



Board of Directors (Public session) Further reading Pack

Thursday 8th May 2025



Recently at an NHS England Children and Young Peoples regional celebration event, our youth worker, Luke Purdy, won an award of recognition for his contribution to Youth Work services within the West Midlands. Luke is currently funded through the Dudley Group NHS Charity.

Luke supports young people living with long term health conditions and he has presented at regional events and meetings to showcase and advocate for the necessity of the Youth Work role within health services. Congratulations to Luke!

BOARD MEETINGS PUBLIC INFORMATION SHEET

The Dudley Group meets in public every other month and welcomes the attendance of members of the public and staff at its Board meetings to observe the Board's decision-making process.

1. Introduction

This sheet provides some information about how Board meetings work.

Name signs for each board member are displayed on the table in front of the member to enable you to identify who is speaking at the meeting.

Some items are confidential (for example if they concern an individual or a commercial contract) – these are dealt with in part II (confidential) of the meeting.

Copies of the agenda and papers are available at the meetings, and on our website <http://dudleygroup.nhs.uk/> or may be obtained in advance from:

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2. Board Members' interests

All members of the Board are required to declare if they have any interests (e.g. financial) which are relevant to the work of the Trust and these are recorded in a register. If you would like to see the register, please contact the Board Secretary or visit our website.

Members are also required to state at the start of the meeting if they have an interest in any of the items under discussion. Special rules govern whether a member who has declared an interest may take part in the subsequent discussion.

3. Opportunity for questions

Members the public, should raise any questions directly to the Chair at the conclusion of the meeting.

4. Debate

The board considers each item on the agenda in turn. Each report includes a recommendation of the action the board should take. For some items there may be presentation; for others this may not be necessary. The board may not actively discuss every item – this does not mean that they have not received careful consideration; it means that nobody at the meeting considers it necessary to debate the subject. A formal vote need not be taken if there is a general consensus on a suggested course of action.

5. Minutes

A record of the items discussed and decisions taken is set out in the minutes, which the board will be asked to approve as a correct record at its next meeting.

The minutes as presented to the next meeting of the Trust Board for approval are added to the website at the same time as the papers for that meeting.

6. Key Contacts

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Audit Committee Chairs Report

Committee Chair: Joanne Hanley

10 th March 2025	
Internal Audit Recommendations	Reasonable Assurance
RSM LCFS Progress Report 2024/25 and 2025/26 Workplan	Reasonable Assurance
Data Quality and Standards Report	Substantial Assurance
Caldicott and Information Governance Summary Report	Reasonable Assurance
Losses and Special Payments	Reasonable Assurance

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE

- Two internal audit reviews published with negative assurance levels. Bank and Agency for medics internal audit review received the lowest minimal assurance rating requiring urgent action to ensure effective management.
- Patient Monies incident whereby a large sum of money went missing with failure to apply controls/adhere to procedures a significant contributory factor.
- Cultural theme weaving through internal audit assessments relating to a need for greater personal responsibility and adherence to the full suite of Trust policies designed to protect staff, patients and the organisation.
- Fragile nature of the Occupational Health service being monitored through the People Committee. There is a sound strategic solution but concerns around ability to maintain a fully effective service in the shorter term.

MAJOR ACTIONS AGREED

- Watching brief around cyber compliance and the evolvement of increasing requirements/assurance in this space.

POSITIVE ASSURANCES TO PROVIDE	DECISIONS MADE
<ul style="list-style-type: none">• Reasonable assurance from internal audit around the Grievances framework and Income & Debtors along with an advisory review of the Maternity Incentive Scheme evidence prior to submission.• Above the line draft annual internal audit 2024/25 report and opinion, recognising progress the Trust has made, the journey and the continued focus on enhancing the risk and control framework.• High Data Quality Maturity index, higher than the national position on a combined basis and across each individual data set.	<ul style="list-style-type: none">• Audit action extension requested approved for Occupational Health & Board Assurance Framework.• Approved 2025/26 annual Internal Audit plan and charter in addition to the 2025/26 Counter Fraud workplan.• Approved External Audit plan and fees, which will include assurance on the DIHC transaction along with an increase in the materiality threshold aligned to revised Financial Reporting Council guidance on materiality.• Approved minor changes to the accounting policies in line with central and national guidance application.• Approved the segmental analysis for the accounts, with a continuation of previous year approach.• Approved prior year accounts adjustment to reflect IFRS 16 impacts for PFI equipment.

Finance and Productivity Committee Chairs Report

Committee Chair: Lowell Williams

27 th March 2025	
Corporate Risk Register	Substantial Assurance
EPRR Strategy Annual Review	Substantial Assurance
Integrated Performance Report – Month 11 2024/25	Reasonable Assurance
Finance Update Month 11 2024/25	Substantial Assurance
Trust Annual Plan and CIP Plan 2025/26	Reasonable Assurance

24 th April 2025	
Green Plan Update	Reasonable Assurance
Integrated Performance Report – Month 12 2024/25	Reasonable Assurance
Ambulance Handovers Deep Dive	Partial Assurance
Patient Transport Service Deep Dive	Partial Assurance
Finance Update Month 12 2024/25	Substantial Assurance
ED Redesign Update	Substantial Assurance

Meeting held on 27th March 2025

<p>MATTERS OF CONCERN OR KEY RISKS TO ESCALATE</p> <ul style="list-style-type: none"> The Trust remained challenged with ambulance handovers, with opportunities to improve ED triage and discharge. The committee noted concerns at the performance of the non-emergency patient transport service operated by West Midlands Ambulance Service. The committee noted that the Trust would not achieve its WTE reduction. 	<p>MAJOR ACTIONS AGREED</p> <ul style="list-style-type: none"> The committee requested a rewording of BAF risk 4 for 2025/26 A deep dive into the patient transport service was requested. A proposal was requested to be brought to the committee for revised reporting arrangements for productivity, CIP and workforce management supported by a dashboard.
<p>POSITIVE ASSURANCES TO PROVIDE</p> <ul style="list-style-type: none"> The Trust demonstrated an overall continued strong operational performance. The February financial performance gave confidence of the Trust achieving a year end budget position of - £1.59m with a strong underlying cash position. 	<p>DECISIONS MADE</p> <ul style="list-style-type: none"> The committee agreed to sign off BAF risks 7 and 8 for 2024/25. The committee approved the revisions to the Emergency Preparedness, Resilience and Response (EPRR) strategy. The committee approved the final budget package for 2025/26 including capital. The extension to the Medirota contract was approved.

Meeting held on 24th April 2025

<p>MATTERS OF CONCERN OR KEY RISKS TO ESCALATE</p> <ul style="list-style-type: none"> The committee noted concerns with the current arrangements for patient transport and requested an urgent review of internal procedures and contractual arrangements with third parties. Whilst noting a general pattern of improvement, the performance of Black Country Pathology Service remains problematic in part. 	<p>MAJOR ACTIONS AGREED</p> <ul style="list-style-type: none"> The committee requested a strategic overview of discharge and length of stay across the Trust including an analysis of discharge outliers. The committee requested a specific review of triage and the impact of ambulance handovers.
<p>POSITIVE ASSURANCES TO PROVIDE</p> <ul style="list-style-type: none"> The committee had assurance of discharge arrangements leading to reduced lengths of stay on C8 and B3. However, the committee noted the need to have a consistent approach cross the Trust. The emergency department redesign is progressing well The draft financial outcome for the Trust in 24/25 shows the Trust hitting the financial plan with a deficit of £1.54m (£47k better than plan). The committee received substantial assurance that the Trust will deliver on workforce targets for 25/26. 	<p>DECISIONS MADE</p> <ul style="list-style-type: none"> The committee agreed the revised reporting of progress against CIP for 2025/26. The score for BAF risk 4 remained at 20. This BAF would be refreshed for the new 2025/26 financial year. The score for BAF risk 5 remained at 12. The score for BAF risk 7 remained at 20. This BAF would be refreshed for the new 2025/26 financial year. To enable the committee to effectively review the Digital Trust Steering Group Update and the Cyber Security Report, it was agreed for these to return to the June committee meeting.

Quality Committee Chair's Report

Committee Chair: Professor Liz Hughes

25 March 2025	
Integrated Quality Report	Reasonable Assurance
Discharge Improvement Work	Reasonable Assurance
Quality Impact Assessment Report	Reasonable Assurance
Response to MBRRACE Dudley Perinatal Mortality Report - 2023 births	Substantial Assurance
Performance Against Workforce Forecast	Reasonable Assurance
Martha's Law	Substantial Assurance
Domestic Abuse Improvement Plan	Partial Assurance
CQC Self-Assessment Report	Substantial Assurance

29 April 2025	
Integrated Quality Report	Reasonable Assurance
Discharge Improvement Work	Partial Assurance
Corporate Risk Register	Reasonable Assurance
Perinatal Quality Report	Substantial Assurance
Quality Priorities Progress Report	Reasonable Assurance
Chief Nurse & Medical Director Report	Substantial Assurance
Performance Against Workforce Forecast	Reasonable Assurance
Learning from Deaths	Substantial Assurance
Medicines Optimisation Delivery Plan 2025-29	Substantial Assurance

<p>MATTERS OF CONCERN OR KEY RISKS TO ESCALATE</p> <ul style="list-style-type: none"> Challenges with timely patient observations noted, with improvement work in place. Slight improvement in vital signs reporting. Safeguarding Children Level 3 training poor compliance; PLACE division training working through since transfer from DIHC. Sepsis pathway not improving as expected, improvement work ongoing; partial assurance received for improving position for sepsis screening and IV antibiotics within the hour for both Medicine and Surgery. Ongoing action plans for maternity and paediatrics monitored via Divisional Governance meetings, as well as weekly assurance oversight at Executive level. Education and training ongoing with Deteriorating Patient Pathway team. Ongoing work for domestic abuse recognition. Receipt of timely and complete reports of the appropriate quality was noted as a significant concern at the Risk & Assurance Group. Furthermore, a number of reports have had extended deadlines or deferments across the reporting cycle. Regulation 28 - Prevention of Future Deaths report received in April, pertaining to patient discharge. Immediate actions were taken at the time of incident (April 2023), and a comprehensive improvement plan is being developed and will be incorporated into Discharge Improvement work. Corporate Risks actions breaching completion dates; governance team actively chasing risk owners to ensure actions complete to close risks. 	<p>MAJOR ACTIONS AGREED/WORK UNDERWAY</p> <ul style="list-style-type: none"> Agreed ratings for CQC self-assessment to be shared with Provider Collaborative. Discharge improvement work continues resulting in recent improvement in daily discharge and weekend planning, but this has not been consistent. Discharge Improvement Group relaunched, and digital bed system in process with Go Live date pending. Weekly Rapid Improvement Group to be established, to focus on key improvement metrics. Agreed joint report to address challenge to be submitted to Quality Committee and Finance & Performance Committee. Performance against workforce forecast reflection and learning from 2024/25 incorporated into 2025/26 plan to include in year developments and known growth, following engagement with divisions, to be triangulated with activity and workstreams established. Digital work ongoing across ICB and all providers to consider joint contracts for the Patient Administration System and Electronic Staff Record.
<p>POSITIVE ASSURANCES TO PROVIDE</p> <ul style="list-style-type: none"> Significant improvement in pressure ulcer incidents in February as a result of ongoing improvement work. There is a longer-term piece of work for pressure ulcers and falls from a PSIRF perspective. Substantial assurance received for the QIA report and CIP. Slight improvement in vital signs reporting, in line with ongoing improvement work. 	<p>DECISIONS MADE</p> <ul style="list-style-type: none"> The assurance level for BAF Risk 1.1 remains as positive with further assurance regarding discharge improvement sought. Recommendation to Board to reduce risk score to 9, meeting the target level. The assurance level for BAF Risk 1.2 remains as positive. BAF refresh underway as part of Trust Strategy work. The Committee reviewed, discussed, and approved the following documents: <ul style="list-style-type: none"> Terms of Reference: Quality Committee

- No evidence of the current workforce reduction plan compromising quality and safety.
- Good assurance on continued implementation of Martha's Law.
- Significant intervention and improvement work following Dudley MBRRACE-UK perinatal mortality report (2023 births), with recent Peer Review of Neonatal Services showing demonstrating significant improvements and reduction in mortality rates.
- There is a public embargo on the outcome of MIS Year 6 at the current time, and the Trust will be notified when this has been lifted, however a positive outcome is currently indicated for the Trust.
- Positive feedback received following LMNS visit to review Maternity Services on 23 April.
- Nursing Safer Staffing establishment within the assessed areas are in a positive position to maintain the provision and delivery of safe, effective and high-quality care. Ongoing work remains with 22% uplift as not applied across organisation consistently.
- Significant assurance for sustained improvement for Learning from Deaths; SHMI and HSMR remain stable within expected range.
- Positive assurance from the Chief Nurse and Medical Director report detailing significant winter pressures 2024/25, despite which the Trust maintained quality and safety. It is noted that some quality metrics were challenged. The next report will focus on staff wellbeing, resilience and psychological safety.
- Good levels of assurance on work underway in matters relevant to their portfolio for Quality & Safety, Risk & Assurance, Internal Safeguarding, Mortality Surveillance, Health, Safety & Fire, and Research, Education & Innovation.

People Committee Chairs Report

Committee Chair: Catherine Holland

25 th March 2025	
<ul style="list-style-type: none"> Workforce Key Performance Indicators continue to provide a good picture overall, with positive assurance that appropriate actions are in place. Still concerned about Sickness, but significant work underway to address this, including a taskforce established. 	Partial Assurance
<ul style="list-style-type: none"> 95% retention rate of international nurses. 	Substantial Assurance
<ul style="list-style-type: none"> Significant work underway to launch and embed 2 new policies (Anti-Bullying and Anti-Discrimination and the Grievance policy). 	Reasonable Assurance

29 th April 2025	
<ul style="list-style-type: none"> Workforce Key Performance Indicators continue to provide a good picture overall, with positive assurance that appropriate actions are in place. Some improvements in February and March for Sickness with targeted action underway. 	Reasonable Assurance
<ul style="list-style-type: none"> Performance against workforce plan - greater level of confidence in future plans due to learning and reflection which has taken place and the outline of actions in place. 	Partial assurance
<ul style="list-style-type: none"> Safer staffing review took place between January-March 2025 in line with national guidance. 	Reasonable Assurance
<ul style="list-style-type: none"> The management and support of Physician Associates demonstrated detailed work undertaken since its inception in June 2024 and the support provided to PAs to ensure patient safety as a result of the GMC guidance. 	Substantial Assurance

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE

March

- Workforce KPI's – concern remains about sickness absence but significant work underway to address via the taskforce.

April

- Sickness absence – have seen an improvement in the in-month figure across February and March, slight increase in 12-month rolling figure, but indicates the trend is levelling out. The Committee heard about the targeted action in place for areas with high levels of absence. Whilst starting to see improvement, it remains above Trust target.
- Level of bank usage across March was significantly high, this was attributed to poor management of annual leave.

MAJOR WORKS COMMISSIONED/ACTIONS AGREED

March

- Significant work underway to launch and embed two new policies (Anti-Bullying and Anti-Discrimination and the Grievance policy).
- Mandatory training – significant monitoring underway, divisions to report on it as part of deep dives, requested by the Committee, following concerns around compliance.
- Bank usage deep dive referred for further work before it comes back to this Committee via Executives.

April

- EDI Journey – positive report with progress on equitable working environment, improvements in retention of a workforce representative of Dudley and clear leadership accountability. The report outlined clear actions for year 3 of the EDI Journey.

POSITIVE ASSURANCES TO PROVIDE

March

- Continued positive assurance on BAF Risks 2 and 3.
- Positive assurance given on the BCPC workforce update, noting the potential risk of escalated union activity if negotiations are unsuccessful.
- Band 2/3 – reasonably assured of the positive relationship with trade union colleagues and progression of this work.
- Turnover, Retention, vacancies, and mandatory training are all within the Trust targets and remain stable.
- The Committee was happy to hear about the 95% retention rate for international nurses.
- There continues to be a significant focus on being a brilliant place to work and thrive, with positive work underway via the Steering Group.
- Staff survey results 2024 – the organisation remained at benchmark average position when compared to peers with a slight decline in scores when compared with 2023 results. Free text analysis would be brought back to Committee for further work. The Committee noted the significant improvements on the Neonatal Unit results as a result of targeted support and recognised the value of targeted support.
- Dudley Improvement Practice workstreams – “Community First” and “Frailty - Hospital Where Necessary” would launch in April.

April

- Annual Committee effectiveness review concluded the Committee worked well overall rated 4-5 across all elements, with positive feedback on timely circulation of papers, high standard of minutes and it was considered well chaired. Small negative was time spent chasing reports.
- Job planning – 93% of consultants had completed a job plan (81% achieved full sign-off), 52% of AHP's had completed a job plan (28% achieved full sign-off).

DECISIONS MADE

March

- Agreed to retain BAF Committee assurance levels as ‘Positive’ for BAF 2 and 3.
- The Committee agreed the Anti-Bullying and Anti-Discrimination focus of the staff survey action plan and ask the Board to formally endorse this.

April

- Approval of the quarterly report on progress against the strategy and annual plan.
- Approved Terms of Reference with amended membership and workplan for submission to Board.

- Band 2/3 - full agreement reached with trade unions for transitional arrangements and back pay.
- Turnover, Retention, vacancies, and mandatory training are all within the Trust targets and remain stable.
- Workforce forecast – greater level of confidence in future plans due to learning which has taken place and there was good engagement demonstrated not only with the divisions but also across Trade Unions.
- Safer staffing review took place between January-March 2025 in line with national guidance, safer staffing establishments in assessed areas were in a positive position, maintaining the provision and delivery of safe, effective, high-quality care. Agreement reached to standardise the approach to headroom/relief by recruiting to 15% and using the remaining 7% for contingency cover – this should have a positive effect on bank use.
- The Physician Associate Working Group report detailed the work undertaken since its inception in June 2024 and the support provided to PAs to ensure patient safety as a result of the GMC guidance.
- Good assurance provided from the Being a Brilliant Place to Work & Thrive, Wellbeing and EDI Steering Groups.

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Integration Committee Chairs Report

Committee Chair: Vij Randeniya

26 th March 2025	
DIHC Transaction Benefits Realisation Review	Substantial Assurance
Quarterly Community Service Plan Update	Reasonable Assurance
Quarterly Lung Cancer Programme Update	Substantial Assurance
University Hospital Trust Application Update	Reasonable Assurance
Dudley Quality Outcomes for Health Framework Update	Substantial Assurance
Information Hub/ Dudley CVS Update	Substantial Assurance

30 th April 2025	
Board Assurance Framework	Substantial Assurance
Integration – Where are we going in next 12 months and beyond	Reasonable Assurance
Quarterly Primary Care Development Plan	Substantial Assurance
Communications and Stakeholder Engagement Update.	Substantial Assurance
Committee Effectiveness Review	Substantial Assurance

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE

26th March 2025

- The committee received an update on noting the positive assurance on Dudley Quality Outcomes for Health Framework (DQOHF) work ongoing, noting the potential risk to the financial income for the practices across Dudley and the Trust practices for next year.

30th April 2025

- No matters of concern or key risks were escalated.

MAJOR WORKS COMMISSIONED/ ACTIONS AGREED

26th March 2025

- Kat Rose will present a further update on DIHC Transaction Benefits Realisation Review highlighting areas of progress against benefits identified.
- Kat Rose agreed to present an update on Accountable Care Organisation at the next committee.
- Amandeep Tung – Nahal updated the committee on the move of the clinical hub into a Care Navigation Centre (CNC). Both Amandeep and Kat are to ensure there is no duplication in work when planning the Operating Model for the Care Navigation Centre (CNC). The joint proposal on working together with Sandwell and West Birmingham NHS Trust, on the Care Navigation Centre is to be presented at a future meeting.

30th April 2025

- Committee Members were asked to give further consideration to the papers outlining Integration – where are we going and next 12 months and beyond and asked to provide feedback in the next three weeks.

POSITIVE ASSURANCES TO PROVIDE

26th March 2025

- The committee received positive assurance on DIHC Transaction Benefits Realisation Review, noting the work completed and recognised nationally by Neighbourhood Health where community partnership teams are aligned with the PCN's.
- Following the update on the Lung Cancer Programme, the committee received positive assurance from the 10 cases which were detected early.
- The committee noted the progress of work underway as part of the University Hospital Trust Application.
- Dudley Quality Outcomes for Health Framework (DQOHF) Update provided the committee with positive assurance noting the work underway to achieve DQOHF.
- The committee received positive assurance on work underway within the Information Hub.

30th April 2025

- A wide discussion had taken place around 'Integration – Where are we going in next 12 months and beyond', where the committee received positive assurance of the plan over the next 12 months which includes , Dudley Health and Care Partnerships, Community First, Plan for Collaboration between Sandwell and West Birmingham NHS Trust and DGFT Clinical Navigation Centres, Developing Accountable Care in Dudley, Dudley Neighbourhood Health 2025/26 Gap Analysis and Dudley Place Maturity Matrix.
- The committee shared positive assurance on the final draft of the Primary Care Development Plan.
- Quarterly Communications & Stakeholder Engagement update provided the committee with positive assurance of work ongoing and building relationships with the voluntary and community sector.

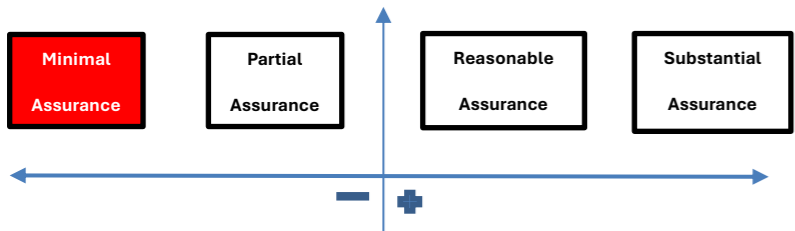
DECISIONS MADE

26th March 2025

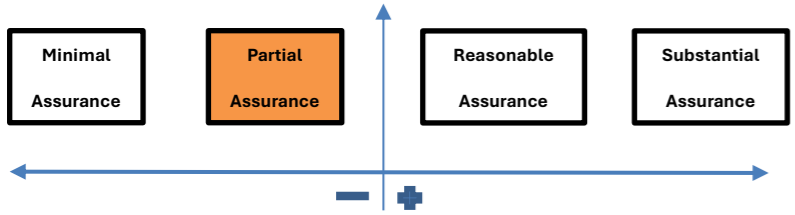
- No major decisions were made at the meeting.

30th April 2025

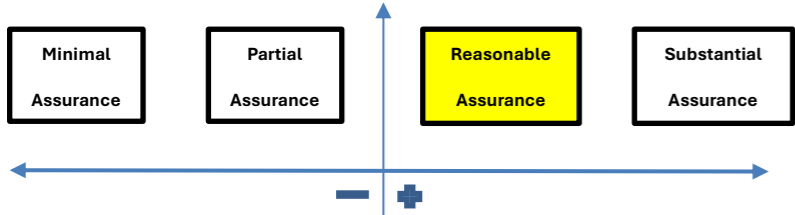
- Helen Board and Kat Rose presented the updated Board Assurance Framework (BAF) which is moving from Risk 6 to an updated Risk 3. The committee agreed the assurance level remains the same.
- The committee agreed the updated Terms of Reference.
- The committee agreed the workplan for 2025/26.



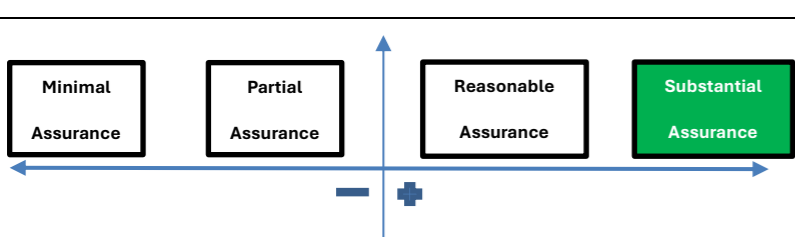
Management cannot clearly articulate the matter or issue; something has arisen at Committee for which there is little or no awareness and no action being taken to address the matter; there are a significant number of risks associated where it is not clear what is being done to control, manage or mitigate them; and the level of risk is increasing.



There is partial clarity on the matter to be addressed; some progress has been made but there remain a number of outstanding actions or progress against any plans so will not be delivered within agreed timescales; independent or external assurance shows areas of concern; there are increasing risks that are only partially controlled, mitigated or managed.



There is evidence of a good understanding of the matter or issue to be addressed; there are plans in place and these are being delivered against agreed timescales; those that are not yet delivered are well understood and it is clear what actions are being taken to control, manage or mitigate any risks; where required there is evidence of independent or external assurance.



There is evidence of a clear understanding of the matter or issue to be addressed; there is evidence of independent or external assurance; there are plans in place and these are being actively delivered and there is triangulation from other sources (e.g. patient or staff feedback)

Charity Committee Chairs Report

Committee Chair: Gary Crowe

27 th May 2025	
Spending Plans – 0305A Baby Bereavement Fund	Substantial Assurance
Finance Update	Substantial Assurance
Fundraising Update	Substantial Assurance

Meeting held on 27th May 2024

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE	MAJOR ACTIONS AGREED
<ul style="list-style-type: none">There were no matters of concern to escalate.	<ul style="list-style-type: none">No major actions were agreed.
POSITIVE ASSURANCES TO PROVIDE	DECISIONS MADE
<ul style="list-style-type: none">The second baby bereavement room had been completed on the delivery suite, which will serve bereaved families and rainbow families.The charity would apply for two upcoming grants to secure additional funding: the Innovation Challenge for young people's mental health and the Workforce Well-being Fund.A generous donation of £10k had been received from a previous patient on the breast care unit.The refurbishment of staff wellbeing rooms was progressing well, B1 work had finished and C5 had started.The Dragon Boat race had three boats with 20 staff from the Trust in each boat, they had raised around £3k towards their fundraising targets.£11.5k had raised for Committee to Excellence and £10.5k had been raised so far for the Glitter Ball.	<ul style="list-style-type: none">The committee supported the spending plans for the baby bereavement fund for improving counselling spaces and sourcing a provider to provide pastoral support for all who had suffered a miscarriage to a neonatal death.The committee supported transferring £250K to Brewin Dolphin for investment after reviewing the cash flow forecast.The committee effectiveness review was completed and the committee discussed the opportunity for additional Board members to join the committee.

EMERGENCY PREPAREDNESS RESILIENCE AND RESPONSE (EPRR) STRATEGY	DOCUMENT TITLE:	EMERGENCY PREPAREDNESS RESILIENCE AND RESPONSE (EPRR) STRATEGY
	Name of Originator/Author /Designation & Specialty:	Simone Smith – Head of Corporate Resilience
	Director Lead:	Chief Operating Officer /Accountable Emergency Officer
	Target Audience:	All staff
	Version:	9.0
	Date of Final Ratification at Board of Directors:	
	Review Date:	February 2025
	Registration Requirements Outcome Number(s) (CQC)	Safe Caring Effective Well Led Responsive
	Relevant Documents /Legislation/Standards	NHSE EPRR Core Standards The Civil Contingencies Act 2004 (Contingency Planning) Regulations 2005 National Risk Assessment
	Contributors:	Designation: Accountable Emergency Officer Senior EPRR and Business Continuity Advisor Corporate Resilience Project Support Officer (EPRR Team)
The electronic version of this document is the definitive version		

CHANGE HISTORY

Version	Date	Reason
1.0	March 2018	New strategy
2.0	September 2018	Addition of Training and Exercising Strategy element for EPRR
3.0	November 2018	Full review inclusion of Trust EPRR overarching risk assessment
4.0	October 2019	Annual Update

5.0	October 2020	Annual Update
6.0	July 2021	Update due to changes of the risk register
7.0	December 2022	Annual Review
8.0	November 2023	Annual Review
9.0	February 2025	Annual Review – Roles and Responsibilities updated to reflect the role of Trust Board; additional clarity added in terms of the COO's appointment as AEO and 'Terafirma' referenced as 'Digital Services'. EPRR reporting line updated. References to Emergency Plans updated to reflect amended document titles. Sections 5.12, 8, 9, 11 and 12 updated and refreshed in line with ICB and NHSE observations. References reviewed and amended.

A translation service is available for this document. The Interpretation/Translation Policy, Guidance for Staff is located on the intranet under Trust-wide Policies.

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THE DUDLEY GROUP NHS FOUNDATION TRUST

EMERGENCY PREPAREDNESS RESILIENCE AND RESPONSE (EPRR) STRATEGY

1. INTRODUCTION

The Dudley Group NHS Foundation Trust (here on referred to as the Trust) has a responsibility to ensure that it is properly prepared to respond to and recover from an emergency as defined by legislation and relevant guidance. This strategy indicates the Trust's programme of work to ensure compliance.

Civil Contingencies Act 2004 (CCA 04)

The CCA 04 defines that, as an acute trust, we are a Category 1 responder and therefore are required to fulfil six core duties:

- Risk Assessment
- Emergency Planning
- Business Continuity Management
- Communicating with the public
- Co-operation
- Information sharing

EPRR Framework 2022

This is the framework of recommendations made by NHS England containing overarching principles required for the embedding of good EPRR across an NHS trust.

EPRR Core Standards

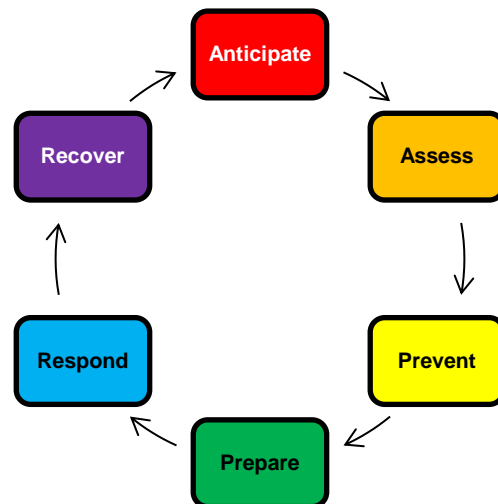
This is the annual assurance process undertaken to demonstrate that suitable EPRR arrangements are in place.

ISO 22301/302

This is the International Standard for Business Continuity that the Trust is expected to be aligned to.

Integrated Emergency Management (IEM)

This is the concept on which UK civil protection is based. IEM is a holistic approach to emergency preparedness. The Trust utilises IEM in the development of the annual work plan and preparation for response to civil emergencies.



Corporate Aims and Objectives

EPRR also considers the Trust's corporate aims and objectives in its IEM cycle.

Corporate Aim/Objective	EPRR Context
Deliver right care every time	The Trust's EPRR processes ensure that patient/staff safety is provided regardless of the incident being dealt with. This also includes aftercare.
Be a brilliant place to work and thrive	EPRR will be at the heart of ensuring that staff feel safe and able to respond to incidents as they occur.
Drive sustainability (financial and environmental)	Using cost save techniques, EPRR will be provided comprehensively whilst ensuring that costs are kept down.
Build innovative partnerships in Dudley and beyond	The Trust's EPRR processes are included within any new project planned and the Trust's Corporate Resilience Team will always ensure that new mechanisms and developments in the field are applied to the Trust's processes.
Improve health and wellbeing	The EPRR team will work to ensure that any resilience intervention that is required will continue to maintain and improve health and wellbeing of staff, patients, and visitors.

2. STATEMENT OF INTENT/PURPOSE

Aim

To indicate the processes by which the Trust ensures compliance against EPRR legislation, and the steps taken to ensure resilience across the Trust.

Objectives

- Ensure a planning process is in place with the full engagement of relevant internal/external stakeholders and multi-agency partners.

- Indicate relevant risks and associated mitigations pertinent to the Trust.
- Indicate processes for raising risks and issues related to EPRR processes.
- Indicate the training needs analysis pertaining to EPRR.
- Indicate the exercising needs analysis pertaining to EPRR.
- Indicate assurance processes for EPRR.

3. DEFINITIONS & ABBREVIATIONS

Emergency

Is defined by the Civil Contingencies Act 2004 as:

- An event or situation which threatens serious damage to human welfare in a place in the United Kingdom.
- An event or situation which threatens serious damage to the environment of a place in the United Kingdom.
- War, or terrorism, which threatens serious damage to the security of the United Kingdom.

Business Continuity Incident	An event or occurrence that disrupts, or might disrupt, an organisation's normal service delivery, below acceptable predefined levels, where special arrangements are required to be implemented until services can return to an acceptable level. This could be a surge in demand requiring resources to be temporarily redeployed.
Critical Incident	Any localised incident where the level of disruption results in the organisation temporarily or permanently losing its ability to deliver critical services, patients may have been harmed or the environment is not safe requiring special measures and support from other agencies to restore normal operating functions.
Major Incident	An occurrence that presents a serious threat to the health of the community, or causes such numbers or types of casualties, requiring special arrangements to be implemented. For the NHS, this will include any event defined as an emergency (as above).
Mass Casualty	Is defined as an incident (or series of incidents) causing casualties on a scale beyond normal resources of emergency and healthcare services' ability to manage. This may involve hundreds or thousands of casualties with a range of injuries; the response to which will be beyond the capacity of normal major incident procedures to cope and requires further measures to appropriately deal with these numbers.

Emergency Preparedness	Is defined as the extent to which emergency planning enables the effective and efficient prevention, reduction, control, mitigation of, and response to emergencies.
Resilience	Is defined as the ability of the community, services, area, or infrastructure to detect, prevent and, if necessary, to withstand, handle and recover from disruptive challenges.
Response	Is defined as decisions and actions taken in accordance with the strategic, tactical, and operational objectives defined by emergency responders.
Command	Is defined as the exercise of vested authority that is associated with a role or rank within an organisation (e.g. the NHS), to give direction in order to achieve defined objectives.
Control	Is defined as the application of authority, combined with the capability to manage resources, in order to achieve defined objectives.
Coordination	Is defined as integration of multi-agency efforts/capabilities in order to achieve pre-defined objectives.

4. DUTIES (RESPONSIBILITIES)

4.1 Chief Executive

Has overall responsibility for EPRR including business continuity.

The Chief Executive is responsible for ensuring that:

- The Trust has the required plans and arrangements in place.
- The Board receives regular updates on EPRR.
- Appropriate resources are made available to facilitate these responsibilities.
- Board level responsibility for EPRR is clearly defined with clear lines of accountability through the organisation leading to the Board.

The Chief Executive may designate these responsibilities to a Trust Accountable Emergency Officer (AEO). For the Trust, this is the Chief Operating Officer (COO).

4.2 Trust Board

All Executive and Non-Executive Directors have a shared responsibility to scrutinise evidence provided to them, gives adequate assurance that the Trust has suitable arrangements in place to meet national EPRR requirements. The Board will collectively ratify the EPRR Strategy when reviewed.

4.3 Accountable Emergency Officer (AEO)

The Chief Operating Officer (COO) is appointed as the AEO as Board-level Executive Director with responsibility for EPRR arrangements across the Trust. They are nominated and accountable to the Trust Board for producing and testing resilience arrangements for the Trust.

The AEO is responsible for ensuring that:

- The Trust, and any sub-contractors, are compliant with EPRR requirements as set out in relevant legislation and guidance.
- The Trust is prepared and resourced to deal with an emergency.
- The Trust has robust business continuity plans (aligned to ISO 22301) in place which will include any third-party contractors.
- The Trust is compliant with requirements set by the Integrated Care Board (ICB), NHS England, or others.
- Co-operation processes are in place to provide external partners with any appropriate information and/or assistance.
- The Trust is appropriately represented at relevant groups internal and external to the Trust i.e., Local Health Resilience Partnerships (LHRP), Local Resilience Forums (LRF) etc.
- The Board is updated and informed on issues relating to EPRR.

4.4 Head of Corporate Resilience

Responsible for:

- Ensuring that the Trust has appropriate response and recovery plans in place that are regularly reviewed, tested, and circulated to partners.
- Ensuring that horizon scanning is conducted, relevant risks are placed onto relevant risk registers, and processes are put in place where possible to mitigate against their effects.
- Ensuring that a robust training and exercising process is in place ensuring relevant roles are trained to fulfill roles when responding to emergencies.
- Facilitating any assurance processes pertaining to EPRR.
- Making recommendations and applying subject matter expertise to Trust projects, ensuring that EPRR is considered within processes.
- Providing internal liaison and subject matter expertise in matters pertaining to EPRR and business continuity.

4.5 EPRR and Business Continuity Advisor

Responsible for:

- Supporting the implementation of emergency plans, business continuity and resilience processes.
- Supporting and assisting with the facilitation of exercises/scenarios to test Trust emergency plans.
- Providing administration support to EPRR processes.
- Providing tactical advice as part of a rota to the Trust senior on call management team.
- Providing 'on scene' tactical advice in the event of a multi-agency incident.

4.6 Corporate Resilience Project Support Officer

Responsible for:

- Supporting the implementation of national standards for EPRR.
- As required, supporting the audit process required by NHS England, providing national and local assurance of compliance against EPRR Core Standards, and assisting in the development of an action plan to mitigate against identified risks.
- Being a second point of contact for Trust staff in relation to issues pertaining to the EPRR portfolio.
- Engaging and assisting staff in understanding the importance of EPRR and business continuity and how it integrates with daily practice.

4.7 Corporate/Divisional Directors

Responsible for ensuring:

- That their departments/divisions have appropriate EPRR arrangements (including local business continuity plans) in place and that these compliment the overall Trust response to emergencies.
- Staff attendance compliance against all relevant training and exercising.
- That, where relevant, any planned works or projects are highlighted to the Head of Corporate Resilience to ensure EPRR is considered in all areas of work.
- That each service/divisional area has an identified lead for EPRR and business continuity and that this individual is made aware to the Head of Corporate Resilience.
- That each service area's EPRR provisions are regularly checked and updated (i.e., Corporate Resilience blue awareness folders), and that any issues are raised immediately to the Head of Corporate Resilience.
- Appropriate representation/attendance at the EPRR Assurance Group.

4.8 Departmental/Ward Managers, Directorate Managers and Matrons

Responsible for ensuring:

- Departmental EPRR and that areas are prepared to respond to emergencies.

- That local plans and processes are regularly updated (i.e., Corporate Resilience blue awareness folders and service level business continuity plans).
- Full engagement in EPRR processes and planning, providing input and updates to relevant plans and processes.
- Identification of all key critical assets and staffing for an emergency through the Trust's business continuity planning process.
- That a robust call-in process for emergencies is in place and that this is adequately maintained.
- That staff are allocated time to attend relevant training and exercises for the purposes of improving Trust resilience.
- That a departmental debrief is conducted following incidents and that recommendations are fed into the Trust-wide debrief.

4.9 All staff

Responsible for ensuring:

- Familiarisation with all relevant EPRR arrangements and plans.
- Where possible, that they exercise 'self-resilience' and assist in the Trust's response to an incident.
- That they regularly update their service contact lists to ensure that they can be contacted in an emergency.
- Completion and compliance against all appropriate training.
- Engagement with the Trust's exercising process.

4.10 Summit (Hard and Soft FM/Security)

Responsible for ensuring:

- That all contractors on site (i.e., Mitie) have robust EPRR and business continuity arrangements in place and that the Trust, as part of the contracting process, is assured that these are in place.
- That these arrangements are created in conjunction with and compliment the Trust's response to emergencies.
- That, where required, relevant subject matter expertise is provided to the Trust in relation to planning for, responding to, and recovering from emergencies.
- Attendance and engagement with the Trust's EPRR training and exercising processes.
- That the Head of Corporate Resilience is informed of any planned works to ensure that EPRR and business continuity arrangements are considered.
- Regular appropriate attendance at the Trust's EPRR Assurance Group.

4.11 Digital Services

Responsible for ensuring:

- That robust EPRR and business continuity arrangements are in place and that the Trust is assured that these are in place.

- BCP and recovery plans are in place for digital systems/ software in use within the organisation describing actions the digital team would take to coordinate their response to cyber attack/ downtime of these systems.
- That these arrangements are created in conjunction with and compliment the Trust's response to emergencies.
- That, where required, relevant subject matter expertise is provided to the Trust in relation to planning for, responding to, and recovering from emergencies.
- Attendance and engagement with the Trust's EPRR training and exercising processes.
- That the Head of Corporate Resilience is informed of any planned works to ensure that EPRR and business continuity arrangements are considered through attendance at Digital Trust Steering Group (DTSG).
- Regular appropriate attendance at the Trust's EPRR Assurance Group.

4.12 Third Party Contractors

Any third party contractors that are requested to conduct work on behalf of or for the Trust will be expected to ensure that:

- They have robust business continuity and EPRR response and recovery elements in place and that the Trust is assured that these are in place as part of the contracting process.
- As required, they engage fully with all EPRR processes as part of the Trust's EPRR arrangements.
- Where required, subject matter expertise is provided to the Trust for the purposes of response and recovery.

4.13 On Call Teams (Manager/Executive/Site Manager)

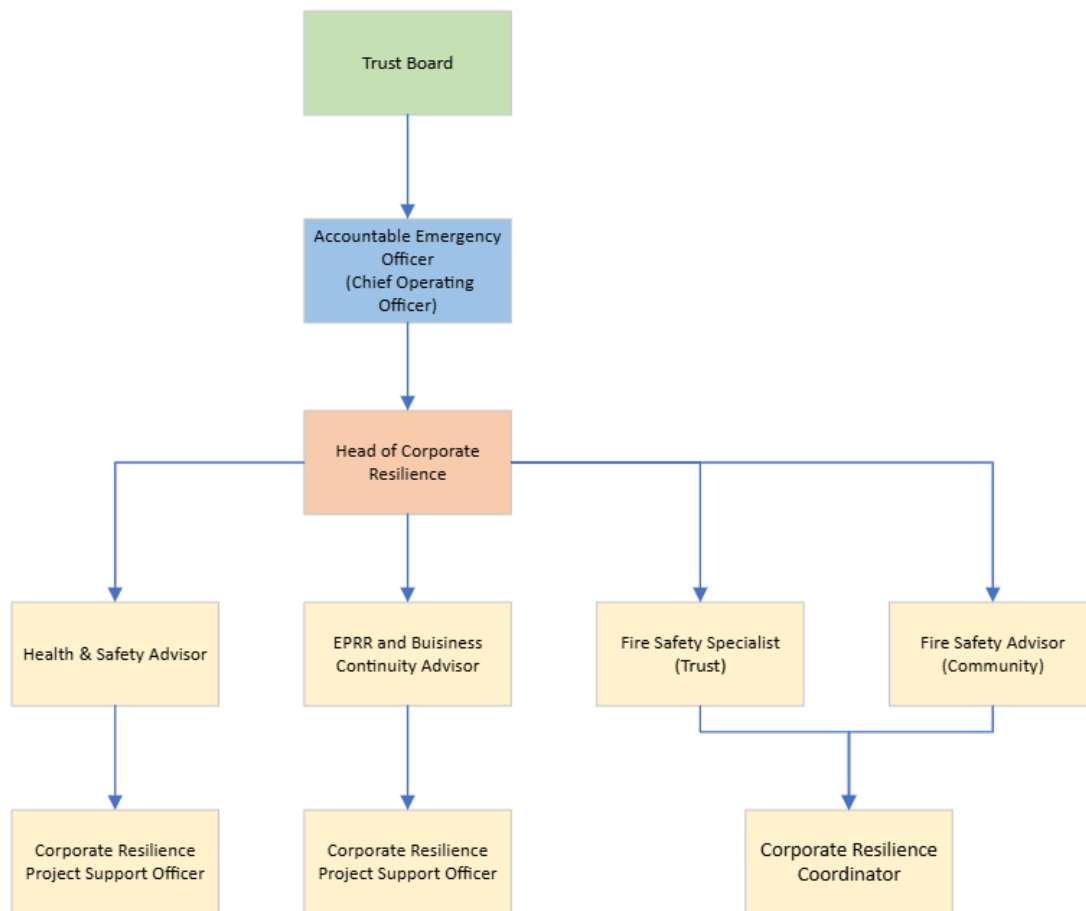
These roles have been pre-identified as having key responsibilities in disaster/emergency response:

- **Executive on call** – will act as the Strategic (Gold) Commander for the Trust during incidents, providing strategic direction and oversight for the Tactical Command Team.
- **Manager on call** – will act as the Tactical (Silver) Commander for the Trust during incidents, providing tactical direction and management of front-line services to minimise disruption whilst providing patient care.
- **Site Manager** – will act as the capacity management lead during an incident, ensuring that the Trust continues to maintain patient flow and safety, and ensuring that the day to day running of the Trust continues whilst providing the link into the incident response.

All of the roles identified above are contactable 24/7 for the period of their on call duties, for incidents affecting the Trust either internally or externally. These members of staff are alerted via Mitie Switchboard (here on referred to as Switchboard).

5. EPRR PROCESS

5.1 Reporting Lines for EPRR INSERT



5.2 Corporate Resilience Team

EPRR forms a key element of the Corporate Resilience Team, under the direct management and supervision of the Deputy Chief Operating Officer. The team is formed by the close working of the EPRR and Health, Safety and Fire Teams, allowing sharing of resource to complete a multitude of projects. The Head of Corporate Resilience retains direct management responsibility for the portfolio of EPRR.

This means that there is sufficient and appropriate resourcing for EPRR processes across the Trust, enabling these processes to be delivered to the required and recommended status.

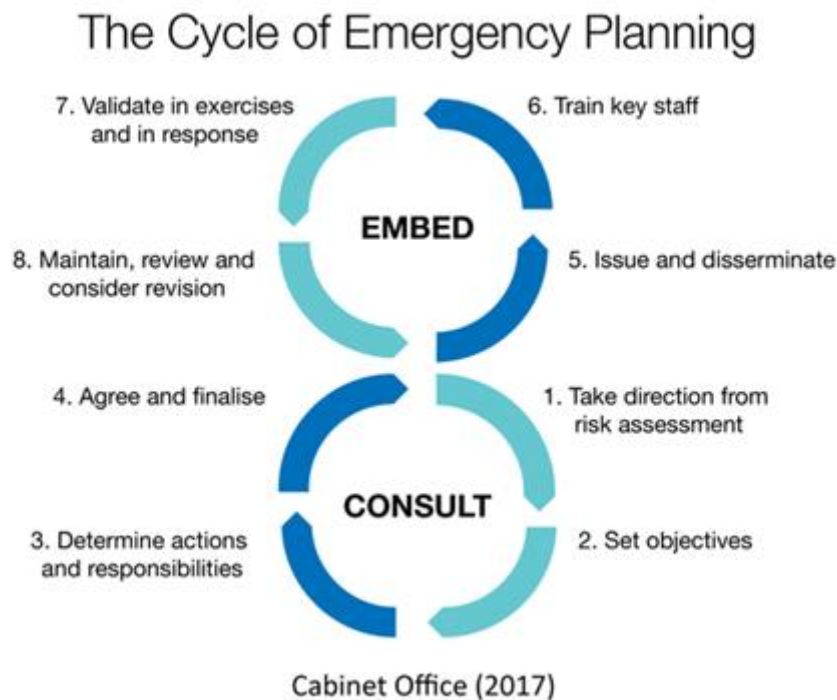
5.3 EPRR Funding

EPRR are now funded as part of the Corporate Resilience Team. Larger projects are identified and costs allocated to the relevant department e.g., Powered Respirator Protective Suit (PRPS) management and servicing is funded by the Emergency Department.

Costs are captured and reflected by Finance and meet the requirements to ensure that EPRR is appropriately funded by the Trust.

5.4 Emergency Planning Cycle

The Trust follows the Emergency Planning Cycle to ensure that all aspects are considered within the Trust's EPRR arrangements.



This cycle will follow an annual refresh pattern with all standing plans and policies being, as a minimum, assessed annually to ensure that new learning can be embedded within the relevant documents. This may also be dynamic dependant on developments within the field of EPRR.

5.5 EPRR Work Plan

Using this process, an annual work plan will be formed. This will indicate what activities the Corporate Resilience Team will undertake during the financial year in order to improve resilience at the Trust. It will take into consideration the national risk assessment, LHRP risk assessments, and risks locally determined and indicated onto the Trust's DATIX system. The work plan is accessible through request to the Corporate Resilience Team.

5.6 Emergency Plans

The Trust ensures that it has policies and standard operating procedures (SOPs) (here to referred as plans) relevant to risks identified in the Trust's risk assessments and/or those identified during the ongoing risk assessment. The Trust will maintain plans which are required as identified by the annual and ongoing risk assessment process. These include:

- Business Continuity Policy
- Incident Response Plan
- Adverse Weather Plan
- Chemical, Biological, Radiological and Nuclear (CBRN)/HAZMAT/Mass Countermeasures and Infectious Diseases Plan

- New and Emerging Pandemic and Excess Deaths Plan
- Lockdown and Bomb Threat Plan
- Evacuation and Shelter Plan
- High Consequence Infectious Disease (HCID) Plan

These plans will be supported and complimented by relevant EPRR guidance, local plans, and standard operating procedures, for example:

- Dudley Local Health Protection Agreement
- Major Incident Clinical Guidelines
- Public Health England CBRN and HAZMAT Guidelines
- Operational Business Continuity Plans
- Operational Lockdown Plans

These documents will also be supported by other standing Trust arrangements and processes.

5.7 Maintenance of Plans

As standard, all plans will be reviewed annually; initially to ensure plans fit with current operational Trust requirements, but they will also be subject to review under the following parameters:

- *Change led:* Plans to be updated if changes are required as a result of audits (internal and external), updates to partner agency plans, or updates to associated legislation and/or guidance.
- *Post Exercise:* Plans will be updated as a result of lessons learnt following an exercise.
- *Post Incident:* Plans will be updated as a result of lessons learnt following an incident.

5.8 Availability of plans

Plans will be made available in relevant areas to ensure full engagement by all members of Trust staff and/or contractors. As plans and policies are updated, these will be communicated to identified service leads and via the Hub page.

As a minimum, these will be available in:

- Hard copies are shared with relevant responders/staff (these are listed in the rear of the 3 main response policies).
- Accessible through the Emergency Planning page on the Trust Hub.
- Located within the Incident Control Centres (ICC).
- Resilience Direct.
- Relevant sections of all plans, policies, and procedures will be available in a blue Corporate Resilience folder located within each service area. ***The maintenance of these is the responsibility of service leads, including:***
 - Service level business continuity arrangements.
 - Lockdown processes.
 - If relevant, major incident clinical processes.

- Maintenance of a call out cascade for usage in incidents.
- Training of staff (available on the Hub).

5.9 Communication of Plan and Process updates

As plans are updated, these will be uploaded to the shared folder and Hub page with communications sent to Directors of Operations, relevant service leads, and the EPRR Assurance Group. There is also an expectation that these updates will be cascaded down through all layers of staffing to ensure resilience and that relevant areas where plans are stored are also updated. These documents will also be shared with key external partners as required and indicated in the final sections of this document.

5.10 EPRR Audit

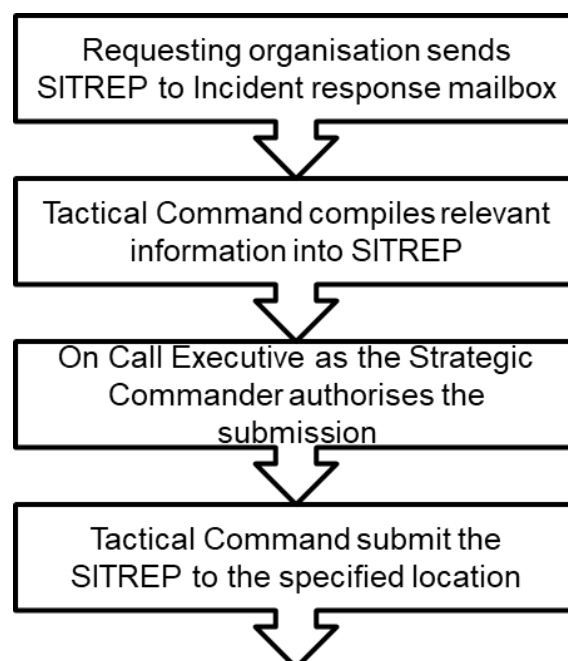
The Corporate Resilience Team will ensure that all key areas are fully audited in relation to EPRR:

- Blue Corporate Resilience folders will be audited bi-monthly.
- Emergency Department Major Incident and CBRN equipment is audited monthly.
- Incident Control Centre equipment is audited monthly.

5.11 Situation Reports (SITREP)

The scale of an incident will dictate the type of SITREP required. Each document contains example SITREPs that may be used during incidents. It must be noted that external partners e.g., LRF, NHS England may release templates during the response that will require completion to the battle rhythm set by the requesting organisation.

The process for sign off at is:



5.12 Mutual Aid

The Trust is able to call on mutual aid as required. This will be coordinated through the local ICB responders and, where required, NHS England.

The process for requesting mutual aid involves the Executive and/or Manager on call contacting the ICB on call and requesting mutual aid. This must include detail of:

- What is required.
- Why it is required.
- When it is required.
- Funding identification (if necessary).

NHS England and/or the ICB will then consider this request and, where necessary, facilitate the mutual aid deployment to the Trust site.

Where the Trust does not have the specific capabilities to manage an emergency response, the military may be considered to augment responses.

Military support in an emergency is provided on an assistance basis, known as Military Aid to the Civil Authorities (MACA). MACA support is not guaranteed and may incur a charge for its provision unless it is in response to an immediate threat to life.

Any request for MACA will be likely to attract media attention and must be considered in the communications strategy. MoD will determine the Defence media stance and will work in conjunction with Department of Health (DH) to ensure coordinated messaging. NHS England (National) communications team will lead the NHS communications in partnership with DH. Templates for mutual aid requests are contained within the Incident Response Plan.

5.13 Information Sharing

The Trust has a responsibility to share relevant information with other responder agencies. This must be necessary and required for the response and all data requests should consider Information Governance processes and how that information is to be shared.

The Trust has access to the Resilience Direct 'Collaborate' page that allows the data storage of key documents and processes in a secure, externally hosted system. This will be the in-facto method of on call staff accessing information if they are offsite or if the internal server for the Trust was to fail.

6. RESILIENT COMMUNICATIONS

Good two-way communications are critical to an effective response. Reliable information must be passed correctly and without delay between those who need to know, including the public (EPRR Framework, 2022). This section details the processes that the Trust has in place to ensure communications resilience. This section also indicates the process for exercising in relation to communications, specifically in relation to the requirement under the EPRR Framework 2022:

"10.4.1 Communications exercise Minimum frequency – every six months.

These exercises test the organisation's ability to contact key staff and other NHS and partner organisations 24/7. They should include testing telephone, email, paging and other communications methods in use. The communications systems exercise

should be conducted both during the in-hours period and the out-of-hours period on a rotational basis and should be unannounced. Participation in a communications systems exercise initiated by another organisation does not remove the requirement for each organisation to undertake its own communications system exercise.”

The Trust's Business Continuity Policy covers the resilience processes utilised in relation to:

- Switchboard.
- Multi-Tone (Bleep system).
- Alert Cascade.
- Internet Provision.
- Radio Provision.

Warning and informing, and Resilient Telecommunications

During an incident, communication with the public, other responders, and those utilising the Trust's services is key. The Trust has a variety of policies in place to manage communications during incidents. The Trust also has a variety of media streams that can be used:

- Twitter.
- Facebook.
- The Hub.
- All staff messaging.

This process and those documents are managed and maintained by the Trust Communications Team. Out of hours, whilst not formally on call, senior members of the Communications Team have made their contact details available for advice and deployment for Major, Critical, or Business Continuity Incidents.

Other departments that would require rapid messages to be dispatched in an incident also have access to facilities to release messages onto the Trust communication systems (i.e., IT).

The Trust's On Call Executive and Manager also have access to contact details for Regional and National advisors in relation to media management.

The Communications Team will provide specific advice and management processes in relation to the press and press management. An area is predetermined for their utilisation during an emergency (Action Heart), which will be staffed and managed by the Communications Team.

The Trust also considers resilience within its communications and telecommunications systems. This is managed through the Trust Resilient Communications Group and a SOP has been released which is managed by this group, indicating the processes in place to ensure resilience of systems to a variety of failure types. This includes key areas such as the Incident Control Centres.

6.1 COMMUNICATIONS PROCESSES USED BY THE DUDLEY GROUP NHS FOUNDATION TRUST

Communications Functions	Dudley Group Capability	
	Primary Communications systems	Secondary communications systems
Public Switched Telephone Network (PSTN)	<ul style="list-style-type: none"> Node hosted Switchboard. Trust mobile phones. 	<ul style="list-style-type: none"> Analogue lines. x4 spare mobile handsets in the ICC.
Data Sharing Capability up to Official-Sensitive and Patient Identifiable	<ul style="list-style-type: none"> NHS.net email to NHS net email. Fixed external VPN connection. 	<ul style="list-style-type: none"> Direct access to Trust systems/server via (and its fixed systems). Hard copy/paper. Telephone. Encrypted disc or encrypted memory stick.
Internet Service	<ul style="list-style-type: none"> NHS-installed internet web browser. 	<ul style="list-style-type: none"> Smart phones (Windows Phone) issued to key staff. x4 spare handsets in the ICC.
Collaboration/file sharing server accessible from the internet	<ul style="list-style-type: none"> NHS-installed shared IT service areas. 	<ul style="list-style-type: none"> Web based shared service – The Hub. Resilience Direct.
Key staff public wide area paging or alerting system	<ul style="list-style-type: none"> Analogue phone lines in Switchboard. Switchboard. Helpdesk. Bleep system. Alert Cascade major incident alerting system. Radio handsets issued to Site Team. 	<ul style="list-style-type: none"> Digital private radio network. Smart phones (Windows Phone) issued to key staff. x4 spare handsets in the ICC.
Monitoring of Public Service news broadcasts and social media	<ul style="list-style-type: none"> Internet Based services. Digital Radio. 	<ul style="list-style-type: none"> Smart phones (Windows Phone) issued to key staff. x4 spare handsets in the ICC. Major Incident radio.
Acute Trust Emergency Departments and Ambulance Trusts should ensure inter-organisational connectivity	<ul style="list-style-type: none"> Hard line telephones. Red alert phone. Radio handsets issued to Site Team. 	<ul style="list-style-type: none"> Smart phones (Windows Phone) issued to key staff. x4 spare handsets in the ICC. Major Incident radio. Digital private radio network.

6.2 MAJOR/CRITICAL AND BUSINESS CONTINUITY INCIDENT CALLOUTS

As per the EPRR Framework 2022 and the Civil Contingencies Act 2004, the Trust has a duty to communicate with key partners during an incident. This includes ensuring that relevant key staff are alerted by the Trust in the event of an emergency to mount an effective response. This is done at the Trust through the callout process delivered and managed by the Switchboard Team.

The Trust utilises Alert Cascade to ensure key on call teams are aware of a Major Incident and the actions required by them.

Departments across the Trust will also be manually contacted to inform them of the Major Incident Standby/Declared message, as well as an alert through Team 20 (bleep system).

Switchboard will gather the required information as indicated by their action card in the Major Incident and Mass Casualty Policy. They will then activate the Major Incident alerting process.

Any delays in contacting will be escalated to the On Call Manager as the Tactical (Silver) Commander for the Trust.

6.3 COMMUNICATING WITH THE PUBLIC AND KEY STAKEHOLDERS

The Trust has an established Communications Team who take responsibility for ensuring that messages pertaining to a response being provided by the Trust are provided across a range of media platforms. As a minimum, the Communications Team have access to:

- Facebook
- Twitter
- WhatsApp
- Press (management of the press and releases to the press will be through the Trust Communications Team)

6.4 EXERCISE HERMES

Exercise Hermes is the Trust's designed exercise to fulfil the requirements indicated above and is completed by the Switchboard Team.

The determined months for the year are designated and approved by the Head of Corporate Resilience and are communicated to the Facilities Contract Manager, Soft Services Manager and the Helpdesk and Switchboard Manager. The Switchboard Team is then responsible for the completion of the tests within this time period.

The tests will be conducted via testing of the call out systems for Major Incidents. The report will be generated automatically via Alert Cascade. There are a number of calls required as part of the Major Incident process which will be recorded to document:

- The length of time taken to respond/answer call.
- No response.
- Estimated time of arrival to site.

The EPRR and Business Continuity Advisor will then collect this data and construct the Post Exercise Report. This will be submitted to the EPRR Assurance Group for approval before submission Executive/Board meetings as necessary.























6.5 ALERT CASCADE

Alert Cascade is the system procured by the Trust to enable Major Incident alerting. The system works through an automated callout system, allowing rapid effective callout of staff required for a Major Incident response. Switchboard provide administration and management of the system as well as the initiation of the callout through contact with Alert Cascade Switchboard. An action card is available to Switchboard staff within the Major Incident and Mass Casualty Policy to assist with the call out process.

7. RISK REGISTER






Risks identified within the National Risk Register, West Midlands CRR and LHRP risk register are detailed in Tables 1 and 2 below. Annex D also details the West Midlands Local Resilience Forum (LRF) Local Risk Register. The Trust's internal risk register is captured on the DATIX system.

Table 1

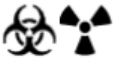

Impact Severity	5					
	4					
	3					
	2				 	
	1					
		1	2	3	4	5
	<u>Likelihood</u> of occurring in the next 5 years					
<i>Natural Hazards</i>			<i>Diseases</i>			
	Storms and Gales			Pandemic Influenza		
	Surface Water Flooding			Emerging Infectious Disease		
	Cold and Snow			Animal Disease		
	Heatwave		<i>Major Accidents</i>			
	Poor Air Quality			Widespread electrical failure		
	Space Weather			Transport accidents		
	Drought			Industrial and urban accidents		





Societal Risks			System failures
	Industrial action		
	Public Disorder		

Table 2 Malicious attack risks

Impact Severity	5					
	4					
	3					
	2					
	1					
		Low	Medium-Low	Medium	Medium-High	High
	Relative <u>plausibility</u> of occurring in the next 5 years					

Malicious Attacks

	Larger scale Chemical, Biological, Radiological, or Nuclear attacks		Attacks on Infrastructure
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	Attacks on Crowded Places/Transport		Cyber-attacks on services
	Cyber-attacks on infrastructure		Smaller scale Chemical, Biological, Radiological, or Nuclear attacks

8. ENGAGEMENT IN MULTI AGENCY PLANNING

As part of its legislative and framework requirements and guidance, the Trust is required to attend and participate in relevant local, regional, and national resilience planning and preparedness processes and arrangements.

The Trust will accomplish this through two mechanisms:

1. Regularly arranged meetings.
2. Ad-hoc meetings specific to an identified risk or resilient activity.

Regularly arranged meetings that will meet the requirements for multi-agency working are indicated below with the appropriate attendee. This may be substituted by an appropriate replacement person to ensure resilience for attendance.

Meeting Title	Function	Named role attendee
Local Health Resilience Partnership (LHRP)	Executive-level Strategic resilience meeting for Birmingham, Solihull, and the Black Country areas. Under the EPRR Core Standards, the Trust is required to attend 75% of these meetings per annum.	Chief Operating Officer
Local Health Resilience Forum (LHRF)	Emergency Planning practitioner level Tactical meeting for Birmingham, Solihull, and the Black Country areas.	Head of Corporate Resilience/ EPRR and Business Continuity Advisor
Safety Advisory Group (SAG)	Risk assessment and planning meeting for events within the Dudley conurbation area.	Head of Corporate Resilience/ EPRR and Business Continuity Advisor
Dudley Local Resilience Forum	Multi-agency planning meeting for the Dudley conurbation area to ensure multi-agency planning for response.	Head of Corporate Resilience/ EPRR and Business Continuity Advisor
Dudley Local Health Protection Forum	Multi-agency planning meeting specific to health protection outbreaks and the preparation for response to these types of incidents.	Head of Corporate Resilience/ EPRR and Business Continuity Advisor
Health Emergency Planners Operational Group (HEPOG)	is a working group of the LHRP which is chaired jointly by the ICB EPRR Leads. HEPOG co-ordinates locally identified risks and ensures	Head of Corporate Resilience/ EPRR and Business Continuity Advisor

	effective tactical and operational planning/response arrangements across the local system.	
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Ad-hoc meetings will be determined at the time of identification and will be allocated to the most appropriate person for the task that is requested. This will be determined by the AEO and the Head of Corporate Resilience.

9. EPRR TRAINING STRATEGY

To ensure EPRR is embedded across the Trust, we are required to engage in training to ensure key roles and those identified by guidance and legislation are appropriately prepared to plan for and respond to an incident within the Trust. These roles and the types of training required are identified within the EPRR Training Needs Analysis below.

Staff Group	Title of training	Format	Frequency	Locally Mandated by Role?
Trust On Call Executives	Strategic Commander Incident Response Training	Face to Face	Annual	Yes
Trust On Call Managers	Tactical Commander Incident Response Training	Face to Face	Annual	Yes
Identified staff	Incident Support and Loggist	Face to Face	Every 3 years	Yes
ED Nursing Team	ED Major Incident and CBRN Training	E-learning Face to Face	Annual	Yes
ED Medics	ED Major Incident and CBRN Training for Medics	E-learning Face to Face	Annual	Yes
Identified Business Continuity Leads	Business Continuity for Leaders	Face to Face	Every 3 years (or as guidance changes)	Yes
All Trust staff including Mitie/Summit etc.	EPRR Awareness	Leaflet at Induction E-learning	Annual	No

Mandatory Training: Elements of EPRR training are mandatory by role under the EPRR Core Standards requirements and those are indicated above.

Responsibility for training: All training is constructed by the EPRR team and is aligned to relevant National Occupational Standards for EPRR. A range of methods for delivery with a variety of dates can be offered; training will be coordinated by the EPRR Team, with service areas having responsibility to plan and coordinate locally specific training with EPRR support. Staff members are ultimately responsible for ensuring that they attend training and keep up to date on EPRR developments.

National Occupational Standards (NOS):

Under the NOS for EPRR, which are Skills for Justice:

- AA3, AB1, AC1, AD1, AE1, AE2, AG2, AG4, AF2, HB6 and HG

There are a number of requirements and core competencies that staff are expected to meet annually to provide an effective response in an incident. The table below identifies what is expected and against which role.

Key

X = Required for role

D = Desirable for role

Requirement	Role			
	Commander Strategic	Commander Tactical	Other roles in the ICC	Loggist
Analytical/Strategic thinking	X	X	X	
Communication/Briefing	X	X	X	X
Consulting	X	X	X	
Creative problem solving	X	X	X	
Decision making using evidence	X	X	X	
Effective leadership	X	X	X	
Influencing & persuasive	X	X	X	
Liaison	X	X	X	X
Negotiation	X	X	X	
Numerical	X	X	X	X
Planning/Project management	X	X	X	
Prioritising/Organising	X	X	X	X
Report/Plan writing	X	X	X	
Knowledge	Role			
	Commander Strategic	Commander Tactical	Other roles in the ICC	Loggist
Current and relevant legislation, policies, procedures, codes of practice, and guidelines in relation to emergency response	X	X	X	
Current and relevant legislation and organisational requirements in relation to health, safety, and welfare	X	X	X	
The principles of effective response and recovery	X	X	X	
The principles of Integrated Emergency Management (IEM) and Joint Emergency Response	D	D		

Interoperability Programme (JESIP)				
The roles and responsibilities of partner organisations in all areas of response and recovery	D	D		
The principles of command, control, and coordination	X	X	X	
How to develop and implement an effective communications strategy	X	D		
The range of tactical options and how they should be communicated, reviewed, and implemented	D	D		
How to formulate an action plan which takes account of all available information	X	X	X	
Circumstances where expertise or coordination are required beyond the tactical level	X	X	X	
The type of resources which may be required and how they can be obtained	X	X	X	
How to assess the short- and long-term human impact of the emergency and identify the most vulnerable groups	X	X	X	
How to conduct briefings and de-briefings	X	X	X	
How to complete Situation Reports and METHANE Reports	X	X	X	
The purpose of recording information and the types of records that must be kept	X	X	X	X
Attitudes	Role			
	Commander Strategic	Commander Tactical	Other roles in the ICC	Loggist
Community Minded	X	X	X	X
Determined	X	X	X	X

Empathetic	X	X	X	X
Flexible	X	X	X	X
Investigative/Problem solving	X	X	X	X
Realistic	X	X	X	X

This will be monitored through continuing professional development (CPD) portfolios that will include a pre-learning assessment by the learner as to their knowledge of the above requirements followed by a post-learning analysis by the trainer. Some aspects will not be completed in training as staff members are expected to undertake CPD, which will be monitored through the individual's CPD portfolio. The process will be managed by the Head of Corporate Resilience.

Types of training

There are a variety of teaching methods that will be used by the Head of Corporate Resilience to deliver training across the Trust, including:

- Face to Face
- E-Learning
- Self-Learning
- Practical
- Exercise based

Training records/lesson plans

These can be made available through the Head of Corporate Resilience at request.

Alternate training resources available to all staff

- [JESIP All staff awareness](#)
- [IOR for the wider NHS](#)
- [UKHSA E-learning system for EPRR](#)

Individual Training Plans

If required, the Corporate Resilience Team are able to develop and deliver individual training plans and processes for staff. These can be requested through the Corporate Resilience Team.

10. EPRR EXERCISING STRATEGY

As a Category 1 responder, the Trust is required to undertake, at a minimum, the following level of exercising:

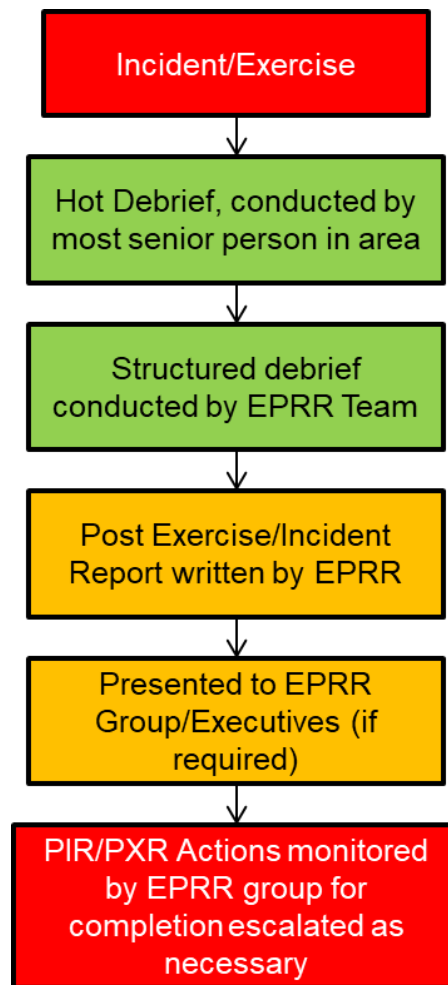
- Six-monthly communications cascade tests (Exercise Hermes) – this requires x1 in hours and x1 out of hours test in the rolling 12-month period.
- Annual tabletop exercise.
- Three-yearly live exercise (a live incident activating key documents during this time will act as a live exercise if appropriate debriefing and lesson learning can be demonstrated).

Following each exercise, the Head of Corporate Resilience or the relevant organiser of the exercise will produce a post exercise report for presentation at EPRR Assurance Group. This will include a series of recommendations and a tracker to indicate progress against this learning.

Ad Hoc exercising

Additional exercises will be planned throughout the year to test new threats or to exercise new plans, documents, or SOPs as required.

11. CONTINUOUS IMPROVEMENT PROCESS



As soon as practicable following an exercise or incident, debriefs will be conducted. These can take two main forms within the Trust:

1. **Hot Debrief** – Conducted immediately at handover or at stand-down. This allows responders within the area for which the debrief is being conducted to capture their immediate thoughts on areas of good practice and those that require improvement. This will be led by the most senior person within the area at the time and will utilise the Trust's hot debrief forms held within the relevant plans.
2. **Structured Debrief** – This will be conducted some time post stand-down from the incident or exercise and will be conducted by the Corporate Resilience Team (trained in performing structured debriefs). This will require representation from key players and individuals involved in the response as well as those that lead the hot debriefing process. This debrief will ensure that full details of areas of good practice and those that require improvement are captured.

Post Incident/Exercise Report (PIR/PXR)

These will be constructed by the Corporate Resilience Team for any incidents that require the activation of a Trust EPRR policy or plans. This process may also be followed for incidents where key learning is identified but activation of a document was not required. The report and actions will then be presented to the Trust EPRR Assurance Group for sign off; exceptions to this will be severe incidents that have major impacts on patients/staff safety, the ability of the Trust to discharge its functions, and those with significant impacts on the financial or reputational status of the Trust. These reports will be presented at executive level with approval from the AEO. All post-exercise reports (internal and external) are uploaded to the Trust intranet 'The Hub'. These reports are available for all staff to view.

Tracking Lessons Learnt and Continuous Improvement

Lessons learnt borne out of incidents, exercises both internal and external, will be captured within the EPRR central action log and actions determined, where viable, to mitigate risk and promote continuous improvement as part of the Plan/ Do /Check /Act cycle. Actions are monitored for completion by the EPRR team and progress and learning shared with the EPRR Assurance Group and fed into the EPRR Workplan.

12. PROCESS FOR MONITORING COMPLIANCE

Monitoring of Compliance Chart

	Lead	Tool	Frequenc y	Reporting arrangemen ts	Acting on recommen dations and Lead(s)	Change in practice and lessons to be shared
Examples of key aspects to include are given below:						
EPRR Strategy	EPRR &BCA	Review	Annually	To F&P via EPRR	Line managers, clinical directors	Via EPRR Assurance Group
EPRR Working Group	EPRR &BCA	Work streams	As required	To F&P via EPRR	Line managers, clinical directors	Via EPRR Assurance Group
Annual EPRR Report	EPRR &BCA	Report framework	Annually	To F&P via EPRR	Line managers, clinical directors	Via EPRR Assurance Group
EPRR Core Standards	EPRR &BCA	NHSE framework	Annually	To F&P via EPRR & NHSE	Line managers, clinical directors	Changes in practices will be communicated Trust wide
Review of EPRR Plans	EPRR &BCA	EPRR agenda	At least annually	To F&P via EPRR	Line managers,	Via EPRR Assurance Group

	Lead	Tool	Frequency	Reporting arrangements	Acting on recommendations and Lead(s)	Change in practice and lessons to be shared
and Procedures					clinical directors	
EPRR Training	EPRR &BCA	EPRR agenda	At least annually	To F&P via EPRR	Line managers, clinical directors	Via EPRR Assurance Group
Live Exercise	EPRR &BCA	Core Standard	3-yearly	To F&P via EPRR	Line managers, clinical directors	Changes in practices will be communicated Trust wide
Command Post Exercise	EPRR &BCA	Core Standard	3-yearly	To F&P via EPRR	Line managers, clinical directors	Changes in practices will be communicated Trust wide
Communications Exercise (Exercise Hermes)	EPRR &BCA	Core Standard	6-monthly	To F&P via EPRR	Line managers, clinical directors	Changes in practices will be communicated Trust wide

13. EQUALITY

The Dudley Group NHS Foundation Trust is committed to ensuring that, as far as is reasonably practicable, the way we provide services to the public and the way we treat our staff reflects their individual needs and does not discriminate against individuals or groups on any grounds.

14. REFERENCES

- Cabinet Office Civil Contingencies Act 2004.
- Health and Social Care Act 2012.
- The Civil Contingencies Act 2004 (Contingency Planning) Regulations 2005.
- Expectations and Indicators of Good Practice Set for Category 1 and 2 responders.
- NHSE EPRR Core Standards.
- ISO 22301 Societal Security – Business Continuity Management Systems – Requirements.
- ISO 22313 Societal Security – Business Continuity Management Systems – Guidance.
- Business Continuity Institute Business Continuity Good Practice Guidelines 2013 – A Guide to Global Practice in Business Continuity.
- The Route Map to Business Continuity Management Meeting the Requirements of ISO 22301.

- NHS England Emergency Preparedness Framework 2022.
- Everyone Counts: Planning for Patients 2013/14.
- NHS England Command and Control Framework for the NHS during significant incidents and emergencies (2013).
- NHS England Core Standards for Emergency Preparedness, Resilience and Response (EPRR).
- Summary of published key strategic guidance for health EPRR.
- NHS England Business Continuity Management Framework (service resilience) (2023).
- Preparation and planning for emergencies: responsibilities of responder agencies and others.
- NHS Emergency Planning Guidance: Planning for the management of burn-injured patients in the event of a major incident: interim strategic national guidance.
- CBRN Incidents: A Guide to Clinical Management and Health Protection.
- The United Kingdom's Strategy for Countering Chemical, Biological, Radiological and Nuclear (CBRN) Terrorism.
- Arrangements for Health Emergency Preparedness, Resilience and Response from April 2013.
- Chapters 5 to 7 Revision to Emergency Preparedness.
- Management of Surge and Escalation in Critical Care Services Standard Operating Procedure for Adult & Paediatric Burns Care Services in England & Wales (2015)

ANNEX A EPRR DOCUMENT RETENTION PROCESS

In line with Information Governance processes, the Corporate Resilience Team will ensure archiving of all relevant EPRR documents and processes in line with national NHS guidelines in relation to document retention. They will be stored as necessary in an online account or hard copies will be securely stored by the Corporate Resilience Team. These are available for view through request via the Corporate Resilience Team, contactable via email to dgft.corporateresilience@nhs.net

Document Type	Period of Retention
EPRR Assurance Group Agendas and associated papers	2 years from date of meeting
EPRR Annual Report	3 years from date of authorisation
EPRR Core Standards	2 years from date of sign off by NHS England
EPRR Work Plan	20 years from date of reporting period
EPRR Incident Report Forms/PIR and PXR	10 years from date of creation
EPRR Policies and SOPs	10 years from date of creation/sign off
EPRR Serious Incidents/Major Incident Report forms	Indefinitely
Corporate Resilience Team applications (Unsuccessful candidate information)	1 year from interview date
Corporate Resilience Team applications (Successful candidate information)	3 years post termination of contract
Corporate Resilience Team Leavers dossier	6 years post termination of contract

ANNEX B EPRR DOCUMENT DISTRIBUTION LIST

This table indicates the minimum roles and/or organisations that the strategy, policies, and SOPs of the Dudley Group NHS Foundation Trust must be shared with to ensure collaboration with our wider partners and embedding within the Trusts resilience strategy.

Role	EPRR Strategy	Major Incident and Mass Casualty Policy	Internal (Critical) Incident Policy	Business Continuity Policy	CBRN/HAZMAT, Mass Countermeasures, Infectious Disease SOP	Lockdown and Bomb Threat SOP	Evacuation and Shelter SOP	Pandemic and Excess Deaths SOP	Incident Coordination Centre SOP
Chief Executive	X	X	X	X	X	X	X	X	X
Chairman	X	X	X	X	X	X	X	X	X
Chief Operating Officer (AEO)	X	X	X	X	X	X	X	X	X
Non-Executive Director for EPRR	X	X	X	X	X	X	X	X	X
On Call Executives and Managers	X	X	X	X	X	X	X	X	X
Site Operations Team	X	X	X	X	X	X	X	X	X
Director/Deputy of Operations	X	X	X	X	X	X	X	X	X
Head of Trust Estates		X	X	X	X	X	X		
Summit		X	X	X	X	X	X		
Mitie FM		X	X	X	X	X	X		
Matrons	X	X	X	X	X	X	X	X	X
Head of Pharmacy		X		X	X			X	
Head of Radiology		X		X					
ED EPRR Clinical Lead		X		X	X				
ED EPRR Nursing Lead		X		X	X				
Incident Control Centres	X	X	X	X	X	X	X	X	X
Black Country ICB	X	X	X	X	X	X	X	X	X
Infection Prevention and								X	

Control Team									
Trust IT			X	X					

ANNEX C EPRR AWARENESS FOR TRUST INDUCTION

Emergency Preparedness, Resilience and Response (EPRR) and you!

What is EPRR?

EPRR is the NHS term used to indicate preparation for and response to incidents. This includes anything from Major Incidents to Business Continuity such as power failure, cyber-attacks etc.

Who is responsible?

Everyone, we are all responsible for ensuring preparation for incidents this includes ensuring local plans are up to date, self-resilience i.e., during times of heavy snow ensuring you have an identified route to access work.

Major Incidents

Are defined as that which threatens community health or incidents where casualty numbers require special arrangements to be enacted, numbers alone do not determine a major incident, and what is a major incident for one service may not be a Major incident for others.

If a Major Incident occurs there are 2 main terms that will be used:

Major Incident Standby:

- This alerts that a major incident is possible or imminent to occur.
- Identified individuals are alerted allowing risk assessment to be undertaken.

Major Incident Declared:

- A Major Incident is occurring now, and a response is required.
- Trust staff will all be alerted to this eventuality.

