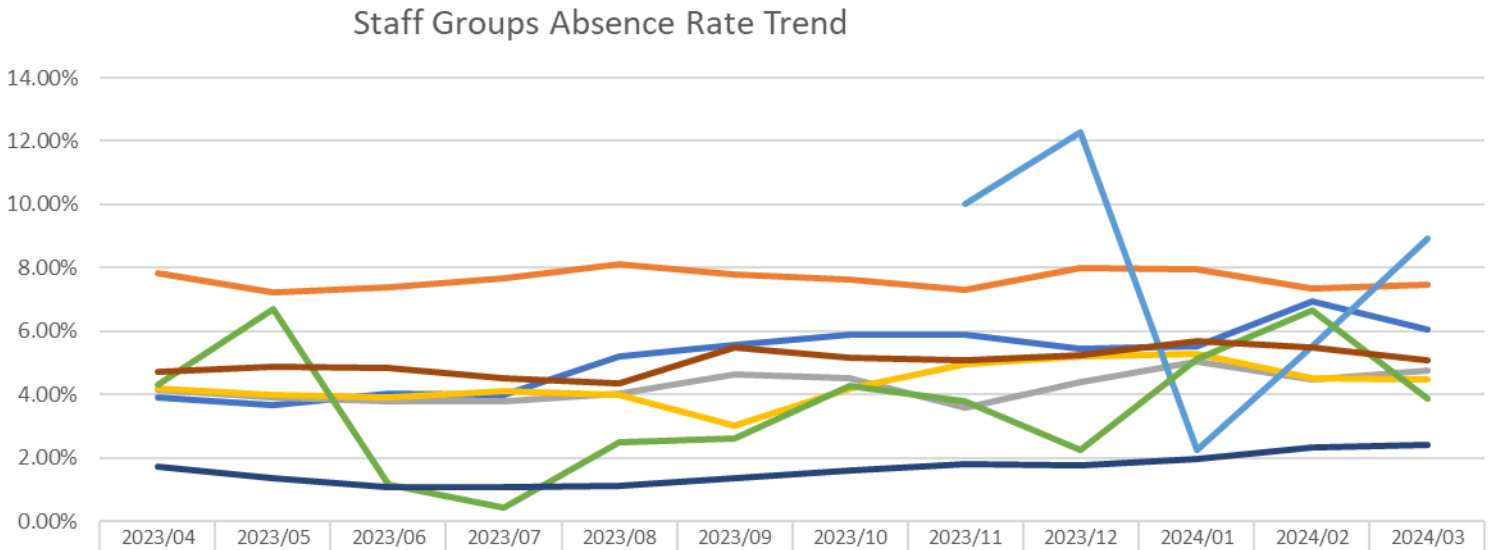
Admin and Clerical and AHP's are the staff groups with the next highest short-term sickness episodes. Whereas AHP's and Additional Professional Scientific and Technical are the next highest in terms of long-term absence episodes.



CARE RESPECT RESPONSIBILITY

Sickness Absence - Staff Groups

The Dudley Group NHS Foundation Trust



	2023/04	2023/05	2023/06	2023/07	2023/08	2023/09	2023/10	2023/11	2023/12	2024/01	2024/02	2024/03
Add Prof Scientific and Technic	3.93%	3.68%	4.03%	3.99%	5.19%	5.59%	5.91%	5.90%	5.44%	5.55%	6.94%	6.07%
Additional Clinical Services	7.82%	7.23%	7.38%	7.66%	8.13%	7.78%	7.65%	7.29%	8.01%	7.94%	7.37%	7.46%
Administrative and Clerical	4.14%	3.91%	3.80%	3.81%	4.03%	4.63%	4.52%	3.61%	4.41%	5.05%	4.47%	4.77%
Allied Health Professionals	4.21%	4.00%	3.91%	4.13%	3.98%	3.01%	4.20%	4.96%	5.21%	5.30%	4.52%	4.46%
Estates and Ancillary								10.00%	12.28%	2.28%	5.52%	8.93%
Healthcare Scientists	4.30%	6.71%	1.17%	0.42%	2.51%	2.62%	4.27%	3.78%	2.24%	5.14%	6.68%	3.89%
Medical and Dental	1.75%	1.35%	1.09%	1.07%	1.14%	1.35%	1.62%	1.79%	1.76%	1.98%	2.33%	2.41%
Nursing and Midwifery Registered	4.72%	4.89%	4.85%	4.53%	4.37%	5.50%	5.18%	5.09%	5.25%	5.70%	5.49%	5.08%

Estates and Ancillary appears to be the staff group with the highest percentage of absence. Nursing and Midwifery is the second highest.

Medical and Dental, Additional Clinical and Admin and Clerical have all increased in their percentage in March. Medical and Dental shows an increasing trajectory in absence percentage across the year.

CARE RESPECT RESPONSIBILITY

Sickness Absence

The Dudley Group NHS Foundation Trust

Top 10 Departments By Time Lost (March)

Department	Absence FTE	Available FTE	Absence FTE %
253 Pharmacy Department Serv	443.87	5,053.44	8.78%
253 Critical Care Serv	326.11	4,203.89	7.76%
253 Maternity Unit Serv	287.58	6,334.77	4.54%
253 Pathology - Phlebotomy Serv	255.48	1,825.01	14.00%
253 Therapy Department Serv	228.59	4,381.69	5.22%
253 Emergency Dept Nursing Serv	206.16	3,672.56	5.61%
253 Ward B4 Serv	176.92	2,374.32	7.45%
253 Imaging - Radiographic Aides Serv	159.93	1,539.95	10.39%
253 Ward B3 Serv	147.76	1,808.00	8.17%
253 Ward C5 Area A Serv	144.76	1,198.00	12.08%

Top 10 Departments By Absence Rate (March)

Department	Absence FTE	Available FTE	Absence FTE %
253 IBD Nurses Serv	26.45	83.91	31.53%
253 Community OPAT Service Serv	91.40	312.48	29.25%
253 Med Secs - GI Serv	60.64	221.96	27.32%
253 Infection Control Serv	82.24	345.96	23.77%
253 HR Learning & Development Serv	95.80	419.95	22.81%
253 Leg Ulcer Service Adult DN Serv	55.96	279.41	20.03%
253 Frailty Assessment Unit Serv	64.76	390.60	16.58%
253 Med Secs - Older People Serv	28.93	174.84	16.55%
253 Health In Pregnancy Support Serv	32.20	198.40	16.23%
253 Ambulatory Neurology CNS Serv	10.00	62.00	16.13%

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

Absence Reason	Headcount	Abs Occurrences	FTE Days Lost	%
S10 Anxiety/stress/depression/other psychiatric illnesses	718	961	22,810.84	22.5
S12 Other musculoskeletal problems	539	644	9,990.87	9.9
S13 Cold, Cough, Flu - Influenza	2193	2,854	9,775.51	9.7
S25 Gastrointestinal problems	1981	2,663	9,183.70	9.1
S28 Injury, fracture	213	231	5,348.51	5.3
S30 Pregnancy related disorders	267	732	5,200.89	5.1
S99 Unknown causes / Not specified	577	697	5,183.11	5.1
S26 Genitourinary & gynaecological disorders	347	439	4,454.84	4.4
S27 Infectious diseases	587	620	3,571.51	3.5
S11 Back Problems	286	334	3,534.99	3.5

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

Absence Reason	Headcount	Abs Occurrences	Abs Days	Abs Estimated Cost	%
S10 Anxiety/stress/depression/other psychiatric illnesses	718	961	27,505	£2,284,423.82	23.2
S12 Other musculoskeletal problems	539	644	11,917	£874,608.67	10.0
S13 Cold, Cough, Flu - Influenza	2193	2,854	11,056	£1,065,212.05	9.3
S25 Gastrointestinal problems	1981	2,663	10,475	£891,785.90	8.8
S28 Injury, fracture	213	231	6,269	£620,514.59	5.3
S99 Unknown causes / Not specified	577	697	6,071	£542,686.77	5.1
S30 Pregnancy related disorders	267	732	5,865	£513,797.28	4.9
S26 Genitourinary & gynaecological disorders	347	439	5,369	£387,408.08	4.5
S11 Back Problems	286	334	4,354	£340,701.06	3.7
S27 Infectious diseases	587	620	4,175	£362,466.69	3.5

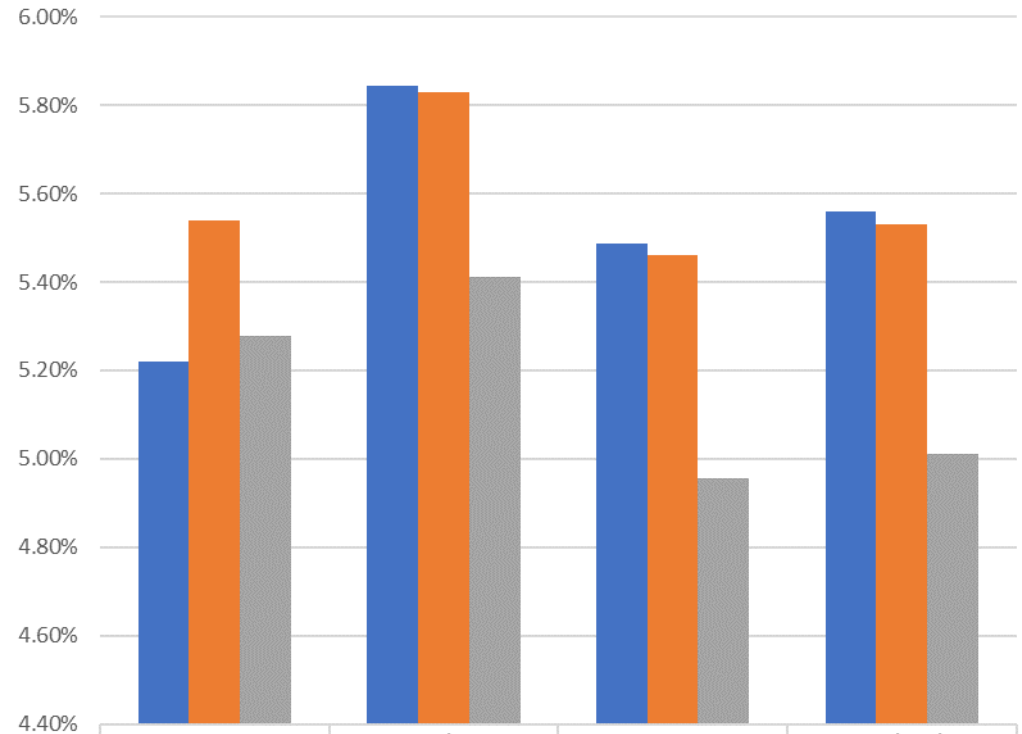
Absence Reasons

- 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
MO9	5.22%	5.84%	5.49%	5.56%
MO10	5.54%	5.83%	5.46%	5.53%
MO11	5.28%	5.41%	4.96%	5.01%

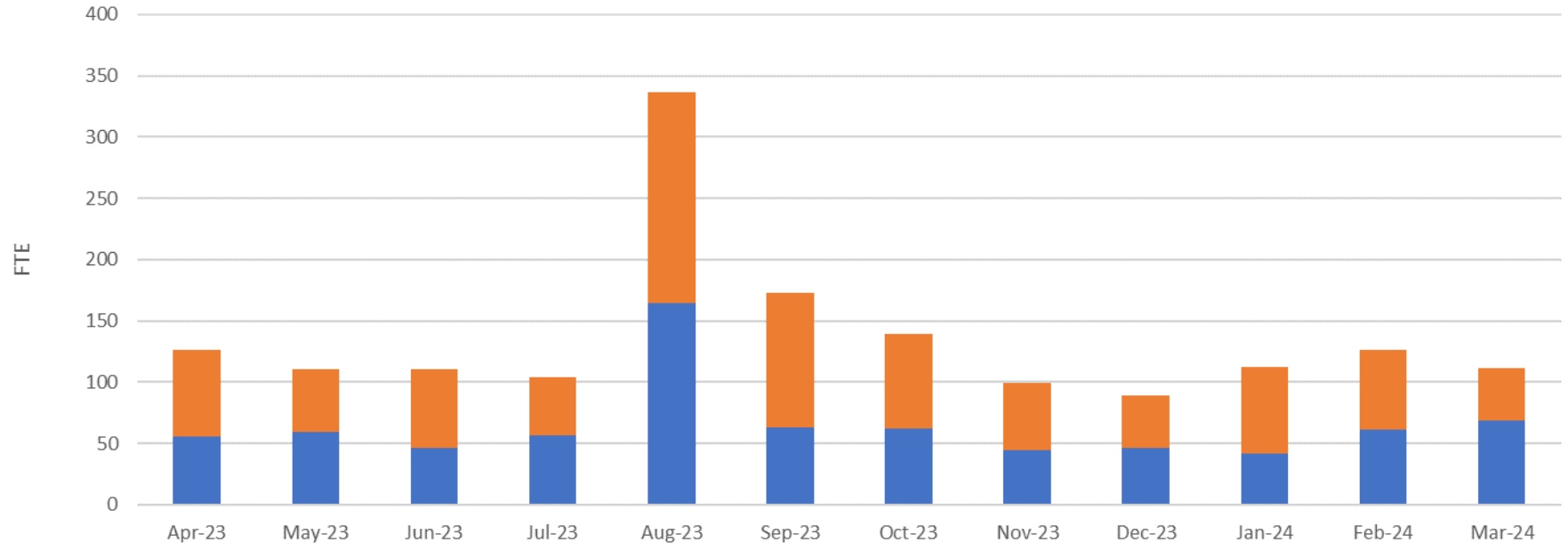
Benchmarking

- National and Regional benchmarking data is only available until end of February 2024
- Due to local differences in timeframes and methods used for recording sickness absences, national and regional comparative data is subject to change. DGFT absence includes COVID related absences and is refreshed each month twelve months in arrears.
- In February 2024 (M10), the Trust's sickness absence rate was lower than the regional Sickness absence benchmarking data but higher than National and England (Country) Sickness Absence rates.

CARE RESPECT RESPONSIBILITY

Starters and Leavers

The Dudley Group NHS Foundation Trust



	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Starters FTE	70.64	50.29	63.5	47.56	172.18	109.84	76.71	54.58	43.14	70.67	65.39	43.48
Leavers FTE	55.66	59.79	46.58	56.66	164.49	62.96	62.53	44.71	46.14	42.08	60.87	68.38

Starters vs Leavers

- This month we have seen more leavers than starters in March 2024.