Patients may arrive at the hospital before we are alerted in this eventuality the Trust has capability to activate a Major Incident response independently.

How do we ensure effective messages are passed?

We utilise SBAR to pass messages internally in relation to any incident.

S	Situation	What is the situation? What is happening now?
B	Background	What has led to this situation occurring?
A	Assessment	What are the impacts being felt by this incident?
R	Recommendation	What are your recommendations? What is required now?

What if an incident is declared and I am on site?

- Observe safety of self, staff, and patients.
- If you identify an incident contact 2222 and inform Switchboard.
- Access your emergency planning folder and follow the relevant action card.

DO NOT contact switchboard or site operations for non-incident enquires

DO NOT use social media to post about actions/response on site

What if I am off site when an incident is declared?

DO NOT attend site if not requested to come in

DO NOT contact switchboard or site operations as they are responding

IF contacted:

- Bring your ID, you won't be allowed on site without it
- Wear your uniform and bring a change of clothes
- Bring plenty of drinks and food for a prolonged shift

Checklist	
Read the relevant action cards in the Trusts emergency plans	
Ensure your manager has up to date contact numbers	
Complete EPRR awareness e-learning (via EPRR hub page)	

ANNEX D WEST MIDLANDS LRF LOCAL RISK REGISTER

West Midlands Local Resilience Forum Local Risk Register



Risk Assessment Workstream

**includes local planning assumptions and capability assessment*

Version 1.09

Date 21 September 2023

West Midlands Local Resilience Forum

This document is security marked **Official - Sensitive**, please contact the Risk Assessment Workstream Chair, Xris_Middleton@sandwell.gov.uk if you wish to share information outside of the West Midlands LRF membership.

The aim of this document is to highlight the most significant risks to the local area. This document provides a single point of information for risk scores, planning assumptions, capability assessment and recommendations.

The following documents are located on Resilience Direct: https://collaborate.resilience.gov.uk/RDService/home/1497/02.-Risk-Management	
Title	Notes
List of Supporting Documents:	
West Midlands LRF Risk Framework - Version 1.1	Explains the Risk Assessment Methodology used in the West Midlands.
WM LRF Local planning Assumptions and Capability Assessment & Methodology - Version 1.0	The aim of the Local Resilience Planning Assumptions (LRPA) is to set out the common consequences that could occur as a result of an emergency. This document highlights the LRPA and capabilities within the West Midlands & identify any gaps which may need further work.
CRR 2021 v0.1	Public Community Risk Register (PDF Version) using the 2019 risks.
2022 New risk IDs comparison	Compares the 2019 and 2022 risk IDs
WM Localised Impact Scores Rationale	This document localises the impact dimensions to the West Midlands. It was last updated 2019.
2023 LRMG & 2023 National Planning Assumptions Summary	Presentation which summarises the Local Resilience Management Guidance and 2023 National Planning Assumptions documents (these documents were produced by Government)
List of Templates	
2023 Local Risk Assessment Template v1.0	
West Midlands LRF template - Capability Gap Analysis v1.0	

ID	National Ref	Local Lead	Hazard Category	Risk	Type	Likelihood Score	Impact Score	National Risk Rating	Local Risk Rating	Risk Priority	Risk Cycle Review	Risk Assessment Date	Review Date	Is risk up to date?	Date Approved by RAWG Group:
R36	R36-DHSC	CSW	Accidents and System Failures	Major Social Care Provider failure	Hazard-related risk	4	2	Medium	Medium	2	2 years	TBC	2022	No	
R37	R37-CO	Emma Smallman, Wolverhampton Council	Accidents and Systems Failures	Insolvency of supplier(s) of critical services to public sector	Hazard-related risk	3	2	Medium	Medium	2	2025	27/07/2023	27/07/2025	Yes	Requires Approval
R38	R38-BEIS	Emma Smallman, Wolverhampton Council	Accidents and Systems Failures	Insolvency affecting fuel supply	Hazard-related risk	4	1	Low	Low	3	2026	27/07/2023	27/07/2026	Yes	Requires Approval
R39	R39 - BEIS	WMP	Accidents and System Failures	Failure of a supplier of CNI chemicals	NEW RISK - requires assessment									New Risk	
R40	R40-DfT	BTP	Accidents and System Failures	Rail Accidents	NEW RISK - requires assessment									New Risk	
R44	R44-DfT	WMFS	Accidents and System Failures	Accident involving high consequence dangerous goods	Hazard-related risk	2	3	Medium	Medium	2	2 years	TBC	2022	No	
R45	R45-DfT	CSW / Airport	Accidents and System Failures	Aviation Collision	Hazard-related risk	1	4	Medium	Medium	2	2 years	TBC	2022	No	
R46	R46-DfT	WMP	Accidents and Systems Failures	Malicious Drone Incident	Hazard-related risk	2	3	Medium	Medium	2	2025	30/08/2023	30/08/2025	Yes	05/09/2023
R47	R47-BEIS	Sheridan Buckley, Walsall Council	Accidents and Systems Failures	Disruption of space-based services	Hazard-related risk	2	3	Medium	Medium	2	2025	06/07/2023	06/07/2025	Yes	05/09/2023
R48	R48-BEIS	Sheridan Buckley, Walsall Council	Accidents and Systems Failures	Loss of Positioning, Navigation and Timing (PNT) Services	Hazard-related risk	2	4	High	High	1	2024	06/07/2023	06/07/2024	Yes	05/09/2023
R49	R49-DCMS	Fran Hyde - Dudley Council	Accidents and Systems Failures	Simultaneous loss of all fixed and mobile forms of communication	Hazard-related risk	3	3	High	High	1	2024	28/07/2023	28/07/2024	Yes	05/09/2023
R50a	R50a-BEIS	NHS & National Grid (supported by Walsall and Dudley)	Accidents and System Failures	Failure of the NETS	Hazard-related risk	3	4	Very High	Very High	1	1 year	TBC	2021	Yes	Requires Approval
R50b	R50b-BEIS	NHS & National Grid (supported by Walsall and Dudley)	Accidents and System Failures	Regional failure of the electricity network	NEW RISK - requires assessment									Yes	Requires Approval
R51	R51-BEIS	NHS	Accidents and System Failures	Failure of gas supply infrastructure	Hazard-related risk	2	1	Medium	Low	3	3 years	TBC	2022	No	
R52	R52-BEIS	MOD	Accidents and System Failures	Civil nuclear accident	Requires an Assessment - not started									New Risk	
R53	R53-BEIS	MOD	Accidents and System Failures	Radiation release from overseas nuclear accident	Requires an Assessment - not started									New Risk	
R54	R54-BEIS	UKHSA / WMFS	Accidents and System Failures	Radiation exposure from transported, stolen or lost goods	Hazard-related risk	2	1	Low	Low	3	3 years	TBC	2023	No	
R55	R55 - HMT	Fran Hyde, Dudley Council	Accidents and Systems Failures	Technological Failure of a Systemically Important Retail Bank Or Critical Market Infrastructure	Hazard-related risk	3	3	High	High	1	2024	28/07/2023	28/07/2024	Yes	05/09/2023
R56	R56-HSE	WMFS	Accidents and System Failures	Accidental fire or explosion at an onshore major hazard (COMAH) site	NEW RISK - requires assessment									New Risk	
R57	R57-HSE	WMFS	Accidents and Systems Failures	Accidental large toxic chemical release from an onshore major hazard (COMAH) site	Hazard-related risk	1	4	Medium	Medium	2	2025	30/05/2023	30/05/2025	Yes	12/06/2023
R59	R59-HSE	WMFS	Accidents and System Failures	Accidental fire or explosion at an onshore fuel pipeline	Hazard-related risk	1	4	Medium	Medium	2	2 years	TBC	2022	No	
R60	R60-HSE	WMFS	Accidents and System Failures	Accidental fire or explosion at an onshore major accident hazard pipeline	Hazard-related risk	1	4	Medium	Medium	2	2 years	TBC	2022	No	
R61	R61-HSE	UKHSA	Accidents and System Failures	Accidental work-related (laboratory) release of a hazardous pathogen	Hazard-related risk	1	3	Low	Medium	2	2 years	TBC	2022	No	
R62	R62-DEFRA	BCC	Accidents and System Failures	Reservoir or Dam Collapse	Hazard-related risk	1	4	Medium	Medium	2	2025	01/09/2023	01/09/2025	Yes	05/09/2023
R63	R63-DEFRA	Seven Trent /Sandwell	Accidents and Systems Failures	Water infrastructure failure or loss of drinking water	Hazard-related risk	2	1	Low	Low	3	2026	10/08/2023	10/08/2026	Yes	05/09/2023
R64	R64-FSA	CSW	Accidents and System Failures	Food Supply Contamination	Hazard-related risk	3	3	High	High	1	1 year	TBC	2021	No	
R65	R65-HO	WMFS	Accidents and System Failures	Major Fire	Hazard-related risk	1	3	Medium	Medium	2	2 years	TBC	2022	No	
R66	R66-HO	WMFS	Accidents and System Failures	Wildfire	Hazard-related risk	2	2	Medium	Medium	2	2 years	TBC	2022	No	
R67	R67-DfT	Katie Rheeston, Sandwell Council	Natural and Environmental Hazards	Volcanic Eruptions	Hazard-related risk	4	3	High	High	1	2024	07/07/2023	07/07/2024	Yes	05/09/2023

R68	R68-DLUHC	Katie Rheeston, Sandwell Council	Natural and Environmental Hazards	Earthquake	Hazard-related risk	1	1	Low	Low	3	2026	06/07/2023	06/07/2026	Yes	05/09/2023
R71	R71-MO	Sheridan Buckley, Walsall Council	Natural and Environmental Hazards	Severe Space Weather	Hazard-related risk	4	3	Very High	High	1	2024	06/07/2023	06/07/2024	Yes	05/09/2023
R72	R72-MO	Katie Rheeston, Sandwell Council	Natural and Environmental Hazards	Storms	Hazard-related risk	3	3	Very High	High	1	2024	07/07/2023	07/07/2024	Yes	05/09/2023
R73	R73-MO	UKHSA / MO	Natural and Environmental Hazards	High temperatures and heatwaves	Hazard-related risk	3	4	Very High	Very High	1	2024	31/05/2023	31/05/2023	Yes	12/06/2023
R74	R74-MO	UKHSA / MO	Natural and Environmental Hazards	Low Temperature and snow	Hazard-related risk	3	3	Very High	High	1	2024	31/05/2023	31/05/2024	Yes	12/06/2023
R75b	R75b-DEFRA	EA / Birmingham Council	Natural Hazards	Fluvial flooding	Hazard-related risk	3	3	Very High	High	1	1 year	TBC	2021	No	
R75c	R75c-DEFRA	CSW / EA	Natural Hazards	Surface Water Flooding	Hazard-related risk	3	2	High	Medium	2	2 years	TBC	2022	No	
R76	R76-DEFRA	EA	Natural Hazards	Drought	Hazard-related risk	2	3	Medium	Medium	2	2 years	TBC	2022	No	
R77	R77-Defra	UKHSA	Human, Animal and Plant Disease	Poor Air Quality	Hazard-related risk	3	2	High	Medium	2	2026	31/05/2023	31/05/2026	Yes	12/06/2023
R78	R78-DHSC	UKHSA	Human, Animal and Plant Disease	Pandemic	Hazard-related risk	4	4	Very High	Very High	1	2024	31/05/2023	31/05/2024	Yes	12/06/2023
R79	R79-DHSC	UKHSA	Human, Animal and Plant Disease	Outbreak of an emerging infectious disease	Hazard-related risk	4	4	Very High	Very High	1	2024	31/05/2023	31/05/2024	Yes	12/06/2023
R80	R80 - Defra	UKHSA	Human, Animal and Plant Disease	Outbreak of Exotic Notifiable Disease in Animals (including birds)	NEW RISK - requires assessment									New Risk	
R80a	R80a - Defra	UKHSA	Human, Animal and Plant Disease	Major outbreak of foot and mouth disease	NEW RISK - requires assessment									New Risk	
R80b	R80b - Defra	UKHSA	Human, Animal and Plant Disease	Major outbreak of highly pathogenic avian influenza	NEW RISK - requires assessment									New Risk	
R81	R81 - Defra	UKHSA	Human, Animal and Plant Disease	Major outbreak of plant pest	NEW RISK - requires assessment									New Risk	
R82	R82-HO	Caftin Leach, West Midlands Police	Societal	Public Disorder	Hazard-related risk	3	2	Medium	Medium	2	2025	13/07/2023	13/07/2023	Yes	05/09/2023
R83	R83-DfT	Transport for West Midlands	Societal	Industrial action - public transport	Hazard-related risk	5	2	Medium	Medium	2	2025	01/09/2023	01/09/2025	Yes	05/09/2023
R84	R84-Ho	WMFS	Societal	Industrial Action (Firefighters)	Hazard-related risk									New Risk	
R85	R85-MOJ	TBC - Birmingham Prison?	Societal	Industrial Action - Prison staff	Hazard-related risk	4	2	Medium	Medium	1	1 year	TBC	2021	No	
R86	R86-BEIS	Emma Smallman, Wolverhampton Council	Societal	Industrial Action - fuel supply	Hazard-related risk	3	3	High	High	1	2024	27/07/2023	27/07/2024	Yes	Requires Approval
R87	R87-DLUHC	CSW Resilience	Societal	Reception and integration of British Nationals arriving from overseas	Hazard-related risk	5	3	High	High	1	2024	25/08/2023	25/08/2024	Yes	05/09/2023
RL02	RL02	Under Review - TBC	Local	Closure or collapse, of a bridge or elevated section of highway	Reviewed Locally	1	3	0	Medium	3	3 years	TBC	2023	No	
RL03	RL03	Under Review - TBC	0	Canal Breach	Reviewed Locally	1	1	0	Low	3	3 years	TBC	2023	No	
RL04	RL04	Under Review - TBC	Local	HS2 Community Impacts in Warwickshire	Reviewed Locally	3	3	0	High	1	1 year	TBC	2021	No	

Strategy Consultation Form

(This page to be deleted from the document prior to adding to HUB Trust Central document page)

Please ensure that you receive either a confirmation or comments from a stakeholder (via an email) before you add their details to the consultation section on the procedural document

During the development or review of the Strategy, consideration must be given to the actual or potential impact on equality. Due care is given to ensure that they do not contravene the article of the Human Rights Act or could be interpreted as containing any matters of a discriminatory nature, including but not limited to age, disability, sex, race, religion or belief, gender reassignment, marriage or civil partnership, pregnancy or maternity.

What is the title of the document:		
EPRR Strategy		
Date of Submission:	15/11/2023	Author Luke Lewis
Is there a similar/same document already in existence? Please state which document this will replace. If the document has a different title or has been merged with another document, please provide details of relevant documents.		
Annual update to current EPRR Strategy		
Please detail under which folder on the Procedural Documents Hub Page that the document is to be stored. Procedural documents can only be stored on the central procedural documents page. If you require the document link to be stored on another page outside of this, please contact IT and ask them to put a link on.		
Emergency Planning		
Consultation: Please list the stakeholders who have been consulted in the development of this document and the date they confirmed agreement of its content. This is any member of staff/groups who will be part of or affected by this. If this was a group please list attendees:		
Name	Designation	Date confirmed agreement (mm/yy)
EPRR Assurance Group	EPRR Assurance Group	16/11/2023
Finance and Productivity Committee	Finance and Productivity Committee	30/11/2023
Board	Board	11/01/2024

Annual Plan 2025/26

ANNUAL PLAN 2025 – 2026

This is how we will deliver our plan

MULTI-YEAR COMMITMENTS



Shift care from
hospital to community



Value our people



Make best use
of our resources



Improve speed of
access to planned care



Develop thriving
partnerships

IN-YEAR OBJECTIVES

- ⊕ Implement care navigation centre
- ⊕ Implement a new model of care for urgent and emergency care
- ⊕ Develop an anti-bullying, anti-discrimination culture
- ⊕ Establish an elective hub south of the Black Country
- ⊕ Transform outpatient services
- ⊕ Transform corporate services

TASK AND FINISH PROJECTS

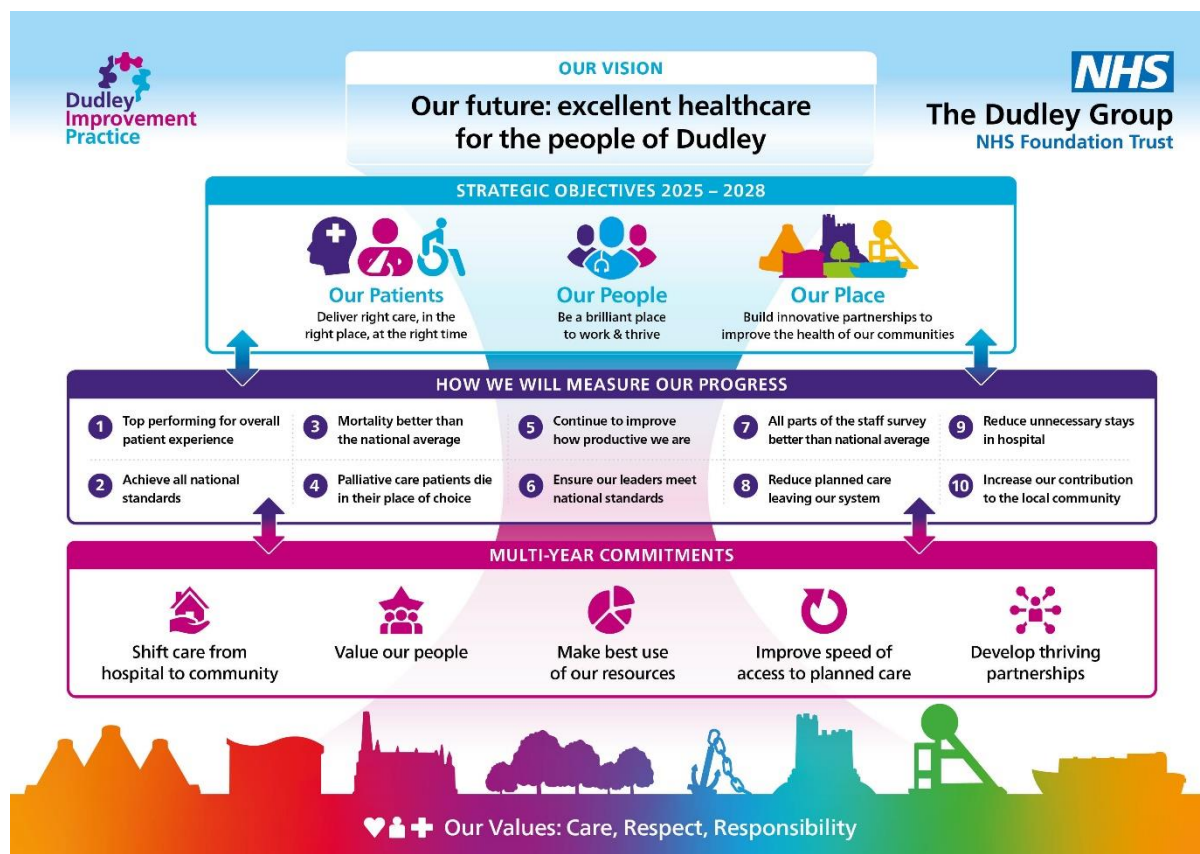
- ⊕ Implement community portal and develop a case for electronic patient records
- ⊕ Maximise potential of same day emergency care by reviewing operating hours
- ⊕ Develop a new model for frailty
- ⊕ Increase membership for all staff networks
- ⊕ Use national manager development framework to develop and deliver internal career progression framework
- ⊕ Implement productivity/financial recovery programme
- ⊕ Improve theatre productivity
- ⊕ Implement the Community Diagnostic Centre
- ⊕ Automation of administration tasks
- ⊕ Optimisation of NHS App
- ⊕ Review of medical workforce
- ⊕ Standardisation of bank rates
- ⊕ Transform clinical services

♥ 👤 ⊕ Our Values: Care, Respect, Responsibility

Context - Strategic objectives and assurance metrics

During 2024 we started to refresh our strategy with the aim of finalising a new one covering the period 2025 – 2028 once the new 10-year health plan is published in spring 2025.

The diagram below shows the proposed new framework. This has been developed in conjunction with staff, governors and patients and paying attention to changes in national policy and the intentions of partner organisations in the Black Country.



This strategy defines our priorities going forwards and will guide where we focus our efforts and investments.

In recognition of the financial challenges faced by the Black Country Integrated Care System as a whole, Black Country Integrated Care Board commissioned PA Consulting to work with the system to develop a **Financial Recovery Plan**. This plan delivers financial balance by 2027/28 and requires all partners to deliver not only the solutions that have been identified by PA Consulting but to develop further solutions through improving the efficiency of corporate functions and potential reconfiguration of clinical services.

In this context, the Trust will finalise the refresh of its strategic plan to cover the period 2025 – 2028 during the first quarter of this annual plan period. This will incorporate the opportunities identified to us by NHS England in the planning support tool and the additional solutions identified during the development of the Financial Recovery Plan.

This annual plan sets out what we need to deliver in the next 12 months to continue to improve and ultimately achieve our new strategy and vision. Alongside our own internal aspirations, these objectives align to:

- **NHS England operational planning guidance 2025/26.** This sets out targets to be achieved by all types of services and organisations in the NHS to improve quality and access. We have prioritised the metrics that will have the biggest impact for patients. In all instances, we have set ourselves at least the national or regional target (set by the Integrated Care System), or higher.
- **Care Quality Commission.** The standards set out by NHS England align with and inform the Care Quality Commission quality standards. Our annual objectives address key areas to improve our overall CQC rating.
- **NHS Staff Survey and People Plan.** Our people annual objectives, like our overall people plan, directly aligns to the national people plan.
- As with our strategy, we have considered other national strategies and guidance such as the [NHS Long Term Plan](#) and the [Joint Forward Plan](#) and [Integrated Care Strategy](#) in our Black Country Integrated Care System.
- The findings of the [Darzi review](#) and the emerging themes likely to feature in the government's 10-year health plan expected to be published in the spring. This is likely to signal the move to make providers accountable care organisations.

In setting these objectives we have prioritised those that will have the biggest impact. We recognise that the environment in which we are working is constantly changing and that our objectives may need refreshing from time to time.

Multi-year commitments

These are commitments that will enable us to deliver our strategy. They will last over the strategy period.

Multi-year Strategic Commitments		
1	Shift care from hospital to community	We will shift care closer to home, so that only those who need to be in hospital are seen there, providing the best experience of care
2	Value our people	We will create an environment which allows everyone to be their best self and provide opportunity for personal growth, to recruit and retain the best talent
3	Make best use of our resources	We will become more efficient by streamlining our processes, optimising our facilities and harnessing technology and AI, to demonstrate best value
4	Improve speed of access to planned care	We will reduce waiting times for investigations and treatments, to provide personalised care at the right time and be the preferred choice for patients
5	Develop thriving partnerships	We will work with partners on innovation, transformation and sustainability to achieve the best outcomes for our communities

Our in-year objectives for 2025/26

The following pages set out each of the six in-year objectives to be achieved by April 2026, setting them in the context of our multi-year commitments.

Strategic Objective	Our patients
Multi-year commitment (from SPF)	Shift from hospital to community care
In-year objective (from SPF)	Implement care navigation centre
What are we striving for? (compelling vision)	A fully integrated “Care Navigation Hub” that has access to step up Virtual Wards and is a single point of access for health and social care in Dudley
Sponsor (Reporting owner)	Kat Rose
Coach (peer support and challenge/critical friend)	Dr Mohit Mandiratta
Scope (what’s in and out)	In: Clinical Hub, community services, enhanced pathways, development of joint model with Sandwell and West Birmingham NHS Trust Out: Social care until 26/27, not to support ward discharge
Timescale (for in-year – 2025/26)	2025/26
Dependencies (what other work is success dependent on?)	Digital infrastructure including a Telephony system & Community EPR (in development) Refinement of pathways & direct referral access to hospital services, (without passing ED)
Balanced measurements of success	
Delivery ED attendances	Quality Frailty care in care home, reduce >65 admissions to B6 & C3
Cost Community care is more cost effective than hospital care Reduced readmissions	Morale Patient experience Partner relationships with Primary Care, Care Homes
How will the goal be achieved? These become the 'What are we striving for?' at the next tier	(top three pieces of work to make it happen) Compelling vision statements defined by project owners
Staffing capacity and skill mix to meet increased demand working with Sandwell and West Birmingham NHS Trust	
Development of a Surgical SDEC and Paediatric Assessment unit pathway from WMAS/Primary care via the Dudley Clinical Hub	
Pathway to support 'step-up' of patients from Primary care/Community to Community hot Clinics and Virtual Wards	

Strategic Objective	Our patients
Multi-year commitment (from SPF)	Shift from hospital to community care
In-year objective (from SPF)	Implement a new model of care for urgent and emergency care
What are we striving for? (compelling vision)	Reduced occupancy so that patients flow through the hospital and can be admitted to a bed when they need it
Sponsor (Reporting owner)	Karen Kelly
Coach (peer support and challenge/critical friend)	
Scope (what's in and out)	In: the inpatient bed base at RHH including temporary surge beds, ED and SDEC Out:
Timescale (for in-year – 2025/26)	2025/26
Dependencies (what other work is success dependent on?)	Objective 'Implement a care navigation centre' above ED and SDEC capacity and capability Available packages of care from Dudley social services
Balanced measurements of success	
Delivery Length of stay Reduced admissions for 65 years and over Virtual ward admissions	Quality Reduced ambulance handovers Reduced incidents relating to omission of care
Cost Spending on staffing temporary ward areas Unit costs for non-elective stays	Morale Patient experience Turnover
How will the goal be achieved? These become the 'What are we striving for?' at the next tier	(top three pieces of work to make it happen) Compelling vision statements defined by project owners
Adequate senior staff early enough in pathway to stream patients to the right service including admission avoidance	
Increased use of call before convey by local ambulance crews	
Increased use of single point of access (see reference to Call Navigation Centre)	

Strategic Objective	People
Multi-year commitment (from SPF)	Value our people
In-year objective (from SPF)	Develop an anti-bullying, anti-discrimination culture
What are we striving for? (compelling vision)	Wouldn't it be great if we empowered people to speak up about bullying or discriminatory behaviour and for them to have confidence that reports will be dealt with appropriately, as a result of line manager skills to intervene earlier. We demonstrate through action that we are an anti-bullying and anti-discrimination workplace,.
Sponsor (Reporting owner)	Karen Brogan
Coach (peer support and challenge/critical friend)	Catherine Holland
Scope (what's in and out)	In: all DGFT staff. Out: behaviour from patients, contracted staff, bank, agency.
Timescale (for in-year – 2025/26)	2025/26
Dependencies (what other work is success dependent on?)	Partnerships with trade unions and staff networks. NHS England national policies could potentially result in a change to local policy.
Balanced measurements of success	
Delivery Increase in caseload tracker (because people speak up)	Quality No. line managers attending 'facilitate difficult conversations' and 'active bystander' training. Feedback from staff formally reporting bullying and harassment
Cost Avoidance of sickness absence (stress/anx/dep) Reduction in formal investigation/increase in local resolution	Morale Annual staff survey – 14b and 14c – reducing % experiencing harassment from managers or colleagues; 16b reducing % not experienced discrimination from managers or colleagues Quarterly Pulse survey – level of confidence to report and that concerns are dealt with (once each year through bespoke questions)
How will the goal be achieved? These become the 'What are we striving for?' at the next tier	(top three pieces of work to make it happen) Compelling vision statements defined by project owners
1. A clear policy framework and expectations	An innovative new policy approach to support all who experience bullying and discrimination to have the confidence to speak out and for those who receive reports to have the capability to take action. The re-launch of the policy will be supported by initial briefing sessions followed by a year-long communications plan and regular promotional events throughout the year.
2. Tools and skills to adopt and sustain	People have the tools and knowledge to help them adopt the policy and embed an anti-bullying and anti-discrimination culture in their teams. Information to support all users is accessible and helps them seek the support they need. We will

	<p>help people understand roles and responsibilities and give skills needed whether they are receiving reports, an active bystander or experiencing bullying or discrimination. We will develop skills to hold facilitated conversations and increase availability of mediators.</p>
<p>3. Bespoke support for challenged teams</p>	<p>We will work with those teams that are most challenged in this area with a tailored plan to help them become beacon teams demonstrating anti-bullying and anti-discrimination and promoting civility and respect.</p> <p>Teams will be identified through data available and soft intelligence.</p>

Strategic Objective	Our patients
Multi-year commitment (from SPF)	Improve speed of access to planned care
In-year objective (from SPF)	Establish an elective hub
What are we striving for? (compelling vision)	Wouldn't it be great if we were able to provide elective surgery in a dedicated facility un-interrupted by emergency pressures and to pathways of care that are best practice
Sponsor (Reporting owner)	Karen Kelly
Coach (peer support and challenge/critical friend)	
Scope (what's in and out)	In: elective orthopaedics and general surgery delivered from Sandwell Health campus Out: other elective surgery delivered by DGFT
Timescale (for in-year – 2025/26)	2025/26
Dependencies (what other work is success dependent on?)	Identification of capital funding to equip theatres and wards at Sandwell Health Campus Ability to earn additional income to cover costs of additional staff and operating costs Availability of staff – various staff groups
Balanced measurements of success	
Delivery Number of patients treated in the elective hub Improvement in RTT position for orthopaedics and general surgery	Quality Length of stay Complication rates including re-admissions Patient surveys including FFT
Cost Cost per weighted activity unit Reduction in waiting list initiatives in orthopaedics and general surgery	Morale Annual staff survey Retention rates
How will the goal be achieved? These become the 'What are we striving for?' at the next tier	(top three pieces of work to make it happen) Compelling vision statements defined by project owners
1. Equipment purchase and refurbishment	
2. Staff recruitment, changes to job plans	
3. Start service delivery	

Strategic Objective	Our patients
Multi-year commitment (from SPF)	Improve speed of access to planned care
In-year objective (from SPF)	Transform outpatient services
What are we striving for? (compelling vision)	Outpatient services that add value to patient care every time delivered in a way that meets patients needs
Sponsor (Reporting owner)	Karen Kelly
Coach (peer support and challenge/critical friend)	
Scope (what's in and out)	In: all outpatient services delivered by DGFT Out:
Timescale (for in-year – 2025/26)	2025/26
Dependencies (what other work is success dependent on?)	GIRFT Further Faster – learning from and implementing best practice Digitisation of outpatient processes Job planning Review of estate utilisation across the Dudley system Community Diagnostic Centre
Balanced measurements of success	
Delivery RTT for outpatient appointments Missed appointment rates Utilisation of patient-initiated follow-up Proportion of appointments delivered virtually	Quality Patient surveys including FFT Complaints relating to outpatient services
Cost Unit cost of outpatient services (from NCCI and Model Hospital) Amount of outpatient services delivered using waiting list initiatives	Morale Annual staff survey
How will the goal be achieved? These become the 'What are we striving for?' at the next tier	(top three pieces of work to make it happen) Compelling vision statements defined by project owners
1. Participation in Further Faster 20 to improve outpatient processes (better utilisation of clinics, reduced missed appointments, better use of PIFU)	
2. Develop a plan for re-locating outpatient services to maximise use of available estate in Dudley and deliver services closer to where people live	
3. Deployment of digital solutions in outpatients to improve efficiency and productivity e.g. patient engagement portal	

Strategic Objective	Our place
Multi-year commitment (from SPF)	Make best use of our resources
In-year objective (from SPF)	Transform corporate services
What are we striving for? (compelling vision)	A shared corporate service which is high-performing, productive and efficient, resilient and fit for purpose
Sponsor (Reporting owner)	Adam Thomas
Coach (peer support and challenge/critical friend)	
Scope (what's in and out)	In: all corporate services deemed to be within scope of the Black Country Provider Collaborative Out:
Timescale (for in-year – 2025/26)	2025/26
Dependencies (what other work is success dependent on?)	
Balanced measurements of success	
Delivery Number of corporate services delivered as part of some shared services arrangement	Quality Services meet agreed key performance indicators (these will be service specific)
Cost Reduced cost of corporate services Corporate service benchmarking	Morale Annual staff survey Retention rates
How will the goal be achieved? These become the 'What are we striving for?' at the next tier	(top three pieces of work to make it happen) Compelling vision statements defined by project owners
Improvements in payroll	
Agreement about model for each service	
Contribution to development of wider system plan for corporate services	

Task & Finish Projects

The following projects have been identified that we intend to complete within 2025/26.

Project	What we plan to do
Community EPR	Implement the community portal and develop a business case for a full Community EPR in conjunction with Black Country System partners.
Maximise potential of Same Day Emergency Care by reviewing operating hours	Review demand and capacity for medical same day emergency services and develop proposals
Develop a new model for frailty	Value Stream Analysis (VSA) with Improvement Practice will identify options that can be implemented to improve pathways for frail patients

Increase membership of all staff networks	Continue to support and develop Staff networks with Executive and Non-executive sponsorship by creating a supportive environment and feedback loop for staff groups, building valuable mechanisms of staff enablement and retention.
Use national manager development framework to develop and deliver internal career progression framework	Continue our implementation of Managers Essentials for all managers Align our programmes with the national manager competencies and curriculum once published in 2025 Refresh competency map and development pathways to align to national framework Deliver development programmes at each stage.
Implement financial recovery programme	Identify ways of realising the cost improvement opportunities identified focusing on non-elective stays, outpatients and reducing spend on temporary staffing
Theatre productivity improvement	Implementation of best practice guidance working towards meeting all GIRFT elective hub accreditation standards
Community Diagnostic Centre	Fully operational following introduction of new services throughout 2024/25. Supports delivery of faster cancer diagnosis standard and expansion of one-stop services to support earlier decision making
Automation of administrative tasks	We have partnered with two third party companies, namely; Heidi and CLEARNotes to look at the use of AI for transcription and to treat the typing backlog. Our collaboration with e18 has identified areas in outpatients, coding, administration and waiting list management which contain elements which could be automated through robotic process automation or AI
Optimisation of NHS App	Our Electronic Patient Record (EPR) provider, Altera have a patient portal which is due for early release imminently. Dudley is an early adopter and will be working with them to ensure functionality meets our requirements and is linked to the NHSApp. Our Patient Engagement Portal (PEP) already meets this requirement as we were one of the first Trusts to implement this nationally
Review of medical workforce	A collaborative project between HR Business Partners, Finance and the Medical Directors office to review the medical workforce establishment, implement robust establishment control and identify clear workforce plans.

Standardisation of bank rates	Work with our partner Acute Trust's as part of the Black country Provider Collaborative to ensure standard rates are paid for all bank work, both medical and non-medical bank.
Transform clinical services (Black Country Provider Collaborative)	Work with partners on proposed developments for renal cancer surgery (nephrectomies and partial nephrectomies), breast reconstruction and vascular surgery

The role of Black Country Provider Collaborative

Some of our objectives will be done in collaboration with the other acute and community trusts in the Black Country. These are highlighted in orange.

The work of the clinical networks will support improvements in elective pathways that will deliver increased elective capacity and help us reduce waiting times.

We will contribute to business cases across the system that consolidate and deliver services currently not available in the Black Country. The services we will be focusing on 2025/26 are:

- Renal cancer centre
- consolidation of breast units
- breast reconstruction
- provision of vascular surgery services for the population of Sandwell

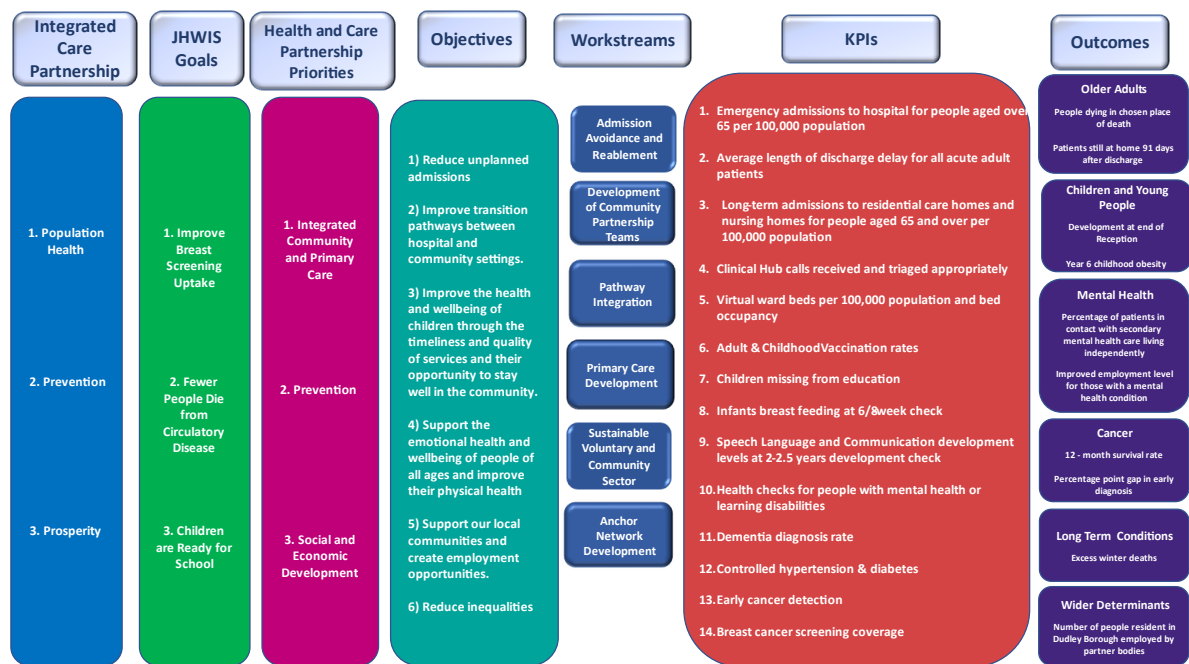
These developments are dependent on the creation of the elective hub which will release the necessary capacity in Russells Hall Hospital.

Corporate services transformation is being led by the Provider Collaborative and is outlined in the section above as it is one of our in-year objectives.

The role of Dudley Health & Care Partnership

Some of our objectives can only be delivered in collaboration with other agencies in Dudley such as Dudley Council, Black Country ICB, primary care and the voluntary and community sector.

The partnership will focus on integrated community and primary care, prevention and social and economic development.



Risks and Mitigations

The following risks to the delivery of the plan have been identified.

Challenges, risks and issues	Mitigating Actions
Activity and finance	
Closure of surge beds and keeping them closed	Alternative pathways in community and at the front door to prevent people requiring hospital admission
Increased demand for UEC following opening of MMUH in autumn 2024	Escalation via ICB UEC Board. Re-adjust UEC activity baselines to reflect
Re-development of resus area in RHH ED expected to continue until November 2025	Work with contractor to conclude project as quickly as possible, certainly ahead of winter 25/26
Financial challenges in Dudley Council leading to restrictions on funding for packages of care	Work with partners in Dudley place to maximise use of additional discharge funding that should be available
Elective Recovery Fund is capped	Ensure that elective activity plan is consistent with funding available and focus on reducing use of waiting list initiatives
Expectation of mutual aid which impacts ability to remove long waiters from our waiting list	Work with system to quantify impact of mutual aid
Community Services do not have a full Electronic Patient Record	Community portal been implemented and a business case will be developed with other places to access national funding if it becomes available.
Financial grip and control impacting on staff morale	Clear communication plan to staff about our situation and how they can contribute
Staff capacity to manage day to day demands and deliver transformation needed to address the financial challenge the system has	Grow the community of improvement practice to support transformation at all levels
Workforce	
Bank rate alignment could see an increase in costs	A system working group has been established to review bank rate alignment, supported by

Changes to staffing levels reflects changes to acuity. Band 2/3 National Profile risk Risk to staff engagement and morale – and potential negative impact on staff survey performance	NHSE framework. This will be overseen by both the Provider Collaborative and the Trust Board. A trust task and finish group are in operation relating to the Band 2/3 National Profile risk, feeding into the provider collaborative to ensure there are consistent solutions The establishment of the Brilliant Place to Work group and the Recruitment and Retention work group to deliver actions associated with the Culture and Learning journey, including staff engagement and morale and workforce planning
Digital	
Investment and delivery capacity of digital teams	Prioritise activities on those that support delivery of in-year objectives
Levelling up digital maturity across the system	Share resource with system partners

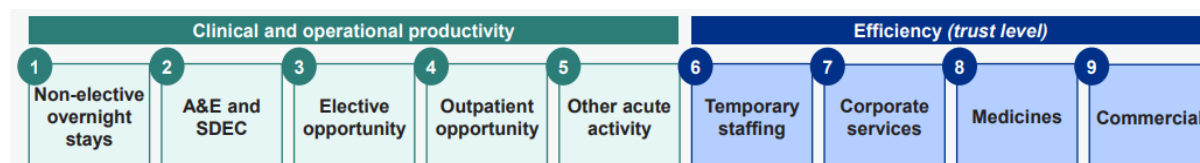
Governance

The Board of Directors collectively own the strategic objectives and multi-year commitments in our strategy.

There is an executive sponsor for each of the in-year objectives.

Progress against the in-year objectives and the effect that this is having on our assurance metrics in the strategy will be reported in a quarterly report which will be discussed in the relevant committees with a summary for assurance at Board of Directors.

Financial Improvement Group will be re-configured to meet monthly and to focus on work being undertaken by the organisation to realise the opportunity to improve costs where these are higher than expected. The groups will be organised around the opportunities identified by NHS England using the categories in the productivity and efficiency packs which have formed part of the guidance for planning in 2025/26. Whilst each opportunity will have an identified team to support, most of the focus will be on non-elective overnight stays, A&E and SDEC, elective, outpatients and temporary staffing since this is where the greatest opportunities can be found.



Monthly monitoring of the key planning trajectories (activity and performance, workforce and finance) are discussed at the Annual Planning Group which consists of representatives from each operational division, with reports being fed into Financial Improvement Group and upward reporting to Finance and Productivity Committee.

Divisional contributions to the delivery of the annual plan are also incorporated into quarterly Divisional Performance Reviews.

Staff appraisals will be informed by the plan and the objectives set out in it. As mentioned above, all staff will be expected to identify an improvement project during their objective setting for the coming year.

Appendix 1 – activity and planning trajectories agreed with ICB / NHSE

Appendix 2 – workforce trajectory agreed with ICB / NHSE

Appendix 3 – financial plan agreed with ICB / NHSE

Appendix 1 – activity and planning trajectories agreed with ICB / NHSE

Electives	Apr 2025- Mar 2026	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Electives Total	64,976	5,136	5,136	5,393	5,907	5,136	5,650	5,907	5,136	5,393	5,393	5,136	5,650
Elective day case spells	58,198	4,601	4,601	4,831	5,291	4,601	5,061	5,291	4,601	4,831	4,831	4,601	5,061
Elective ordinary spells	6,778	536	536	563	616	536	589	616	536	563	563	536	589

Total outpatient attendances	Apr 2025- Mar 2026	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Total	705,544	55,774	55,774	58,563	64,140	55,774	61,352	64,140	55,774	58,563	58,563	55,774	61,352
Number of episodes moved or discharged to a PIFU pathway	32,505	1,785	1,927	2,172	2,543	2,353	2,744	3,032	2,779	3,067	3,216	3,205	3,682
PIFU as percentage of total outpatient attendances	4.61	3.20	3.45	3.71	3.96	4.22	4.47	4.73	4.98	5.24	5.49	5.75	6.00

Consultant-led outpatient attendances	Apr 2025- Mar 2026	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
First	154,292	12,197	12,197	12,807	14,027	12,197	13,417	14,027	12,197	12,807	12,807	12,197	13,417
Follow-up	236,186	18,671	18,671	19,604	21,471	18,671	20,538	21,471	18,671	19,604	19,604	18,671	20,538

Outpatients - ERF definition	Apr 2025- Mar 2026	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Outpatient procedures - ERF definition	79,180	6,259	6,259	6,572	7,198	6,259	6,885	7,198	6,259	6,572	6,572	6,259	6,885
Outpatient first attendances without a procedure - ERF definition	204,581	16,172	16,172	16,981	18,598	16,172	17,790	18,598	16,172	16,981	16,981	16,172	17,790
Outpatient follow up attendances without procedure - ERF definition	317,038	25,062	25,062	26,315	28,822	25,062	27,569	28,822	25,062	26,315	26,315	25,062	27,569
Time to first attendance		Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Patients waiting less than 18 weeks		18,695	18,695	18,695	18,695	18,695	18,695	18,695	18,695	18,695	18,695	18,695	18,695
Total patients waiting for first attendance		29,971	29,757	29,543	29,329	29,115	28,901	28,686	28,472	28,258	28,044	27,830	27,606
Incomplete RTT pathways		Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
RTT waiting list - total		44,339	44,064	43,789	43,514	43,239	42,964	42,689	42,414	42,138	41,863	41,588	41,313
RTT waiting list - 52+ weeks		691	600	415	277	139	-	-	-	-	-	-	-

RTT waiting list - less than 18 weeks		26,570	26,576	26,581	26,583	26,583	26,581	26,576	26,570	26,561	26,551	26,538	26,523
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RTT	Apr 2025-Mar 2026	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
The number of completed admitted RTT pathways	24,023	1,899	1,899	1,994	2,184	1,899	2,089	2,184	1,899	1,994	1,994	1,899	2,089
The number of completed non-admitted RTT pathways	83,390	6,592	6,592	6,922	7,581	6,592	7,251	7,581	6,592	6,922	6,922	6,592	7,251
The number of new RTT pathways in the reporting period	124,193	10,731	10,698	9,861	10,848	10,076	10,123	11,479	10,419	9,088	10,619	10,440	9,811

Diagnostic tests	Apr 2025-Mar 2026	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Magnetic Resonance Imaging	28,150	2,384	2,488	2,488	2,483	2,417	2,385	2,326	2,310	2,147	2,219	2,065	2,438
Computed Tomography	54,527	4,251	4,591	4,591	4,609	4,752	4,528	4,976	5,015	4,138	4,471	4,141	4,464
Non-Obstetric Ultrasound	65,649	4,863	5,288	5,288	5,723	5,412	5,330	6,169	5,718	4,855	5,864	5,339	5,800
Colonoscopy	4,236	335	377	377	381	317	286	336	389	327	388	369	354
Flexi Sigmoidoscopy	2,315	218	190	190	158	145	128	186	204	233	213	217	233
Gastroscopy	4,432	409	397	397	313	305	351	394	353	352	359	418	384

Cardiology - Echocardiography	12,676	961	1,042	1,042	1,065	1,035	1,007	1,122	1,090	922	1,172	1,088	1,130
DEXA scan	3,292	253	283	283	267	284	255	287	277	265	297	261	280
Audiology	3,786	323	336	336	344	252	264	369	319	268	366	308	301

A&E attendances	Apr 2025-Mar 2026	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Type 1	111,958	9,177	9,483	9,177	9,483	9,483	9,177	9,483	9,177	9,483	9,483	8,871	9,483

Same Day Emergency Care (SDEC)	Apr 2025-Mar 2026	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
SDEC	-	-	-	-	-	-	-	-	-	-	-	-	-

Non-Electives	Apr 2025-Mar 2026	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Non-elective spells	60,820	4,999	5,166	4,999	5,166	5,166	4,999	5,166	4,999	5,166	5,166	4,666	5,166
Non-elective spells with a length of stay of zero days	32,458	2,668	2,757	2,668	2,757	2,757	2,668	2,757	2,668	2,757	2,757	2,490	2,757
Non-elective spells with a length of stay of one or more days	28,361	2,331	2,409	2,331	2,409	2,409	2,331	2,409	2,331	2,409	2,409	2,176	2,409

Number of patients discharged on discharge ready date	Apr 2025-Mar 2026	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Number of patients discharged on discharge ready date	22,646	1,772	1,861	1,677	1,914	1,990	1,876	2,064	2,006	1,997	1,836	1,767	1,886
Number of patients discharged	28,429	2,206	2,317	2,088	2,400	2,496	2,353	2,595	2,522	2,511	2,322	2,234	2,385

General & acute bed occupancy	Apr 2025-Mar 2026	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Average number of overnight G&A beds occupied	618	610	616	612	611	609	618	638	631	636	618	606	610
Average number of overnight G&A beds occupied	633	633	633	633	633	633	633	633	633	633	633	633	633

Average delay	Apr 2025-Mar 2026	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Total duration of delays (days)	32,799	2,633	2,641	2,538	2,395	2,761	2,347	3,025	2,526	3,071	2,994	2,760	3,108
Number of discharges (excluding zero delay)	5,781	442	444	426	469	541	460	547	456	555	487	449	505
Average delay	5.7	6.0	5.9	6.0	5.1	5.1	5.1	5.5	5.5	5.5	6.1	6.1	6.2

Appendix 2 – workforce trajectory agreed with ICB / NHSE

	2023/24	Mid 24/25	2024/25	25/26	25/26	25/26	25/26	25/26	25/26	25/26	25/26	25/26	25/26	25/26	25/26	25/26	Change	Change
	Outturn	DIHC	Forecast	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Mar 25 -	Mar 25 -	
	WTE	Addition	Mar													%	%	
	WTE	WTE	WTE															
Total Substantive	5,680	199	5,914	5,900	5,902	5,902	5,889	5,890	5,877	5,865	5,849	5,832	5,812	5,795	5,779	(2%)	(135)	
Total Bank	597	2	611	542	529	516	501	487	474	476	463	415	436	428	415	(32%)	(196)	
Total Agency	12	-	10	7	7	6	6	6	6	6	6	6	6	6	6	(40%)	(4)	
Grand Total	6,290	201	6,535	6,449	6,438	6,424	6,396	6,383	6,357	6,347	6,318	6,253	6,254	6,229	6,200	(5%)	(335)	

Appendix 3 – financial plan agreed with ICB / NHSE

Statement of comprehensive income		04FOTPT	04PLANM01	04PLANM02	04PLANM03	04PLANM04	04PLANM05	04PLANM06	04PLANM07	04PLANM08	04PLANM09	04PLANM10	04PLANM11	04PLANM12	04PLANCT
		Forecast Out- turn 31/03/2025 Year Ending £'000	Plan 30/04/2025 Month 1 £'000	Plan 31/05/2025 Month 2 £'000	Plan 30/06/2025 Month 3 £'000	Plan 31/07/2025 Month 4 £'000	Plan 31/08/2025 Month 5 £'000	Plan 30/09/2025 Month 6 £'000	Plan 31/10/2025 Month 7 £'000	Plan 30/11/2025 Month 8 £'000	Plan 31/12/2025 Month 9 £'000	Plan 31/01/2026 Month 10 £'000	Plan 28/02/2026 Month 11 £'000	Plan 31/03/2026 Month 12 £'000	Plan 31/03/2026 Year Ending £'000
Operating income from patient care activities	+	578,917	48,418	48,422	48,419	48,421	48,419	48,422	48,418	48,422	48,419	48,421	48,420	48,445	581,066
Other operating income	+	33,171	2,488	2,488	2,488	2,488	2,488	2,488	2,488	2,488	2,488	2,488	2,488	2,499	29,867
Employee expenses	-	(388,883)	(33,643)	(33,546)	(33,427)	(33,213)	(33,167)	(32,999)	(32,990)	(32,862)	(32,378)	(32,505)	(32,387)	(32,247)	(395,364)
Operating expenses excluding employee expenses	-	(203,960)	(16,314)	(17,093)	(17,274)	(17,160)	(15,952)	(15,905)	(15,476)	(16,296)	(15,341)	(15,783)	(15,705)	(15,413)	(194,312)
OPERATING SURPLUS/(DEFICIT)	+-	19,245	349	271	206	536	1,788	2,006	2,440	1,752	3,188	2,621	2,816	3,284	21,257
FINANCE COSTS															
Finance income	+	1,446	75	75	75	75	75	75	75	75	75	75	75	75	900
Finance expense	+-	(36,358)	(10,985)	(986)	(985)	(986)	(985)	(986)	(986)	(985)	(986)	(985)	(985)	(986)	(21,826)
PDC dividend expense	i	0	0	0	0	0	0	0	0	0	0	0	0	0	0
NET FINANCE COSTS	+-	(34,912)	(10,910)	(911)	(910)	(911)	(910)	(911)	(911)	(910)	(911)	(910)	(910)	(911)	(20,926)
Other gains/(losses) including disposal of assets	+-	10	0	0	0	0	0	0	0	0	0	0	0	0	0
Share of profit/(loss) of associates/joint ventures	+-	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Gains/(losses) from transfers by absorption	i	(680)	0	0	0	0	0	0	0	0	0	0	0	0	0
Movements in fair value of investments, investment property, financial liabilities and finance lease receivables	+-	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Corporation tax expense	-	(92)	(8)	(8)	(8)	(8)	(8)	(8)	(8)	(8)	(8)	(8)	(8)	(4)	(92)
SURPLUS/(DEFICIT) FOR THE PERIOD/YEAR	+-	(16,429)	(10,569)	(648)	(712)	(383)	870	1,087	1,521	834	2,269	1,703	1,898	2,369	239

Adjusted financial performance		04FOTPT	04PLANM01	04PLANM02	04PLANM03	04PLANM04	04PLANM05	04PLANM06	04PLANM07	04PLANM08	04PLANM09	04PLANM10	04PLANM11	04PLANM12	04PLANCT
		Forecast Out- turn 31/03/2025 Year Ending £'000	Plan 30/04/2025 Month 1 £'000	Plan 31/05/2025 Month 2 £'000	Plan 30/06/2025 Month 3 £'000	Plan 31/07/2025 Month 4 £'000	Plan 31/08/2025 Month 5 £'000	Plan 30/09/2025 Month 6 £'000	Plan 31/10/2025 Month 7 £'000	Plan 30/11/2025 Month 8 £'000	Plan 31/12/2025 Month 9 £'000	Plan 31/01/2026 Month 10 £'000	Plan 28/02/2026 Month 11 £'000	Plan 31/03/2026 Month 12 £'000	Plan 31/03/2026 Year Ending £'000
Surplus/(deficit) for the period/year	+-	(16,429)	(10,569)	(648)	(712)	(383)	870	1,087	1,521	834	2,269	1,703	1,898	2,369	239
Add back all I&E impairments/(reversals)	i	5	0	0	0	0	0	0	0	0	0	0	0	0	0
Adjust (gains)/losses on transfers by absorption	+-	680	0	0	0	0	0	0	0	0	0	0	0	0	0
Surplus/(deficit) before impairments and transfers	+-	(15,744)	(10,569)	(648)	(712)	(383)	870	1,087	1,521	834	2,269	1,703	1,898	2,369	239
Retain impact of DEL I&E (impairments)/reversals	i	(5)	0	0	0	0	0	0	0	0	0	0	0	0	0
Remove capital donations/grants/peppercom lease I&E impact	i	92	16	16	18	16	16	19	16	16	17	16	16	16	198
Prior period adjustments to correct errors and other performance adjustments	i	0													
Remove net impact of consumables donated from other DHSC bodies	+-	0													
Remove loss recognised on peppercom lease disposals	+-	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Remove PFI revenue costs on an IFRS 16 basis	+-	69,211	13,824	3,824	3,823	3,826	3,826	3,828	3,829	3,830	3,830	3,873	3,872	3,876	56,061
Add back PFI revenue costs on a UK GAAP basis	+-	(54,557)	(4,708)	(4,708)	(4,708)	(4,709)	(4,708)	(4,708)	(4,708)	(4,709)	(4,708)	(4,708)	(4,707)	(4,709)	(56,498)
Adjusted financial performance surplus/(deficit)	+-	(1,003)	(1,437)	(1,516)	(1,579)	(1,250)	4	226	658	(29)	1,408	884	1,079	1,552	0
Adjusted financial performance excluding Non-Recurrent Deficit															
Adjusted financial performance surplus/(deficit)	+-	(1,003)	(1,437)	(1,516)	(1,579)	(1,250)	4	226	658	(29)	1,408	884	1,079	1,552	0
Less Non-Recurrent Deficit Funding	-	(30,975)	(1,765)	(1,766)	(1,765)	(1,766)	(1,765)	(1,766)	(1,765)	(1,766)	(1,765)	(1,766)	(1,765)	(1,766)	(21,186)
Adjusted financial performance surplus (deficit) excluding Non-Recurrent Deficit Funding	+-	(31,978)	(3,202)	(3,282)	(3,344)	(3,016)	(1,761)	(1,540)	(1,107)	(1,795)	(357)	(882)	(686)	(214)	(21,186)

This is the submission made on 30th April and represents the final financial plan.

Section B: Provider Assurance

Assurance statement	Confirmed (Yes / No)	Additional comments or qualifications (optional)
<i>Governance</i>		
The Board has systematically reviewed and assured the operational, workforce and financial plans for 2025/26 that form the basis of the organisation's submissions to NHS England.	Yes	Board training and development day on 13 th February was dedicated to annual plan 25/26. Exec team has approved headline submission on 14 th February. Discussion on the content of the plan at exec directors weekly since then and at private board on 13 th March and again at joint board development day on 21 st March prior to final submission
The Board has reviewed its quality and finance governance arrangements, and put in place a clinically led process to support prioritisation decisions.	Yes	Quality and productivity workstreams have been set up including identified clinical leadership to develop plans to realise the opportunity identified to the trust in the planning support tool. Reporting will be via the Financial Improvement Group to Finance & productivity committee to board
Prioritisation decisions were reviewed by the Board, including explicit consideration of the principles set out in planning guidance.	Yes	Priorities are reflected in the in-year objectives for the trust which include implementing a care navigation centre to support shift away from hospital care and implementation of a new model of urgent and emergency care (AMRAT) to put emergency patients on the right care pathway

A robust quality and equality impact assessment (QEIA) informed development of the organisation's plan and has been reviewed by the Board.	Yes	The trust has a QEIA process. Any service changes resulting from the plan will go through this process including the cost improvement programme. Reporting to Quality committee on a regular basis
The organisation's plan was developed with appropriate input from and engagement with system partners.	Yes	The trust has played an active part in system-wide discussions and sought to align our plan with the plans of other partners. This is with particular reference to the impact of opening MMUH and the planned elective hub at Sandwell

Assurance statement	Confirmed (Yes / No)	Additional comments or qualifications (optional)
<i>Plan content and delivery</i>		
The Board has systematically reviewed and is assured that it has plans in place address the key opportunities to meet the national priorities for the NHS in 2025/26. This includes the actions against the national delivery plan 'checklists' and the use of benchmarking to identify unwarranted variation / improvement opportunities.	Yes	Board reviewed the planning support tool in detail at the development day on 13 th February. The plan has been developed to reflect the priorities identified
The Board is assured that all possible realistic in-year productivity and efficiency opportunities have been considered and are reflected across the organisation's operational, workforce and financial plans.	Yes	Productivity and efficiency opportunities are being actively considered within the Quality and productivity workstreams described above

<p>The Board is assured that any key risks to quality linked to the organisation's plan have been identified and appropriate mitigations are in place.</p>	<p>Yes</p>	<p>Key risks have been identified and are documented in the annual plan. PIDs are being developed for all cost improvement schemes and the trust has a robust QEIA process as highlighted above which all schemes will be subject to</p>
<p>The Board is assured of the deliverability of the organisation's operational, workforce and financial plans. This includes appropriate profiling and triangulation of plan delivery, and mitigations against key delivery challenges and risks.</p>	<p>Yes</p>	<p>The trust has used the triangulation tool provided by NHS England to assure plans</p> <p>The key risk to delivery is the large amount of CIP (total £38.976m which is 6.2% of operating expenses) and the development of detailed delivery plans to support this. Of the £30m with schemes identified, most of these are in the 'opportunity' category and being worked up. There is considerable risk around the further £8.9m which is currently unidentified, on top of an already stretching target. The workforce reduction plan which forms part of the plan will contribute to this</p>

Appendix 1 – activity and planning trajectories agreed with ICB / NHSE

Electives	Apr 2025- Mar 2026	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Electives Total	64,976	5,136	5,136	5,393	5,907	5,136	5,650	5,907	5,136	5,393	5,393	5,136	5,650
Elective day case spells	58,198	4,601	4,601	4,831	5,291	4,601	5,061	5,291	4,601	4,831	4,831	4,601	5,061
Elective ordinary spells	6,778	536	536	563	616	536	589	616	536	563	563	536	589

Total outpatient attendances	Apr 2025- Mar 2026	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Total	705,544	55,774	55,774	58,563	64,140	55,774	61,352	64,140	55,774	58,563	58,563	55,774	61,352
Number of episodes moved or discharged to a PIFU pathway	32,505	1,785	1,927	2,172	2,543	2,353	2,744	3,032	2,779	3,067	3,216	3,205	3,682
PIFU as percentage of total outpatient attendances	4.61	3.20	3.45	3.71	3.96	4.22	4.47	4.73	4.98	5.24	5.49	5.75	6.00

Consultant-led outpatient attendances	Apr 2025- Mar 2026	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
First	154,292	12,197	12,197	12,807	14,027	12,197	13,417	14,027	12,197	12,807	12,807	12,197	13,417
Follow-up	236,186	18,671	18,671	19,604	21,471	18,671	20,538	21,471	18,671	19,604	19,604	18,671	20,538

Outpatients - ERF definition	Apr 2025- Mar 2026	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Outpatient procedures - ERF definition	79,180	6,259	6,259	6,572	7,198	6,259	6,885	7,198	6,259	6,572	6,572	6,259	6,885
Outpatient first attendances without a procedure - ERF definition	204,581	16,172	16,172	16,981	18,598	16,172	17,790	18,598	16,172	16,981	16,981	16,172	17,790
Outpatient follow up attendances without procedure - ERF definition	317,038	25,062	25,062	26,315	28,822	25,062	27,569	28,822	25,062	26,315	26,315	25,062	27,569
Time to first attendance		Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Patients waiting less than 18 weeks		18,695	18,695	18,695	18,695	18,695	18,695	18,695	18,695	18,695	18,695	18,695	18,695
Total patients waiting for first attendance		29,971	29,757	29,543	29,329	29,115	28,901	28,686	28,472	28,258	28,044	27,830	27,606
Incomplete RTT pathways		Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
RTT waiting list - total		44,339	44,064	43,789	43,514	43,239	42,964	42,689	42,414	42,138	41,863	41,588	41,313
RTT waiting list - 52+ weeks		691	600	415	277	139	-	-	-	-	-	-	-

RTT waiting list - less than 18 weeks		26,570	26,576	26,581	26,583	26,583	26,581	26,576	26,570	26,561	26,551	26,538	26,523
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RTT	Apr 2025-Mar 2026	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
The number of completed admitted RTT pathways	24,023	1,899	1,899	1,994	2,184	1,899	2,089	2,184	1,899	1,994	1,994	1,899	2,089
The number of completed non-admitted RTT pathways	83,390	6,592	6,592	6,922	7,581	6,592	7,251	7,581	6,592	6,922	6,922	6,592	7,251
The number of new RTT pathways in the reporting period	124,193	10,731	10,698	9,861	10,848	10,076	10,123	11,479	10,419	9,088	10,619	10,440	9,811

Diagnostic tests	Apr 2025-Mar 2026	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Magnetic Resonance Imaging	28,150	2,384	2,488	2,488	2,483	2,417	2,385	2,326	2,310	2,147	2,219	2,065	2,438
Computed Tomography	54,527	4,251	4,591	4,591	4,609	4,752	4,528	4,976	5,015	4,138	4,471	4,141	4,464
Non-Obstetric Ultrasound	65,649	4,863	5,288	5,288	5,723	5,412	5,330	6,169	5,718	4,855	5,864	5,339	5,800
Colonoscopy	4,236	335	377	377	381	317	286	336	389	327	388	369	354
Flexi Sigmoidoscopy	2,315	218	190	190	158	145	128	186	204	233	213	217	233
Gastroscopy	4,432	409	397	397	313	305	351	394	353	352	359	418	384

Cardiology - Echocardiography	12,676	961	1,042	1,042	1,065	1,035	1,007	1,122	1,090	922	1,172	1,088	1,130
DEXA scan	3,292	253	283	283	267	284	255	287	277	265	297	261	280
Audiology	3,786	323	336	336	344	252	264	369	319	268	366	308	301

A&E attendances	Apr 2025-Mar 2026	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Type 1	111,958	9,177	9,483	9,177	9,483	9,483	9,177	9,483	9,177	9,483	9,483	8,871	9,483

Same Day Emergency Care (SDEC)	Apr 2025-Mar 2026	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
SDEC	-	-	-	-	-	-	-	-	-	-	-	-	-

Non-Electives	Apr 2025-Mar 2026	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Non-elective spells	60,820	4,999	5,166	4,999	5,166	5,166	4,999	5,166	4,999	5,166	5,166	4,666	5,166
Non-elective spells with a length of stay of zero days	32,458	2,668	2,757	2,668	2,757	2,757	2,668	2,757	2,668	2,757	2,757	2,490	2,757
Non-elective spells with a length of stay of one or more days	28,361	2,331	2,409	2,331	2,409	2,409	2,331	2,409	2,331	2,409	2,409	2,176	2,409

Number of patients discharged on discharge ready date	Apr 2025-Mar 2026	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Number of patients discharged on discharge ready date	22,646	1,772	1,861	1,677	1,914	1,990	1,876	2,064	2,006	1,997	1,836	1,767	1,886
Number of patients discharged	28,429	2,206	2,317	2,088	2,400	2,496	2,353	2,595	2,522	2,511	2,322	2,234	2,385

General & acute bed occupancy	Apr 2025-Mar 2026	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Average number of overnight G&A beds occupied	618	610	616	612	611	609	618	638	631	636	618	606	610
Average number of overnight G&A beds occupied	633	633	633	633	633	633	633	633	633	633	633	633	633

Average delay	Apr 2025-Mar 2026	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Total duration of delays (days)	32,799	2,633	2,641	2,538	2,395	2,761	2,347	3,025	2,526	3,071	2,994	2,760	3,108
Number of discharges (excluding zero delay)	5,781	442	444	426	469	541	460	547	456	555	487	449	505
Average delay	5.7	6.0	5.9	6.0	5.1	5.1	5.1	5.5	5.5	5.5	6.1	6.1	6.2

Appendix 2 – workforce trajectory agreed with ICB / NHSE

	2023/24	Mid 24/25	2024/25	25/26	25/26	25/26	25/26	25/26	25/26	25/26	25/26	25/26	25/26	25/26	25/26	25/26	Change	Change
	Outturn	DIHC	Forecast	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Mar 25 -	Mar 25 -	
	WTE	Addition	Mar													%	%	
	WTE	WTE	WTE															
Total Substantive	5,680	199	5,914	5,900	5,902	5,902	5,889	5,890	5,877	5,865	5,849	5,832	5,812	5,795	5,779	(2%)	(135)	
Total Bank	597	2	611	542	529	516	501	487	474	476	463	415	436	428	415	(32%)	(196)	
Total Agency	12	-	10	7	7	6	6	6	6	6	6	6	6	6	6	(40%)	(4)	
Grand Total	6,290	201	6,535	6,449	6,438	6,424	6,396	6,383	6,357	6,347	6,318	6,253	6,254	6,229	6,200	(5%)	(335)	

Appendix 3 – financial plan agreed with ICB / NHSE

Statement of comprehensive income		04FOTPT	04PLANM01	04PLANM02	04PLANM03	04PLANM04	04PLANM05	04PLANM06	04PLANM07	04PLANM08	04PLANM09	04PLANM10	04PLANM11	04PLANM12	04PLANCT
		Forecast Out- turn 31/03/2025 Year Ending £'000	Plan 30/04/2025 Month 1 £'000	Plan 31/05/2025 Month 2 £'000	Plan 30/06/2025 Month 3 £'000	Plan 31/07/2025 Month 4 £'000	Plan 31/08/2025 Month 5 £'000	Plan 30/09/2025 Month 6 £'000	Plan 31/10/2025 Month 7 £'000	Plan 30/11/2025 Month 8 £'000	Plan 31/12/2025 Month 9 £'000	Plan 31/01/2026 Month 10 £'000	Plan 28/02/2026 Month 11 £'000	Plan 31/03/2026 Month 12 £'000	Plan 31/03/2026 Year Ending £'000
Operating income from patient care activities	+	578,917	48,418	48,422	48,419	48,421	48,419	48,422	48,418	48,422	48,419	48,421	48,420	48,445	581,066
Other operating income	+	33,171	2,488	2,488	2,488	2,488	2,488	2,488	2,488	2,488	2,488	2,488	2,488	2,499	29,867
Employee expenses	-	(388,883)	(33,643)	(33,546)	(33,427)	(33,213)	(33,167)	(32,999)	(32,990)	(32,862)	(32,378)	(32,505)	(32,387)	(32,247)	(395,364)
Operating expenses excluding employee expenses	-	(203,960)	(16,314)	(17,093)	(17,274)	(17,160)	(15,952)	(15,905)	(15,476)	(16,296)	(15,341)	(15,783)	(15,705)	(15,413)	(194,312)
OPERATING SURPLUS/(DEFICIT)	+-	19,245	349	271	206	536	1,788	2,006	2,440	1,752	3,188	2,621	2,816	3,284	21,257
FINANCE COSTS															
Finance income	+	1,446	75	75	75	75	75	75	75	75	75	75	75	75	900
Finance expense	+-	(36,358)	(10,985)	(986)	(985)	(986)	(985)	(986)	(986)	(985)	(986)	(985)	(985)	(986)	(21,826)
PDC dividend expense	i	0	0	0	0	0	0	0	0	0	0	0	0	0	0
NET FINANCE COSTS	+-	(34,912)	(10,910)	(911)	(910)	(911)	(910)	(911)	(911)	(910)	(911)	(910)	(910)	(911)	(20,926)
Other gains/(losses) including disposal of assets	+-	10	0	0	0	0	0	0	0	0	0	0	0	0	0
Share of profit/(loss) of associates/joint ventures	+-	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Gains/(losses) from transfers by absorption	i	(680)	0	0	0	0	0	0	0	0	0	0	0	0	0
Movements in fair value of investments, investment property, financial liabilities and finance lease receivables	+-	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Corporation tax expense	-	(92)	(8)	(8)	(8)	(8)	(8)	(8)	(8)	(8)	(8)	(8)	(8)	(4)	(92)
SURPLUS/(DEFICIT) FOR THE PERIOD/YEAR	+-	(16,429)	(10,569)	(648)	(712)	(383)	870	1,087	1,521	834	2,269	1,703	1,898	2,369	239

Adjusted financial performance		04FOTPT	04PLANM01	04PLANM02	04PLANM03	04PLANM04	04PLANM05	04PLANM06	04PLANM07	04PLANM08	04PLANM09	04PLANM10	04PLANM11	04PLANM12	04PLANCT
		Forecast Out- turn 31/03/2025 Year Ending £'000	Plan 30/04/2025 Month 1 £'000	Plan 31/05/2025 Month 2 £'000	Plan 30/06/2025 Month 3 £'000	Plan 31/07/2025 Month 4 £'000	Plan 31/08/2025 Month 5 £'000	Plan 30/09/2025 Month 6 £'000	Plan 31/10/2025 Month 7 £'000	Plan 30/11/2025 Month 8 £'000	Plan 31/12/2025 Month 9 £'000	Plan 31/01/2026 Month 10 £'000	Plan 28/02/2026 Month 11 £'000	Plan 31/03/2026 Month 12 £'000	Plan 31/03/2026 Year Ending £'000
Surplus/(deficit) for the period/year	+-	(16,429)	(10,569)	(648)	(712)	(383)	870	1,087	1,521	834	2,269	1,703	1,898	2,369	239
Add back all I&E impairments/(reversals)	i	5	0	0	0	0	0	0	0	0	0	0	0	0	0
Adjust (gains)/losses on transfers by absorption	+-	680	0	0	0	0	0	0	0	0	0	0	0	0	0
Surplus/(deficit) before impairments and transfers	+-	(15,744)	(10,569)	(648)	(712)	(383)	870	1,087	1,521	834	2,269	1,703	1,898	2,369	239
Retain impact of DEL I&E (impairments)/reversals	i	(5)	0	0	0	0	0	0	0	0	0	0	0	0	0
Remove capital donations/grants/peppercom lease I&E impact	i	92	16	16	18	16	16	19	16	16	17	16	16	16	198
Prior period adjustments to correct errors and other performance adjustments	i	0													
Remove net impact of consumables donated from other DHSC bodies	+-	0													
Remove loss recognised on peppercom lease disposals	+-	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Remove PFI revenue costs on an IFRS 16 basis	+-	69,211	13,824	3,824	3,823	3,826	3,826	3,828	3,829	3,830	3,830	3,873	3,872	3,876	56,061
Add back PFI revenue costs on a UK GAAP basis	+-	(54,557)	(4,708)	(4,708)	(4,708)	(4,709)	(4,708)	(4,708)	(4,708)	(4,709)	(4,708)	(4,708)	(4,707)	(4,709)	(56,498)
Adjusted financial performance surplus/(deficit)	+-	(1,003)	(1,437)	(1,516)	(1,579)	(1,250)	4	226	658	(29)	1,408	884	1,079	1,552	0
Adjusted financial performance excluding Non-Recurrent Deficit															
Adjusted financial performance surplus/(deficit)	+-	(1,003)	(1,437)	(1,516)	(1,579)	(1,250)	4	226	658	(29)	1,408	884	1,079	1,552	0
Less Non-Recurrent Deficit Funding	-	(30,975)	(1,765)	(1,766)	(1,765)	(1,766)	(1,765)	(1,766)	(1,765)	(1,766)	(1,765)	(1,766)	(1,765)	(1,766)	(21,186)
Adjusted financial performance surplus (deficit) excluding Non-Recurrent Deficit Funding	+-	(31,978)	(3,202)	(3,282)	(3,344)	(3,016)	(1,761)	(1,540)	(1,107)	(1,795)	(357)	(882)	(686)	(214)	(21,186)

This is the submission made on 30th April and represents the final financial plan.

Chief Medical Officer and Chief Nurse Report.

Executive Summary

The King's Fund reports a perpetual cycle of significant winter pressures related to increasing demand not met by capacity within organisations, and NHS England also draws attention to the wide variation in Emergency Department (ED) performance across the Country with 50% remaining static, 25% improving and 25% worsening. ED crowding is associated with poor operational performance, increased costs and a reduction in safety due to delay in treatments and omissions of care.

Whilst winter pressures have been a feature of the annual cycle at the Dudley Group NHS Foundation Trust (DGFT), 2024/25 were considered to be more pronounced occurring in the context of three additional factors which included 1) the opening of the Midland Met with uncertainty as to changes in patient flow, 2) the closure of four beds as part of building work to create a new fit for purpose ED resuscitation area and 3) a significant increase in patient admissions with respiratory symptoms.

Mindful of the impact and anticipating their effect, the Trust has had in place enhanced levels of oversight of the safety of care and the delivery of care bundles at the front door and across the organisation. This paper demonstrates stabilised mortality measures and increases in bundle compliance for key pathways. There have been no never events reported and in hospital cardiac arrest data remains within the 95% confidence interval. While there were some specific challenges relating to falls and pressure ulcer incidents, overall quality of care appears to have been maintained during this period.

Despite the challenges outlined in this paper, there have been examples of innovation and collaboration that should be recognised. Many of these will lay the foundation for collaboration and integration, a key component of mitigating the impact of winter pressures in 2025/26.

Significant work has been undertaken to maintain a positive patient experience in challenging circumstances. Both anecdotal and key metrics indicate staff have been detrimentally impacted by the pressures faced by the Trust during this period. It is recommended that the impact on staff is explored fully in the next CMO/CNO report.

This report provides overview of quality at DGFT predominantly during Q3 and Q4 of 2024/25 and considers some of the challenges and successes.

1.0 Context

On 9th December 2024, Health Secretary Wes Streeting called an extraordinary meeting of NHS senior leaders in response to unprecedented demand for services across the United Kingdom. The ask of providers was to focus on the safety of patients (GOV.UK, 2024). The effects on quality and safety due to winter pressures in the health and social care system are well documented.

“Extreme pressures in A&E are the bellwether for a health care system that is under intense strain” (Kings Fund, 2025)

The Royal College of Emergency Medicine (RCEM) summarised the multifactorial impact of hospital crowding in 2024 “Harm caused by crowding affects patients in terms of worsening mortality, morbidity, reduced quality of care, and poor patient experience. Harm due to




crowding also affects staff and has a serious adverse effect on staff experience, leading to moral injury, burnout, and lack of staff retention. This places the future of the emergency medicine workforce at risk.” (RCEM, 2024).

Q3 and Q4 2024/25 were particularly challenging for the Trust, spending several continuous days at operational Escalation Level 4. The period included the opening of Midland Metropolitan University Hospital (MMUH) with the impact for DGFT resulting in 53 extra attendances per week from patient geographies where historically Sandwell / City was the nearest ED alongside a further 29 as a result of patients reverting back to their nearest ED where SWBH had historically been utilised. (BC ICB modelling March 2025).

The winter period has impacted on Emergency Access Standards, with the Trust only meeting 1 of 7 standards. Significant challenges in relation to Ambulance offload times were noted with 25 patients waiting over 8 hours between October 2024 and January 2025. No patients waited over 8 hours in February and March 2025.

Emergency Access Standards – Weekly Performance Against New Measures										
		Target	Sept 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	March 25	Status
Group 1	Ambulance Offload <15mins	95%	↓ 17%	↓ 12%	→ 12%	↓ 0%	↑ 10%	→ 10%	↑ 11%	Not Met
	Ambulance Handover (Triage) <15mins	95%	→ 95%	→ 95%	→ 95%	↓ 90%	↑ 91%	→ 91%	↑ 93%	Not Met
	Time To Initial Assessment (Dept) <15mins	95%	↓ 75%	↑ 77%	↓ 75%	↑ 73%	↑ 79%	↓ 76%	↑ 78%	Not Met
Group 2	Mean Time In Dept (non-Admitted)	< 240 mins	↓ 211	↑ 206	↓ 214	↓ 224	↑ 215	↓ 217	↑ 210	Met
	Mean Time In Dept (Admitted)	< 240 mins	↓ 426	→ 426	↓ 444	↓ 498	↑ 481	↑ 489	↑ 450	Not Met
Group 3	Clinically Ready To Proceed	< 60 mins	↓ 105	↑ 100	↓ 111	↓ 127	↓ 133	↑ 122	↑ 105	Not Met
Group 4	12 Hours Spent in ED	< 2%	↓ 9%	→ 9%	↓ 10%	↓ 12%	→ 12%	↑ 11%	↑ 9%	Not Met

The department remained focussed on ensuring that patient arrivals by ambulance were triaged in a timely manner, with over 90% of patients triaged within 15 minutes of arrival. Although short of the 95% target, this demonstrates a focus on safety and early intervention. Triage performance in the wider department remained a challenge.

Triage (15 min target for Majors, Ambulances & Paediatrics, 60 min target for Minors)									   Week on Week Improvement / Decline / Static Text Colour: Below 85% , 85-95% , above 95%
		Target	Sept 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	March 25
Triage	Front Triage Performance	95%	↓ 58%	↑ 61%	↓ 50%	↓ 44%	↑ 52%	↓ 50%	→ 50%
	Minors Triage Performance	100%	↑ 80%	↑ 92%	↓ 88%	↑ 91%	↑ 98%	↓ 90%	↓ 86%
	Ambulance Triage Performance	95%	→ 95%	→ 95%	→ 95%	↓ 90%	↑ 91%	→ 91%	↑ 93%
	Paediatrics Triage Performance	95%	↓ 68%	↓ 60%	↑ 68%	↓ 66%	↑ 73%	↑ 74%	↑ 82%

During this period, it became apparent that there were some challenges in meeting key safety standards within Paediatric ED. As a result, the Medical Director and Chief Nurse instigated a weekly oversight meeting to address Paediatric performance which has seen the development of an assurance plan for the Acutely Unwell Child. The plan has been supported by both the ED and Paediatric teams and has seen improvements implemented at pace. As a result of the actions and assurance provided, the oversight group has now been stood down.

The department have successfully managed to meet key workforce metrics despite increasing pressure for staff on each shift. 100% of registered nurses are DGFT employees and a 16-hour consultant presence has been maintained consistently at 100%.

Workforce

			Target	Sept 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	March 25
Workforce	>80% of registered nurses on duty will be Dudley Group staff	Day	80%	→ 100%	→ 100%	→ 100%	→ 100%	→ 100%	→ 100%	→ 100%
		Night		→ 100%	→ 100%	→ 100%	→ 100%	→ 100%	→ 100%	→ 100%
	Provision of 16 cover hours per day by a consultant across 7 days		100%	→ 100%	→ 100%	→ 100%	→ 100%	→ 100%	→ 100%	→ 100%

The challenging winter pressures in the Emergency Department were compounded with additional operational challenges including, lack of simple and complex patient discharges impacting on organisational flow and increased incidence of respiratory infection incidence.

Healthcare Associated Infections

Trust HCAI Thresholds:

The Trust's HCAI thresholds are set by the Department of Health and Social Care. The Trust is required under the NHS Standard Contract to minimise rates of both *Clostridioides difficile* (*C. difficile*) and of Gram-negative Bloodstream Infections so that they are no higher than threshold levels set. NHSE aim to review the annual HCAI thresholds and classification and follow a more scientific approach in the future.

Table showing the number of HOHA (Hospital-Onset HCAI) and COHA (Community-Onset HCAI) by month during 2024/25

C.Diff: 73

Month	COHA	HOHA	Total
01 April 2024	4	4	8
01 May 2024	6	5	11
01 June 2024	5	5	10
01 July 2024	4	0	4
01 August 2024	2	2	4
01 September 2024	8	4	12
01 October 2024	4	3	7
01 November 2024	3	2	5
01 December 2024	2	6	8
01 January 2025	6	8	14
01 February 2025	2	6	8
01 March 2025	3	3	6
Total	49	48	97

MRSA

Month	COHA	HOHA	Total
01 June 2024	1	0	1
01 September 2024	1	0	1
Total	2	0	2

E.Coli: 75

Month	COHA	HOHA	Total
01 April 2024	3	5	8
01 May 2024	1	2	3
01 June 2024	1	1	2
01 July 2024	5	3	8
01 August 2024	7	0	7
01 September 2024	2	7	9
01 October 2024	2	0	2
01 November 2024	13	2	15
01 December 2024	1	4	5
01 January 2025	3	4	7
01 February 2025	3	3	6
01 March 2025	3	4	7
Total	44	35	79

Klebsiella: 19

Month	COHA	HOHA	Total
01 April 2024	1	4	5
01 May 2024	3	1	4
01 June 2024	0	2	2
01 July 2024	3	2	5
01 August 2024	2	1	3
01 September 2024	1	1	2
01 October 2024	1	1	2
01 November 2024	1	1	2
01 December 2024	1	0	1
01 January 2025	1	1	2
01 February 2025	0	1	1
01 March 2025	0	3	3
Total	14	18	32

MSSA

Month	COHA	HOHA	Total
01 April 2024	5	2	7
01 May 2024	0	4	4
01 June 2024	1	3	4
01 July 2024	4	3	7
01 August 2024	1	4	5
01 September 2024	1	1	2
01 October 2024	3	2	5
01 November 2024	0	4	4
01 December 2024	0	3	3
01 January 2025	2	3	5
01 February 2025	1	3	4
01 March 2025	1	1	2
Total	19	33	52

Pseudomonas: 12

Month	COHA	HOHA	Total
01 April 2024	1	1	2
01 May 2024	2	1	3
01 June 2024	3	1	4
01 July 2024	1	1	2
01 August 2024	0	1	1
01 October 2024	0	1	1
01 November 2024	1	0	1
01 December 2024	0	1	1
01 January 2025	0	1	1
01 February 2025	0	2	2
Total	8	10	18

DGFT reported 97 healthcare associated CDI toxin cases since 1st April 2024 exceeding the threshold for 2024/25 set by the Department of Health and Social Care. A thematic review has been conducted creating a CDI improvement plan which includes PSIRF themed opportunities for learning.

The increase in CDI cases have been recognised nationally across all patient age groups. During December 2024, UKHSA declared that the cause of increase is likely multifactorial but not yet established. NHSE are reviewing additional epidemiological and microbiological investigations to better understand recent increase and help target control measures and investigations. A joint CDI webinar event by UKHSA and NHSE was hosted in December 2024, covering epidemiology, general guidance and trust learning.

Four of the HOHA CDI toxin cases identified are the same patient. This patient has a complex medical history and had been an inpatient for an excessive period, refusing recommended treatment. Another two of the HOHA CDI toxin cases identified are the same patient. This case was categorised as a relapse, the second sample was obtained during the same admission, 30 days following the first. Patient completed two course of second line treatment and was discharged home asymptomatic.

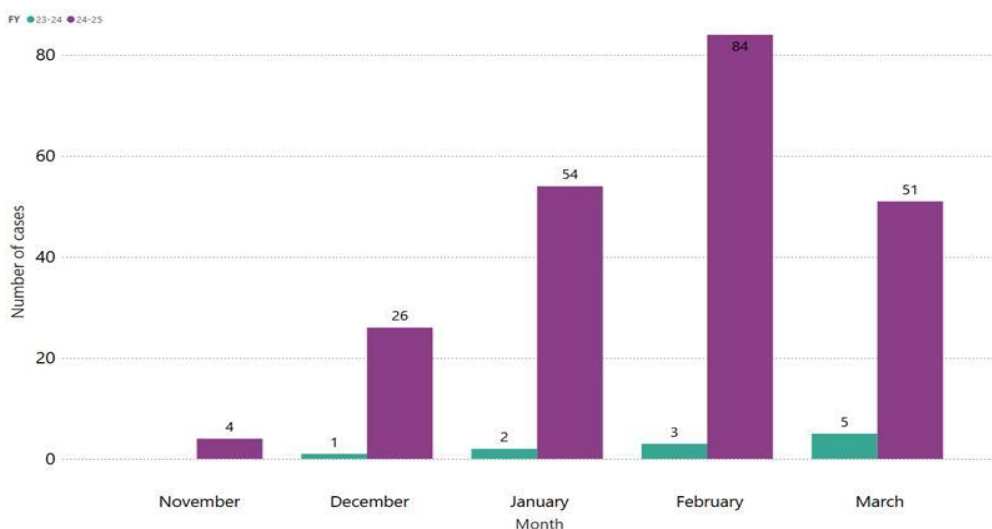
Gram negative BSI thresholds have also been exceeded; and there is a review in progress related to Central Venous Access Device (CVAD) pre and post insertion care a themed opportunity for learning identified via PSIRF.

A further MRSA bacteremia COHA case was identified in September, the previous case was identified in June. Meetings were held, and learning has been disseminated throughout DGFT Multidisciplinary team.

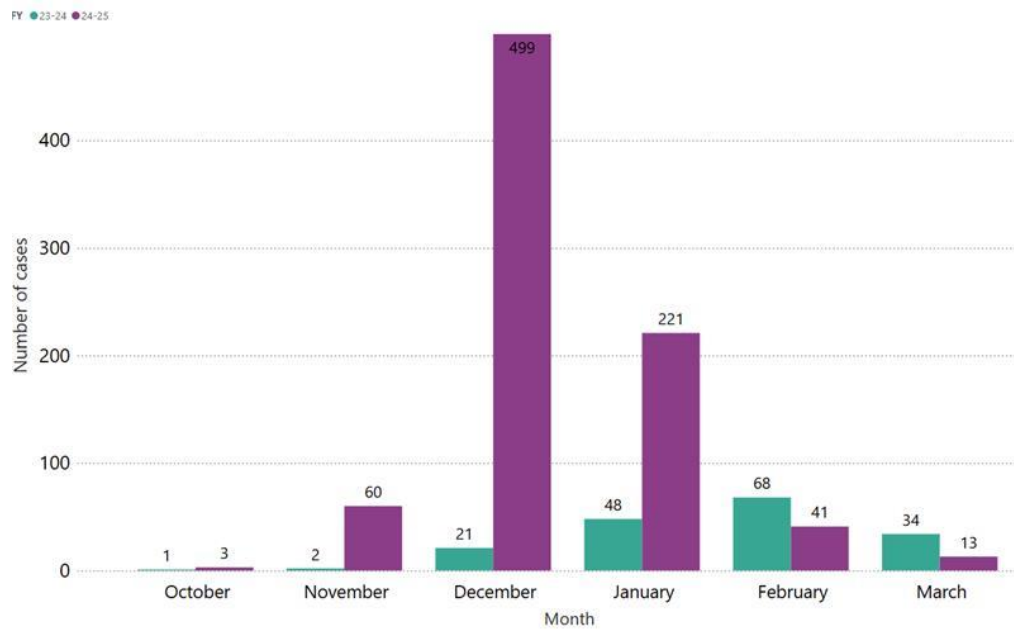
Acute Respiratory Illness Prevalence

While COVID-19 activity has decreased, there has been a national increase in influenza activity with a noted increase in ED attendances for influenza-like illnesses. Respiratory syncytial virus (RSV) activity peaked in December 2024 within our paediatric setting.

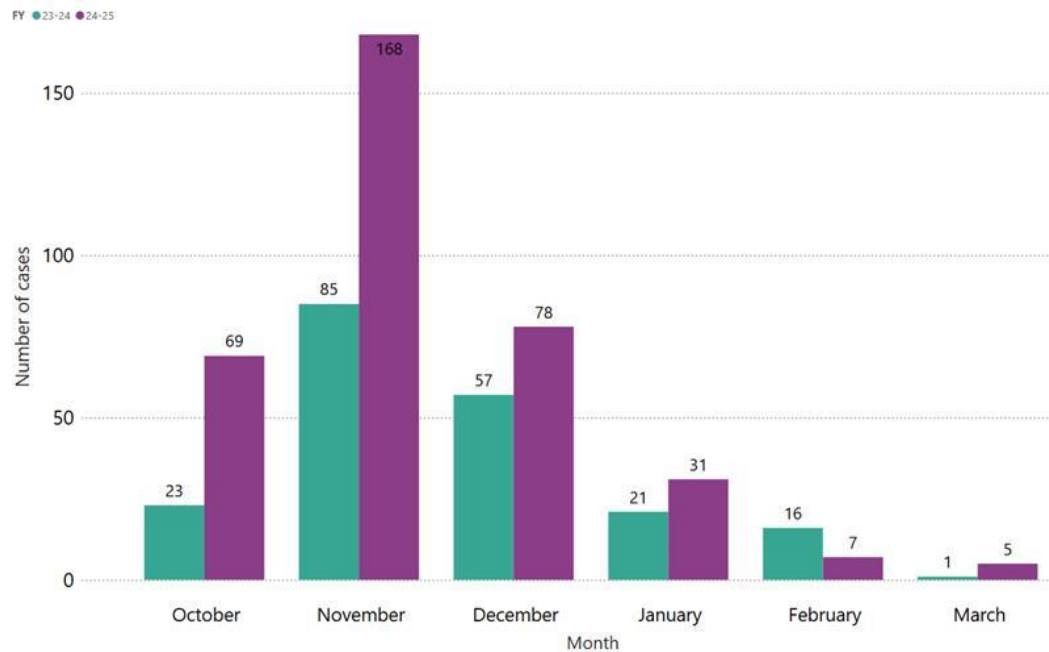
Graph showing Influenza B comparison between Winter 2023/24 and 2024/25



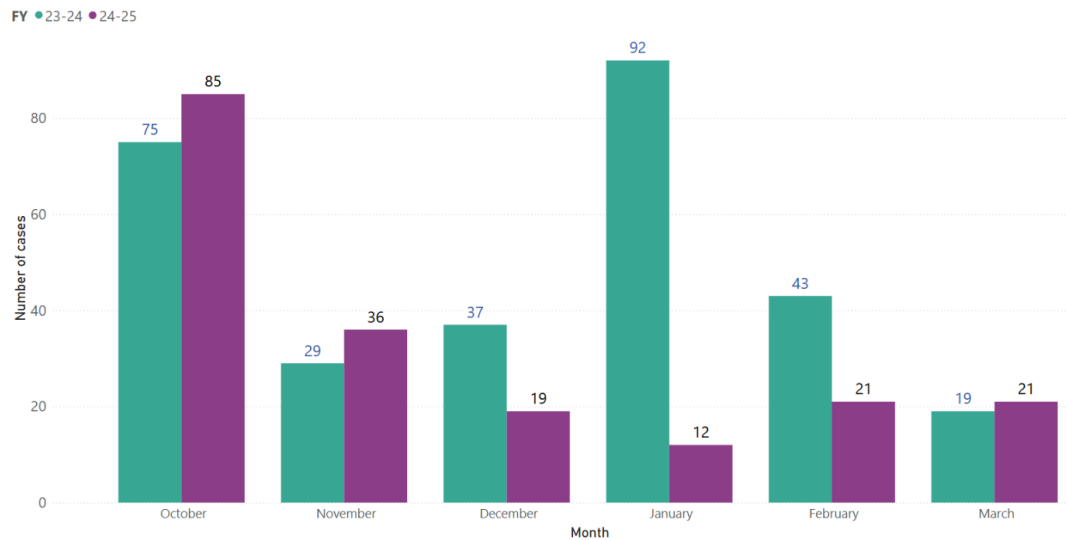
Graph showing Influenza A comparison between Winter 2023/24 and 2024/25



Graph showing RSV comparison between Winter 2023/24 and 2024/25



Graph showing COVID 19 comparison between Winter 2023/24 and 2024/25

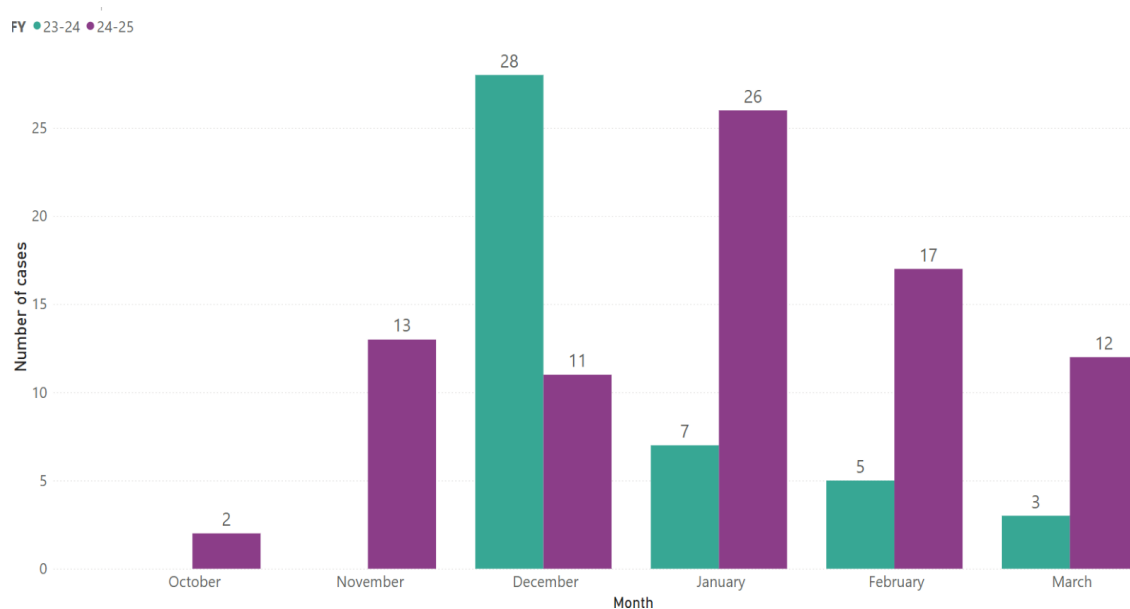


On 31st December 2024, the decision was made to introduce Fluid Resistant (Type IIR) Surgical Mask (FRSM) wearing across our portals of entry sites including C5 (respiratory ward). From 4th February, following careful consideration and review of the Trust's position regarding respiratory illnesses, the wearing of FRSMs will now be on a risk assessment basis and not compulsory in any area/ward/department.

Norovirus Prevalence

Norovirus levels in hospitals across England have been higher than the same period last year.

Graph showing Norovirus comparison between Winter 2023/24 and 2024/25



Outbreak and Period of Increased Incidence

To help reduce the risk of infection spreading, some bays were closed to admissions and transfers, to protect new patients from being exposed to the virus.

During Q3/Q4 2024/25, there were 10 Covid outbreaks and 10 Norovirus outbreaks cross wards and this has continued into Q1 of 2025/26. In addition, there were 3 Influenza A outbreaks.

Identified opportunities for learning include:

- Inappropriate glove use.
- Missed hand hygiene opportunities.
- Consideration of visiting on the wards during periods of increased infection incidence.
- Cleaning compliance.

There were further outbreaks identified that were not consistent with previous years such as an outbreak of Carbapenemase-producing Enterobacteriaceae (CPE) and Vancomycin-resistant Enterococcus (VRE).

10 cases of VRE were identified across critical care, with one linked environmentally to another case on C4 (totalling 11 cases). At present 5 belong to the same cluster (NEWC20EC-5). An external meeting was held with NHSE, BCICB and DMBC alongside an external visit with Deputy Director of IPC from Sandwell and West Birmingham NHS Trust. While external parties were content with current actions and management, minor suggestions were made that have been included within the current improvement plan.

Unfunded activity

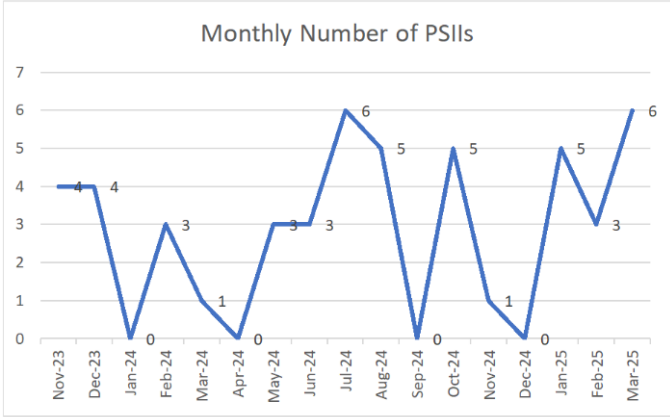
To meet the demand of operational capacity challenges, the Trust utilised additional capacity totalling c£1.160m as follows:

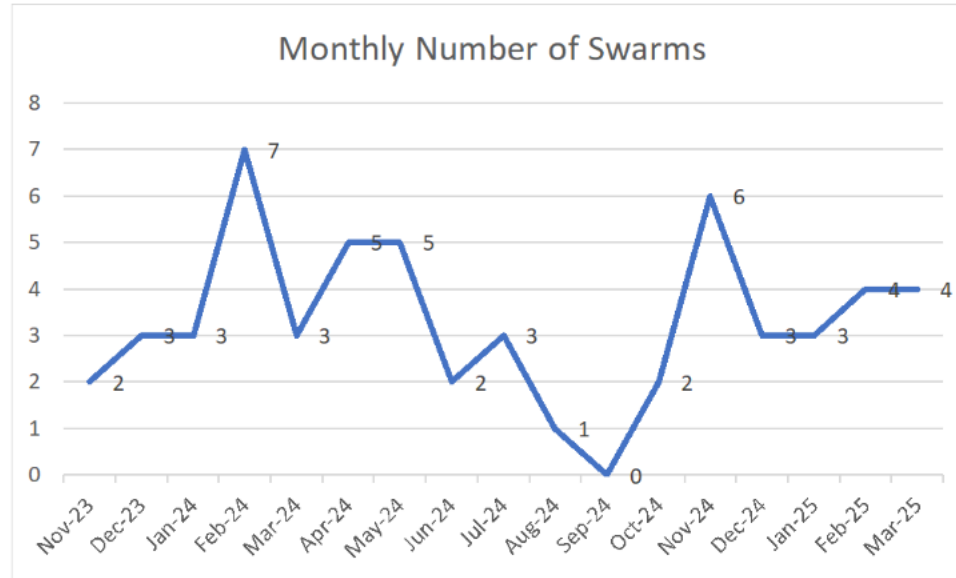
- 16 bedded Discharge Lounge as a surge area.
- Super surge in SDEC for up to 26 beds.
- 10 additional beds have been added to the permanent bed base across AMU 1 and 2.
- 3 bedded temporary escalation space within ED Imaging.
- Allocation of extra patients to the base wards.
- As required, beds situated in the ambulance corridor to facilitate ambulance offload.

These areas have been staffed by bank and corporate nursing staff. This outlines a complex multi-faceted winter period, exacerbated by an ageing population presenting with complex health needs. The high frequency of respiratory complications compounded by delays in transfers of care.

Assurance

Despite the operational challenges summarised, the organisation has continued to focus on patient safety and the quality of care throughout the winter period. The following section of this report triangulates key data sources in relation to incidents, patient outcomes, quality measures and patient/staff experience during Q3 and Q4.

Assurance (Positive and Negative)	Mitigations																																				
Incidents																																					
<ul style="list-style-type: none"> 14 PSIIIs were launched in Q4 compared to 6 in Q3:  <table border="1"> <caption>Monthly Number of PSIIIs</caption> <thead> <tr> <th>Month</th> <th>Number of PSIIIs</th> </tr> </thead> <tbody> <tr><td>Nov-23</td><td>4</td></tr> <tr><td>Dec-23</td><td>4</td></tr> <tr><td>Jan-24</td><td>0</td></tr> <tr><td>Feb-24</td><td>3</td></tr> <tr><td>Mar-24</td><td>1</td></tr> <tr><td>Apr-24</td><td>0</td></tr> <tr><td>May-24</td><td>3</td></tr> <tr><td>Jun-24</td><td>3</td></tr> <tr><td>Jul-24</td><td>6</td></tr> <tr><td>Aug-24</td><td>5</td></tr> <tr><td>Sep-24</td><td>0</td></tr> <tr><td>Oct-24</td><td>5</td></tr> <tr><td>Nov-24</td><td>1</td></tr> <tr><td>Dec-24</td><td>0</td></tr> <tr><td>Jan-25</td><td>5</td></tr> <tr><td>Feb-25</td><td>3</td></tr> <tr><td>Mar-25</td><td>6</td></tr> </tbody> </table> <ul style="list-style-type: none"> 11 Swarms were launched in Q4 consistent with 11 in Q3: 	Month	Number of PSIIIs	Nov-23	4	Dec-23	4	Jan-24	0	Feb-24	3	Mar-24	1	Apr-24	0	May-24	3	Jun-24	3	Jul-24	6	Aug-24	5	Sep-24	0	Oct-24	5	Nov-24	1	Dec-24	0	Jan-25	5	Feb-25	3	Mar-25	6	<p>Each Swarm and PSII response identifies learning under the PSIRF framework. Improvement plans and associated outcome measures have been developed to underpin the required learning for focus areas. These are monitored by the Divisional Governance structure and receive oversight at Risk and Assurance Group.</p> <p>From the 25 Swarm and PSII responses launched in Q4. The initial high-level themes identified are:</p> <ul style="list-style-type: none"> Communication – 9/25 (36%)
Month	Number of PSIIIs																																				
Nov-23	4																																				
Dec-23	4																																				
Jan-24	0																																				
Feb-24	3																																				
Mar-24	1																																				
Apr-24	0																																				
May-24	3																																				
Jun-24	3																																				
Jul-24	6																																				
Aug-24	5																																				
Sep-24	0																																				
Oct-24	5																																				
Nov-24	1																																				
Dec-24	0																																				
Jan-25	5																																				
Feb-25	3																																				
Mar-25	6																																				



- 17/25 PSII and Swarm responses launched in Q4 relate to the following top reporting services: Urgent and Acute Care (10), Women and Children's and Surgery (6), Urology and Vascular (1).
- There were no new Never Events reported during Q4; furthermore, there have been no Never Events across 24/25, this represents an improved position compared to 23/24.

- Imaging (e.g. Delay in reporting of imaging, Imaging rejected, misreported) – 7/25 (28%)
- Lack of investigations or review – 6/25 (24%)
- Documentation – 5/25 (20%)
- Escalation/ lack of referral – 5/25 (20%)
- Acknowledgement of results – 4/25 (16%)

These will be further explored and consolidated through the response process.

Mortality

Mortality indicators have shown a positive trend, with SHMI decreasing in December despite increased front door pressure.

SHMI – Jan 24 to Dec 24 = 101.11

CVA and fractured neck of femur were two of the highest scoring SHIMI.

Figure 2b: Time Series for SHMI (Rebasing period up to October 2024) - Rolling 12-mth Trend

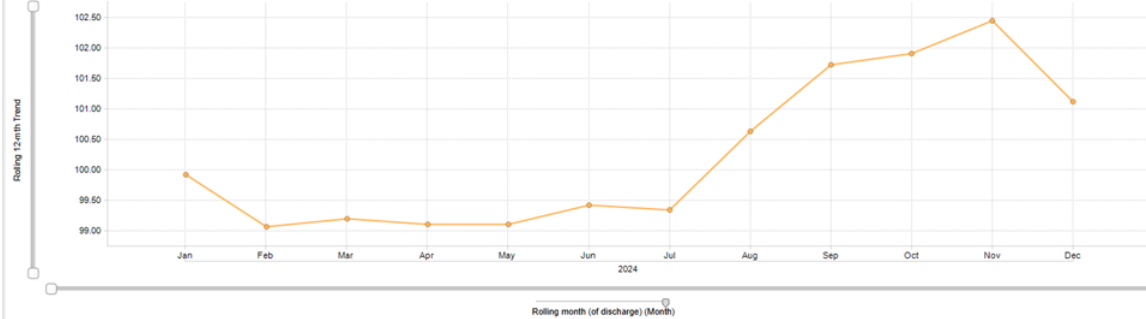
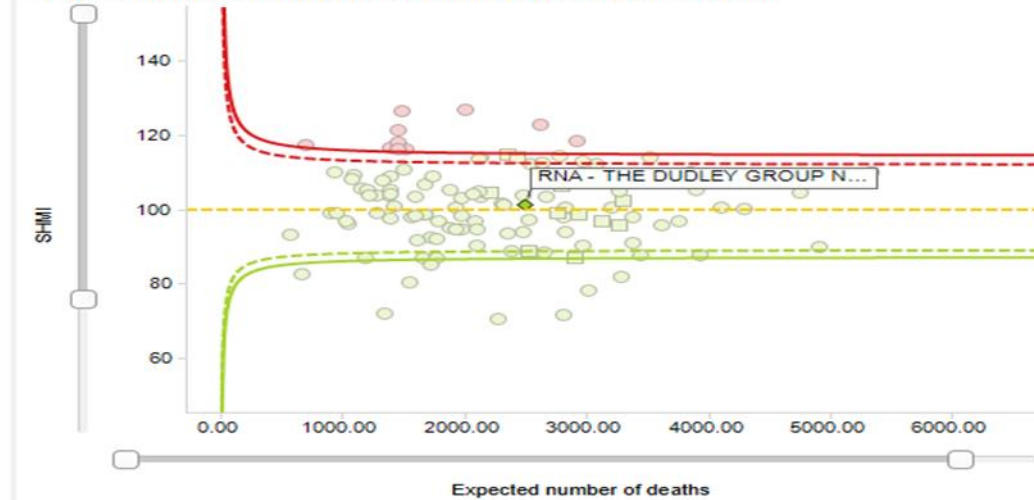


Figure 1b: Funnel Plot (Rebasing period up to October 2024)



HSMR remains a positive outlier nationally. HSMR Jan 23 to Dec 24 = 86.38

These were our focus for quality priorities for 24/25.

SHIMI reduced from 133 to 113 in 12 months for Fractured neck of femur.

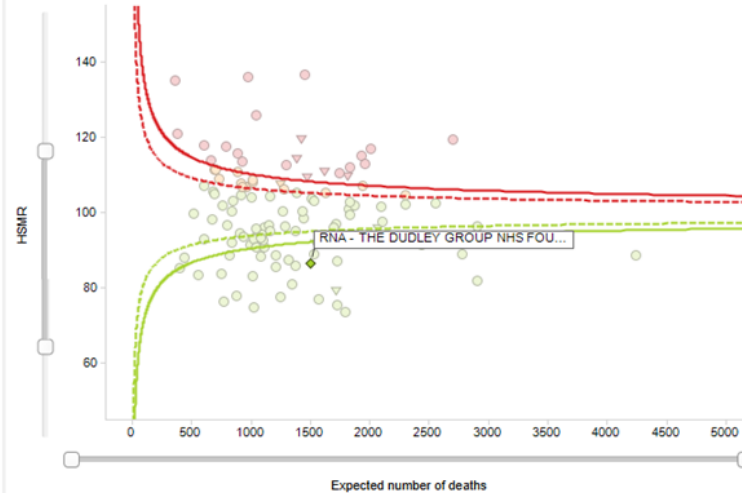
CVA reduced from 135 to 103 within 12 months.

The improvement work across these work streams will have contributed to the significant reduction in the Trusts SHIMI and HSMR.

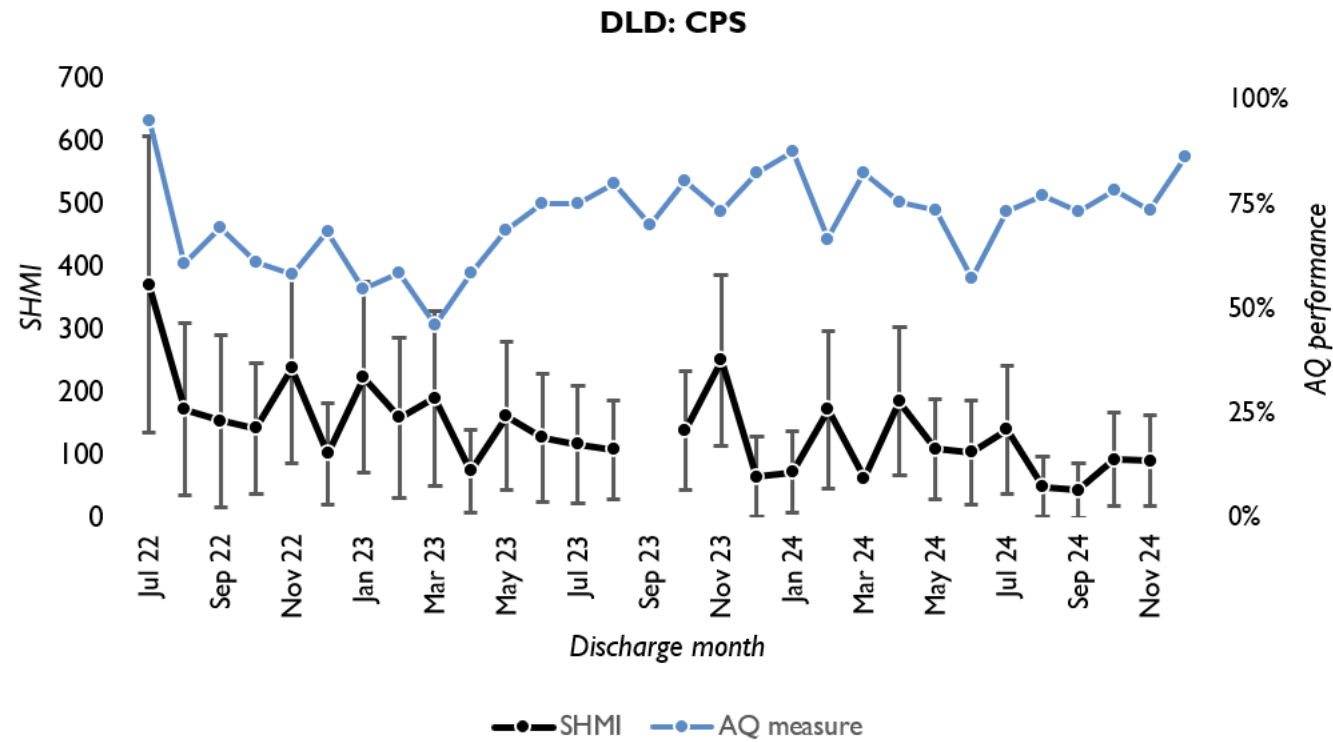
Figure 2b: Time Series for HSMR (Rebasing period up to January-25)

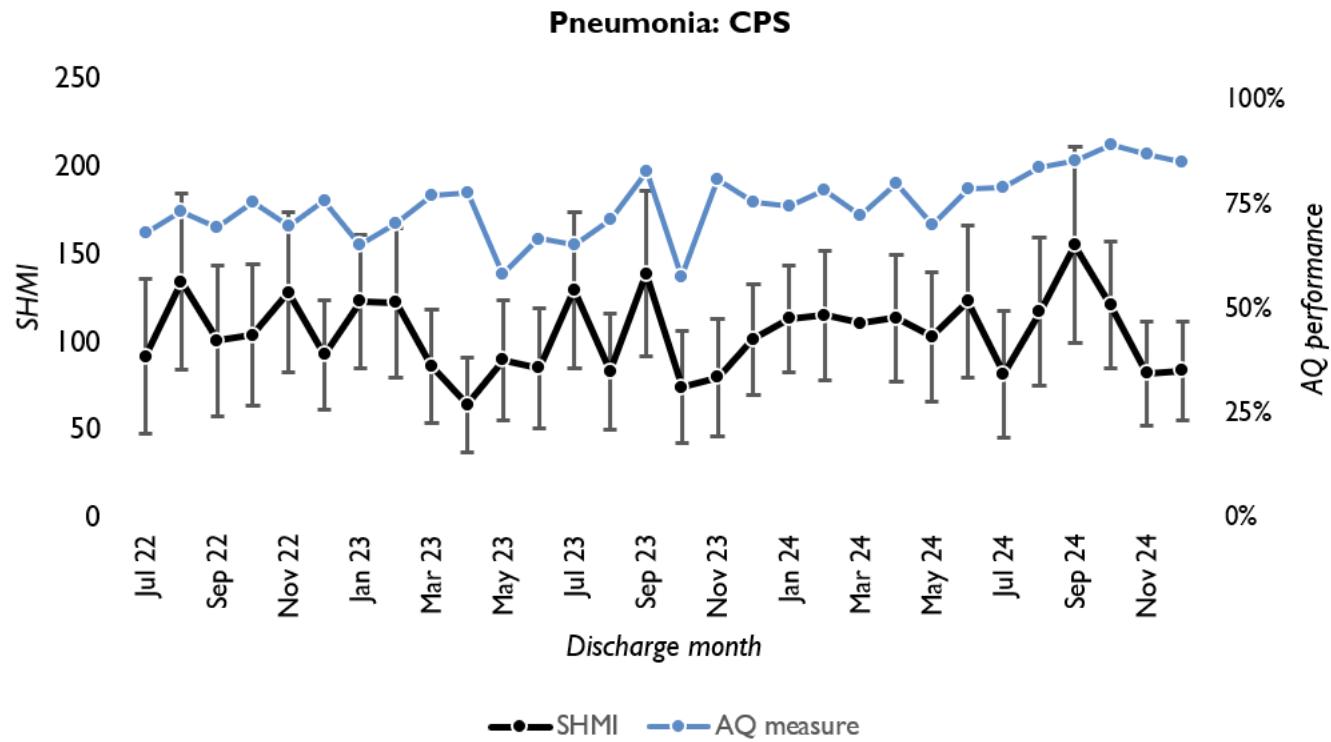


Figure 1b: Funnel Plot (Rebasing period up to January-25)



Advancing Quality bundle compliance for Liver Disease, Pneumonia and Sepsis has maintained performance over the reporting period. Pneumonia recorded the highest composite score since the bundles were implemented in January 2025 with 90% of patients receiving the 'perfect' care. The graphs below detail the bundle compliance and impact on SHMI up to the end of 2024.

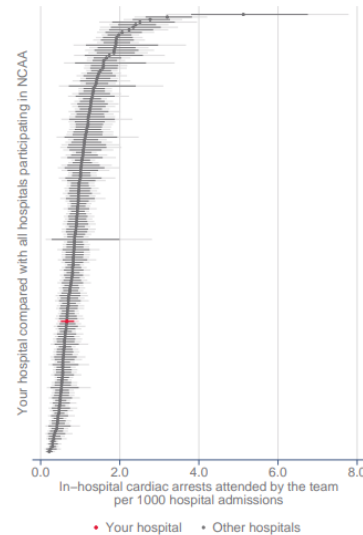




<p style="text-align: center;">Sepsis: CPS</p> <p>SHMI</p> <p>AQ measure</p> <p>Discharge month</p>	
<p>MET calls and in hospital cardiac arrest data have sustained the decrease gained by the introduction of the deteriorating patient pathway in November 2022. It is noticeable from the NCAA data that there is an increase in calls for 2024-25 currently 0.66/1000 when compared with 2023-25 (0.58/1000). Quarter 4 NCAA data is not yet available to view the entire year (Q3 released 04/03/25) but DGFT remains within the 95% confidence interval</p>	<p>DGFT participates in the National Cardiac Arrest Audit (NCAA) reporting any resuscitation event commencing in-hospital, where an individual (excluding neonates) receives chest compressions and/or defibrillation and is attended by the medical emergency team (MET) in response to a 2222 call. These data are reported per 1000</p>

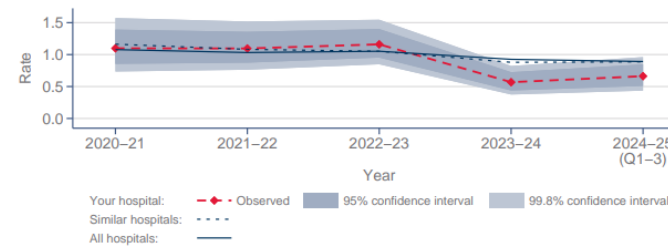


Rate of cardiac arrests per 1000 hospital admissions



Russells Hall Hospital
NCAA Report: 1 April 2024 to 31 December 2024

	Hospital admissions	Eligible team visits	Rate per 1000 hospital admissions	95% confidence interval	99.8% confidence interval
Quarter 1	30596	19	0.62	(0.37, 0.97)	(0.27, 1.20)
Quarter 2	32177	22	0.68	(0.43, 1.04)	(0.32, 1.26)
Quarter 3	33805	23	0.68	(0.43, 1.02)	(0.32, 1.24)
Quarter 4					
Year to date	96578	64	0.66	(0.51, 0.85)	(0.44, 0.96)



Definition

- Hospital admissions: Total includes elective, non-elective and day cases (excludes babies born in your hospital and neonates)
- Eligible team visits: All reported in-hospital cardiac arrests attended by the team
- Observed rate: The total number of cardiac arrests attended by the team divided by the total number of admissions to your hospital multiplied by 1000 to give a rate per 1000 hospital admissions
- Confidence interval: Reflects the degree of uncertainty surrounding your observed rate, given the total number of admissions to your hospital

Date of report: 04/03/2025
©Resuscitation Council UK & ICNARC

admissions and can be compared to other similar hospitals.

MET data are also reported per 1000 admissions to facilitate comparison from year to year despite variation in footfall.

2222 calls at RHH are responded to by a range of teams:

- Adult MET
- Paediatric team
- Obstetric team
- Neonatal team

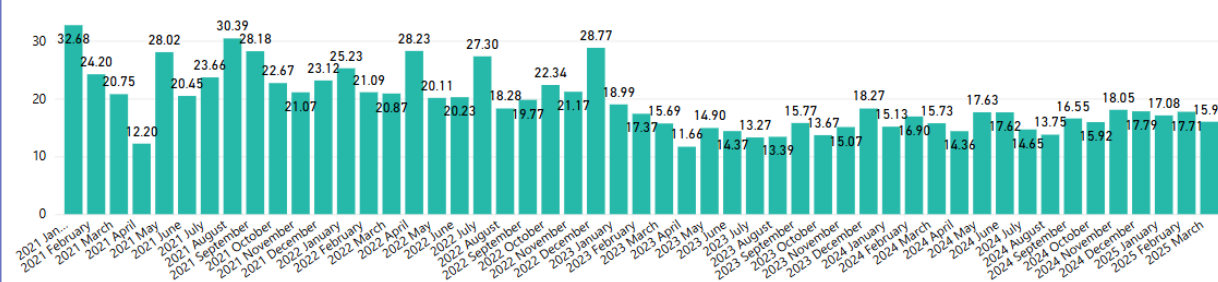
Each of the above teams contain medical staff with specialist airway skills or knowledge relating to that team as part of it 24/7.

Guest & Corbett outpatient centres have 3 emergency response bleep holders Monday –Friday 0800-1700 who are either nurses or a physio. Any patients requiring further care require a 999 call and transfer to RHH ED.

Any deterioration outside of these hours is a 999 call only (Imaging operates a service 7/7 0800-2000).

A full review of the off-site emergency response is currently being undertaken by the surgical women's and children's division to ensure there is a standard

Calls per 1000 admissions (only calls made to 2222 switchboard)



Medical

emergency team (MET) calls per 1000 admissions Jan 2021-March 2025.

Although MET calls in general have maintained the decrease in numbers since DPP was introduced there has been a significant rise in 2222 calls at both the Guest & Corbett outpatient centres.

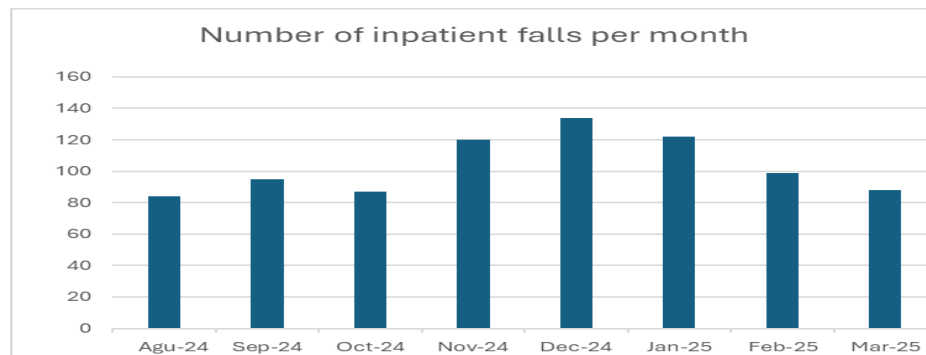
Year	Guest	Corbett
2023 (Jan-Dec)	1	31
2024 (Jan-Dec)	13 (including 1x cardiac arrest)	59
2025 (Jan-Mar)	6	21

approach the whole-time patients are on each site (0800-2000 Mon-Sun).

Quality Outcomes

Over winter we have seen an impact on quality metrics due to the challenges faced by the trust, similarly the impact has been reflected in previous winter months.

Falls



The overall number of inpatient falls has fluctuated over Q3/Q4, seeing a peak across November and December. However, since January we have seen a gradual but continual decline. It is unknown what the direct impact on the additional open beds and staffing resource has had on the number of falls, however we do know that this has created additional challenge when cohorting and tagging high risk of falls patients. After action reviews (AARs) has shown that we have a greater number of vulnerable and high risk of falls patients being admitted with multiple comorbidities.

Harm levels Q3/4

- 5 in Nov 2024 - 4 at moderate harm and 1 low harm incident
- 7 in December 2024 - 4 at moderate harm and 3 at low harm

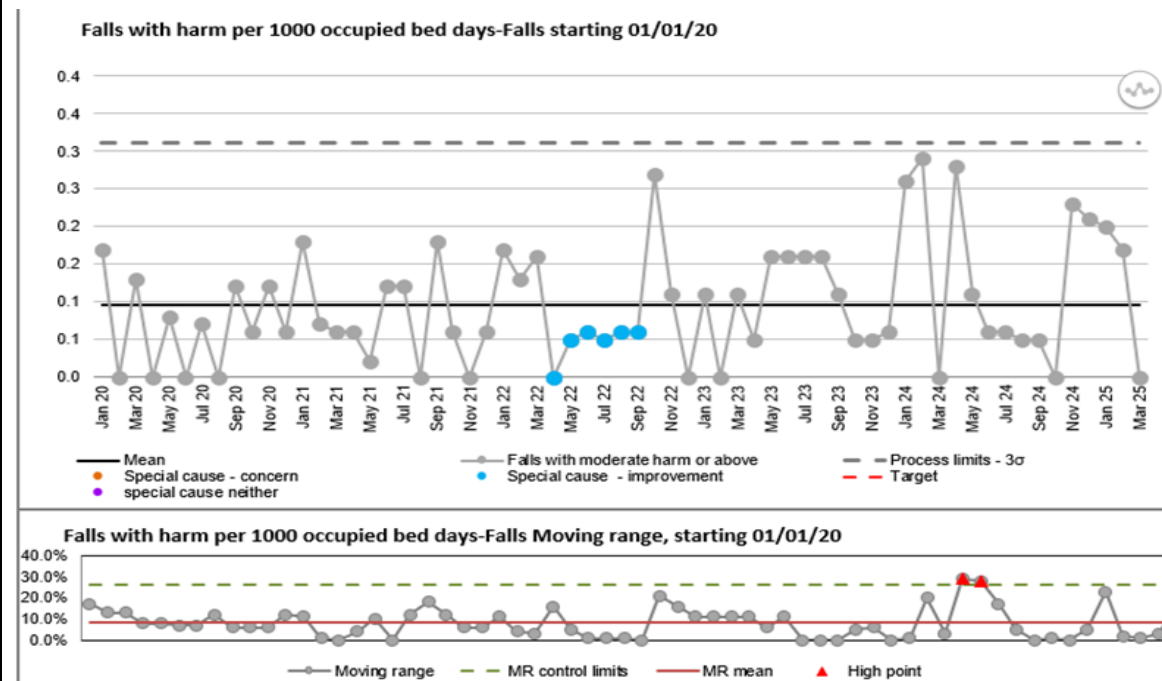
Falls

The trust has a Falls improvement plan that has an MDT approach following the patients journey between acute and community setting, exploring strategies to improve prevention.

Developed a robust process around responding to falls incidents to ensure a timely AAR review is in place to identify key learning to help reduce further incidence of falls.

- 6 in January 2024 - 4 at moderate harm and 2 at low harm
- 4 in February 2024 - 3 at moderate harm and 1 at low harm
- 1 in March 2024 - 0 at moderate harm and 1 at low harm

There have been 23 AAR. The overall number of AARs is a combination of Moderate and Low harm. 15/23 resulted in Moderate harm and 8/23 was concluded as Low harm. We saw a higher number of moderate harm across Q3 and the start of Q4, however started to see a decline at the end of Q4, March seeing no moderate harm.

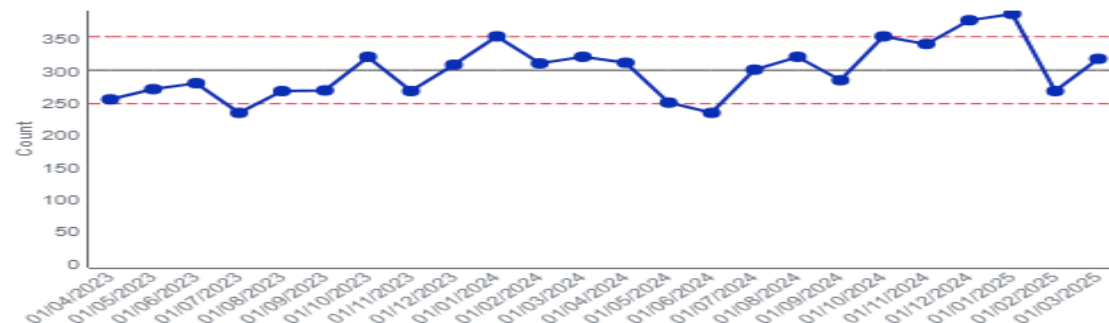


The national average for the number of falls with moderate harm or above per 1000 occupied bed days is 0.19. The Dudley Group was peaking slightly above, close to the national average at 0.20 in January 2025, this was due to seasonal pressures and additional capacity. However, in March 2025, the Trust has declined below the national average at 0.

Areas of improvement - 1) Escalating for additional staff and adapting care in line with operational pressure by introducing intentional rounding 2) Ensuring bed rail risk assessment aligns with the patient's condition by using clinical judgement 3) Consistency in documenting and reassessing where necessary - MDT approach in recording patient mobility to avoid de-condition during admissions.

Pressure Ulcers – Trust Acquired

All PU Trust acquired



In February there was a decline across acute and community, however slight increase in March, but remains lower than previous months. Despite the higher incidence of pressure ulcers across acute and community, Q3 saw 1 pressure ulcer deemed moderate harm and Q4 has seen no moderate harm related to acquired pressure ulcers.

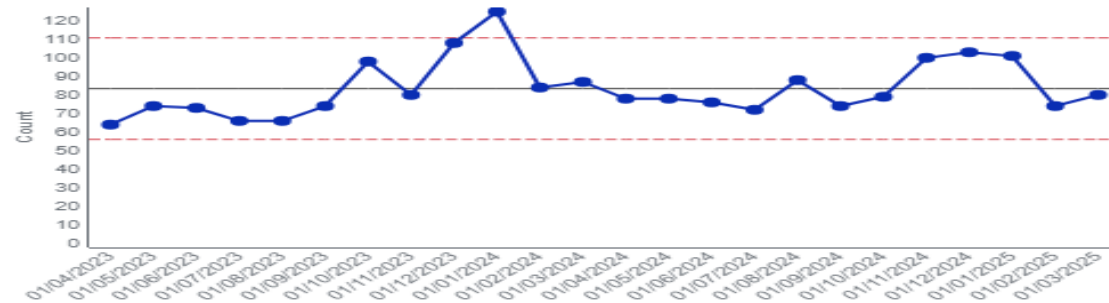
Pressure Ulcers

Acute and community divisions have an improvement plan and working closely with tissue viability around upskilling of junior staff.

The community teams are awaiting a photography app which will support remote monitoring and virtual assessments with tissue viability, to ensure wounds are validated correctly against pressure ulcer coding, as some concerns that junior staff may be missing differential diagnosis and misinterpreting as a pressure ulcer.

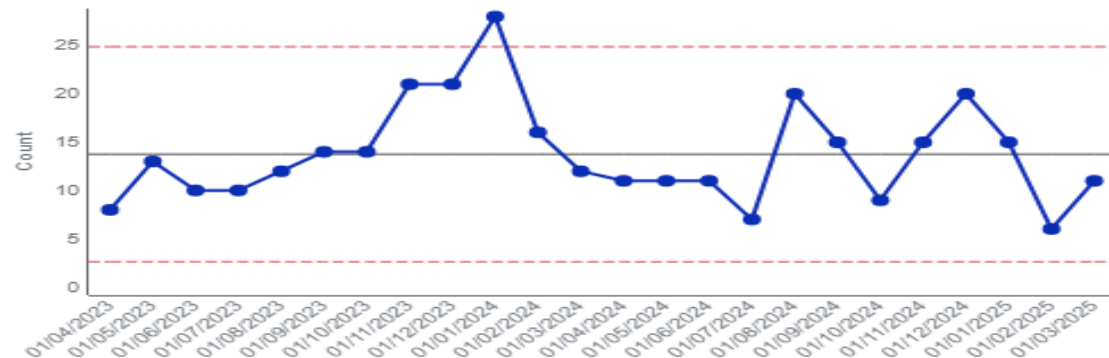
Tender for pressure relieving equipment is due to go out for consultation on 28th April.

Hospital acquired PUs reported



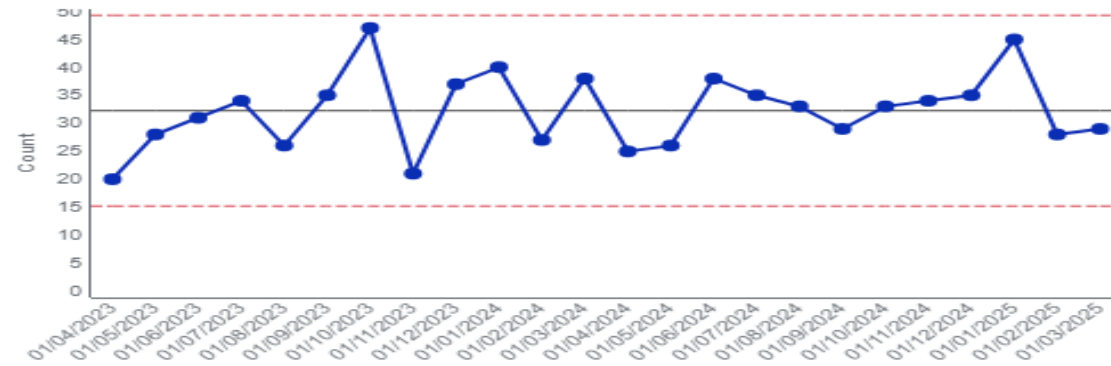
Hospital inpatient acquired pressure ulcers have seen sporadic numbers across Q2/3/4. We saw a decline in Feb 2025, however unsure if this was due to a shorter month, as we have had a slight increase in March, but still lower than previous months.

Hospital acquired C3, C4 & unstageable

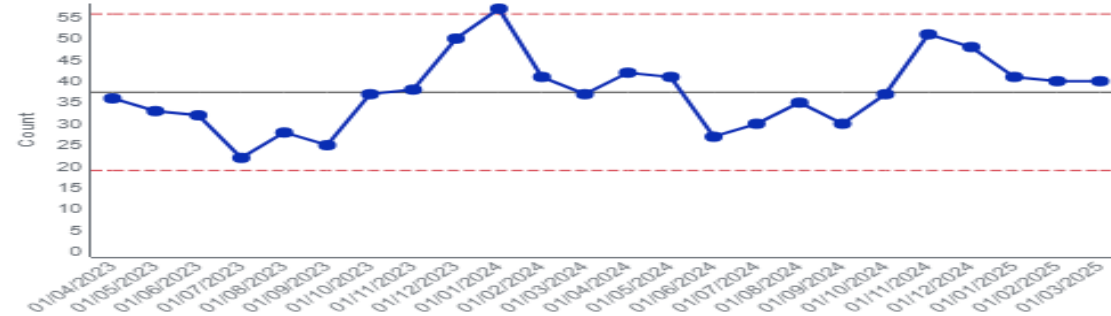


Review of processes around accessibility of cushions for community teams to prevent delays in equipment going out to patients.

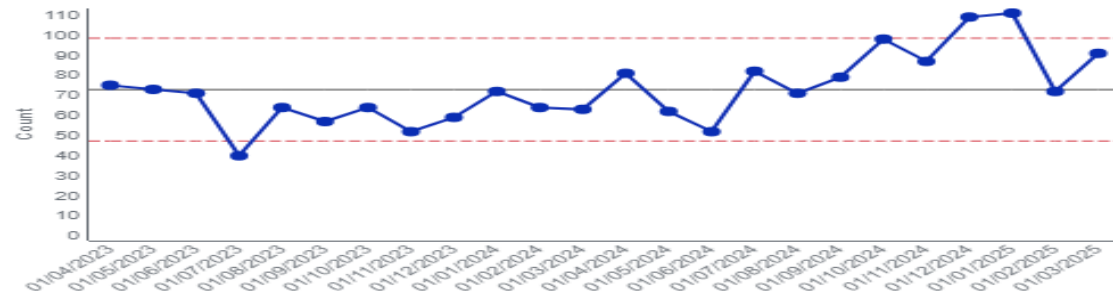
Hospital acquired DTI



Hospital acquired C2



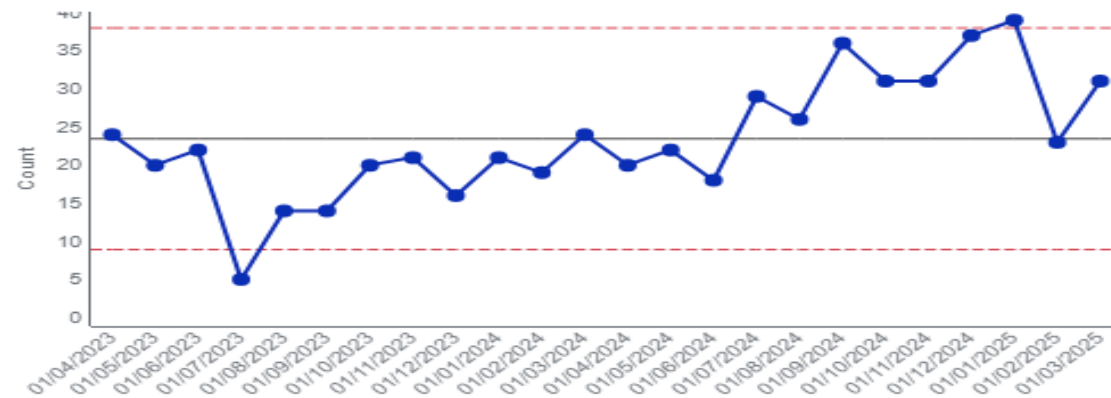
Community acquired PUs reported



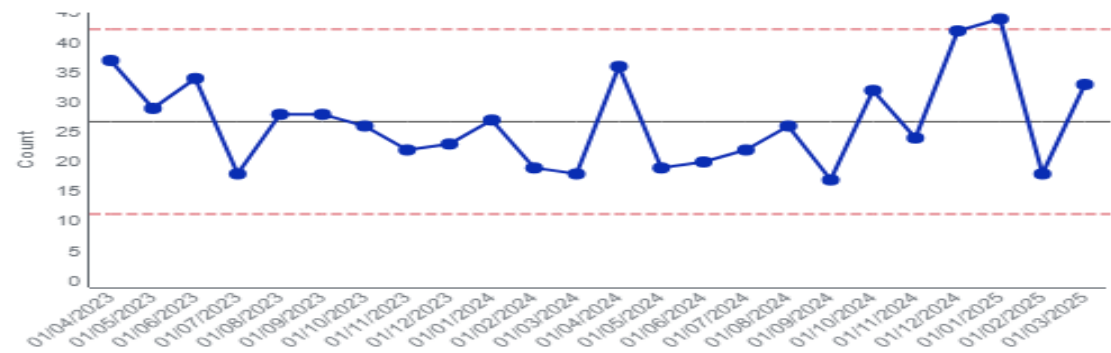
Community have seen a continuous increase since June 2024, which could be linked to multiple factors such as aging population, with multiple comorbidities and keeping more patients at home, that historically would have been admitted into an acute bed.

The community team have seen pressures around increased caseload demand, high vacancy numbers, and a junior workforce. In Nov, Dec and Jan there were equipment issues relating to high-risk cushions being unavailable which could be linked to the higher number of sacral/ buttock and ischium pressure ulcers. This resolved towards the end of Jan 2015. Another challenge community faced was that repose cushions had been removed from community and stored at Russell's Hall Hospital, resulting in the community teams having to attend the hospital site to obtain a cushion, causing delays.

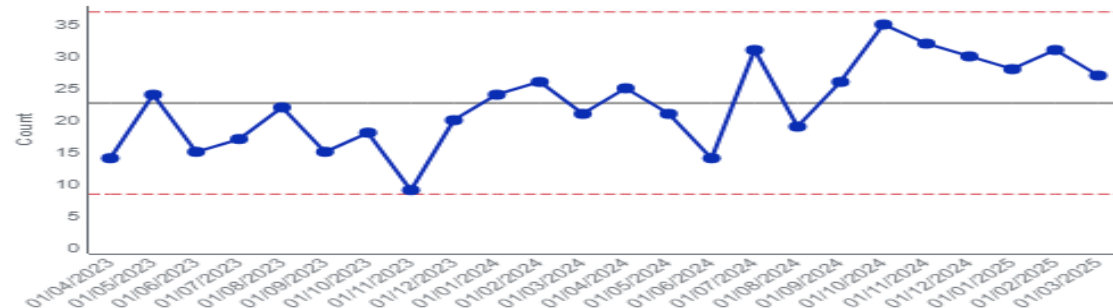
Community acquired C3, C4 and unstageable



Community acquired C2



Community acquired DTI



The community team have seen pressures around increased caseload demand, high vacancy numbers, and a junior workforce. In Nov, dec and Jan there were equipment issues relating to high-risk cushions being unavailable which could be linked to the higher number of sacral/ buttock and ischium pressure ulcers. This resolved towards the end of Jan 2015. Another challenge community faced was that repose cushions had been removed from community and stored at Russell's hall, resulting in the community teams having to attend the hospital site to get a cushion, causing delays to patients and compromising pressure areas.

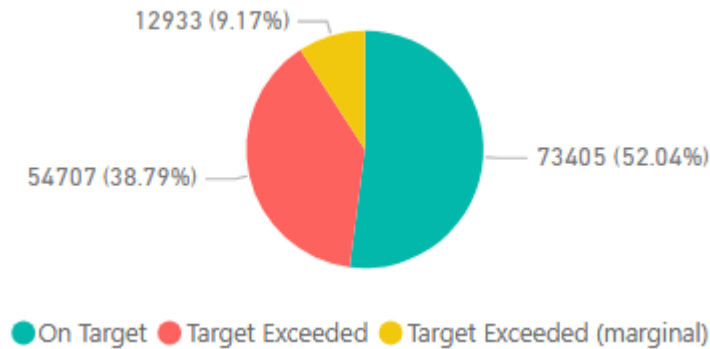
E-Obs March 2025

Due to the size of the data, our dashboards facilitate a review of the past month's compliance in vital signs therefore there is no Q3 & 4 table overview of eObs. Currently however, there is little variation, and each month has shown a similar picture to the level of compliance for observations on time depicted below.

E-Obs March 2025

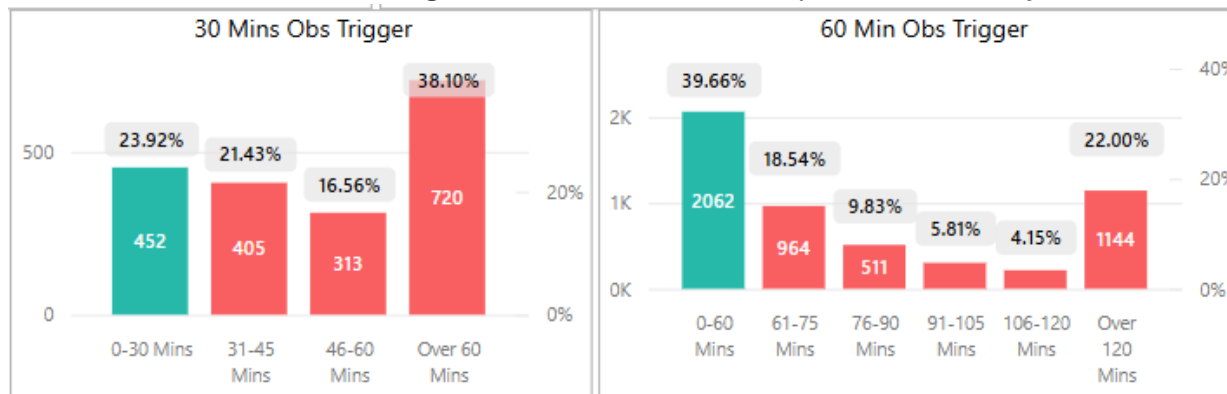
The clinical risk determined by the appropriate early warning score is displayed both within a pop-up message at time of documenting the vital signs and on the tracking board in RAG rated colours with the score as a visual prompt

Compliance For Observation On-Time



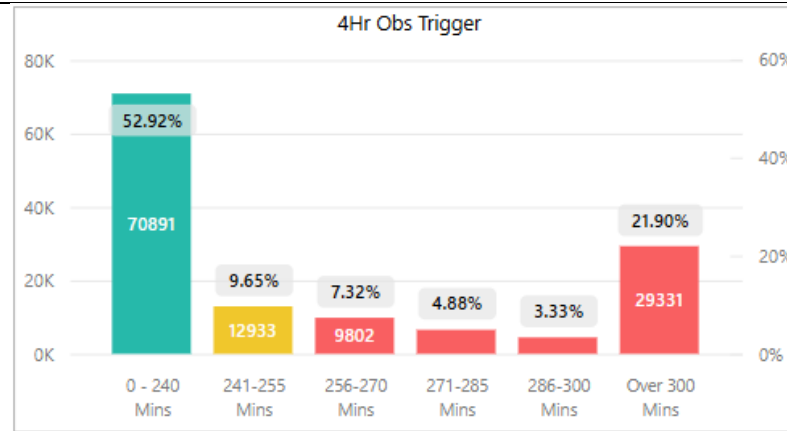
Frequency of vital signs recordings are mandated by the clinical risk determined by the appropriate early warning score (NEWS2 = adults, NPEWS = paediatrics, MEOWS = maternal patients, [NEWTT = neonatal – not currently on EPR]).

The compliance for observations (vital signs) on time demonstrates an increase in compliance from 51.11% to 52.05% of all vital signs recorded in March compared to February.



Task and Finish group commencing May 2025, with 4 ward areas across medicine and surgery to have a focused approach.

The electronic tracking boards in each clinical area contains a countdown clock for each patient for when their next vital signs are due, this flashes amber once they are due in the next 15 minutes.



Vital signs are often continued in patients reaching their end of life unnecessarily, these patients may be scoring highly on NEWS2 requiring increased monitoring that can be uncomfortable, these will account for some of the 30- and 60-minute vital signs being recorded late.

A second issue with vital signs recordings is the time taken from recording to documentation, in time critical conditions (e.g. sepsis) this delay in documentation could be detrimental to the patient.

- There remains a significant number of patients (5848) that staff have taken over 15mins to document vital signs from the point of undertaking them.
- 2.28% (a reduction from 2.45%) of vital signs have been documented over 60minutes after they have been recorded, this indicates staff are writing vital signs on paper then documenting later rather than at the point of care (1846 patients).

- Best performing areas for March are PAU (98.63%), PCCU (98.19%), C5 (97.94%), day case unit (97.83%), C1 (97.6%) and A2 super-surge (97%).
- The areas with the highest proportion of vital signs documented later than 0-15 mins are: CAPD (40%), A2 (68.5%), maternity delivery suite (71.15%), MECU (77.38%), maternity ward (77.65%) and POCU (78.38%).

Key learning:

- Ensuring vital signs are documented at the point of care would increase the compliance of vital signs of time.
- Assessing the frequency and downgrading where appropriate
- Ensuring observations are recorded as patient centred rather than doing bays at a time

Priority 1 AMaT Audit compliance Q3/Q4

	Oct	Nov	Dec	Jan	Feb	Mar
Tissue Viability SKIN audit (CQUIN 12)	97.1%	96.5%	97.6%	96.3%	97.3%	97.4%
Hand Hygiene '5 moments' audit (v2)	98.5%	98.7%	98.6%	98.3%	98.6%	99.2%
Hand Hygiene Environment Audit	98.9%	98.9%	98.7%	98.7%	99.0%	98.9%
Matron In Patient Audit	86.3%	87.3%	90.5%	90.8%	89.9%	88.5%
Matron Audit - Out Patient Areas	95.5%	96.7%	96.7%	96.4%	95.4%	97.0%
Lead Nurse In Patient Audit	93.9%	91.7%	94.2%	93.2%	93.4%	93.7%

Compliance on AMaT audits have been consistent, apart from the inpatient matron audits, that have been amber multiple times across Q3&4.

Priority 1 AMaT Audit compliance Q3/Q4

From January, Chief Nurse approved that all audits could be submitted within the reporting month, rather than the first 145 days, this was changed to provide more time to submit audits as previous months had seen no submissions.

Improved functions within AMaT will mean that all areas will need to ensure

- Gaps in completion of nursing documentation (Divisions addressing this with wards)
- Safer care tool completion not fully completed (Associate Chief Nurse – Workforce addressing this with Division Leads)
- Missing emergency equipment checks (Divisions addressing with wards, reminders sent to ward leads daily)
- Sepsis screening and IV antibiotics standards below 90% (IV antibiotics is reliant on doctors prescribing the treatment, dashboard alerts ward staff to sepsis screening data)
- E-obs not completed within 30 minutes (Task and finish group set up to address this Trust wide)
- Mandatory training below 90% (Lead nurses addressing, two weekly reminders to individual staff via email)
- AMaT audits/actions not completed as expected (some audits have since been identified as n/a for certain wards and have now been removed)

Lead nurses during Q4 were working 2 clinical days to support staffing levels and reduction in bank spend, this meant their level of oversight on quality metrics were reduced.

they supply the correct number of audit observations for the audit to be deemed submitted. This has been communicated to all areas as part of the Quality Working Group.

- Monthly quality confirm and challenge reviews with matron and leads nurses at Divisional level to ensure action plans are in place and making progress.
- Quality Working Group are monitoring AMaT data monthly to ensure Divisions are taking appropriate actions and to share good practice.
- 10 additional beds on AMU and 4 trolleys in ED X-Ray to meet capacity demand – placement on these beds means negative scores in some respects on the audits (e.g. no behind the bed boards).

Chief Nurse Dashboard

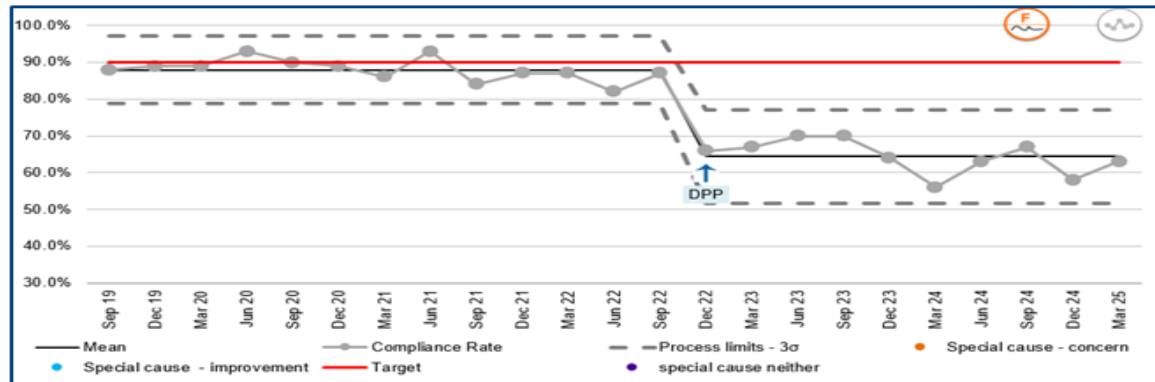
Ward Level Quality Matrix																			
Date Report Refreshed: 02/04/2025 08:47:22																			
Ward/Group	Budget WTE	Contracted WTE	Vacancy %	Sickness %	All Unavailability %	Parenting	All Unavailability	Stat CIPP0	Mandatory Training %	NBT Inpatient Good & Verygood	Open Complaints (at the end of previous month)	Pressure Score - Cat 4, Unstable	Pressure Ulcers (Cat 3 & above)	Moisture Associated Skin Damage	Falls with Harm	Cardiac Arrest Calls	Total Positive C-Diff Cases	Patient Observations Completed On Time %	Patient Observations Completed On Time %
AMU	218.0	195.9	10.1%	13.2%	52.8%	13.6	102.5		100%	100%	11	3	2	3	0	0	0	100%	100%
CCU	54.1	48.3	10.9%	11.2%	64.0%	8.8	30.9		100%	100%	1	1	0	0	0	0	0	100%	100%
Critical Care	120.4	128.4	6.6%	18.8%	71.2%	16.9	91.4		100%	100%	1	0	0	0	0	0	0	100%	100%
Discharge Lounge	11.9	10.7	9.2%	22.8%	64.3%	2.0	6.9		100%	100%	2	2	0	0	0	0	0	100%	100%
ED	188.7	161.8	14.6%	21.4%	70.5%	17.9	114.0		100%	100%	30	1	0	0	0	0	0	100%	100%
ESH	73.7	74.5	1.1%	12.2%	52.3%	9.1	39.0		100%	100%	3	0	0	0	0	0	0	100%	100%
FNUJ	44.4	41.2	7.2%	18.2%	50.4%	3.9	20.7		100%	100%	2	0	0	0	0	0	0	100%	100%
Maternity	151.3	161.9	7.6%	16.3%	78.0%	15.4	126.3		100%	100%	6	0	0	0	0	0	0	100%	100%
MECU	21.4	20.8	3.2%	19.2%	52.4%	1.0	10.9		100%	100%	0	0	0	0	0	0	0	100%	100%
Neonatal Unit	48.0	39.5	17.5%	16.4%	71.6%	4.1	42.6		100%	100%	0	0	0	0	0	0	0	100%	100%
Renal Unit	37.5	37.2	0.8%	26.7%	63.9%	2.2	23.8		100%	100%	0	0	0	0	0	0	0	100%	100%
SDEC	71.0	65.8	7.4%	18.8%	53.3%	3.4	35.1		100%	100%	9	0	0	0	0	0	0	100%	100%
Ward A2	31.0	30.6	1.3%	15.7%	54.9%	2.1	17.4		100%	100%	2	0	0	0	0	0	0	100%	100%
Ward B1	50.0	50.8	1.6%	16.4%	50.6%	3.4	25.7		100%	100%	1	0	0	0	0	0	0	100%	100%
Ward B2 Hip	42.1	42.9	1.9%	16.3%	48.3%	1.1	20.7		100%	100%	3	0	0	0	0	0	0	100%	100%
Ward B2 Trauma	44.2	43.2	2.3%	16.3%	58.7%	5.2	37.1		100%	100%	2	1	0	0	0	0	0	100%	100%
Ward B3	80.1	75.9	5.2%	17.0%	60.2%	8.2	45.7		100%	100%	6	3	0	0	0	0	0	100%	100%
Ward B4	25.2	21.7	13.1%	16.8%	61.5%	4.3	13.4		100%	100%	1	0	0	0	0	0	0	100%	100%
Ward C1A	37.4	34.0	8.3%	16.2%	50.4%	3.7	17.1		100%	100%	1	0	0	0	0	0	0	100%	100%
Ward C1B	38.1	37.1	2.6%	15.2%	58.4%	1.5	21.6		100%	100%	3	0	0	0	0	0	0	100%	100%
Ward C2	58.1	53.1	8.8%	19.3%	64.7%	4.5	34.3		100%	100%	2	0	0	0	0	0	0	100%	100%
Ward C3	56.5	53.5	5.3%	18.8%	39.9%	5.3	21.3		100%	100%	2	0	0	0	0	0	0	100%	100%
Ward C4	44.2	43.6	1.4%	16.3%	60.2%	9.4	38.3		100%	100%	2	0	0	0	0	0	0	100%	100%
Ward C5A	41.3	39.3	5.3%	13.4%	49.7%	0.9	19.5		100%	100%	0	0	0	0	0	0	0	100%	100%
Ward C5B	44.4	44.3	0.2%	17.2%	61.4%	4.7	27.2		100%	100%	0	0	0	0	0	0	0	100%	100%
Ward C6	31.8	34.8	9.1%	15.7%	60.4%	4.8	21.0		100%	100%	0	0	0	0	0	0	0	100%	100%
Ward C7	44.1	41.5	6.1%	16.3%	71.1%	7.4	43.7		100%	100%	3	0	0	0	0	0	0	100%	100%
Ward C8	81.9	74.1	9.4%	18.2%	60.8%	6.3	45.1		100%	100%	3	1	0	0	0	0	0	100%	100%
Total	1,853.1	1,784.2	3.7%	16.8%	61.3%	171.1	1,094.3		100%	100%	96	12	2	27	2	5	0	100%	100%

- 8 ward areas now reported as RAG red for vacancy WTE data – 50% increase in areas reporting this since January 2025.
- Rising sickness continues to be attributed to seasonal illness was 9.49% overall in January 2025, now 15.9%.
- A task and finish group to review patient observations completed on time is in progress to focus on improving performance.
- The AMaT issues identified in last month's report, caused by the software programme update, have been addressed.
- AMaT compliance scores have altered: 90% + is green RAG. However, AMaT reports anything from 89.1% to 90% as green RAG rated – the dashboard recognises 90% as the green RAG rating, hence the discrepancy in RAG ratings between data drawn directly from AMaT (previous slide) and that from the Chief Nurse dashboard.

Sepsis March 2025

Quarterly sepsis submissions for ED-Emergency Department starting 30/09/19

A



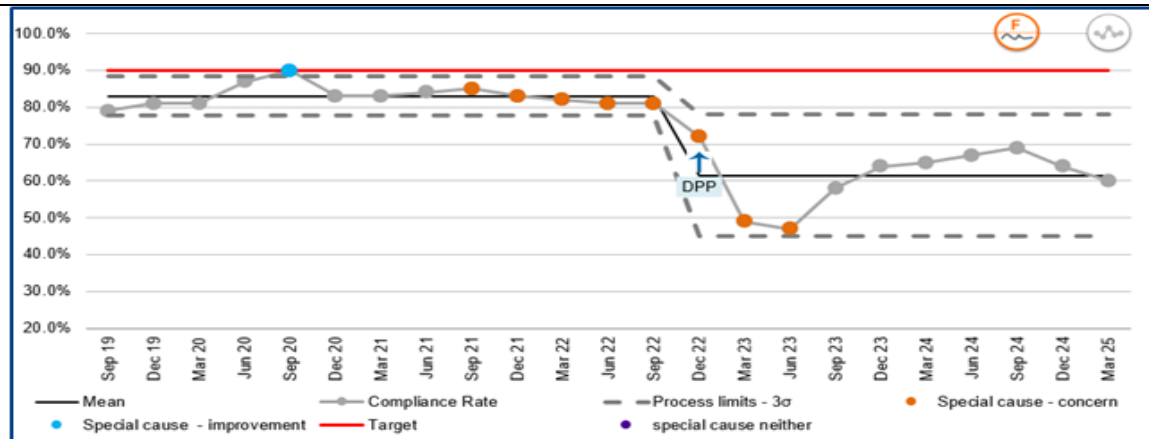
Quarterly sepsis submissions for inpatients-DPT starting 30/09/19

Sepsis March 2025

ED sepsis data is examined monthly as part of the AQUA programme, in comparison to the other 16 organisations taking part our sepsis performance is 2nd for the composite process score and 4th for IV antibiotics within an hour.

The deteriorating patient team undertook a deep dive into all 263 patients treated for suspected sepsis in ED in December to compare ambulance arrivals with the impact on time zero to treatment or review (broken down into 2-hourly periods across all 31 days).

ED sepsis improvement plan project group meet monthly to formulate action plans based upon deep dive analysis December patient journeys &



will repeat the deep dive analysis for the March data for more learning.

Divisions asked to report sepsis action plans to next Deteriorating patient group (DPG) in May.

Quarterly submissions for sepsis are divided into the following two groups:

- A) users presenting to the emergency department who undergo sepsis screening and who, where screening positive, receive IV antibiotic treatment ≤ 1 hour of time zero (Q4=63%)
- B) in-patients who undergo sepsis screening and who, where screening positive, receive IV antibiotic treatment ≤ 1 hour of time zero (Q4=60%).

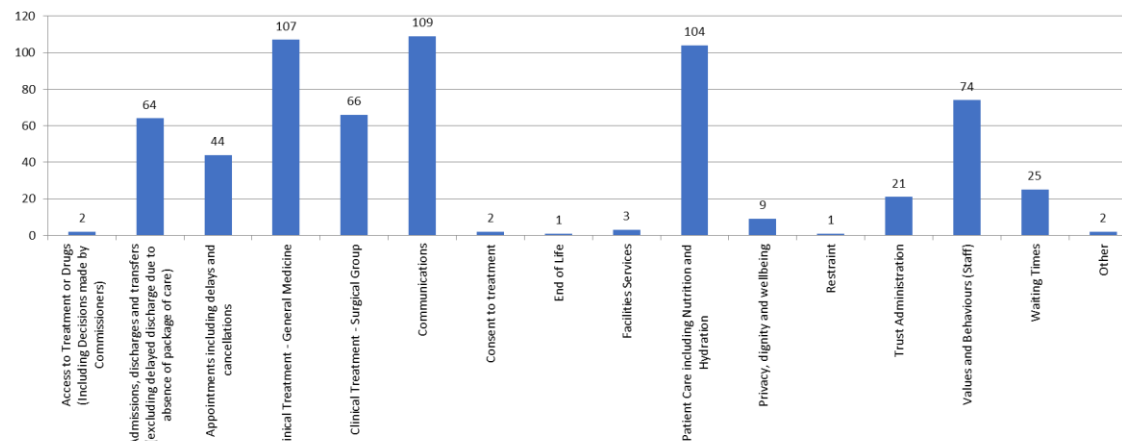
- Delays of documentation of vital signs at the point of care
- Delays in commencing screening tool at time zero
- Delay in senior clinical review will impact time available to administer antibiotics
- Increase in additional patients to standard ward format is impacting on timeliness of treatment of inpatients with suspected sepsis

March data for ED has increased from 62% in Feb to 72% (from total 162 patients in March v 158 patients in Feb). March data for inpatients has remained at 61% the same as Feb (from total 61 patients in March v 88 in Feb).