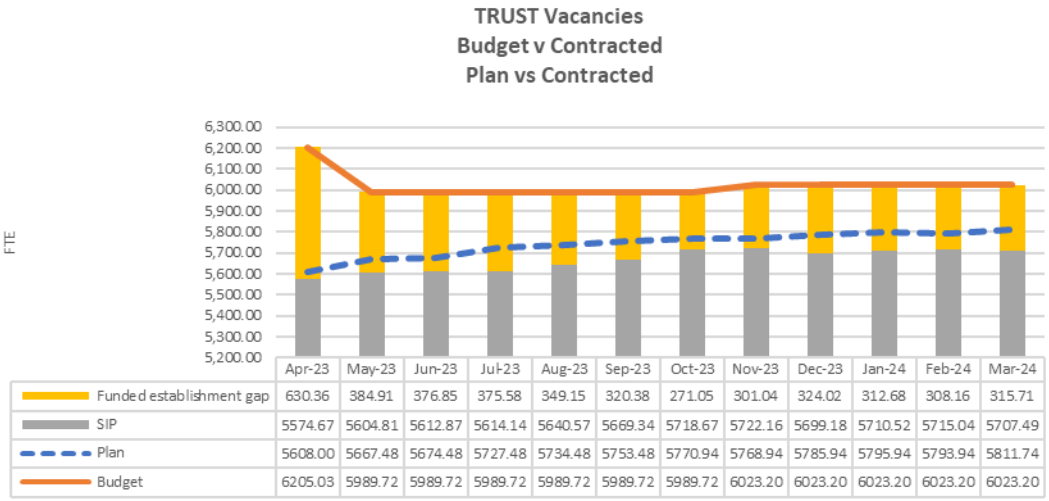
Assurance

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

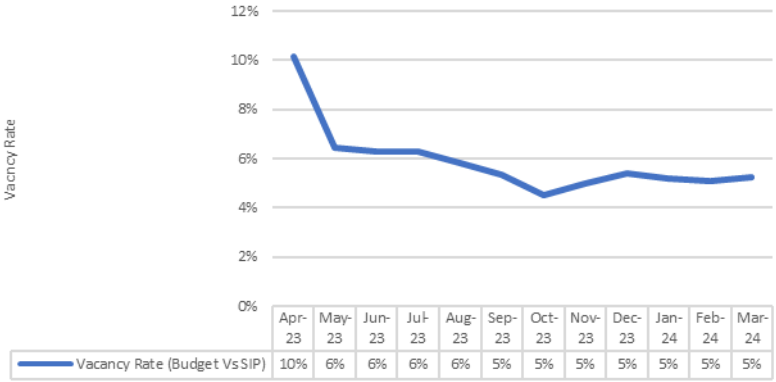
CARE RESPECT RESPONSIBILITY

Recruitment/Vacancies/Turnover - TRUST

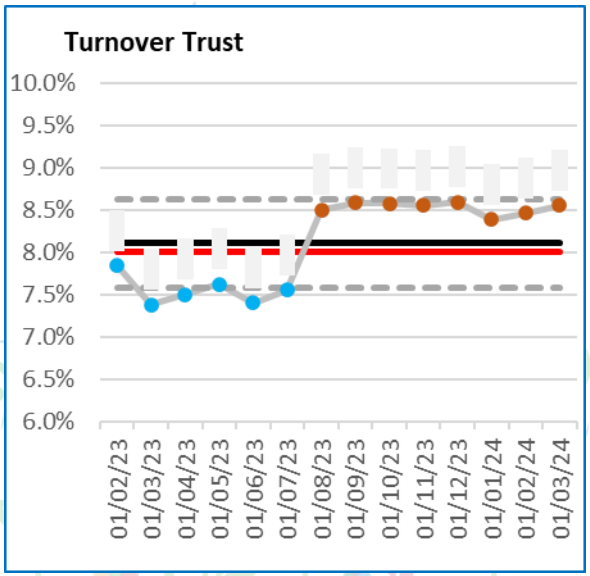
The Dudley Group NHS Foundation Trust

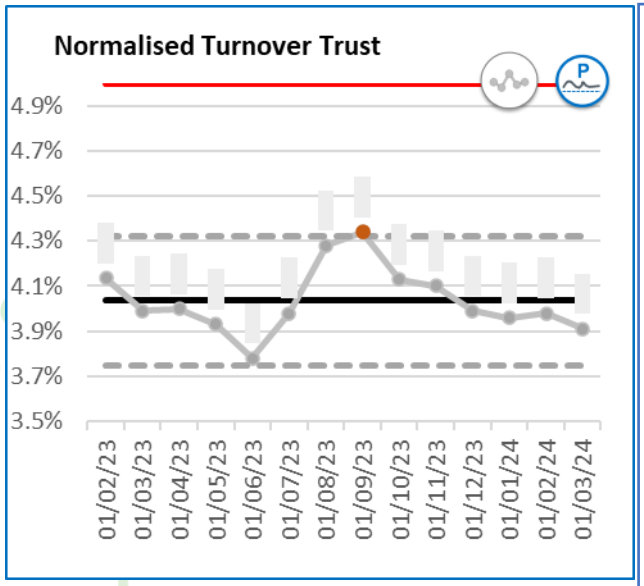


	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Funded establishment gap	630.36	384.91	376.85	375.58	349.15	320.38	271.05	301.04	324.02	312.68	308.16	315.71
SIP	5574.67	5604.81	5612.87	5614.14	5640.57	5669.34	5718.67	5722.16	5699.18	5710.52	5715.04	5707.49
Plan	5608.00	5667.48	5674.48	5727.48	5734.48	5753.48	5770.94	5768.94	5785.94	5795.94	5793.94	5811.74
Budget	6205.03	5989.72	5989.72	5989.72	5989.72	5989.72	5989.72	6023.20	6023.20	6023.20	6023.20	6023.20



	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)	10%	6%	6%	6%	6%	5%	5%	5%	5%	5%	5%	5%





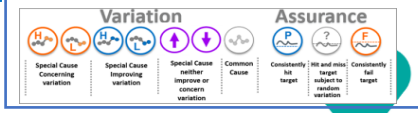
Contracted WTE staff has decreased from 5715.04 in February 2024 to 5707.49

For substantive staff this is 104.25 WTE under the workforce plan.

The total vacancies stands at 315.71 WTE in March 2024. This equates to a vacancy factor of 5%.

Overall staff turnover (rolling twelve months average) is at 8.46%, with normalised turnover at 3.98% in February 2024. Both of which are slight increases from January 2024.

	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Trust Turnover	7.50%	7.62%	7.40%	7.55%	8.50%	8.58%	8.57%	8.55%	8.59%	8.38%	8.46%	8.55%
Trust Normalised Turnover	4.00%	3.93%	3.78%	3.98%	4.28%	4.34%	4.13%	4.10%	3.99%	3.96%	3.98%	3.91%



RESPECT RESPONSIBILITY

Top 5 Departments - High Vacancies

The Dudley Group
NHS Foundation Trust

	Budget WTE	Contracted WTE	Vacancy WTE	Vacancy %
ED Nursing	150.74	116.99	33.75	22.39%
Ward AMU	61.06	46.88	14.18	23.22%
Medcial Staff Paediatrics	57.25	44.37	12.88	22.50%
Ward C3	64.5	52	12.5	19.38%
RHH Day Case Ward	38.12	27.3	10.82	28.38%

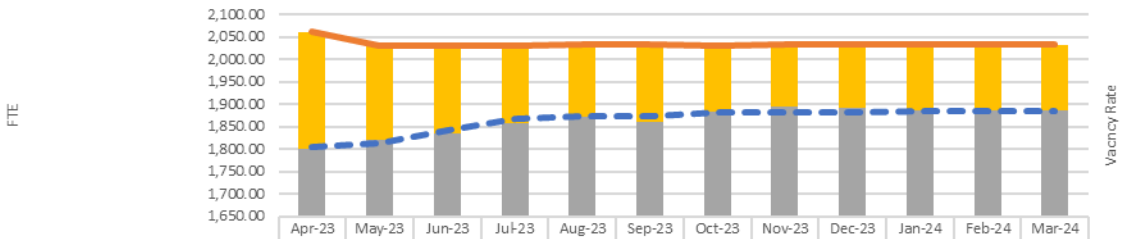
ED Nursing has the highest WTE vacancies in March 2024 with 33.75 WTE which equates to 22.39% vacancy rate.

CARE RESPECT RESPONSIBILITY

Recruitment/Vacancies/Turnover - Registered Nursing & Midwifery

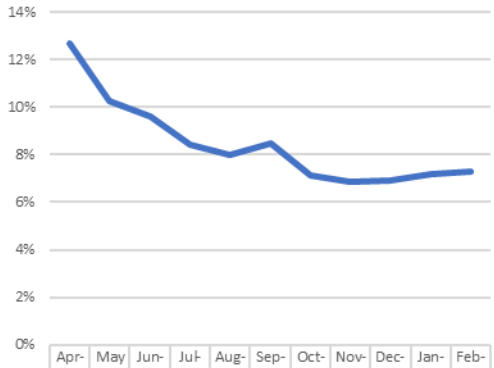
The Dudley Group NHS Foundation Trust

NURSING Vacancies Budget v Contracted Plan vs Contracted



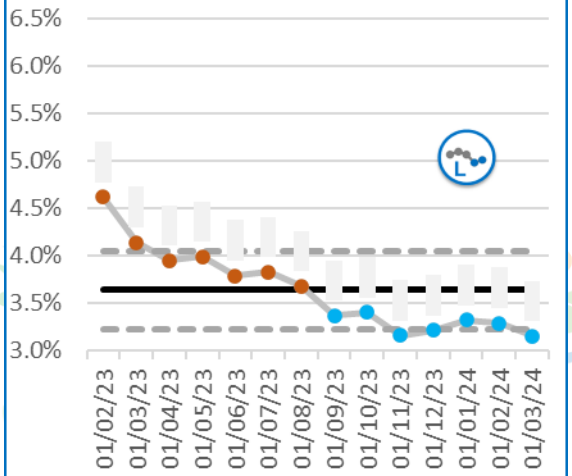
	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Funded establishment gap	261.76	208.15	195.27	171.28	162.46	172.35	145.19	139.78	140.19	146	148.29	147.84
SIP	1799.22	1821.39	1834.27	1858.26	1871.08	1860.19	1884.63	1893.32	1892.91	1887.1	1884.81	1885.26
Plan	1805.00	1813.00	1842.00	1867.00	1873.00	1874.00	1882.00	1883.00	1883.00	1885.00	1885.00	1885.00
Budget	2060.98	2029.54	2029.54	2029.54	2033.54	2032.54	2029.82	2033.10	2033.10	2033.10	2033.10	2033.10

NURSING Vacancy Rate (Budget Vs SIP)

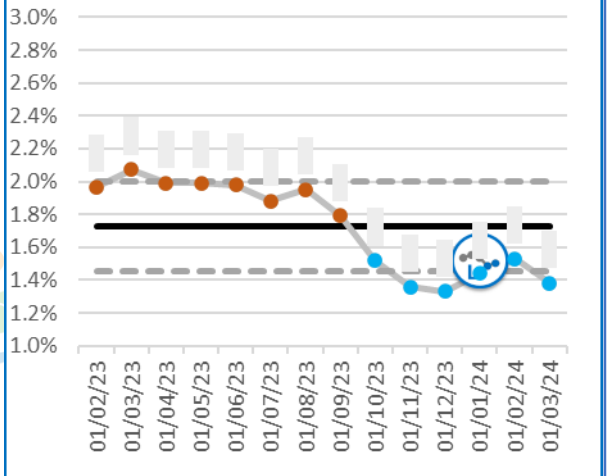


	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24
Vacancy Rate (Budget Vs SIP)	13%	10%	10%	8%	8%	8%	7%	7%	7%	7%	7%

Turnover Nursing



Normalised Turnover Nursing



	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Nursing Turnover	3.95%	3.99%	3.79%	3.83%	3.68%	3.37%	3.40%	3.16%	3.21%	3.32%	3.29%	3.15%
Nursing Normalised Turnover	1.99%	1.99%	1.98%	1.88%	1.95%	1.79%	1.52%	1.36%	1.33%	1.44%	1.53%	1.38%

Contracted WTE for nursing and midwifery staff has increased from 1884.81 in February 2024 to 1885.26 in March 2024.

This is 0.26 WTE above the workforce plan.

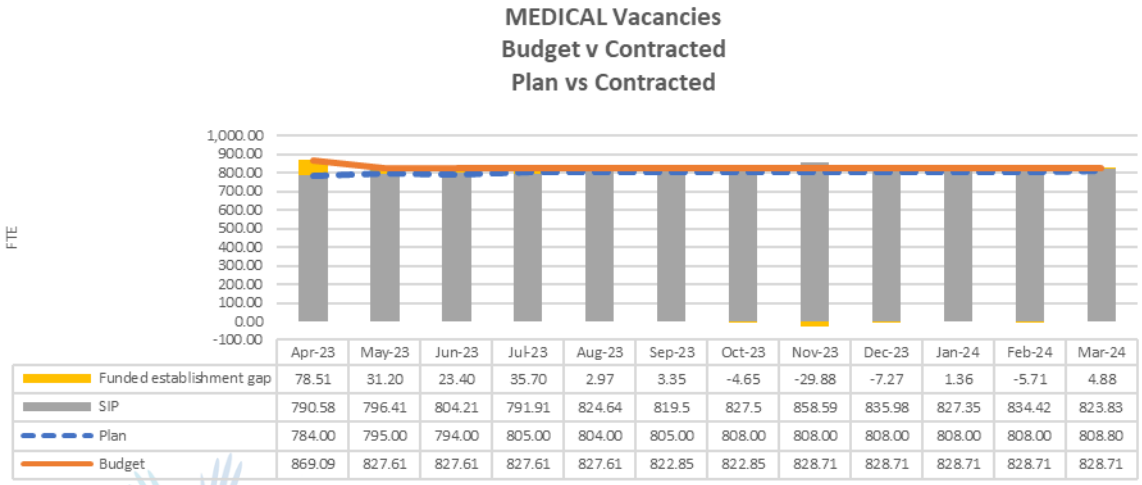
The total nursing and midwifery vacancies reported stands at 147.84 WTE, which equates to a vacancy rate of 7%.

Staff turnover for nursing (rolling 12 months average) is at 3.15%, with normalised turnover at 1.38% in March 2024. Both a decrease from the previous month.

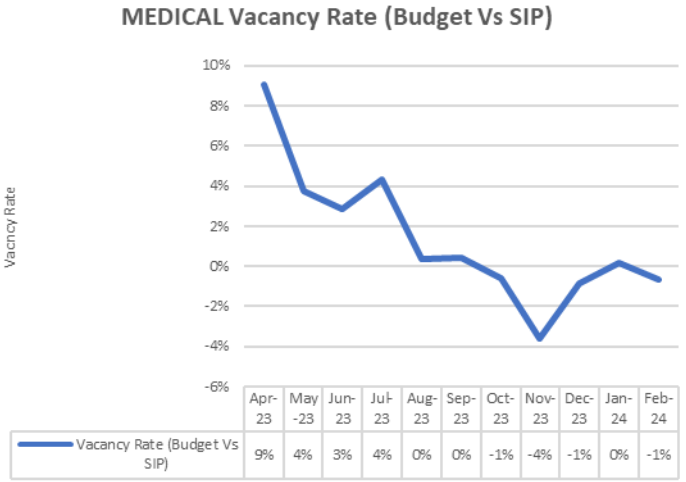
CARE RESPECT RESPONSIBILITY

Recruitment/Vacancies/Turnover - Medical & Dental

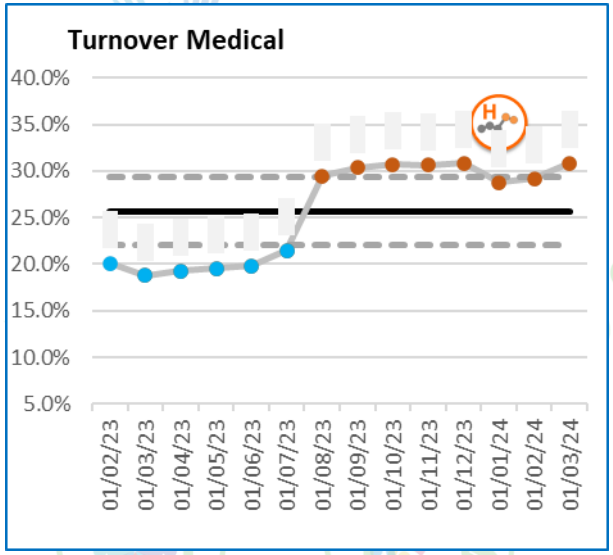
The Dudley Group NHS Foundation Trust

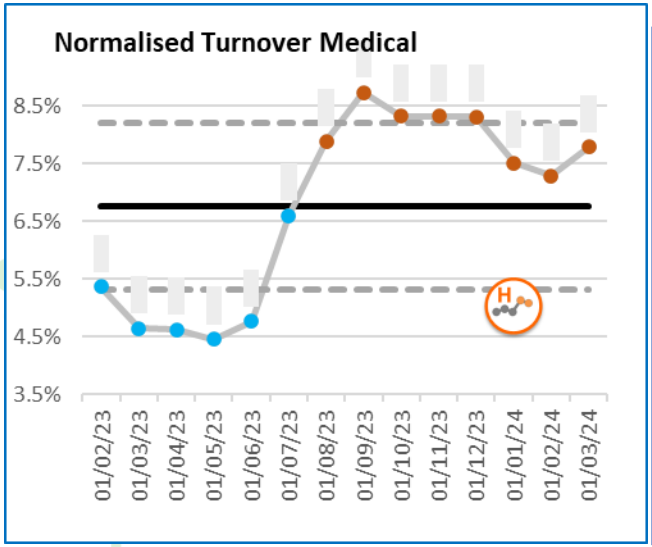


	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Funded establishment gap	78.51	31.20	23.40	35.70	2.97	3.35	-4.65	-29.88	-7.27	1.36	-5.71	4.88
SIP	790.58	796.41	804.21	791.91	824.64	819.5	827.5	858.59	835.98	827.35	834.42	823.83
Plan	784.00	795.00	794.00	805.00	804.00	805.00	808.00	808.00	808.00	808.00	808.00	808.80
Budget	869.09	827.61	827.61	827.61	827.61	822.85	822.85	828.71	828.71	828.71	828.71	828.71



	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)	9%	4%	3%	4%	0%	0%	-1%	-4%	-1%	0%	-1%



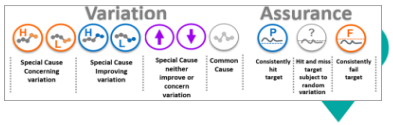


Contracted WTE for medical and dental staff has decreased from 834.42 in February 2024 to 823.83 WTE in March 2024.

The total medical and dental vacancies stands at 4.88 WTE. The vacancy rate is -1%

Staff turnover for medical and dental (rolling 12 months average) has increased to 30.86% in March 2024 from 29.19%. Normalised Turnover also increased from 7.29% in February 2024 to 7.78% in March 2024.