Patient Experience

Total of 291 complaints received between 1 November 2024 to 11 February 2025

New complaints by subject - 1 November 2024 to 11 February 2025



- Practical support to frontline teams such as drinks rounds and wellbeing checks
- Volunteers have been liaising with ambulances outside the Emergency Department to fetch drinks for waiting patients. They have also supported the Emergency Department over the weekends to provide additional support during the winter months.
- Patient experience team conducting 'Talk to me' rounds to gain real time insight and address issues

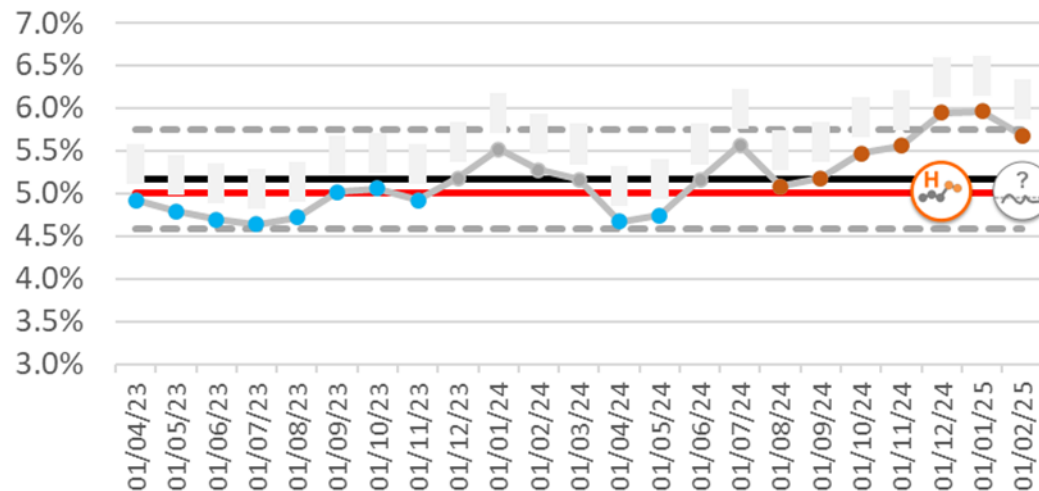
- Presence of patient experience teams in surge areas to support comfort and dignity
- Deployment of corporate teams to support care provision
- Continuing to focus on making complaints early resolution/PALS.
- Patient Experience Champions – ensure the voice of patients and promote positive patient experience within their area.
- Patient Voice Volunteers – to share their perspective and experience of using local services to support service development.
- Patient Experience Improvement Plan 2024-2027 (improving communication, building partnerships, capturing feedback and celebrating success).
- Showcasing good practice/spotlight sessions/Feedback Friday/Thank You

Thursday/focus groups, panels and forums.

- Development and monitoring of action plans.
- Patient, Public and Stakeholder Engagement Plan
- Four workstreams taken from the 2023 Inpatient Survey: communication, pain management, nutrition and hydration and discharge.

Staff Experience

Absence in Month



Absence

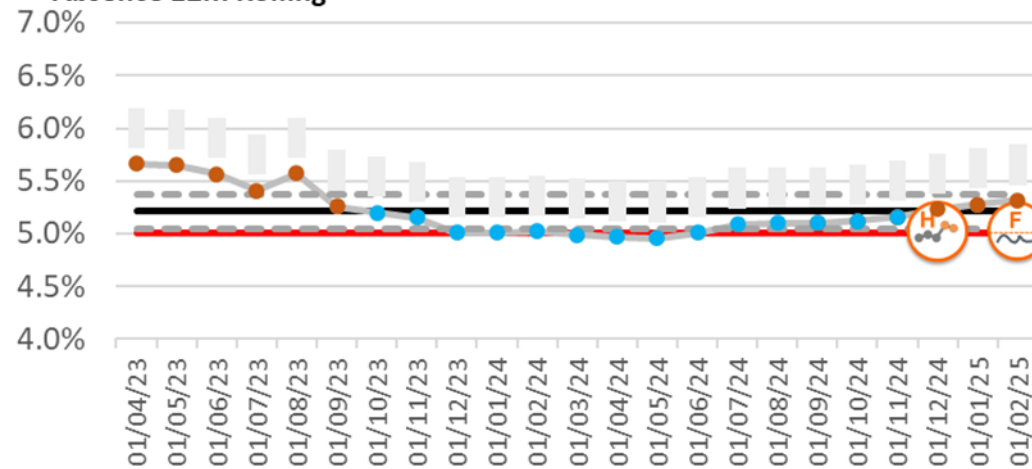
In-Month Sickness Absence

In-month sickness absence for February 2025 is 5.68%, a decrease from 5.96% in January 2025, but remains above Trust target of 5%.

Rolling 12 M Sickness Absence

The rolling 12-month absence for February 2025 is 5.31%, an increase from 5.28% in January 2025.

Absence 12m Rolling



What next

- Recording sickness absence training launches in March.
- Supporting attendance Hub page in draft.
- Managers' guide being developed.
- Hot spot areas – work continues with the 3 identified areas.
- Policy being reviewed given the downwards trend started to occur shortly after implementation of the new policy.

Through the Being a Brilliant Place to work and thrive committee the focus continues to be on workstreams that support high retention and engagement. There is ongoing delivery of communications, engagement and training plan to support delivery of anti-bullying and anti-discrimination policies and work programme.

Delivery of year 3 of Dudley People Plan and delivery Journeys.

Re-launch of MakeitHappen feedback loop.

Launch of framework around Listen, Act and Feedback to improve visibility

Safer staffing

Safer Nursing Care Tools (SNCTs) January 2025

The safer staffing review was undertaken using the latest validated Safer Nursing Care Tools (SNCTs). This is a NICE-endorsed evidence-based tool currently used in the NHS.

- Overall, the safer staffing establishments within the assessed areas are in a positive position to maintain the provision and delivery of safe, effective, high-quality care.
- No serious concerns pertaining to quality and safety have been identified by the Divisional Chief Nurses based on the current establishments. However, based on professional judgement and triangulation of quality metrics and acuity, some clinical areas feel additional staffing or change of skill mix may enhance care and experience in these areas. The Nurse Sensitive Indicators reviewed as part of the review, indicate that ongoing improvement work is required for example, with regards to patient observations, medicine management, pressure ulcers and falls amongst others.
- Inconsistent approach in how the 22% headroom/relief is applied and how this is utilised where in place has been noted, negatively contributing to the bank usage. A discussion was held with the Chief People Officer (interim), Chief Nurse (CN) and Divisional CNs, and agreement reached to standardise the approach across the Trust by recruiting into the 10% headroom/relief and using the rest for contingency cover which should see a positive impact on bank use.
- It is evident from the quantitative data that there is a disconnect between the recommended staffing establishments and the current funded staffing establishments, due to quantitative data collection issues, which we continue to work on. Professional judgement has been a key guiding factor with decision making and the knowledge of seasonal variation within the patient cohorts, the impact of flow and capacity challenges during the data collection month and the additional measures undertaken to support patient flow and patient experience.

of actions and change happening within the organisation.

Improved promotion of Being a Brilliant Place to Work Group and associated activities.

Jan 25	Beds	Recommended WTE (Reg)	Recommended WTE NR	Recommended Overall Total	Funded Budget	Diff FB is to Rec Over	Ward Profile Document WTE
AMU1	34	51.66	20.09	69.59	79.45	9.86	-2.54
AMU2	30	52.3	22.45	74.72	59	-15.72	-0.83
AMU3 (A4)	12	19.94	8.54	28.48	24.57	-3.91	-1.46
AMUA	22	25.61	10.94	36.58	61.06	24.48	-2.17
B1	26	19.91	8.53	28.45	30.58	2.13	1.16
B2H	24	30.7	11.94	42.64	50.86	8.22	-3.82
B2T	24	28.54	12.23	40.77	44.06	3.29	0.75
B3	36	47.47	20.35	67.82	66.16	-1.66	-3.05
B4	48	63.22	26.67	88.85	81.91	-6.94	-5.97
B6	16	21.15	9.06	30.22	25.57	-4.65	-1.49
C1A	24	33.48	14.35	47.83	38.9	-8.93	-0.54
C1B	24	36.3	14.12	50.41	38.9	-11.51	-0.54
C2	47	37.9	19.6	57.2	59.31	2.11	-1.7
C3	36	68.1	29.19	97.29	60.29	-37	-0.47
C4	24	18.98	8.48	27.11	40.48	13.37	-1.35
C5A	24	34.04	14.59	48.63	42.3	-6.33	2.19
C5B	24	37.34	14.52	51.87	50.49	-1.38	-1.54
C6	19	16.58	7.1	23.68	33.68	10	-3.31
C7	36	46.45	19.91	66.36	67.33	0.97	-0.19
C8	44	48.68	20.86	69.54	87.04	17.5	-2.59
CCU	24	27.81	11.92	39.72	56.85	17.13	0
DL	16	20.77	8.9	29.68	10.85	-18.83	-13.84
ESH	26	44.42	19.04	63.45	73.92	10.47	-5.25
MECU	8	11.3	4.84	16.15	22.52	6.37	-0.54

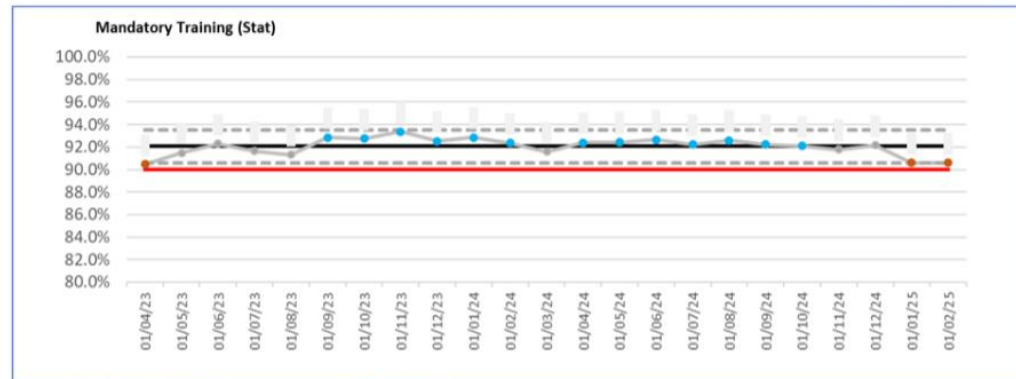
FMU	16	45.81	19.63	65.44	47.09	-18.35	-0.54
SS	24	29.29	12.55	41.84		-41.84	
ED Adults	----- -	115.8	18.5	133.8	149.74	15.94	-0.8
ED Paeds	----- -	20	8.6	28.6	35.43	6.83	-3.93

Metric	Rate	Target	Trend	
Absence – In Month	5.68	<=5%		<u>Sickness Absence</u> In-month sickness absence for February 2025 is 5.68%, which is a decrease from 5.96% in January 2025.
Absence - 12m Rolling	5.31%	<=5%		The rolling 12-month absence has increased from 5.28% in January 2025 to 5.31% in February 2025.
Turnover	7.14%	<=8%		<u>Turnover</u> Turnover (all terminations) has decreased from 7.17% in January 2025 to 7.14% in February 2025.
Normalised Turnover	3.09%	<=5%		Normalised Turnover has increased from 3.08% in January 2025 to 3.09% in February 2025. 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)	92.2%	>=80%	=	<u>Retention</u> The 12-month retention rate has remained static at 92.2%.
Vacancy Rate	5%	<=7%	=	<u>Vacancy Rate</u> The vacancy rate has remained static at 5%.
Mandatory Training	90.59%	>=90%		<u>Mandatory Training</u> Statutory Training decreased from 90.60% in January 2025 to 90.59% in February 2025. Overall, it has remained above 90% target for a sustained period.

Mandatory training

Performance over overall continues to be stable; there is some decline as a seasonal trend of reduced compliance in winter months but no different compared to last year. This will continue to be monitored, and divisions have been tasked to producing rectification plans

Mandatory Training



The overall rate for February has maintained above Trust target performance however shows a declining trend and two weeks during January performance was below target overall. Further work is planned to review areas of under-performance. Challenges in transferring Place Division has now been resolved but has left pockets of non-compliance for those teams. They are working on a rectification plan to achieve target within the next 2 months.

	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25
Mandatory Training (Stat)	91.59%	92.39%	92.44%	92.65%	92.24%	92.60%	92.22%	92.09%	91.79%	92.16%	90.60%	90.59%

Variation

Assurance



Pulse Survey January 2025

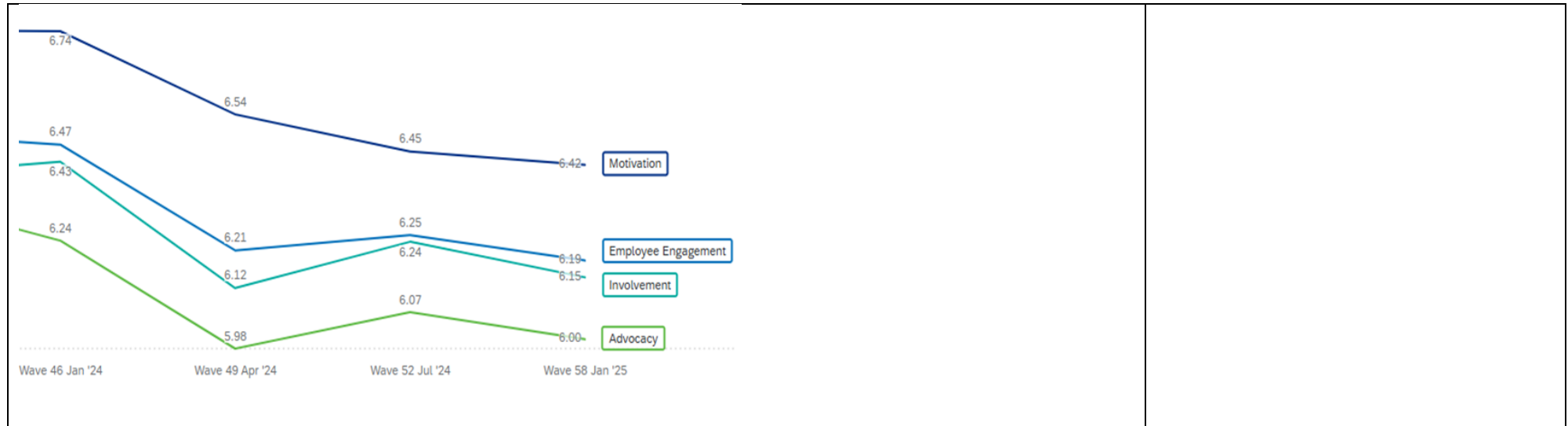
Our January 2025 Pulse Survey saw 550 responses with 51% of staff feeling positive about their work with phrases such as 'content' 'connected' and 'optimistic' being used. For the 49% of staff who were not feeling positive about their work using words such as 'stressed', 'demotivated' and 'isolated'.

Positive	Less positive
<ul style="list-style-type: none"> ✓ General positivity ✓ workload is manageable ✓ enjoy the job ✓ feel productive ✓ accomplished ✓ wellbeing is prioritised ✓ able to have a break ✓ provide satisfactory care for patients 	<ul style="list-style-type: none"> ❖ Management and other staff are not supportive or are difficult to work with ❖ under stress ❖ high workload ❖ short staffed ❖ unable to provide satisfactory care for patients ❖ lack of respect/bullying ❖ not being appreciated

The top themes from the survey were;

1. We are understaffed (23%) (we are safe & healthy and we are a team)
2. Communication needs to improve (23%) (We are a team/We each have a voice that counts)
3. We are over-worked (21%) (we are safe and healthy and we are a team)
4. Management needs to improve (20%) (we are recognised & rewarded and we are a team)

Motivation, employee engagement, involvement and Advocacy have all dropped since January 2024.



"In the midst of every crisis lies great opportunity" Albert Einstein

As challenging as the winter has been, there are countless examples of innovation, creativity and success that should be celebrated across the organisation. Some key moments include:

- **Dudley Place**

The Trust welcomed Dudley Place colleagues providing opportunities to realise an integrated healthcare provider.

- **Census work**

The Trust ensured every patient in the Trust was reviewed in a single day, identifying actual discharges and unblocking any delays to reduce overall length of stay. Over 600 patients were reviewed by a multi-disciplinary team utilising a standardised audit tool.

- **Weekend discharges**

There has been a focus by the Medical Director to prospectively identify establish numbers of discharges before the weekend in line with the NHSe UEC toolkit.

- **Operational Performance**

Despite emergency pressures, the clinical and operational teams should be commended for the delivery of key performance metrics relating to cancer and elective care as evident in the Integrated Performance Report. Performance related to missed appointment and PIFU are amongst the strongest in the Black Country and wider Midlands region.

- **Clinical Hub - Community first**

The Trust is working to promote a culture of community first to reduce numbers of attendances within emergency portals. There is a comprehensive plan to establish a full Care Navigation system, care home admissions which currently number 10 a day and a step-up model of virtual wards accessed at each stage of referral.

- **Virtual Wards**

Our 6 virtual wards cared for over 2050 patients during Q3 and Q4, a significant increase from the previous quarters and 790 more patients compared to the same period in 2023/24.

- **Teams without walls**

We have seen a flexible and supportive approach within teams during this period across all disciplines. Corporate based teams have willingly supported patient facing colleagues and will continue to do so.

"Safety brings first aid to the uninjured." – F.S. Hughes

The available literature suggests organisations will see a decline in quality and safety during winter pressures, and while this report identifies some areas for improvement, there is a

significant safety system in place. The Trust is well established in the national patient safety space and has presented our deteriorating patient work widely. NHS England's approach to patient safety follows the 'PIER' model [NHS England » Managing acute physical deterioration through the 'prevention, identification, escalation, response' \(PIER\) approach](#) and it is evident the Trust's approach to safety is in line with this system as mapped below

<p>P – prevention</p> <p>Developing systems and processes that support the design of reliable and safe care pathways that include continuous assessment to help monitor or reduce individual risk, prevent deterioration where prevention is clinically expected, and ensure care is personalised and reflects what matters to the person.</p>	<ul style="list-style-type: none"> ➤ Our deteriorating patient pathway is well established ➤ Advancing Quality bundles are in use and measured across a range of specialties ➤ Our Hospital at Night team actively use the DPP and monitor bundle compliance out of ours ➤ Gold Standard Framework accreditation ➤ Quality and Safety delivery plan ➤ Infection control audit plan
<p>I – identification</p> <p>Tools and methods for the standardised and timely recognition of physical acute deterioration through the reliable monitoring, identification and assessment of people.</p>	<ul style="list-style-type: none"> ➤ DPP ➤ Sepsis ➤ PEWs/NEWs ➤ Marthas Rule applied across organisation with 65% of staff having an awareness of the work (Pulse, Jan25) ➤ Safeguarding principles applied in all areas. ➤ QI methodology applied with oversight of improvements and sustainability
<p>E – escalation</p> <p>The principles of escalation should ideally be the same whether this takes place within an organisation or across a system. Tools such as 'situation, background, assessment, recommendation' (SBARD) or 'age, time, mechanism, injury, signs, treatment' (ATMIST) have been shown to improve the reliability of communication and handover and safeguard against safety-critical</p>	<ul style="list-style-type: none"> ➤ DPP ➤ Marthas Rule. ➤ Safeguarding referrals ➤ Early identification and escalation of potential risk of infections. ➤ DNAR / treatment limitations and application of GSF applied were appropriate in the community. Accessible to all partners so that appropriate care

information being lost between clinical teams.	can be provided in the right time and right place.
R – response Within a hospital this might be a senior clinician or specialist rapid response team. In a community setting this could be a GP, community nurse or other care professional. The response should be based on agreed parameters of severity and accommodate the patient's personalised care choices.	<ul style="list-style-type: none"> ➤ DNACPR / treatment limitations ➤ Application of GSF GP / Community ➤ Safeguarding principles applied ➤ Responding to complaints identifying themes for improvement.

Focus for 2025/26

The workstreams below provide structure and opportunities in relieving the pressure on the acute hospital by proposing initiatives to maximise integration by diverting activity from the entry portals of the hospital by providing care closer to home.

<u>Preparation</u>	<ul style="list-style-type: none"> ➤ Facilitated debrief of 24/25 winter period identifying key themes and lessons ➤ Integrated Multi agency plan for 25/26 ➤ Community first model of care to be developed ➤ Winter plan that is robust and responsive ➤ Quality Priorities 25/26 via the Quality and Safety Delivery Plan
<u>Staffing and Workforce</u>	<ul style="list-style-type: none"> ➤ Recruitment, retention, and flexible staffing models are crucial (link to work and thrive group and staff survey actions) ➤ Being a brilliant place to work ➤ Clinical Accreditation work stream
<u>Messaging</u>	<ul style="list-style-type: none"> ➤ Encouraging the public to take preventative measures, such as getting vaccinated against the flu, COVID, RSV ➤ Staff communication and engagement ➤ Encourage community screening for our local population as a preventative improvement plan

	<ul style="list-style-type: none"> ➤ Encourage use of virtual wards and SDEC model of care ➤ Encourage the use of the Trust Community first model of care as alternative pathway
<u>Partnerships</u>	<ul style="list-style-type: none"> ➤ Strong collaboration between hospitals, ambulance service, and other healthcare providers ➤ Clinical Hub Working Group to oversee Care Navigation plan focusing of surgical pathways initially ➤ Integrated Care Board, NHS England and upcoming new landscape ➤ Care Quality Commission
<u>Patient Experience</u>	<ul style="list-style-type: none"> ➤ Patient Experience Delivery Plan ➤ Quality and Safety Delivery Plan ➤ Patient Experience Surveys and resultant actions ➤ Feedback on complaints to be shared with divisional teams

Conclusion and Lessons

The winter of 24/25 was particularly challenging for the Trust, however there are some opportunities to learn from excellence demonstrated during the period. The systematic approach to safety through the deployment of the deteriorating patient pathway and use of care bundles have protected patients from harm. Our mortality outcomes and maintenance of zero never events during this period provide assurance that care is safe, despite the challenges faced.

Our comprehensive audit programme of wards has provided assurance that quality has been maintained in the round, despite challenges relating to falls and pressure ulcers. Early learning from these quality measures suggest staffing levels and skill mix are vital to avoiding declines in performance in 2025/26.

There is a genuine opportunity to improve staff experience in 2025/26 and it is recommended that the next report from the CMO/CNO should focus on this topic.

References

[RCEM Crowding Guidance Jan 2024 final.pdf](#)

[Health Secretary asks NHS to prioritise patient safety for winter - GOV.UK](#)

[1544789063_effects-of-winter-on-the-nhs-web.pdf](#)

[winter-warning.pdf](#)

[NHS England » Working together to deliver a resilient winter – system roles and responsibilities](#)

[Response to winter pressures in acute services: analysis from the Winter Society for Acute Medicine Benchmarking Audit - PubMed](#)

Paper for submission to the Executive Team on 22nd April, Quality and People Committees on 29th April and Trust Board on 8th May 2025.

Report title:	Nursing Safer Staffing Review. Including – Emergency Departments, Adult Acute Assessment Units, Adult inpatient wards, Children and Young People inpatient ward, Operating Theatres, Neonatal Unit and Critical Care Unit.
Sponsoring executive:	Martina Morris – Chief Nurse and Director of IPC
Report author:	Philippa Brazier – Associate Deputy Chief Nurse – Workforce and Professional Development

Summary of key issues

This report outlines the approach taken by the Trust to undertake the safer staffing review during January – February 2025, in line with national guidance, and provides the outcome and recommendations for individual clinical areas from an establishment and skill mix perspective.

Safer Nursing Care Tools (SNCTs) – summary of the review:

- Overall, the safer staffing establishments within the assessed areas are in a positive position to maintain the provision and delivery of safe, effective, high-quality care.
- No serious concerns pertaining to quality and safety have been identified by the Divisional Chief Nurses based on the current establishments. However, based on professional judgement and triangulation of quality metrics and acuity, some clinical areas feel additional staffing or change of skill mix may enhance care and experience in these areas. The Nurse Sensitive Indicators reviewed as part of the review, indicate that ongoing improvement work is required for example, with regards to patient observations, medicine management, pressure ulcers and falls amongst others.
- Inconsistent approach in how the 22% headroom/relief is applied and how this is utilised where in place has been noted, negatively contributing to the bank usage. A discussion was held with the Chief People Officer (interim), Chief Nurse (CN) and Divisional CNs, and agreement reached to standardise the approach across the Trust by recruiting into the 15% headroom/relief and using the rest for contingency cover which should see a positive impact on bank use.
- It is evident from the quantitative data that there is a disconnect between the recommended staffing establishments and the current funded staffing establishments, due to quantitative data collection issues, which we continue to work on. Professional judgement has been a key guiding factor with decision making and the knowledge of seasonal variation within the patient cohorts, the impact of flow and capacity challenges during the data collection month and the additional measures undertaken to support patient flow and patient experience.

The following table provides a summary of the recommendations, including where changes have been requested. Should these changes be approved, they would be subject to the Divisions identifying solutions in line with their financial envelope, annual plan requirements, underpinned by Quality Impact Assessments:

Jan 25	Requests suggested by ward leadership.	Changes supported by Division	Jan 25	Requests suggested by ward leadership.	Changes supported by Division	Jan 25	Requests suggested by ward leadership.	Changes supported by Division
AMU1	No	No	B6	Yes	Yes	C7	No	No
AMU2	Yes	Yes	C1A	Yes	Yes	C8	Yes	Yes
AMU3 (A4)	Yes	Yes	C1B	No	No	CCU	Yes	Yes
AMUA	No	No	C2	Yes	Yes	DL	Yes	Yes
B1	No	No	C3	Yes	Yes	ESH	No	No
B2H	No	No	C4	No	No	MECU	Yes	No
B2T	No	No	C5A	No	No	FMU	No	No
B3	No	No	C5B	No	No	ED Adults	No	No
B4	No	No	C6	No	No	ED Paeds	Yes	Yes

Establishment change requests

AMU 2	Increase in RN overnight 1 WTE.
AMU3	Appoint a Band 7 Lead Nurse 1 WTE (same lead nurse also responsible for AMU2).
B6	Increase nighttime CSW by 1 WTE - would reduce the overall temporary staffing use.
C3	Increase nighttime CSW by 1 WTE - would reduce the overall temporary staffing use.
C1 A	Increase nighttime CSW by 1 WTE - would reduce the overall temporary staffing use.
C8	Review parity of workload for the Lead Nurse, responsible for 3 areas, and consider how the stroke Clinical Nurse Specialists can support.
CCU	Increase nighttime CSW by 2 WTE.
DL	Work to reinstate as a Discharge Lounge.
SS	Temporary ward reliant on bank with no funded establishment. *This is no longer applicable and is no longer used for this purpose.
C2	Increase 1 WTE RN Band 5 for PAU area. *See the CN recommendation section for other steps to be considered in the first instance.
ED paeds	Change of establishment within present budget of Band 6s to a Band 7 to ensure senior cover across all shifts.

Theatre, Neonatal and Critical Care staffing review:

- The first safer staffing review was completed in these areas in September 2024, that provided a benchmark of future safer staffing reviews to be undertaken in alignment with the system.

September 24	Requests suggested by ward leadership	Changes supported by Division
Day Case Theatre Corbett Hospital	No	No
RHH Day Case Theatre & Recovery	No	No
RHH Day Case Theatre Ward	No	No
Theatres General, Urology, ENT & Plastics	No	No
Theatres Obs, Gynae, Vascular & Emergency	No	No
Theatres Recovery and Anaesthetics	No	No
Theatres T&O Dept	No	No
Critical Care (inc. CCOT)	No	No
Neonatal Unit	No	No

Following Divisional reviews, the Chief Nurse and her team have met with the Divisional Chief Nurses/deputies to review the outcome of all reviews and agreed the following:

- For the majority of clinical areas which have requested an increase or change, this cannot be supported at the present time. It is felt that as part of the focussed work to be undertaken with regards to Bank use, standardisation of how the 22% headroom/relief is applied and strengthened oversight of workforce deployment by implementing the use of Safe Care tool, this should result in benefit realisation without the need for increasing workforce establishments. No significant impact on quality has been raised by the Divisions regarding the current establishments in these areas, including concerns that they are not safely staffed. QIAs will be completed by the Divisions to outline any risks and mitigations associated with this decision.
- Review of parity of workload for the Lead Nurse on C8 to be completed.
- Closure of all additional capacity areas, including reinstatement of the Discharge Lounge, which will positively impact on bank use.
- The Neonatal Unit has had a business case approved in January 2025 to meet the BAPM staffing requirement, which means that the budget is now in place to meet it. Separate to this, a business case for AHP service provision in critical care and neonates is being developed as this has continually been raised as a gap as part of the Neonatal Network reviews.
- There are two areas, which the Chief Nurse recommends that changes are approved. These would be managed within the existing financial envelopes:
 - **Paediatric ED** – skill mix change from Band 6 to 7 to ensure that there is 24/7 senior nursing presence in this area across all shifts and to enable attraction of a stronger calibre of workforce.
 - There are currently 2.73 WTE Band 6 twilight shifts which despite extensive efforts have not been recruited into. It is proposed that these posts are converted into Band 7 posts and the change managed within the existing financial envelope. It is felt that if offered as a Band 7, this would attract more suitable individuals and ensure senior nursing cover across all shifts.
 - PAU and paediatric ED co-location needs to be expedited prior to any further workforce changes being considered.
 - **C2/PAU** – staffing has been particularly challenged during times of extreme pressures, resulting in very high allocation of patients to one nurse. The ward already has a model of reviewing and redistributing staff across the whole area as required, but this has been challenging during times of high activity. Associated risks are being mitigated and the Chief Nurse has agreed a temporary solution with the Divisional Chief Nurse to maintain safety on the ward and unit. It is therefore recommended to increase staffing establishment by 1 WTE Band 5 RN. However, prior to this establishment change being enacted, if approved, the following steps should be taken in the order indicated:
 - The ward will shortly be trialling different work patterns to increase support into PAU.
 - A clinical Band 7 post is being considered (funding is already available), to strengthen flow and coordination on the ward.
 - PAU and paediatric ED co-location needs to be expedited prior to any further workforce changes being considered. This may also mean that an increase of 1 WTE Band 5 RN may not be required.
 - In early April 2025, the Division completed a review of whether a more flexible workforce model would be appropriate to respond to the seasonal variation in activity. This review did not recommend any establishment changes, and this will be revisited following the co-location.

2. Alignment to our Vision

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

3. Report journey
Executive team on 22 nd April 2025. Quality Committee on 29 th April 2025. People Committee on 29 th April 2025.

4. Recommendation(s)
The Executive Team, Quality Committee and People Committee are asked to:
a. Receive this report for assurance and evidence of the Trust's compliance with reviewing safer staffing (nursing) in line with national requirements.
b. Debate and provide a view on the proposed skills-mix and establishment changes.

5. Impact		
Board Assurance Framework Risk 1.1	X	Deliver high quality, safe person centred care and treatment
Board Assurance Framework Risk 1.2	X	Achieve outstanding CQC rating.
Board Assurance Framework Risk 2.0	X	Effectively manage workforce demand and capacity
Board Assurance Framework Risk 3.0	X	Ensure Dudley is a brilliant place to work
Board Assurance Framework Risk 4.0	X	Remain financially sustainable in 2023/24 and beyond
Board Assurance Framework Risk 5.0		Achieve carbon reduction ambitions in line with NHS England Net Zero targets
Board Assurance Framework Risk 6.0		Build innovative partnerships in Dudley and beyond
Board Assurance Framework Risk 7.0	X	Achieve operational performance requirements
Board Assurance Framework Risk 8.0	X	Establish, invest and sustain the infrastructures, applications and end-user devices for digital innovation
Is Quality Impact Assessment required if so, add date: Y TBC		
Is Equality Impact Assessment required if so, add date: N		

Safer Staffing Review

January - February 2025

1. EXECUTIVE SUMMARY

The purpose of this report is to inform the Executive team, Quality Committee, People Committee and subsequently Trust Board, of the outcomes of the January - February 2025 assessment of safe staffing levels using the Safer Nursing Care Tools (SNCTs - Shelford Group 2023) and professional judgement. The Developing Workforce Safeguards, published by NHS improvement in 2018 builds on various publications by the National Quality Board (2018) and Lord Carter of Coles review (February 2016) providing guidance and recommendations in relation to the reporting of safe staffing to Trust Boards.

The Developing Workforce Safeguards (NHSI 2018) reinforces the requirement for Trusts to adopt a triangulated approach for the use of evidence-based tools, professional judgement, and patient outcomes to provide assurance of safer, sustainable, and effective staffing. Compliance with the principles outlined in the document is to be assessed annually.

In relation to workforce planning, the guidance recommends that establishment setting must be undertaken bi-annually and this process should consider the following:

- Patient acuity and dependency using the latest validated Shelford Safer Nursing Care Tool
- Activity levels
- Professional Judgement
- Seasonal variation in demand
- Service developments/changes and commissioning.
- Staff supply and experience including e-rostering data
- The use of temporary staffing above the set establishment
- Patient and staff outcome measures

Additionally, comprehensive quality impact assessments must be completed when new roles are introduced, there is workforce redesign or a change in skill mix is considered.

This review will make comparisons between this information and the Authorised Funded Establishment (AFE) for each ward which is adjusted to reflect the number of nursing staff (registered and non-registered) who provide direct care to patients. Housekeepers, cleanliness support and ward clerks are not included in the calculation as they do not provide direct nursing care to patients. In addition, when planning the staffing, there is a need for an allowance to be made for periods of leave to ensure that there are sufficient nurses available to provide the planned level of nurse staffing.

This report fulfils expectations of the Nursing Quality Board's requirements for Trusts in relation to safer nurse staffing and fulfils several of the requirements outlined in the NHS Improvement Developing Workforce Safeguards guidance which sets out how to support providers to deliver high quality care through safe and effective staffing. This review also meets standards outlined in the RCN Nursing Workforce Standards (May 2021). Organisations are expected to be compliant with the recommendations in these reports and are subject to review on this as part of the CQC inspection programme under both 'safe' and 'well led' domains.

At The Dudley Group NHS Foundation Trust, the level of cover (headroom/relief) built into ward establishments is 22% (429 hours) per Whole Time Equivalent (WTE) staff member. This includes:

- 17.5% Annual leave and Bank Holiday
- 3.5% Short term sickness
- 1% Mandatory Training time

It is recognised that the allocated 1% (15 hours) time for mandatory training is not sufficient. The undertaking of Priority 1 training, priority 2 and 3 training, appraisal support and preparation, professional registration reflections, Practice Supervisor and Assessor requirements and any additional champion/link roles requires on average 143 hours for a nurse, midwife or Allied Health Professionals (AHP). Priority one training is being reviewed nationally as from beginning of April we should have an update of what this consists of for priority 1 training. Other areas to be reviewed is the disparity with AHP staff protected time for CPD, that is not part of the Nurses allocated time just mandatory training. A discussion was held with the Chief People Officer (interim), Chief Nurse (CN) and Divisional CNs, and agreement reached to standardise the approach across the Trust by recruiting into the 10% headroom/relief and using the rest for contingency cover which should see a positive impact on bank use.

Authorised funded establishments should also afford staff in leadership roles the time to assume supervisory status which is evidenced to improve staff engagement and improve patient outcomes. The SNCT includes an allowance for ward leaders to undertake their leadership roles in a supervisory capacity for 40% of their time.

As a Trust we have committed to supporting our Lead Nurses to have 80% of their time in a supervisory capacity. This was flexed during times of operational extremis and decreased to 60% and has had a negative impact on their supervisory roles. The Tool provides clear guidance of expectations to follow called Red Rules. Our compliance with these rules is detailed in Appendix 1.

The report also includes the staffing review undertaken in September 2024 in Operating Theatres, Neonates and Critical Care Unit which was based on the Theatre Association of per-operative practitioners' guidelines, British Association of perinatal care (BAPM) and British Association of critical care nurses (BACCN)/ Royal college of Nursing RCN Critical Care Forum and Intensive Care Society ICS guidelines. This was the first staffing review undertaken in the Trust for Operating Theatres and Critical Care Unit and will be used as a benchmark for future reviews as only a verbal professional judgement was undertaken so the report has no written narrative to clarify findings. The next safer staffing review for these areas will be in April 2025, aligned to the system workforce approach. This data collection will follow the same process as the inpatient ward areas, which includes data collection and professional judgement, then the divisional challenge and confirm meetings and finally professional conversation with the Chief Nurse. However, no quality and safety concerns were raised, and the service leads agreed to no changes in the establishments.

2. PROCESSES

The safer staffing review has been undertaken using the latest validated Safer Nursing Care Tools (SNCTs). This is a NICE-endorsed evidence-based tool currently used in the NHS. The overall data collection output when using the tool can be viewed at Appendix 2.

The SNCT includes a suite of tools for different settings:

Used by the Trust:

- Adult inpatient wards in acute hospitals (updated 2023 – all previous versions of the tool are no longer valid).
- Adult acute assessment units (updated 2023 – all previous versions of the tool are no longer valid).
- Children and young people's inpatient wards in acute hospitals.
- Emergency Departments.

Not applicable to the Trust:

- Mental health inpatient wards.

The SNCT has been developed to help NHS Hospitals measure patient acuity and/or dependency to inform evidence-based decision making on staffing and workforce. Each tool has their own decision matrix (Appendix 3/4) to support the measurements. The tool, when aligned to Nurse Sensitive Indicators (NSIs), offers nurse leaders a reliable method against which to deliver evidence-based workforce plans to support existing service or the development of new services.

Acuity and dependency measurements should take place twice yearly as a minimum with data collection timeframes locally agreed. Trusts should collect data across the wards on the same months/timeframe to enable benchmarking. An average of the combined data sets is used to support nurse establishment setting/resetting (Appendix 5). Ultimately this evidence base should support workforce plans for nursing that should accurately predict and enable resources to be identified to support nursing establishments that meet patient and service needs.

During data collection periods it is strongly recommended that external validation of acuity and dependency measurements is undertaken weekly in partnership with the designated ward nurse. This validation must be undertaken by a senior professional who has been appropriately trained. The Trust identified key senior professionals who were allocated areas to quality assure and validate data collection.

Quality control is seen as fundamental to ensure a robust approach to the data collection. This process ensures accuracy and consistency of scoring whilst providing greater assurance to the Trust board in relation to the tool's recommendations.

Patient Flow The tool considers patient flow, such as admissions, discharges transfers/escorts. There for the addition of resources for these elements may result in double counting and lead to inaccurate recommendations.

Enhanced therapeutic observations (present in previous versions of the tool) of the additional staffing requirement to support patient needs for safety reasons and/or reducing risk of harm, was not included and needed to be collected separately. The new version of the tool, used in the review has new levels of acuity to meet this progressing need.

Nurse Sensitive Indicators are quality outcomes linked to nursing care. They inform nurses of good and poor patient outcomes enabling sharing of good practice and review of potential reasons for poor quality. Nurse sensitive indicators when aligned to acuity and dependency data and supported with professional judgement will enable agreement of nursing establishment appropriate to meet the needs of each ward/department. These indicators or outcomes can vary between speciality and therefore should be locally agreed for each clinical area.

The main NSIs reviewed as part of this review are unplanned omissions in providing patient medication and patient observation's (Early Warning Scores EWS) not assessed or recorded as outlined in the plan of care. It is recommended that a delay of 30 minutes in providing pain relief is also reviewed, however this data is challenging to obtain due to the lack of preset family groupings of the medications on the system.

It is widely accepted that these NSIs can be linked to nurse staffing challenges, including leadership, establishment levels, skill-mix and training and development of staff.

Critical Care Unit and Neonatal Unit process

In critical care, the patient acuity and staffing levels are recorded twice a day 6am and 6pm and as part of the safer staffing review, this will be recorded as part of the tool for 28 days. For the next data collection, the Nurse care indicators as part professional judgement will be taken into consideration as part of the data collection. BAPM standards apply and have been utilised for the Neonatal Unit.

Operating Theatres process

Operating theatres collect daily actual throughput data for each individual theatre along with the number of cases booked which would also show number cancelled by each theatre. The staffing is templated by day so they can also be cross-referenced showing number of staff to case ratio for example. Anaesthetic type can also be added to provide an overview of acuity along with the ASA grade for patients seen by anaesthetists. This data is collected over the 28 periods of the safer staffing to be analysed and reviewed to ensure safe staffing. For the next data collection, the Nurse care indicators as part professional judgement will be taken into consideration as part of the data collection

3. SKILL MIX

The minimum skill mix recommended by the Royal College of Nursing (RCN) is a ratio of 65/35 Registered Nurses/Care Support Workers. The Trust agreed aspirational skill mix is 70/30 ratio. However, this is often not achieved with an average ratio of 60/40.

Jan 25	RN/CSW%	Jan 25	RN/CSW%	Jan 25	RN/CSW%
AMU1	60/40	B6	55/45	C7	50/50
AMU2	55/45	C1A	50/50	C8	55/45
AMU3 (A4)	50/50	C1B	50/50	CCU	80/20
AMUA	55/45	C2	80/20	DL	60/40
B1	60/40	C3	55/45	ESH	70/30
B2H	40/60	C4	70/30	MECU	75/25
B2T	50/50	C5A	60/40	FMU	30/70
B3	55/45	C5B	55/45	ED Adults	60/40
B4	50/50	C6	50/50	ED Paeds	50/50

The RCN recommendations do not currently include Nursing Associates (RNA) in their Registered Nurse category. As a Trust we have understood the benefits of and therefore supported numerous RNAs into our workforce. Currently the Trust has 59 RNAs with a further 9 undertaking the conversion programmed to Level 1 Registered Nurse, which is in line with the plan agreed in 2024.

Within the areas where there is clear derogation from the RCN skill mix recommendation, assurances have been provided by the ward leadership teams that dynamic risk assessments were in place at the point of derogation, and it was often felt that having knowledgeable Nursing Associates and Care Support Workers, was safer for the patients than having Registered Nurses who were not familiar with the ward/clinical area.

Skill-mix continues to evolve due to the development and introduction of new roles within the Nursing and Midwifery workforce. In many areas where the acuity and intensity of patients has increased, and treatment and medication regimes are complex, further reduction in the overall skill-mix of registered to unregistered staff is not appropriate to maintain safe staffing levels and ensure adequate supervision. Focus is required to continue reviewing the overall registered to unregistered ratios to ensure any derogation is linked to planned model of care changes.

The ratio of Registered Nurses to Care Support Workers may be lower in some less acute areas such as areas where care needs are greater than nursing skill needs, or where other staff are involved in delivering care, for example, Assistant Practitioners and Allied Health Professionals (registered professionals) contribute significantly towards meeting patient needs.

Whilst the Safer Nursing Care Tool focuses on the clinical acuity and dependency of the patient, when triangulating the national standards, it is necessary to have a mixed economy in terminology. The RCN standard of 1 nurse to 8 patients during the day equates to each patient receiving nursing focus for 7.5 minutes of every hour. In many areas the ration of RN/CSW falls short of the national standard. Whilst we are moving away from the ratio's many of the national documents still refer to the ratios. Below provides an indication of what this means:

Nurse: Patient Ratio	Nurse time per hour (In minutes)	Nurse time per 12-hour shift
1:4	15	180 minutes or 3 hours
1:6	10	120 minutes or 2 hours
1:8	7.5	90 minutes or 1 1/2 hours
1:10	6	72 minutes
1:12	5	60 minutes or 1 hour

It should be noted that on average, a routine set of observations/vital signs should take 5 minutes to complete with the average patient medicine round taking over 20 minutes to complete, providing no intravenous (IV) medication is required. If a patient is on IV fluids, a nurse must review the cannula site (VIP Score) hourly and record how much fluid has been infused. If undertaken efficiently this action takes just under 6 minutes to complete. If a patient is not mobile or has an increase in risk of pressure area damage, review, and regular skin assessments to support intervention will take between 10 – 25 minutes dependant on the mobility and care needs of the patient. It must also be noted that when safeguarding thresholds are met and additional needs are required, a referral often takes over 60 minutes to complete with additional unaccounted for time from the ward-based teams when supporting the ongoing process once referrals have been made. To note there were 126 safeguarding referrals.

Theatres skill mix: Association of per-operative practitioners' guidelines (AfPP Safe staffing Guidelines V.4)

Minimum staffing for single cavity theatre cases		
Team members	Role	Number
Registered practitioner	Anaesthetic Practitioner	1
Registered Practitioner, Nursing Associate or Assistant Practitioner	Scrub Role	2
Registered Practitioner, Nursing Associate Assistant Practitioner or CSW	Circulator	1
Registered practitioner	Recovery Practitioner	1
Minimum staffing for dual cavity theatre cases		
Team members		Number
Registered practitioner	Anaesthetic Practitioner	1
Registered Practitioner, Nursing Associate or Assistant Practitioner	Scrub Role	3
Registered Practitioner, Nursing Associate Assistant Practitioner or CSW	Circulator	2
Registered practitioner	Recovery Practitioner	1
Minimum staffing for treatment rooms with planned operating lists		
Team members		Number
Registered practitioner	Anaesthetic Practitioner	1
Registered Practitioner, Nursing Associate or Assistant Practitioner	Scrub Role	1
Registered Practitioner, Nursing Associate Assistant Practitioner or CSW	Circulator	1

Neonatal skill mix: British Association of Perinatal Medicine (BAPM) standards are:

Department	Nurse ratio
ITU	1:1 Registered Nurse
HDU	2:1 Registered Nurse
Special care and transitional care	1:4 Registered Nurse / Midwife

Neonatal ITU/HDUs, should ensure that either or both, registered nurses or midwives care for the babies. Staff looking after transitional care babies should be at least 1 staff: 4 babies. Non-registered clinical staff may care for these babies under the direct supervision and responsibility of a registered nurse or midwife. Staffing in this area must be sufficient to ensure support for parents with all care for their baby including enteral tube feeding, low flow oxygen administration and any other additional needs. Other staff the standard recommend are outreach Nurses and Practice educators.

Critical care skill mix: The GPICs v2.1 dictates nursing ratios as below:

Patient Acuity level	Nurse ratio
Level 3 patient	1:1 Registered Nurse
Level 2 patient	2:1 Registered Nurse

A part of the critical care skill mix it is expected that each designated critical care unit must have an identified lead nurse who has overall responsibility for the nursing elements of the service. There must be a supernumerary (i.e. not rostered to deliver direct patient care to a specific patient) senior registered nurse who provides the supervisory clinical coordinator role on duty 24/7. Units with greater than ten beds must have additional supernumerary senior registered nursing staff over and above the supervisory clinical coordinator to enable the delivery of safe care.

Critical Care Unit must have a dedicated Clinical Nurse Educator responsible for coordinating the education, training and CPD (Continuing Professional Development) framework for intensive care nursing staff and pre-registration student allocation. This should equate to a minimum of 1.0 WTE per 75 nursing staff. 7. All nursing staff appointed to intensive care must be allocated a period of supernumerary practice to enable achievement of basic specialist competence. Then a minimum of 50% of registered nursing staff must be in possession of a post-registration academic programme in Critical Care Nursing.

4. FILL RATES

Acute trusts are required to collate and report staffing fill rates for external data submission to NHSE/I monthly. Fill rates are calculated by comparing planned (rostered) hours against actual hours worked for both RN and CSW. The summary position for the last three months to the data collection is shown in table below. A more detailed position for January – February 25 is in Appendix 6.

% Fill Rate	Nov 24	Dec 24	Jan 25
Registrant Day	87	88	88
Registrant Night	93	94	94
Non-Registered Day	84	88	84
Non-Registered Night	94	96	94

It should be noted that there were still some wards where shifts were below expected levels and that the fill rates are based on current expected levels and may not reflect the required numbers from SNCT and professional judgement results. It should also be noted that a low fill rate does not always mean that staffing levels were unsafe as bed occupancy may have been lower and the anticipated acuity of the patients may have been different. Throughout January - February 2025, the demand on services would not have allowed for a lower bed occupancy.

Fill rates also do not consider the skill-mix within an area including what percentage of this fill was temporary staff; all of which are contributing factors to quality and safety within the clinical environment. Following the RCN standards advice, the Trust makes every effort to not have more than 50% of the clinical team as temporary staff.

5. NICE RED FLAGS & NURSE SENSITIVE INDICATORS (Appendix 7 for full data set)

Nursing Red Flags are specified in Safer Staffing for Nursing in Adult Inpatient Wards in Acute Hospitals overview (NICE 2021). 2 key red flags have been examined through this review, patient vital signs not assessed or recorded as outlined in the care plan, and unplanned omissions in providing patient medications.

Patient vital signs not assessed or recorded as outlined in care plan

Patient Vital Signs	Sets to be completed	Number over the required time	% Observations on time
30 min observations	1533	1212	21
Hourly observations	3905	2643	33.2
4 hourly observations	123,811	60,127	52.5

The observation interval '30 minutes' has an additional requirement of a Medical Emergency call being placed and an emergency team response being activated. Throughout the month of January there were 166 Medical Emergency Team calls

Area	Number of MET calls	Area	Number of MET calls	Area	Number of MET calls
AMU1	23	B4	6	C5A	10
AMU2	10	B5	16	C5B	8
AMU3	1	B6	1	C6	9
AMUA	10	C1A	5	C7	9
B1	2	C1B	4	C8	10
B2 T	1	C3	3	CCU	6
B3	11	C4	9	MECU	6
SS	2	B2 H	3	FMNU	0

Unplanned omission in providing patient medications

There were over 64 thousand late or missed medications throughout this data collection, compared to 96 thousand in June 2024 data collection. 22058 were late (30 minutes or more after the directed time on the prescription) and 44979 which were not performed. Due to the significant number of given medications, it is currently too challenging to create a stable report to provide data on those which were administered on time. As part of the quality priorities for 25/26, time critical medication is being reviewed so this will hopefully contribute to the improvement of late medication.

Nurse Sensitive Indicators

Nurse sensitive indicators (NSIs) refer to quality outcomes that can be linked to nurse staffing issues, including leadership, establishment levels, skill-mix and training and development of staff. This information can be further used to support ward staffing requirements identified through acuity and dependency measurement. Medication errors, slips, trips & falls and pressure ulcers are all NSIs which have been identified as key indicators of quality of care with specific sensitivity to nursing intervention and lack of.

These are regularly scrutinised across the divisions and within the clinical areas, with a significant amount of work being undertaken to support their reduction.

Pressure Ulcer Damage and Falls

Throughout January 2025 there were 95 falls across the areas and 129 Pressure Ulcers reported through the DATIX system (to note the data extract at the end of January 25 and used by the Divisions would have been unvalidated data and all incidents would not have gone through the Trust internal validation frameworks e.g. Pressure ulcer scrutiny Group or Falls Group). Since the data collection in June 2024, we have reduced the falls, but the pressure ulcers have increased that was recorded on Datix.

PRESSURE ULCER DAMAGE					
Jan-25	No PU	Jan 25	No PU	Jan 25	No PU
AMU1	5	B6	2	C7	3
AMU2	5	C1A	4	C8	10
AMU3 (A4)	3	C1B	2	CCU	4
AMUA	0	C2	0	DL	5
B1	2	C3	6	ESH	1
B2H	6	C4	2	MECU	2
B2T	10	C5A	7	FMU	2
B3	5	C5B	1	ED Adults	0
B4	9	C6	2	ED Paeds	0
				Super surge	0

FALLS										
Jan 25		No Falls		Jan 25		No Falls		Jan 25		No Falls
AMU1		2		B6		2		C7		3
AMU2		8		C1A		4		C8		10
AMU3 (A4)		3		C1B		2		CCU		4
AMUA		0		C2		0		DL		5
B1		1		C3		6		ESH		1
B2H		4		C4		2		MECU		2
B2T		9		C5A		7		FMU		3
B3		10		C5B		1		ED Adults		0
B4		5		C6		2		ED Paeds		0
SS		1								
INFECTION PREVENTION CONTROL ESCALATIONS										
Jan 25			Jan 25			Jan 25				
AMU1		2 Norovirus	B6		14 Norovirus	C7				
AMU2		2 CDI 1 Norovirus	C1A		1 CDI	C8				
AMU3 (A4)		2 Norovirus	C1B		1 E-coli	CCU				
AMUA		2 CDI 1 Covid 19	C2		1 - MSSA	DL		1 cdi		
B1			C3		1 CDI 1 Norovirus	ESH		2 E- Col i		
B2H		1 E-coli	C4			MECU				
B2T			C5A			FMU				

B3	1 - MSSA	C5B	1 CDI 1 Norovirus	ED Adults	19 E- coli 3 CDI
B4B	1 - MSSA	C6		ED Paeds	
Surge	1 CDI				

In addition to the above indicators, the number of complaints which are received is also a strong indicator of nursing care and levels of staffing. Throughout January 2025, there were 28 complaints. Safeguarding the nature and complexity of the referrals is not to be underestimated and the workload this creates is substantial for both the teams undertaking the initial referrals and subsequently the teams who support with the inpatient care of these patients. Throughout the review period there were 126 safeguarding referrals.

Jan 25	NO complaints			Jan 25	No complaints
AMU1	3	B6		C7	
AMU2		C1A		C8	2
AMU3 (A4)		C1B		CCU	
AMUA	2	C2	2	DL	1
B1		C3		ESH	2
B2H		C4		MECU	
B2T		C5A		FMNU	1
B3	1	C5B	1	ED Adults	11
B4	1	C6	1	ED Paeds	
SS					

Jan 25	No safeguarding				Jan 25	No safeguarding
AMU1	1		B6	0	C7	1
AMU2	0		C1A	0	C8	0
AMU3 (A4)	0		C1B	0	CCU	0
AMUA	0		C2	2	DL	0
B1	0		C3	0	ESH	1
B2H	0		C4	0	MECU	0
B2T	1		C5A	1	FMU	0
B3	1		C5B	0	ED Adults	57
B4	1		C6	1	ED Paeds	135
SS	1					

A breakdown of the nurse sensitive indicators per clinical area can be reviewed in Appendix 8.

As part of the Operating Theatres, Critical Care Unit and Neonatal Unit's safer staffing review, this data was not captured as part of the data collection in September but for the next data collection it will align to the other inpatient ward areas.

6. CHPPD

Care Hours per Patient Day (CHPPD) is a useful means of benchmarking against other NHS Trusts via the Model Hospital website. CHPPD is calculated by dividing the total numbers of nursing hours on a ward or unit by the number of patients in beds at the midnight census. This calculation provides the average number of care hours available for each patient on the ward or unit. A detailed individual ward position is available in appendix 6.

CHPPD	November 25	December 24	January 25
Registered	5.24	5.2	5.15
Care Staff	3.57	3.45	3.45
Total	8.81	8.65	8.6

7. PROFESSIONAL JUDGEMENT

Professional judgement can be described as the use of accumulated knowledge and experience, as well as critical reasoning to make an informed professional decision – often to help solve a problem, or in relation to a patient; or policies and procedure affecting patients. Staffing decisions based solely on professional judgement are considered subjective and may not be transparent.

However, professional judgement remains an essential element of safer staffing decisions. For this reason, the Trust uses a triangulated approach, with safer staffing data, clinical quality indicators and professional judgement. Details of the data sources, in addition to the below can be found in Appendix 8.

As part of the safer staffing reviews professional judgement must include consideration of the following:

- **Ward layout/facilities:** The configuration of wards and facilities affect the nursing time available to deliver care to patients, and this can be reflected in staffing establishments through professional judgement. For example, ward layouts, might make adequate surveillance of vulnerable patients more difficult. Some ward layouts are associated with significantly more walking between patients than others. Some wards have essential functions (dirty utility) out of the main ward environment.
- **Escort duties:** This is not captured by the Safer Nursing Care tool. Consideration needs to be given if this role is likely to affect the numbers of staff required, a local data collection and analysis exercise must be undertaken to determine a percentage to be added to the establishment to ensure staffing remains responsive to daily patient care need. This data has been captured using the Safecare (Allocate) system and the data has been made available for review.
- **Shift pattern:** The type of shifts (long day versus short day) in use may affect the overall establishment required to ensure shift-to-shift staffing levels. These should be monitored to understand the impact and effect on staff and patients.
- **Multi-professional working:** Consider the make-up of the care team for the ward. Would specific AHPs or support roles meet the needs of patient groups at particular periods of the day more appropriately? Conversely the absence of administrative support staff such as ward clerks may increase nurses' workload at particular times.

The following questions have been considered throughout this review:

- What is the care/treatment to be provided?
- What competencies are required to deliver that care/treatment?
- Which staff member (taking into consideration the wider multidisciplinary team) is competent and best placed to deliver that care/treatment?
- Can aspects of the care/treatment be safely delegated with appropriate education and training (if so, to whom)?

- What are all members of the team responsible for?

Another key item which has been factored into the review is the time commitments required when undertaking our safeguarding processes. Anecdotally each referral takes 45-60 minutes with additional work following for case conferences, preparation of reports and ensuring the additional safety requirements of the patients are met.

It is clear from the quantitative data that there is a disconnect between the tools recommended staffing establishments and the current funded staffing establishments. Throughout the reviews gaps have been scrutinised as best as possible and all the available data has been triangulated. However, it is recognised that some data has not been collected in the desired way. Professional Judgement has been a key guiding influence with this and the knowledge of seasonal variation within the patient cohorts, the impact of flow and capacity challenges during the data collection month and the additional measures undertaken to support patient flow, and experience.

8. TRAINING

The initial safer staffing all individuals involved in the data collection and data assurance had to undertake training re knowledgeable and competent to assess acuity and use the Safer Nursing Care Staffing Tool. Prior to this data collection training sessions were advertised for virtual sessions for staff new to the data collection or staff who required refreshers. Following completion of training, individuals who were undertaking the reviews or quality assuring the reviews completed an assessment to verify competence. This training is required two yearly or if staff require a refresher, this then gives data integrity can be assured by ensuring staff have relevant training and are competent.

9. WHAT DOES THE DATA TELL US

Overall, the safer staffing establishments are in a positive position to ensure the provision of safe, effective, high-quality care. The data was collected at 15:00 each day within the inpatient and assessment unit areas for 30 days. Within the Emergency Department, the data was collected over a period of 2 weeks, twice a day with the times staggered to capture every hour in the day and night (Appendix 10). To reduce the risk of transcription errors a bespoke Microsoft form was created for each ward area along with a bespoke quality assurance/validation document. The approach this time ensured that Divisional Chief Nurses/Matrons were able to independent have oversight of data collection to ensure this was completed daily. Quality assurance/validation was more challenging to ensure on this occasion due to the operational pressures across the Trust and as a result, some colleagues have had to review additional areas per week to ensure all areas were subject to quality assurance weekly.

Following the period of data collection the data was collated and analysed, it was made available for the Divisional Chief Nurses to undertake their confirm and challenge conversations. A list of what this included is available in Appendices 7/8/10.

Divisional Chief Nurses at ward level undertook their confirm and challenge conversations with their Lead Nurses, Matrons, HR and Finance Business partners. All the available data was scrutinised and triangulated to understand what the ward and service need. As part of this, the professional judgement framework was used as a template for the conversations and guidance to ensure all items were given due consideration. Appendix 12 provides an overview of each area of their professional judgement and key data sources.

At these conversations, some ward areas approached their divisional review with requests for changes to their establishments. These requests have been scrutinised by the Divisional Chief Nurses and the viability and other options have been reviewed.

Below is the collated detail ward level requests, Divisional Chief Nurse level ask and whether supported by the Trust's Chief Nurse.

Area	Ward/Department Request/Amendments	Divisional Chief Nurse (DCN) Outcome of Divisional Confirm and Challenge	Chief Nurse Outcome of Professional discussion with Divisional CNs
AMU 1	If extra beds are permanent will need to meet SAM guidance and need to address lead nurse covering two areas as non-compliant with RCN guidance.	<p>Lead nurse is also responsible for AMU assessment (Breach of RCN guidance) this accounts for 55 patient spaces including 8 level 1 and over 140 staff.</p> <p>Monitored beds – high demand this winter period patients in bed base who should have been in monitored beds. 187 transfers into monitored beds. 35 patients went to a level 2 or 3 facility (increase from 15 last census).</p> <p>High volume of admissions 483 Direct admissions from ED Ward rounds are continuous throughout the day hours. Ligature free rooms x 2 with reduced visibility Bays are covid compliant with expanse of gaps horizontally between bays, unable to observe to patients unless physically in the bay Increased number of escorts internal and external.</p> <p>Recommend – no change if beds are temporary and mitigate increase by bank Consider the Lead Nurse position of covering two wards</p>	For the majority of clinical areas which have requested an increase or change, this cannot be supported at the present time. It is felt that as part of the focussed work to be undertaken with regards to Bank use, standardisation of how the 22% headroom/relief is applied and strengthened oversight of workforce deployment by implementing the use of Safe Care tool, this should result in benefit realisation without the need for increasing workforce establishments. No significant impact on quality has been raised by the Divisions regarding the current establishments in these

Area	Ward/Department Request/Amendments	Divisional Chief Nurse (DCN) Outcome of Divisional Confirm and Challenge	Chief Nurse Outcome of Professional discussion with Divisional CNs
			areas, including concerns that they are not safely staffed. QIAs will be completed by the Divisions to outline any risks and mitigations associated with this decision.
AMU2	Current staffing establishment does not support the national SAM guidance for the night shift staffing. Request 1 RN overnight.	<p>Lead nurse is also responsible for AMU 3 (Breach of RCN guidance) Need to scope if extra beds are long term.</p> <p>Lead nurse covering 2 areas in breach of RCN guidance.</p> <p>High volume of admissions 462 up from (392) last census, 153 discharges down from 157 discharges last census and 268.</p> <p>Transfers to wards and 32 to SDEC/surge up from 206 patient transfers out last census. Direct admissions from ED 32 patient shad a news of 5-7 11 news over 7 I patient went to MECU and one to ITU during census period.</p> <p>Recommend – increase RN 1 WTE at night to meet SAM guidance</p>	Same outcome applies as stated for AMU 1.
AMU 3	Lead Nurse required	<p>Census data suggested an increase of 2WTE team disagree and suggest the need is for a band 7 Lead nurse is also responsible for AMU 2 (Breach of RCN guidance).</p> <p>114 admissions this census month and 35 discharges improved picture from last census when data illustrates: 40 admissions and 20 discharges Improved once band 7 moved from AA to support census data suggested 1d activity that was correct mental health guidance and security guidance.</p> <p>Recommend – Band 7 WTE to be considered</p>	Same outcome applies as stated for AMU 1.
AMU A	none	Lead nurse is also responsible for AMU 1 (Breach of RCN guidance) this accounts for 55 patient spaces including 8 level 1 and 140 staff.	Agreed with no change.

Area	Ward/Department Request/Amendments	Divisional Chief Nurse (DCN) Outcome of Divisional Confirm and Challenge	Chief Nurse Outcome of Professional discussion with Divisional CNs
		<p>PDN 1.0 WTE for all AMU areas 16 single cubicles and 1 x 4 bedded bay not visible in main dept and one side room. No formal additional patients due to layout but patients regularly que on entry to department.</p> <p>Admissions 777 an increase from 735 last census discharged 148 as opposed to 114 last census and transferred 629 an increase from 621 last census out to bed base. This does not include transfers on top Activity consistent for 12-month period high acuity patients: 4 patients moved to level 2 facility during census period.</p> <p>Recommend – no changes</p>	
B1	none	<p>Even though the data states 1.57 over establishment the ward has a higher turnover of patient's elective patients compared to the non-elective wards from the admission, post operative care and discharge.</p> <p>What the data didn't capture 50 ward attenders that required staff to review wounds and some required removal of clips.</p> <p>Recommend – no changes</p>	Agreed with no change.
B2 H	none	<p>The data collection indicated 8 WTE less than the present establishments, upon review the DCN and matron feel the data collected may not be accurately categorised as most patients require additional intervention to mitigate risk and maintain safety at any one time. One suggestion was to ensure before the next data collection staff underwent refresher training.</p> <p>Recommend- no changes</p>	Agreed with no change.
B2 T	none	<p>The data relatively matches the present establishments. The proposed establishment includes 2 x band 7 co-ordinations who do not care for a cohort of patients. The only additional request for staffing are 1-1 care or transfers to other hospitals that cannot be managed by the budget.</p> <p>Recommend- no changes</p>	Agreed with no change.
B3	none	<p>The proposed staffing establishment increases by 1.66 WTE. While the team does not believe that additional staffing is necessary, there are times when</p>	Agreed with no change.

Area	Ward/Department Request/Amendments	Divisional Chief Nurse (DCN) Outcome of Divisional Confirm and Challenge	Chief Nurse Outcome of Professional discussion with Divisional CNs
		extra staff are requested to accommodate the needs of 1-1 patient care or to manage an increase in VASCU activity. Recommend- no changes	
B4	none	The proposed staffing establishment increases by 6.94 WTE once non-clinical staff are excluded from the figures. While the team does not believe that additional staffing is necessary, there are times when extra staff are requested to accommodate the needs of 1-to-1 patient care or to manage an increase in POCU activity. Recommend- no changes	Agreed with no change.
B5 (ESH)	none	The proposed staffing establishment has been assessed and compared using a template which identified 36 inpatient beds, triage trollies and treatment chairs within ESH. The staffing proposals do not include Surgical Same Day Emergency Care (SSDEC) or Gynaecology Assessment Unit (GAU) waiting areas and does not capture all activity within the Emergency Surgical Hub. Recommend- no changes	Agreed with no change.
B6	Request for an additional 1.0 WTE CSW from 2 to 3 on day and night shifts	The geographical layout can hinder the care due to the sluice not on the main ward and the 4 bays not visible by the nursing station. Complex discharges Recommend – an increase in CSW 2 WTE, day and night shift would reduce the requirement for additional staff.	Same outcome applies as stated for AMU 1. Proposed ward re-location associated with B6 to be presented to the Executive team and then enacted.
C1A	Band 2 – 1.0 WTE – nights	Increased numbers of patients with learning disabilities, and patients who do not fit into the normal specialities. 39 extra additional support requested only 22 filled, just outside census this ward had to have Prometheus to support a complex mental health patient. Recommend – An additional CSW 1 WTE, would mitigate some Bank spend overnight	Same outcome applies as stated for AMU 1.

Area	Ward/Department Request/Amendments	Divisional Chief Nurse (DCN) Outcome of Divisional Confirm and Challenge	Chief Nurse Outcome of Professional discussion with Divisional CNs
C1B	none	<p>To improve patient experience patients are starting to be dialysed on the unit. Need a PDSA model to be costed and reviewed for this expansion of service provision.</p> <p>Recommend – no change. But complete PDSA work and cost up appropriately</p>	<p>Agreed with no change and recommended review.</p>
C2		<p>The staffing proposal does not capture the full activity and staffing ratios as the decision was made not to remove PAU from the main census data collection which would have allowed a true, and accurate picture of PAU and the activity, demand and acuity.</p> <p>PAU (11 patients). Although capacity is dedicated to 11 in PAU, they will very often flex over this due to capacity demands.</p> <p>Compared to the previous years (23/24) there is an increase of patient admissions to PAU by 23%. July to January 2023/24 saw 3384 total admissions, whereas July to January 2024/25 saw an increase to 4170 admissions.</p> <p>Staffing establishment has not been increased to manage the increased number of patients attending C2/ PAU.</p> <p>Completed PAU and Paeds ED co-location.</p> <p>Recommend – 1 additional WTE Band 5 RN for the PAU area.</p> <p>It is proposed that from a funding available to the Divisional CN (8a level), a Band 7 clinical lead post would be created that would ensure that there is improved management of capacity and flow and strengthened oversight of the ward area.</p>	<p>C2 – PAU staffing has been particularly challenged during times of extreme pressures, resulting in very high allocation of patients to one nurse. The ward already has a model of reviewing and redistributing staff across the whole area as required, but this has been challenging during times of high activity. Associated risks are being mitigated and the Chief Nurse has agreed a temporary solution with the Divisional Chief Nurse to maintain safety on the ward and unit. It is therefore recommended to increase staffing establishment by 1 WTE Band 5 RN. However, prior to this establishment change being enacted, if approved, the following steps should be taken in the order indicated:</p> <p>-The ward will shortly be trialling different work patterns to increase support into PAU.</p>

Area	Ward/Department Request/Amendments	Divisional Chief Nurse (DCN) Outcome of Divisional Confirm and Challenge	Chief Nurse Outcome of Professional discussion with Divisional CNs
			<p>-A clinical Band 7 post is being considered (funding is already available), to strengthen flow and coordination on the ward.</p> <p>-PAU and paediatric ED co-location needs to be expedited prior to any further workforce changes being considered. This may also mean that an increase of 1 WTE Band 5 RN may not be required.</p> <p>-In early April 2025, the Division completed a review of whether a more flexible workforce model would be appropriate to respond to the seasonal variation in activity. This review did not recommend any establishment changes, and this will be revisited following the co-location.</p>
C3	Increase of CSW 1.0 WTE	<p>Due to complexity of pathway 3 waits on FMN, this means c3 take that extended group of more complex patients with difficult social needs. Only 5 CSW's on day shift and night shift. We need to do a specific piece of work like C7 regarding high number of additional requests.</p> <p>Recommend – an increase in CSW WTE on day and night shift which would reduce the requirement for additional staff.</p>	Same outcome applies as stated for AMU 1.
C4	No changes	No national standard but 1:3 ratio required to support patients in isolation facility.	Agreed with no change.

Area	Ward/Department Request/Amendments	Divisional Chief Nurse (DCN) Outcome of Divisional Confirm and Challenge	Chief Nurse Outcome of Professional discussion with Divisional CNs
		High demand for escorts to New Cross and QE, intense psychological support for patient cohort. Out of hours isolation pick up the out of hours line activity varies on this line. Recommend – no changes	
C5a	No changes	Unit supports the NIV bleep service for ED, this is shared between MECU C5a and C5b. CCOT level one competencies required for these staff on the Respiratory enhanced unit. Recommend - no changes	Agreed with no change.
C5b	No changes	Unit supports the NIV bleep service for ED, this is shared between MECU C5a and C5b. Additional patient every day on c5a during census period (treatment room away from station). Multiple escorts required from this area due to oxygen demand and need for physiological investigations off site at CITY/QE, and transfers for cardiothoracic intervention at New cross for the pneumothorax patients. High number of Bariatric patients. CCOT level one competencies required for these staff on the Respiratory enhanced unit. Recommend - no changes	Agreed with no change.
C6	No changes	The January data suggests that C6 required less CSWs then are currently established; there is currently no CSW rostered for Prostate Biopsy clinic which has been recommended due to monitoring patients post procedure. This is in line with NICE guidelines. A business case to address this is being written at present, therefore cannot support the reduction in CSW workforce. C6 are currently supporting 1 registered nurse in a seconded role (gynae CNS). There are no current vacancies at present but remain over established due to	Agreed with no change. Proposed ward re-location associated with B6 to be presented to the Executive team and then enacted.

Area	Ward/Department Request/Amendments	Divisional Chief Nurse (DCN) Outcome of Divisional Confirm and Challenge	Chief Nurse Outcome of Professional discussion with Divisional CNs
		<p>IEN recruitment drive and the Band 3 TNA programme which were never funded by the ward and a cleanliness support worker not employed for patient care.</p> <p>Also, the layout of the ward is not conducive for patient care so the possibility of a ward swap to B6.</p> <p>Recommend- no changes and review the possibility of a ward move with B6</p>	
C7	No changes	<p>C7 transfers patients to level 2/3 facility, they also receive step downs from level 2/3. Patients require isolation/barrier nursing due to gastroenterology pathology.</p> <p>Recommend – no changes to establishment</p>	Agreed with no change.
C8	Fill vacancies and consider the using of CNS to bridge gap in ratio	<p>2 extra patients for the full census period day and night</p> <p>5.46 WTE are stroke bleep holders Stroke referral is usually 344 for month of January averaging approx. 11 a day, CNS accompanies patient to scanning Stroke coordinator/SNAp coordinator Band 7 2x CNS in budget but not on daily rota.</p> <p>Recommend – CSW vacancies to be approved through exec VAR, 8 x CSW vacancies but holding 4 for novices CSWs on an apprenticeship programme presently</p>	<p>CSW vacancies approved – not related to this specific review.</p> <p>Review parity of workload for the Lead Nurse, currently responsible for 3 areas, and consider how the stroke Clinical Nurse Specialists can support.</p> <p>No other changes agreed.</p>
CCU	Increase of CSW on both PCCU & CCU, night shift	<p>The initial data captured cath lab and cardiac day case unit this equivalent to 2 WTE RN band 5/CSW 1 WTE. Demand and capacity modelling required for the cath lab and day case, this will form part of the biosense proposal.</p> <p>Matron will review rota for weekend mitigation</p> <p>Recommend – CSW 2 WTE on both PCCU/CCU at night</p>	Same outcome applies as stated for AMU 1.
MECU	Team would like to have a Nurse in charge	<p>Funded for 8 beds (6 and 2 side rooms), increase to 9 at times commence treatment pathways prior to transfer to C5 Poor visibility of side rooms</p> <p>RCN recommended guidance for level 1 facility 1:4 plus NIC</p> <p>NCEpod guidance 1:2 for patients on acute NIV</p>	Agreed with no change.

Area	Ward/Department Request/Amendments	Divisional Chief Nurse (DCN) Outcome of Divisional Confirm and Challenge	Chief Nurse Outcome of Professional discussion with Divisional CNs
		Recommend – Team would like their nurse in charge restored but Division feels in this climate no changes recommended	
FMNU	none	Working with admiral nurse to help with clinical supervision and reflective practise and building relationships with Holyrood at Bushey fields to help staff understand complexity of MH disease in this patient group Standalone unit with makes it difficult to benchmark staffing Dementia UK recommends there should be stimulation activities, matron is happy that current staffing levels can provide this. Recommend – no changes	Agreed with no change.
DL	Increase RN to 3 when operating as a discharge lounge/ Plans have to be made to push establishment up to B6 equivalent during winte pressure bedding	Currently funded as a discharge lounge: 1RN 1CSW Sat/Sunday 2RN 2CSW Monday to Friday However, it has been an inpatient ward since November 2023 Lead nurse supports c8, DL and surge that is 96 beds (not compliant with RCN guidance) Recommendation: Need to have a staffing establishment in place as reliance on Bank is not feasible Plan to restore DL to original state, only one RN on weekend shifts so makes checking drugs difficult	Reinstatement as a Discharge Lounge to be achieved.
ED	Consider the impact of the resus build	The data showed a decrease of staff, but the geographical location hinders the best of resources. Patients in the waiting room requiring treatment and at busy times patients can be exceed 12 hrs waits during which time in care and treatment from nursing care is given. Complex safeguarding referrals. Recommendation – no changes no, however the need to consider the resus redesign and increase in triage and sepsis targets	Agreed with no change.
ED paed	Change to template to provide 24/7 Band 7 cover	Need to consider seasonal adjustments. Paediatrics and reflect this in staffing data in the winter months attendances will be higher due to respiratory illnesses. During the summer months we will see more minor injuries. The turnover and throughput in Paediatric ED vary depending on the time of day, tend to get busy after school times. 135 SG referrals in Jan Datix trends assault at school, mental health overdose, minor injuries.	Paediatric ED – skill mix change from Band 6 to 7 to ensure that there is 24/7 senior nursing presence in this area across all shifts and to enable attraction of a stronger calibre of workforce:

Area	Ward/Department Request/Amendments	Divisional Chief Nurse (DCN) Outcome of Divisional Confirm and Challenge	Chief Nurse Outcome of Professional discussion with Divisional CNs
		<p>Recommendation - amend the template from Band 6 to 7 due to difficulties with recruiting into Band 6 posts.</p> <p>Band 6 vacant posts (2.73 WTE) to Band 7. This means that the number of nursing hours would reduce by 14.5 hours per week, but that would be covered by the lead nurse. In effect, it is the lead nurse supervisory role that would reduce from the current 37.5 down to 23 hours per week. This change is supported by the Divisional Chief Nurse (interim) and the deputy matron would provide additional support with supervisory duties.</p>	<p>-There are currently 2.73 WTE Band 6 twilight shifts which despite extensive efforts have not been recruited into. It is proposed that these posts would be converted into Band 7 posts and the change managed within the existing financial envelope. It is felt that if offered as a Band 7, this would attract more suitable individuals and ensure senior nursing cover across all shifts.</p> <p>-PAU and paediatric ED co-location needs to be expedited prior to any further workforce changes being considered.</p>
SS		<p>Open to 26 patients, 28-day census with predominately bank staff. Redeployed to surge: Band 4 from c7 Band 4 from c5 Band 5 from c3, Band 2 from FMN No budget for this temporary ward area.</p> <p>Recommend - establishment is completely reliant on bank – area needs to close</p>	Area now closed as super surge.

All, apart from two (C2/PAU and Paediatrics ED) recommended establishment changes, would require a business case to support them. The review has also highlighted there is wider work which is ongoing looking at the location of current specialities, in particular B6 and C6 relocation and Paediatric ED and PAU co-location. As this would be cross divisional, a collaborative approach is being taken to progress this work further.

	Ward/department request, /amendments	Divisional Chief Nurse (DCN) Outcome of divisional confirm and challenge	Chief Nurse Outcome of confirm and challenge
Operating Theatres	<p>As a whole theatres are not over established as these are not accounted in the financial templates. Double cavity cases difficult to predict frequency as cancer cases majority and list planning does not account for this.</p> <p>Podiatry now take place at RHH and is not part of the established Theatre template (3hrs Tuesday & Thursday. Full theatre team required).</p> <p>Ophthalmology Wednesday as above (all evening lists).</p> <p>Vascular Tuesday evening list booth surgeon & anaesthetist are templated theatre are not.</p> <p>Frequent all day elective obs lists all day list increased to 9hrs from templated 4.5hrs every Wednesday and ad hoc according to need. High C-section rate in area 44%.</p> <p>Bi-weekly major cases involving two or three teams, depending on points of surgery these often continue to 23:00hrs. Example week beginning 17/03/2025 surgeon predicting a 23:00 finish.</p> <p>All Weekend operating outside of emergencies are currently WLI due to not being templated as are majority of evening sessions. (please see theatre planner for extra detail).</p> <p>Robot theatre staffing requires a 5-member team along with Monday, Thursday Friday for complex urology cases finance aware but advised continue at cost pressure.</p> <p>Ophthalmic list require with high throughput Over 5 cataracts require extra staff member for productivity and safety.</p> <p>Day case RHH Recovery and anaesthetics merged with RHH Main A&R finance aware. Dual skilled staff are used to flex into different areas and skill requirements including scrub. Band 7 workforce includes a number of staff with reduced hours due to retire rehire and hrs not backfilled.</p>	<p>Discussion was held between the Matron and Deputy Chief Nurse.</p>	<p>Agreed with no change.</p>

	<p>Starred ODP not templated but acknowledged as best practice and requirement for ACSA accreditation.</p> <p>Paediatric MRI list requiring ODP, CSW & Recovery.</p> <p>GI propofol list requiring ODP & Recovery.</p> <p>Future GA in endoscopy requiring ODP and Recovery.</p> <p>Band 7 staff complete at least 1 clinical shift per week.</p> <p>Matron & deputy Matron both complete clinical shifts as part standard duties.</p> <p>Rostering Team both complete clinical shifts as part standard duties.</p> <p>AfPP guidelines dictate safer staffing numbers required for any given list or situation.</p> <p>Recommendation - no changes to the establishments</p>		
Neonates	<p>Since the data collection, NNU are now- 90% equates BAPM, which equates to 9 x RNs/shift which has now been approved by execs.</p> <p>Band 6 line includes NCOT team and 1 x Band 6 educator as well as clinical Band 6 and Band 7 line includes Band 7 NCOT lead and Band 7 Educator</p> <p>Recommendation - no changes to the establishments</p>		Business case approved to ensure BAPM compliance.
ICU	<p>Due to footprint we struggle to cohort wardable patients and often care for them on 1:4 ratios. Based on our level 3 equivalent commissioned capacity at 15, level 3 and footprint. We also have 3 SN in charges (as per GPICS V2.1) so establishment is to 18 X RNs/shift. The budget also includes the CCOT service (1 RN 24/7) and 1 X WTE rehab nurse.</p> <p>Recommendation - no changes to the establishments</p>		Agreed with no change.

11. RISKS

Data quality

The tool asks for data to be collected for 30 days at the prescribed time and by a maximum of 3 collectors each day. Throughout our review there has been significant improvement of the data captured in this period. The only exception was Paediatric ED as the data did not provide a full 24 hrs overall sample of the department, so this data collection was repeated to ensure an accurate reflection of the department. Where we need to improve the tool as it states that a maximum 3 of the most senior ward staff, including the ward manager should identify the patient acuity, this wasn't the case in some wards and a variety of staff completed the data collection.

Jan 25	Data days collected (?/30)	Weekly QA numbers (?/4)		Jan 25	Data days collected (?/30)	Weekly QA numbers (?/4)		Jan 25	Data days collected (?/30)	Weekly QA numbers (?/4)
AMU1	30	3		B6	29	4		C7	30	3
AMU2	29	4		C1A	29	4		C8	27	4
AMU3 (A4)	30	4		C1B	29	4		CCU	29	4
AMUA	30	3		C2	30	3		DL	27	3
B1	30	4		C3	30	4		ESH	29	3
B2H	30	4		C4	30	3		MECU	30	2
B2T	30	4		C5A	30	4		FMU	39	4
B3	30	4		C5B	30	3		ED Adults	23/24	1/2
B4	29	4		C6	29	3		ED Paeds	24/24	1/2
SS	28	4								

The quality assurance process was followed with most areas being reviewed over 50% of the required ask.

Jan 25	Beds	Recommended WTE (Reg)	Recommended WTE NR	Recommended Overall Total	Funded Budget	Diff FB is to Rec Over	Ward Profile Document WTE
AMU1	34	51.66	20.09	69.59	79.45	9.86	-2.54
AMU2	30	52.3	22.45	74.72	59	-15.72	-0.83
AMU3 (A4)	12	19.94	8.54	28.48	24.57	-3.91	-1.46

AMUA	22	25.61	10.94	36.58	61.06	24.48	-2.17
B1	26	19.91	8.53	28.45	30.58	2.13	1.16
B2H	24	30.7	11.94	42.64	50.86	8.22	-3.82
B2T	24	28.54	12.23	40.77	44.06	3.29	0.75
B3	36	47.47	20.35	67.82	66.16	-1.66	-3.05
B4	48	63.22	26.67	88.85	81.91	-6.94	-5.97
B6	16	21.15	9.06	30.22	25.57	-4.65	-1.49
C1A	24	33.48	14.35	47.83	38.9	-8.93	-0.54
C1B	24	36.3	14.12	50.41	38.9	-11.51	-0.54
C2	47	37.9	19.6	57.2	59.31	2.11	-1.7
C3	36	68.1	29.19	97.29	60.29	-37	-0.47
C4	24	18.98	8.48	27.11	40.48	13.37	-1.35
C5A	24	34.04	14.59	48.63	42.3	-6.33	2.19
C5B	24	37.34	14.52	51.87	50.49	-1.38	-1.54
C6	19	16.58	7.1	23.68	33.68	10	-3.31
C7	36	46.45	19.91	66.36	67.33	0.97	-0.19
C8	44	48.68	20.86	69.54	87.04	17.5	-2.59
CCU	24	27.81	11.92	39.72	56.85	17.13	0
DL	16	20.77	8.9	29.68	10.85	-18.83	-13.84
ESH	26	44.42	19.04	63.45	73.92	10.47	-5.25
MECU	8	11.3	4.84	16.15	22.52	6.37	-0.54
FMU	16	45.81	19.63	65.44	47.09	-18.35	-0.54
SS	24	29.29	12.55	41.84		-41.84	
ED Adults	-----	115.8	18.5	133.8	149.74	15.94	-0.8
ED Paeds	-----	20	8.6	28.6	35.43	6.83	-3.93

The use of professional judgements remains subjective, however has been extremely important with the understanding as to the differences in recommendations between the tools and the actual of the current establishments. The interpretation of the data available is also subjective however it is felt that the scrutiny and wider understanding of the information by the Chief Nurse, Deputy Chief Nurse and Associate Deputy Chief Nurse has been able to support the Divisional Chief Nurses interpretation.

Due to how the data is made available and the need for collation, there has been a significant amount of transcription of information undertaken. This ranges from the need and necessity of the tool requirements to the manual collation of the information from the data collection. This has all had to be manually collated and inputted which increases the risk of transcription and human error. Where possible all data transcription has been double checked and any formulas used within software packages has also been reviewed. Divisional Chief Nurses have also been asked to ensure the data reflects their knowledge and wider narrative.

12. NEXT STEPS

The proposed next steps are as follows:

- Executive Team, Quality Committee and People Committee to discuss, consider and provide view on the outcome and recommendations of the review.
- Further data collection and review to be undertaken in line with national guidance and Black Country system plan.
- Further training sessions to be made available in May 2025 before the next data collection is undertaken.
- Ensure 3 named staff are identified for the next review per department to ensure a consistent approach to data collection.
- Work with colleagues in Operating Theatres, Neonates and critical care to ensure the professional judgement element is completed in the next review.

APPENDICES

Trust Compliance with Safer Nursing Care Tool Red Rules - Appendix 1

	SNCT Red Rule	January 2025 Compliance	RAG		SNCT Red Rule	January 25 Compliance	RAG
AIP AAU CYP ED	Nominate a senior registered nursing lead to quality control the data collection, process and outputs. This will include data collection timeframes, training records, external validation rotas, data analysis and dissemination of results. This should be a senior member of the corporate nursing team.	Philippa Brazier Assoicate Deputy Chief Nurse		AIP AAU CYP ED	Ensure a training and education process is in place, on how to implement the SNCT in practice encompassing and inter-rater reliability assessment and ongoing refresher training. Up to date and accessible training records must be maintained and held at trust level.	Numerous training sessions facilitated throughout the month leading up to the data collection month and throughout the data collection month. Further dates have been planned and in place for the next review. Training records are stored on a central Teams folder which is accessible the Division Chief nurses, their deputies and the corporate team.	
AIP AAU CYP	Identify no more than 3 leads per ward to complete the scoring daily for the duration of the data collection period.	Clear instructions were given to the ward teams. The collated data sets support a maximum of 3 people in ward collected data each day		AIP AAU CYP ED	The data collection should take place a minimum of twice per year to allow incorporation of variation within the year. The average combined data sets are used to support establishment setting/resetting.	Agreed across the Black Country Provider Collaborative that data collection will take place every June and January	
ED	Identify a sufficient cohort if leads/shift leaders in the department to complete the scoring twice daily for the duration of the data collection period						

AIP AAU CYP ED	The three leads must include the Ward manager. If no Ward Manager is available a nominated member of staff should be agreed with the senior nurse for the Directorate/Division	Clear instructions were given to the ward teams, that the Lead Nurse and if not available the NIC should be one of the 3 people.		AIP AAU	During data collection periods, every patient needs to have a level of care recorded daily for a minimum of 30 days using the decision matrix measuring the patient care required/received retrospectively for the previous 24 hours.	Data collected as directed at 15:00 each day. ED data collected at the prescribed hours.	
				CYP	During data collection periods, every patient needs to have a level of care recorded daily for a minimum of 20 days using the decision matrix measuring the patient care required/received retrospectively for the previous 24 hours.		
				ED	Acuity and dependency data should be collected for each patient in the department at the set twice daily intervals.		
AIP AAU	Data collection should be undertaken over 30 consecutive days and be undertaken by appropriately trained and assessed staff.	AIP, AAU and CYP areas collected data for the entire month of June. ED collected data for 14 days.		AIP AAU CYP ED	Acuity and dependency data should be collected for each patient in each bed at the same agreed time, as part of a bed ward round.	As above for all areas/	
CYP	Data should be collected for a minimum of 20 days						
ED	Data should be recorded on every patient present in the department for a total of 12 days minimum.						

AIP AAU CYP ED	External validation is conducted weekly with the designated ward nurse as part of the daily ward round by a senior nurse outside of the ward's budgetary responsibility	Rota plan created and disseminated for the QA areas.		AIP AAU CYP ED	Nurse sensitive indicators/quality outcomes data for the same timeframe are to be collected retrospectively by a senior nurse or directly pulled from the electronic incident reporting system	Data collated from the central systems where possible. Datix, Allocate safecare and Sunrise being the main ones. These were collated by the Corporate team and reviewed by the leading Deputy Chief Nurse.	
AIP AAU CYP ED	Ensure the senior nurses undertaking the external validation has been appropriately trained and assessed.	All asked to undertake the training and the AIP assessment. Cross referencing this		AIP AAU CYP ED	Results should be provided to Ward Managers, Matrons, Heads of Departments Directors of nursing as soon as possible	All results were available to the Lead Nurse, Matron, Deputy Divisional Chief Nurse, Divisional Chief Nurse, HR Business Partner, Finance Business Partner, Trust Deputy Chief Nurses and Trust Chief Nurse by 14 th February 25	
				AIP AAU CYP ED	These results should be reviewed within your biannual establishment setting process in line with the National Quality Board and Developing Workforce Safeguards guidance.	Challenge conversations within the divisions was undertaken in March 25	

AIP – Adult Inpatient

AAU – Adult Assessment Unit

CYP – Children & Young People

ED – Emergency Department

Data Collection Output At a Glance - Appendix 2a

Jan-25	Beds	Acuity 0	Acuity 1a	Acuity1b	Acuity1c	Acuity1d	Acuity2	Acuity3	Acuity BE	Data days collected (?/30)	Weekly QA numbers (?/4)	No safeguarding	No Falls	No PU	Covid 19	Norovirus	CDI	E Coli	MRSA	Observations post target			Medicines Late/Unplanned omission		RN/CSW%	Recommended WTE (Reg)	Recommended WTE NR	Recommended Overall Total	Funded Budget - June 24	Funded budget Jan 25
																					L	M	H	Late	Unplanned Omission					
AMU 1	34	1.46	14.70	9.16	1.20	0.06	7.40	0.00	0.00	30	3	1	2	2	0	2	0	0	0	2725	219	158	182	2682	60/40	51.66	20.09	69.59	79.98	79.45
AMU2	30	1.17	16.27	12.68	3.58	0.00	1.06	0.00	0.00	29	2	0	8	5	0	1	2	0	0	3012	136	45	203	2189	55/45	52.3	22.45	74.72	59.16	59
AMU3 (A4)	12	0.33	5.66	4.96	0.23	0.66	0.00	0.00	0.73	30	3	0	3	3	0	2	0	0	0	1119	17	14	59	741	50/50	19.94	8.54	28.48	24.03	24.57
AMUA	22	5.00	7.53	6.40	0.30	0.00	0.13	0.00	0.63	30	3	0	0	0	1	0	2	0	0	1758	50	21	111	1829	55/45	25.61	10.94	36.58	63.23	61.06
B1	26	11.44	5.55	2.86	0.03	0.00	0.00	0.00	4.68	30	3	0	1	2	0	0	0	0	0	1166	3	1	546	1138	60/40	19.91	8.53	28.45	31.86	30.58
B2H	24	3.78	0.21	17.46	1.28	0.00	0.00	0.00	0.21	30	4	0	4	6	0	0	0	1	0	2080	26	10	486	2453	40/60	30.7	11.94	42.64	48.69	50.86
B2T	24	5.86	0.26	15.56	1.23	0.00	0.00	0.00	0.03	30	3	1	9	10	0	0	0	0	0	2152	24	3	437	1071	50/50	28.54	12.23	40.77	42.06	44.06
B3	36	3.46	1.80	25.66	2.06	0.00	1.90	0.00	0.10	30	4	1	10	17	0	0	0	0	0	3431	34	5	452	2823	55/45	47.47	20.35	67.82	65.82	66.16
B4	48	2.93	11.72	24.96	3.72	0.31	2.24	0.00	0.10	29	4	1	5	16	0	0	0	0	0	3330	34	4	189	3633	50/50	63.22	26.67	88.85	84.84	81.91
B6	16	5.82	1.27	5.34	2.89	0.00	0.00	0.00	0.55	29	4	0	2	4	0	14	0	0	0	1562	8	2	117	1092	55/45	21.15	9.06	30.22	25.52	25.57
C1A	24	2.34	0.58	17.93	2.44	0.00	0.00	0.00	0.68	29	3	0	4	4	0	0	1	0	0	2107	82	29	145	1237	50/50	33.48	14.35	47.83	42.24	38.9
C1B	24	2.31	2.13	18.13	0.10	0.00	0.00	0.00	0.68	29	4	0	2	1	0	0	0	1	0	2112	44	13	414	1646	50/50	36.3	14.12	50.41	42.24	38.9
C2	47	26.66	1.06	1.26			0.43	0.03	12.53	30	3	2	0	1	0	0	0	0	0	1158	299	45			80/20	37.9	19.6	57.2	53.51	59.31
C3	36	3.43	0.00	16.86	14.63	0.00	0.06	0.00	0.03	30	4	0	6	2	0	1	1	0	0	2647	27	8	154	2612	55/45	68.1	29.19	97.29	60.76	60.29
C4	24	4.33	13.13	2.93	0.40	0.00	0.03	0.00	0.16	27	4	0	2	4	1	0	0	0	0	1707	113	19	118	946	70/30	18.98	8.48	27.11	42.19	40.48
C5A	24	2.30	9.03	6.96	3.96	0.56	0.00	0.00	0.50	30	3	0	7	3	0	0	0	0	0	2439	72	51	315	1252	60/40	34.04	14.59	48.63	41.15	42.3
C5B	24	2.31	2.13	18.75	0.10	0.00	0.00	0.00	0.68	30	3	0	1	6	1	1	0	0	0	2400	130	90	282	1507	55/45	37.34	14.52	51.87	51.94	50.49
C6	19	11.24	0.20	6.48	0.00	0.00	0.00	0.00	0.06	29	3	1	2	0	0	0	0	0	0	1629	27	13	155	1823	50/50	16.58	7.1	23.68	33.01	33.68
C7	36	5.46	7.90	20.16	2.66	0.00	0.06	0.00	1.70	30	3	1	3	7	0	0	0	0	0	3482	46	24	188	2577	50/50	46.45	19.91	66.36	66.93	67.33
C8	44	8.55	5.03	27.04	1.62	0.00	1.03	0.00	0.29	27	4	0	10	7	0	0	0	0	0	4117	88	50	409	3380	55/45	48.68	20.86	69.54	91.8	87.04
CCU	24	3.37	12.31	7.13	0.41	0.00	2.06	0.00	0.48	29	3	0	4	11	0	0	0	0	0	874	12	1	384	856	80/20	27.81	11.92	39.72	52.1	56.85
DL	16	2.37	0.40	13.14	0.11	0.00	0.00	0.00	1.51	27	3	0	5	7	0	0	1	0	0	1090	5	0	125	865	60/40	20.77	8.9	29.68	25.3	10.85
ESH	26	15.24	11.48	7.79	0.37	0.00	0.13	0.00	1.96	29	4	1	1	2	0	0	0	2	0	3078	73	46	687	3013	70/30	44.42	19.04	63.45	69.58	73.92
MECU	8	0.36	1.06	2.16	0.20	0.00	2.76	0.03	2.40	30	3	0	2	1	0	0	0	0	0	296	5	3	58	517	75/25	11.3	4.84	16.15	23.18	22.52
FMU	16	0.10	0.03	4.10	10.70	1.43	0.00	0.00	0.63	30	3	0	3	5	0	0	0	0	0	1131	5	3	34	923	30/70	45.81	19.63	65.44	49.34	47.09
Surge	26	7.71	0.46	17.03	0.00	0.00	0.00	0.00	1.42	28	4	0	0	1	0	0	1	0	0				231	1354	70/30	29.29	12.55	41.84		
ED Adults	-----	120.00	18.00	27.00	16.00		5.00	3.00		23/24	1	0			10	0	3	19	0	446	443	284	32	346	60/40	115.8	18.5	133.8	164.19	149.74
ED Paeds	-----	5.58	2.45	0.91	0.00		0.08	0.00	13.91		1	0	0		1	0	0	0	0	21	15	8			50/50	20	8.6	28.6	35.43	35.43

Data Collection Output At a Glance - Appendix 2b

Jan-25	Beds	Acuity0	Acuity1a	Acuity1b	Acuity1c	Acuity1d	Acuity2	Acuity3	Acuity BE	Data days collected (?/30)	Weekly QA numbers (?/4)	Recomm ended WTE (Reg)	Recomm ended WTE NR	Recomm ended Overall Total	Funded Budget - June 24	Funded budget Jan 25	Diff FB is to Recc Over	Ward Profile Document WTE	Change requested WTE
AMU 1	34	1.46	14.70	9.16	1.20	0.06	7.40	0.00	0.00	30	3	51.66	20.09	69.59	79.98	79.45	9.86	-2.54	
AMU2	30	1.17	16.27	12.68	3.58	0.00	1.06	0.00	0.00	29	2	52.3	22.45	74.72	59.16	59	-15.72	-0.83	↑ RN at night
AMU3 (A4)	12	0.33	5.66	4.96	0.23	0.66	0.00	0.00	0.73	30	3	19.94	8.54	28.48	24.03	24.57	-3.91	-1.46	↑ band 7 - lead
AMUA	22	5.00	7.53	6.40	0.30	0.00	0.13	0.00	0.63	30	3	25.61	10.94	36.58	63.23	61.06	24.48	-2.17	
B1	26	11.44	5.55	2.86	0.03	0.00	0.00	0.00	4.68	30	3	19.91	8.53	28.45	31.86	30.58	2.13	1.16	
B2H	24	3.78	0.21	17.46	1.28	0.00	0.00	0.00	0.21	30	4	30.7	11.94	42.64	48.69	50.86	8.22	-3.82	
B2T	24	5.86	0.26	15.56	1.23	0.00	0.00	0.00	0.03	30	3	28.54	12.23	40.77	42.06	44.06	3.29	0.75	
B3	36	3.46	1.80	25.66	2.06	0.00	1.90	0.00	0.10	30	4	47.47	20.35	67.82	65.82	66.16	-1.66	-3.05	
B4	48	2.93	11.72	24.96	3.72	0.31	2.24	0.00	0.10	29	4	63.22	26.67	88.85	84.84	81.91	-6.94	-5.97	
B6	16	5.82	1.27	5.34	2.89	0.00	0.00	0.00	0.55	29	4	21.15	9.06	30.22	25.52	25.57	-4.65	-1.49	↑ CSW day/night
C1A	24	2.34	0.58	17.93	2.44	0.00	0.00	0.00	0.68	29	3	33.48	14.35	47.83	42.24	38.9	-8.93	-0.54	↑ CSW to reduce bank costs
C1B	24	2.31	2.13	18.13	0.10	0.00	0.00	0.00	0.68	29	4	36.3	14.12	50.41	42.24	38.9	-11.51	-0.54	complete PDSA and cost up effectively
C2	47	26.66	1.06	1.26			0.43	0.03	12.53	30	3	37.9	19.6	57.2	53.51	59.31	2.11	-1.7	
C3	36	3.43	0.00	16.86	14.63	0.00	0.06	0.00	0.03	30	4	68.1	29.19	97.29	60.76	60.29	-37	-0.47	↑ addiional CSW day/night
C4	24	4.33	13.13	2.93	0.40	0.00	0.03	0.00	0.16	27	4	18.98	8.48	27.11	42.19	40.48	13.37	-1.35	
C5A	24	2.30	9.03	6.96	3.96	0.56	0.00	0.00	0.50	30	3	34.04	14.59	48.63	41.15	42.3	-6.33	2.19	
C5B	24	2.31	2.13	18.75	0.10	0.00	0.00	0.00	0.68	30	3	37.34	14.52	51.87	51.94	50.49	-1.38	-1.54	
C6	19	11.24	0.20	6.48	0.00	0.00	0.00	0.00	0.06	29	3	16.58	7.1	23.68	33.01	33.68	10	-3.31	
C7	36	5.46	7.90	20.16	2.66	0.00	0.06	0.00	1.70	30	3	46.45	19.91	66.36	66.93	67.33	0.97	-0.19	
C8	44	8.55	5.03	27.04	1.62	0.00	1.03	0.00	0.29	27	4	48.68	20.86	69.54	91.8	87.04	17.5	-2.59	
CCU	24	3.37	12.31	7.13	0.41	0.00	2.06	0.00	0.48	29	3	27.81	11.92	39.72	52.1	56.85	17.13	0	↑ CSW on night for both PCCU/CCU
DL	16	2.37	0.40	13.14	0.11	0.00	0.00	0.00	1.51	27	3	20.77	8.9	29.68	25.3	10.85	-18.83	-13.84	↑ RN weekend, back to a discharge lounge ,
ESH	26	15.24	11.48	7.79	0.37	0.00	0.13	0.00	1.96	29	4	44.42	19.04	63.45	69.58	73.92	10.47	-5.25	
MECU	8	0.36	1.06	2.16	0.20	0.00	2.76	0.03	2.40	30	3	11.3	4.84	16.15	23.18	22.52	6.37	-0.54	
FMU	16	0.10	0.03	4.10	10.70	1.43	0.00	0.00	0.63	30	3	45.81	19.63	65.44	49.34	47.09	-18.35	-0.54	
Surge	26	7.71	0.46	17.03	0.00	0.00	0.00	0.00	1.42	28	4	29.29	12.55	41.84			-41.84		no, establishment plan to close this ward
ED Adults	-----	120.00	18.00	27.00	16.00		5.00	3.00		23/24	1	115.8	18.5	133.8	164.19	149.74	15.94	-0.8	need to consider resus redesign
ED Paeds	-----	5.58	2.45	0.91	0.00		0.08	0.00	13.91		1	20	8.6	28.6	35.43	35.43	6.83	-3.93	amend the template as planned to include the band 7 staff

Safer Nursing Care Tool Decision Matrix Adult Inpatient and Adult Acute Assessment Units- Appendix 3

Safer Nursing Care Tool (SNCT)

Care level	Descriptor
	<i>Care requirements may include the following:</i>
Level 0 Hospital Inpatient Needs met by provision of normal ward cares.	<ul style="list-style-type: none"> Underlying medical condition requiring on-going treatment. Post-operative / post-procedure care - observations recorded as per local policy. National Early Warning Score (NEWS) is within normal threshold. Patients requiring oxygen therapy. Patients not requiring enhanced therapeutic observations (according to local policy). Patients requiring assistance of one with some activities of daily living.
Level 1a Acutely ill patients requiring intervention or those who are UNSTABLE with a GREATER POTENTIAL to deteriorate.	<ul style="list-style-type: none"> Step down from Level 2 care. Requiring continual observation / invasive monitoring/physiological assessment. NEWS local trigger point reached and requiring intervention/action/review. Pre-operative optimisation/post-operative care for complex surgery. Requiring additional monitoring/clinical interventions/clinical input including: <ul style="list-style-type: none"> Patients at risk of a compromised airway Oxygen therapy greater than 35%, + / - chest physiotherapy 2–6 hourly or intermittent arterial blood gas analysis Post 24 hours following insertion of tracheostomy, central lines, epidural or multiple chest drains Severe infection or sepsis New spinal injury/cord compression
Level 1b Patients who are in a STABLE condition but are dependent on nursing care to meet most or all of their care needs.	<ul style="list-style-type: none"> Complex wound management requiring more than one nurse or takes more than one hour to complete. Patients with stable Spinal/Spinal Cord Injury. Patients who consistently require the assistance of two or more people with mobility or repositioning. Requires assistance with most or all care needs. Complex Intravenous Drug Regimes – (including those requiring prolonged preparatory/administration/post-administration care). Patient and/or carer's requiring enhanced psychological support owing to poor disease prognosis or clinical outcome. Patients requiring intermittent or within eyesight observations according to local policy. Facilitating a complex discharge where this is the responsibility of the ward-based nurse.
Level 1c Patients who are in a STABLE condition but are requiring additional intervention to mitigate risk and maintain safety	<ul style="list-style-type: none"> Patients requiring arm's length or continuous observation as per local policy.

Care level	Descriptor
	<i>Care requirements may include the following:</i>
Level 1d Patients who are in a STABLE condition but are requiring additional intervention to mitigate risk and maintain safety	<ul style="list-style-type: none"> Patients requiring arm's length or continuous observation by 2 or more members of staff (provided from within ward budget) as per local policy.
Level 2 Patients who may be managed within clearly identified, designated beds with the resources, expertise and staffing levels required OR may require transfer to or be cared for in a dedicated Level 2 facility/unit.	<ul style="list-style-type: none"> Deteriorating / compromised single organ system. Step down from Level 3 care or step up from Level 1a. Post-operative optimisation/ extended post-op care. Cardiovascular, renal or respiratory optimization requiring invasive monitoring. Patients requiring non-invasive ventilation/respiratory support; CPAP/BiPAP in acute respiratory failure. First 24-hours following tracheostomy insertion or patients post 24-hours requiring 2-hourly suction. CNS depression of airway and protective reflexes. Patients with burns where more than 30% body surface area is affected or requiring conscious sedation for dressing changes. Requires a range of therapeutic interventions which may include: <ul style="list-style-type: none"> Greater than 50% oxygen continuously Requiring close observation due to acute deterioration and needing advanced organ support Drug Infusions requiring more intensive monitoring e.g. vasoactive drugs (amiodarone, inotropes, gtn) or potassium, magnesium CNS depression of airway and protective reflexes Invasive neurological monitoring including ICP, external ventricular drains and lumbar drains
Level 3 Patients needing advanced respiratory support and/ or therapeutic support of multiple organs.	<ul style="list-style-type: none"> Monitoring and supportive therapy for compromised/collapse of two or more organ/ systems. Respiratory or CNS depression/compromise requires mechanical/invasive ventilation. Invasive monitoring, vasoactive drugs, treatment of hypovolaemia/haemorrhage/ sepsis or neuro protection.

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Safer Nursing Care Tool Decision Matrix Children and Young People - Appendix 4

The Children's & Young People's Safer Nursing Care Tool - Decision Matrix

The Children's & Young People's Safer Nursing Care tool (C&YP SNCT) is based upon, but not aligned to, the Paediatric Intensive Care Society classifications (Paediatric Intensive Care Society 2010). These classifications have been adapted to support measurement across a range of C&YP wards/specialties.

Children's & Young Peoples Safer Nursing Care Tool - Decision Matrix

Levels of Care	Descriptor
Level 0 Child/young person requires hospitalisation - needs met through normal inpatient care	Care requirements may include the following <ul style="list-style-type: none"> Oxygen therapy less than 40% and patient stable May have underlying medical condition requiring on-going treatment Patients awaiting discharge Post-operative/post-procedure care – observations recorded half hourly initially then 4-hourly. Regular observations 2 – 4 hourly Basic fluid Management Intravenous Medication Regimes – (NOT requiring prolonged preparation/administration/post-administration care) Early Warning Score is within normal threshold.
Level 1a Child /young person is acutely ill requiring close supervision and monitoring, or is unstable with a greater potential to deteriorate usually available through normal inpatient care	Care requirements may include the following <ul style="list-style-type: none"> Oxygen therapy greater than 40% +/- Chest Physiotherapy six hourly Respiratory care requiring two hourly nebulised medicine Stable nasopharyngeal airway Post op care following complex trauma/surgery in acute phase Patient within 24 hour of returning from PICU/ICU Instability requiring increased level of observation and therapeutic intervention or continual observation Patient on PCA/NCA/Epidural Emergency Admissions requiring immediate therapeutic intervention. Early Warning Score - trigger point reached and requiring escalation.

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Levels of Care	Descriptor
Level 1b Child/young person is stable but dependent on nursing care interventions/intensive therapy to meet most or all their care.	Care requirements may include the following <ul style="list-style-type: none"> Unaccompanied children Established High Humidity, High Flow Nasal Cannula (HHFNC) Recurrent apnoea-self resolving Stable patient requiring two hourly blood sampling Post op care following complex trauma/surgery in rehab phase Complex wound management requiring more than 1 nurse or takes more than 1 hour to complete. Spinal Instability/Spinal Cord injury – rehab phase Mobility or repositioning difficulties requiring two staff Complex Intravenous Drug Regimes – (including those requiring prolonged preparation/administration/post-administration care) Patient and/or carers requiring enhanced psychological support due to poor disease prognosis or clinical outcome or high level of emotional support End of life care Confused children/young people who are at risk or requiring constant supervision Potential for self-harm and requires constant observation Facilitating a complex discharge where this is the responsibility of the ward-based nurse High level Safeguarding input Tracheostomy – post seven-days.
Level 2 Child/young person who may require closer observation & monitoring than is usually available through normal inpatient care.	Care requirements may include the following <ul style="list-style-type: none"> CPAP/ BiPAP Unstable nasopharyngeal airway Tracheotomy- initial seven days Instability requiring a range of therapeutic interventions and invasive monitoring Respiratory care requiring IV therapy Unstable diabetic ketoacidosis Single organ monitoring and support Exchange transfusions Chest drains Hypovolaemic/neurogenic shock Complex fluid +/- electrolyte management Glasgow coma scale 8-12 Prolonged seizures requiring intervention Recurrent apnoea requiring intervention Patients requiring NIV/respiratory support as a step down from level three care or acute illness phase
Level 3 Child/young person is unstable and requires advanced respiratory and therapeutic support for multiple organ problems.	Care requirements may include the following <ul style="list-style-type: none"> Monitoring and Supportive Therapy for Compromised/Collapse of two or more Organ/Systems Respiratory or CNS depression/compromise requires Invasive ventilation Children requiring advanced respiratory support whilst awaiting transfer i.e. PICU admission. CPAP/BiPAP Tracheotomy- initial seven days in a single room facility Active resuscitation Invasive monitoring, vasoactive drugs, treatment of hypovolaemia/haemorrhage/sepsis or neuro-protection Child/Young person receiving 1:1 nurse 'specialising'

Safer Nursing Care Tool Acuity Data- Appendix 5

Jan-25	Beds	Acuity 0	Acuity 1a	Acuity1b	Acuity1c	Acuity1d	Acuity2	Acuity3
AMU 1	34	1.46	14.70	9.16	1.20	0.06	7.40	0.00
AMU2	30	1.17	16.27	12.68	3.58	0.00	1.06	0.00
AMU3 (A4)	12	0.33	5.66	4.96	0.23	0.66	0.00	0.00
AMUA	22	5.00	7.53	6.40	0.30	0.00	0.13	0.00
B1	26	11.44	5.55	2.86	0.03	0.00	0.00	0.00
B2H	24	3.78	0.21	17.46	1.28	0.00	0.00	0.00
B2T	24	5.86	0.26	15.56	1.23	0.00	0.00	0.00
B3	36	3.46	1.80	25.66	2.06	0.00	1.90	0.00
B4	48	2.93	11.72	24.96	3.72	0.31	2.24	0.00
B6	16	5.82	1.27	5.34	2.89	0.00	0.00	0.00
C1A	24	2.34	0.58	17.93	2.44	0.00	0.00	0.00
C1B	24	2.31	2.13	18.13	0.10	0.00	0.00	0.00
C2	47	26.66	1.06	1.26			0.43	0.03
C3	36	3.43	0.00	16.86	14.63	0.00	0.06	0.00
C4	24	4.33	13.13	2.93	0.40	0.00	0.03	0.00
C5A	24	2.30	9.03	6.96	3.96	0.56	0.00	0.00
C5B	24	2.31	2.13	18.75	0.10	0.00	0.00	0.00
C6	19	11.24	0.20	6.48	0.00	0.00	0.00	0.00
C7	36	5.46	7.90	20.16	2.66	0.00	0.06	0.00
C8	44	8.55	5.03	27.04	1.62	0.00	1.03	0.00
CCU	24	3.37	12.31	7.13	0.41	0.00	2.06	0.00
DL	16	2.37	0.40	13.14	0.11	0.00	0.00	0.00
ESH	26	15.24	11.48	7.79	0.37	0.00	0.13	0.00
MECU	8	0.36	1.06	2.16	0.20	0.00	2.76	0.03
FMU	16	0.10	0.03	4.10	10.70	1.43	0.00	0.00
Surge	26	7.71	0.46	17.03	0.00	0.00	0.00	0.00
ED Adults	-----	120.00	18.00	27.00	16.00		5.00	3.00
ED Paeds	-----	5.58	2.45	0.91	0.00		0.08	0.00

Safer staffing summary report – Appendix 6

Date		January 2025																															
Safer Staffing Summary		Jan		Days in Month		31																											
Day RN		Day RN		Day CSW		Day CSW		Night RN		Night RN		Night CSW		Night CSW		RN Day %		CSW Day %		RN N %		CSW N %		Sum 24:00 Actual CHPPD									
Ward		Plan		Actual		Plan		Actual		Plan		Actual		Plan		Actual										Occ		Registered		Care staff		Total	
B1		127		101		63		59		62		62		51		49		79%		93%		100%		96%		418		4.43		2.96		7.39	
B2(H)		124		107		194		184		93		87		184		176		86%		95%		94%		96%		734		3.17		5.75		8.92	
B2(T)		124		109		131		114		93		82		115		106		88%		87%		88%		92%		725		3.16		3.64		6.80	
B3		194		185		205		173		186		179		173		164		95%		85%		96%		95%		1,185		3.61		3.41		7.02	
B4		226		182		267		197		187		178		212		185		80%		74%		95%		87%		1,309		3.23		3.50		6.72	
B5		253		215		175		143		243		222		111		102		85%		82%		91%		92%		1,136		4.71		2.53		7.24	
B6		97		72		80		45		63		58		82		74		74%		57%		92%		91%		492		3.09		2.92		6.02	
C1 A		126		131		147		111		93		90		118		112		104%		76%		97%		95%		736		3.51		3.63		7.14	
C1 B		129		124		136		122		93		90		99		90		95%		90%		97%		91%		736		3.40		3.37		6.77	
C2		283		232		64		70		249		225		63		62		82%		108%		90%		99%		556		9.65		2.79		12.43	
C3		217		226		433		370		187		176		417		400		104%		85%		94%		96%		1,605		3.01		5.64		8.65	
C4		209		165		74		63		125		92		68		75		79%		84%		74%		110%		675		4.45		2.35		6.80	
C5 A		121		106		171		106		93		93		142		133		87%		62%		100%		94%		740		3.26		3.87		7.13	
C5 B		162		151		130		102		155		150		101		93		93%		78%		97%		92%		732		4.84		3.20		8.03	
C6		97		89		99		79		93		85		72		68		92%		80%		91%		94%		574		3.57		3.08		6.65	
C7		218		166		194		179		156		147		189		178		76%		92%		94%		94%		1,097		3.35		3.91		7.25	
C8		259		246		226		181		217		200		186		171		95%		80%		92%		92%		1,324		3.95		3.19		7.13	
CCU_PCCU		256		238		70		47		218		214		40		31		93%		67%		98%		78%		768		6.91		1.21		8.13	
Critical Care		525		452		124		87		527		465						86%		70%		88%				540		20.37		1.93		22.30	
AMU		551		525		465		398		498		530		468		451		95%		86%		106%		96%		2,468		5.02		4.13		9.15	
Maternity		852		795		262		189		527		515		156		142		93%		72%		98%		91%		1,391		9.01		2.79		11.80	
MECU		93		91		34		27		93		92						98%		80%		99%				225		9.76		1.34		11.10	
NNU		389		258						268		225						66%				84%				314		18.40		0.00		18.40	
TOTAL		5,630		4,965		3,743		3,044		4,519		4,255		3,047		2,863		88%		81%		94%		94%		20,480		5.19		3.43		8.61	

Nursing Sensitive Indicators – January 25 - Appendix 7

Jan-25	No safeguarding	No Falls	No PU	Covid 19	Norovirus	CDI	E Coli	MRSA	Observations post target			Medicines Late/Unplanned omission	
									L	M	H	Late	Unplanned Omission
AMU 1	1	2	2	0	2	0	0	0	2725	219	158	182	2682
AMU2	0	8	5	0	1	2	0	0	3012	136	45	203	2189
AMU3 (A4)	0	3	3	0	2	0	0	0	1119	17	14	59	741
AMUA	0	0	0	1	0	2	0	0	1758	50	21	111	1829
B1	0	1	2	0	0	0	0	0	1166	3	1	546	1138
B2H	0	4	6	0	0	0	1	0	2080	26	10	486	2453
B2T	1	9	10	0	0	0	0	0	2152	24	3	437	1071
B3	1	10	17	0	0	0	0	0	3431	34	5	452	2823
B4	1	5	16	0	0	0	0	0	3330	34	4	189	3633
B6	0	2	4	0	14	0	0	0	1562	8	2	117	1092
C1A	0	4	4	0	0	1	0	0	2107	82	29	145	1237
C1B	0	2	1	0	0	0	1	0	2112	44	13	414	1646
C2	2	0	1	0	0	0	0	0	1158	299	45		
C3	0	6	2	0	1	1	0	0	2647	27	8	154	2612
C4	0	2	4	1	0	0	0	0	1707	113	19	118	946
C5A	0	7	3	0	0	0	0	0	2439	72	51	315	1252
C5B	0	1	6	1	1	0	0	0	2400	130	90	282	1507
C6	1	2	0	0	0	0	0	0	1629	27	13	155	1823
C7	1	3	7	0	0	0	0	0	3482	46	24	188	2577
C8	0	10	7	0	0	0	0	0	4117	88	50	409	3380
CCU	0	4	11	0	0	0	0	0	874	12	1	384	856
DL	0	5	7	0	0	1	0	0	1090	5	0	125	865
ESH	1	1	2	0	0	0	2	0	3078	73	46	687	3013
MECU	0	2	1	0	0	0	0	0	296	5	3	58	517
FMU	0	3	5	0	0	0	0	0	1131	5	3	34	923
Surge	0	0	1	0	0	1	0	0				231	1354
ED Adults	0			10	0	3	19	0	446	443	284	32	346
ED Paeds	0	0		1	0	0	0	0	21	15	8	26	26

Data Sources Supporting the Professional Judgement - Appendix 8

TOPIC	CONTENT
Complaints	All complaints received and summary of content
Falls	Number of falls per team extracted from incident management system
Medications	All late, missed or unexpected omitted medications
Safeguarding	Number of safeguarding referrals made per team
Pressure Ulcers	Number of pressure ulcers per team extracted from incident management system
Observations	Total number of observations and which were recorded early, on time or late
Red Flags	Number and reason for red flags raised in Safecare (e-rostering) per team
Professional Judgement	The records of all professional judgements recorded in Safecare per team
Ward attenders	The number of ward attenders per team
Patient Transfers / escorts	Number of patient transfers and escorts per team

Patient Acuity /Dependency Summary Sheet Schedule Emergency Department – Appendix 9

Jun-24																												
Day	Day 1		Day 2		Day 3		Day 4		Day 5		Day 6		Day 7		Day 8		Day 9		Day 10		Day 11		Day 12		Day 13		Day 14	
Time	00:00	12:00	01:00	13:00	02:00	14:00	03:00	15:00	04:00	16:00	05:00	17:00	06:00	18:00	07:00	19:00	08:00	20:00	09:00	21:00	10:00	22:00	11:00	23:00	00:00	12:00	01:00	13:00

Data Collection Theatres/NNC/Critical care – Appendix 10a

[illegible]

Data Collection Theatres/NNC/Critical care – Appendix 10b

Sum of WTE	Requirement vs Actua								
Unit	Unregistered	Registered	Grand Total	Comments					
Day Case Theatre Corbett Hospital	0.86	-6.01	-5.15	Shortfall in staff covered by movement of staff from other theatre areas and staff bank.					
RHH Day Case Theatre & Recovery	3.59	-1.00	2.60	Excess rostered staff utilised in other theatre and ward areas to accomodate shortfalls					
RHH Day Case Theatre Ward	-2.77	-2.94	-5.71	Shortfall in staff covered by movement of staff from allied theatre areas and staff bank.					
Theatres General, Urology, ENT & Plastics	-1.17	3.37	2.20	x1 Band 5 leaving trust x1 transferring to ward					
Theatres Obs, Gynae, Vascular & Emergency	1.99	-6.95	-4.96	x3 Band 5 positions allocated to ODP's when qualified currently under A&R					
Theatres Recovery and Anaesthetics	8.74	1.31	10.05	x9.74 WTE equivalence (x6.74 Band 2, x1 Band 3 & x2 Band 4) undergoing ODP Training funded by Trust					
Theatres T&O Dept	1.61	-0.33	1.28	x1 Band 2 TNA training funded by trust					
Grand Total	12.85	-12.54	0.31	Excess of 0.31 WTE in a total team of 224.4 WTE (0.14% over) 7.74WTE Unregistered staff currently undergoing ODP training					
Critical Care (inc. CCOT)	0.04	1.51	1.55	Staffing establishment based on 15 ICU beds. Significant Maternity leave ongoing and planned. Peak December 2024/January 2025 17%.					
Neonatal Unit	-3.94	-6.28	-10.22	Staffing establishment based on BAPM at 90%.					

Quality KPIs

April 2025 Report (March 2025 Data)

Martina Morris Chief Nurse
Dr Julian Hobbs Medical Director

NHS

The Dudley Group
NHS Foundation Trust



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Friends and Family - Recommended



Background

FFT is an important feedback tool that provides patients and relatives an opportunity to share their experience of the care and treatment received. Listening to the views of patients helps identify what is working well, what can be improved and how.

Performance

Date

March 2025

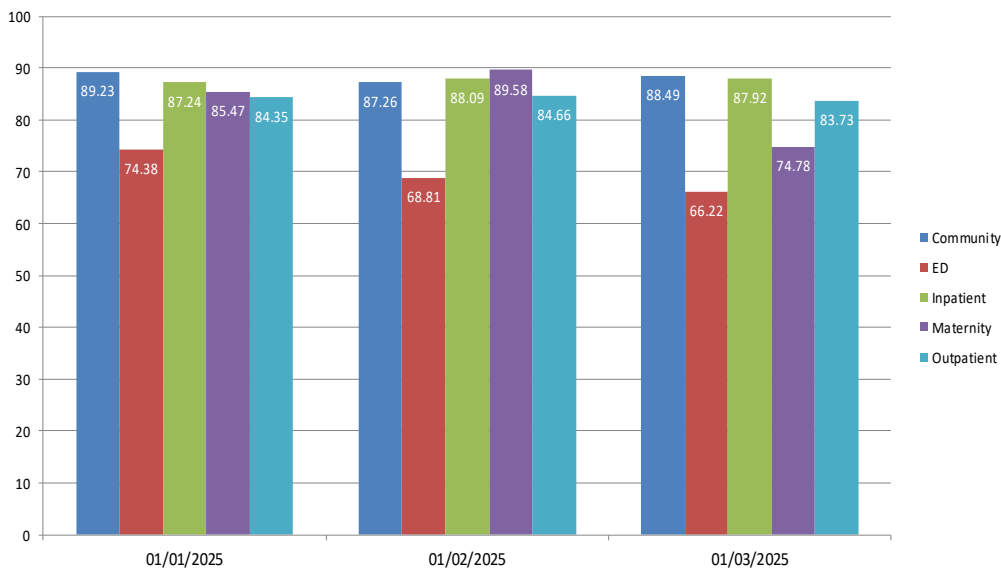
Trust Performance

See Graph

Performance Target / KPI

Above national average/% positive scores are increasing

Friends & Family Recommended (%)



What are the charts showing us

Overall, 80% of respondents have rated their experience of Trust services as 'very good/good' in March 2025, a decline since February 2025 (82%). A total of 8% of patients rated their experience of Trust services as 'very poor/poor' in March 2025, in comparison to 6% in February 2025.

In March 2025, the A&E Department received the lowest percentage score for patients rating their overall experience as 'very good/good' at 66% a decline from the previous month (69%). The 'very poor/poor' scores for the A&E Department remain the highest of all departments at 17%, an increase of 2% since February 2025. The Inpatient Department/Community received the highest positive ratings this month at 88%.

Areas Impacting on Compliance

FFT percentage very good/good scores remain below the national average for all divisions.

Mitigations / Timescales / Blockers

FFT percentage very good/good scores are monitored through the divisional updates at the Patient Experience Group for assurance and to highlight action taken to improve scores at ward/department level.

Risk Register

No

Key Points to Note

The decline in positive scores for the Trust overall and the increase in the number of patients rating their overall experience as very poor/poor.

Complaints



Background

Monitoring compliance against complaint responses

Performance

Date

March 2025

Trust Performance

A) 35 & 26% B) 101 C) 55.9%

Performance Target / KPI

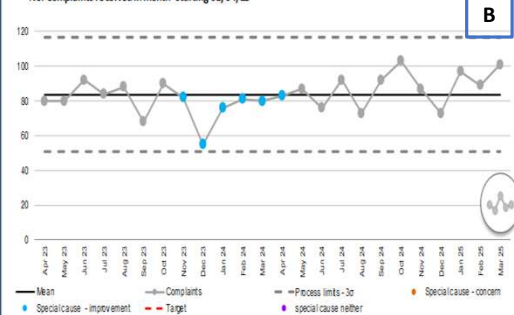
49.3% against KPI of 90% response rate

Overdue Complaints & Overdue Rate



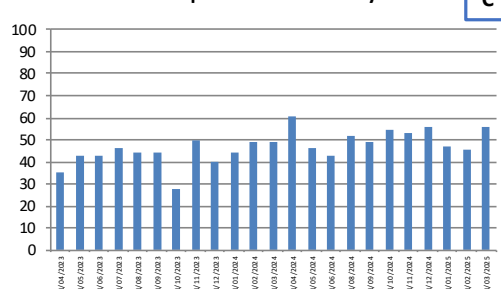
A

No. Complaints received in month-starting 01/04/23



B

% Completed within 30 days



C

What are the charts showing us

In March 2025, PALS received 344 concerns, 11 comments and 145 signposting contacts totalling 500 compared to 448 in February 2025. The main theme being appointment delays and cancellations.

The Trust received 101 new complaints in March 2025 compared to 89 for February 2025. Of the 101 complaints received, all were acknowledged within 3 working days. The main theme for complaints for March 2025 was communication.

In March 2025, the Trust closed 119 complaints compared to 71 in February 2025. All complainants are given a 30-working day timeframe. Of those 119 closed, 61 (51.2%) were closed within 30 working days.

Not including re-opened complaints and Ombudsman cases, there were 102 complaints closed (first response) and of those 102 complaints, 57 were within 30 working days (55.8%), which is an increase of 10.5% on last month's response rate of 45.3% (first response complaints). The Trust is not attaining its 90% response rate KPI.

As of 31 March 2025, there were 153 complaints open in total (this includes reopened complaints and Ombudsman cases) with 53 in backlog (34.6% in backlog). There were 134 complaints open (excluding reopened complaints and excluding Ombudsman cases) with 35 of those in backlog (26.1%). Of those 134 complaints; 7 are local resolution meetings, 15 are with complaints (including those in the final stages of review) and 112 are with divisions (including those for response, queries and approval).

Areas Impacting on Compliance

The response rate of 90% remains a challenge, along with the backlog. The complaints team continue to monitor and escalate to senior management when complaints have been open longer than 20 working days without a response from division(s).

Mitigations / Timescales / Blockers

The team have an escalation process in place bringing overdue complaints to the attention of the associated director.

Risk Register- no longer on the risk register

Key Points to Note

There is a slow increase in the backlog each month, a large number of complaints were received (101) but a large number of complaints were closed (119). The response rate has improved from February 2025 (45% for all complaints closed, 45.3% for first response complaints closed).

Incidents



Background

Incident reporting and patient harm monitoring is an essential approach for monitoring safety and the learning culture of an organisation

Performance

Date

March 2025

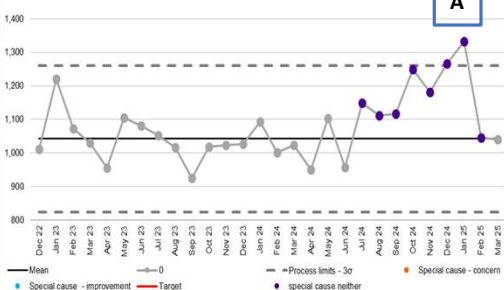
Trust Performance

A) 1041 B) 1713 C) 0.93% (16)

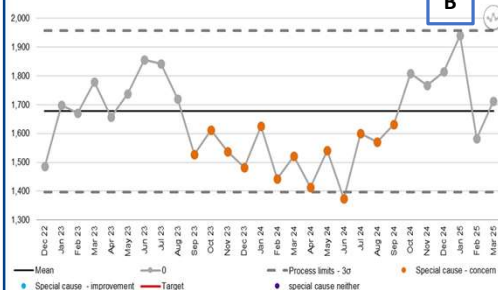
Performance Target / KPI

N/A

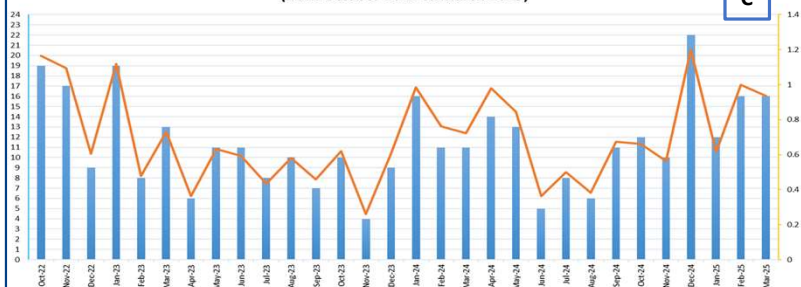
Total Number of Patient Safety Incidents (by Rep Date)- starting 01/12/22



Overall Monthly Incidents (by Rep Date)- starting 01/12/22



Monthly Moderate+ Harm and as Percentage of Overall Incidents (from October 2022 to March 2025)



What are the charts showing us

The overall number of incidents reported in March has **increased** compared to reporting in February with numbers more in line with the Q3/4 period; reporting is above the rolling average and within expected limits/natural variation. The number of patient safety incidents reported in March remains consistent with that reported in February; which is lower than that seen over the previous period.

The number of incidents reported to result in significant harm (moderate/severe/death) has remained similar to that in February. Harm levels in the reporting month **are still under review** and are likely to reduce following incident review and investigation. Historical monthly data sets will be refreshed upon collation of each report.

There were no new Never Events reported in March (no never Events across the annual period 24/25).

Areas Impacting on Compliance

The increase in overall incident reporting is likely to reflect the full month of reporting and no Datix downtime (which reduced reporting in February).

The Patient Safety Team continue to work to promote reporting through communication plans and training schedules

The proportion of incidents resulting in significant harm remains low. Harm levels in March are still under review at the time of reporting and will be refreshed in the next report

Mitigations / Timescales / Blockers

Incidents resulting in significant harm are subject to a prompt and robust initial MDT review to determine immediate learning and the level of response required.

Risk Register

N/A

Key Points to Note

Incidents



Background

Incident reporting and patient harm monitoring is an essential approach for monitoring safety and the learning culture of an organisation

Performance

Date

March 2025

Trust Performance

A) 6 B) 4

Performance Target / KPI

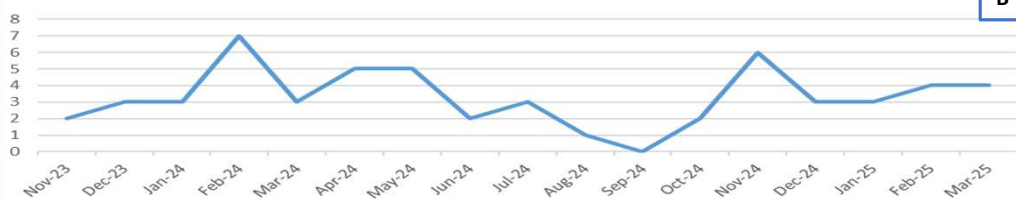
N/A

PSII (From November 2023 to March 2025)



A

SWARM (Nov 2023 to February 2025)



B

What are the charts showing us

Chart A illustrates the monthly number of full investigations (PSII) commissioned under the Patient Safety Incident Response Framework (PSIRF). There were 6 new PSII/ full investigations launched in March. The monthly numbers are consistent with natural variation, however during Q4 the overall number of PSII is higher compared to previous quarters. Chart B illustrates the monthly number of Swarm responses launched; Swarm responses are designed to be initiated as soon as possible after an incident and involves an MDT discussion to gather information about what happened and why it happened and what needs to be done to reduce the risk of reoccurrence. There were 4 new Swarm reviews commissioned in March; consistent with reporting in February. Statutory duty of candour compliance is being closely monitored to ensure appropriate enactment can be evidenced. There are no breaches in the regulation however at the time of report writing there is 1 incidents where the notification is in progress. These have been appropriately chased and escalated via the Governance Framework

Areas Impacting on Compliance

The numbers of responses launched monthly appear to be fluctuating in line with natural variation with an emerging trend in Q4 of higher numbers of PSII's. Incident themes are being closely reviewed and monitored to understand this further

Incidents reviewed at IDLG over the last three months raise potential themes:

- Communication
- Imaging (e.g. Delay in reporting of imaging, Imaging rejected, misreported)
- Lack of investigations or results review
- Documentation
- Escalation/ lack of referral

Mitigations / Timescales / Blockers

Decisions regarding the requirement for PSII, swarm or other reviews under the PSIRF are made collectively as part of the Incident Decision and Learning Group. Immediate assurances were shared, and initial concerns will be fully explored as part of the review process.

A wider thematic review of incident response findings alongside SJR outcomes has been completed and presented at IDLG. A follow up discussion is planned to review improvement activity aligned to the agreed priorities.

Risk Register

nil

Key Points to Note

nil

Doc Compliance (12 Months)	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Total
Compliant	10	11	6	10	7	3	11	8	16	23	7	6	118
In Progress												1	1
Total	10	11	6	10	7	3	11	8	16	23	7	7	119

Safer Staffing – Dashboard



Date

March 2025

Safer Staffing Summary

Mar

Days in Month

31

Ward	Day RN		Day CSW		Night RN		Night CSW		RN Day %	CSW Day %	RN N %	CSW N %	Sum 24:00 Actual CHPPD			
	Plan	Actual	Plan	Actual	Plan	Actual	Plan	Actual					Occ	Registered	Care staff	Total
B1	129	107	66	61	64	64	56	45	83%	93%	100%	80%	441	4.41	2.75	7.15
B2(H)	124	100	195	182	95	87	176	167	80%	93%	92%	95%	728	3.08	5.62	8.70
B2(T)	124	111	136	118	94	90	106	96	90%	87%	96%	90%	724	3.33	3.54	6.87
B3	194	180	207	182	185	178	184	175	93%	88%	96%	95%	1,146	3.68	3.74	7.41
B4	226	176	250	192	186	182	189	179	78%	77%	98%	95%	1,298	3.24	3.44	6.68
B5	259	196	178	149	244	221	115	104	76%	84%	91%	91%	989	5.17	3.00	8.17
B6	97	70	70	56	63	63	71	62	73%	80%	100%	87%	496	3.15	2.85	6.00
C1 A	128	128	131	108	93	92	103	100	100%	83%	99%	97%	742	3.48	3.37	6.85
C1 B	129	124	138	124	93	89	107	97	96%	90%	96%	91%	742	3.37	3.50	6.87
C2	282	239	66	48	253	227	63	55	85%	73%	90%	87%	650	8.40	1.87	10.27
C3	217	215	419	358	186	183	400	384	99%	86%	98%	96%	1,612	2.96	5.42	8.38
C4	206	158	68	60	124	93	62	83	77%	88%	75%	133%	676	4.34	2.44	6.78
C5 A	122	106	164	114	93	92	141	122	87%	69%	99%	87%	741	3.24	3.83	7.07
C5 B	161	152	143	103	155	153	113	100	94%	72%	99%	88%	736	4.87	3.31	8.18
C6	98	87	92	77	93	89	63	59	89%	83%	96%	93%	559	3.71	2.90	6.61
C7	226	178	206	167	165	155	196	187	79%	81%	94%	95%	1,102	3.54	3.85	7.39
C8	259	247	232	189	217	201	195	184	95%	82%	93%	94%	1,332	3.94	3.36	7.31
CCU_PCCU	250	233	62	54	217	217	32	29	93%	86%	100%	91%	768	6.88	1.29	8.17
Critical Care	537	436	125	81	527	437			81%	64%	83%		545	19.21	1.77	20.98
AMU	550	513	464	389	496	523	465	455	93%	84%	105%	98%	2,464	4.94	4.11	9.05
Maternity	847	764	263	183	528	494	155	136	90%	70%	94%	88%	1,349	8.93	2.77	11.70
MECU	93	94	38	33	94	93			101%	86%	99%		233	9.61	1.54	11.15
NNU	383	237			267	211			62%		79%		227	23.63	0.00	23.63
TOTAL	5,641	4,850	3,714	3,027	4,533	4,233	2,992	2,820	86%	82%	93%	94%	20,300	5.16	3.42	8.58

Safer Staffing



Background

Performance

Date

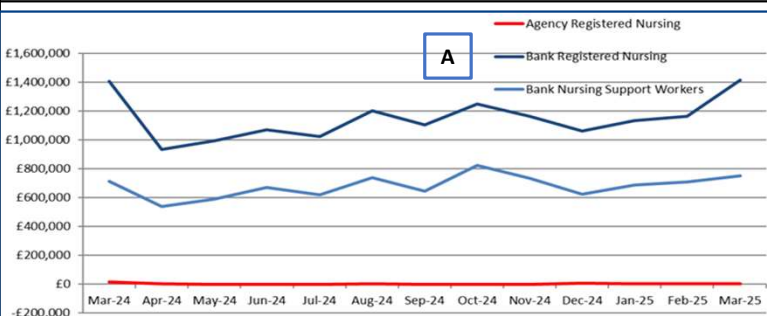
March 2025

Trust Performance

A) B)

Performance Target / KPI

N/A



A - Bank Usage

B - Top 10 depts. using Bank & Agency, Mar 2025

Area	Nursing Vacancy %	Agency Registered Nursing	Bank Registered Nursing	Bank Nursing Support Workers	Grand Total
Emergency Department Nursi	13%	£0	£130,119	£51,134	£181,254
Discharge Lounge	9%	£0	£73,553	£56,377	£129,930
Ward AMU 1	14%	£0	£65,260	£37,688	£102,948
Ward AMU 2	-7%	£0	£56,558	£41,514	£98,072
I.T.U.	-4%	£0	£82,369	£9,215	£91,584
Theatres Weekend Lists		£0	£60,366	£28,764	£89,131
Ward C8	13%	£0	£41,289	£44,738	£86,027
Ward C7	6%	£0	£46,499	£35,880	£82,379
Ward AMU Assessment	16%	£0	£45,106	£22,818	£67,924
Maternity Unit	-10%	£0	£49,856	£14,936	£64,792

What are the charts showing us

- Safe staffing % and CHPPD are around the same for March as compared to Feb 25
- Chart A - note increase in bank costs for registered nursing and support workers is up due to additional beds still open
- Table B - bank remains high in areas with increase vacancy rates

Areas Impacting on Compliance

Unfunded additional capacity in AMU 1&2 10 additional beds and TES area in ED.

Mitigations / Timescales / Blockers

Additional beds on super surge are now closed but additional beds on AMU are still open. TES area continues to be utilised based on capacity needs and recently to utilise the corridor when a high increase of capacity.

Risk Register

Key Points to Note

- Safer staffing report for January (see appendix ?) Overall, the safer staffing establishments within the assessed areas are in a positive position to maintain the provision and delivery of safe, effective, high-quality care. However, based on professional judgement and triangulation of quality metrics and acuity, some clinical areas feel additional staffing or change of skill mix may enhance care and experience in these areas. The Nurse Sensitive Indicators reviewed as part of the review, indicate that ongoing improvement work is required for example, with regards to patient observations, medicine management, pressure ulcers and falls amongst others.

Recruitment and Retention of staff

- 36 Student Nurse are due to qualify between Jan and July 2025, 6 already offered jobs with us and the remaining 30 still looking

Mixed Sex Accommodation



Background

KPI monitors all unjustified occurrences of patients receiving care that are in breach of the sleeping accommodation guidelines to enable enhanced patient choice and to drive improvement.

Performance

Date

March 2025

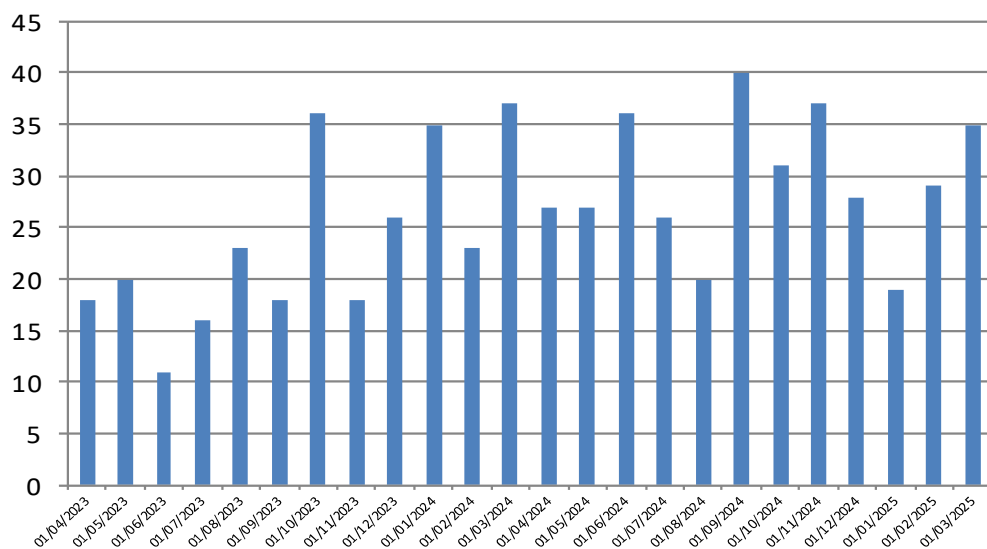
Trust Performance

35

Performance Target / KPI

0

Mixed Sex Accommodation



What are the charts showing us

Mixed sex breaches increased in March 2025 to 35.

Areas Impacting on Compliance

Step downs from level 2/3 areas can be challenging against our ability to manage demand through our ED. This month continues to see a high demand at the front door requiring a balanced approach.

Mitigations / Timescales / Blockers

The Trust and site team are sighted on patients that require stepping down from critical care areas and the impact this may have on our patients staying in this environment for longer periods.

Risk Register

Delayed discharges from critical care which could impact upon timely admission to critical care is on the corporate risk register. Currently under review to consider psychological impact for patients

Key Points to Note

This is impacted by the high number of wardable patients on the unit making cohorting in bays challenging.

Dementia



Background

Patients aged 75 and over who have been identified as potentially having dementia and are appropriately assessed and referred on to specialist services. The number of patients readmitted within 30 Days with a diagnosis of Dementia.

Performance

Date

March 2025

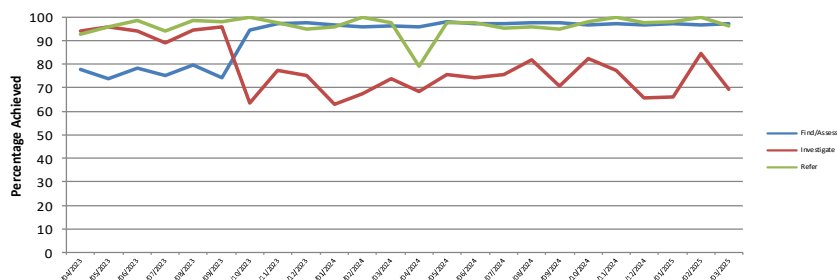
Trust Performance

Find) 97.14% / Investigate) 69.35% / Refer) 96.43%

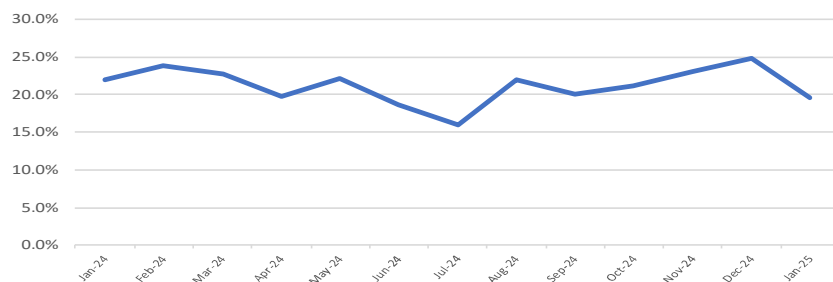
Performance Target / KPI

90%

Dementia Screening



% readmitted within 30 days of a previous dementia diagnosis (in any position)



What are the charts showing us

The first chart provides data regarding the number of patients who have been screened for dementia by inpatient staff using the AMT4 and the subsequent investigation and referral by the Dementia and Delirium Team using the FAIR process. The Find completed by the wards is compliant at 97.14%. The data cleanse that has taken place supports that clinical areas are compliant. The data cleanse reviewed data from the past 18 months which allows past data collection to demonstrate compliance has been consistent. The initial non-compliance is in line with the transferring of data collection from paper to digital collection on Sunrise. The Dementia and Delirium Team who complete the Investigate is non-compliant at 69.35%. The Dementia and Delirium Team who refer the patients that they have investigated is compliant at 96.43%. The second chart shows the number of patients with dementia who were readmitted within 30 days of discharge. The latest available data is for January 2025 where there is a downward trend of readmission.

Areas Impacting on Compliance

The Dementia and Delirium Team are working at reduced capacity, which is in line with Investigate levels as they do not have the ability to respond to every referral before they are discharged. Despite this, the patients that they do work with have a high level of input regarding support and referral, hence the high rate of refer levels for the patient population that they have contact with. A review of the reasons for readmission has been investigated. From this, there are common themes for readmission and are following national trends, including a reduction over the summer months and an increase over the winter period. The January data for 2025 is slightly lower than for January 2024.

Mitigations / Timescales / Blockers

The Dementia and Delirium Team will expand by 1 Nursing Associate working 30 hours per week. This should improve the Investigate rate. They commence with the Trust 21.04.25 and with time for induction and to develop the new role, an impact on Investigate levels will take time to take effect.

Risk Register

Key Points to Note

Mental Health

Background

Performance

Date

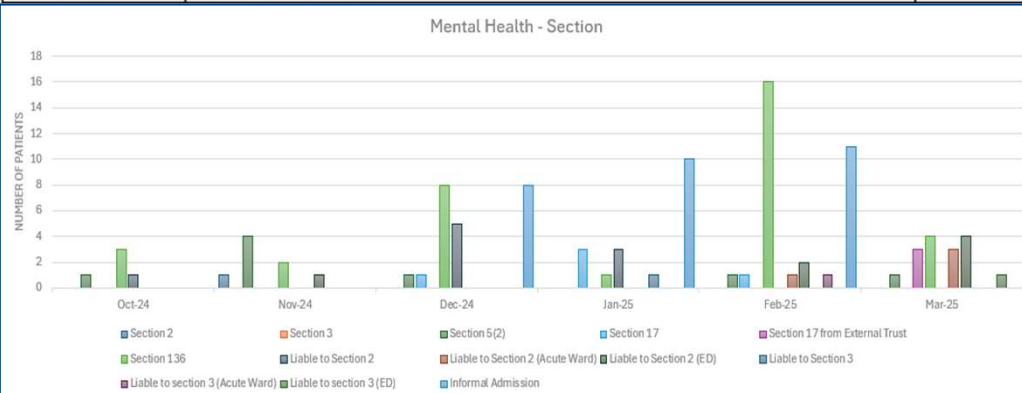
March 2025

Trust Performance

Performance Target / KPI

CQC compliant

Date of Admission	Section (Locate details C/O Rio if not on Sunrise and upload docs to Sunrise)	Amount
Mar-25	Section 5 (2) - Following MHAA patient discharged from detention	1
Mar-25	Section 17 from External Trust	3
Mar-25	Section 136 - Discharged home x3, Section 3 - x1	4
Mar-25	Liabile to Section 2 - Acute Ward	3
Mar-25	Liabile to section 2 - ED	4
Mar-25	Liabile to section 3 - ED	1



What are the charts showing us

There has been 0 patients detained to DGFT on a section 2 or 3 and 1 patient detained on a section 5(2) during March 2025. There have been 3 patients who have been liable to be detained on a section 2 who have been admitted on acute wards. All three patients, once they completed their physical health treatment, were transferred to mental health hospitals where the section was applied. There has been MHA activity from patients visiting the acute hospital as 3 patients were admitted to RHH who were on section 17 leave from a mental health unit. There have been 3 section 136's in ED which is a reduction from February 25. ED had 4 patients liable to be detained on a section 2 and 1 patient on a section 3. Again, these sections did not become live until they were admitted to mental health hospitals. In terms of informal activity, we were not able to report on this for March 25 as there is a new process in place to report on all MH activity.

Areas Impacting on Compliance

There are concerns that not all patients on section 17 leave to the acute hospital are being captured as they are not being reported as standard. They are identified either by chance, when manually reviewing ED data or the occasional Datix. MHA awareness training for all staff in Trust is available weekly. Section 5(2) bite size training is available daily and has been advertised via In the Know and the Mental Health Hub Page. It is accessed via a QR code and so pre-booking does not need to take place for section 5(2) training. Attendance for this training has been very low, often with no staff attending. The new MHA policy has been ratified and live. There is concern that the patients who were admitted to an acute ward who were liable to be detained, never had consideration for the section to be applied to DGFT. This is due to the new process not being followed, which consists of escalation to the Trust Executives to consider the application to the Trust. A conversation has taken place with the Approved Mental Health Practitioner Lead who will ask their Approved Mental Health Practitioners to request that the wards escalate a request for this process. Not following the process places the Trust in a vulnerable legal position.

Mitigations / Timescales / Blockers

Risk Register

Key Points to Note

MHA data and how to identify this from patient activity is under constant review and development to ensure maximum transparency of this activity.

Mental Health - CYP

Background

Performance

Date

March 2025

Trust Performance

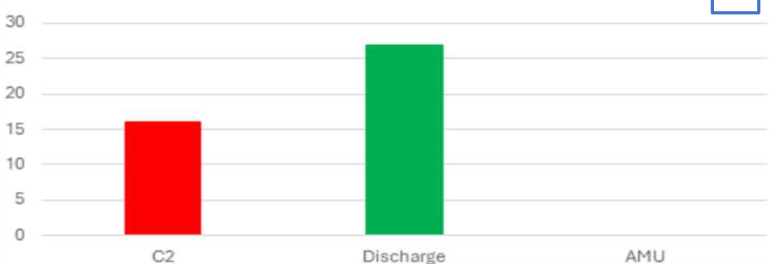
A) C2, 16 D/C, 27 AMU, 0 B) <24,9 24-48,5 >48,2

Performance Target / KPI

CQC compliant

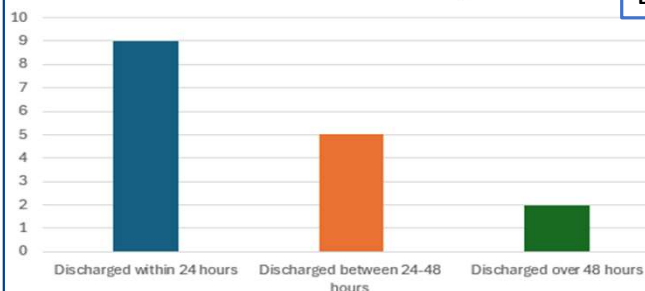
Outcome following attendance to ED - March

A



CYP admitted to C2 and review by CAMHS

B



What are the charts showing us

Chart A details that during March, 43 children with mental health concerns attended the Trust. This is a similar figure to the previous month. Of which, 27 CYP were reviewed within ED and discharged. The remaining 16 were admitted to C2. AMU did not receive any admissions during this period. This information includes all attendances and does not differentiate if they attended multiple times.

ED were able to discharge 27 CYP when they were medically fit, who did not require admission to the Trust. There were 4 self-discharges during March. This includes advising staff that they did not want to wait (completing DAMA form) and leaving before being seen (not completing DAMA form).

There were 5 identified reasons for admission in March (deliberate self-harm, overdose, suicidal ideation, behaviour concerns and anxiety). Some CYP did attend with more than 1 reason (e.g. deliberate self-harm and overdose). Data is categorised by the most severe symptom.

Chart B details that C2 saw 16 CYP being admitted following review within paediatric ED. CYP that were discharged within 24 hours of admission equates to 52.9% (9). Those that remained for 24-48 hours equates to 29.4% (5) and over 48 hours is 11.8% (2). Those with over 24-hour discharge times is due to treatment requirements, and social services interventions. All children were discharged when they were medically fit and had been reviewed by a member of the CAMHS team with a community plan put in place. The children that have been discharged from C2 went to their usual place of residence.

Areas Impacting on Compliance

In terms of the age range of CYP contact for mental health purposes, the 14-15 and 16-17 year old population are the main age groups with mental health concerns. 12-13 year olds have seen reductions over the past 3 months. Females continue to be the main gender that attends the Trust with mental health concerns.

March has seen a slight reduction compared to February of CYP activity with 43 patients in March compared to 45 patients in February attending ED. There are mock exams being undertaken at schools which may be influencing CYP's mental health. There is also home/family life to take into consideration.

With the monitoring of the out of area attendances, Sandwell patients are continuing to have a greater representation within the Trust. This may be due to RHH being closer to patients homes than the new 'MET' hospital that has been built.

Mitigations / Timescales / Blockers

Risk Register

Key Points to Note

There were no MHA detentions to the Trust and no CYP requiring a tier 4 bed.

Mental Health - ED

Background

Performance

Date

March 2025

Trust Performance

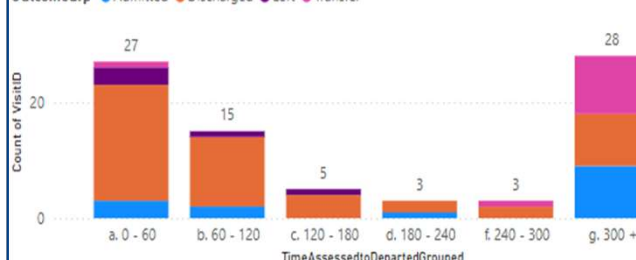
A) B) C)

Performance Target / KPI

CQC compliant

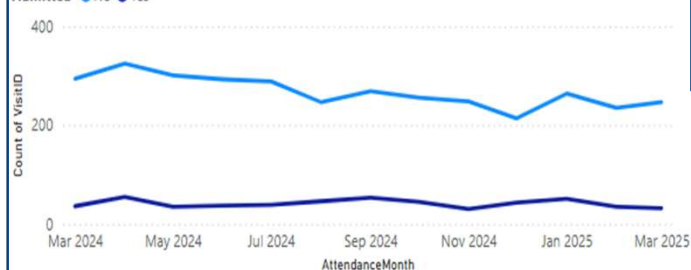
ED Time Assessed to Time Departed by Outcome

OutcomeGrp ● Admitted ● Discharged ● Left ● Transfer



ED Mental Health Attendances by Month

Admitted ● No ● Yes



What are the charts showing us

Chart A details the breakdown of patients with mental health issues contacting ED. The longer time frame for ED Departure are linked with awaiting mental health beds for admission to mental health hospitals and assessments requiring admission within DGFT.

Chart B details the waiting time for patients to be seen by Mental Health Liaison Services. This indicates that 30 patients were seen outside of the 1-hour timeframe directed by Core-24 guidance.

Chart C details that during February 2025, ED mental health activity indicates a reduction in the number of patients admitted from ED. There has been an increase from February 25 of the number of patients discharged from ED.

Areas Impacting on Compliance

There have been patients that have been assessed as requiring admission to an inpatient MH hospital that have had extreme waits. There were 4 patients awaiting an informal admission that had to wait in excess of 1 day in ED before a bed within a mental health hospital could be located. These time frames commence from the point that they were admitted to ED. It is noted that most excessive waits for mental health beds are when patients are awaiting informal admissions as opposed to being detained under the Mental Health Act 1983.

MHLS are contracted to respond to a referral within one hour. A response consists of a review to decide on the type of assessment needed and arranging appropriate resources for the assessment. A full biopsychosocial assessment should take place within 4 hours.

It is not clear where the data for the delays for MHLS to review is obtained as the data does not represent the documentation when a deep dive of patients notes took place. Despite this, there are occasions when patients are assessed outside of this timeframe. Themes for delays include when there are pending Mental Health Act assessments and if a medical review is required with increased wait times during nights shifts. When patients are pending treatment for physical health before they are assessed by MHLS, this is a factor for increased wait times. Increased wait times are also noted during hand over periods and when the team have cited a large number of patients to assess. On other occasions, the rational for the delays are not known/not documented.

Mitigations / Timescales / Blockers

Risk Register

Key Points to Note

Core 24 identifies that the assessment need for physical and mental health should be a parallel process, and the assessment should commence with MHLS if the patient is accessible to commence this. NICE guidelines identify to not delay the psychosocial assessment until after medical treatment is completed

Falls



Background

Monitoring the number of falls resulting in moderate harm and above allows for progress to be reviewed and learning from incident to be identified. This helps to ensure the most appropriate mitigations are in place to reduce risk of falls and associated injury.

Performance

Date

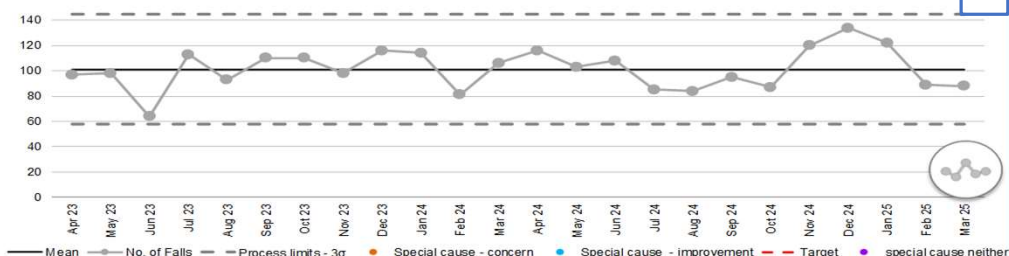
March 2025

Trust Performance

A) 88 B) 4 C) 0

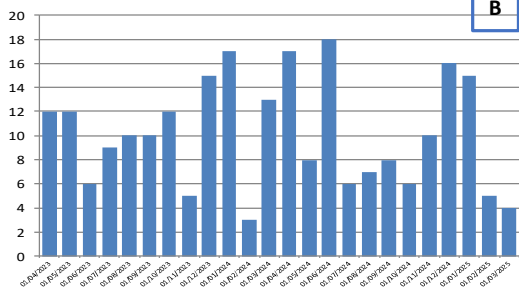
Performance Target / KPI

No. of Falls - starting 01/04/23



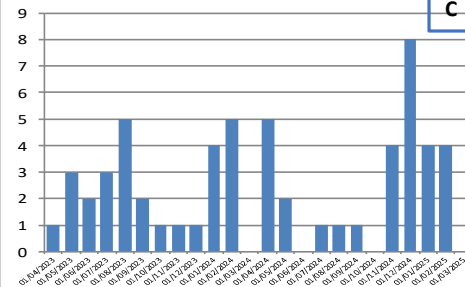
A

Multiple Falls



B

Falls resulting in moderate harm or above



C

What are the charts showing us

The overall number of recurrent and inpatient falls have declined further since February. Similarly, the number of moderate harm falls have decreased significantly in comparison to previous quarter. In March there was 0 moderate harm incidents reported.

Areas Impacting on Compliance

- Additional capacity and demand
- Additional inpatient occupancy
- Medics utilising Post fall documentation to evidence post fall medical review

Mitigations / Timescales / Blockers

- Back to basic falls training workshops in collaborations with practice development leads
- Learning slides introduced on the Falls Incident and Learning channel for wider learning.
- Falls Prevention training above trust target

Risk Register

There are no risks related to falls

Key Points to Note

- HSIB Training date in April to support staff with report writing as part of the findings from Thematic Review 3.

Pressure Ulcers



Background

Trend against pressure ulcer prevention performance

Performance

Date

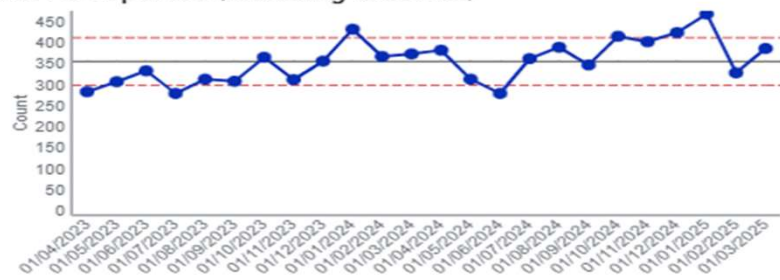
March 2025

Trust Performance

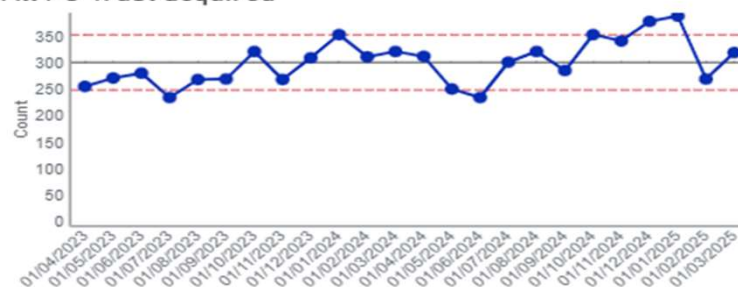
See chart

Performance Target / KPI

All PU reported (including external)



All PU Trust acquired



What are the charts showing us

There has been an increase in all Trust acquired Pressure Ulcers of 171 incidents reported in March. Acute 80 PUs and Community 91 PUs (this excludes MASD & External). Although March has seen an increase from Feb, this may be due to the shorter month in Feb, however the trend is lower than previous months, which demonstrates an improvement overall.

- Inpatient area pressure ulcers – 11 C3/ C4/ Unstageable, 29 DTIs, 40 C2s
- Community pressure ulcers – 31 C3/ C4/ Unstageable, 27 DTIs, 33 C2s

The trust has seen a continuous decline in MASDs.