	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
M&D Turnover	19.28%	19.52%	19.82%	21.45%	29.45%	30.34%	30.71%	30.63%	30.82%	28.79%	29.19%	30.86%
M&D Normalised Turnover	4.62%	4.46%	4.76%	6.60%	7.89%	8.73%	8.32%	8.32%	8.31%	7.51%	7.29%	7.78%



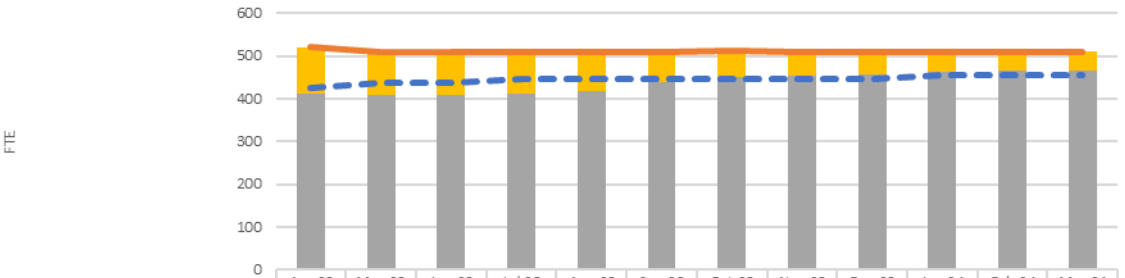
RESPECT

RESPONSIBILITY

Recruitment/Vacancies/Turnover - Allied Health Professional

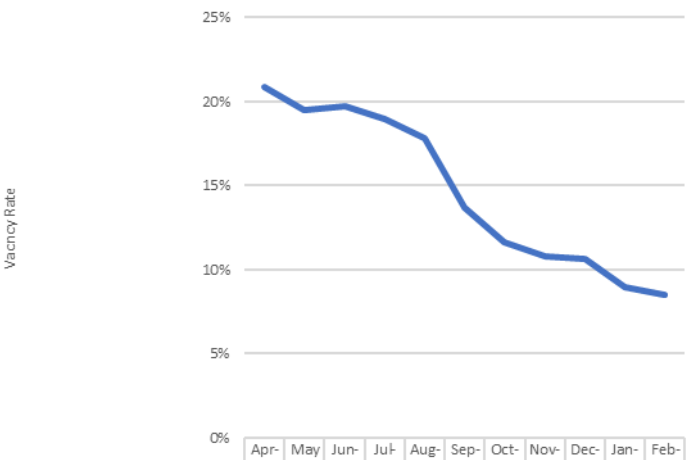
The Dudley Group NHS Foundation Trust

AHP Vacancies Budget v Contracted Plan vs Contracted



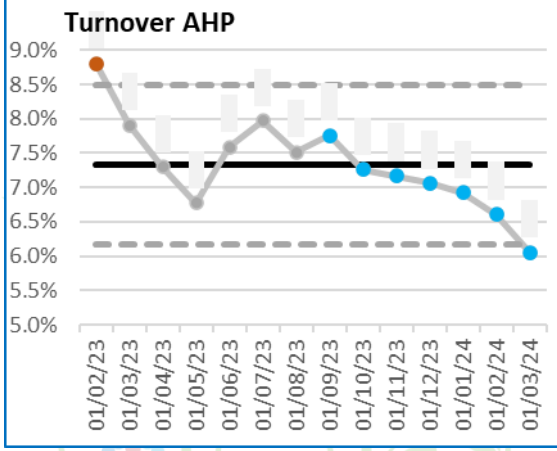
	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Funded establishment gap	108.64	99.19	100.27	96.58	90.43	69.64	59.35	55.06	54.21	45.77	43.28	43.12
SIP	412.38	409.49	408.41	412.1	418.25	439.04	452.05	454.49	455.34	463.78	466.27	466.43
Plan	424.00	437.38	437.38	445.38	445.38	446.38	447.38	447.38	447.38	456.38	456.38	456.38
Budget	521.02	508.68	508.68	508.68	508.68	508.68	511.40	509.55	509.55	509.55	509.55	509.55

AHP Vacancy Rate (Budget Vs SIP)

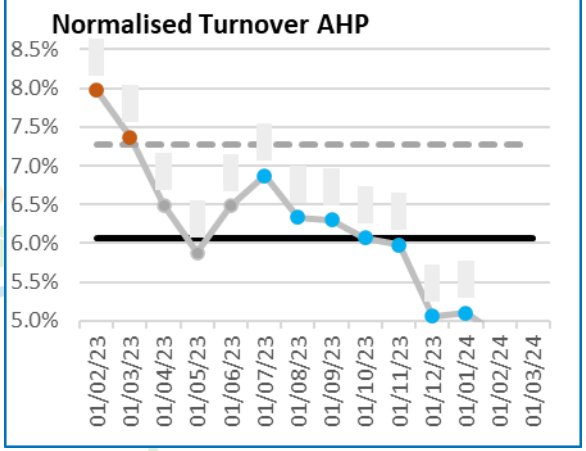


	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24
Vacancy Rate (Budget Vs SIP)	21%	19%	20%	19%	18%	14%	12%	11%	11%	9%	8%

Turnover AHP



Normalised Turnover AHP



Contracted WTE for AHP's has increased from 466.27 WTE in February 2024 to 466.43 in March 2024.

This is 10.05 WTE above the workforce plan.

The total AHP vacancies in February 2024 are 43.12 WTE, this equates to a vacancy factor of 8%.

Staff turnover for AHP's (rolling 12 months average) is at 6.05%, with normalised turnover at 4.12%, both a decrease from February 2024.

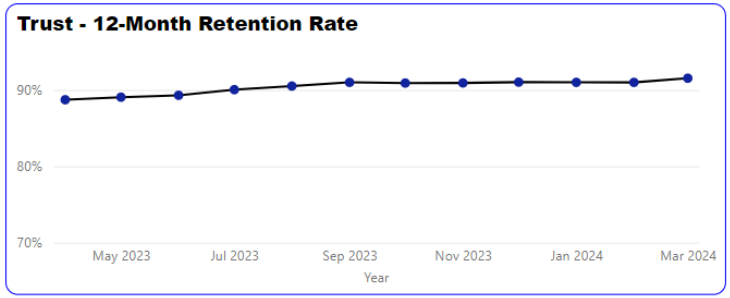
	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
AHP Turnover	7.30%	6.77%	7.59%	7.97%	7.51%	7.76%	7.26%	7.17%	7.06%	6.92%	6.61%	6.05%
AHP Normalised Turnover	6.49%	5.88%	6.48%	6.87%	6.33%	6.30%	6.07%	5.98%	5.06%	5.10%	4.81%	4.12%

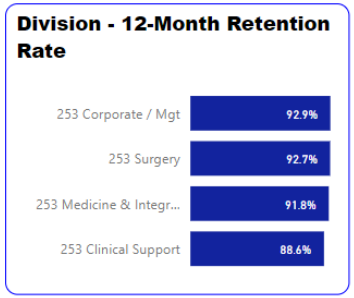
RESPECT

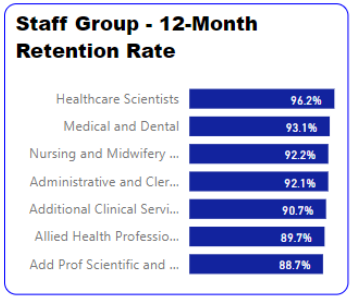
RESPONSIBILITY

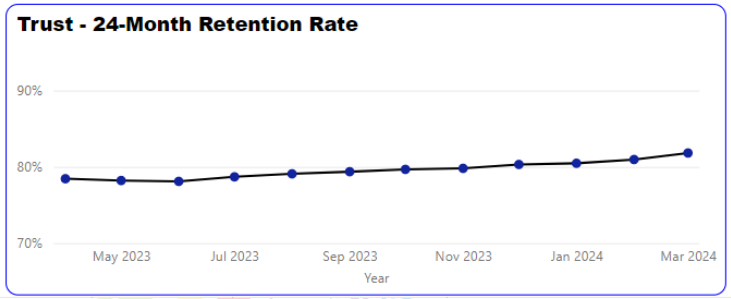
Retention

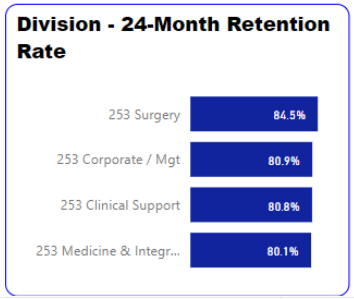
The Dudley Group
NHS Foundation Trust

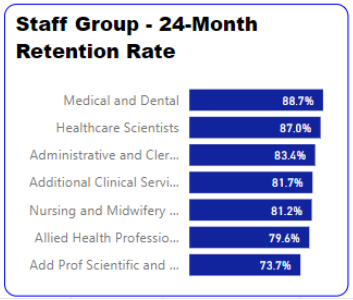












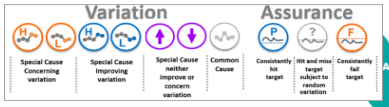
March 2024

12-Month	Trust 91.5%
24-Month	Trust 81.8%

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 has been since September 2023, the 24-month rate is showing an increasing trajectory.

The division with the lowest 24-month retention rate is Medicine at 80.1% but this is an improvement on the previous month ; both Additional Professional, Scientific and Technical staff and Allied Health Professionals are two staff groups that lower retention rates.

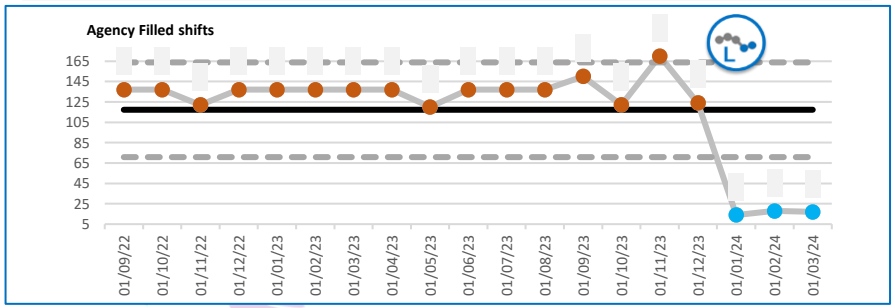


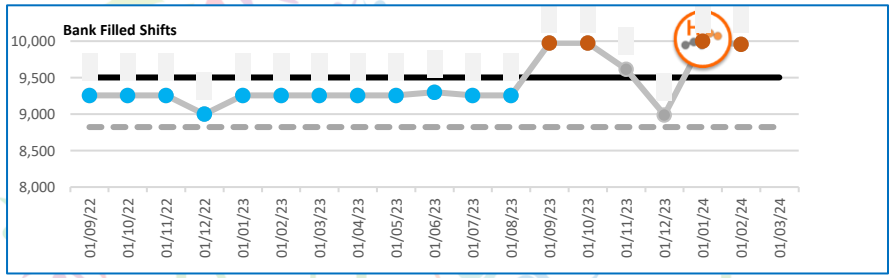
Bank and Agency Usage

The Dudley Group NHS Foundation Trust

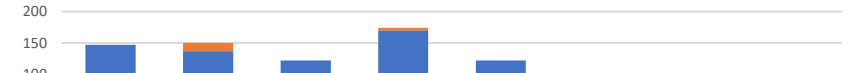
Bank v Agency (actual use) by Supplier Type

	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Bank	98.53%	98.43%	98.78%	98.26	98.64%	99.87%	99.82%	99.87%
Agency	1.47%	1.57%	1.22%	1.74%	1.36%	0.13%	0.18%	0.13%



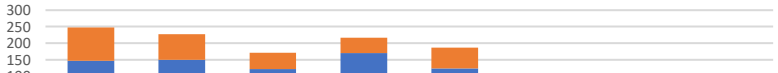


Agency use by Framework / Non-Framework Supply



	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
NFW		13		4	0	2	0	0
FW	147	137	122	170	122	12	18	17

Agency - Filled / Unfiled



	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Unfilled Shifts	101	77	49	47	63	0	0	0
Filled shifts	147	150	122	170	124	14	18	17

Bank - Filled / Unfiled

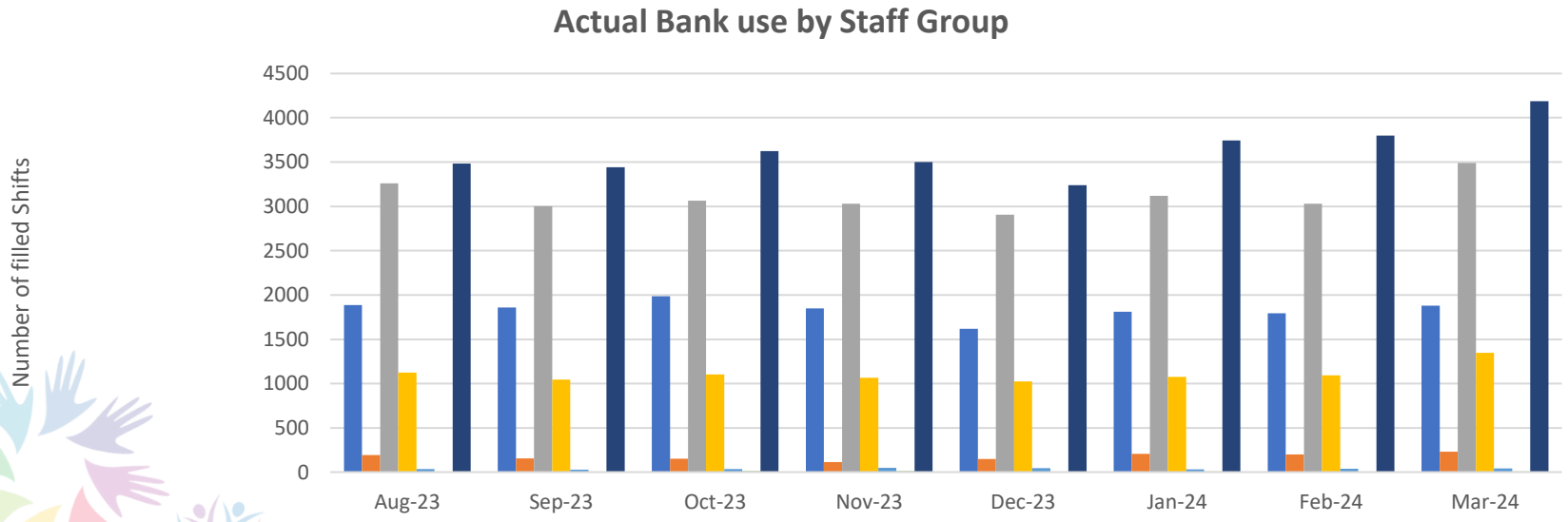
	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Unfilled Shifts	1967	1806	1528	1303	1695	1671	1506	1486
Filled Shifts	9845	9534	9975	9615	8988	9999	9958	11187

Agency remains minimal with 17 filled shifts during March 2024, a slight decrease by 1 shift compared with February 2024.
Bank fill rates were at an impressive 88% in March 2024. There were also more shifts requested via bank in March 2024 than February 2024.

CARE RESPECT RESPONSIBILITY

Bank Usage by Staff Group

The Dudley Group NHS Foundation Trust



	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
A&C	1888	1860	1985	1848	1619	1812	1793	1881
Add Prof Scientific and Technic	195	155	152	115	150	208	201	230
Additional Clinical Services	3259	3001	3065	3028	2907	3120	3028	3490
AHP	1125	1044	1103	1065	1024	1076	1094	1348
Healthcare Scientists	35	30	35	48	47	32	38	44
Medical & Dental	6	2	12	11	2	8	5	8
Nursing & Midwifery Registered	3484	3442	3623	3500	3239	3743	3799	4186

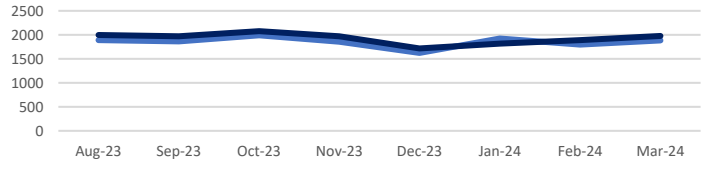
There was an increase in bank shifts across all staff groups during March 2024, the biggest increase was in additional clinical services.