Areas Impacting on Compliance

- Workforce challenges continue with 1wte on LTS and 1 0.8wte undertaking a phased return.
- 1wte B6 vacancy approved by executives – has been advertised and awaiting interview.
- Thematic review conducted across both inpatient and community was presented at quality and safety group in March – single improvement plan to be updated to support further improvement.
- Junior workforce in community which could be impacting on validation/ categorisation of pressure ulcers and consideration of differential diagnosis – TVN has carried out a training needs analysis to allow focused planning of some dedicated training

Mitigations / Timescales / Blockers

Transition to Purpose T continues, P&O accepted, initial meeting held await IT implementation date. E learning for health module on TV hub available for all to access.

Risk Register

Challenges with workforce to deliver the contract.

Key Points to Note

Tissue viability implementing a 60/40 acute and community support model, to enhance skills, knowledge and management of wounds across all teams. Plan being agreed

Pressure Ulcers



Background

Trend against pressure ulcer prevention performance

Performance

Date

March 2025

Trust Performance

See chart

Performance Target / KPI

What are the charts showing us

See detail on slide 15

Areas Impacting on Compliance

Workforce challenges.

Mitigations / Timescales / Blockers

As per slide 15

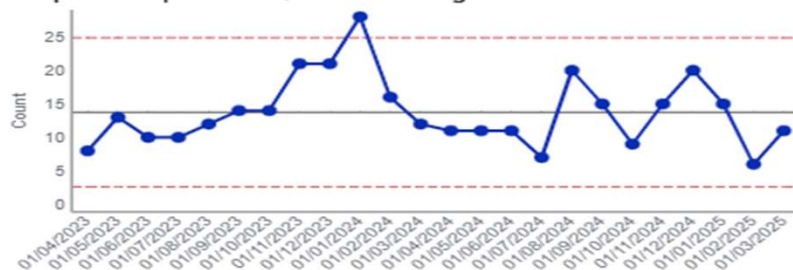
Risk Register

Challenges with workforce to deliver the contract.

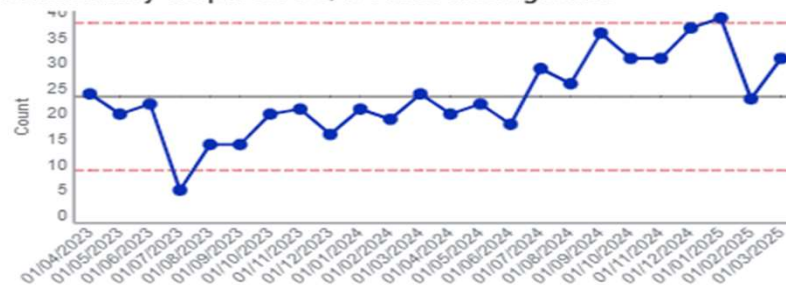
Key Points to Note

- Workforce model continues to be a challenge
- Tender for equipment due for submission 28th April 2025 - Aiming to create an acute and community non managed service by October 2025
- Interim contract extension with Drive and Direct healthcare for 6 months to commence April 2025.

Hospital acquired C3, C4 & unstageable



Community acquired C3, C4 and unstageable



Pressure Ulcers



Background

Trend against pressure ulcer prevention performance

Performance

Date

March 2025

Trust Performance

See chart

Performance Target / KPI

What are the charts showing us

The average working days for SITs to be approved has reduced further to approx. 9 days between reporting and approval following previous backlog over the holiday period. No moderate or severe harm in month.

Areas Impacting on Compliance

Workforce challenges across all teams.

Mitigations / Timescales / Blockers

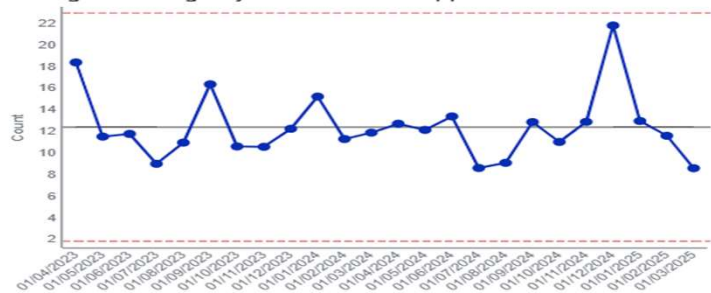
Each reported category 3, 4 and unstageable pressure ulcer is reviewed by the pressure ulcer group to determine level of harm. The PUG group terms of reference and Pressure Ulcer investigation SOP are being updated to reflect current process, and further work is required to strengthen the PSIRF model.

Risk Register

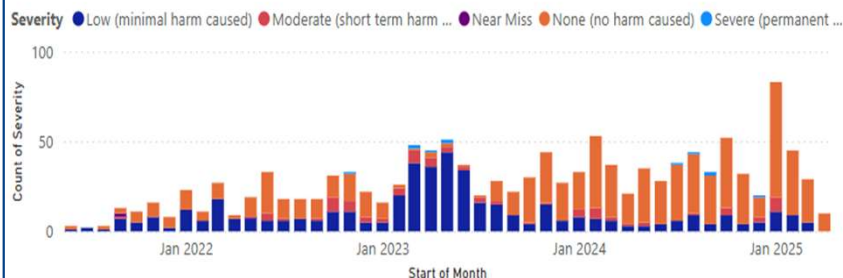
Key Points to Note

As detailed on previous slide

Average working days for SIT to be approved



Harm level determined by PUG



Safeguarding



Background

The Trust has a statutory duty under the Children Act 1989 and Care Act 2014 to refer any cases of abuse to adults and children to the Local Authority. The Trust also has a statutory duty to undertake section 42 investigations into allegations of abuse within the Trust

Performance

Date

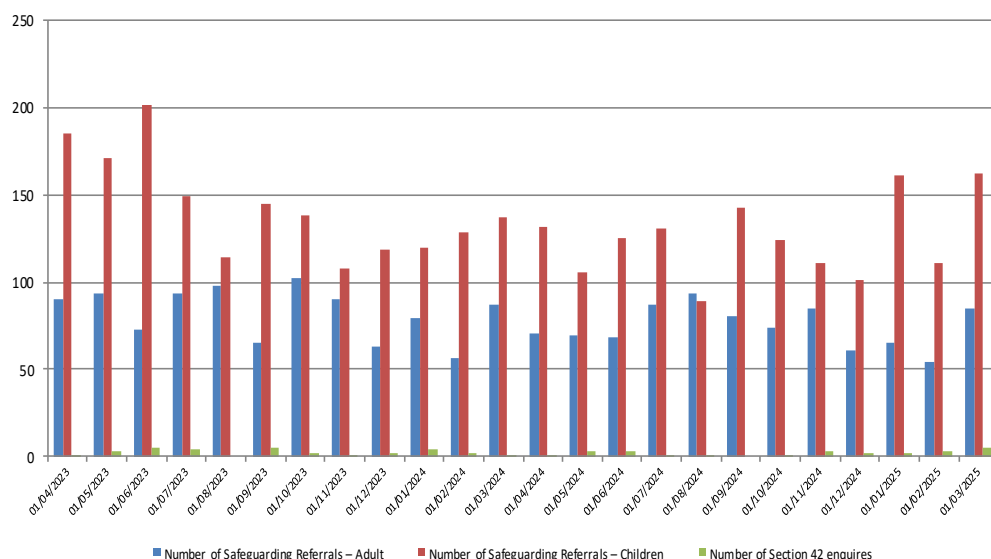
March 2025

Trust Performance

Adult) 85 / Children) 162 / Section 42) 5

Performance Target / KPI

Safeguarding



What are the charts showing us

The charts provide information regarding the number of safeguarding referrals for adults and children where staff have recognised potential or actual abuse of adults or children and provides the number of safeguarding enquiries against the Trust regarding standards of our care. The number of children's safeguarding referrals in March has increased in March which reflects usual trends for this time of year. The increase is also likely to be due to significant increase in attendance of children to ED in March compared to previous 3 months. Main areas of abuse that have seen in an increase in reporting this month is concerns re parental risk factors, non-accidental injury and neglect. These figures provide assurance that staff are recognising and reporting abuse. Adult safeguarding referrals have also increased during March with significant increases in reporting of self-neglect and domestic abuse. This provides some assurance that the 2 areas where there have been recent concerns regarding staff's recognition of these categories of abuse have been raised with divisional leadership. There have been 3 S42 enquiries raised regarding concerns of care provided by the Trust. Two are in respect of neglect and one in respect of self-neglect. All enquiries are in progress and any actions will be tracked via Datix. (the remaining 3 S42 enquiries are caused to CHC to investigation allegations of abuse within care homes)

Areas Impacting on Compliance

There were 8 missed safeguarding referrals for children of adults who attend ED with parental risk factors such as domestic abuse, substance abuse and mental health concerns. This is a slight improvement on last month. Safeguarding Children Level 3 training is 76% The training is offered flexibly and has Teams and E-learning options. Divisions have been informed that they need to take action to address the poor compliance and provide trajectories

Mitigations / Timescales / Blockers

The Safeguarding Team and Deputy Matron are working together to raise awareness the impact of parental health on parenting capacity to reduce the number of missed opportunities to safeguarding children. Level 3 children's safeguarding has an annual compliance meaning that even staff who are not currently compliant have received some safeguarding training within in the last 12 to 24 months which remains in line with the intercollegiate document. There have been no identified patient safety incidents directly related to poor compliance with training. The actions to address the risk are held locally within Divisions and are monitored regularly as part of divisional governance meetings.

Risk Register

Key Points to Note

Infection Control



Background

IPC Healthcare Associated Data

Performance

Date

March 2025

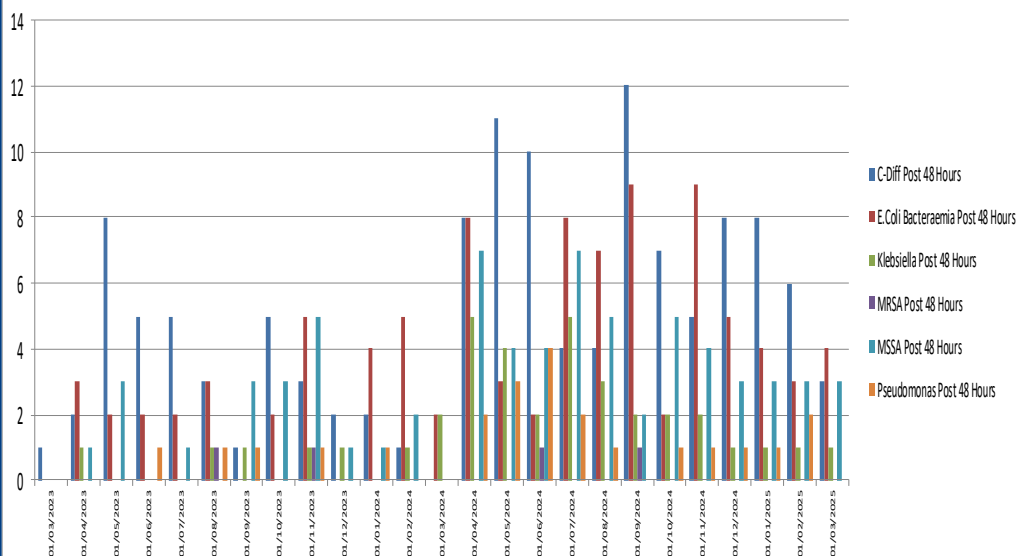
Trust Performance

Threshold reached for MRSA, Kelbsiella and Pseudomonas BSI HCAI infections

Performance Target / KPI

HCAI reportable infections

Infection Control



What are the charts showing us

The Trust has received thresholds for reportable HCAI's from NHSE for 2024/25. The IPCT report on HOHA and COHA cases.

2 COHA MRSA bacteremia have been reported 1 in June, and one in September 2024. Meetings were held, and learning has been disseminated throughout the Trust.

The trust has reported 3 HOHA cases of CDI and 3 COHA in March 2025, this shows a total of 97 against a threshold of 73 for 2024/25. As CDI continues to increase nationally, the trust attends the ICB task and finish CDI group. The IPCT completed a CDI thematic review for Q3, Q4 is underway at present there is no new identified learning. When comparing CDI cases and DGFT admissions they have similar peak patterns, there is a noticeable increase in both CDI cases and admissions over the past three financial years.

4 HOHA and 3 COHA cases of E coli BSI, a total of 79 against a threshold of 75 for 2024/25.

0 HOHA and 0 COHA cases of *Pseudomonas aeruginosa* BSI. 5 of the COHA cases relate to the same patient. A total of 18 against a threshold of 12 for 2024/25.

3 HOHA and 3 COHA cases of *Klebsiella spp.* BSI, a total of 32 against a threshold of 19 for 2024/25.

1 HOHA and 1 COHA MSSA bacteremia cases but there is no threshold set, a total of 52 for 2024/25.

10 cases of VRE have been identified across critical care, one can be linked environmentally to a case on C4 (totalling 11 cases). At present four belong to the same cluster (NEWC20EC-5). An external meeting was held with NHSE, BCICB and DMBC alongside an external visit with DIPC from Sandwell, some suggests have been identified and are being actioned.

Areas Impacting on Compliance

A cleaning and disinfection of the environment policy has been agreed alongside PFI partners.

Hand hygiene compliance is <94% across trust – our Q1 25/26 initiative is to focus on effective hand hygiene while reducing glove use.

Mitigations / Timescales / Blockers

The Trust has adopted the PSIRF response to HCAI looking for themes and trends.

Risk Register

The trust has a risk on the Trust and system risk registers for CPE screening. The Trust has a CPE policy in place.

Key Points to Note

The Trust reported 2 Norovirus outbreak.

MPOX is no longer considered a HCID.

Gold Standards Framework (One Month in Arrears)



Background

KPI based on Nacel and Nice Guidance

Performance

Date

February 2025 (one month behind)

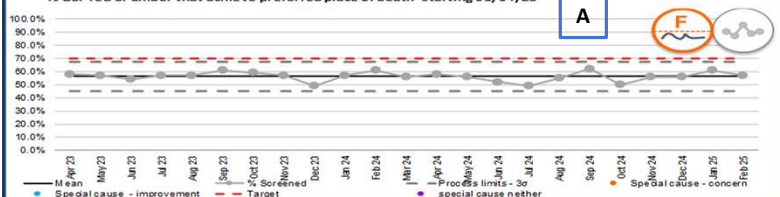
Trust Performance

A) 57.0%/ B) 18.0%/ C) 67.0%

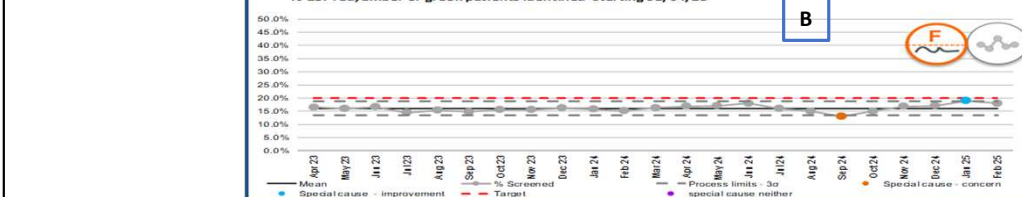
Performance Target / KPI

70%/20%/75%

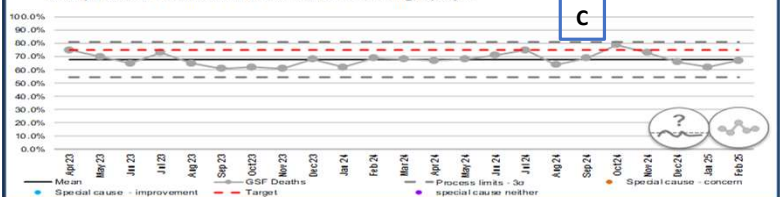
% GSF red or amber that achieve preferred place of death- starting 01/04/23



% GSF red, amber or green patients identified- starting 01/04/23



% hospital deaths identified as GSF Amber or red- starting 01/04/23



What are the charts showing us

The target for identification of patients GSF (Green/Amber/Red) is currently set at 20%, as a trust we have seen an increase again to 19% for January, however, February is slight decrease at 18% Local and national evidence/research/ reviews/audits all support that 30% of adult inpatients are in the last year of life.

Areas Impacting on Compliance

Need for continued education on the wards – time taken for specialist palliative care team

Mitigations / Timescales / Blockers

- GSF bundle on sunrise to replace GSF document –launch date 16th April which when implemented will allow more detailed data including section on care after death
- Specialist palliative care team support all wards regarding GSF identification including reviewing those patients GSF identified on a previous admission

Risk Register

Rapid Discharge added to the risk register as no assurance regarding standards fast track or rapid discharge and this is having an impact on quality and capacity and flow – approximately 1000 excess bed days as not meeting the 48-hour standard for fast-track discharge

Key Points to Note

Need to maintain improvement in identification of GSF patients
Fast track on the risk register and regular agenda item on Trust EOLC group
GSF bundle implementation 16th April and this will replace GSF document on sunrise and there will transition regarding data for IPR and working with data analyst to validate once switch completed.

VTE (One Month in Arrears)



Background

Achieving required VTE RA target of 95% (first assessment)

Performance

Date

February 2025

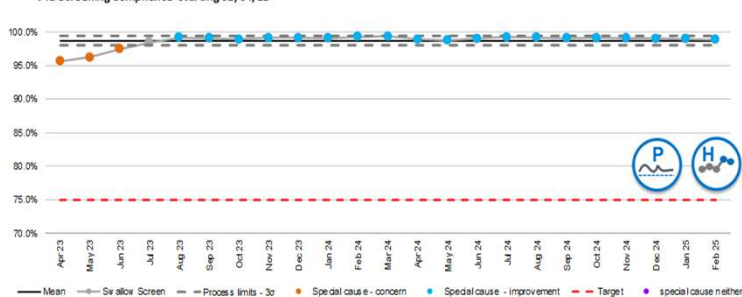
Trust Performance

98.8%

Performance Target / KPI

95%

VTE Screening Compliance - starting 01/04/23



Second Assessment <24 hours from Admission (only spells over 24 hours in denominator)

MonthYear	Total	IRA	CRA	Total RA	% Compliance
01/09/2024	1073	126	1	127	11.83
01/10/2024	1219	139	1	140	11.48
01/11/2024	1166	125	0	125	10.72
01/12/2024	1153	131	0	131	11.36
01/01/2025	1187	101	1	102	8.59

What are the charts showing us

Forcing function within Sunrise now in place.
Complaint with initial VTE screening, however low compliance on second assessments.

Hospital associated thrombosis (HAT)

Positive scans are identified & cross referenced with admission system to identify if associated with hospital admission.
cases of Hospital associated VTE (HAT) identified from radiology data
April 2024- 05/02/2025 - 159 cases of Hospital associated thrombosis 43 cases potentially preventable VTE
Main themes identified

- Missed/not signed for doses (inappropriate omissions)
- Delays in/failure to prescribe prophylaxis following risk assessment
- Although compliance with first assessment meets target, we are concerned about quality of assessments some are inappropriately identifying patient not at risk of VTE when they have risk factors

Thematic review being undertaken biannually to identify common issues and action plan to address presented at Risk and Assurance Meeting

Mitigations / Timescales / Blockers

- All radiological data for VTE reviewed for potential HAT. Investigation undertaken same week where possible
- Where issues identified reported back to responsible team to investigate further and implement actions. If no response team recontacted re outcome
- Where significant issue/harm identified Patient safety team contacted to review whether requires discussion at the Incident Decision and Learning Group.

Risk Register

Potential risk - risk must be owned by each clinical division to ensure that where cases of potentially preventable HAT are identified that they implement mitigations locally to reduce risk of recurrence

Key Points to Note

- All incidents of hospital associated thrombosis reported on Datix
- Where issues identified reported back to responsible team to investigate further and action
- Patient safety team contacted and asked to review whether requires discussion at WMOH
- Concerns raised at Thrombosis Group meeting at how incidents in Datix are graded
- Thematic review being undertaken biannually to identify common issues and develop actions to address
- Work being undertaken to develop metrics to monitor progress with HAT
- Mandatory training programme updated awaiting learning and development to deploy

Cardiac Arrests / MET Calls



Background

Medical emergency calls and cardiac arrests per 1000 admissions (data is pre-validation by National Cardiac Arrest Audit)

Performance

Date

March 2025

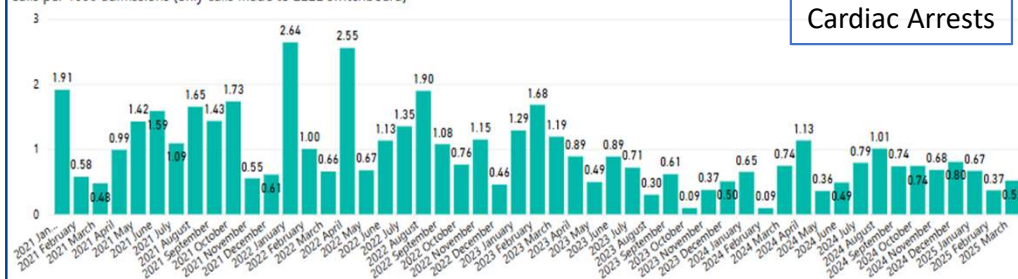
Trust Performance

Cardiac arrests 0.52 /MET calls 15.99

Performance Target / KPI

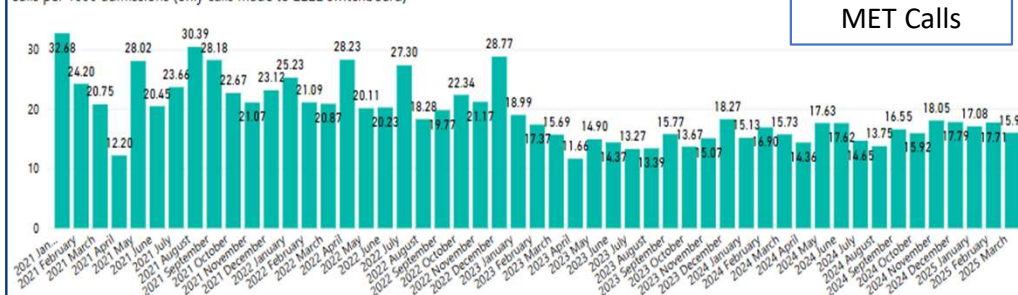
N/A

Calls per 1000 admissions (only calls made to 2222 switchboard)



Cardiac Arrests

Calls per 1000 admissions (only calls made to 2222 switchboard)



MET Calls

What are the charts showing us

Of the 8 cardiac arrests in March, only 2 occurred during the Mon-Fri 0900-1700 time frame. All others were out of hours with 2 Mon-Fri 1701-0859, 3 on Saturdays & 1 on Sunday.

Areas Impacting on Compliance

A decrease from 40.83% to 39.96% (of 1354 inpatients) had a documented treatment, escalation & resuscitation plan (TERP) in March, of which 85% of the documents contained DNACPR decisions (34% of all inpatients) and 15% were for full active treatment (6% of all inpatients).

Mitigations / Timescales / Blockers

- 54% of patients triggering on the deteriorating patient pathway (DPP) received a senior clinical review within 60 mins of trigger in March an increase from February (49%).
- MET calls receive an immediate review by the medical registrar on calls within 5 minutes of the 2222 call being placed on the RHH site. There is no medical emergency team at Guest or Corbett (nurse & AHP bleed holders will respond).
- 22% of patients triggering on the DPP received a TERP as a result of the review at the point of deterioration.

Risk Register

- UC2350 [Due to a lack of nursing presence to undertake visual observations in the front waiting room \(Emergency Department\) this could lead to a failure to recognise a deteriorating patient and potentially result in patient harm](#)
- ASM2413 [A potential patient safety risk associated with a lack of assurance that observations are completed on time and with the correct process for compliance with the deteriorating patient policy.](#)

Key Points to Note

- There is a noticeable increase in 2222 calls on both Guest & Corbett Outpatient centre sites with 6 calls at Guest & 21 at Corbett in Q4 versus 0 & 13 in the same time frame last year.
- More robust treatment & escalation plans placed during normal working hours may reduce the number of out of hours cardiac arrests.

Sepsis

Background

Quarterly submissions for compliance with intravenous antibiotic administration within 60 mins of deterioration in patients with suspected sepsis

Performance

Date

March 2025 (Q4 2024/2025)

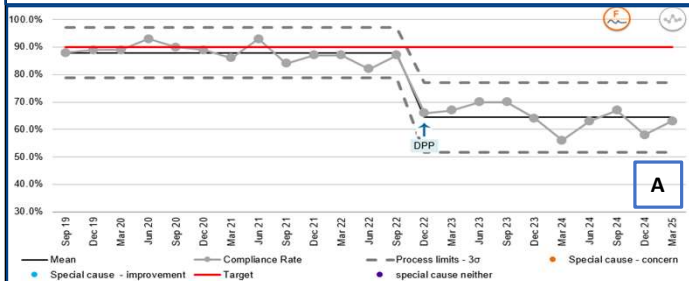
Trust Performance

A) 63% B) 60%

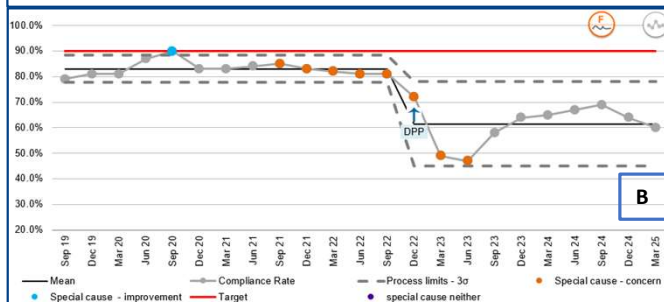
Performance Target / KPI

>90%

Quarterly sepsis submissions for ED-Emergency Department starting 30/09/19



Quarterly sepsis submissions for inpatients-DPT starting 30/09/19



What are the charts showing us

Quarterly submissions for

A) users presenting to the emergency department who undergo sepsis screening and who, where screening positive, receive IV antibiotic treatment ≤ 1 hour of time zero (63%)

B) inpatients who undergo sepsis screening and who, where screening positive, receive IV antibiotic treatment ≤ 1 hour of time zero (60%)

Areas Impacting on Compliance

- Delays of documentation of vital signs at the point of care
- Delays in commencing screening tool at time zero
- Delay in senior clinical review will impact time available to administer antibiotics
- Increase in additional patients to standard ward format is impacting on timeliness of treatment of inpatients with suspected sepsis

Mitigations / Timescales / Blockers

- ED sepsis improvement plan project group now meet monthly to formulate action plans based upon deep dive analysis of the 263 December patient journeys & will repeat the deep dive analysis of every patient for the March data within the next month for more learning.
- Divisions asked to report sepsis action plans to next Deteriorating patient group (DPG) in May.

Risk Register

COR1015, COR1420, COR1894, COM2386, COM2164, UC2259, ASM2264, ACC2265, ASM2268

Key Points to Note

- March data for ED has increased from 62% in Feb to 72% (from total 162 patients in March v 158 patients in Feb)
- March data for inpatients has remained at 61% the same as Feb (from total 61 patients in March v 88 in Feb)
- ED have started a monthly departmental sepsis action group

Vital Signs Compliance

Background

Vital signs should be documented at the point of care (within 6 mins of recording) and frequency according to risk level from early warning score (EWS)

Performance

Date

March 2025

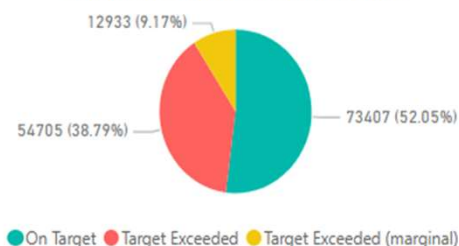
Trust Performance

52.05% on time/92.82% in 0-15mins

Performance Target / KPI

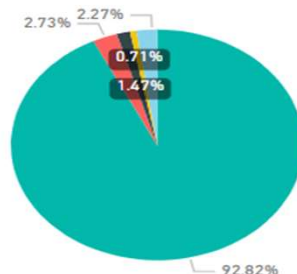
Vital signs recorded on time(via EWS risk level)

Compliance For Observation On-Time



Time to Enter Obs

- 0-15 mins
- 15-30 mins
- 30-45 mins
- 45-60 mins
- Over 60 mins



What are the charts showing us

Frequency of vital signs recordings are mandated by the clinical risk determined by the appropriate early warning score (NEWS2 = adults, NPEWS = paediatrics, MEOWS = maternal patients, [NEWTT = neonatal – not on EPR]).

The compliance for observations (vital signs) on time demonstrates an increase in compliance from 51.11% to 52.05% of all vital signs recorded in March.

2.28% (a reduction from 2.45%) of vital signs have been documented over 60minutes after they have been recorded, this indicates staff are writing vital signs on paper then documenting later rather than at the point of care (1846 patients).

Areas Impacting on Compliance

- Vital signs are often continued in patients reaching their end of life unnecessarily, these patients may be scoring highly on NEWS2 requiring increased monitoring that can be uncomfortable.
- There remains a significant number of patients (5848) that staff have taken over 15 minutes to document the vital signs from the point of undertaking them

Mitigations / Timescales / Blockers

- The areas with the highest proportion of vital signs documented later than 0-15 mins are: CAPD (40%), A2 (68.5%), maternity delivery suite (71.15%), MECU (77.38%), maternity ward (77.65%) and POCU (78.38%).
- Best performing areas for March are PAU (98.63%), PCCU (98.19%), C5 (97.94%), day case unit (97.83%), C1 (97.6%) and A2 supersurge (97%).

Risk Register

ASM2413, UC2350

Key Points to Note

- Ensuring vital signs are documented at the point of care would increase the compliance of vital signs on time.
- Call for concern was activated for 19 patients in March across 9 clinical areas, with the highest number of patients on AMU 1 (4).

Quality KPI Dashboard



Background

Performance

Date

March 2025

Trust Performance

AMaT RAG: **Red <84%**; **Amber 85% – 89%**; **Green 90% +**

Performance Target / KPI

90%

Priority 1 AMaT audits October 2024 – March 2025

Audit	Frequency	Compliance over last 6 periods						
Tissue Viability SKIN audit (CQUIN 12)	M	97.1%	96.5%	97.6%	96.3%	97.3%	97.4%	
Hand Hygiene '5 moments' audit (v2)	M	98.5%	98.8%	98.6%	98.3%	98.6%	99.2%	
Hand Hygiene Environment Audit	M	98.9%	99.0%	98.8%	98.7%	99.1%	98.9%	
Matron In Patient Audit	M	86.3%	87.3%	90.5%	90.8%	89.9%	88.5%	
Matron Audit - Out Patient Areas	M	95.5%	96.7%	96.7%	96.4%	95.4%	97.0%	
Lead Nurse In Patient Audit	M	93.9%	91.7%	94.2%	93.2%	93.4%	93.7%	

The standard of documentation audit has maintained a green RAG rating quarterly therefore it has been removed from this report. Should this change, it will be reinstated.

The other priority 1 audits remain on monthly monitoring, even though consistently green RAG rated, as these are key indicators to nursing care delivery Any drop in compliance needs to be reviewed and monitored to ensure concerns identified are addressed, for example the matron inpatient audit this month.

What are the charts showing us

- Matron inpatient audit is not achieving the required compliance level of 90%. This is due to the eobs question being moved from the lead nurse audit into the matron audit.

Areas Impacting on Compliance

- Gaps in completion of nursing documentation (*Divisions addressing this with wards*)
- Safer care tool completion not fully completed (*Associate Chief Nurse – Workforce addressing this with Division Leads*)
- Missing emergency equipment checks (*Divisions addressing with wards, reminders sent to ward leads daily*)
- Sepsis screening and IV antibiotics standards below 90% (*IV antibiotics is reliant on doctors prescribing the treatment, dashboard alerts ward staff to sepsis screening data*)
- E-obs not completed within 30 minutes (*Task and finish group set up to address this Trust wide*)
- Mandatory training below 90% (*Lead nurses addressing, two weekly reminders to individual staff via email*)
- AMaT audits/actions not completed as expected (*some audits have since been identified as n/a for certain wards and have now been removed*)

Mitigations / Timescales / Blockers

- Monthly quality reviews with Matrons and Lead Nurses at Division level to ensure action plans are in place to address areas of concern in Medicine and SWC Division.
- Quality Working Group are monitoring AMaT data monthly to ensure Divisions are taking appropriate action and to share good practice identified.
- 10 additional beds on AMU and 4 trolleys in ED x-ray to meet capacity demand – placement of these beds means negative scores in some aspects of the audits (e.g. no behind the bed boards)

Risk Register

- Nil reported

Key Points to Note

- Lead Nurses/Senior nursing/midwifery/AHP staff are working on wards in clinical shifts to deliver patient care, this affects timely completion of quality audits and actions.

Chief Nurse Dashboard (Inpatient areas)



Date

March 2025

Ward Level Quality Matrix

Date Report Refreshed:

02/04/2025 08:47:22

The Dudley
NHS Foundation

WardGroup	Budget WTE	Contracted WTE	Vacancy %	Sickness %	All Unavailability %	Parenting %	All Unavailability %	Total CHPPD	Mandatory Training %	%FFT Inpatient, Good & Very Good	Open Complaints (at the end of previous month)	Pressure Ulcer - Cat3, 4, Unstageable	Pressure Ulcers (Cat 3 & above)	Moisture Associated Skin Damage	Falls with Harm	Cardiac Arrest Calls	Total Positive C-Diff Cases	Patient Observations Completed On Time %	WardGroup	Hand Hygiene 5 moments audit (v2)	Hand Hygiene Environment Audit - Monthly	Lead Nurse In Patient Audit	Matron In Patient Audit	Tissue Viability SKIN audit (COLIN 12)	WardGroup	Has a falls risk assessment been completed?	MUST or MUAC completed	Waterlow completed
AMU	218.0	195.9	10.1%	13.3%	52.8%	13.4	103.5		95.6%	100%	11	3	2	3	0			90%	AMU	99.3%	100.0%	89.7%	89.2%	97.2%	AMU	100.0%	70.0%	75.0%
CCU	54.1	48.3	10.7%	17.4%	64.0%	6.8	30.9		93.8%		1	1	0	3	0	1		48%	CCU	100.0%	100.0%	n/a	89.8%	n/a	CCU	n/a	n/a	n/a
Critical Care	120.4	128.4	6.7%	18.8%	71.2%	16.9	91.4		91.5%	100%	1	0	0	0	0			57%	Critical Care	100.0%	100.0%	86.7%	87.5%	100.0%	Critical Care	68.0%	40.0%	10.0%
Discharge Lounge	11.9	10.7	9.2%	22.0%	64.3%	2.0	6.9		91.7%		2	2	0	0	0			13%	Discharge Lounge	85.7%	94.7%	n/a	84.2%	95.3%	Discharge Lounge	n/a	n/a	n/a
ED	188.7	161.8	14.3%	21.4%	70.5%	17.9	114.0		10.5%		30	1	0	1	0	1		85%	ED	99.0%	100.0%	n/a	n/a	n/a	ED	n/a	n/a	n/a
ESH	73.7	74.5	1.1%	12.2%	52.3%	9.1	39.0		97.3%	73%	3	0	0	3	0	1		92%	ESH	100.0%	100.0%	91.3%	85.7%	100.0%	ESH	100.0%	100.0%	10.0%
FMNU	44.6	41.2	7.6%	10.2%	50.4%	3.9	20.7		92.6%		2	0	0	0	0			77%	FMNU	100.0%	100.0%	n/a	90.9%	97.5%	FMNU	n/a	n/a	n/a
Maternity	151.3	161.9	7.0%	16.8%	78.0%	15.4	126.3		91.6%		6							32%	Maternity	100.0%	100.0%	n/a	n/a	98.9%	Maternity	n/a	n/a	n/a
MECU	21.4	20.8	3.3%	15.2%	52.4%	1.0	10.9		97.1%	92%	0	0	0	1				18%	MECU	100.0%	100.0%	97.4%	92.6%	100.0%	MECU	100.0%	90.0%	100.0%
Neonatal Unit	48.0	59.5	23.9%	14.2%	71.6%	4.1	42.6		97.3%	0%								45%	Neonatal Unit	100.0%	100.0%	n/a	n/a	n/a	Neonatal Unit	n/a	n/a	n/a
Renal Unit	37.5	37.2	0.8%	26.3%	63.9%	2.2	23.8		92.0%									78%	Renal Unit	98.7%	94.7%	n/a	n/a	n/a	Renal Unit	n/a	n/a	n/a
SDEC	71.0	65.8	7.4%	13.3%	53.3%	3.4	35.1		90.2%	96%	9	0	0	0	0			55%	SDEC	100.0%	100.0%	n/a	n/a	n/a	SDEC	n/a	n/a	n/a
Ward A2										50%								70%	Ward A2	n/a	100.0%	n/a	n/a	n/a	Ward A2	n/a	n/a	n/a
Ward B1	31.0	30.6	1.5%	15.1%	56.9%	2.1	17.4		99.0%	90%	2							65%	Ward B1	100.0%	100.0%	98.7%	91.5%	100.0%	Ward B1	100.0%	100.0%	100.0%
Ward B2 Hip	50.0	50.8	1.5%	14.6%	50.6%	3.4	25.7		90.3%	78%	1	0	0	0	0	1		27%	Ward B2 Hip	100.0%	100.0%	97.0%	94.0%	100.0%	Ward B2 Hip	100.0%	90.0%	100.0%
Ward B2 Trauma	42.1	42.9	1.9%	14.3%	48.3%	1.1	20.7		99.6%	57%	3	0	0	3	0			37%	Ward B2 Trauma	100.0%	100.0%	95.2%	89.5%	95.8%	Ward B2 Trauma	100.0%	90.0%	100.0%
Ward B3	64.2	63.2	1.6%	16.8%	58.7%	5.2	37.1		92.6%	69%	2	1	0	7	0			48%	Ward B3	100.0%	88.9%	n/a	85.4%	n/a	Ward B3	n/a	n/a	n/a
Ward B4	88.1	75.9	13.3%	21.6%	60.3%	8.2	45.7		92.7%	76%	6	3	0	2	0			48%	Ward B4	100.0%	83.3%	n/a	84.1%	100.0%	Ward B4	100.0%	90.0%	100.0%
Ward B6	25.2	21.7	13.3%	6.7%	61.5%	4.3	13.4		91.7%	100%	1	0	0	0	0			28%	Ward B6	n/a	n/a	n/a	91.5%	98.4%	Ward B6	n/a	n/a	n/a
Ward C1A	37.4	34.0	9.1%	10.2%	50.4%	3.7	17.1		85.6%	43%	1	0	0	0	0			26%	Ward C1A	77.4%	100.0%	95.7%	92.3%	100.0%	Ward C1A	100.0%	80.0%	100.0%
Ward C1B	38.1	37.1	2.6%	11.3%	58.4%	1.5	21.6		92.3%		3	0	0	1	0			17%	Ward C1B	98.0%	100.0%	97.6%	99.2%	100.0%	Ward C1B	100.0%	100.0%	100.0%
Ward C2	58.1	53.1	9.0%	19.5%	64.7%	6.5	34.3		89.9%		2							62%	Ward C2	n/a	n/a	n/a	n/a	n/a	Ward C2	n/a	n/a	n/a
Ward C3	56.5	53.5	5.1%	19.0%	39.9%	5.3	21.3		89.5%	75%	2	0	0	1	0			48%	Ward C3	n/a	n/a	n/a	91.2%	n/a	Ward C3	n/a	n/a	n/a
Ward C4	64.2	63.6	1.0%	16.0%	60.2%	9.4	38.3		96.2%	100%	2	0	0	1	1			10%	Ward C4	97.3%	100.0%	97.1%	88.3%	n/a	Ward C4	98.0%	70.0%	100.0%
Ward C5A	41.3	39.3	5.1%	21.4%	49.7%	0.9	19.5		93.5%	56%		0	0	0	0	1		28%	Ward C5A	95.5%	100.0%	98.1%	78.2%	100.0%	Ward C5A	100.0%	100.0%	100.0%
Ward C5B	46.6	44.3	5.1%	9.3%	61.4%	4.7	27.2		90.0%			0	0	0	0			22%	Ward C5B	100.0%	100.0%	97.3%	89.8%	100.0%	Ward C5B	90.0%	100.0%	100.0%
Ward C6	31.8	34.8	9.4%	13.1%	60.4%	4.8	21.0		89.9%	82%		0	0	0	0			50%	Ward C6	97.3%	100.0%	n/a	83.1%	97.0%	Ward C6	n/a	n/a	n/a
Ward C7	64.1	61.5	4.0%	18.1%	71.1%	7.4	43.7		92.9%	75%	3	0	0	1	0			28%	Ward C7	100.0%	100.0%	n/a	82.8%	96.5%	Ward C7	n/a	n/a	n/a
Ward C8	81.9	74.1	9.3%	13.2%	60.8%	6.3	45.1		90.9%	69%	3	1	0	0	0			18%	Ward C8	92.7%	89.5%	83.7%	89.5%	94.5%	Ward C8	100.0%	80.0%	100.0%
Total	1,853.1	1,786.2	3.6%	15.9%	61.3%	171.1	1,094.3		90.1%	82%	96	12	2	27	2	5		50%	Total	99.4%	98.3%	91.1%	88.5%	98.2%	Total	92.4%	83.2%	96.9%

Notes:

- 8 ward areas now reported as RAG red for vacancy WTE data – 50% increase in areas reporting this since January 2025.
- Rising sickness continues to be attributed to seasonal illness was 9.49% overall in January 2025, now 15.9%.
- A task and finish group to review patient observations completed on time is in progress to focus on improving performance.
- The AMaT issues identified in last months report, caused by the software programme update, have been addressed.
- AMaT compliance scores have altered: 90% + is green RAG. However, AMaT reports anything from 89.1% to 90% as green RAG rated – the dashboard recognises 90% as the green RAG rating, hence the discrepancy in RAG ratings between data drawn directly from AMaT (previous slide) and that from the Chief Nurse dashboard.

Kitemark Explanation

Element	Definition
Timeliness	<p>The time taken between the end of the data period and when the information can be produced and reviewed.</p> <p>The acceptable data lag will be different for different performance indicators.</p> <p>Data should be captured as quickly as possible after the event or activity and must be available for the intended use within a reasonable time period.</p> <p>Data must be available quickly and frequently enough to support information needs and to influence the appropriate level of service or management decisions.</p>
Monitoring	<p>The degree to which the trust can drill down into data in order to review and understand operational performance.</p> <p>The level to which the trust needs to drill down into the data will vary for different performance indicators. Some information should always be available at patient level for performance monitoring purposes. Whereas some information may be sufficient if it is available at speciality level for all specialties or even trust level for performance monitoring purposes.</p>
Completeness	<p>The extent to which all of the expected attributes of the data are populated but also the extent to which all of the records for the relevant population are provided.</p>
Validation	<p>The extent to which the data has been validated to ensure it is accurate and in compliance with relevant requirements. For example, correct application of rules and definitions. The level of validation required will vary from indicator-to-indicator and will depend on the level of data quality risk.</p> <p>Final validation is classified as sufficient where validation has been completed and where the indicator has received final approval from responsible individuals.</p>
Audit	<p>The extent to which the integrity of data (completeness, accuracy, validity, reliability, relevance, and timeliness) has been audited by someone independent of the KPI owner (for example, Internal Audit, External Audit, Clinical Audit or Peer Review) and the extent to which the assurance provided from the audit is positive.</p>

Element	Definition
Reliability	<p>The extent to which the data is generated by a computerised system, with automated IT controls, or a manual process. It also relates to the degree of documentation outlining the data flow, i.e. documented process with controls and data flows mapped.</p> <p>Data should reflect stable and consistent data collection processes across collection points and over time, whether using manual or computer-based systems or a combination. Managers and stakeholders should be confident that progress toward performance targets reflects real changes rather than variations in data collection approaches or methods.</p>
Relevance	<p>The extent to which the data is captured for the purposes for which it is used. This entails periodic review of the selection of key performance indicators to reflect changing needs, such as new strategic objectives. For example, is this indicator the right indicator by which to measure performance against a strategic objective. Strategic objectives will be defined within the scoping document for proposed new measures.</p>



- Insufficient
- Insufficient, but under active review/management
- Sufficient
- Not Yet Assessed

Click [HERE](#) for full kitemark explanation & policy

Performance KPIs

April Report (March 2025 Data for National Performance & February 2025 Data for Cancer & VTE)

Karen Kelly, Chief Operating Officer











Constitutional Targets Summary	Page 2
ED Performance	Pages 3-10
Cancer Performance	Pages 11-13
RTT Performance	Pages 14-15
DM01 Performance	Pages 16-17
VTE	Page 18
Screening Programmes	Page 19
Kitemark Explanation	Page 20



The Dudley Group
NHS Foundation Trust



Constitutional Performance

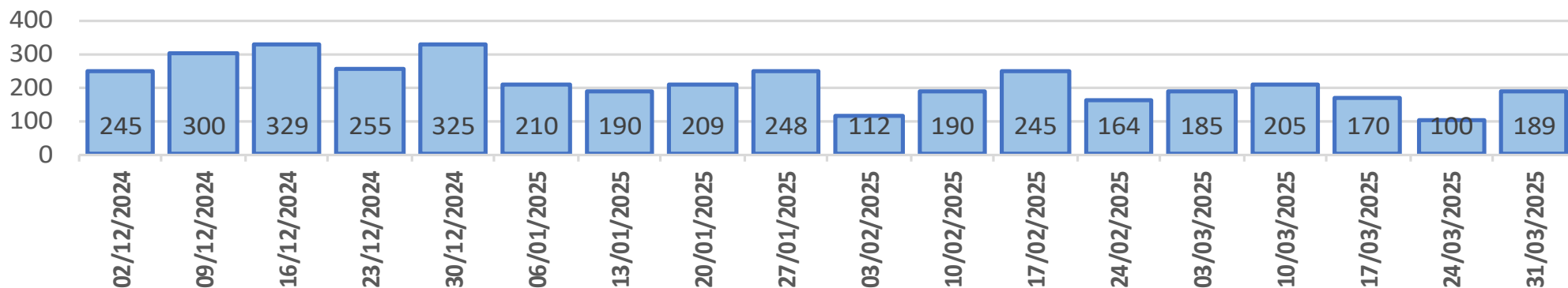
Constitutional Standard and KPI		Target															
			Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25		
Emergency Access Standard (EAS)	Combined 4hr Performance	78.0%	78.7%	80.3%	81.2%	81.6%	79.9%	83.6%	81.2%	81.9%	81.9%	78.1%	77.8%	78.7%	80.5%		
Triage	Triage - All	95.0%	80.7%	74.2%	79.5%	80.2%	73.3%	75.9%	81.4%	78.1%	84.3%	73.0%	76.4%	73.6%	76.1%		
Referral to Treatment (RTT)	RTT Incomplete	92%	56.5%	57.8%	58.2%	58.6%	58.6%	57.2%	57.5%	58.3%	59.2%	58.2%	58.7%	58.9%	59.9%		
Diagnostics	DM01 - Diagnostics achieved within 6 weeks	85%	91.3%	89.6%	88.4%	86.9%	88.3%	86.3%	86.2%	89.2%	90.4%	85.8%	85.2%	87.8%	86.5%		
VTE	% Assessed on Admission	95%	99.3%	98.9%	98.7%	99.0%	99.1%	99.2%	99.1%	99.1%	99.1%	98.9%	98.7%	98.9%	N/a		



Ambulance Handovers 60+ Mins



Ambulance Handovers 60+ mins



Performance

This month's activity saw 10,120 attendances. This has increased when compared to the previous month of February with 8,402.

21 out of the 31 days saw >300 patients.

3,215 patients arrived by ambulance; this shows an increase from the 3,189 ambulances that attended last month.

529 of these offloads took <1hr (16%). This is the same as our performance when compared with last month's performance of 16%.

Over the month, the average length of stay (LOS) in ED was 210 mins for non-admitted patients and 450 mins for those waiting for a bed following a decision to admit. This represents an Improvement when compared to last month where the LOS was 217 mins and 469 mins, respectively.

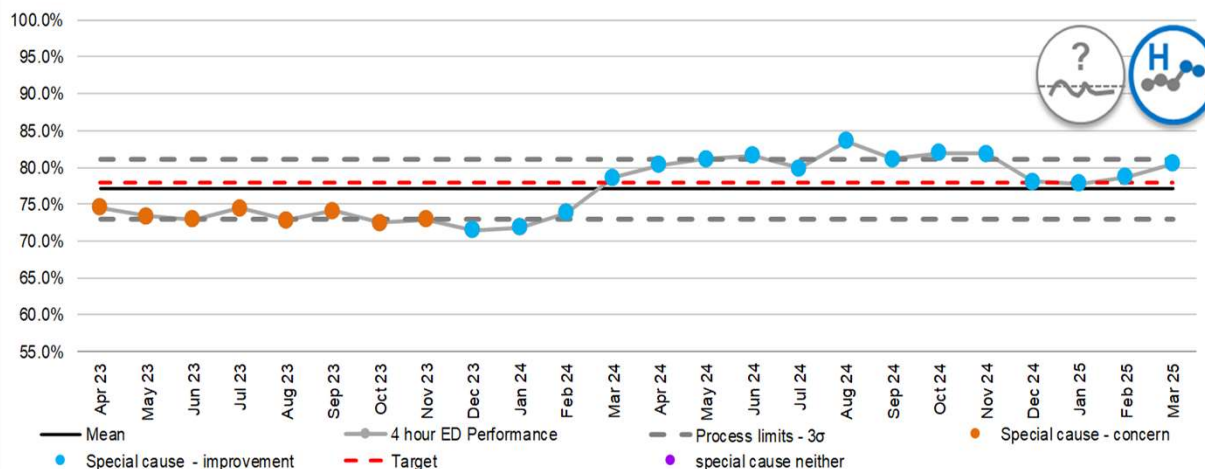
Action

- We continue to use RAT for all ambulance patients to ensure assessment, treatment and medication are given quickly
- New front door model proposed, presence of AMU doctor, ED medic, receptionist, ambulance tracker, and triage nurse to streamline patient flow and improve efficiency. This is still under review, currently being scoped with divisional management.
- Escalation of ambulances without a plan to offload at 30mins to Site Team with additional role cards to link AMU & Site teams based on the Kings College Model- Continues to be in progress
- Additional trolley capacity now in place to ensure offloads can happen promptly at the ambulance entrance- Implemented and Operational
- Streamers and triage nurses continue to utilise pathways as early as possible and sit out suitable patients to free up ambulance- We continue to utilise pathways to allow efficient ambulance offload
- Designated ED Tracker monitoring ambulance offloads/pinning. Regular escalation to both halo, site, ops management and NIC- Ongoing monitoring and regular escalation in place
- ED operational escalation bleep initiated through office hours and point of contact for urgent escalations- this is currently in use
- Requirement for all CAT 3 ambulances to contact Dudley Clinical Hub, even if already presented at hospital, to explore potential community-based interventions and avoid any unnecessary hospital admissions- In progress, on-going work to streamline communication and ensure full implementation
- Utilise TES space (four additional beds) to support patient flow and alleviate ambulance handover delays- TES space staffed by site team, with NIC identifying suitable patients

ED Performance



ED seen with 4 hours Combined Performance- starting 01/04/23



Latest
Month
80.5%

Latest
Month
112

3rd
For
Mar 2025

EAS 4 hour target
78% for Type 1 &
3 attendances

DTA 12 hour
breaches -
target zero

DGFT ranking
out of 13 West
Midlands area
Trusts

Performance

RHH ED Performance for February is 2nd best in the black country despite high ambulance and walk-in attendance when compared to our regional neighbours.

We continue to validate performance and record reasons for each breach which is then explored by the ops team and the department tri.

Last month's data have allowed for identification of themes and increased focus on these have been:

- GP letter patients straight to SDEC/Surgical SDEC.
- Agree new streaming template with UCC for patients with letters to go direct to Speciality.
- Altering the registration process for patients arriving by the front door.

Action

- Deputy Matrons are further highlighting 4hr performance whilst on clinical floor to teams.
- Continued scrutiny that GP letters are being directly streamed to appropriate area to avoid being booked into ED.
- Focus now on NHSE's 5 priority ED improvement initiatives
 - Streaming & Redirection
 - Rapid Assessment & Treatment
 - Maximising UTC use
 - Improving Ambulance Handover process
 - Reducing the time in department

ED 4 Hour Waits Benchmarking

National 4 hour EAS Target Comparison

This is based on trust activity for the following:
Inclusion of Type 1-4
Inclusion of 111 booked activity for all types

March 2025

Latest Refresh

10/04/2025 10:09:37

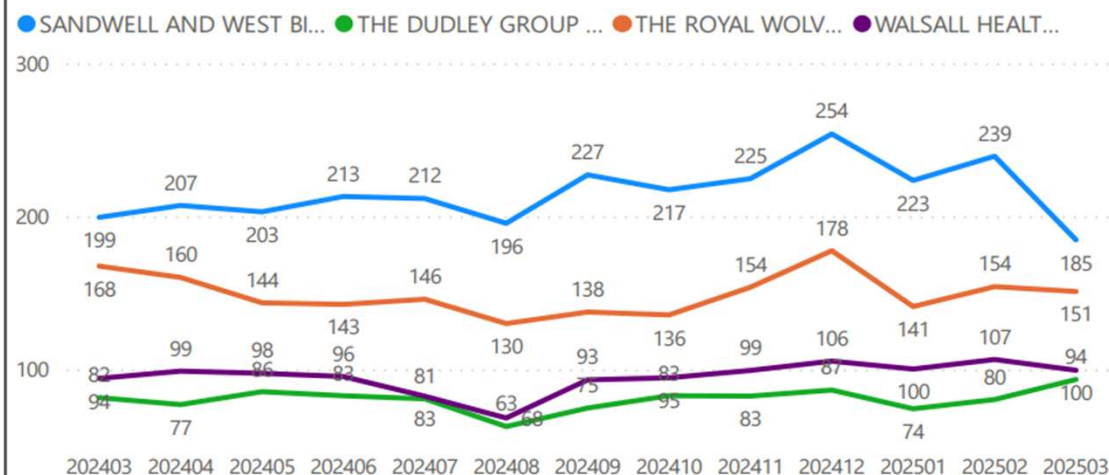
Name	Value	National Rank
Birmingham Women's And Children's NHS Foundation Trust	87.69%	4
The Royal Wolverhampton NHS Trust	81.60%	15
The Dudley Group NHS Foundation Trust	80.49%	16
Walsall Healthcare NHS Trust	75.30%	40
Sandwell And West Birmingham Hospitals NHS Trust	75.01%	42
University Hospitals Coventry And Warwickshire NHS Trust	72.21%	56
South Warwickshire NHS Foundation Trust	69.17%	79
George Eliot Hospital NHS Trust	66.35%	92
Worcestershire Acute Hospitals NHS Trust	65.97%	94
University Hospitals Of North Midlands NHS Trust	64.58%	101
Wye Valley NHS Trust	63.23%	105
University Hospitals Birmingham NHS Foundation Trust	62.76%	107
The Shrewsbury And Telford Hospital NHS Trust	52.48%	120

DGH

Ranking out of 122 Trusts

Source: [Daily EAS - Power BI](#)

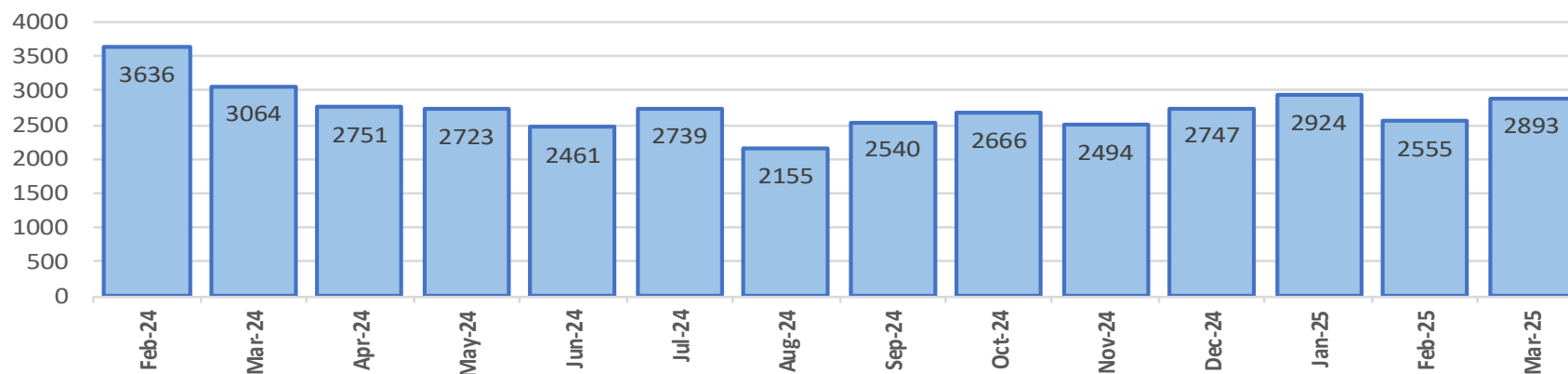
Mean Time (mins) from Arrival to Treatment (All ED Attendances)



ED 4 Hour Wait Number of Breaches



ED 4 Hour Wait Breach Numbers

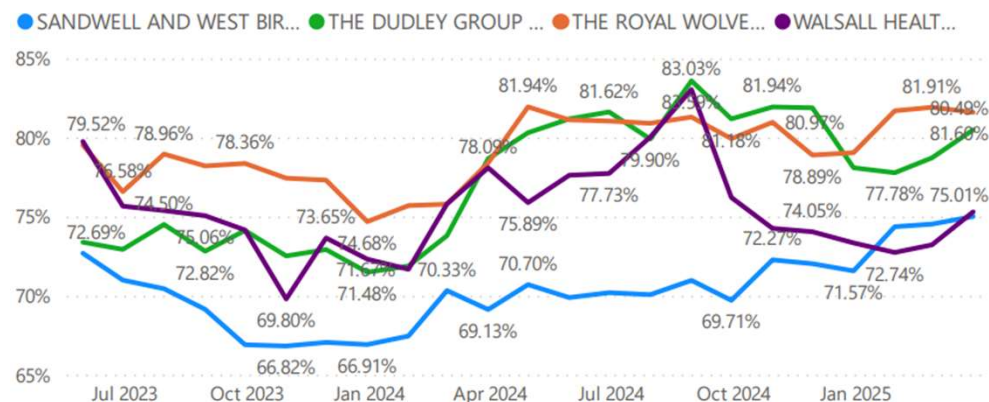


Date	No. Breaches
Feb-24	3636
Mar-24	3064
Apr-24	2751
May-24	2723
Jun-24	2461
Jul-24	2739
Aug-24	2155
Sep-24	2540
Oct-24	2666
Nov-24	2494
Dec-24	2747
Jan-25	2924
Feb-25	2555
Mar-25	2893

Performance

ED remains the 2nd best performing department in the black country and in the top 12 nationally.

ED Total Performance



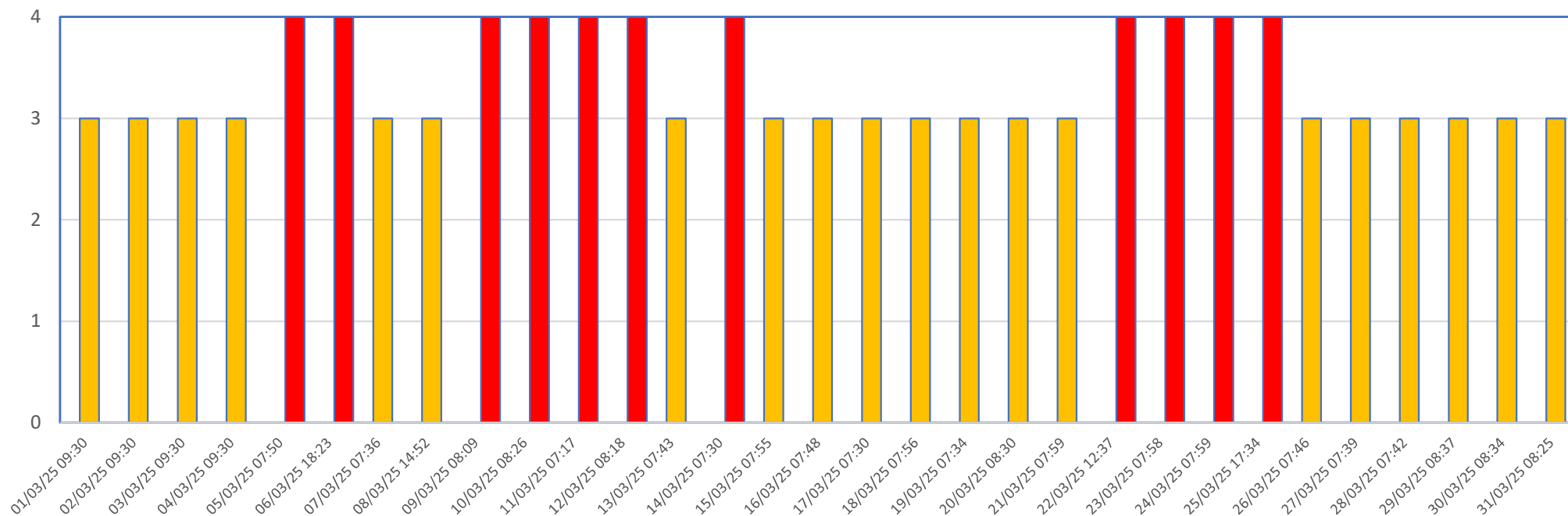
Action

- The ED performance for March was at 80.49% vs the national target of 78%.
- Last month's data have allowed for identification of themes and increased focus on these have been:
 - GP letter patients straight to SDEC/Surgical SDEC.
 - Agree new streaming template with UCC for patients with letters to go direct to Speciality.
 - Joint working with Surgery to ensure proactivity to take patients from ED even when full.
 - Organizational agreement that specialties must take patients directly and not wait to assess them in ED.
 - Extra Validation resource.



DGH EMS Levels for March

(Highest recorded level each day)



Performance

EMS Levels 4 during March.

3,215 patients arrived by ambulance; this shows an increase from the 3,189 ambulances that attended last month.

529 of these offloads took <1hr (16%). This shows is the same as our performance when compared with last month's performance of 16%.

In terms of capacity the trust continues to be impacted by medically optimised for discharge patients, which is further exacerbating flow issues and leading to pressure at both the front and back door.

Action

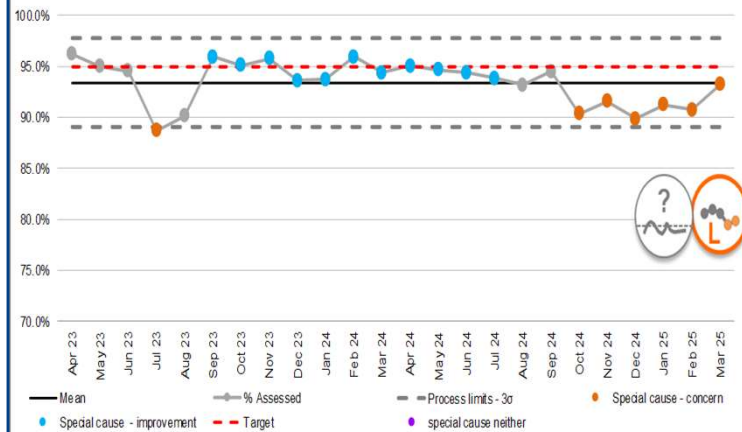
- To continue to utilise non-admitted pathways wherever possible.
- Maintain step downs from acute areas to ensure provision available for the highest acuity patients.
- Focus now on NHSE's 5 priority ED improvement initiatives
 - Streaming & Redirection
 - Rapid Assessment & Treatment
 - Maximising UTC use
 - Improving Ambulance Handover process
 - Reducing the time in department



- Deputy Matrons continue to lead on Triage improvement
- ED assurance report now submitted monthly to Execs.
- Daily triage continues to be monitored by the Deputy Matrons.
- Front door triage demand continues to be higher than the available capacity of area and staff.
- More nurses have received their ESI training with additional codes which have been purchased.

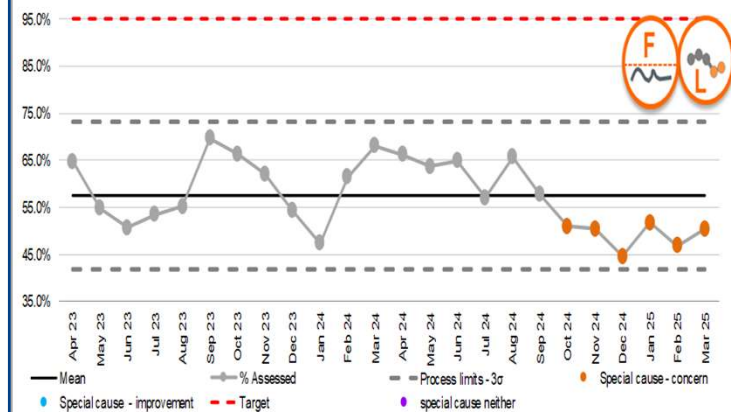


Ambulance - starting 01/04/23



Latest Month
93.2%

Major - starting 01/04/23



Latest Month
50.5%

Performance

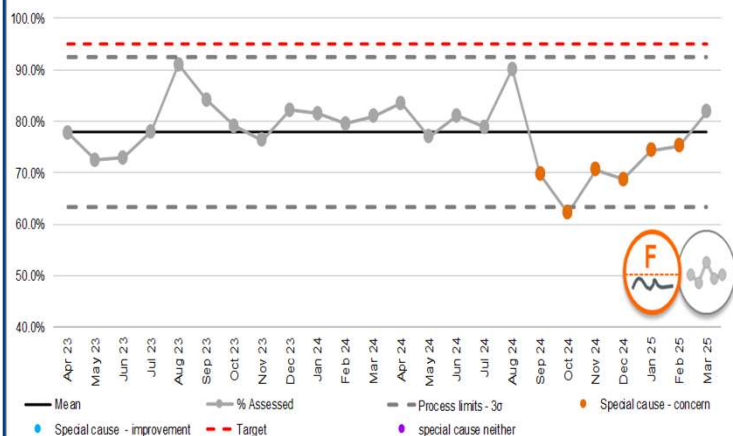
ED have reconfigured the treatment areas following the floor works and ahead of the planned building works and now have a dedicated triage space and we are monitoring performance daily

Action

- Time spent in triage continues to be monitored
- Increased focus in direct to speciality patients being sent from UCC rather than being triaged in ED

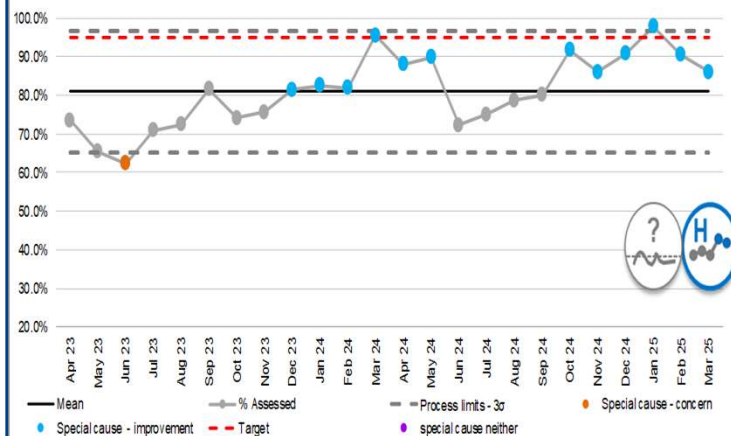


Paediatrics-starting 01/04/23



Latest
Month
81.8%

See and Treat-starting 01/04/23



Latest
Month
86.0%

Performance

ED have reconfigured the treatment areas following the floor works and ahead of the planned building works and now have a dedicated triage space and we are monitoring performance daily

Action

- Paeds daily huddles continue to good effect and triage performance and escalations are discussed.
- Develop process for quickly monitoring and altering when minor's patients need to begin having early "eyes on" assessments rather than just seeing and treating patients all in one go – this is being developed and supported by Nurse/ENP/Medical teams.



	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25
28 Day Combined (75%)	81.3%	78.4%	83.3%	81.9%	81.6%	83.5%	82.0%	80.9%	81.9%	84.1%	81.5%	87.1%
31 Day Combined (96%)	86.7%	91.1%	92.5%	90.3%	94.1%	89.9%	90.8%	92.9%	91.7%	94.3%	88.8%	93.6%
62 Day Combined (85%)	71.5%	72.8%	67.2%	70.3%	74.4%	72.6%	71.7%	76.4%	70.3%	80.5%	74.9%	70.5%

Latest Month 87.1%	Latest Month 93.6%	Latest Month 70.5%
All cancer 28 Day FDS waits – target 77%	31 day Combined Target 96%	62 Day Combined Target 70%

Performance

*All cancer data reports two months behind. Data included is up to and including February 2025:

28-day Faster Diagnosis Standard (FDS)

- Performing well at 87.1% and remains above national target of 77%.. Increased focus on individual tumour site pathways.

31 day combined

- 31 day combined achieving 93.6% against national target of 93.6%. Surgical and diagnostic capacity and BCPS reporting delays impact performance. 31 day trajectory to achieve 96% submitted to ICB. Renal and skin are tumour sites most challenged.

62 day combined

- Achieved 70.5% and remains above NHSE target of 70% by end of March 2025. (This target does not supersede the 85% constitutional standard but set to support tiering measures for cancer performance).
- Late Tertiary referrals closely monitored. Primarily urology, colorectal and lung. Actions in place to reduce. Cancer performance is reviewed at Regional Performance Tier Calls with NHSE.

Action

28-day FDS

-Performance to be sustained. Forecast shows continued achievement.

31 day combined & 62 combined

- Gynae: remains challenged. ICB aware and the team are working on extra capacity.
- Prostate – increased first OPA and biopsy capacity required for April. Extra capacity planned.
- Extra capacity across all pathways continues to be monitored.

BCPS

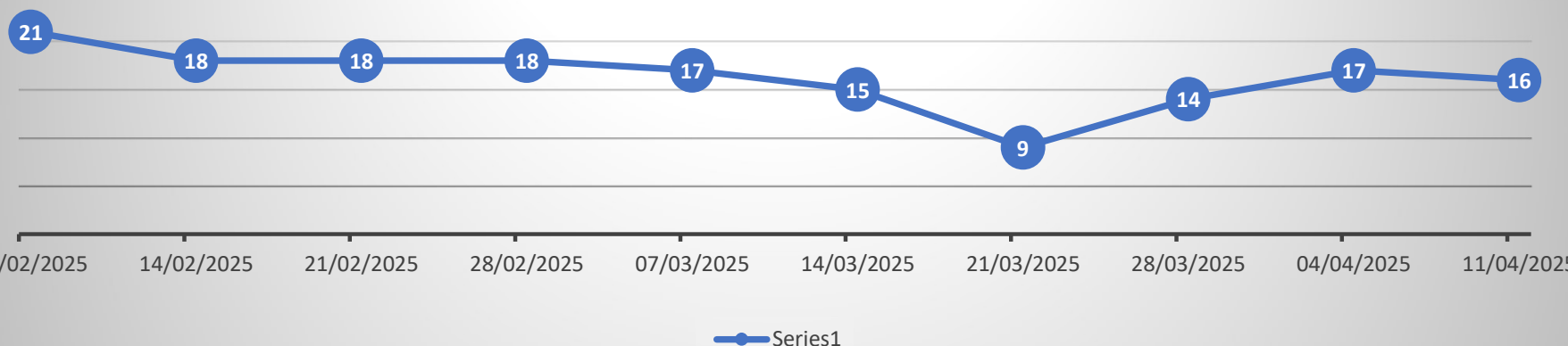
- Urgent 10-day Histology: March 2025 was 60% against national target of 70% and is same as March performance at SWBH. 57% was reported at RWT and WHT. For urgent cases March 2025 performance has remained static at 55%, SWBH was 52%, RWT was 45% and WHT 36%. Compass pilot is due to go live once all SOPs and policies have been ratified at relevant committees and Gastro continue to work through the technical issues. Blood sciences urgent test TAT was 91.3% in March compared to 86.6% in February.

Cancer Performance – 104 Day – Harm Review



104 + days patients

Source: Weekly Cancer Performance



Latest
Week

(11/04/25)

16

All 104 week waits,
target 10 Patients

Performance


- Of the 16 over 104 days patients, urology remains the most challenged pathway with 8 patients waiting over 104 days as surgical capacity is limited.
- 10 of the 16 breaches have treatment plans / treatment dates. Those without treatment plans were awaiting surgery dates, best interest meetings or further investigations.
- In February we treated 20 patients waiting over 104 days at DGFT and tertiary centres

Action

- Monthly harm review undertaken for patients waiting over 104 days on the cancer pathway
- Focus on reducing the backlog of 104 day waits to release treatment capacity for 31 day and 62-day targets continues. Improve patient engagement earlier in the pathway
- It is anticipated that actions taken to improve combined 62-day performance will support the reduction of patients waiting over 104 days
- Tertiary Referrals: Lung requires multiple diagnostics. PET scans and histology are causing main delays, and this is being addressed. Prostate biopsy capacity is in scope.

Cancer Benchmarking

28-Day Faster Diagnosis Standard vs Planning Trajectory

		Oct-24		Nov-24		Dec-24		Jan-25		Feb-25		Mar-25		Apr-25	
		Plan	Actual	Plan	Actual	Plan	Actual	Plan	Actual	Plan	Unvalidated	Plan	Unvalidated	Plan	Unvalidated
															
WHT - FDS		75.2%	88.3%	76.0%	75.9%	75.8%	70.1%	76.1%	83.7%	76.4%	87.4%	77.1%	84.3%	82.4%	79.8%
RWT - FDS		77.0%	76.7%	79.0%	80.3%	78.0%	80.8%	78.0%	77.5%	79.0%	81.7%	80.0%	78.3%	80.0%	84.5%
DGH - FDS		77.0%	80.9%	77.1%	81.9%	77.1%	84.1%	77.1%	81.5%	77.0%	87.1%	77.1%	86.9%	82.0%	88.5%
SWB - FDS		75.4%	79.2%	76.0%	75.5%	76.5%	76.0%	75.4%	72.4%	77.0%	80.4%	77.1%	79.3%	76.8%	85.8%

31-day CWT Trust Trajectory Progress

		Oct-24		Nov-24		Dec-24		Jan-25		Feb-25		Mar-25		Target	Apr-25	
		Plan	Actual	Plan	Actual	Plan	Actual	Plan	Actual	Plan	Unvalidated	Plan	Unvalidated	24/25	Plan	Unvalidated
	Y															
WHT - 31d		96.0%	98.4%	96.1%	96.0%	96.4%	98.7%	97.3%	100.0%	98.1%	100.0%	99.0%	96.6%	96%	96.6%	100.0%
RWT - 31d		96.0%	90.2%	90.4%	90.0%	91.0%	91.6%	91.2%	90.1%	91.7%	91.8%	92.0%	84.0%	96%	91.8%	75.7%
DGH - 31d		96.0%	92.9%	96.0%	91.7%	96.0%	94.3%	96.0%	88.8%	96.0%	93.6%	96.0%	93.5%	96%	94.2%	89.3%
SWB - 31d		96.0%	85.9%	96.0%	86.3%	84.1%	87.2%	86.6%	86.8%	90.4%	87.7%	94.9%	92.8%	96%	96.5%	87.5%

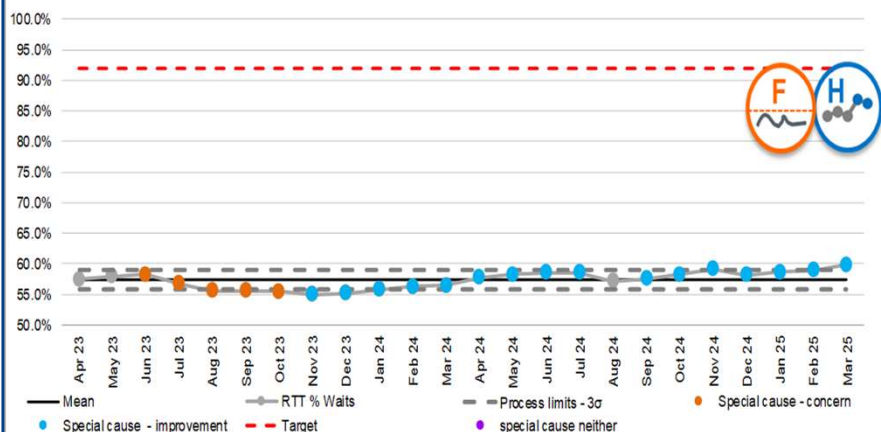
62-day CWT Trust Trajectory Progress

		Oct-24		Nov-24		Dec-24		Jan-25		Feb-25		Mar-25		Target	Apr-25	
		Plan	Actual	Plan	Actual	Plan	Actual	Plan	Actual	Plan	Unvalidated	Plan	Unvalidated	24/25	Plan	Unvalidated
	🔽														79.4%	60.0%
WHT - 62d		75.4%	81.6%	75.8%	84.7%	70.9%	76.2%	75.4%	81.2%	76.9%	77.7%	77.6%	78.4%	70%	70.5%	23.0%
RWT - 62d		58.0%	63.9%	60.0%	65.6%	64.0%	67.4%	71.0%	70.2%	71.0%	70.3%	71.0%	53.3%	70%	71.4%	63.8%
DGH - 62d		70.0%	76.4%	70.0%	70.3%	73.2%	80.5%	69.8%	74.9%	70.2%	70.5%	70.0%	67.9%	70%	73.3%	77.8%
SWB - 62d		71.4%	71.9%	71.1%	67.3%	70.8%	70.1%	70.0%	70.6%	70.0%	65.3%	70.0%	66.3%	70%	72.3%	45.6%

RTT Performance



RTT Incomplete Pathways - % still waiting within 18 Weeks- starting 01/04/23

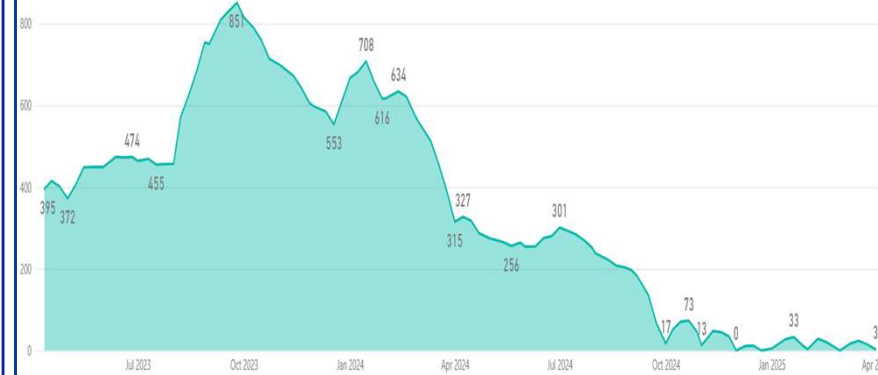


Latest
Month

59.9%

RTT Incomplete
pathways target
92%

>65 Breach RTT Pathways



Taken from: [RTT Incompletes - Post Validation Analysis - Power BI Report Server](#)

Performance

March has shown continued improvement in the RTT performance. Unfortunately, 2 65-week breaches were reported at the end of the month. 1 patient breached as we were unable to provide complex endometriosis surgery, due to sickness of the only surgeon able to undertake this. Patient 2 was a gastroenterology patient, whose procedure was deferred in order to treat a more clinically urgent patient. Mutual aid options were explored for both patients

52-week performance has shown some deterioration in month, with the latest position now 388 behind plan. Given the additional activity delivered in March, further work is underway to understand and rectify the cause of this adverse variation.

We are focused on achieving the 52 week standard for children and young people by the end of March 25, with 43 patients remaining in the cohort.