CARE RESPECT RESPONSIBILITY

Bank Fill Rates

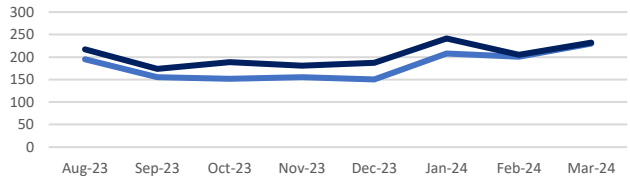
The Dudley Group NHS Foundation Trust

Bank A&C Filled / Requested



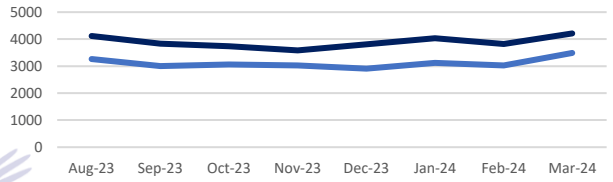
	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
A&C Filled	1888	1860	1985	1852	1619	1919	1793	1881
Total Request	1994	1965	2074	1971	1717	1812	1885	1977

Bank Add Prof Scientific and Technic Filled / Requested



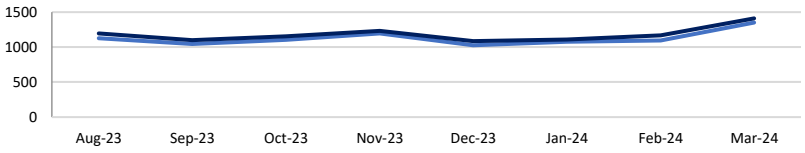
	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Add Prof Scientific and Technic Filled	195	155	152	155	150	208	201	230
Total Request	217	174	189	181	187	241	205	232

Additional Clinical Services Filled / Requested



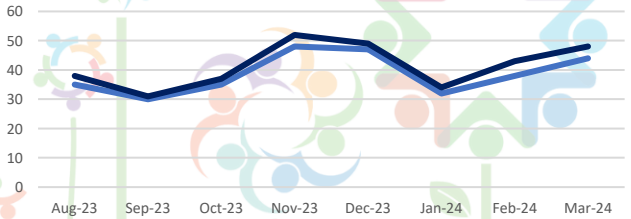
	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Additional Clinical Services Filled	3259	3001	3065	3028	2907	3120	3028	3490
Total Request	4116	3831	3733	3581	3812	4027	3819	4211

AHP - Filled / Requested



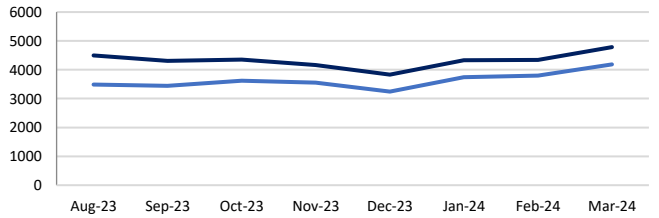
	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
AHP Filled	1125	1044	1103	1193	1024	1076	1094	1348
Total Request	1193	1100	1155	1231	1083	1109	1165	1410

Healthcare Scientists Filled / Requested



	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Healthcare Scientists Filled	35	30	35	48	47	32	38	44
Total Request	38	31	37	52	49	34	43	48

Registered Filled / Requested

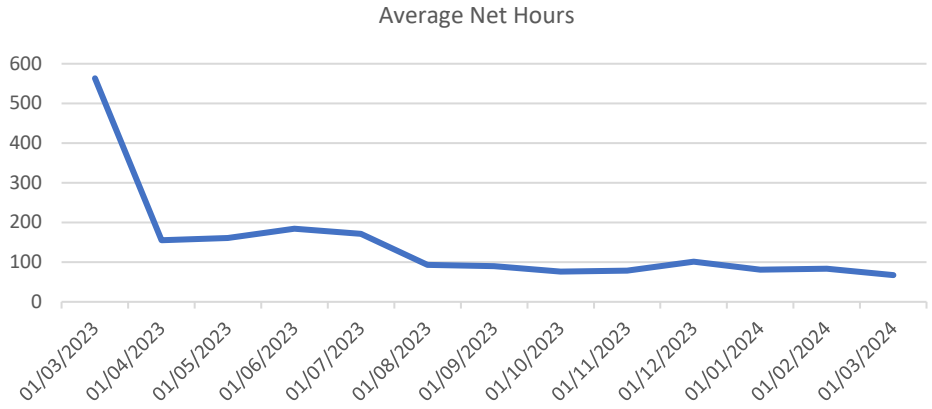


	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Nursing & Midwifery Registered Filled	3484	3442	3623	3550	3239	3743	3799	4186
Total Request	4493	4311	4349	4163	3832	4330	4342	4787

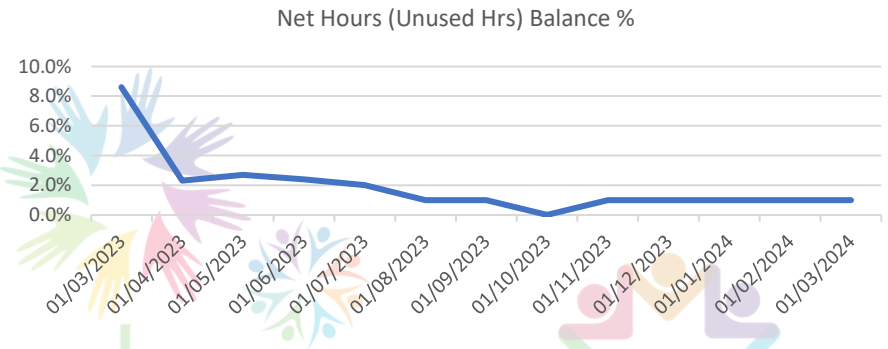
CARE RESPECT RESPONSIBILITY

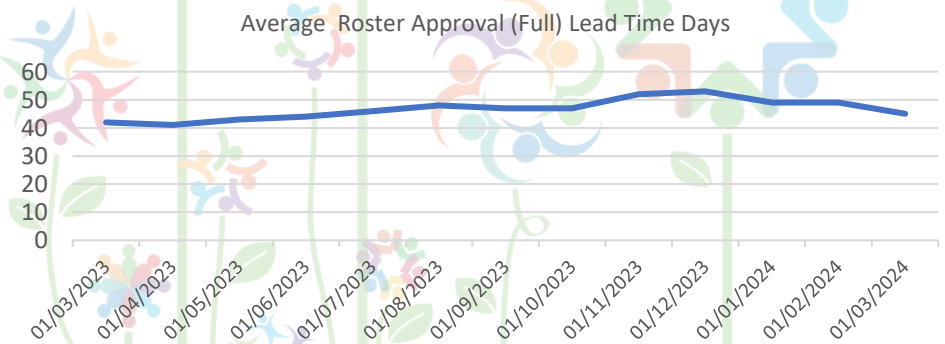
Rostering KPI

The Dudley Group
NHS Foundation Trust



Average net hours have been declining across the year. March 2024 saw a further reduction to less than 100 hours.



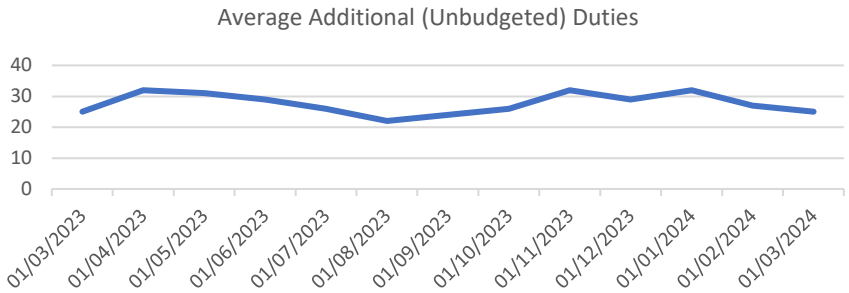


The average roster approval lead time in days fell below 50 days for the first time since November 2023. (Trust target 55 days).

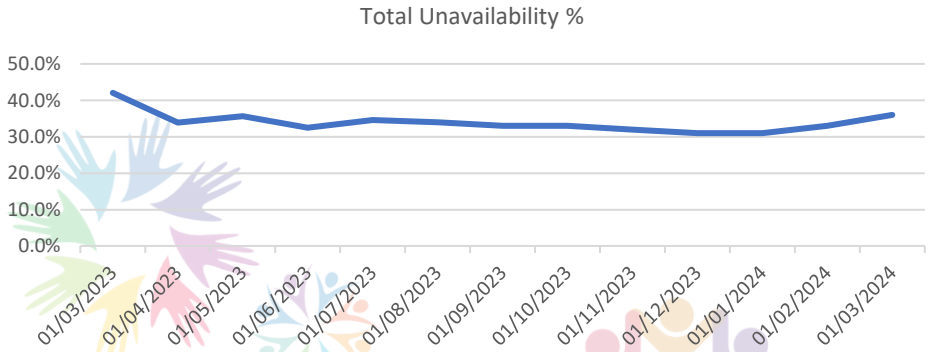
CARE RESPECT RESPONSIBILITY

Rostering KPI

The Dudley Group
NHS Foundation Trust



The average additional (unbudgeted) duties decreased over the last two months.

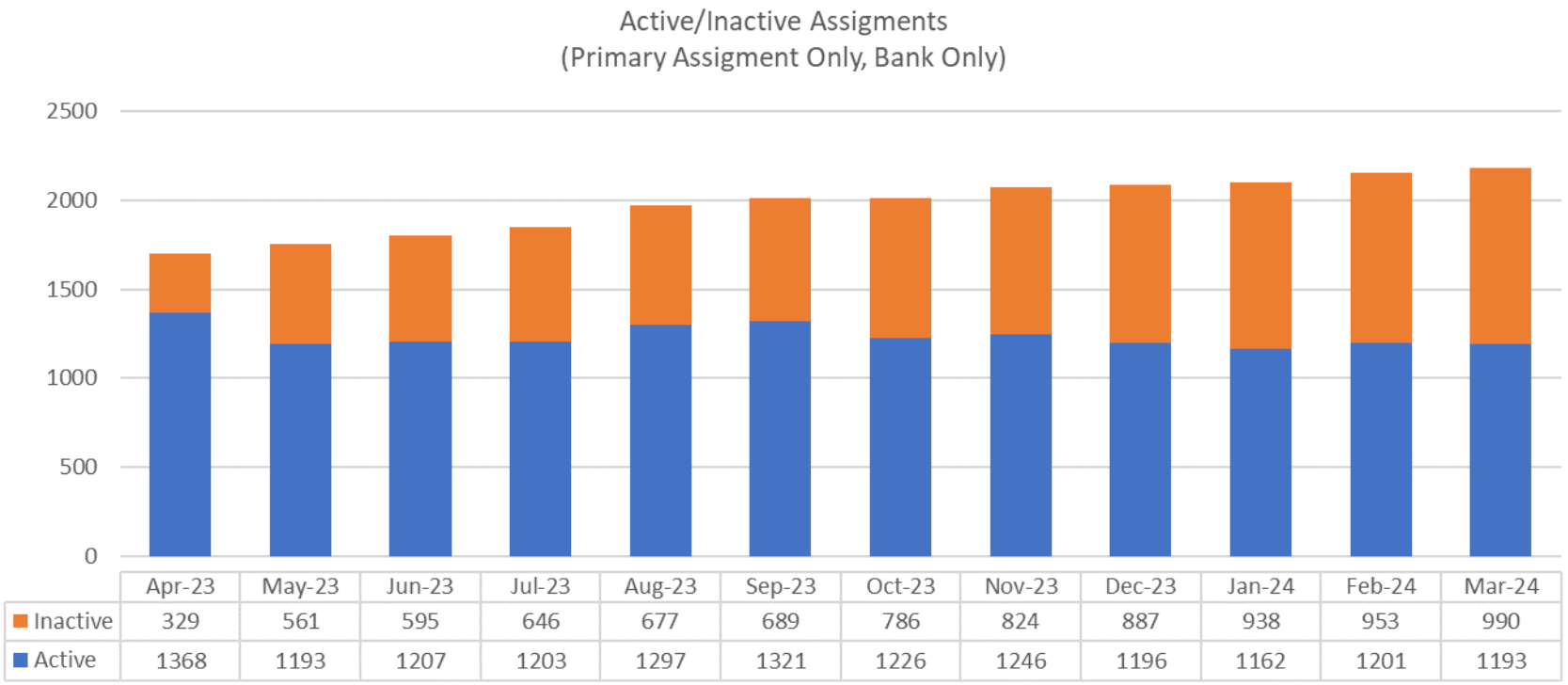


Total unavailability increased in March 2024, which would account for the increase in bank requests. Unavailability includes annual leave 19%, sickness 7%, parental leave 4%, other leave 1%, study leave 1% & working day leave 3%.

CARE RESPECT RESPONSIBILITY

Active / Inactive Assignments

The Dudley Group NHS Foundation Trust



	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Inactive	329	561	595	646	677	689	786	824	887	938	953	990
Active	1368	1193	1207	1203	1297	1321	1226	1246	1196	1162	1201	1193

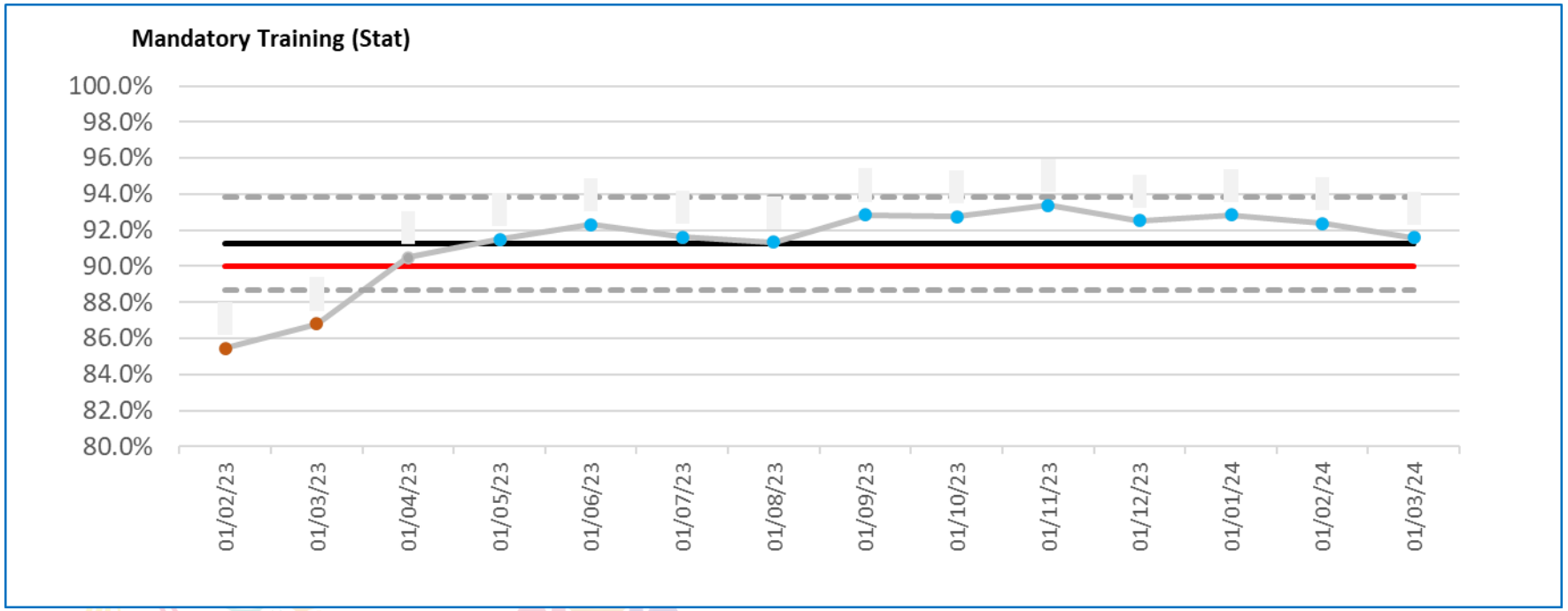
1193 bank assignments are recorded as inactive records as opposed to the 953 previously recorded as inactive (not worked in 17-week period).

The process by which to deregister inactive workers was delayed slightly during Q4, meaning and increase in inactive records. All inactive workers have now been written to and terminations should be complete by early May 2024 at the latest. An improvement should be seen next month.

CARE RESPECT RESPONSIBILITY

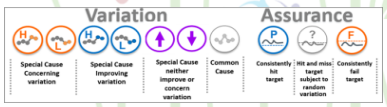
Mandatory Training

The Dudley Group
NHS Foundation Trust



Performance against target remains above 90% for the month. This is an ongoing sustained performance at above target since Q2 23/24. There has been an ongoing decline throughout the winter period. This is an expected seasonal trend.

	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Mandatory Training (Stat)	90.48%	91.48%	92.30%	91.63%	91.32%	92.86%	92.74%	93.38%	92.52%	92.85%	92.37%	91.59%



CARE RESPECT RESPONSIBILITY

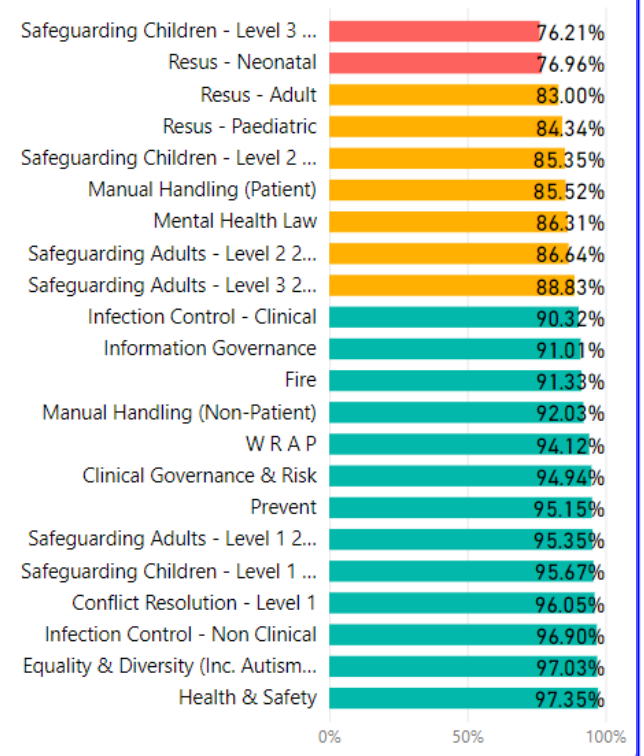
Mandatory Training – Priority 1

The Dudley Group
NHS Foundation Trust

Month: March 2024	Trust	CS	Corporate	MIC	Surgery
	91.59%	92.97%	94.56%	91.23%	90.33%

Course Compliance

Course Compliance (based on selections)



Depts by no. required to achieve 90%

Ward/Service (based selections)

Group5Description	Actual	No. >90%	%' tage
253 Medical Staff - Acute Medicine Serv	1,033	100	82.11%
253 General Surgery Medical Staff Serv	541	88	77.50%
253 Theatres Recovery & Anaesth Serv	588	78	79.56%
253 Medical Staff - GI Serv	204	60	69.62%
253 Medical Staff (Older People) Serv	244	59	72.61%
253 Medical Staff Cardiology Serv	233	57	72.36%
253 Urology Medical Staff Serv	173	53	68.92%
253 Ward C8 Serv	898	51	85.19%
253 Paediatric Medical Staff Serv	377	42	81.07%
253 Maternity Unit Serv	3,032	35	88.99%
253 Main Theatre Other Specialities Serv	446	31	84.15%
253 Maxillofacial Surgery Medical Staff Serv	70	31	62.50%
253 Medical Staff - Respiratory Serv	297	30	81.81%
253 Cardiology Clinical Measurement Serv	487	28	85.13%
253 MOC Medical Staff Serv	459	28	84.84%
253 Obs.and Gynae. Medical Staff Serv	455	28	84.88%
253 Med Staff (Clin Haematology) Serv	162	27	77.14%
253 Anaesthetics Medical Staff Serv	1,140	25	88.09%
253 Medical Staff (Emergency Med) Serv	854	24	87.58%
253 Patient Management Centre Serv	328	23	84.10%
Total	**71,359**	**-1241**	**91.59%**

Medicine and Surgery Divisions are the lowest performing Divisions currently.

Statutory Training remains above target but with a declining position over the last three months.

The five subjects requiring most improvement are Resuscitation Adult, Paediatrics and Neonatal, Safeguarding Children Level 2 and Level 3.

Work continues with Divisions to focus on improvements to these core areas.

CARE RESPECT RESPONSIBILITY

Work Experience and Widening Participation

The Dudley Group NHS Foundation Trust

Work Experience

2 face to face department-led placements (one was clinical, one non-clinical).

New Centralised WEx programme commencing in May 2024 for College Students – specific programme for those interested in careers in Nursing, Midwifery, and AHPs.

The advertisement for this was live during Feb/March 24 (via trac for the first time) – 24 applications and 22 under offer.

Work Related Learning

Behind the Scenes – Event took place on 7th March 2024 – with **52 students** (from year 9-11) from 4 local secondary schools.

Springpod – 2nd year virtual programme.
24 student enrolments during March 2024.

Total of 262 enrolments as at the end of March 2024 since the start of the programme in July 2023. The average number of hours participants spent engaging was 4.7 hours. The average rating participants gave the programme on a scale of 1-10 was 9.

The Q4 March 2024 report (from just the 2nd year) state that out of 262 enrolments, 18 students completed over 70% of the programme, 8 students completed between 35 – 70% of the programme, and 25 students completed up to 35% of the programme.

Ambassadors

78 ambassadors currently registered. Ambassador promotion went out on 'In The Know' – linked to the Behind the Scenes success story during March. One person dropped out due to capacity.

Employability Programmes

'I CAN Get Started' pre-employment programme recruitment commenced in Jan with first 4 candidates commenced on their 6 month paid placements during Feb, with another 1 candidate commenced in March 24.

Into Employment Programme – 4 week pre-employment programme coordinated by the Adult Learning team at Dudley Council. We provide NHS staff to speak to the candidates each week, and guaranteed interviews for roles if they meet the essential criteria.

From the previous programme, 11 were invited to interview: 5 were successful in gaining a place on the 12-week CSW bank training programme and 1 gaining a ICan- Get Started placement. The 6 unsuccessful were due to: 3 x DNA, 1 x No right to work, and 1 x was unsuccessful at interview.

There has been 3 weeks of employer talk sessions during March (to compete the 4 week programme that started in Feb). 9 learners completed this programme. 6 have been invited to interview of which 5 will take place in April. 1 has been unsuccessful at interview.

Careers Education Information Advice and Guidance (CEIAG)

115 contacts were recorded during March (including 2 x employer talks, one at a local secondary school, and another at a pre-employment programme, a local MP career event, and a local College career event).

Ambassadors - March			
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
Q4	78	0	0

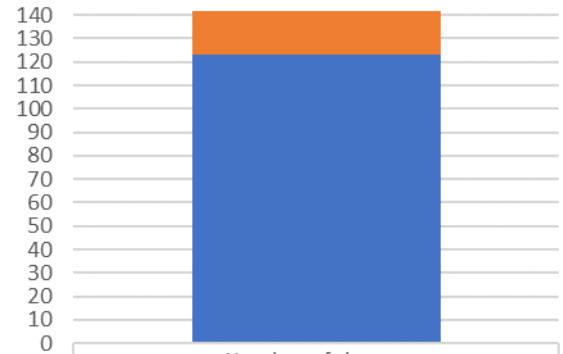
CARE RESPECT RESPONSIBILITY

Apprenticeships

The Dudley Group NHS Foundation Trust

Apprenticeships - as of Mar 24

Number of Signups against year plan (142)



	Number of signups
Remaining signups	19
Sign ups	123

Total Active Apprenticeships **262**	
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
Expired Levy Oct 23	£26,522.63
Expired Levy Nov 23	£16,922.89
Expired Levy Dec 23	£0
Expired Levy Jan 24	£0
Expired Levy Feb 24	£0
Expired Levy Mar 24	£18,785.21

Target for 2023/24 was not achieved – this was due to a range of factors including:

Expected recruitment activity was not able to go ahead as planned for the novice apprenticeship programme in January and nursing associate programme in March due to lack of available posts.
Cohorts planned in Q4 for the 4th CMI level 5 cohort and Senior Health Care Support Worker Level 3 have been moved to April due to capacity and availability of resources at the College.

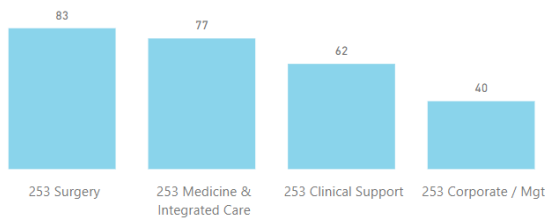
Sign up activity has included:

31 degree / master level apprenticeships including Chartered Manager, Senior Leader, Operating Department Practitioner, Occupational Therapy, Physiotherapy and Registered Nurse.
Continuation of Business Administration, Medical Administration, Pharmacy programmes and the 3rd CMI level 5 in July.
Introduction of IT programmes at level 4 and 6.
Introduction of Dietetic Masters level 7.

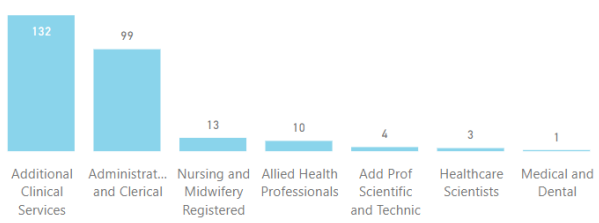
Work continues to promote internal apprenticeship opportunities in order to compensate for lack of new apprentice opportunities.

Active Apprenticeships breakdown

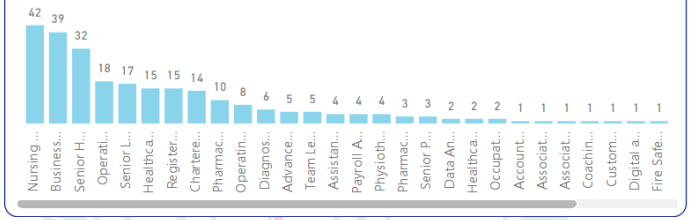
Division



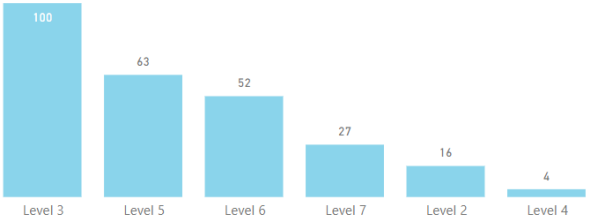
Staff Group



Programme



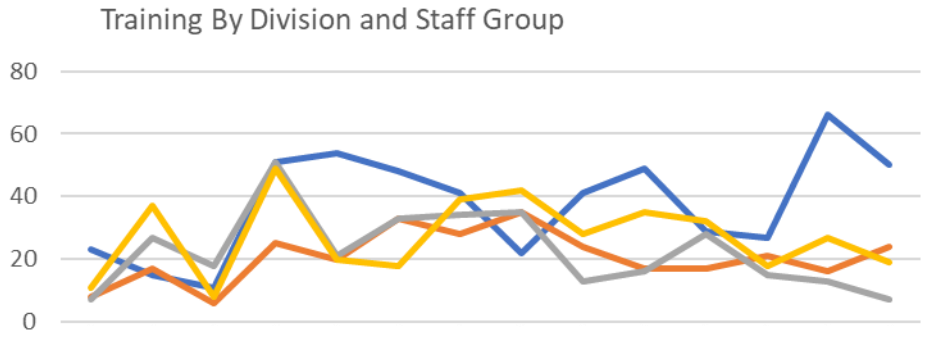
Apprenticeship Level



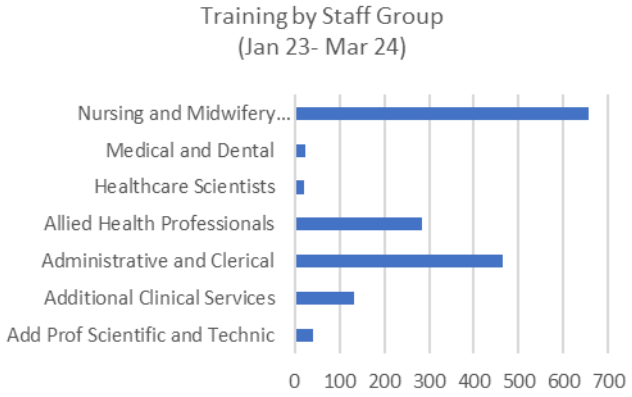
CARE RESPECT RESPONSIBILITY

Organisational Development

The Dudley Group
NHS Foundation Trust



	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24
253 Clinical Support	23	15	11	51	54	48	41	22	41	49	29	27	66	50
253 Corporate / Mgt	8	17	6	25	20	33	28	35	24	17	17	21	16	24
253 Medicine & Integrated Care	7	27	18	51	21	33	34	35	13	16	28	15	13	7
253 Surgery	11	37	8	49	20	18	39	42	28	35	32	18	27	19



Course	Jan-23	Feb-23	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	Grand total
253 Admin Essentials												8				8
253 Annual Review Training	4	7	6	83	68	34	1								12	215
253 Bespoke Training					16											16
253 Coaching					2		7			1					5	15
253 Communications 1					5	3	13	12	8	13	19	24		5	10	112
253 Communications 2													10	13		23
253 Developing Leaders	8								6							14
253 Leading People at Dudley													5		8	13
253 Living The Values		6	15	3	3	22	12	5	10	37	13		32	21	11	190
253 Local Induction Training						30	12	7	8		2		6		2	67
253 Managers Essentials	25	20	15	20	9	22	20	18	25	30	35	20	27	24	23	333
253 Welcome 2 Dudley Induction	7	3	2		2	10	11	12	11	18	10	9	21	17	14	147
253 Wellbeing 1		4	3	6	3	8	11	24	18		16	14	12	13	7	139
253 Wellbeing 2		2	2	5	4	3	4	8	9	11	11	6	9	7	6	87
253 Wellbeing Adhoc		54		54			41	48								197
253 Wellbeing Champions	5			5	3		10		11	7					6	47
Grand Total	49	96	43	176	115	132	142	134	106	117	106	81	122	100	104	1623

Training activity remains steady – with a continuing focus on ensuring that Manager's Essentials courses are delivered to capacity and reach all managers. There are two courses each month; with around 30-40 participants booked in April and May. Manager Induction is now running monthly. The development prospectus is in the process of update for April 2024 onwards. There is ongoing work to increase access and reduce DNA rates on courses.

CARE RESPECT RESPONSIBILITY

Implementing our strategic plan Shaping #OurFuture

Quarterly Report January – March 2024

This report provides an update on implementation of the strategic plan 2021 – 2024 in two parts:

Part 1 – a summary of the status of each of the measures of success

Part 2 – progress against each of the five goals with updates on the measures of success

Part 3 – progress against each of the three transformation programmes that will help make progress against the goals

Part 4 – a matrix summarising the level of maturity of partnership by service.

Progress has been RAG rated where:

	Actions are on track
	Actions started but not yet completed
	Actions not started or at risk of not achieving

Part 1 – Summary of status for measures of success

Goal	Measure of Success	Target and timescale	Current status	RAG rating	
				This quarter	Last quarter
Deliver right care every time	CQC good or outstanding	Target: good or outstanding	No change in ratings during quarter Good progress is being made with action plans in response to the inspection reports for Urgent Care and Children's services reports. Importantly these have been fed back to the CQC through an engagement meeting this quarter – positive assurance shared and no concerns were raised. Timely responses to CQC enquiries continue without significant concern/exceptions. Ward to Board walkabouts recommenced in Q4 to build upon engagement with staff and assurance levels There were no new inspections.		
	Improve the patient experience results	Target: top quartile performance (England) by 2025	Family and Friends Test (FFT) largely unchanged from previous quarter. New approach to treating minors in ED hopes to improve patient experience		
Be a brilliant place to work and thrive	Reduce the vacancy rate	Target: achieve 7% by Jun-2023 and sustain	Current vacancy rate is 5% and has been stable since May 2023		
	Improve the staff survey results	Target: better than England average by 2024/25	Benchmark average across all People Promises. Improvement against historic performance in 4 out of 9. Improved scores on recommend as a place to work.		
Drive sustainability	Reduce cost per weighted activity	Target: better than England average for overall, medical, and nursing costs by 2024/25	Schemes to cover the cost improvement target for the current year set to over-perform with increase in recurrent savings to 67% of the programme		
	Reduce carbon emissions	Target: year-on-year decrease achieving net zero by 2040 (NHS carbon footprint) and 2045 (NHS Carbon footprint plus)	First Green Week for nurses and midwives; some remanufactured devices implemented saving cost and carbon; 229 staff redeemed codes for free bus travel from National Express		
Build innovative partnerships in	Increase the proportion of local people employed	Target: 70% by Mar-2025	This proportion has increased from 66% in September 2021 to 68% currently; first placements on the 'ICan' pre-employment programme started.		