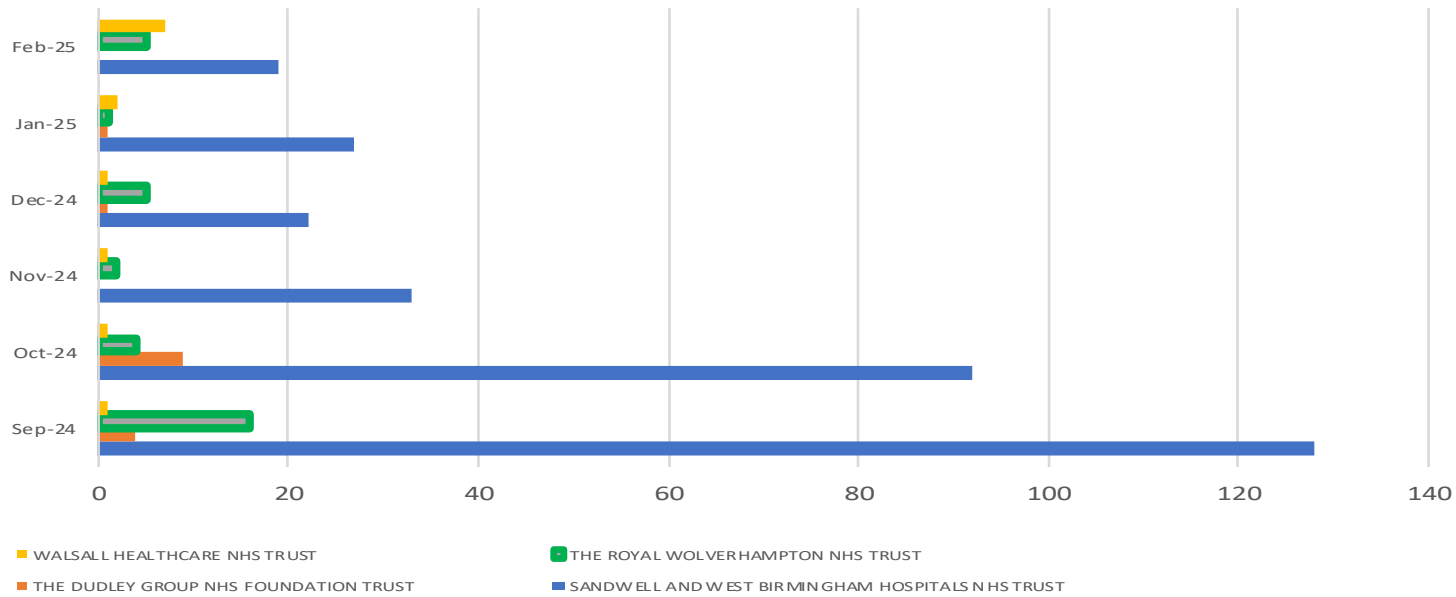
March RTT position 59.9% vs 25/26 target of 64.2% by end of March 2026. In month improvement seen

Action

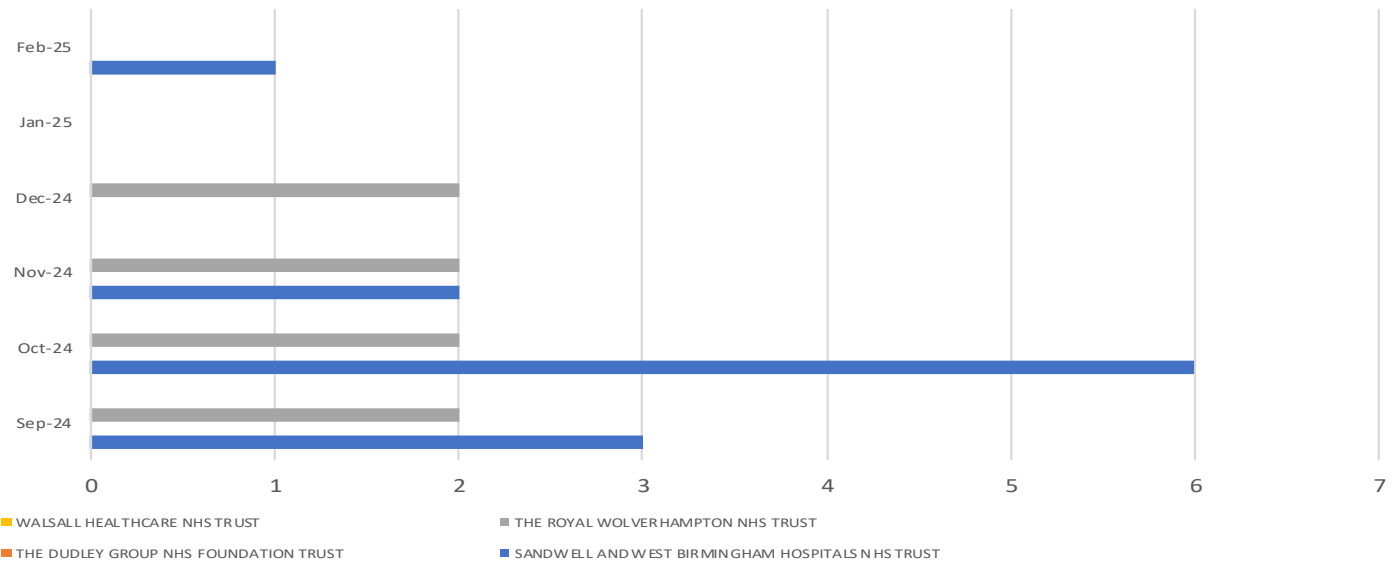
- Gynaecology service are finalising an outsourcing model to support reduction in waits for first outpatient appointments.
- 52 week recovery trajectories and action plans requested from gynaecology, T&O, oral surgery, dermatology and neurology.
- Additional focused weekend children's day case sessions over the Easter holidays to support achievement of 52-week standard for Children and Young People.

RTT Benchmarking

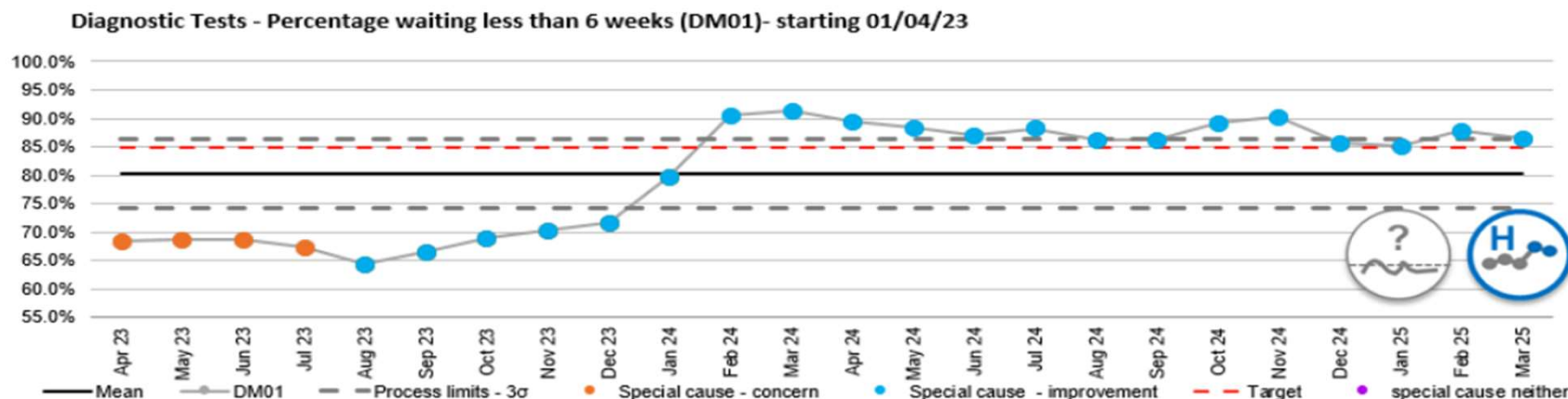
RTT 65 Weeks



RTT 78 Weeks



DM01 Performance



Latest
Month

86.5%

DM01 combining
15 modalities -
target 85%

Performance

- March DM01 performance achieved 86.5%. The overall backlog of patients waiting to be seen has reduced by approx. 2100 patients since April 2024. NHSE target by end of March 2025 to report zero 13 week breaches and 95% of patients to be seen within 6 weeks.
- Dexam, Endoscopy, Cardiology and Ultrasound are all performing well at 95% or above. Sleep Studies, Cardiac MRI and Cardiac CT remain challenged.
- Sleep studies backlog has significantly impacted the overall DM01 position. March performance is 41.63%. There is a recovery plan to increase capacity to improve this position by end of June 2025.
- NOUS has continued to improved to 95.18% in March.
- Of the 257 breaches over 13 weeks in March, 201 were waiting sleep studies and 55 breaches were reported in MRI cardiac.
- CT cardiac achieved trajectory and reported zero 13 week breaches at end of March. Patients waiting between 6 and 12 weeks remain area of focus.
- CT and MRI cardiac wait times are increasing across the system.

Action

- Short term recovery plan for sleep studies using bank continues. Increased staffing and additional equipment will provide extra capacity. Recovery plan and trajectory will clear 6+ week backlog by end of June 2025. Respiratory to commence in CDC over coming weeks. Suitable space for services to operate is in progress.
- Cardiology and Imaging working in collaboration to increase capacity. increased number of unsupervised slots at RHH and additional supervised lists to support MRI and CT pressures. Apps training completed in February will provide additional capacity on new CDC CT scanner at Guest. RWT are providing mutual aid for very small volume of patients, an additional 8 patients has been agreed for May to support reduction of 13 week breaches.
- System support for mutual aid CT Cardiac and Ultrasound ENT requested to prevent 13 week breaches in April.
- A trajectory has been developed to reduce 13 week breaches in MRI to zero by end of July.
- Diagnostic performance is reviewed with NHSE on fortnightly system tiering call.

DM01 Benchmarking

DM01 Benchmarking (NHSE/I)

Last Refresh : 11/04/2025 07:19

Region

Midlands Commissioning Region

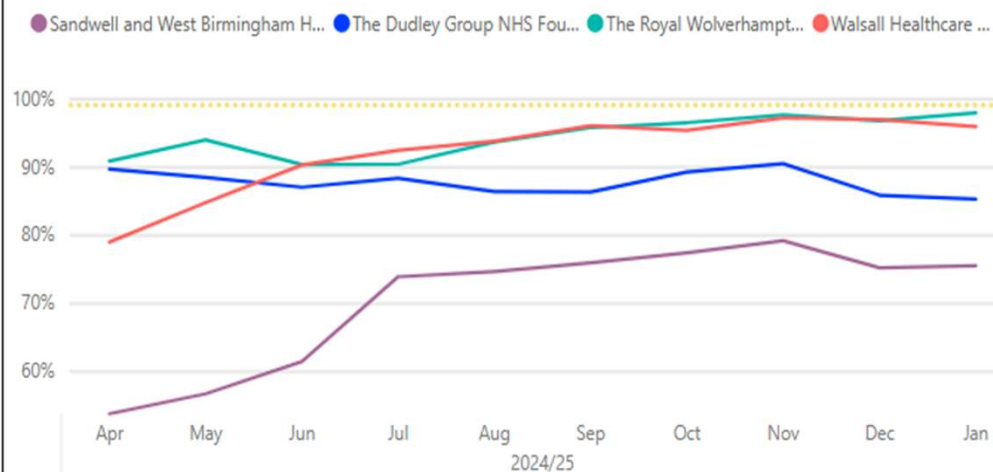
Provider

Multiple selections

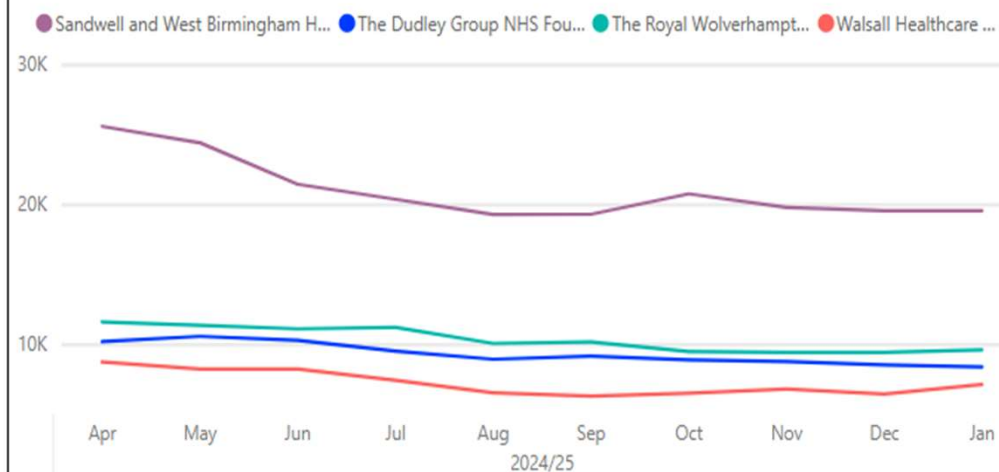
Diagnostic Test

All

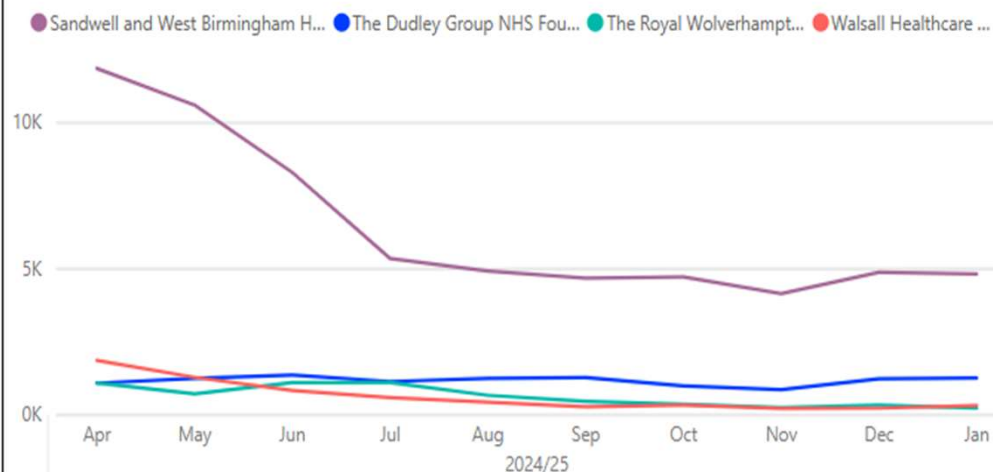
Performance



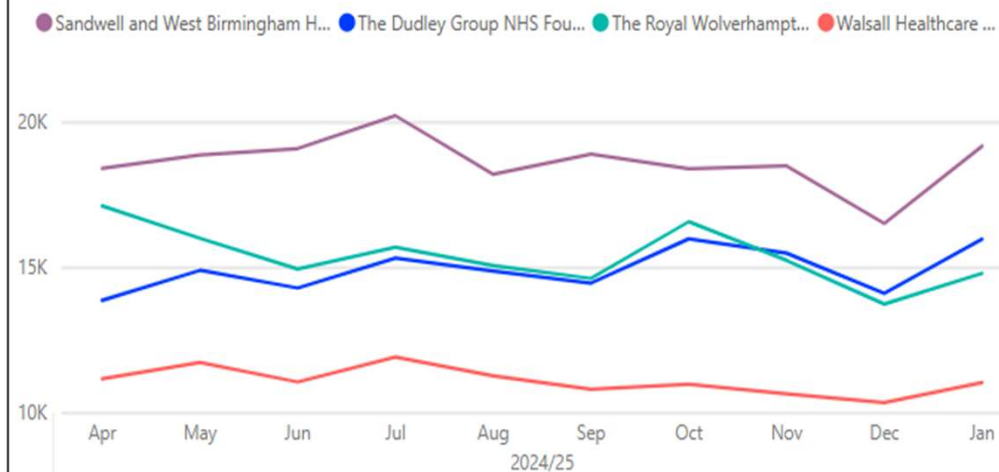
Waiting List



6 Week Breaches



Activity

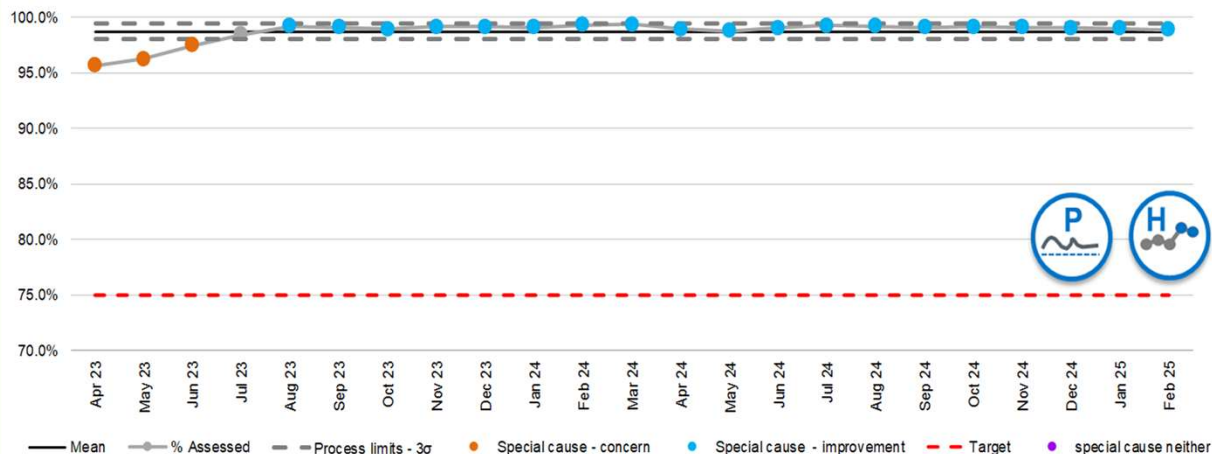


Source: [Imaging Cardiology CRIS Dashboard - Power BI](#)

VTE Performance Please note: VTE figures now run 1 month in arrears



VTE Screening Compliance- starting 01/04/23



Latest Month
98.9%

Latest Month
99.1%

Latest Month
98.7%

**Trust
overall
Position**

**Medicine
& IC**

**Surgery,
W & C**

Performance

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

Action

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

Screening Programmes

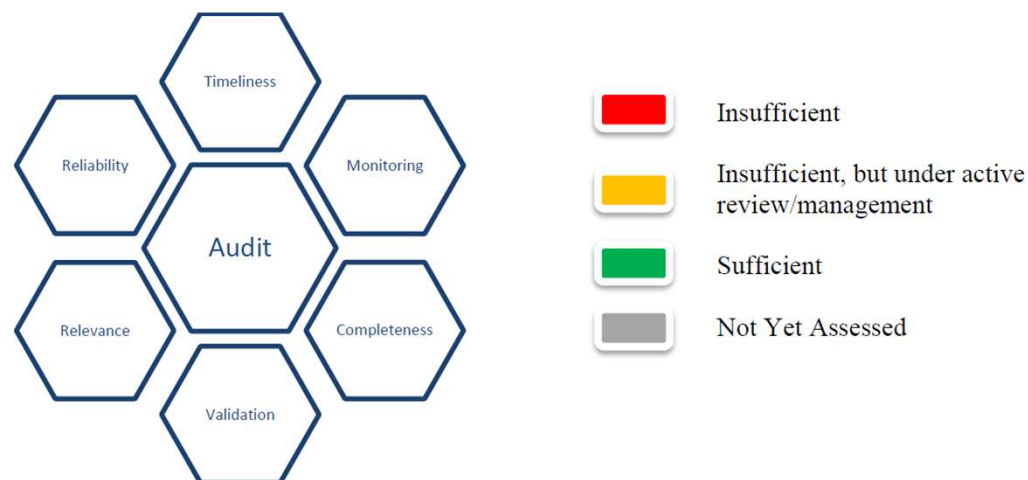
Screening Programme Performance for IPR (F&P)

Description	Comments	Reference	Target	Q1	Q2
NHS Abdominal Aortic Aneurysm Screening Programme (AAA) 2023/24 (@ ICB level)	Percentage of abnormal screens reviewed ≤ 21 days of the initial screen date within the reporting period.	AAA-S12	Acceptable: ≥60.0% Achievable: ≥95.0%	16.67%	29.41%
NHS Breast Screening Programme 2023/24 (@ ICB level)	The proportion of eligible women who have a technically adequate screen less than or equal to 6 months from date of first offered appointment	BSP-S03a	Acceptable: ≥70.0% Achievable: ≥80.0%	69.00%	77.00%
NHS Colposcopy Intervention/treatment 6 week appointment 2023/24	Proportion of women who are offered a colposcopy within 6 weeks of referral due to a positive HR-HPV test and negative cytology OR borderline changes or low-grade dyskaryosis.	CSP-S11	≥99% Green <99% Red	87.00%	100.00%
NHS FASP Trisomy screening 2023/24	Indequate samples for Downs/Edwards/Patau screening a) Combined samples	FA4	To be Set	0.70%	1.20%
NHS FASP Trisomy screening 2023/25	Indequate samples for Downs/Edwards/Patau screening a) Quadruple samples	FA4	To be Set	0.70%	2.00%
NHS Infectious Diseases in Pregnancy Screening 2023/24	The proportion of pregnant women eligible for human immunodeficiency virus (HIV) screening for whom a confirmed screening result is available at the day of report	ID1(IDPS-S01)	≥99% Green 95%-99% Amber <95% Red	99.80%	99.90%
NHS Infectious Diseases in Pregnancy Screening 2023/24	The proportion of pregnant women eligible for hepatitis B screening for whom a confirmed screening result is available at the day of report	ID3(IDPS-S02)	≥99% Green 95%-99% Amber <95% Red	99.80%	99.90%
NHS Infectious Diseases in Pregnancy Screening 2023/24	The proportion of pregnant women eligible for syphilis screening for whom a confirmed screening result is available at the day of report	ID4(IDPS-S03)	≥99% Green 95%-99% Amber <95% Red	99.80%	99.90%
NHS FASP Fetal Anomaly scan 2023/24	The proportion of pregnant women eligible for NIPT screening for whom a conclusive screening result is available at the day of report.	FASP NIPT-S01	Thresholds are not set for this metric	81.00%	80.00%
NHS Sickle Cell and Thalassaemia screening 2023/24	The proportion of pregnant women having antenatal sickle cell and thalassaemia screening for whom a screening result is available ≤10 weeks + 0 days gestation	ST2	≥75% Green 50%-75% Amber <50% Red	43.20%	50.10%
NHS Newborn Blood Spot screening 2023/24	The proportion of first blood spot samples that require repeating due to an avoidable failure in the sampling process	NB2 (NBS-S06)	≤1% 1%-2% Amber ≥2% Red	0.80%	1.00%
NHS Newborn Hearing Screening 2023/24	Coverage	NHSP-S01 & KPI NH1	≥99.5% Green 98%-99.5% Amber <98% Red	98.50%	Not Yet Available
NHS Newborn and Infant Physical Examination screening 2023/24	Coverage	ANNB NIPE NP1	≥97.5% Green 95%-97.5% Amber <95% Red	96.60%	95.90%
NHS Newborn and Infant Physical Examination screening 2023/24	Timeliness	ANNB NIPE NP3	≥95% Green 90%-95% Amber <90% Red	85.20%	91.40%
Child Vision screening commenced in September				Not Yet Available	

Kitemark Explanation

Element	Definition
Timeliness	<p>The time taken between the end of the data period and when the information can be produced and reviewed.</p> <p>The acceptable data lag will be different for different performance indicators.</p> <p>Data should be captured as quickly as possible after the event or activity and must be available for the intended use within a reasonable time period.</p> <p>Data must be available quickly and frequently enough to support information needs and to influence the appropriate level of service or management decisions.</p>
Monitoring	<p>The degree to which the trust can drill down into data in order to review and understand operational performance.</p> <p>The level to which the trust needs to drill down into the data will vary for different performance indicators. Some information should always be available at patient level for performance monitoring purposes. Whereas some information may be sufficient if it is available at speciality level for all specialties or even trust level for performance monitoring purposes</p>
Completeness	<p>The extent to which all of the expected attributes of the data are populated but also the extent to which all of the records for the relevant population are provided.</p>
Validation	<p>The extent to which the data has been validated to ensure it is accurate and in compliance with relevant requirements. For example, correct application of rules and definitions. The level of validation required will vary from indicator-to-indicator and will depend on the level of data quality risk.</p> <p>Final validation is classified as sufficient where validation has been completed and where the indicator has received final approval from responsible individuals.</p>
Audit	<p>The extent to which the integrity of data (completeness, accuracy, validity, reliability, relevance, and timeliness) has been audited by someone independent of the KPI owner (for example, Internal Audit, External Audit, Clinical Audit or Peer Review) and the extent to which the assurance provided from the audit is positive.</p>

Element	Definition
Reliability	<p>The extent to which the data is generated by a computerised system, with automated IT controls, or a manual process. It also relates to the degree of documentation outlining the data flow, i.e. documented process with controls and data flows mapped.</p> <p>Data should reflect stable and consistent data collection processes across collection points and over time, whether using manual or computer-based systems or a combination. Managers and stakeholders should be confident that progress toward performance targets reflects real changes rather than variations in data collection approaches or methods.</p>
Relevance	<p>The extent to which the data is captured for the purposes for which it is used. This entails periodic review of the selection of key performance indicators to reflect changing needs, such as new strategic objectives. For example, is this indicator the right indicator by which to measure performance against a strategic objective. Strategic objectives will be defined within the scoping document for proposed new measures.</p>



Click [HERE](#) for full kitemark explanation & policy



National Infection Prevention and Control Board Assurance Framework

Version 1.0 March 2023

Publication approval reference:

Introduction



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

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

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

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

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

Links

[NHS England » National infection prevention and control manual \(NIPCM\) for England](#)

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

Legislative framework

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

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

Links

[Health and Social Care Act 2008: code of practice on the prevention](#)

[Health and Safety at Work etc. Act 1974](#)

[Primary care, community care and outpatient settings](#)

[Acute Inpatient areas](#)

[Primary and community care dental settings](#)



Instructions for use

The adoption and implementation of the National Infection Prevention and Control Board Assurance Framework remains **the responsibility of the organisation and all registered care providers** must demonstrate compliance with the Health and Social Care Act 2008. This requires demonstration of compliance with the ten criteria outlined in the Act.

The Board Assurance Framework worksheet is ordered by the ten criteria of the Act and allows for evidence of compliance, gaps in compliance, mitigations, and comments to be recorded in a text format.

The compliance rating column allows for the selection of a RAG rating for each criteria using a drop down list. Specifically: not applicable, non-compliant, partially compliant, compliant.

Once options have been selected a summary plot for each criteria is generated automatically, which are displayed in the corresponding worksheet. The overall RAG status for an organisation/provider across all ten criteria is shown in plots under the summary worksheet.

N.B. Use of the framework is **not compulsory** but should be used by organisations to ensure compliance with infection prevention and control (IPC) standards (unless alternative internal assurance mechanisms are in place). In addition, not all of the criteria outlined in the framework will be relevant or applicable to all organisations or settings.

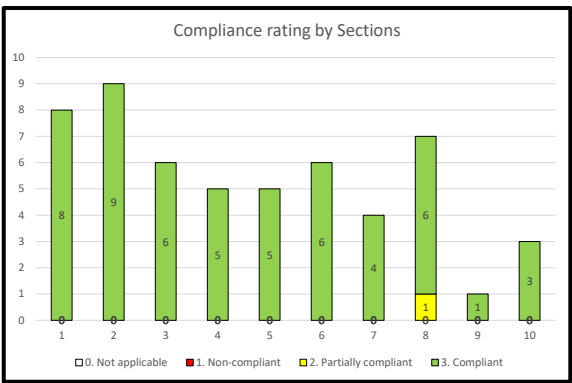
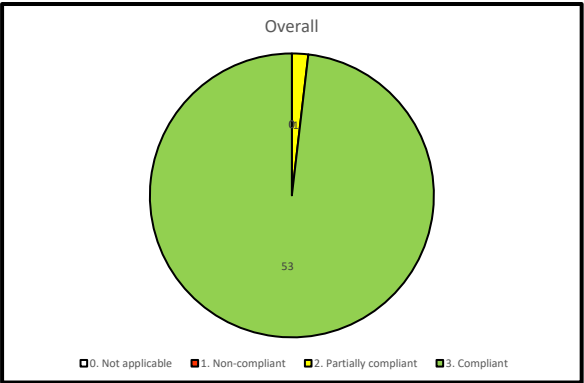
Please note: Specific URL's referred to in the document can be accessed via the 'Hyperlinks included in the BAF' tab. Or alternatively, can be accessed by

Links



Section 1	
1.4	NIPCM
1.6	NICPM
	Primary care, community care and outpatient settings.
1.8	Acute inpatient areas
	Primary and community care dental settings
Section 2	
2.1	National cleanliness standards
2.2	Patient-Led Assessments of the Care Environment (PLACE)
2.4.1	HTM:03-01
2.4.2	HTM:04-01
2.5	HBN:00-09
2.6	HTM:01-04
	NIPCM
2.7	HTM:07-01
	HTM:01-01
2.8	HTM:01-05
	HTM:01-06
Section 3	
3.2	UK AMR National Action Plan
3.3	UK AMR National Action Plan.
	NICE Guideline NG15
3.4	TARGET
	Start Smart, Then Focus
Section 5	
5	NIPCM
Section 6	
6.2	Roles and responsibilities
Section 7	
7	NIPCM
Section 9	
	UKHSA
9	A to Z Pathogen
	NIPCM

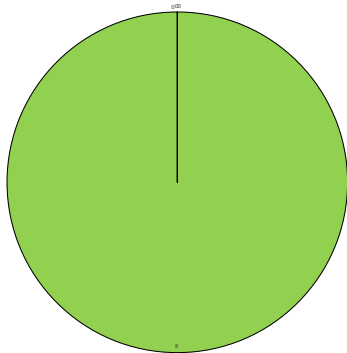




Infection Prevention and Control board assurance framework 2024/2025 v1.4						
	Key Lines of Enquiry	Evidence	Gaps in Assurance	Mitigating Actions	Comments	Compliance rating
1. Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks their environment and other users may pose to them						
Organisational or board systems and process should be in place to ensure that:						
1.1	There is a governance structure, which as a minimum should include an IPC committee or equivalent, including a Director of Infection Prevention and Control (DIPC) and an IPC lead, ensuring roles and responsibilities are clearly defined with clear lines of accountability to the IPC team.	The Trust has both a DIPC and Deputy DIPC in post. There is an Decontamination lead in post. There is a clearly defined structure with clear accountability IPC meeting meetings monthly with TOR agreed annually.			January 2025 Deputy DIPC post replaced with IPC Matron. February 2025 IPC Matron commenced in post.	3. Compliant
1.2	There is monitoring and reporting of infections with appropriate governance structures to mitigate the risk of infection transmission.	HCAI data is reported to IPCG, Quality Committee, CQRM, IPR and in the Chief Nurse and Medical Director report. Divisions report into IPCG All outbreaks are reported internally and externally to UK HSA, ICB, and NHSE There is an IPC Governance structure in place from IPCG Meeting to Public Board via Quality Committee. HCAI data is presented to external partners e.g. UK HSA, ICB, Dudley and Walsall Place and Dudley Metropolitan Council.				3. Compliant
1.3	That there is a culture that promotes incident reporting, including near misses, while focusing on improving systemic failures and encouraging safe working practices, that is, that any workplace risk(s) are mitigated maximally for everyone.	DATIX reporting is encouraged. There is a Freedom to Speak up Guardian in place. There are separate DATIX streams for IPC and Decontamination incidents to be reported and actioned. Health and safety and Staff Health and Wellbeing attend IPCG. Decontamination incidents are raised at the Sterile Services and Decontamination Meetings. Meeting minutes available. Incidents are included in IPCG reporting.				3. Compliant
1.4	They implement, monitor, and report adherence to the IPC/M .	An IPC programme of audit is detailed in the IPC Annual Programme. Audits are recorded on Amat and monitored via the IPCG meeting and Chief Nurse and Medical Director reports to Board. IPC Audit tools are fluid documents and are reviewed annually and updated as required. IPCG minutes detail audit scores. Meeting minutes are available				3. Compliant
1.5	They undertake surveillance (mandatory infectious agents as a minimum) to ensure identification, monitoring, and reporting of incidents/outbreaks with an associated action plan agreed at or with oversight at board level.	HCAI data is reported to IPCG, CQRM, Quality committee and IPR. Divisions report into IPCG All outbreaks are reported internally and externally to UK HSA, ICB and NHSE. There is an IPC Governance structure in place from IPCG Meeting to Public Board via Quality Committee SSI data is recorded and uploaded to UK HSA database				3. Compliant
1.6	Systems and resources are available to implement and monitor compliance with infection prevention and control as outlined in the responsibilities section of the IPC/M .	An IPC programme of audit is detailed in the IPC Annual Programme. A audits are recorded on Amat. Audit scores are monitored via the IPCG meeting reports.				3. Compliant
1.7	All staff receive the required training commensurate with their duties to minimise the risks of infection transmission.	IPC Training for both clinical and non-clinical staff is available via e-learning following the Health Education England programme. IPC induction training is delivered face to face. Bespoke training is delivered where required. IPC mandatory training data is reported via IPCG meetings and divisional reports. IPC induction 2 training is delivered face to face at level 2 for all attendees				3. Compliant
1.8	There is support in clinical areas to undertake a local dynamic risk assessment based on the hierarchy of controls to prevent/reduce or control infection transmission and provide mitigations. Primary care, community care and outpatient settings, acute inpatient areas, and primary and community care dental settings	Risk assessments are available for use. Policies and procedures are developed to facilitate autonomy. IPC Doctor/Consultant Microbiologist is on call out of ours for advice and support. IPC team attends daily site meetings IPC team to provide weekend on site cover for December and January A weekend plan with IPC is developed on a Friday and available to site and capacity A winter plan has been developed Policies, procedures, SOP, pathways and guidance is available via the Hub				3. Compliant
IPC team are providing weekend cover for December and January.						
System and process are in place to ensure that:						
2.1	There is evidence of compliance with National cleanliness standards , including monitoring and mitigations. (excludes some settings e.g. ambulance, primary care/dental unless part of the NHS standard contract these setting will have locally agreed processes in place)	Decontamination of the Environment Policy incorporating the National standards of Cleanliness adopted April 2022 Cleanliness audits completed and presented at IPCG Sign-on the doors are displayed on the entrances to area There is a 3 Minuted Cleaning meeting with PFI partners Cleaning is increased during an outbreak of infection			September 2024. A project is underway to review our cleaning FR ratings and cleaning contract against the national specification with an external agency. The cleaning and decontamination of the environment policy is also being review to reflect any changes to ratings.	3. Compliant
2.2	There is an annual programme of Patient and Associates of the Care, Environment (P.A.C.E.) visits and completion of action plans monitored by the board.	IPC audits and Quality walk rounds are recorded on Amat. P.A.C.E visits completed November 2024				3. Compliant
2.3	There are clear guidelines to identify roles and responsibilities for maintaining a clean environment (including patient care equipment) in line with the national cleanliness standards.	Cleaning is outsourced to PFI partners. Cleanliness audits and scores on the doors are produced Mitie follow the Trust's Decontamination of the Environment policy			September 2024. A project is underway to review our cleaning FR ratings and cleaning contract against the national specification with an external agency. The cleaning and decontamination of the environment policy is also being review to reflect any changes to ratings.	3. Compliant

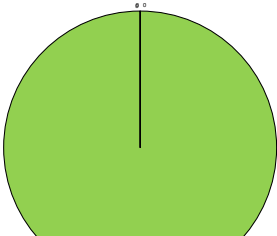


1. Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks posed by their environment and other service users



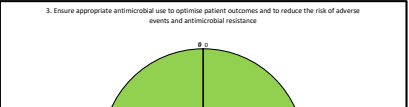
☐ Non-compliant
 ☐ Partially compliant
 ☒ Compliant

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

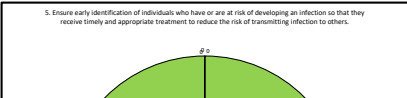
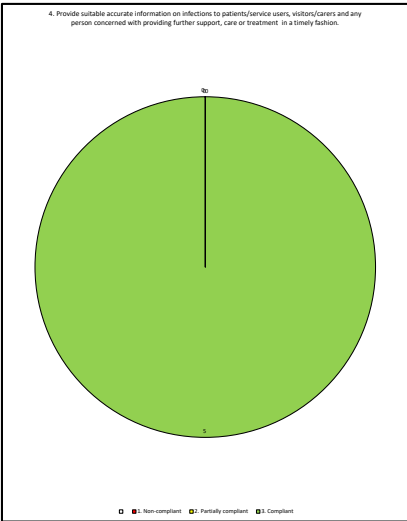


☐ Non-compliant
 ☐ Partially compliant
 ☒ Compliant

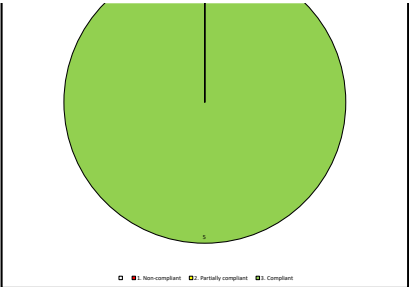
2.4	There is monitoring and reporting of water and ventilation safety, this must include a water and ventilation safety group and plan. 2.4.1 Ventilation systems are appropriate and evidence of regular ventilation assessments in compliance with the regulations set out in LTA(03.04.2.4.2 Water safety plans are in place for addressing all actions highlighted from water safety risk assessments in compliance with the regulations set out in HTM 04.01 .	<p>Ventilation</p> <p>The Trust has a ventilation group with PFI partners</p> <p>Mitie has an appointed authorising engineer for Ventilation</p> <p>Mitie undertake PPM and ventilation audits which are reported to the Ventilation Group</p> <p>Water</p> <p>The Trust has a Water Safety Plan and policies and procedures</p> <p>The Trust has a water safety group with PFI partners</p> <p>Mitie has an appointed authorising engineer for water</p> <p>Flushing, sampling regimes and results are reported to the Water Safety group</p> <p>The trust has trained competent appointed responsible persons for water.</p> <p>The above meetings report to IPCG via the Estates and Facilities report</p>				3. Compliant
2.5	There is evidence of a programme of planned preventative maintenance for buildings and care environments and IPC involvement in the development new builds or refurbishments to ensure the estate is fit for purpose in compliance with the recommendations set out in HBN 00.09	<p>Maintenance Controls</p> <p>1.8 year and 5 year Maintenance Programme issued annually</p> <p>2.Most condition survey</p> <p>3.Trust Helpdesk for reporting issues</p> <p>4.Monthly Report to demonstrate compliance</p> <p>5.Trust Monitoring Team for compliance</p> <p>Maintenance Improvements</p> <p>1.Mitie Jument to revisit asset lists</p> <p>2.New CAFM system being implemented</p> <p>3.Improved self-reporting for non-performance of PPMs</p> <p>IPC Capital Schemes Controls</p> <p>1.Trust interface for small works and capital projects</p> <p>2.Trust Policy for IPC in capital schemes</p> <p>3.Shares shared with IPC for comment (Larger schemes)</p> <p>IPC Capital Schemes improvements</p> <p>1.Full implementation of IPC policy for capital schemes</p> <p>2.Trust to gain IPC sign off for designs</p> <p>3.Trust to develop a Capital Works Policy</p> <p>4.ME Water and Ventilation to sign off design and commissioning</p>				3. Compliant
2.6	The storage, supply and provision of linen and laundry are appropriate for the level and type of care delivered and compliant with the recommendations set out in HTM 03.04 and the NICE .	<p>Linen and laundry are supplied by Mitie via a PFI contract.</p> <p>Laundry is supplied and processed via a contract with Eli and duty of Care assurance visits are undertaken with the Trust and Mitie.</p> <p>Items are also laundered on site in a laundry operated by Mitie with is regularly audited but the Trust.</p> <p>Microbiological sampling on the laundry is also undertaken.</p> <p>These are reported to IPCG for assurance via the Estates and Facilities report.</p>				3. Compliant
2.7	The classification, segregation, storage etc of healthcare waste is consistent with HTM 02.01 which contains the regulatory waste management guidance for all health and care settings (NHS and non-NHS) in England and Wales including waste classification, segregation, storage, packaging, transport, treatment, and disposal.	<p>Healthcare waste and the segregation of waste is provided by our PFI partner Mitie.</p> <p>A PFI partner waste group meets monthly.</p> <p>Waste segregation is included on the IPC induction and IPC training programmes.</p> <p>Waste is included on the estates and facilities report to IPCG</p> <p>Duty of Care visits are undertaken with the Trust and PFI partners to outside contractors including Tradebe, Elis, Biffa, Clinwaste and Sharpomat.</p> <p>Joint duty of care visits are completed annually with the Trust and PFI partners.</p>				3. Compliant
2.8	There is evidence of compliance and monitoring of decontamination processes for reusable devices/surgical instruments as set out in HTM 01.01 , HTM 01.05 and HTM 01.06 .	<p>Standard infection precautions policy available on the Hub</p> <p>1 air clean cickers are in use throughout the Trust</p> <p>Decontamination policy updated September 2022 available on the Hub</p> <p>Reusable non-invasive medical devices are decontaminated using universal wipes or Chlorine releasing agent in line with Trust policy and/or manufacturers instructions.</p> <p>Sterile Services follow the HTM 01-01 guidelines.</p> <p>Sterile Services policies and procedures are audited internally and then followed through with our External Approved Body SAS annually.</p> <p>Decontamination programme of audit in place</p> <p>PAQ enquiries are completed with Procurement, EBME and the IPC teams prior to the purchasing of equipment to ensure it can be decontaminated</p> <p>New products are approved via the Trusts Clinical Product Evaluation Group.</p> <p>Health Edge is in place for the track and trace of instruments</p>		Health edge for track and traceability of sterile surgical instruments is required for renal unit. The department do have a paper based log book that is used while finance review the request.		3. Compliant
2.9	Food hygiene training is commensurate with the duties of staff as per food hygiene regulations. If food is brought into the care setting by a patient/service user, family/carer or staff this must be stored in line with food hygiene regulations.	<p>Food hygiene training is undertaken by staff and recorded in ESR.</p> <p>Trust Staff have access to Food Hygiene Basics for Nursing and core staff.</p> <p>Food hygiene regulations.</p> <p>Food hygiene slide incorporated in IPC mandatory training</p>				3. Compliant
3. Ensure appropriate antimicrobial stewardship to optimise service user outcomes and to reduce the risk of adverse events and antimicrobial resistance						
Systems and process are in place to ensure this						
3.1	If antimicrobial prescribing is indicated, arrangements for antimicrobial stewardship (AMS) are maintained and where appropriate a formal lead for AMS is nominated.	AMS Group in place with AMS lead for the Trust and antimicrobial stewardship principles are implemented throughout the Trust.				3. Compliant
3.2	The board receives a formal report on antimicrobial stewardship activities annually which includes the organisation's progress with achieving the JAG National Action Plan goals.	AMS is reported via the AMS lead attending IPCG	A formal report goes to board via medicines management group which covers AMS activities, achievements and risks.	It is also included in annual IPC report to the board.		3. Compliant
3.3	There is an executive on the board with responsibility for antimicrobial stewardship, JAMS, as set out in the JAG National Action Plan .	Chief Nurse is the executive on the board with responsibility for AMS.	Chief Nurse is also the Director of Infection Prevention and Control.			3. Compliant



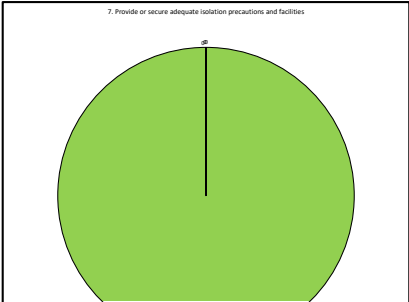
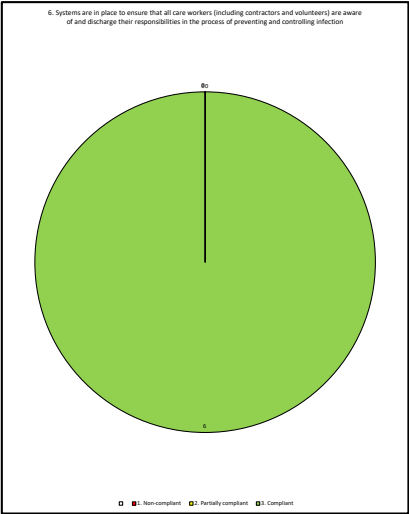
3.4	<p><u>NICE guideline NG15</u> Antimicrobial Stewardship: systems and processes for effective antimicrobial medicine use or Treat Antibiotics Responsibly, Guidance, Education, Tools (TARGET) are implemented and adherence to the use of antimicrobials is managed and monitored:</p> <ul style="list-style-type: none"> • optimal patient outcomes • minimise inappropriate prescribing • ensure the principles of <u>Start Smart, Then Focus</u> are followed. 	<p>The principles of Antimicrobial Stewardship are embedded and tools, processes and support is available for effective antimicrobial use.</p> <p>NICE NG15 baseline assessment completed</p> <p>AMS ward rounds across identified areas for support.</p> <p>AMS teaching sessions to Pharmacists, Drs and Nurses.</p> <p>AMS quality improvement projects.</p> <p>And effective monitoring system around antimicrobial consumption as a whole.</p>				3. Compliant
3.5	<p>Contractual reporting requirements are adhered to, progress with incentive and performance improvement schemes relating to AMR are reported to the board where relevant, and boards continue to maintain oversight of key performance indicators for prescribing, including:</p> <ul style="list-style-type: none"> • total antimicrobial prescribing • broad spectrum prescribing • intravenous route prescribing • treatment course length 	<p>All contractual reporting requirements are met and reports sent to Drugs and Therapeutics Group, Medicines management Group and IPC Group which are then sent to Quality Committee and highlights presented to board.</p>				3. Compliant
3.6	<p>Resources are in place to support and measure adherence to good practice and quality improvement in AMS. This must include all care areas and staff (permanent, flexible, agency, and external contractors)</p>	<p>AMS team.</p> <p>Electronic prescribing aids (72 hours review)</p> <p>Micro guide (Trusts antibiotic guidelines) and induction sessions on antimicrobial stewardship.</p> <p>The Trust has adopted and promotes the IV to oral Switch.</p>				3. Compliant
4. Provide suitable accurate information on infections to patients/service users, visitors/carers and any person concerned with providing further support, care or treatment nursing/medical in a timely fashion						
Systems and processes are in place to ensure that:						
4.1	<p>Information is developed with local service user representative organisations, which should recognise and reflect local population demographics, diversity, inclusion, and health care needs.</p>	<p>Patient facing information available on the Trust web site</p> <p>Patient leaflets available on the Trust website, different languages are available</p> <p>Interpreter service available</p> <p>DDPFC attends Dudley Health Board meetings</p> <p>DDPFC attends system IPC meetings chaired by the ICB</p> <p>DDPFC attended system health protection and promotion meetings with Walsall Place</p> <p>Updates and alerts received from NHSE, UK HSA are disseminated</p> <p>Meetings attended with NHSE weekly updates</p>				3. Compliant
4.2	<p>Information is appropriate to the target audience, remains accurate and up to date, is provided in a timely manner and is easily accessible in a range of formats (e.g. digital and paper) and platforms, taking account of the communication needs of the patient/service user/care giver/visitor/advocate</p>	<p>Leaflets are reviewed annually and when guidance changes</p> <p>Paper and digital information is available</p> <p>Interpreter service is available</p> <p>PALS service available</p> <p>DDPFC attends Dudley Health Board meetings</p> <p>DDPFC attends system IPC meetings chaired by the ICB</p> <p>DDPFC attended system health protection and promotion meetings with Walsall Place</p> <p>Updates and alerts received from NHSE, UK HSA are disseminated</p>				3. Compliant
4.3	<p>The provision of information includes and supports general principles on the prevention and control of infection and antimicrobial resistance, setting out expectations and key aspects of the registered provider's policies on IPC and AMR.</p>	<p>Information is available on IPC and AMR.</p> <p>Information days are held at the Health Hub to promote AMR, Hand Hygiene and IPC weeks.</p> <p>Prescribing information available</p> <p>Micro guide is available to all staff</p> <p>IPC Policies and procedures available on the Hub</p> <p>CDI ward round held weekly with IPC and Pharmacy</p> <p>External partner CDI meetings attended</p> <p>Antimicrobial pharmacist attends IPCG</p> <p>AMR Systems meetings attended by IPC</p>				3. Compliant
4.4	<p>Roles and responsibilities of specific individuals, carers, visitors, and advocates when attending with or visiting patients/service users in care settings, are clearly outlined to support good standards of IPC and AMR and include:</p> <ul style="list-style-type: none"> • Hand hygiene, respiratory hygiene, PPE (mask use if applicable) • Supporting patients/service users' awareness and involvement in the safe provision of care in relation to IPC (e.g. cleanliness) • Reportations of infections such as incident/outbreak management and action taken to prevent recurrence. • Provide published materials from national/local public health campaigns (e.g. AMR awareness/vaccination programmes/seasonal and respiratory infections) should be utilised to inform and improve the knowledge of patients/service users, care givers, visitors and advocates to minimise the risk of transmission of infections. 	<p>Supporting information available for visitors, patients and relatives.</p> <p>Patient leaflets and information available in paper or digital form.</p> <p>Interpreter available</p> <p>PALS service available</p> <p>Information available on hand hygiene, specific micro-organisms</p> <p>Hand hygiene provision at the entrance at the hospital and ward entrances, information banners on entry to the building</p> <p>Information days are held at the Health Hub to promote AMR, Hand Hygiene and IPC weeks.</p> <p>Information available on fluid resistant and FFP3 surgical masks.</p> <p>Clinical information given to patients documented in the patients notes or Sunrise</p>				3. Compliant
4.5	<p>Relevant information, including infectious status, invasive device passports/care plans, is provided across organisation boundaries to support safe and appropriate management of patients/service users.</p>	<p>Discharge documentation is completed</p> <p>Patients information is given on a need to know basis in line with IG procedures and governance</p>				3. Compliant
5. Ensure early identification of individuals who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to others.						
Systems and processes are in place to ensure that patient placement decisions are in line with the NPSIM.						
5.1	<p>All patients/individuals are promptly assessed for infection and/or colonisation risk on arrival/transfer at the care area. Those who have, or are at risk of developing, an infection receive timely and appropriate treatment to reduce the risk of infection transmission.</p>	<p>Low priority patients are screened on admission or pre-admission and placed accordingly.</p> <p>Nursing documentation is completed on Sunrise</p> <p>Alerts are added to Sunrise as prompts for infection and previous infection notification</p>	<p>Trust does not always have side rooms available</p> <p>Datix is completed if isolation cannot be accommodated</p> <p>Patient is isolated in the bay until suitable placement can be arranged.</p>	<p>Datix is completed if a patient cannot be isolated with 2 hours.</p> <p>Side room requests are escalated to site.</p>		3. Compliant



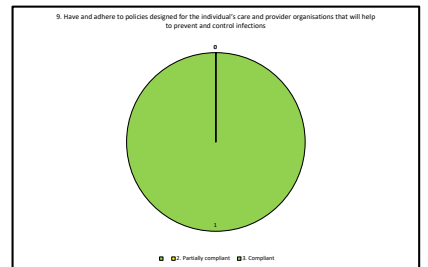
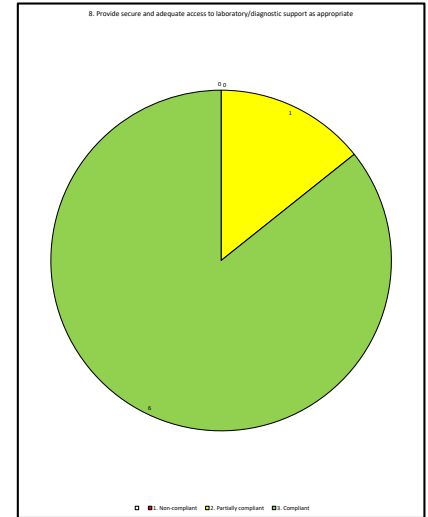
5.2	Patients' infectious status should be continuously reviewed throughout their stay/period of care. This assessment should influence placement decisions in accordance with clinical/care needs). If required, the patient is placed /isolated or cohorted accordingly whilst awaiting test results and documented in the patient's notes.	Patient is nursed in most appropriate place. If cannot be nursed in isolation then this is risk assessed and documented on Sunrise Isolation signs are available for protected and Source Isolation Nursing notes are documented on Sunrise. Breaches in isolation times are reported via DATIX				3. Compliant
5.3	The infection status of the patient is communicated prior to transfer to the receiving organisation, department, or transferring services ensuring correct management/placement.	Discharge documentation is completed Patients information is given on a need to know basis in line with IG procedures and governance				3. Compliant
5.4	Signage is displayed prior to and on entry to all health and care settings instructing patients with respiratory symptoms to inform receiving reception staff, immediately on their arrival.	Notice and floor length banners are available at entrances to educate and remind patients and visitors. Social media is also used to advise visitors to the Trust				3. Compliant
5.5	Two or more infection cases (or a single case of serious infection) linked by time, place, and person triggers an incident/outbreak investigation and this must be reported via governance reporting structures.	Outbreak policy available on the Hub. Outbreak criteria reviewed and all potential outbreaks reviewed All outbreaks reported externally. Outbreaks reported to external partners including: NHSE, UK HSA and ICB Outbreak meetings held if required External partners invited to outbreak meetings		September 2024. Outbreak policy is currently under review. To be presented at the IPC Group on 2.10.24 for ratification and adoption.		3. Compliant



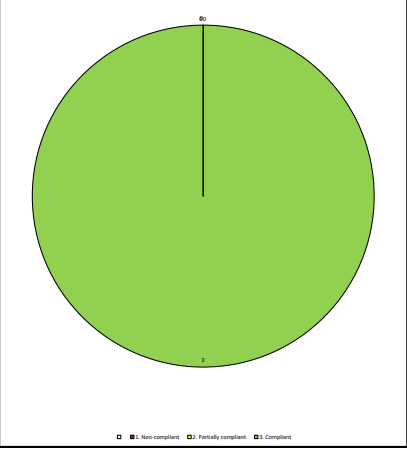
6. Systems are in place to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection						
Systems and processes are in place to ensure:						
6.1	Induction and mandatory training on IPC includes the key criteria (SICPs/TBPs) for preventing and controlling infection within the context of the care setting.	IPC induction training is face to face and includes information on HCA, SIPC, PPE donning and doffing, single use and is community and acute focused. IPC training is developed to the Skills for Care Level 2 standard and includes waste, sharps and decontamination.				3. Compliant
6.2	The workforce is competent in IPC commensurate with their role responsibilities .	Policies and procedures are available on the Hub IPC is included in staff job descriptions IPC training is mandatory Nursing staff complete annual hand hygiene assessments as part of the appraisal process.				3. Compliant
6.3	Monitoring compliance and update IPC training programs as required.	Notice and floor length banners are available at entrances to educate and remind patients and visitors.				3. Compliant
6.4	All identified staff are trained in the selection and use of personal protective equipment / respiratory protective equipment (PPE/RPE) appropriate for their place of work including how to safely put on and remove (donning and doffing) PPE and RPE.	PPE and Donning and doffing is included in mandatory face to face induction training. Information is available on the hub including NHSE/ UK HSA Donning and doffing video IPC information is provided to contractors attending site to undertake work. The trust has train the trainer session for FFP3 fit testing and regular sessions for fit testing are held throughout the Trust. Videos detailing donning and doffing are available on the Hub page				3. Compliant
6.5	That all identified staff are fit tested as per Health and Safety Executive requirements and that a record is kept.	All staff who are required to wear FFP3 masks are fit tested every 2 years or when required if sooner. The Trust holds train the trainer sessions for fit testing throughout the Trust. Records are held by the Health and Safety Department				3. Compliant
6.6	If clinical staff undertake procedures that require additional clinical skills, for example, medical device insertion, there is evidence staff are trained to an agreed standard and the staff member has completed a competency assessment which is recorded in their records before being allowed to undertake the procedures independently.	Competence and additional training is provided for specific clinical procedures e.g. venepuncture, catheterisation.				3. Compliant
7. Provide or secure adequate isolation precautions and facilities						
Systems and processes are in place in line with the NHS UK to ensure that:						
7.1	Patients that are known or suspected to be infectious as per criterion 5 are individually clinically risk assessed for infectious status when entering a care facility. The result of individual clinical assessments should determine patient placement decisions and the required IPC precautions. Clinical care should not be delayed based on infectious status.	As per policy patients are screened on admission or pre-admission and placed accordingly.	Side rooms are not always available immediately	Datix is completed Patient is isolated in the bay until suitable placement can be arranged. Site team are notified if side room is required.		3. Compliant
7.2	Isolation facilities are prioritised, depending on the known or suspected infectious agent and all decisions made are clearly documented in the patient's notes. Patients can be cohorted together if: •High rooms are in short supply and if there are two or more patients with the same confirmed infection. •There are situations of service pressure, for example, winter, and patients may have different or multiple infections. In these situations, a preparedness plan must be in place ensuring that organisation/board level assurance on IPC systems and processes are in place to mitigate risk.	Isolation facilities' in side rooms are provided Isolation matrix available to aid clinical placement Patients are cohorted, if appropriate Fit pandemic plan available IPC Business continuity plan available IPC Team attends capacity daily and more frequently when required Weekend plan produced Winter plan produced				3. Compliant

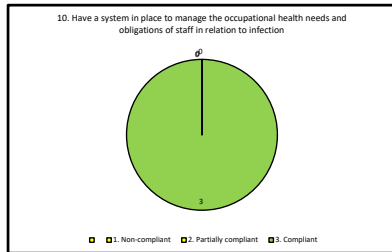
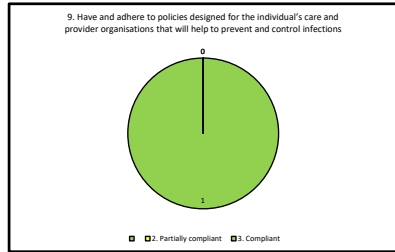
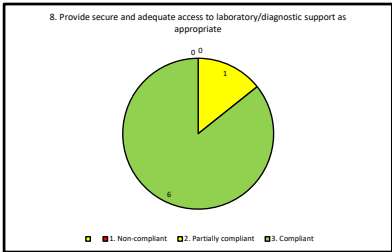
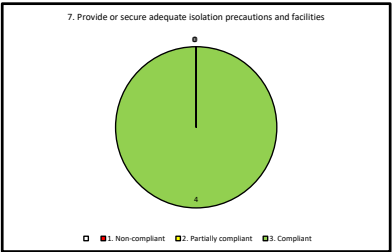
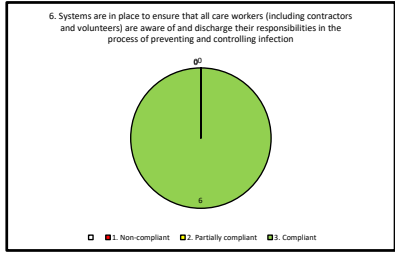
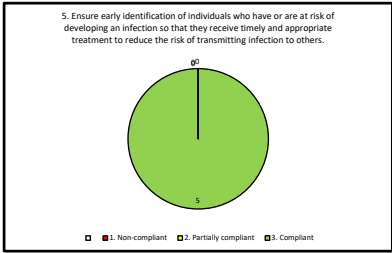
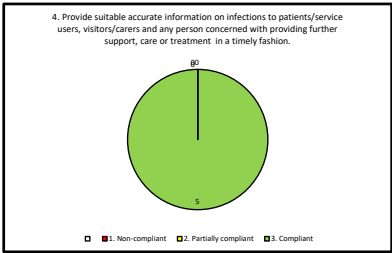
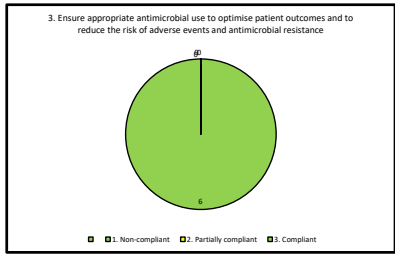
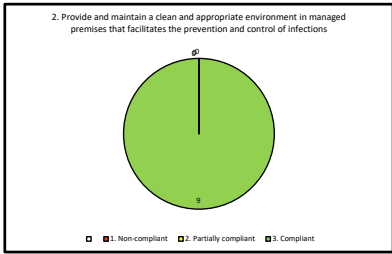
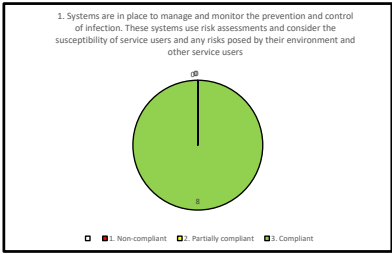


7.3	Transmission based precautions (TBPs) in conjunction with SICPs are applied and monitored and there is clear signage where isolation is in progress, outlining the precautions required.	Standard Infection Preventoin and control Policy available on the Hub PPE readily available Isolation signage available for use source or protective signage available				3. Compliant
7.4	Infectious patients should only be transferred if clinically necessary. The receiving area (ward, hospital, care home etc.) must be made aware of the required precautions.	All infectious patients are reviewed by the IPC team prior to relocation or transfer. Patients are transferred when clinically appropriate.				3. Compliant
8. Provide secure and adequate access to laboratory/diagnostic support as appropriate						
Systems and processes to ensure that pathogen-specific guidance and testing in line with UKHSA are in place:						
8.1	Patient/service user testing for infectious agents is undertaken by competent and trained individuals and meet the standards required within a nationally recognised accreditation system.	All swabs are sent to BCPS accredited lab at Royal Wolverhampton Hospital. POC testing in ED and C2 is undertaken by trained competent staff				3. Compliant
8.2	Early identification and reporting of the infectious agent using the relevant test is required with reporting structures in place to escalate the result if necessary.	Trust has access to IC NET laboratory reporting system All results are pulled through onto the Trusts Sunrise system IPC Team has access to WinPath	Screening for CPE following the latest Department of Health guidance Awaiting outcome of review from ICB and BCPS for funding to meet the new guidance	Trust has an in date CPE policy based on the Department for Health guidance All in patients who meet the criteria and are high risk are screened for CPE on admission Rectal and faecal screening for CPE can be provided A new CPE policy following the new guidance has been drafted and approved. This is recorded as a risk on the IPC risk register.	CPE screening not following the latest Department of Health guidance has been raised with the ICB and has been recorded as a risk on their risk register. The IPC risk register is reviewed monthly at the IPC Group meeting.	2. Partially compliant
8.3	Protocols/service contracts for testing and reporting laboratory/pathology results, including turnaround times, should be in place. These should be agreed and monitored with relevant service users as part of contract monitoring and laboratory accreditation systems.	Policies and procedures in place. Agreed with Black County Pathology Services. Concerns raised via DATIX or via direct contact with the Laboratory.				3. Compliant
8.4	Patient/service user testing on admission, transfer, and discharge should be in line with national guidance, local protocols and results should be communicated to the relevant organisation.	Policies, procedures and SOPs in place for testing for infections pre admission, admission and discharge. COVID-19 staff and screening policy in place Staff have access to LFD for patients, these are available from Capacity COVID-19 rapid swabs available on request POC testing available in ED and C2 Influenza screening when requested or annually during flu season as advised by the Department of Health.				3. Compliant
8.5	Patients/service users who develops symptom of infection are tested / retested at the point symptoms arise and in line with national guidance and local protocols.	PCR testing is available for symptomatic in patients for COVID-19 Patients for all other infections are tested at the point symptoms arise. POCT is available in ED Testing and retesting are available for all patients who require testing. Policies and SOPs available on the hub				3. Compliant
8.6	There should be protocols agreed between laboratory services and the service user organisations for laboratory support during outbreak investigation and management of known/ emerging/ novel and high risk pathogens.	Policies and procedures are in place with BCPS for outbreak investigation and high risk pathogens				3. Compliant
8.7	There should be protocols agreed between laboratory services and service user organisations for the transportation of specimens including routine/ novel/ emerging/high risk pathogens. This protocol should be regularly tested to ensure compliance.	Policies and procedures are in place for the transportations of specimens to the laboratory in RWT.				3. Compliant
9. Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections						
9.1	Systems and processes are in place to ensure that guidance for the management of specific infectious agents is followed (as per UKHSA , A to Z , antibiotic resistance , and the HICAM). Policies and procedures are in place for the identification of and management of outbreaks/incidence of infection. This includes monitoring, recording, escalation and reporting of an outbreak/incident to the registered provider.	Policies, procedures and SOPs are in place for specific micro-organisms Outbreak and isolation policies are available All policies, procedures and SOPs are in date and available on the Trusts Hub. The Trust has access to IC NET IPC Team have access to WinPath All outbreaks are reported to external partners HICAM data is recorded and reported externally both and nationally. Outbreak meetings are held when required Specimens are sent for Ribotyping when required The trust has adopted the PSIRF approach to incident investigation.				3. Compliant
10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection						
Systems and processes are in place to ensure that any workplace risk(s) are mitigated maximally for everyone. This includes access to an occupational health or an equivalent service to ensure:						
10.1	Staff who may be at high risk of complications from infection (including pregnancy) have an individual risk assessment.	Risk assessments are completed for staff who are at risk of complications from infection. Risk assessments are kept in staffs' personal file Staff have access to the Staff Health and Wellbeing Service (SHAW)				3. Compliant



10.2	Staff who have had an occupational exposure are referred promptly to the relevant agency, for example, GP, occupational health, or accident and emergency, and understand immediate actions, for example, first aid, following an occupational exposure including process for reporting.	<p>The Trust has a Sharps Injury Policy and have access to a 24 hour Emergency Department on Site.</p> <p>A WY FFP service is available</p> <p>A Data system is available to all staff and there is a joined up service between Health and Safety and SHAW for the monitoring and reporting of Sharps injuries</p> <p>All injuries are reported via the IPCG meeting</p> <p>A sharps flow chart is available for staff to follow in the event of an injury</p> <p>Sharps handling and injuries are covered in IPC mandatory face to face training</p> <p>The Trust has a sharps safety task and finish group</p> <p>Safer sharps are promoted</p> <p>Vaccinations are given as required.</p> <p>Seasonal flu and COVID vaccination service provided in house.</p> <p>staff are encouraged to report all injuries via the DATIX system</p> <p>Staff Health and Wellbeing report into IPCG Meeting via a separate report</p>				3. Compliant
10.3	Staff have had the required health checks, immunisations and clearance undertaken by a competent adviser (including those undertaking exposure prone procedures (EPPs)).	<p>Pre employment checks for all staff are completed via the Staff Health and Wellbeing Service.</p> <p>Pre employment screening is undertaken on those staff undertaking EPP.</p>				3. Compliant





Performance Against Workforce Forecast – M12



The Dudley Group
NHS Foundation Trust



	In month update – M12 (March 2025)
Finance Will the workforce plan support the delivery of the financial plan	<p>Following the transfer of DIHC in October, the substantive and agency plans have been increased by 211.78 WTE and 2.25 WTE respectively.</p> <p>Substantive staff are 211.70 WTE behind target in March. Accounting for increased Deanery, hosted and externally funded posts reduces the shortfall to 188.82 WTE. In summary, after adjustments, the Trust’s substantive workforce reduced by 22 WTE in March. The reduction is as expected due to the impact of the vacancy freeze. The adverse financial variance has increased from £4.887m to £6.312m (of which £2.336m relates to the CSW Band 2 to 3 issue). The March costs are also skewed by provisions made for backdated consultant pay claims.</p> <p>Bank WTE in March increased significantly to 258.35 WTE over target. Adjusting for surge beds, ERF workload and the impact of Midland Met/Winter Pressures reduces the variance to 161.92 WTE (101 WTE higher than February). This results in an adverse financial variance of £8.525m. The main driver for the increase appears to be linked to much higher levels of annual leave in March. There may also be a link to the rates which are due to reduce in April. Note that the first week in April shows a significant decline in the number of bank shifts.</p> <p>Agency also increased in March but remained below target by 1.28 WTE. This results in a cumulative overspend of £626k. Overall, agency remains very low with Trust spend of 0.7% of pay bill versus the target of 3.2%. The vast majority of the spend relates to medical staff.</p>
People Committee adverse impact associated with the financial and transformational plan	<p>Across workforce metrics, whilst turnover has increased, it remains below target. Sickness absence has reduced in month. There are no material changes or evidence of adverse impact associated with the current measures to achieve the financial and transformational improvements, however given that turnover is low, and retention is high this will impact on the efficiencies available to be released.</p>
Quality/Safety Patient Experience adverse impact associated with the financial and transformational plan	<p>The monitored quality indicators have continued to stabilise following the increase in some incidents and harms such as falls, pressure ulcers and IPC outbreaks, noted during December 2024 and January 2025. The latest HED SHMI and HSMR data is indicating an increase, with sepsis and stroke being the areas of requiring a further attention and this has been discussed in detail with the Divisions. The Integrated Quality Report includes more detail, which is reported via the agreed governance process. The nursing & midwifery quality dashboard continues to be available, which provides a triangulated overview of key metrics, to showcase best practice and identify areas for improvement. Strengthened QIA process remains in place. Improvements are being taken forward via the existing programmes of work. A variety of QIAs have been completed and subject to formal review and sign off by the Chief Nurse and Medical Director.</p>

M12 Performance – Overview



The Dudley Group NHS Foundation Trust

Following the transfer of DIHC in October, the substantive and agency plans have been increased by 211.78 WTE and 2.25 WTE respectively. The performance until the end of March remains off target.

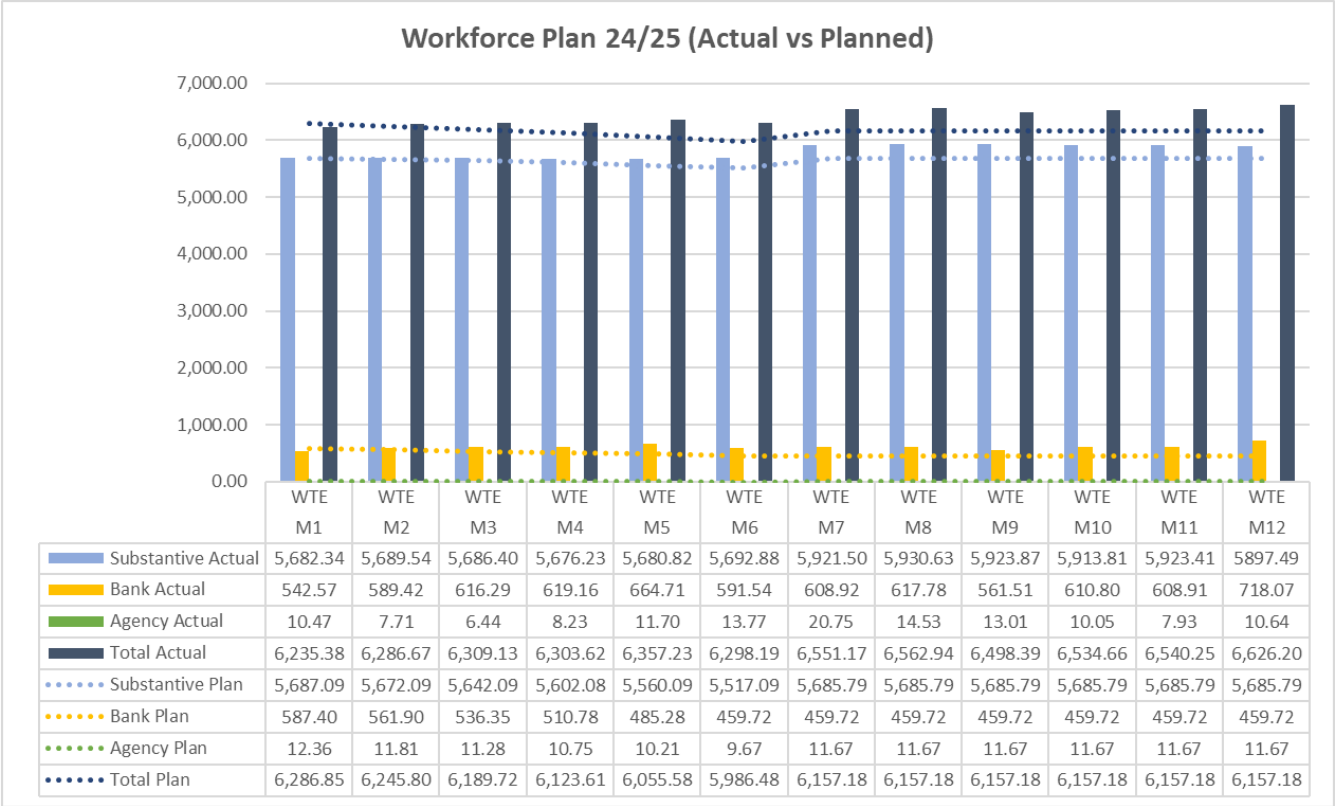
The Trust performance in month 12 shows a variance against the total workforce forecasted M12 position of 468.77 WTE (7.6% above plan), compared to 382.82, 6.2% above plan at M11.

There has been an in-month movement of +85.95 WTE (significant rise in bank part negated by a reduction in substantive). Adjusting for fully funded income backed posts (not in the plan), additional Deanery posts, hosted posts, the impact of open surge beds/Midland Met/Winter Pressures and the total impact of ERF reduces the adverse WTE variance to 349.46 (5.7%).

Substantive workforce variance against workforce forecasted M12 position is 211.70 WTE above plan (3.7%), compared to 237.62 WTE (4.2%) above plan at M11). There has been an in-month movement of –25.92 WTE. After adjustments, the variance is 188.82 WTE, the adverse financial variance has increased from £4.887m to £6.312m (of which £2.336m relates to the CSW band 2 to 3 issue).

The bank workforce variance against workforce forecasted M12 position increased to 258.35 WTE above plan (56.2%) compared to 149.19 WTE (32.4%) above plan at M11. There has been an in-month movement of +109.16 WTE. After adjustments, the M12 variance reduces to 161.92 WTE. This results in an adverse financial variance of £8.525m.

Agency workforce variance against workforce forecasted M12 position is 1.28 WTE better than plan – compared to 3.99 WTE better than plan at M11. Overall, agency remains very low with Trust spend of 0.7% of pay bill versus the target of 3.2%. The vast majority of spend relates to medical staff.



				ADJUSTMENTS						
	TARGET	ACTUAL	DIFF	INCOME	DEANERY	SURGE	MMet/WP	ERF	Hosted	NET
Substantive	5,685.79	5,897.49	-211.70	3.72	10.78	4.20	0.00	0.00	4.18	-188.82
Bank	459.72	718.07	-258.35			33.74	11.95	50.74		-161.92
Agency	11.92	10.64	1.28							1.28
Total	6,157.43	6,626.20	-468.77	3.72	10.78	37.94	11.95	50.74	4.18	-349.46



M12 Performance



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Following the transfer of DIHC in October, the substantive and agency plans have been increased by 211.78 WTE and 2.25 WTE

Variance to plan:

- 468.77 WTE (7.6%) away from plan
- Adjusting for MMUH, Income back developments, deanery doctors, ERF, and escalation capacity, this becomes 349.46 WTE (5.7%)

Breakdown

- Substantive is 211.70 WTE away from plan (3.7%)
- Accounting for MMUH, Income backed developments, deanery doctors this reduces to 188.82 WTE (3.3%)
- Adverse financial variance has increased from £4.887m to £6.312m (of which £2.336m relates to the CSW band 2 to 3 issue).
- Bank is 258.35 WTE away from plan (56.2%)
- Accounting for MMUH, Income backed developments, ERF, and escalation capacity this reduces to 161.92WTE (35.2%)
- Adverse financial variance of £8.525m
- Agency is 1.28 WTE better than plan (10.7%)
- There is a cumulative overspend of £626k.
- Agency remains very low with Trust spend of 0.7% of pay bill versus the target of 3.2%.
- **Position since March 2024 (to March 2025)**
 - Movement in total workforce (includes substantive, bank and agency since March 2024 is (6289.5 to 6626.2) +336.7 WTE (5.4%)
 - Accounting for DIHC staff in post, this becomes +144.91 WTE (2.3%)
 - Accounting for MMUH, Income backed developments, deanery doctors, ERF, and escalation capacity, (119.31 WTE) – This would give us an increase of 25.6 WTE (0.4%). It should be noted, however, that bank was significantly skewed in March (WTE was 115.2 higher than the average for April to February).



Data Pack



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M12 - Risks/Mitigations to Delivery



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Risks:

- Hosted/Income backed posts – impact on substantive posts (7.90 WTE in M12)
- Increased Deanery doctors due to national shortfall of places (10.78 WTE in M12)
- Increased Activity (ERF) – impact on bank usage estimated at 50.74 WTE in M12)
- Demand and capacity – Surge beds – impact on bank usage (33.74 WTE bank in M12 and 4.20 WTE on substantive) and increase of adverse events during times of high operational pressures
- Midland Met and Winter Pressure mitigations – impact on bank of 11.95 WTE in M12)
- Industrial action by Junior Doctors - impact on bank usage (14.11 WTE in M3 and 4.81 WTE in M4)
- Reduced turnover and increased retention (7.14% in M10)

Mitigations:

- Divisional, Executive and ICB vacancy control process
- Divisional trajectories developed – monitored and challenged through Executive led confirm and challenge meetings and Finance Improvement group
- Additional oversight and controls regarding bank and agency usage, including a system wide plan
- Oversight of quality and safety as described in slide two, including senior nursing, midwifery and AHP presence within clinical areas (Back to the Floor/Night Visits/support during times of significant operational pressures)

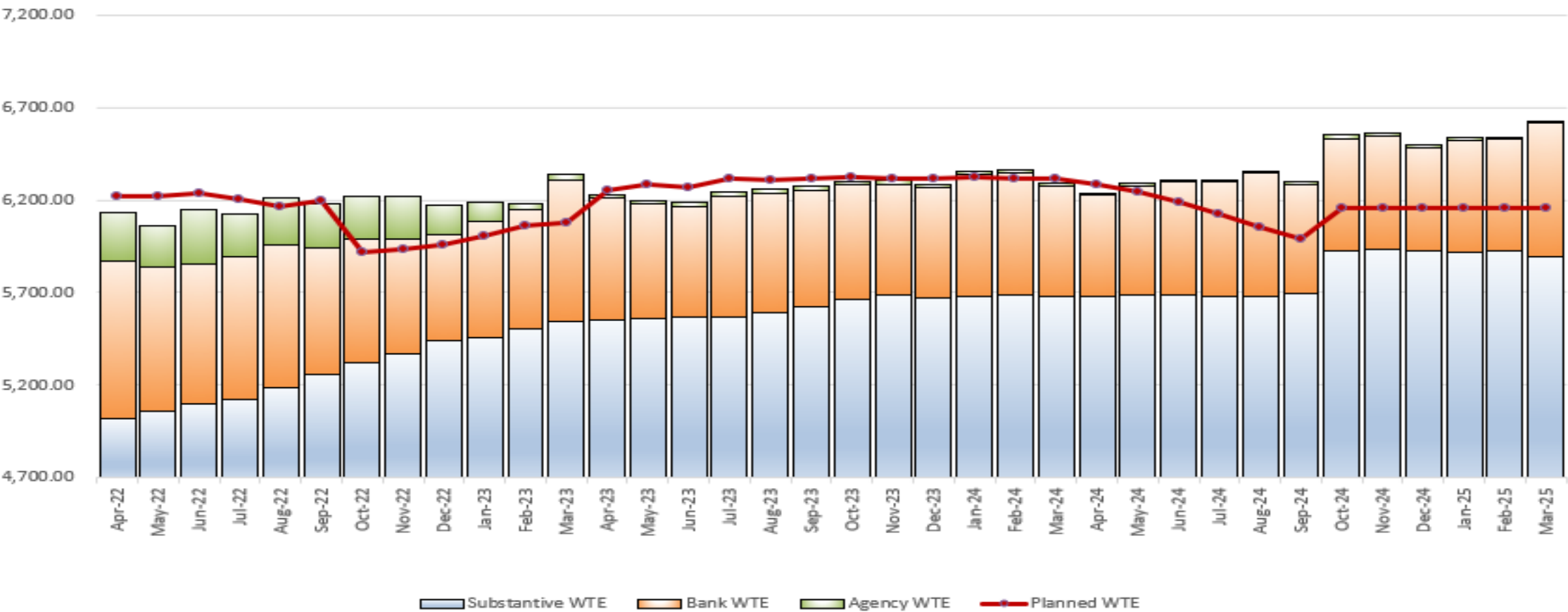


WTE Plan/Actuals from April 2022



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Overall WTE Actual and Plan



M12 Performance - Substantive



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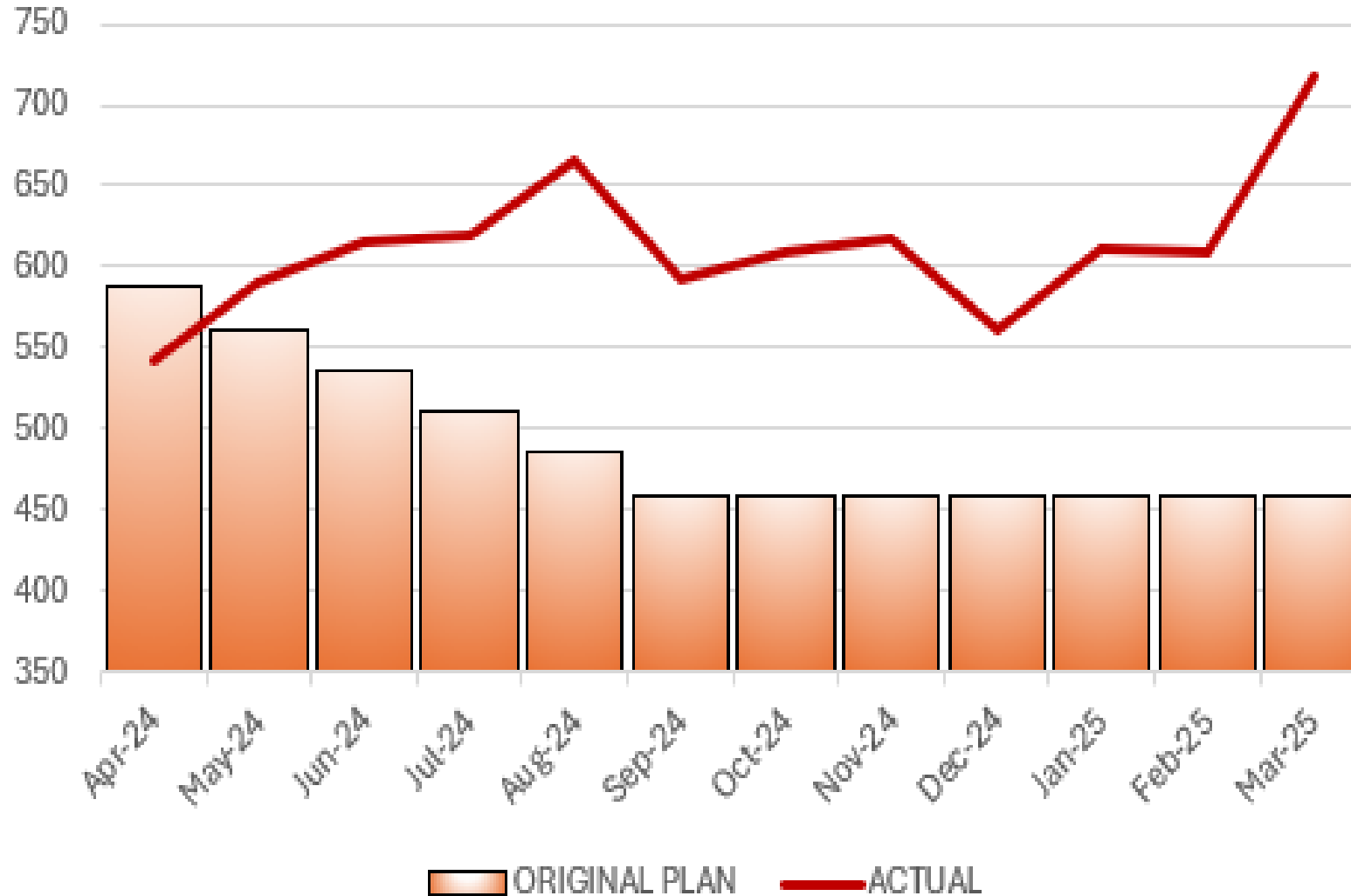
- Original plan shows 4% workforce reduction;
- Actual cost/WTE lower than figures assumed in plan (£67/person/month);
- Reasons include case mix, pay award and higher averages used in plan;
- As expected, there was a reduction in March due to the delayed impact of the vacancy freeze.