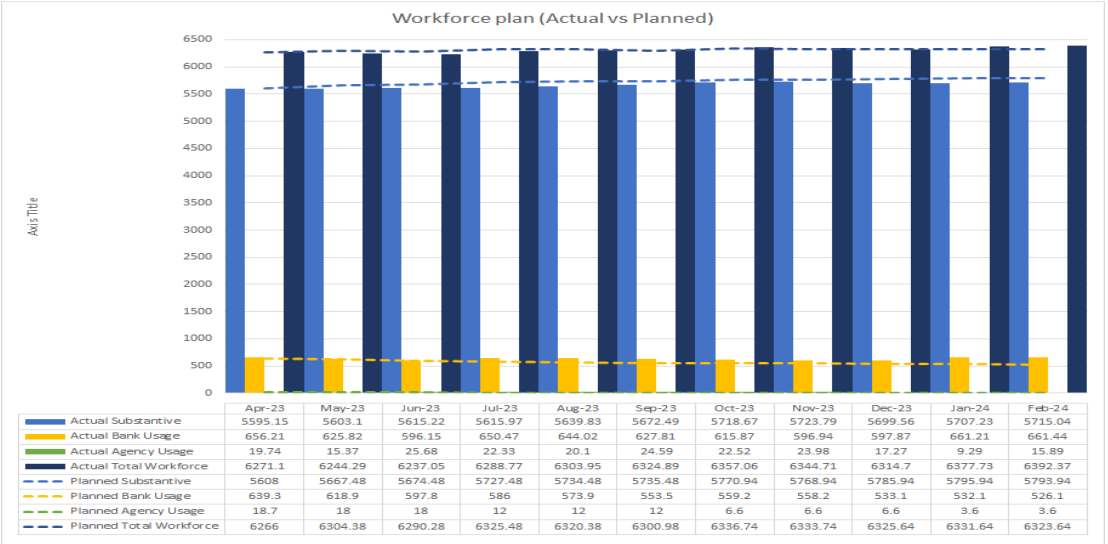
Goal	Measure of Success	Target and timescale	Current status	RAG rating	
				This quarter	Last quarter
Dudley and beyond	Increase the number of services jointly delivered across the Black Country	Target: increase maturity of collaboration as measured by maturity matrix	Leadership and active participation in Black Country provider collaborative; On track with DIHC transaction and development of Dudley Health and Care Partnership		
Improve health & wellbeing	Improve rate of early detection of cancers	Target: 75% of cancers diagnosed at stages I &II by 2028 (NHS Long Term Plan)	Latest available data for Q3 showed 44% of patients diagnosed at stage I, II; business case for targeted lung health checks progressing through governance process and delivery group established		
	Increased planned care and screening for the most disadvantaged groups	Target: Breast screening uptake - Acceptable level: greater than or equal to 70.0% - Achievable level: greater than or equal to 80.0%	Latest (unvalidated) uptake for Q3 is 68% so does not meet the acceptable level; mobile unit in place at Dudley Central and service continues to work with stakeholders to put on community events		

Part 2 – Goals and measures of success

Goal: Deliver right care every time		**Executive lead: Medical Director / Chief Nurse/ Director of Governance**	
Metric: CQC good or outstanding			
Target: good or outstanding			
Workstreams	**Current status**	**Summary of progress this quarter**	**Actions planned for next quarter**
Compliance	The Trust's overall rating remains the same. There were no new CQC inspections in Q4	Good progress is being made with action plans in response to the inspection reports for Urgent Care and Children's services reports. Importantly these have been fed back to the CQC through an engagement meeting this quarter – positive assurance gained and no concerns were raised. Timely responses to CQC enquiries continue without significant concern/exceptions. Ward to Board walkabouts recommenced in Q4 to build upon engagement with staff and assurance level	Post inspection action completion, monitoring and effectiveness testing continues. Quality and Safety Reviews continue to help prepare the Trust for further inspection. CQC Self-assessment work to commence.
Quality & Safety Reviews	There were 3 quality and safety reviews during Q4 (Cardiology, Gastroenterology / ENT and General OPD / ophthalmology).	In all cases action plans are either in development or underway. All Q&S action plans are monitored and reviewed at Quality and Safety Group. Breaches in action timescales are escalated in line with governance process Programme of work for 2024/25 has been devised and schedule set up to ensure a review is started on the 3rd week of every month. Areas to be reviewed are scheduled with the caveat that areas with increased risk or specific issues can be prioritised for review. This allows a more flexible approach and timely response to any potential concerns.	Introduction of self-assessment process to compliment Q&S reviews and allow a comprehensive database of information to be created
Patient safety	Overall incident reporting remains comparable to quarter 3 when comparing average number of incidents reported per day. Levels of reporting are reduced slightly when	During this period there has been a significant system changes related to a shift in external reporting to LfPSE (Learning from Patient safety Events). This has led to several period of downtime for Datix which may have impacted on reporting numbers. On the 1st November the Trust transitioned to manging incidents under PSIRF (Patient Safety Incident Response Framework). New ways of working are being tested.	Overall incident reporting levels will be closely monitored. IPR report for incident management to be strengthened to represent PSIRF and to include Statistical Process Control Charts.

	compared to the same quarter in the previous year. Harm levels during this period remain proportionally low. There were no 'Never Events' reported in Q4.	Good progress continues in working through the historical serious incidents and yellow investigations already in the system.	PSIRF response tools to be strengthened based on feedback from completed responses and processes to be formalised (Standard Operating Procedures developed). Staff and Patient engagement monitoring to be further strengthened through quarterly and annual spot checks Data gathering to commence for newly identified Venous thromboembolism thematic review (added to thematic review schedule).
Deteriorating patient		• Clinical Director for Patient Safety appointed in March 2024 • SHMI and HSMR reduced again to 100.66 and 85.95 respectively • Stroke operational performance improved following working group establishment • Visit to Imperial to share deteriorating patient work	• Acute Kidney Injury nurse business case to be reviewed to ensure bundle compliance • Martha's Rule to be launched. Any patient/carer with concerns will be able to request a second opinion.
Metric: Improve the patient experience survey results			
Target: top quartile performance (England) by 2025			
National CQC Patient Experience Surveys	There are no national surveys to report in Q4.		
Friends and Family Test	Percentage 'very good/good' scores have seen a small increase in Q4.	A total of **4831** responses were received in February 2024 in comparison to **4645** in January 2023. Overall, 83% of respondents have rated their experience of Trust services as 'very good/good' in February 2024, a small increase since January 2024 (82%). A total of 6% of patients rated their experience of Trust services as 'very poor/poor' in February 2024, no change from the previous month.	FFT activity and action taken to improve scores and response rates are presented through divisional updates at the quarterly Patient Experience Group.

		The A&E Department received the highest percentage negative score with 13% of patients rating their overall experience as very poor/poor in February 2024. This score has seen an improvement of 3% since January 2024. The Community/Inpatient Department received the highest percentage score for patients rating their overall experience as very good/good at 89%.	To improve the very poor/poor scores within A&E a new approach is being trialled around seeing and treating patients within the minor's service. From the hours of 10am-10pm an Advanced Care Practitioner will now be based in that area. This will allow for more patients to be streamed to minors for the ACP to treat. The benefits from this will be a reduction in crowding in the main waiting room as all patients will be directed to minors along with minors being able to see a more diverse set of injuries. This will aid flow and decrease length of stay. The department are also now streaming all GP referrals from Urgent Care to avoid them coming to the Emergency Department. This will include all patients sent from their GP to be reviewed by either SDEC, ESH or PAU. The figures demonstrate that this this is roughly 20 – 30 patients a day. Any improvements from this change in practice will be monitored locally and collected through FFT quantitative data.

Goal: Be a brilliant place to work and thrive	Executive lead: Chief People Officer		
Metric: Reduce the vacancy rate			
Target: achieve 7% by Jun-2023 and sustain			
Workstreams	**Current status**	**Summary of progress this quarter**	**Actions planned for next quarter**
Reduce the vacancy rate	Contracted WTE staff has decreased from 5722.16 WTE in November 2023 to 5715.04 in February 2024. The vacancy rate in February 2024 remains stable at 5% in February 2024 with total vacancies of 308.16 WTE. In February overall workforce is just over plan (1.1% variance – 68.73 WTE over plan) with less substantive staff but more bank usage than planned.	It is important to triangulate turnover, vacancies, and retention to evidence our performance in recruiting and retaining our workforce. Turnover (all terminations) increased in February 2024 but continues to perform under the national average for the NHS between 10-12%. Normalised turnover (voluntary resignations) increased slightly in February 2024. Retention has remained stable at 91% in February 2024. The vacancy rate in February 2024 remains stable at 5% in February 2024 with total vacancies of 308.16 WTE.  As demonstrated in the table below, the overall workforce growth year to date (April 23 and February 24) in 23/24 (inclusive of bank and agency staffing) is 1.92%,	Work is now focused on retention: this includes embedding grip and control through the Vacancy Approval Process and visibility of vacancies to maintain our current position through actions on turnover and retention.

	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24
Actual Substantive	5595.15	5603.1	5615.22	5615.97	5639.83	5672.49	5718.67	5723.79	5699.56	5707.23	5715.04
Actual Bank Usage	656.21	625.82	596.15	650.47	644.02	627.81	615.87	596.94	597.87	661.21	661.44
Actual Agency Usage	19.74	15.37	25.68	22.33	20.1	24.59	22.52	23.98	17.27	9.29	15.89
Actual Total Workforce	6271.1	6244.29	6237.05	6288.77	6303.95	6324.89	6357.06	6344.71	6314.7	6377.73	6392.37
Planned Substantive	5608	5667.48	5674.48	5727.48	5734.48	5735.48	5770.94	5768.94	5785.94	5795.94	5793.94
Planned Bank Usage	639.3	618.9	597.8	586	573.9	553.5	559.2	558.2	533.1	532.1	526.1
Planned Agency Usage	18.7	18	18	12	12	12	6.6	6.6	6.6	3.6	3.6
Planned Total Workforce	6266	6304.38	6290.28	6325.48	6320.38	6300.98	6336.74	6333.74	6325.64	6331.64	6323.64

<table>
<tr><td></td><td></td><td>specifically for substantive staff this is 2.13% growth (119.27 WTE), bank staff 0.80% and agency staff -19.50%

<table><tr><th></th><th>Apr-23</th><th>Feb-24</th><th>Difference</th><th>Variance</th></tr><tr><td>Total Workforce (WTE)</td><td>6271.1</td><td>6391.75</td><td>120.65</td><td>1.92%</td></tr><tr><td>Total Substantive</td><td>5595.15</td><td>5714.42</td><td>119.27</td><td>2.13%</td></tr><tr><td>Total Bank</td><td>656.21</td><td>661.44</td><td>5.23</td><td>0.80%</td></tr><tr><td>Total Agency</td><td>19.74</td><td>15.89</td><td>-3.85</td><td>-19.50%</td></tr></table>
Principal areas of growth within substantive staff have been seen in registered scientific, therapeutic and technical staff (10%), registered nursing, midwifery and health visiting Staff (5%) and medical and dental staff (5%).</td><td></td></tr>
<tr><td colspan="3">Metric: Improve the staff survey results</td><td></td></tr>
<tr><td colspan="4">Target: better than England average by 2024/25</td></tr>
<tr><td>Improve and sustain staff satisfaction & morale</td><td>Staff survey results published. Benchmark average for all People Promises and Themes. Improvements across most promises with significant improvements in 4 our of 9 including morale. Improved performance on ‘recommend as a place to work’ increase of 3% against 2023.</td><td>Dudley People Plan and 5 associated journeys have been ratified. Activity within journeys outlines what our people can expect to change to ensure we are a brilliant place to work and thrive. Activity has continued on the delivery plans which includes: launch of flexible working training (Q4), health and wellbeing events (menopause support and training), wellbeing training, ongoing delivery of Managers Essentials (over 700 people now completed) and the launch of a new cohort of Developing Leaders programme, delivery of Admin Essentials, launch of Manager Induction, workstreams established on careers advice and guidance, inclusive recruitment and branding.

Make it happen engagement was undertaken in January alongside the quarterly People Pulse.

Revised Behaviour Framework approved and plan developed to embed and share.</td><td>Make It Happen engagement planned for Q1 24/25 to share and embed People Plan, feedback from Staff Survey and Behaviour Framework.
Training programmes continue with relaunched Prospectus.
Annual reviews during Q1.</td></tr>
</table>

Goal: Drive sustainability		Executive lead: Director of Finance	
Metric: Reduce the cost per weighted activity			
Target: better than England average for overall, medical and nursing costs			
Workstreams	**Current status**	**Summary of progress this quarter**	**Actions planned for next quarter**
Cost Improvement Programme	The CIP target for 2023/24 is £26.233m	At month 11, the predicted over performance of £762k against year-end target of £26.233m with 67% of the programme being recurrent following an exercise to convert non-recurrent schemes to recurrent.	The CIP target for 24/25 is currently £28.69m of which at month 11 £7.62m has been found with £5.47m being recurrent, leaving a significant gap to find. Work is ongoing with all divisions in order to identify this
Improving productivity	Productivity metrics from Model Hospital for 2021/22 were published in June 2023 The Trust is in the highest quartile for overall cost per weighted activity unit (WAU), medical and nurse staffing costs per WAU	**<u>Outpatient Transformation</u>** Key objectives for continuous OPD efficiencies & productivity, monitored through the OPD Transformation Group, Divisional Forums, Trust Finance & Improvement Group & Black Country Integrated Care Systems: - **The National GIRFT Further Faster Trust & Specialty Meetings** continue into 2024 across SWC, MIC, CCCS specialties to monitor progress against the below metrics, reduction of waiting list backlog and share Specialty specific practice. Continue to embed and monitor against the **GIRFT Further Faster Checklists / Metrics** across all Divisions: - Pre-appointment Advice & Guidance / Referral Assessment Service / Cinapsis – Reducing & Managing DNAs – Remote Appointments – Outpatient Activity & Capacity – PIFU – Specialty Specific actions. **OPD 642 Scheduling Meetings** – Trust commenced across all Divisions from November 23 – now embedded to drive clinic utilisation & improve productivity. **On the day DNAs** – DNA Access Policy - convert to Virtual appt – move to PIFU DNA pathway – understand Specialty plans to address on the day DNAs – monitored through the weekly OPD 642 Mtgs to understand trends. **OPD Clinic Efficiency Tool** – commenced across all Divisions to support deep dives: - clinic utilisation / DNAs / New:FU ratio / inactive clinic sessions.	Ongoing OPD transformations workstreams into 2024 to improve efficiencies & productivity through the National GIRFT Further Faster Programme.

		Data Quality – Continue to undertake PIFU/Partial Booking validation. Continue to embed OPD transformation workstreams through: - Divisions, Specialty Tri teams / Chiefs of Service / Divisional Medical Huddles / Medical Directors Office. **Work Underway: -** Pilot Digital PIFU / eForms from April 24 – Empower patients to manage their care from anywhere with the convenience of their smartphone or tablet. In return, PIFU is proven to lead to better outcomes and less hospital visits, whilst releasing capacity for patients that need face to face appointments. **Acute & Primary Care Collaboration** – collaborative working to support referral pathways / discharge pathways. **Digital IT Programmes** – prep work during 2024 for Digital Referral integration to Sunrise / Digital Outcome Forms / Digital OPD Procedure Forms / Voice Recognition. **THEATRES** Theatre utilisation has improved recently with both capped and uncapped values being higher at 80.8% and 84% respectively (Feb-24). Uncapped utilisation is above national and on par with regional peers, while capped is comfortably above both with the Trust remaining in the top quartile nationally. Specialties consistently and comfortably achieving their 85% target remain General, Gynae, Urology, T&O and Vascular – which are currently in the 87 – 93% range, with plastics improving to 87.6% this month. Other specialties with high volume lists remain a challenge while additional work in ophthalmology is taking effect. Visit from the NHSE Regional Theatre Productivity team in March explored ways of increasing cataract throughput. The Trust has submitted its application to GIRFT to be considered for Elective Surgical Hub accreditation. If successful, our evaluation should be complete mid-June 24. **KEY ACTIONS: -** Theatre management team re-focussed on removing obstacles to on time/early starts and reducing downtime.	Ongoing drive theatre utilisation. Progress Elective Hub application. Address utilisation of high-volume lists. Estates project to expand recovery area to improve flow and throughput.

		List planning process has continued successfully despite recent strikes which have impacted both forward and backward looks and show that they impact list planning for consecutive weeks. Utilisation of high-volume lists still under scrutiny. Overlap model in place in all theatres. Ophthalmics now recording start of intervention to minimise recorded down time which has improved utilisation with initiatives mentioned above planned and increase number of simple cataracts. MPR improvement works started 4th March 2024. Service will be maintained, with works complete by 30th March 2024 when patient throughput will be increased. Multiple WLIs running each weekend with weekly feedback to specialties. **<u>Discharge Improvement Group Updates / Next Actions – March 2024</u>** There are several areas that are being looked at around discharge to assess, home for lunch, perfect discharge lounge, discharge planning on admission and the Dudley System Place. The group is working with all external partners. There are several pieces of work that are happening across the West Midlands. An assessment by NHS England (NHSE) was undertaken which focused on observations, following the patient journey, and looking at the processes that are in place. Overall, it was a positive experience. There were some recommendations identified, and the group is responding to those actions. Most of the work is already taking place and NHSE are keen to come back to review how the group are progressing. There have been structural changes to the discharge team and how they are overseen, and that work has been embedded over the last few weeks. In terms of performance the group are constantly looking at discharges and failed discharges, which is a cause for concern. The aim is to reduce and minimise the reasons why it is happening. Since the end of January there	On going Discharge workstreams to support timely hospital discharge at the point of medially optimised for discharge.

		has been a double measure put in place to reduce delays around medication to take home and transport issues, which have caused considerable pressures. Since January there has been a reduction in failed discharges which is positive. The main reason for failed discharges currently are patients that are no longer fit for discharge. This may be due to the length of time waiting for specific pathways to commence. They are working within a tight regime with external colleagues around availability of packages of care, so all processes need to be in place so that patients are discharged in a timely manner. The team are not looking at patients who become unfit for discharge as they can be managed in the community. The group are constantly reviewing community pathways and looking at patients that could have been seen in an alternative pathway such as community services, or virtual ward clinics. They have amended part of their work to include some of the virtual wards to be able to understand access pathways and optimise what is possible. There is work around the electronic transfer of care document which will commence on arrival and will include the ethos around home first. The transfer of care document will ask if all options have been considered first and 'Own Bed Instead' (OBI) should be one of those pathways. The group is working with external colleagues as part of the Urgent Care Operational Group to capture failed discharges, those patients that reattend/ readmitted based on care that is not working. The group are hopeful that the new electronic system will make a difference to the way the teamwork. Senior members of the discharge team will be able to be out on the wards to support with challenging patients though a multidisciplinary team (MDT) approach to support their discharge. There have been successes in implementing an MDT with clinicians, community, and continuing health care partners to ensure patients are going to the right place first time. They have introduced a document to capture the MDT approach to ensure they are tracking the patients. The group are launching a dashboard around the discharge and that will be available on the power BI system. Each area will be able to look at their patients, and the patient journey and understand where they are at and what	

		they are waiting for. It has been discussed at the DIG to have one single system that captures information around the discharge process. Colleagues from the Dudley Integrated Care Board (ICB) joined the DIG last month, and they have developed an action plan that they will be working on as part of a discharge improvement week held in March 2024. The ICB observed that good systems are in place, but that the length of stay to discharge patients from the point they become medically fit is longer than it could be. The ICB will be helping the DIG to look at how they can coordinate this differently on a daily basis.	
Metric: Reduce carbon emissions			
Target: year-on-year decrease achieving net zero by 2040 (NHS carbon footprint) and 2045 (NHS Carbon footprint plus)			
Workstreams	**Current status**	**Summary of progress this quarter**	**Actions planned for next quarter**
Governance	Green Plan Working Group met in March 2024 with limited engagement.	Launched the first Green Week for nurses and midwives. Shared the national event series with the Green Team, visited wards to raise awareness and promote the prize draw. Limited engagement, running the prize draw to include AHP week in April.	Promote Greener AHP week in April
Estates and Facilities	-47% emission from 2019/20 by 2032. 22/23 saw a -1% change in emissions.	A detailed carbon report reviewing data from 2019/20 to 2022/23 was presented to F&P committee in January 24. The report included overall progress against NHSE targets as well as reviewing the carbon intensity based on the patient bed day,104.02 kgCO2e/BD, seeing a 2% increase since the baseline year	
Travel and transport	226 National Express free travel codes have been redeemed. 77 members of Kinto Join, no recorded journeys.	381 codes have been claimed for the one-month free bus travel, estimated saving of 5 tCO2e for the month. The scheme will run till the end of the year, only one code per person. 281 codes in total redeemed via the NX Bus ticket system, this includes the codes used for new starters, international recruitment and car users, differing from the 381 codes that have been sent to staff via requests.	Review the analysis on the impact of virtual outpatient clinics and share key findings. Increase engagement with Kinto Join app. Review the possibility of a system wide platform.
Supply chain and procurement	Stakeholders buy-in is slow given competing pressures from clinical workloads	Vanguard remanufactured devices implemented saving £17,946.87 and reduced carbon impact by 25% with around 104kgCo2e saved. Vanguard collections up and running in theatres	Theatre Cap purchase order being completed in March 2024 Considering rub instead of scrub, moving away from

		GBUK pre-filled saline syringe savings made which will also reduce waste from packaging and drawing up moving from 3 products with 3 packets, to 1 product with 1 packet. Reusable tourniquet evaluation approved following success at Sandwell	water and chlorhexidine to a hand rub to reduce water use, and reduce impact of chlorhexidine in the sewerage system (it can't be broken down and neutralised)

Goal: Build innovative partnerships in Dudley and beyond		**Executive lead: Director of Strategy & Integration**	
Metric: Increase the proportion of local people employed			
Target: 70% by Mar-2025			
Workstreams	**Current status**	**Summary of progress this quarter**	**Actions planned for next quarter**
Anchor Network Development	Partnership opportunities with Dudley College and local schools being developed	Two posts funded by the Commonwealth Legacy Fund – one in Local Authority, and one in DGFT - commenced in Q4, to focus on recruitment culture, community partnerships and supporting local employment initiatives, advocating for health and social care employment inequalities. The "I Can Get Started" programme has delivered 11 paid work experience placements for local people experiencing challenges in accessing employment (6 in the LA, 5 at DGFT) which commenced in Q4. DGFT has collaborated with the Local Authority on two Sector Based Work Programmes in Q4, "Into Employment" under the "I Can" initiative. This entailed supporting a guaranteed interview scheme for course attendees, which included interviewing 7 candidates for a novice healthcare support worker (HCSW) training programme to pilot this entry pathway to employment on temporary staffing bank. Another successful "Behind the scenes" event hosting four local schools took place on 7th March and was attended by 52 students (details below).	Plan recruit to second cohort of ICan paid work experience placements, following evaluation of pilot. Undertake interviews with 5 prospective/aspiring HCSW's from second cohort of "Into Employment" programme. Support third cohort of "Into Employment" programme commencing April. Launch of HCSW training pilot to follow.

Apprenticeships and work experience	Proportion of substantive staff who live in Dudley and Rowley/Tipton is 68% (census taken Apr-24) with 4189 people employed. This is 651 higher than the baseline of 3538 in September 2021	**Apprenticeships** The target number of sign-ups for 2023/2024 was 142. The number for Q4 was 37. In total we have achieved 123. Several factors have impacted achievement of the target. • Expected recruitment activity was not able to go ahead as planned for the novice apprenticeship programme in January and nursing associate programme in March due to lack of available posts. • Cohorts planned in Q4 for the 4th CMI level 5 cohort and Senior Health Care Support Worker Level 3 have been moved to April due to capacity and availability of resources at the College. • Withdrawals of expressions of interest. • No interest received for AHP Support Worker level 3 or Community Health and Wellbeing Worker level 3. Sign up activity has included: • 31 degree / master level apprenticeships to include Chartered Manager, Senior Leader, Operating Department Practitioner, Occupational Therapy, Physiotherapy and Registered Nurse. • Continuation of Business Administration, Medical Administration, Pharmacy programmes and the 3rd CMI level 5 in July. • Introduction of IT programmes at level 4 and 6 • Introduction of the Dietetic Masters level 7. **Work Experience, Pre-employment & Widening Participation** T-Levels The Trust has supported two local education providers (Halesowen College and Dudley College) with T-Levels again this year offering 24 T-Level Care students. The students from Dudley College have completed their programme in March, with the Halesowen cohort completing during April. For the first time we have taken on 3 digital T-Level students that have completed their industry placements with IT during Q4. This has been a positive experience, and so the digital team will be taking further	**Apprenticeships** Activity will continue to promote apprenticeships, support administration and leadership programmes as well as: • Supporting the AHP development pathway from level 2 to level 6. • Introduction of maternity support pathway • Radiology degree apprenticeships • ODP and other pathways within theatres • Doctor degree apprenticeship scope for 2025. Continued Engagement Another date is planned for Behind the Scenes (July 24), with a further date to be confirmed for a session targeted to SEND students in partnership with local specialist schools.

		students on in the future. The Department of Health have asked the team to present at a webinar aimed at other NHS Trusts (nationally) to encourage them to get involved with T Levels. <u>Careers Education Information Advice and Guidance & Work-Related Learning</u> A total of 171 contacts were recorded for the quarter from a range of careers events, including 2 local MP events, local school and college events, employer talks, and Behind the Scenes event. 'Behind the scenes' event with 4 local schools took place on 7th March, which is the 3rd event of its kind. Fifty-two students attended from 4 local secondary schools (from year 9-11). The event started with a career marketplace, supported by several departments. Students were then taken to different departments to see 'behind the scenes' and learn about the different kinds of roles that are available within the NHS. Trust departments involved in offering interactive tours included maternity, therapies, pharmacy and cardiology along with Action Heart. Positive feedback was received from the small number of responses received. <u>Work Experience</u> Seven department-led face to face placements have taken place during Q4, of which 5 were clinical, and 2 were non-clinical. Two were with a purpose to gain access to higher education or professional training such as medical school, and the other 5 were part of organised college work experience. New Centralised clinical work experience programme launching in May 2024 for college/sixth form students. The pilot is specific to those interested in nursing, midwifery, and AHP careers. This was advertised to all local colleges and sixth forms during Q4 with applications being administered via Trac for the first time. There were 24 applications	Meet the Expert Sessions have been requested by some of the Dudley Academies Trust schools. Potential developments in next quarter include scoping work with local primary schools around schools' engagement. Centralised Clinical Work Experience Programme Roll out w/c 13th May 2024. Springpod programme review and scoping of alternative options.

		received and 22 are under offer. The 2 applications that were not offered were due to them wanting medicine specific work experience. "Springpod – Inspiring our Future Workforce" virtual programme: The 2-year Springpod programme was funded through charity funds awarded specifically to youth volunteering in 22/23. The contract ended at the end of March. Students already enrolled have 2/3 months to complete their programme. A review of the programme will be given in the Q1 24/25 strategy report. <u>Employability Programmes</u> 'I CAN Get Started' pre-employment programme recruitment commenced in Q4, with 5 recruits commencing on placement at DGFT in non-clinical roles. "Into Employment" programme – is a 4-week pre-employment programme coordinated by the Economic Growth & Skills - Adult Learning team at Dudley Council. We are working in partnership with them by providing NHS staff to speak to the candidates each week, and guaranteed interviews for roles if they meet the essential criteria. From this programme 11 have been invited to interview, of which 7 attended. Out the 11, 5 were successful in gaining a place on the pilot 12-week HCSW bank training programme. This pilot will commence when the minimum quota of 12 places are filled. <u>Ambassadors</u> 79 ambassadors currently registered (1 new ambassador registered, and 1 ambassador un-registered due to capacity). Ambassador promotion went out on 'In The Know' in March – linked to the Behind-the-Scenes success story.	Further breakdown of reporting for ambassadors and potential development of this programme depending on team capacity.
Metric: Increase the number of services jointly delivered across the Black Country			
Target: increase maturity of collaboration as measured by maturity matrix			
Black Country Provider	Services already provided via formal collaboration across Black Country	The following are the key messages from the Black Country Provider Collaborative (BCPC) **1) Clinical Improvement Programme**	Finalise the BCPC case for change.

Collaborative (BCPC)	Trusts are: vascular surgery, ENT, cardiology, oncology, pathology. Urology delivered via the emerging Urology Area Network (UAN). Programme Director and Clinical leads in post for 9 services appointed including 2 from the Trust (Ophthalmology and Orthopaedics). PMO established to support this. Permanent Chair of BCPC Board in place with Executive Chaired by the SRO and Clinical Leads Group chaired by PC Medical Director.	The following were key performance highlights and updates: ▪ Appointed Anna Pierson (DGFT) as pre-operative medical optimisation lead for the BCPC, for a period of 6 months, Anna is linking with network leads for the programme of work. ▪ Centralisation of Bariatric Surgery at WHT (Walsall Healthcare NHS Trust) discussed at the last Clinical Leads Group (CLG). Awaiting a formal paper to articulate this with possible repatriation from Birmingham & Solihull (BSol), Stoke and Shrewsbury agreed in principle but need to agree further details. ▪ Further work still required to agree a Networked Service Solution for vascular and stroke services between SWBT (Sandwell & West Birmingham NHS Trust) and DGFT. ▪ Centralisation of renal robotics service to DGFT is work in progress, work to centralise MDT (multi-disciplinary team) at Dudley, discussion with RWT (Royal Wolverhampton NHS Trust) surgeon moving to Dudley. ▪ As part of modernisation of urological work, pelvic oncology work is to be centralised formally at RWT, which includes prostate cancer, mini prostate cancer and bladder cancer work, will become further facilitated with other developments. ▪ Percutaneous Nephrolithotomy (renal stone) work – looking to be centralised at either SWBH or DGFT. A formalised process is needed on how this decision will be made. ▪ Review of existing clinical leads and networks is underway, to ascertain need for future years work plan to retain a clinically led momentum. Important to recognise the excellent work that has been done through these Clinical Leads, and the significant improvement in trust and relationships across the system. **2) Corporate Improvement programme** An update was presented on the Corporate Improvement Programme and the Collaborative Executive heard about the progress being made on the three key priority areas:	Continue to progress the clinical improvement programme and the corporate improvement programme. Confirm the BCPC priorities and workplan for 2024/2025. Establish how the BCPC will support the delivery of the ICS financial recovery plan.

		▪ Payroll – looking at consistency work and ESR (electronic staff record) automation standards, investigating alignment within both areas. Exploring structures and benefits of WHT payroll team going to RWT. ▪ Procurement – Work ongoing to support MOU (memorandum of understanding) agreed with BC Metrics, savings, joint savings and workplans, work on track although limited due to SWBH focus on MMUH (Midland Metropolitan University Hospital). Focussing on Financial Recovery Plan (FRP) opportunities and joint work plan. PA Consulting work establishes a procurement board. Undergoing discussions with provider collaboratives with regards to this. Working with CFOs (Chief Financial Officers) on contract management case as part of the FRP. ▪ Mandatory Training – a draft business case is in development and will be presented to the Collaborative Executive shortly. **3) BCPC Case for Change** The current 'case for change' is still a draft and will be engaged more widely through the Collaborative Executive and sovereign Trusts, before being finalised for approval in the coming months. **4) Joint Board Development programme** A proposal paper was received and discussed regarding the planned programme of Joint Board Development workshops. Direction was provided for the 19th April agenda, and will be finalised at the next meeting. It is intented that the Joint Board workshops should replace work being undertaken by individual organisations, with governance leads encouraged to review and reduce as soon as possible. The BCPC CEO will work withal Board Secretary's to align this work at a system level, with the possibility of including the ICB also. **5) Communications workstream** The points to note include: ▪ ICB drafting a paper to establish a joint 'JHOSC' (Joint Health & Overview Scrutiny Committee), following this can have one single conversation with the four chairs of the four 'JHOSC'.	

		▪ Awaiting the output of a 'listening exercise' undertaken by STAND (*this is the name of a company*), who have concluded their findings, with the report hopefully to be presented at February's meeting. ▪ Anticipation of pre-elective period from the 20th of March, in the process of establishing what we can and cannot do prior to this period. **6) Workforce Workstream** The key points to note are: ▪ The Collaborative Executive received a Closure report for the ESR (Electronic Staff Record) project, with lots of lessons to learn from and a clear set of recommendations to consider, which were agreed 'in principle'. ▪ The Collaborative Executive received a proposal for the pursuit of Centralised Recruitment Function as the next part of the consolidation work within the HR & Workforce.	
Dudley Health & Care Partnership	Dudley Health and Care Partnership Board in place. Full Time Programme Director in post to support the development of the Partnership. Partnership has agreed an Integrated Model of care which is being worked to. 5 workstreams delivered via 8 work programmes support the implementation and development of the integrated model of care. Black Country Place Action Learn Set meets monthly.	➢ Dudley Health and Care Partnership Board Terms of Reference have been updated to reflect the new arrangements. ➢ A draft Memorandum of Understanding is currently being coproduced by the members of the Place Professionals Network. Version 5 has been shared with the Executive Team with plans for the final version to be circulated to DHCPB members for on at their April meeting. ➢ A plan on a page has been produced (Appendix 1) which shares: ➢ The Board's Priorities, as set out in the Joint Forward Plan. ➢ 3 Intermediate Priorities for 2024/2025. ➢ 6 recommended objectives for the Board to have oversight. ➢ Workstreams that will drive improvements. ➢ A set of KPI's for the Board to monitor. The Joint Forward Plan refresh has been prepared by the ICB which includes a refresh and update of Dudley's Joint Forward Plan. **Partnership Engagement Event** • On Tuesday 12th March the Partnership held its second primary care/community and secondary care networking event at Brierley Hill Civic Centre.	Agree Memorandum of Understanding for the Partnership with ICB. Refine KPI's and outcomes and establish performance reporting structure. Review model for Dudley's People Panel to take the conversation to a more diverse range of people (via existing arrangements/events). Re-launch Community Partnership Teams with a revised SOP and celebrate success sharing Yr1 data with partners and stakeholders. Introduce Shopshire Community Health NHS Trust to the Partnership. Provide evidence for Family Hubs / Start for Life Programme

	Ambitions for Dudley Place were presented to the ICB. Priority agreed for 2024/25. 5 Family Hubs are operational. Partnership agreed that DGFT will be the host of the partnership and that we work towards DGFT been the lead provider.	• Over 100 people attend the event to include over 20 stall holders offering a vibrant marketplace for clinicians to find out about the wide offer of voluntary, community and statutory services on offer. • The Chair of the Partnership, Dr Ruth Edwards shared recent developments at place which included a look back in time at her long career as a GP in Dudley. • The focus of the event was falls prevention and colleagues from the Local Authority, Dudley Integrated Health and Care and Dudley Group showcased the current pathway. • All attendees joined in a demonstration of the exercises used in Stream 0 Falls Prevention Sessions led by the Park Activators. • A report and feedback from the event will be shared once completed. **Mental Health and LDA Strategic Development Group** • BCH coordinated the first Mental Health and LDA Strategic Development Group which was attended by the Programme Director and colleagues from Dudley Place. As it was an inaugural meeting the agenda included some programme scene setting which provided a spotlight on some partnership work. • The purpose of the group is to provide a transformational steer to the ongoing developments of the MH/LDA programme/partnership boards to ensure there is a coherent strategy and approach across the pathway. **Dudley People Panel** • In partnership with the ICB, Dudley hosted its 4th "People Panel" on Saturday 9th March at the Brett Young Carers Centre in Halesowen. The purpose of 'People Panels' is to provide a mutually beneficial space that promotes meaningful conversation, deep listening and which leads to stronger relationships, wiser action, and real collaboration. • Over 30 people attended the event which was hosted for the first time on a weekend.	and support the financial planning for sustainability. Support the co-production of the ICP strategy. Use learning from the HSJ Health Inequalities Network to inform future plans. Support the launch of the Dudley Community Information Directory (DCID) with a focus on care coordination and navigation. Plan and deliver an online engagement event for Primary, Community and Secondary Care colleagues to broaden the reach and offer an alternative method of engagement i.e. podcasts etc. Produce a 2023/2024 Annual Report for the Partnership

Goal: Improve health and wellbeing		Executive lead: Chief Operating Officer	
Metric: Improve rate of early detection of cancers			
Target: 75% of cancers diagnosed at stages I,II by 2028 (NHS Long Term Plan)			
Workstreams	**Current status**	**Summary of progress this quarter**	**Actions planned for next quarter**
Understanding the data	Data held by Cancer Outcomes and Services (COSD) for Q3 23/24 shows a staging completeness of 85.4% against 62 diagnosed patients. 44% of patients in Q3 were stage I or II (22 out of 62, 14 patients not staged)	Data completeness has improved for the last 12 months, there are still patients who have not been staged at multi-disciplinary team (MDT) but this may be down to factors such as patient has passed away before full diagnosis or referred straight for best supportive care etc. Staging has increased for lung and there has been a decrease of missing staging. Data for 2019/20 was updated retrospectively and submitted to ensure that there is baseline data for the Targeted Lung Health Check programme. We continue to monitor patients where data in incomplete using missing data reports	Cancer services working with local implementation team (LIT) to review staging data and the completeness of data. LIT are interested in looking at GP data and the staging of patients they have referred. Cancer Services team to review 2023/24 missing data during April 24.
Lung cancer	Programme manager for Targeted Lung Health Checks started and business case going through trust governance	Programme manager started from 1st January Business case finalised and discussed at exec team 26th March and finance committee 28th March ahead of recommendation to board on 11th April Preparation of contract with third party supplier Monthly Delivery Group in place chaired by System Diagnostics Lead, recruitment for other programme posts including clinical director started and development of communications and engagement plan	Appointment of remaining programme roles Sign contract with supplier and implement mobilisation plan with aim of commencing first scans in Q2 24/25
Metric: Increased planned care and screening for the most disadvantaged groups			
Target: BSP 03- Uptake - Acceptable level: greater than or equal to 70.0% - Achievable level: greater than or equal to 80.0%			
Breast screening	Uptake across the service has increased with updated figures for Q2 and unvalidated for Q3 figures	Q3 - Uptake There will be several open episodes from this period that are yet to attend screening for various reasons, therefore it is possible this figure could increase slightly. Record of attendance is not included in data until the episode is closed.	Q4- Q1 events - Dudley Cancer bus in Dudley town centre engaging with local communities.

	would not be extracted for validation until 6 weeks post quarter end. (Figures taken from KC62) Q1 updated figures – 69% Q2 updated figures 77% Denominator 7683 – Numerator 5915 Q3 (unvalidated) 68% Denominator 8077 Numerator 5480	The service continues to work with external stakeholders to put on community events which will commence during the Q4 due to the time of year and also the absence of the Health Equity Lead during Q3 who has now returned to duty. The clinics for the Dudley Central mobile are now in place and will commence from 20/3/24. Implementation of second timed appointments is on hold as further consideration is needed due to staffing issues that the service has sustained more recently and may impact on the capacity of appointments available.	Visiting Practice Managers of Keeling House and St James. Regular GP visits will continue across the patch GP event at Copthorne where we engaged with GP's and Practice staff Working with Parminder/Shelagh with Pharmacy/Optical Services. Using pharmacy bags with logo. Posters in Surgery, advice to be given by Pharmacists if approached Working closely with Care Co Ordinator for the PCN alongside ICB Cancer Facilitator to support the Practices. We have asked to be invited to the next Practice Managers Meeting for the PCN, which is held monthly to talk about the importance of engaging and being proactive which will see a rise in uptake
Planned care	Trust continues to monitor key performance metrics such as total elective list, long waiters and DNA rates by ethnicity and deprivation	Health Inequalities Core Group reviewed available metrics and looking at ways to make specialty level information available to services Developed poverty proofing proposal for childrens services to offer free bus passes to children and those accompanying them to their hospital appointments	Pilot the programme and monitor impact on missed appointment rates

Part 3 – Transformation Programmes

Programme: Black Country system service transformation		**Executive lead: Chief Operating Officer / Director of Strategy & Integration**	
Workstream	**RAG**	**Summary of progress this quarter**	**Actions planned for next quarter**
Urgent and Emergency Care		Urgent and Emergency Care continues to be a challenging area of focus. Emergency Department 4-hour performance for February was 73.8% vs 76% national target. Concerted efforts by all staff led to the trust exceeding the request to achieve 76% in March (unvalidated result showing 77.7%) and trust is waiting to hear if this qualifies for incentive monies from NHS England. Overall Triage Performance for February was 80.6% vs 95% national target. We remain best in the region for our triage performance. Utilisation of pathways remains negligible with most days recording single figures of calls to Hub from WMAS and the proposed call before convey scheme did not start as planned. Call before you convey is having little difference on the number of ambulances arriving at ED and this has been flagged to the wider system. The Integrated Front Door team that started in November 2023 aims to help identify patients that are suitable for alternative pathways. The team consists of the discharge team, care coordinators, and therapy teams. Since commencement of this group there has been an increase in referrals from 120 to over 250 and ensures that people can go home and have the appropriate support at the front door.	Additional trolly capacity now in place to ensure offloads happen promptly at the ambulance entrance ED operational escalation bleep initiated through office h and point of contact for urgent escalations New flow working group has been started with Karen Ha as chair with the purpose of designing new pathways an ensuring optimisation of existing patient flow, both prehospital and via discharges

Restoration of Elective services		Update has been provided under 'Drive sustainability' above	Update has been provided under 'Drive sustainability' above
Cancer services redesign		The 28 day Faster Diagnostic Standard (FDS) achieved 82.5% (January validated) against the constitutional standard of 75% and expected to achieve in February and March. Performance in January achieved 58.6% compared to 68% the previous month. This is below the national target of 85% and the NHSE target of 70% by the end of March 2024. CDC Dermoscopy service commenced in January, this is to support dermatology referrals for suspected cancers. Patients to receive imaging in the community setting to support robust triage of referrals to ensure that we utilise rapid access capacity appropriately	Weekly PTL meetings to incorporate 31-day decision to treat date in addition to 62-day decision to treat date.
Black Country Provider Collaborative (BCPC)		Update has been provided under goal 'Build innovative partnerships' above	Update has been provided under goal 'Build innovative partnerships' above

Programme: Local Leadership to address health inequalities		**Executive lead: Medical Director / Director of Strategy & Integration**	
Workstream	**RAG**	**Summary of progress this quarter**	**Actions planned for next quarter**
Leading as an anchor institution in Dudley		The Trust has held more 'Behind the Scenes' events to promote NHS career opportunities and the options available to young people who are currently in the process of picking their career paths. The students were taken to a variety of locations such as Pharmacy and Maternity. Alongside this, they had the chance to meet with staff at the market 'stalls' set up for them, this included representatives from the Staff Networks and the volunteers.	Further 'Behind the Scenes' events are scheduled for the next quarter and there has also been an invite for staff to become Dudley Group Career Ambassadors to help inspire future generations to consider a career within the NHS.

		The Dudley 'ICAN' scheme interviews have been conducted and placements have begun. This scheme provides apprenticeships to those who don't have formal qualifications and develops their skills through the workplace.	Apprentices will continue to start in the trust in the next quarter and will be supported through their time of employment and beyond.
Addressing health inequalities		Work has begun on a poverty proofing project with agreement reached with National Express for free bus passes for children and those accompanying them to their hospital appointments. A proposal has been created to provide food vouchers to children and young people who will miss their free school meal due to their hospital appointment. The request has been made of Mitie to contribute towards this, with charitable funds providing the rest. The Health Inequalities Core Group continues to meet monthly, and the promotion of the HEAT (Health Equity Assessment Tool) continues.	If the poverty proofing proposal is approved, there will be a pilot period of 6 months with diabetes, asthma and epilepsy specialties (which are the focus of the NHSE initiative of Core20PLUS5). If this is successful in decreasing the Was Not Brought rates in these specialties a further proposal will be brought for all paediatric specialties. The Health Inequalities Core Group will continue to meet monthly, and work is ongoing on dashboards for patient level metrics in order to comply with NHSE requirements.

Programme: Research & Development, Education and innovation		**Executive lead: Medical Director**	
Workstream	**RAG**	**Summary of progress this quarter**	**Actions planned for next quarter**
Research & Development		Two out of the three planned NIHR grant submissions were submitted. The colorectal surgery bid submitted in November 2023 was unsuccessful; pending outcome (June 2024) of the orthopaedic/community joint bid; the bid relating to breast screening with Wolverhampton University was paused. Showcase i-research, i-innovate, and i- educate video is complete. Editing and formatting and still images ongoing. Launch individual edited interviews on HUB, In the Know has commenced.	• Funding opportunities/grant applications to be promoted more widely to staff to encourage a pipeline of applications for the year ahead • opening new studies, commercial study portfolio to be enhanced, to increase income • Working with Alcohol Prevention Care Team to submit NIHR Health Technology Assessment (HTA) programme bid, closing date 22.05.24 • Further showcase events planned: poster presentation event with Sandwell and Birmingham – 6th May for one week

		Research and Innovation seminar in February 2024, was successful, feedback is being collated. Continued with monthly Research and Innovation Support sessions and Research Champion Meetings Research & Innovation information now included in new starters induction booklet Non-medical student placements re-commenced, 1 x Physiotherapy student completed 4-week placement; continue to host nursing students. 50/50 studentships with Aston University: Student working with Mr M Wall, research study submitted to ethics committee for approval, pending outcome; Student working with Mr A Akingboye is undertaking baseline laboratory work to inform research project. 6 new Principal Investigators for NIHR portfolio studies	• Re-launch Research Champions as existing group is merging with AHP ABC Research Champion Group (established via Clinical Research Network funding and secondment post) • Meeting with DIHC research leads to work collaboratively and build existing capabilities • Development of research activity dashboard for intranet (Hub), to promote activity awareness • Progress with formalising joint clinical/academic contracts for DGFT/University staff
Education		• Lead Clinical Support Worker for professional development awarded national nursing officer award • PACES exams successfully hosted • Ron Grimley awards held with high quality entries commended • NETs survey results received – Medical areas of concern in foundation medicine and general paediatrics around facilities, team work, work load and supervision. Action pans commenced.	• FRCS Vascular to be hosted in May 2024 • Business Case for medical apprenticeship programme to be submitted • Chief registrar recruitment for 2024/25 • Three Counties Medical School placements to commence in May 2024 • Medical work experience running June 2024 • ACP E-portfolio to be launched • GMC NTS survey results due late May/early June
Innovation		Continued with logging all innovations as much as possible and promoting support available to develop ideas. Hub pages are up to date with the process to follow and useful links. Collaborative approach across the organisation, to promote and support staff to develop ideas, including organisational development, Dudley Improvement Practice, strategy team.	Enhance and continue to promote support for any staff ideas (whether evaluation, improvement, innovation, research)

		Good established links with Health Innovation Network and MidTech. Presented at Research Showcase in February 2024. Continue with Research and Innovation sessions to nurture ideas. Research & Innovation now included in new starters induction booklet	

Part 4 – Increase the number of services jointly delivered across the Black Country (Maturity matrix of level of collaboration)

Key:

None or minimal	
Moderate	
Considerable	
Extensive	
No applicable / out of scope	

Level of collaboration assessed from perspective of The Dudley Group NHS FT.

Factors to be considered when assigning scores:

- Established clinical network in the Black Country, either as part of the ICS or provider collaborative
- Plans for changing pathways have been developed by teams from different organisations
- Plans for changing pathways are implemented by teams from different organisations
- Clinical staff provide care across more than one locatio0n under an agreement between organisations
- Joint staff appointments

Service	**Provider collaborative**		**Place-based partnership**	
	Score	**Comment**	**Score**	**Comment**
General Surgery including colorectal		Colorectal clinical network contributed to development of robotic business case and is developing plans to move work around the system		
Urology		UAN well established, surgeons practice at different hospitals under SLA, plans to move work around the system including creation of renal cancer centre at DGFT		
Vascular Surgery		Network well established, some consultants have moved to DGFT as host, SLA between RWT & DGFT		
ENT		Long standing shared consultants between RWT & DGFT, participation in provider collaborative clinical network		Not aware of any discussions with primary care about pathways e.g. audiology
Ophthalmology		Provider collaborative clinical network lead from DGFT, not yet led to pathway changes		Discussions about transforming pathways with local optometrists just started
Oral Surgery		Not aware of any formal collaboration		Not aware of any formal collaboration
Plastic Surgery		Mohs surgery has now launched with participation from Dudley, Wolverhampton and Walsall trusts; participation in provider collaborative clinical network for skin		

Trauma & Orthopaedics		Provider collaborative clinical network from DGFT, plans for pathway changes at an early stage		MSK pathways being considered as one of the clinical pathways as part of implementation of model of care in Dudley. Business case has been developed
Pain Management		Services under pressure across the system with some discussions started		Plans being developed to use vacancies in secondary care to fund GP with special interest to manage demand
Obstetrics and maternity		Participation in Local Maternity and Neonatal System (LMNS)		Community midwifery integrated with health visiting and children's social care in the Family Hubs across Dudley to support First 1001 Days
Gynaecology		Participation in provide collaborative clinical network, not yet led to any pathway changes		Relationship with primary care being considered as part of clinical network discussions but no plans yet
Paediatrics		Not aware of any formal collaboration		Children's services is one of the workstreams for the Implementation of Model of Care in Dudley. Service investigating which outpatient services can be delivered from Family Hubs
Critical Care		Participation in provider collaborative clinical network and WM network		
Emergency Medicine		Not aware of any formal collaboration		Department works closely with partners in place via the A&E Delivery Board, Urgent Care Centre is co-located. Development of the Clinical Hub is a core workstream for the Implementation of Model of Care in Dudley
Acute & General Medicine		Not aware of any formal collaboration		See above. SDEC takes referrals from primary care via the clinical hub
Gastroenterology		Not aware of any formal collaboration although informal networking between Alcohol Care Teams within the Black Country as part of the national roll-out		
Respiratory Medicine		Not aware of any formal collaboration		There are local implementation teams for both COPD and lung cancer with representation from different agencies. Contributed to creation of Acute Respiratory Infection hubs
Cardiology		Long standing arrangement of DGFT consultants practicing at RWT, Black Country Cardiovascular Network being re-established		Not aware of anything specific going on with primary care
Oncology		Long standing arrangement of RWT consultants practicing at DGFT		

Diabetes & endocrine		Not aware of any formal collaboration		Department contributes to diabetes MDTs in primary care
Renal medicine		Not aware of any formal collaboration		
Stroke		Discussions other trusts to develop a business case including provision of dedicated rehab beds away from Russells Hall		
Dermatology		Participation in provider collaborative clinical network for skin		Tele-dermatology solution is being implemented across ICS including primary care
Rheumatology		Not aware of any formal collaboration		MSK pathways being considered as one of the clinical pathways as part of implementation of model of care in Dudley. Business case has been developed
Neurology		Not aware of any collaboration between trusts in BC ICS, DGFT trying to establish relationship with UHB		
Community Services				Community Partnership Teams are one of the workstreams for the Implementation of Model of Care in Dudley using a population health management approach
Imaging		Participation in WM Imaging Network, potential to link Sandwell CDC implementation to existing CDC in Corbett		
Cancer screening		DGFT provides breast screening service to both Dudley and Wolverhampton; RWT provides bowel screening (FIT) for Dudley		
Pathology		BCPS fully established, workforce hosted by RWT		
Pharmacy		Participation in provider collaborative clinical network. Regular contact between pharmacy departments offering professional peer review and support.		Participation in ICB group, pharmacy leadership. Area Clinical Effectiveness Groups meets intermittently. Following dissolution of DIHC, all pharmacy teams will be in one organisation