M12 Performance - Bank



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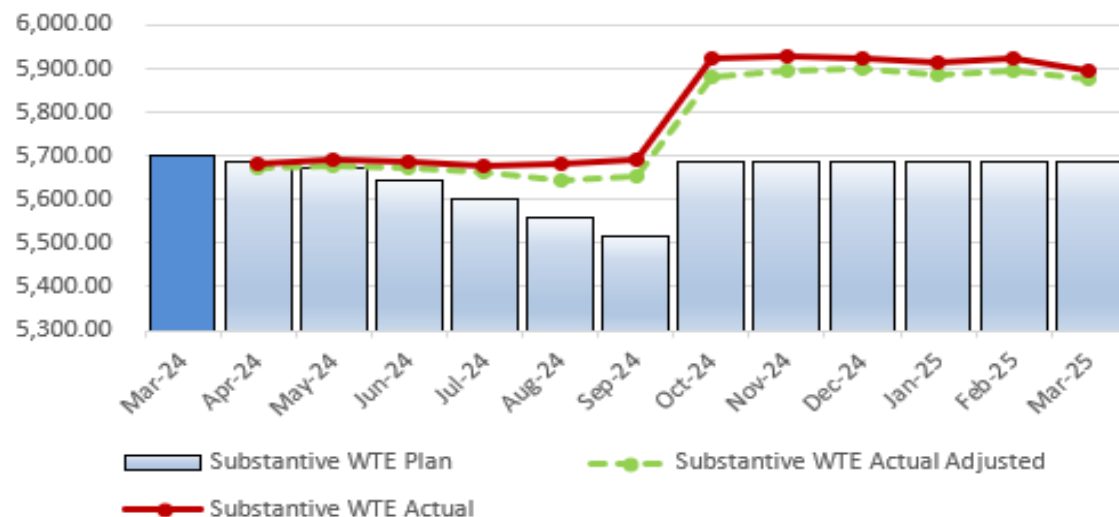
- Original plan shows 25% reduction;
- Average cost/WTE lower than figures used in plan;
- Will be distortions due to bank holidays etc.;
- March shows significant increase (well above average for year).
- Increase driven by high level and annual leave in March (the first week in April has reduced markedly)

M12 Performance - Substantive

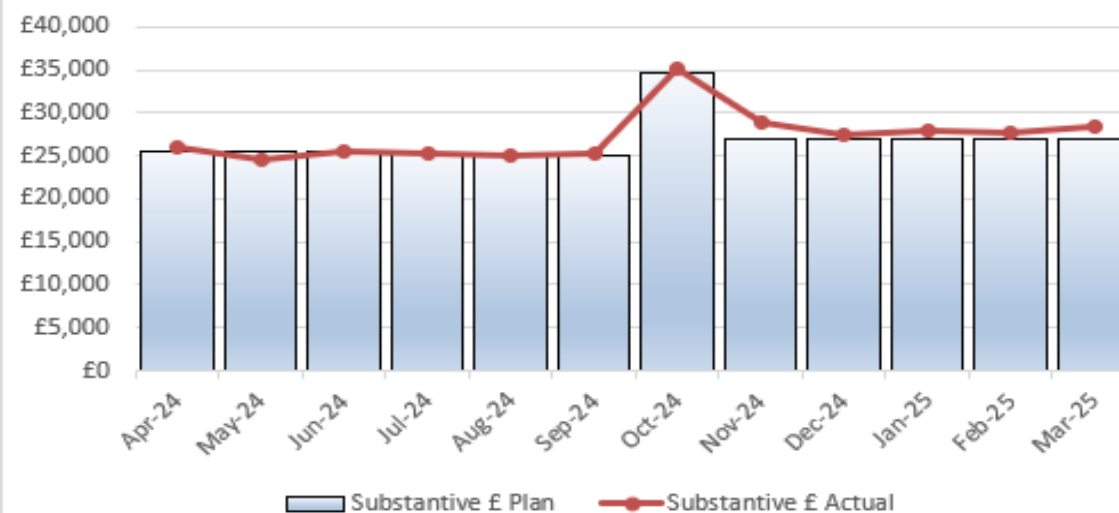


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Substantive WTE



Substantive £



	LATEST
Med	-63.56
C&CCS	-78.09
D Place	9.61
Surg	-62.97
Corp	-16.69
TOTAL	-211.70

	LATEST
Admin	-45.51
Medic	-27.23
RN	-74.34
CSW	12.62
Other	-7.55
Sci/AHP	-69.70
TOTAL	-211.70

	YTD
Med	-£2,688
C&CCS	-£1,698
D Place	£477
Surg	-£3,003
Corp	£601
TOTAL	-£6,312

	YTD
Admin	-£705
Medic	-£2,395
RN	-£456
CSW	-£714
Other	-£312
Sci/AHP	-£1,730
TOTAL	-£6,312

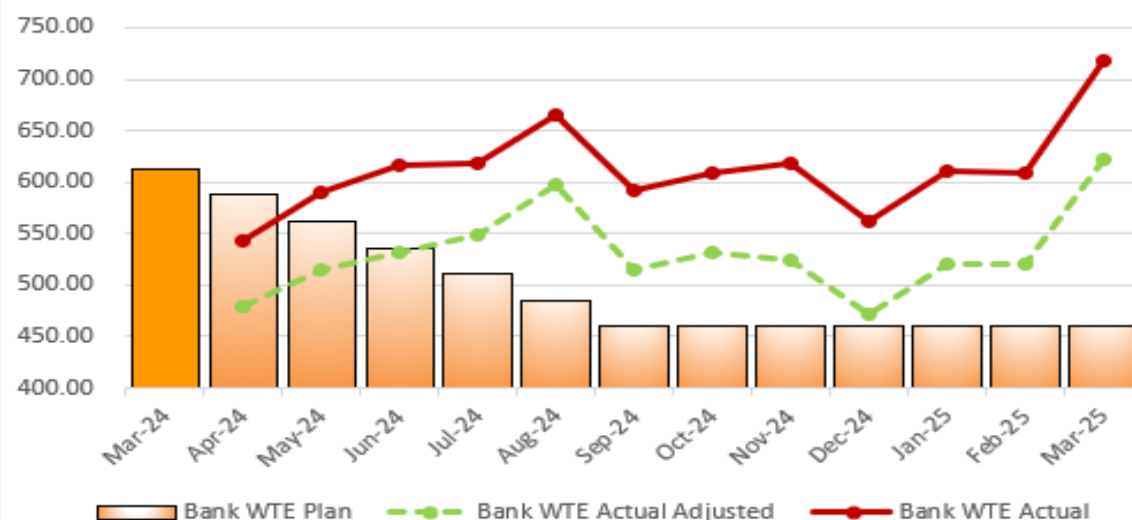


M12 Performance - Bank

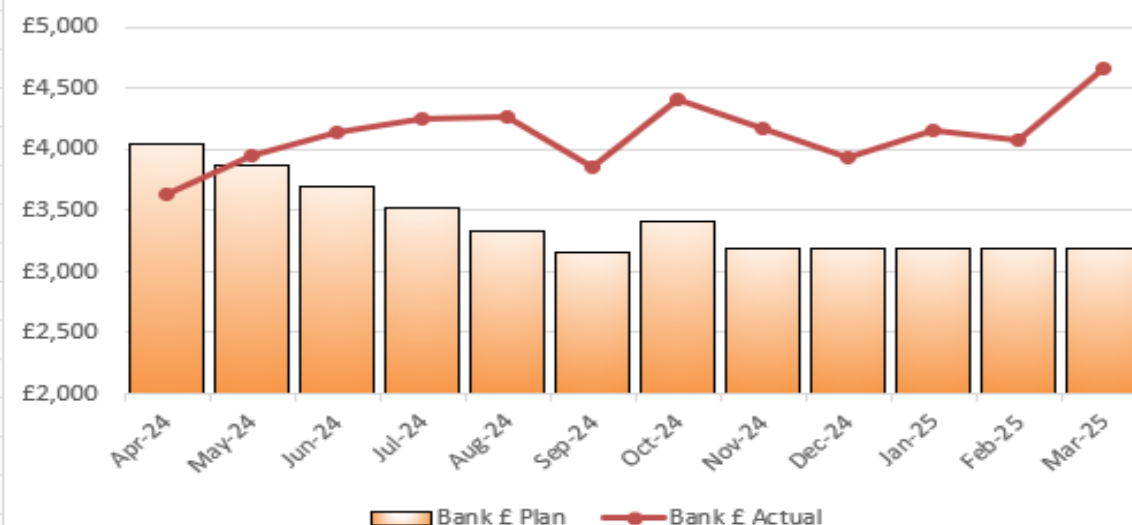


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Bank WTE



Bank £



	LATEST
Med	-141.76
C&CCS	-25.30
D Place	-10.32
Surg	-74.81
Corp	-6.15
TOTAL	-258.35

	LATEST
Admin	-5.01
Medic	-27.86
RN	-97.39
CSW	-91.20
Other	0.03
Sci/AHP	-36.91
TOTAL	-258.35

	YTD
Med	-£3,336
C&CCS	-£846
D Place	-£423
Surg	-£3,951
Corp	£32
TOTAL	-£8,525

	YTD
Admin	£32
Medic	-£2,160
RN	-£2,692
CSW	-£2,466
Other	-£3
Sci/AHP	-£1,235
TOTAL	-£8,525

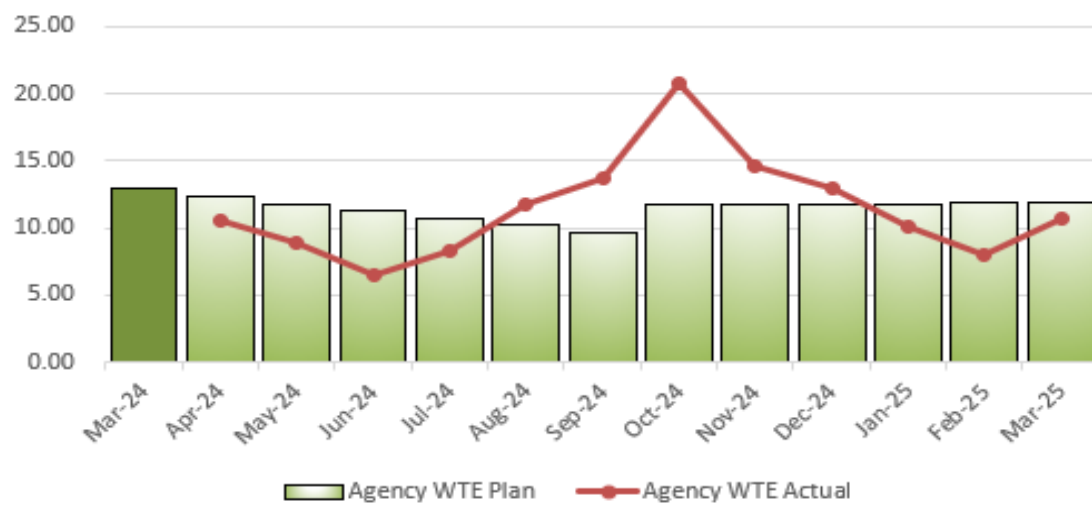


M12 – Performance Agency

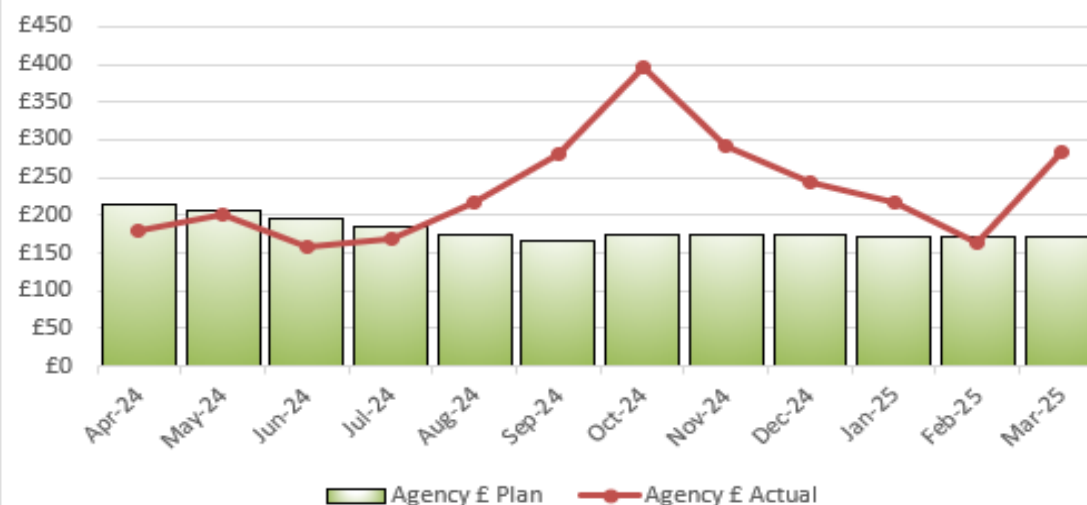


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Agency WTE



Agency £



	LATEST
Med	-1.28
C&CCS	0.24
D Place	1.75
Surg	0.57
Corp	0.00
TOTAL	1.28

	LATEST
Admin	1.00
Medic	-2.20
RN	1.70
CSW	0.00
Other	0.00
Sci/AHP	0.79
TOTAL	1.28

	YTD
Med	-£468
C&CCS	-£99
D Place	£33
Surg	-£92
Corp	£0
TOTAL	-£626

	YTD
Admin	£12
Medic	-£835
RN	£158
CSW	£0
Other	£0
Sci/AHP	£39
TOTAL	-£626

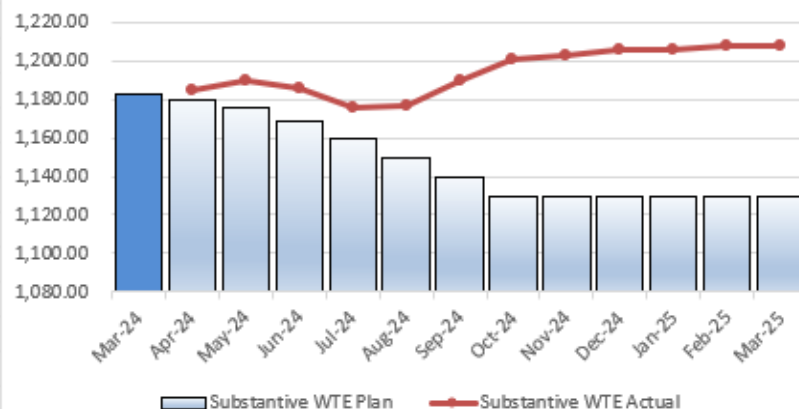


M12 – C&CCS

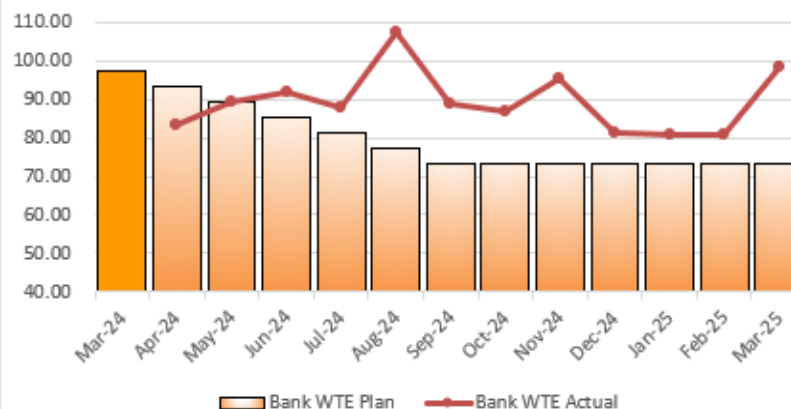


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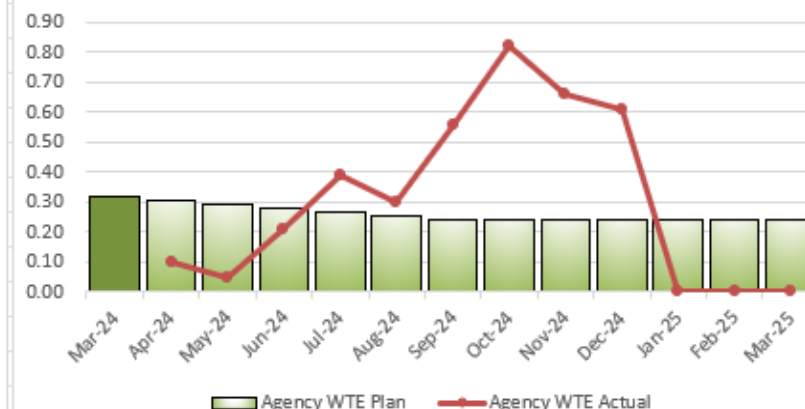
C&CCS Substantive WTE



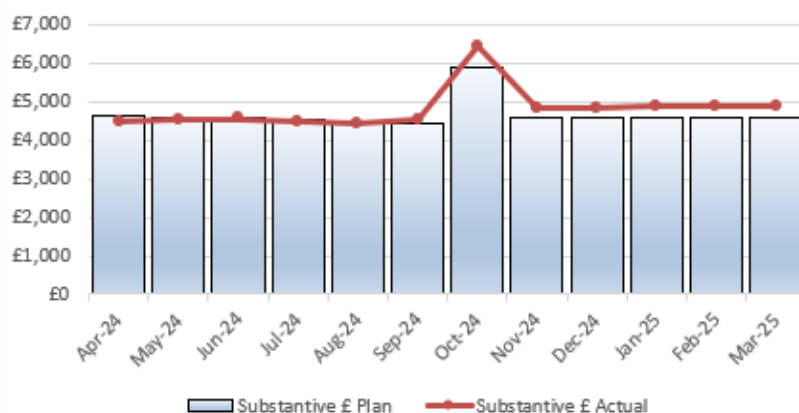
C&CCS Bank WTE



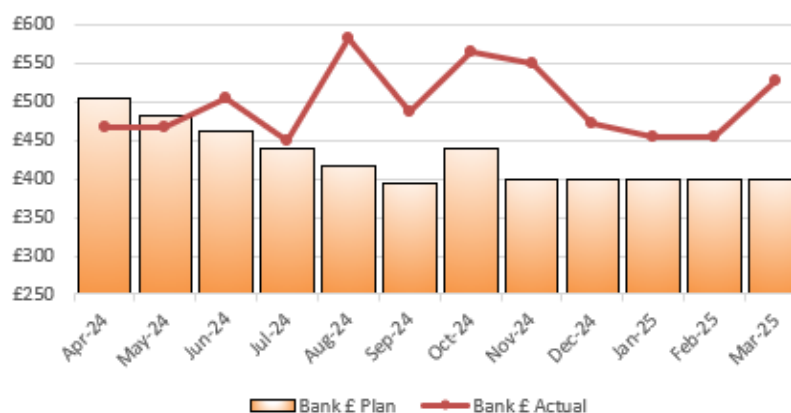
C&CCS Agency WTE



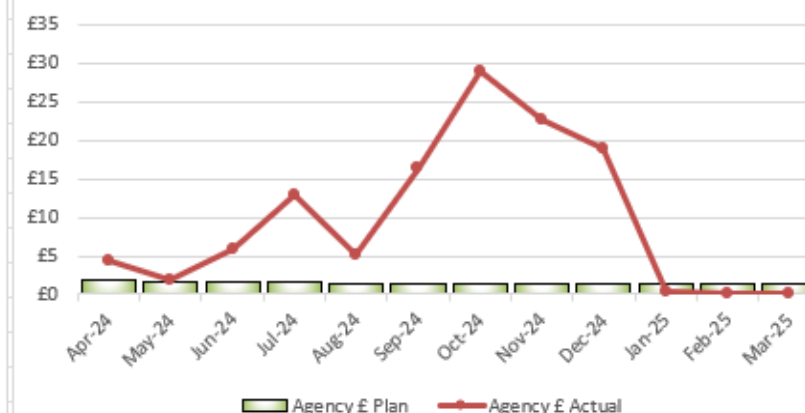
C&CCS Substantive £



C&CCS Bank £



C&CCS Agency £

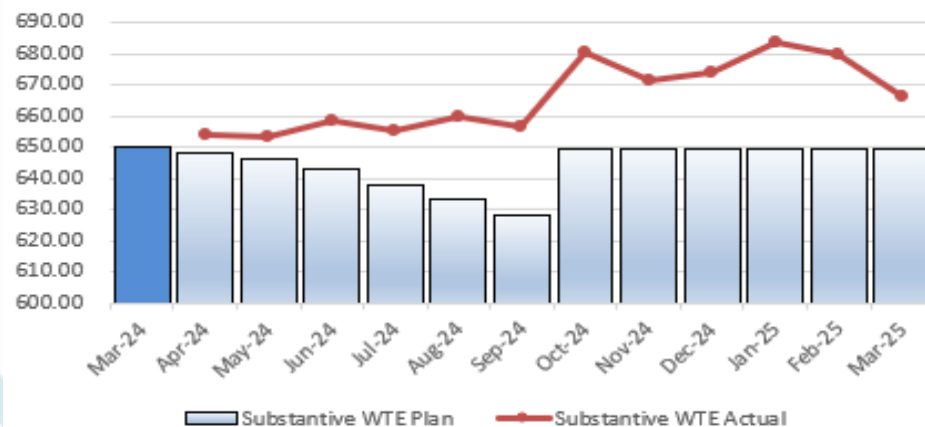


M12 – Corporate

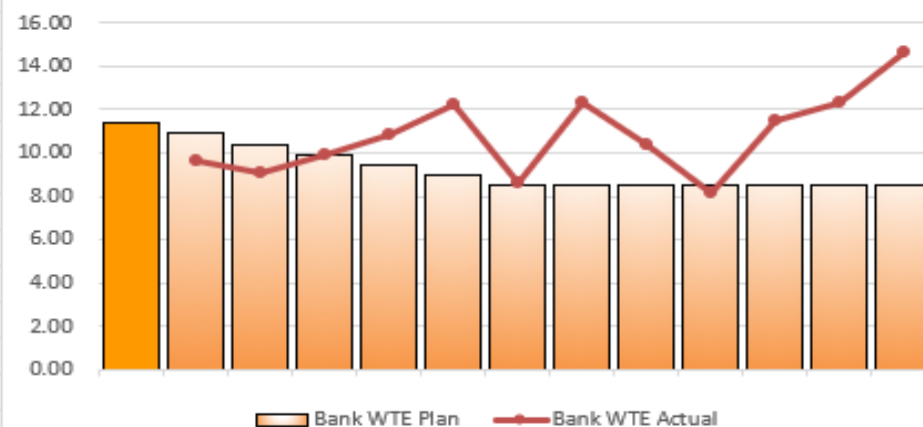


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Corporate Substantive WTE



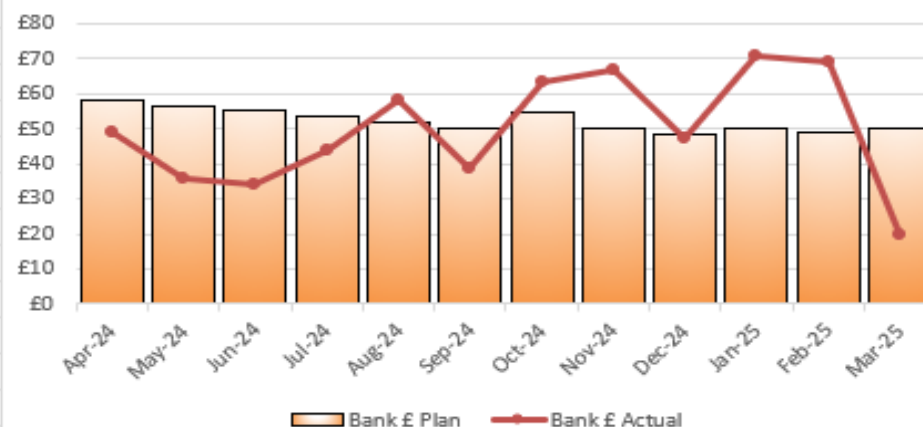
Corporate Bank WTE



Corporate Substantive £



Corporate Bank £

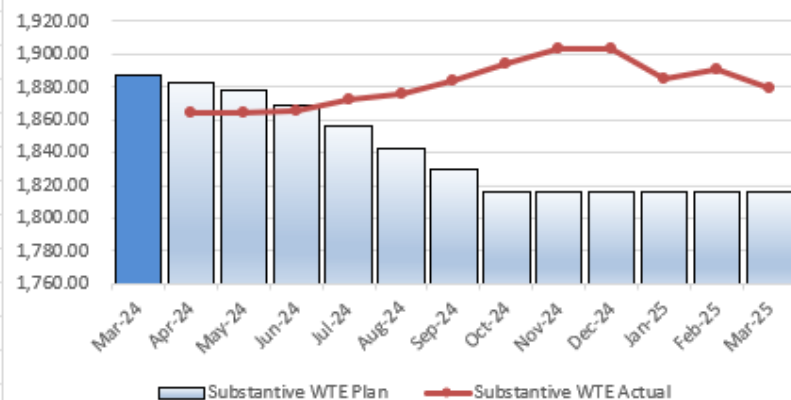


M12 – Medicine

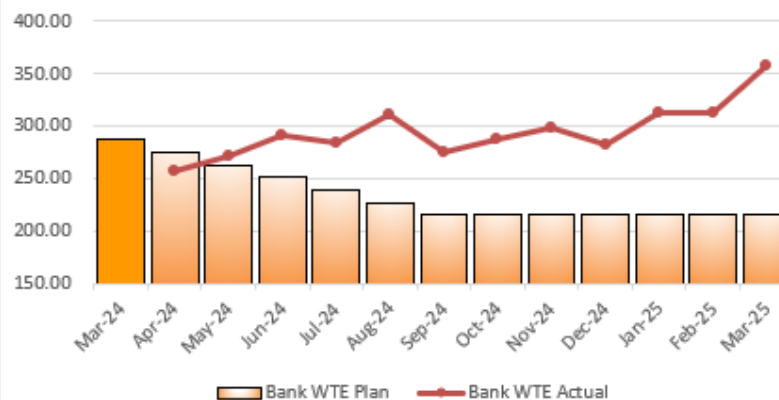


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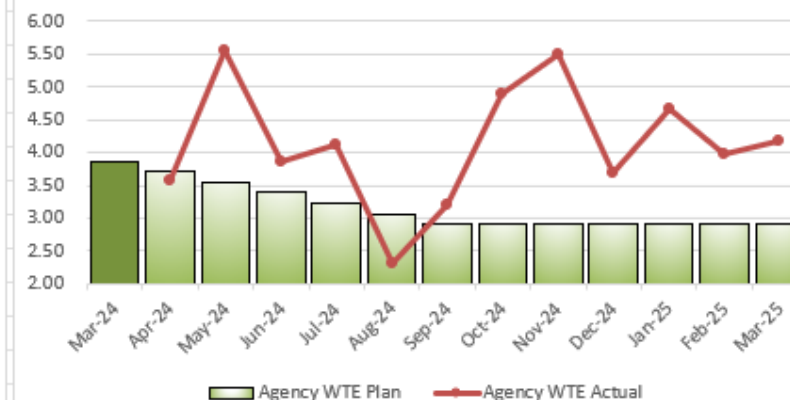
Medicine Substantive WTE



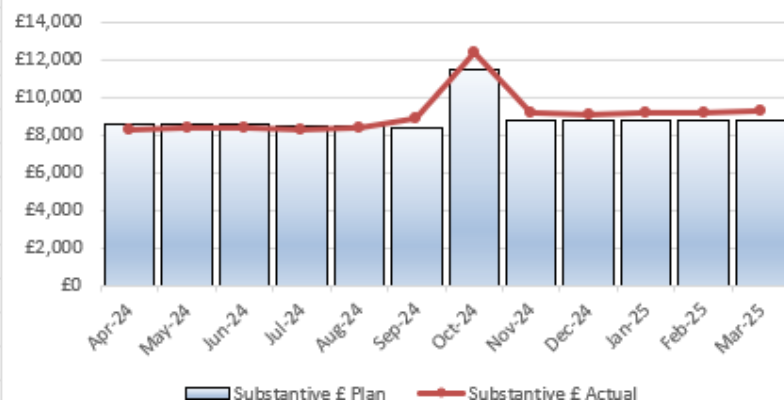
Medicine Bank WTE



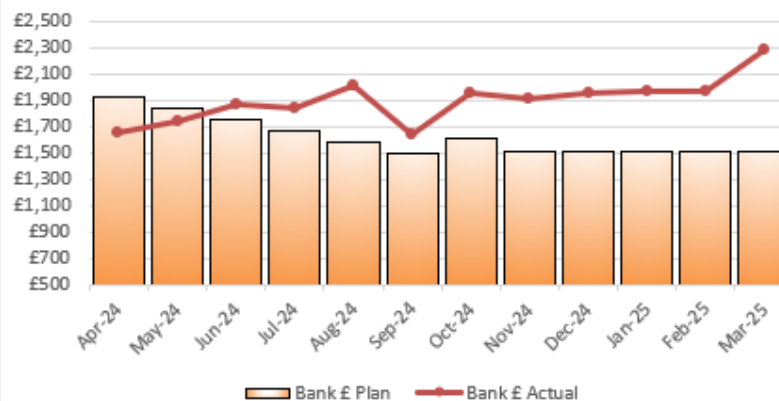
Medicine Agency WTE



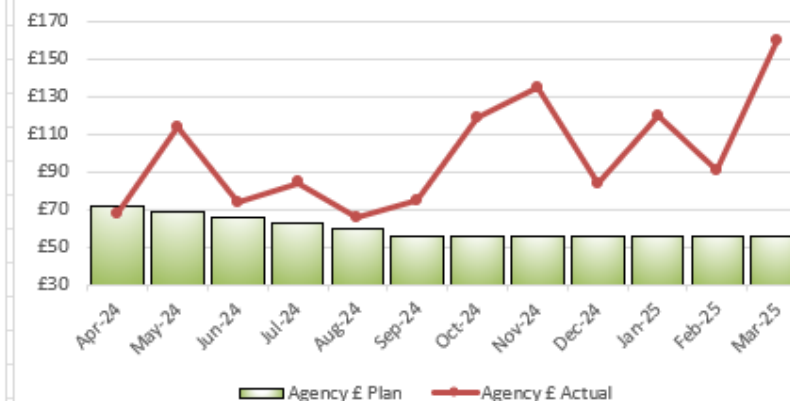
Medicine Substantive £



Medicine Bank £



Medicine Agency £

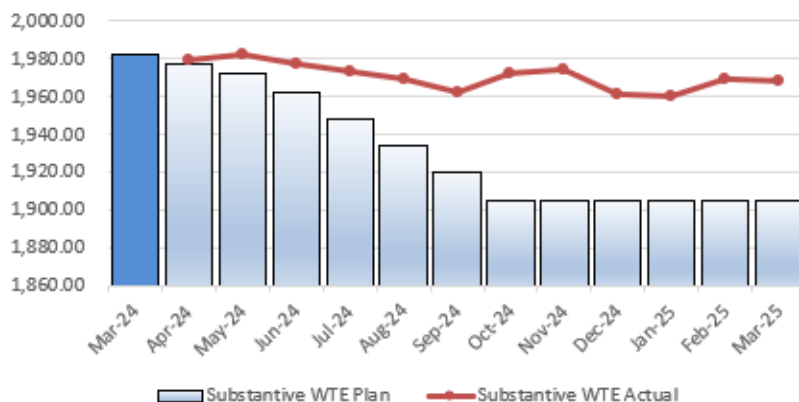


M12 – Surgery

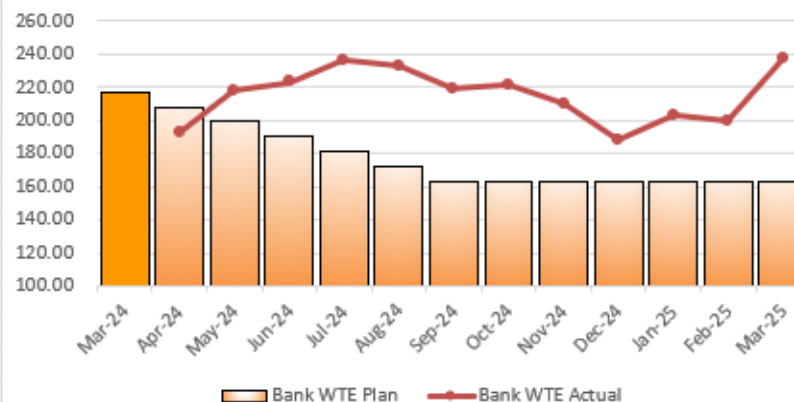


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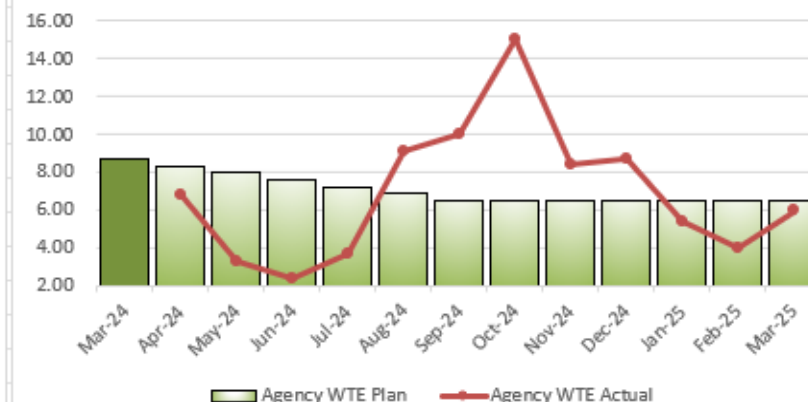
Surgery Substantive WTE



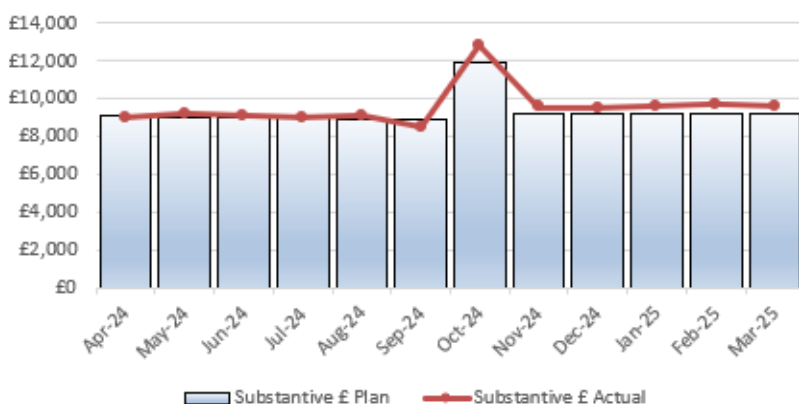
Surgery Bank WTE



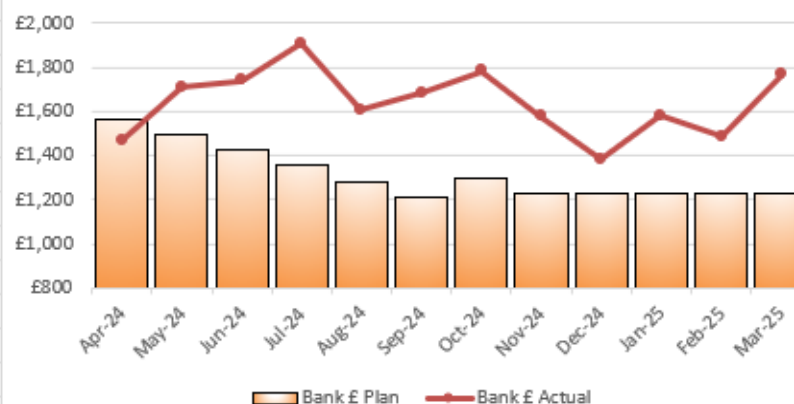
Surgery Agency WTE



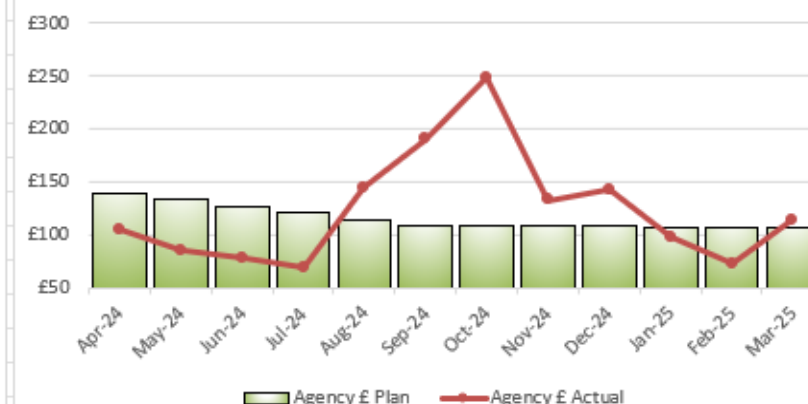
Surgery Substantive £



Surgery Bank £



Surgery Agency £

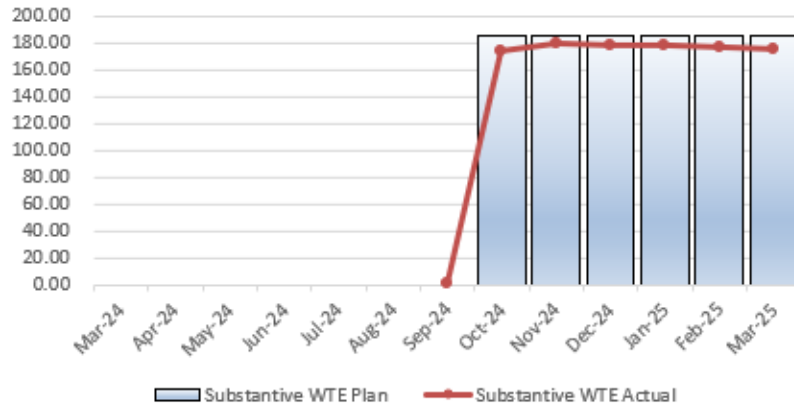


M12 – Dudley Place

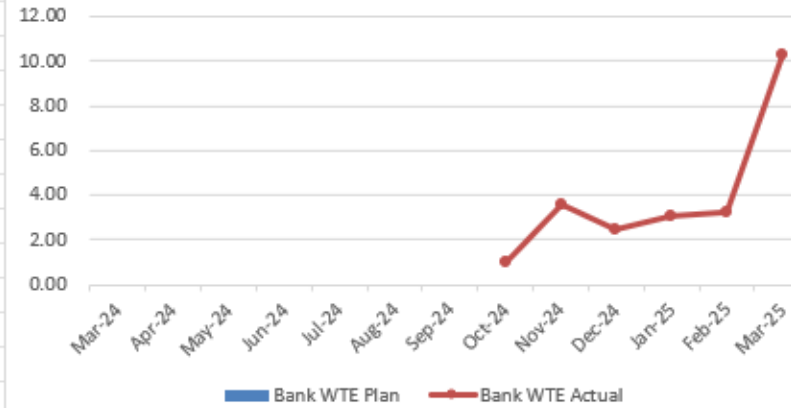


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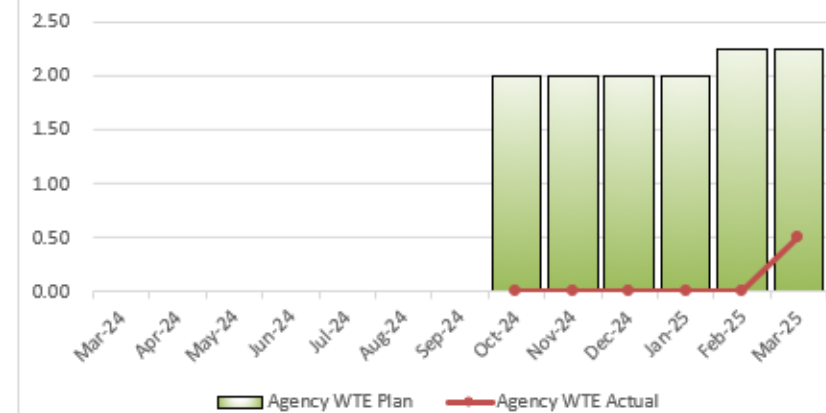
Dudley Place Substantive WTE



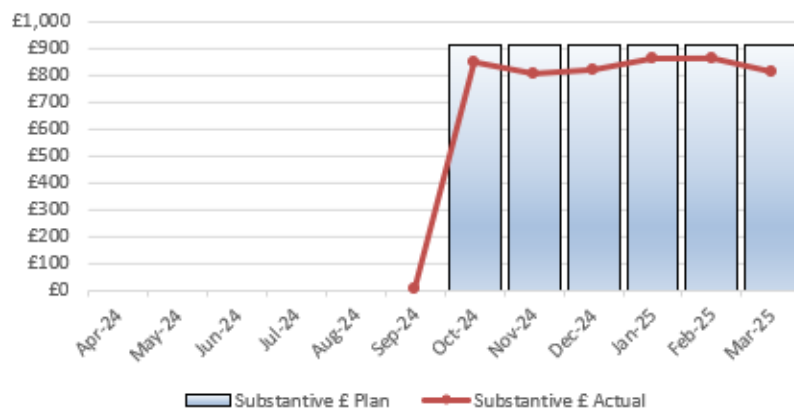
Dudley Place Bank WTE



Dudley Place Agency WTE



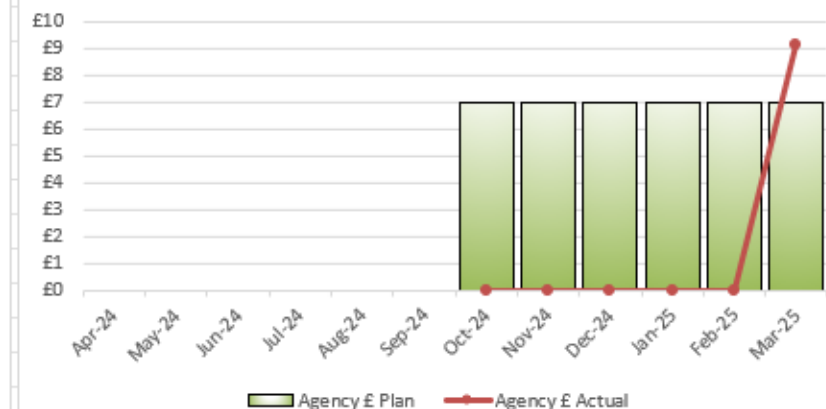
Dudley Place Substantive £



Dudley Place Bank £



Dudley Place Agency £



M12 – Workforce Metrics



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Metric	Rate	Target	Trend	
Absence – In Month	5.39%	<=5%	↓	<u>Sickness Absence</u> In-month sickness absence for March is 5.39% which is a decrease from 5.68% in February 2025
Absence - 12m Rolling	5.33%	<=5%	↑	The rolling 12-month absence has increased from 5.31% in February 2025 to 5.33% in March 2025
Turnover	7.24%	<=8%	↑	<u>Turnover</u> Turnover (all terminations) has increased from 7.14% in February to 7.24% in March 2025
Normalised Turnover	3.16%	<=5%	↑	Normalised Turnover has increased from 3.09% in February 2025 to 3.16% in March 2025 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)	92.4%	>=80%	↑	<u>Retention</u> The 12-month retention rate has increased to 92.4%.
Vacancy Rate	6%	<=7%	↑	<u>Vacancy Rate</u> The vacancy rate has increased to 6%.
Mandatory Training	90.88%	>=90%	↑	<u>Mandatory Training</u> Statutory Training increased from 90.59% in February 2025 to 90.88% in March 2025. Overall, it has remained above 90% target for a sustained period.



M12 – Vacancy Control Panel



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	Divisional Vacancy Control Panel					Executive Vacancy Control Panel				
Date	Post Presented	Posts Rejected	Posts Rejected %	Posts Approved	Posts Approved %	Post Presented	Posts Rejected	Posts Rejected %	Posts Approved	Posts Approved %
24/03/2025	58	1	1.72%	57	98.28%	57	12	21.05%	45	78.95%
31/03/2025	41	6	14.63%	35	85.37%	35	5	14.29%	30	85.71%
07/04/2025	39	5	12.82%	34	87.18%	34	1	2.94%	33	97.06%
Total	138	12	8.70%	126	91.30%	126	18	14.29%	108	85.71%



M12 - Quality Impact Assessments Cost Improvement bi-monthly report (March 2025)



The Dudley Group NHS Foundation Trust

Level 4 – Scheme gone live and financially delivering.

Scheme No	Scheme Name	Divisional Project Lead	Overall QIA Risk Score	Reassessment Return Date
CCS-2425-002	Medicines Optimisation Rebate 24/25 - Pharmacy Share	Onajite Okoro	5	31/03/2025
CCS-2425-003	Medicines Optimisation Tocilizumab Biosimilar - Pharmacy Share	Onajite Okoro	5	31/03/2025
CCS-2425-004	Pharmacy Procurement - 24/25	Sarah Kinnerley	6	31/03/2025
CCS-2425-004a	Pharmacy Procurement 24/25 - Apixaban Saving	Sarah Kinnerley	6	31/03/2025
CCS-2425-005	Tendering of Consumables across BCPS	Raghuinder Ram	1	31/03/2025
CCS-2425-006	Introduction of decontamination units	Bill Norton	1	18/03/2025
CCS-2425-009	Children's Services Medicines Optimisation - Pharmacy Share	Jack Henderson	2	18/03/2025
CCS-2425-010	CCGS Procurement Savings	Amandeep Tung-Nahal	4	31/03/2025
CCS-2425-011	Ranibizumab Biosimilar Switch - Pharmacy Share	Onajite Okoro	6	31/03/2025
CCS-2425-031	Further develop CDC Dermoscopy to resolve ASI Challenge	Bes Hodo	1	31/03/2025
CCS-2425-032	CDC Efficiencies (Gastro)	Bes Hodo	1	31/03/2025
CCS-2425-033	CDC Efficiencies (CT & MRI Mobiles Units)	Bes Hodo	2	31/03/2025
CCS-2425-037	Division Wide Smaller Saving Schemes	Bes Hodo	1	31/03/2025
CCS-2425-038	CCGS Budget Nonflex Review	Amandeep Tung-Nahal	1	31/03/2025
CCS-2425-039	CCGS ERF Over Performance	Amandeep Tung-Nahal	3	18/03/2025
CCS-2425-040	Review of CDC Reserve	Amandeep Tung-Nahal	2	31/03/2025
CCS-2425-041	IR & CTC Nurse Led Clinics	Amandeep Tung-Nahal	2	31/03/2025
CCS-2425-042	Reduce DNA rates in Diabetics & Chemical Pathology	Amandeep Tung-Nahal	1	31/03/2025
CCS-2425-043	Record Acute SLT Activity on OASIS	Amandeep Tung-Nahal	3	31/03/2025
CCS-2425-001	MIC Procurement Savings	Rory McMahon	3	31/03/2025
MIC-2425-002	MIC Division Wide Vacancy Factor	Rory McMahon	4	31/03/2025
MIC-2425-003a	MIC budget review	Rory McMahon	1	31/03/2025
MIC-2425-003b	MIC budget review	Rory McMahon	1	31/03/2025
MIC-2425-007	Medicines Optimisation Rebate Medicine 24/25	Onajite Okoro	5	31/03/2025
MIC-2425-009	Medicines Optimisation Tocilizumab Biosimilar - Medicine Share	Onajite Okoro	5	31/03/2025
MIC-2425-011c	Overperformance at Virtual Ward Elective Recovery Plan	Rory McMahon	1	31/03/2025
MIC-2425-011a	Overperformance of Virtual Ward Elective Recovery Plan	Rory McMahon	1	31/03/2025
MIC-2425-014	CDC Dermoscopy increased activity	Kate Keating	1	31/03/2025
MIC-2425-016	Neurology Review of services	Kate Keating	1	31/03/2025
MIC-2425-017	Recruitment of 2 Gastroenterology Consultants	Lucy Ford	1	31/03/2025
MIC-2425-020	Hepatology Workforce	Lucy Ford	1	31/03/2025
MIC-2425-021	Alcohol Care Team	Lucy Ford	1	31/03/2025
MIC-2425-032c	Pharmacy Procurement 24/25 - Apixaban Saving	Rory McMahon	6	31/03/2025
MIC-2425-032b	Pharmacy Procurement 24/25 - Apixaban Saving	Rory McMahon	6	31/03/2025
MIC-2425-032g	Pharmacy Procurement 24/25 - Apixaban Saving	Rory McMahon	6	31/03/2025
MIC-2425-032u	Pharmacy Procurement 24/25 - Apixaban Saving	Rory McMahon	6	31/03/2025
MIC-2425-036	5th Endoscopy Room	Lucy Ford	1	31/03/2025
MIC-2425-039	MIC-4% Reduction in Actually Employed WTE in post	Rory McMahon	13	31/03/2025
MIC-2425-040	MIC- Review posts vacant for 3 months	Rory McMahon	3	31/03/2025
MIC-2425-042	Counting and Coding ERF Activity	Rory McMahon	1	31/03/2025
MIC-2425-044	Overperformance of Elective Recovery Plan	Rory McMahon	1	31/03/2025
MIC-2425-046	MIC - Review posts vacant for 3 months - non-recurrent	Rory McMahon	3	31/03/2025
SWC-2425-001	SWC Procurement Savings	Jack Richards	4	31/03/2025
SWC-2425-004	TCAPP - Additional Income over ERF plan	Jack Richards	3	31/03/2025
SWC-2425-006	SWC RAS Referral Review	Jack Richards	3	31/03/2025
SWC-2425-007	Gynaecology Medicines Optimisation	Annie Willets	3	31/03/2025
SWC-2425-010	Ranibizumab Biosimilar Switch - SWC Share	Steve Randle	6	31/03/2025
SWC-2425-011	Children's Services Medicine Optimisation - SWC Share	Jack Henderson	2	18/03/2025
SWC-2425-012	Review Attend Anywhere licence renewal	Jack Richards	4	20/03/2025
SWC-2425-015	3D Printing in Oral Surgery	Steve Randle	1	31/03/2025
SWC-2425-018	PHB pathway reduction in Histology sampling	Je Malpass	2	31/03/2025
SWC-2425-020	Reduce use of printed patient leaflets	Robecca Ward	1	31/03/2025
SWC-2425-023	Oto & Gynaec - Additional Income above ERF plan	Je Malpass	3	31/03/2025
SWC-2425-024	Children's Services - Additional Income above ERF plan	Robecca Ward	3	31/03/2025
SWC-2425-025	Specialist Surgery - Additional Income above ERF plan	Steve Randle	3	31/03/2025
SWC-2425-026	SUV - Additional Income above ERF plan	Emily Bennett	3	31/03/2025
SWC-2425-027	T&O (inc. Plastics) - Additional Income above ERF plan	Jenny Workman	3	31/03/2025
SWC-2425-029	T&O - Pharmacy Procurement 24/25 - Apixaban Saving	Jenny Workman	6	31/03/2025
SWC-2425-030	SUV - Pharmacy Procurement 24/25 - Apixaban Saving	Emily Bennett	6	31/03/2025
SWC-2425-031	Obstetrics Medicines Optimisation	Annie Willets	3	31/03/2025
SWC-2425-035	Coding	Jack Richards	3	31/03/2025

Scheme No	Scheme Name	Divisional Project Lead	Overall QIA Risk Score	Reassessment Return Date
SWC-2425-006	OPD Booking	Steve Randle	1	31/03/2025
SWC-2425-037	ECT Contract	Matt Fisher	1	31/03/2025
SWC-2425-040	Review posts vacant for 3 months	Jack Richards	3	31/03/2025
SWC-2425-043	Nursing home fees	Jack Richards	1	31/03/2025
SWC-2425-044	Computer Annual Licence	Steve Randle	1	31/03/2025
SWC-2425-045	Productivity Programme	Jack Richards	3	31/03/2025
CORP-2425-001	Corporate Procurement Savings	Paul Mallar	4	31/03/2025
CORP-2425-002	EDME 3rd Party Maintenance Rationalisation	Nigel Ford	1	31/03/2025
CORP-2425-003	PFI Commercial Agreement	Nigel Ford	4	31/03/2025
CORP-2425-009	Delay in Cloud Upgrade	Chris Benfield	1	31/03/2025
CORP-2425-010	IT 3rd Party Contracts	Sarah Ellis	1	31/03/2025
CORP-2425-011	Review Posts Vacant for 3 Months - Medical Director	Becky Edwards	2	31/03/2025
CORP-2425-012	Lung Health Checks	Adam Thomas	1	31/03/2025
CORP-2425-015	Review posts vacant for 3 months - Finance	Richard Price	1	31/03/2025
CORP-2425-016	Governance Legal Fees	Andy Proctor	1	31/03/2025
CORP-2425-017	Review posts vacant for 3 months - Governance	Andy Proctor	1	31/03/2025
CORP-2425-018	Review posts vacant for 3 months - IT	Sarah Ellis	3	31/03/2025
CORP-2425-019	Nursing Director Income	Marina Morris	6	31/03/2025
CORP-2425-020	Review Posts Vacant for 3 Months - Nursing Director	Marina Morris	2	31/03/2025
CORP-2425-021	Review posts vacant for 3 months - Strategy & Transformation	Adam Thomas	1	31/03/2025
CORP-2425-022	Finance Estates Trust Energy Costs	Nigel Ford	1	31/03/2025
CORP-2425-023	Finance Estates Rent and Service Charge Income	Nigel Ford	1	31/03/2025
CORP-2425-024	Review Posts vacant for 3 months - HR	Karen Brogan	1	31/03/2025
CORP-2425-025	Medical Director Training	Becky Edwards	2	31/03/2025
CORP-2425-026	HR Non-Recurrent Income	Karen Brogan	1	31/03/2025
CORP-2425-027	4% Reduction in actually employed WTE in post - IT	Ravinder Sahota-Thand	18	31/03/2025
CORP-2425-028	4% Reduction in actually employed WTE in post - Strategy & Transformation	Adam Thomas	5	20/03/2025
CORP-2425-029	PFI Energy ETA	Nigel Ford	1	31/03/2025
CORP-2425-030	Finance PFI Commercial Agreement REC	Chris Walker	4	31/03/2025
CORP-2425-031	Additional Income - Urgent & Emerg Care Growth Funding from ICB contract	Richard Price	1	31/03/2025
CORP-2425-032	HR Staffing Establishment VAC Reviews	Karen Brogan	1	31/03/2025
CORP-2425-033	4% Reduction in Actually Employed WTE in post - Corporate Resilience Bank	Karen Kelly	18	31/03/2025
CORP-2425-034	Review posts vacant for 3 months - Operational Management	Karen Kelly	1	31/03/2025
CORP-2425-035	Review posts vacant for 3 months - R&D	Gail Parsens	2	31/03/2025
CORP-2425-036	IT 3rd Party Maintenance Contracts	Sara Ellis	1	19/03/2025
CORP-2425-037	Nursing Director Vacancy	Marina Morris	2	31/03/2025
CORP-2425-039	Improving Practice Non Pay	Peter Lowe	1	31/03/2025
PLC-2425-001	Release of DIHC Annual Leave Accrual	Adam Houliston	1	31/03/2025
PLC-2425-002	Place Related Corporate Savings	Adam Houliston	1	31/03/2025
PLC-2425-003a	Slippage in Service Budgets - Div Mgmt	Adam Houliston	1	31/03/2025
PLC-2425-003b	Slippage in Service Budgets - H&C Pshp	Adam Houliston	1	31/03/2025
PLC-2425-003c	Slippage in Service Budgets - PC Delivery	Adam Houliston	1	31/03/2025
PLC-2425-003a	Slippage in Service Budgets - CHC	Adam Houliston	1	31/03/2025

During March 2025, from the 115 active schemes, 113 were subject to the Quality Impact Assessment process to date and of these, 63 were of a clinical nature and 50 were financial. None were rejected, but a number of them required further work before being signed off. The remaining 2 projects in the overall programme are currently going through the scoping phase. Once financially validated these will then go through the Quality Assessment process. There were 104 schemes to review and formally close in terms of the Recall for Review process. These consists of: 3 Red rag rated schemes 16 Amber rag rated schemes 85 Green rag rated schemes. 4 additional schemes were also considered as part of the QIA process since January 2025. Currently there are no immediate QIA related risks to the programme from the schemes listed in terms of their Quality Impact Assessment Scoring or review call back schedule.



M12 - Summary of Nursing KPI Audits (March 2025)



The Dudley Group
NHS Foundation Trust

	Oct	Nov	Dec	Jan	Feb	Mar
Tissue Viability SKIN audit (CQUIN 12)	97.1%	96.5%	97.6%	96.3%	97.1%	97.4%
Hand Hygiene '5 moments' audit	98.5%	98.8%	98.6%	98.3%	98.6%	99.2%
Hand Hygiene Environment Audit	98.9%	99%	98.8%	98.7%	99.1%	98.9%
Matron In Patient Audit	86.3%	87.3%	90.5%	90.8%	89.9%	88.5%
Matron Audit - Out Patient Areas	95.5%	96.7%	96.7%	96.4%	95.4%	97%
Lead Nurse In Patient Audit	93.9%	91.7%	94.2%	93.2%	92.3%	93.7%

Notes:

The standard of documentation audit has maintained a green RAG rating quarterly therefore it has been removed from this report. Should this change, it will be reinstated.

The other priority 1 audits remain on monthly monitoring, even though consistently green RAG rated, as these are key indicators to nursing care delivery. Any drop in compliance needs to be reviewed and monitored to ensure concerns identified are addressed, for example the matron inpatient audit this month.



M12 - Summary of Nurse Sensitive Indicators – CN

quality dashboard (March 2025)



The Dudley Group
NHS Foundation Trust

Ward Level Quality Matrix

Date Report Refreshed:

02/04/2025 08:47:22



WardGroup	Budget WTE	Contracted WTE	Vacancy %	Sickness %	All Unavailability %	Parenting	All Unavailability	Total CHPPD	Mandatory Training %	%FFT Inpatient, Good & Very Good	Open Complaints (at the end of previous month)	Pressure Ulcer - Cat3, 4, Unstageable	Pressure Ulcers (Cat 3 & above)	Moisture Associated Skin Damage	Falls with Harm	Cardiac Arrest Calls	Total Positive C-Diff Cases	Patient Observations Completed On Time %
AMU	218.0	195.9	10.1%	13.3%	52.8%	13.6	103.5		96.5%	100%	11	3	2	3	0			50%
CCU	54.1	48.3	10.7%	17.4%	64.0%	6.8	30.9		93.3%		1	1	0	3	0	1		48%
Critical Care	120.4	128.4	6.7%	18.8%	71.2%	16.9	91.4		91.5%	100%	1	0	0	0	0			57%
Discharge Lounge	11.9	10.7	9.5%	23.0%	64.3%	2.0	6.9		91.7%		2	2	0	0	0			13%
ED	188.7	161.8	14.3%	21.4%	70.5%	17.9	114.0		90.6%		30	1	0	1	0	1		85%
ESH	73.7	74.5	-1.1%	12.2%	52.3%	9.1	39.0		97.3%	73%	3	0	0	3	0	1		53%
FMNU	44.6	41.2	7.6%	10.2%	50.4%	3.9	20.7		92.5%		2				0			17%
Maternity	151.3	161.9	-7.0%	16.5%	78.0%	15.4	124.3		91.6%		6							52%
MECU	21.4	20.8	3.3%	15.2%	52.4%	1.0	10.9		97.1%	92%		0	0	1				38%
Neonatal Unit	48.0	59.5	-23.9%	16.2%	71.6%	4.1	42.6		97.3%	0%								45%
Renal Unit	37.5	37.2	0.6%	24.7%	63.9%	2.2	23.8		92.7%									78%
SDEC	71.0	65.8	7.4%	13.3%	53.3%	3.4	35.1		90.2%	96%	9	0	0	0	0			55%
Ward A2									50%									70%
Ward B1	31.0	30.6	1.5%	15.1%	56.9%	2.1	17.4		99.0%	90%	2							27%
Ward B2 Hip	50.0	50.8	-1.5%	14.4%	50.6%	3.4	25.7		93.3%	78%	1	0	0	0	0	1		31%
Ward B2 Trauma	42.1	42.9	-1.9%	14.1%	48.3%	1.1	20.7		99.6%	57%	3	0	0	3	0			53%
Ward B3	64.2	63.2	1.6%	16.3%	58.7%	5.2	37.1		92.4%	69%	2	1	0	7	0			48%
Ward B4	80.1	75.9	5.3%	21.0%	60.3%	8.2	45.7		92.7%	76%	6	3	0	2	0			28%
Ward B6	25.2	21.7	13.8%	6.5%	61.5%	4.3	13.4		91.7%	100%	1	0	0	0	0			28%
Ward C1A	37.4	34.0	9.1%	10.2%	50.4%	3.7	17.1		86.6%	43%	1							17%
Ward C1B	38.1	37.1	2.6%	11.3%	58.4%	1.5	21.6		92.5%		3	0	0	1	0			62%
Ward C2	58.1	53.1	8.7%	19.5%	64.7%	6.5	34.3		89.9%		2							18%
Ward C3	56.5	53.5	5.4%	10.0%	39.9%	5.3	21.3		89.5%	75%	2	0	0	1	0			50%
Ward C4	64.2	63.6	1.0%	16.3%	60.2%	9.4	38.3		96.3%	100%	2	0	0	1	1			28%
Ward C5A	41.3	39.3	4.7%	21.4%	49.7%	0.9	19.5		93.5%	56%		0	0	0	0	1		22%
Ward C5B	46.6	44.3	4.9%	9.3%	61.4%	4.7	27.2		95.0%			0	0	0	1			50%
Ward C6	31.8	34.8	-9.6%	15.1%	60.4%	4.8	21.0		89.9%	82%		0	0	0	0			28%
Ward C7	64.1	61.5	4.0%	18.1%	71.1%	7.4	43.7		93.9%	75%	3	0	0	1	0			18%
Ward C8	81.9	74.1	9.5%	13.2%	60.8%	6.3	45.1		94.0%	69%	3	1	0	0	0			50%
Total	1,853.1	1,786.2	3.6%	15.9%	61.3%	171.1	1,094.3		93.1%	82%	96	12	2	27	2	5		50%

WardGroup	Hand Hygiene 5 moments audit (v2)	Hand Hygiene Environment Monthly	Lead Nurse In Patient Audit	Matron In Patient Audit	Tissue Viability SKIN audit (COUIN 12)
AMU	99.3%	100.0%	89.7%	89.2%	97.2%
CCU	100.0%	100.0%	n/a	89.8%	n/a
Critical Care	100.0%	100.0%	86.7%	87.5%	100.0%
Discharge Lounge	85.7%	94.7%	n/a	84.2%	95.3%
ED	99.0%	100.0%	n/a	n/a	n/a
ESH	100.0%	100.0%	91.3%	85.7%	100.0%
FMNU	100.0%	100.0%	n/a	94.9%	97.3%
Maternity	100.0%	100.0%	n/a	n/a	96.9%
MECU	100.0%	100.0%	97.6%	92.6%	100.0%
Neonatal Unit	100.0%	100.0%	n/a	n/a	n/a
Renal Unit	98.7%	94.7%	n/a	n/a	n/a
SDEC	100.0%	100.0%	n/a	n/a	n/a
Ward A2	n/a	100.0%	n/a	n/a	n/a
Ward B1	100.0%	100.0%	96.7%	91.5%	100.0%
Ward B2 Hip	100.0%	100.0%	97.0%	84.7%	100.0%
Ward B2 Trauma	100.0%	88.9%	95.2%	89.5%	95.9%
Ward B3	100.0%	83.3%	n/a	84.2%	n/a
Ward B4	100.0%	100.0%	93.1%	83.1%	100.0%
Ward B6	n/a	n/a	n/a	91.5%	96.4%
Ward C1A	97.4%	100.0%	96.7%	93.3%	100.0%
Ward C1B	98.0%	100.0%	97.6%	98.3%	100.0%
Ward C2	n/a	n/a	n/a	n/a	n/a
Ward C3	n/a	n/a	n/a	91.7%	n/a
Ward C4	99.3%	100.0%	91.1%	88.3%	n/a
Ward C5A	95.5%	100.0%	98.4%	78.7%	100.0%
Ward C5B	100.0%	100.0%	97.3%	89.8%	100.0%
Ward C6	99.3%	100.0%	n/a	81.1%	97.0%
Ward C7	100.0%	100.0%	n/a	82.8%	96.8%
Ward C8	99.7%	89.5%	83.1%	89.5%	96.5%
Total	99.6%	98.5%	93.5%	88.5%	98.2%

WardGroup	Has a falls risk assessment been completed?	MUST or MUAC completed	Waterlow completed
AMU	100.0%	70.0%	95.0%
CCU	n/a	n/a	n/a
Critical Care	83.0%	63.0%	73.0%
Discharge Lounge	n/a	n/a	n/a
ED	n/a	n/a	n/a
ESH	90.0%	50.0%	90.0%
FMNU	n/a	n/a	n/a
Maternity	n/a	n/a	n/a
MECU	100.0%	90.0%	100.0%
Neonatal Unit	n/a	n/a	n/a
Renal Unit	n/a	n/a	n/a
SDEC	n/a	n/a	n/a
Ward A2	n/a	n/a	n/a
Ward B1	100.0%	100.0%	100.0%
Ward B2 Hip	100.0%	90.0%	100.0%
Ward B2 Trauma	100.0%	90.0%	100.0%
Ward B3	n/a	n/a	n/a
Ward B4	100.0%	100.0%	100.0%
Ward B6	n/a	n/a	n/a
Ward C1A	100.0%	80.0%	100.0%
Ward C1B	100.0%	100.0%	100.0%
Ward C2	n/a	n/a	n/a
Ward C3	n/a	n/a	n/a
Ward C4	50.0%	70.0%	100.0%
Ward C5A	100.0%	100.0%	100.0%
Ward C5B	90.0%	100.0%	100.0%
Ward C6	n/a	n/a	n/a
Ward C7	n/a	n/a	n/a
Ward C8	100.0%	80.0%	100.0%
Total	92.6%	83.2%	98.0%

Notes:

- 8 ward areas now reported as RAG red for vacancy WTE data – 50% increase in areas reporting this since January 2025.
- Rising sickness continues to be attributed to seasonal illness: was 9.49% overall in January 2025, now 15.9%.
- A task and finish group to review patient observations completed on time is in progress to focus on improving performance.
- The AMaT issues identified in last month's report, caused by the software programme update, have been addressed.



M12 - Safer Staffing Data (March 2025)



Safer Staffing Summary Mar

Days in Month 31

Ward	Day RN	Day RN	Day CSW	Day CSW	Night RN	Night RN	Night CSW	Night CSW	RN	CSW	RN	CSW	Sum 24:00 Actual CHPPD			
	Plan	Actual	Plan	Actual	Plan	Actual	Plan	Actual	Day %	Day %	N %	N %	Occ	Registered	Care staff	Total
B1	129	107	66	61	64	64	56	45	83%	93%	100%	80%	441	4.41	2.75	7.15
B2(H)	124	100	195	182	95	87	176	167	80%	93%	92%	95%	728	3.08	5.62	8.70
B2(T)	124	111	136	118	94	90	106	96	90%	87%	96%	90%	724	3.33	3.54	6.87
B3	194	180	207	182	185	178	184	175	93%	88%	96%	95%	1,146	3.68	3.74	7.41
B4	226	176	250	192	186	182	189	179	78%	77%	98%	95%	1,298	3.24	3.44	6.68
B5	259	196	178	149	244	221	115	104	76%	84%	91%	91%	989	5.17	3.00	8.17
B6	97	70	70	56	63	63	71	62	73%	80%	100%	87%	496	3.15	2.85	6.00
C1 A	128	128	131	108	93	92	103	100	100%	83%	99%	97%	742	3.48	3.37	6.85
C1 B	129	124	138	124	93	89	107	97	96%	90%	96%	91%	742	3.37	3.50	6.87
C2	282	239	66	48	253	227	63	55	85%	73%	90%	87%	650	8.40	1.87	10.27
C3	217	215	419	358	186	183	400	384	99%	86%	98%	96%	1,612	2.96	5.42	8.38
C4	206	158	68	60	124	93	62	83	77%	88%	75%	133%	676	4.34	2.44	6.78
C5 A	122	106	164	114	93	92	141	122	87%	69%	99%	87%	741	3.24	3.83	7.07
C5 B	161	152	143	103	155	153	113	100	94%	72%	99%	88%	736	4.87	3.31	8.18
C6	98	87	92	77	93	89	63	59	89%	83%	96%	93%	559	3.71	2.90	6.61
C7	226	178	206	167	165	155	196	187	79%	81%	94%	95%	1,102	3.54	3.85	7.39
C8	259	247	232	189	217	201	195	184	95%	82%	93%	94%	1,332	3.94	3.36	7.31
CCU_PCCU	250	233	62	54	217	217	32	29	93%	86%	100%	91%	768	6.88	1.29	8.17
Critical Care	537	436	125	81	527	437			81%	64%	83%		545	19.21	1.77	20.98
AMU	550	513	464	389	496	523	465	455	93%	84%	105%	98%	2,464	4.94	4.11	9.05
Maternity	847	764	263	183	528	494	155	136	90%	70%	94%	88%	1,349	8.93	2.77	11.70
MECU	93	94	38	33	94	93			101%	86%	99%		233	9.61	1.54	11.15
NNU	383	237			267	211			62%		79%		227	23.63	0.00	23.63
TOTAL	5,641	4,850	3,714	3,027	4,533	4,233	2,992	2,820	86%	82%	93%	94%	20,300	5.16	3.42	8.58

CARE

RESPECT

RESPONSIBILITY

Staff Wellbeing at The Dudley Group

Supporting our people to give excellent healthcare



The Dudley Group
NHS Foundation Trust



Reality check – our challenges?

<p>Workforce Pressures</p> <ul style="list-style-type: none"> ➤ High workload, emotional demands ➤ Ongoing staff shortages ➤ Financial constraints impacting day-to-day operations 	<p>The Balancing Act</p> <ul style="list-style-type: none"> ➤ Supporting staff wellbeing while meeting operational demands ➤ Navigating conflicting messaging around care and system changes
<p>Leading with Compassion</p> <ul style="list-style-type: none"> ➤ Compassionate leadership: listen, understand, support ➤ Creating psychologically safe environments ➤ Prioritising kindness and empathy, especially in challenging times 	<p>Honest Conversations</p> <ul style="list-style-type: none"> ➤ Being open and transparent about current realities ➤ Acknowledging difficulties while focusing on shared purpose ➤ Building trust through consistent, authentic communication

Staff survey – high level results 2020-24

We are safe and healthy



The Dudley Group
NHS Foundation Trust

Historical

		2020	2021	2022	2023	2024
q11a	Organisation takes positive action on health and well-being	*	51%	55%	55%	54%
q11b	In last 12 months, have not experienced musculoskeletal (MSK) problems as a result of work activities	72%	70%	69%	71%	70%
q11c	In last 12 months, have not felt unwell due to work related stress	52%	54%	54%	56%	57%
q11d	In last 3 months, have not come to work when not feeling well enough to perform duties	48%	44%	43%	44%	42%
q11e	Not felt pressure from manager to come to work when not feeling well enough	70%	72%	77%	76%	77%
q12a	Never/rarely find work emotionally exhausting	*	18%	19%	21%	21%
q12b	Never/rarely feel burnt out because of work	*	24%	24%	26%	27%
q22	I can eat nutritious and affordable food at work	-	-	-	51%	49%



Why is this critical?

Healthy Staff = Better Patient Care

- Staff wellbeing directly impacts care quality, safety, and outcomes
- Lower sickness absence, better retention, improved performance

Our Data Tells the Story

- Staff survey results highlight key areas for improvement (organisation approach to wellbeing, work related stress, nutrition and hydration, presenteeism)
- Consideration for what our sickness data is telling us (mental health and MSK remain highest level of S/A) & the risk factors that healthcare staff face and what protective factors we have in place.

Wellbeing = Smart Investment

- Every £1 invested in wellbeing = £4.70 return (Deloitte, 2022)

Taking Action Before It's Too Late

- We know the risks of waiting until staff reach burnout — by then, it's often too late.
- Rather than being reactive, we are **choosing to act early** to protect our people.
- This approach is not just compassionate — it's essential to sustaining safe, high-quality care.

That's why this matters — we need to work together to build a culture where our people can thrive, not just survive.

Our wellbeing vision

- A Safe, valued and supported workforce.
- Strategic alignment - Grounded in the **NHS People Promise** — “We are safe and healthy”, Fully embedded in our Trust Strategy and the Dudley People Plan, a key driver in our ongoing wellbeing journey.
- Wellbeing is woven into core strategy at all levels of the organisation, not seen as an ‘add on’ or a ‘nice to have’.
- Shared responsibility across all levels
Individual, Teams, Organisational.



Our wellbeing journey

- Launched 23/24 and running until 26
- Utilising the NHS wellbeing diagnostic tool to shape our journey, understanding wellbeing is holistic
- Listening to our people – staff survey, engagement with staff

Summary of journey delivery

The table below outlines some key activities that are planned to be delivered.

2023/24	2024/25	2025/26
<ul style="list-style-type: none"> • Launch menopause support group and menopause working group • Recruit wellbeing champions and training provided • Streamline and update staff wellbeing hub pages • Start ICS wellbeing work to include wellbeing week in April 24 and wellbeing strategy • Develop wellbeing dashboard to include more established data recording • Develop wellbeing offer utilising external and in house support • Roll out health checks and SISU Health booths 	<ul style="list-style-type: none"> • Communications plan to incorporate mental health as a focus area • Further embedding of wellbeing conversations • Debriefing programme to be developed, with in house facilitators • In house Mental Health First Aid (MHFA) training rolled out across the organisation • Actively promote and campaign around 'getting the basics' right, utilising the Wellbeing Champions to support, guidance produced to support this • Yearly calendar of events focusing on key awareness days, with a focus on health promotion • Wellbeing Champions profile shared across the organisation • Implement financial wellbeing product for staff to allow for better financial resilience to include savings, education and more 	<ul style="list-style-type: none"> • Serious incident pathways and crisis pathways developed • Develop the wellbeing offer further, linking in with the Trust Staff Networks, Wellbeing Champions, and the wider organisation • All service areas to have fit for purpose break rooms reflective of a restful environment • Wellbeing Champions recruited to each department / team • Delivery of wellbeing engagement / workshops • Regular communications and information sharing • Bi monthly wellbeing steering group • Bi monthly wellbeing champions meeting • Wellbeing conversations with teams / staff

Achievements



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Goal 2 – all staff have access to financial education and support.

- Financial wellbeing van onsite offering information and guidance
- Financial wellbeing sessions provided monthly (to include budgeting etc)
- Promotion of financial wellbeing resources and signposting to staff

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Name of Webinar	Dates and times of Webinars
A beginner's guide to investing Before you invest your money, it's important to invest your time into learning the basics and understanding the risks. Our session helps you navigate the world of investing, from investment advice and considerations to risk appetite and market volatility.	Every Monday, 12:30pm to 1:15pm Click here to book
Creating a budget One of the key ways to take control and manage your financial health is creating a budget. Budgeting can help you to create a spending plan for your money, so that your money could work harder for you and that you stay on the right track to reaching your financial goals.	Every Tuesday, 11:00am to 11:45am Click here to book
Retirement - thinking ahead No matter when you plan to retire, life beyond work gives you the chance to focus on what matters most to you. Our session covers pension funding options and taxes, retirement forecasting and income, and the potential value of investment portfolios.	Every Wednesday, 9:30am to 10:30am Click here to book
New to UK Make the most of your new life in the UK with support from our presentation. To help you settle, we will supply an overview of key areas to think about. We look at the essentials such as how to set up your bank accounts in the UK, understanding credit scoring, right through to some top tips around your health, insurances and understanding the language often used.	Every Thursday, 9:30am to 10:30am Click here to book
Credit scoring The concept of a credit score can be tricky to understand at the best of times, but with this presentation, we explain how a credit score is put together and what your score means for you.	Every Friday, 10:00am to 10:45am Click here to book

Financial education and support



Financial wellbeing
education sessions



Tools and support to
include budget planners



Debt advice and support



Debt management plans
and support

Access to discounts, cost savings and salary sacrifice



Access to discounted surplus
food from your favourite shops
& restaurants



Free membership for
discounted groceries for
NHS staff



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Salary sacrifice: lease cars,
home electrics, cycle to
work scheme



Access to a variety of discounts
and cost savings to include
major retailers



Exclusive discounted
National Express travel



Exclusive discounted
tickets for live events
around the UK



Rubery Uniform
SWOP Shop



Achievements

Goal 3 – staff experiencing the menopause are supported in the workplace.

- Menopause working group launched + support sessions
- Menopause risk assessment launched
- Menopause awareness training developed
- Regular promotion of menopause support




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AGENDA
MENOPAUSE WORKING GROUP
Wednesday 9th April 2025, 11:00am – 12:00pm
Microsoft Teams


	Time	Item	Enclosure	Presented By
1.	11:00am	Welcome & Introductions	Verbal	All
2.	15:05pm	Review Action Log & update	Enc 1	All
3.	15:25pm	Menopause Policy update	Verbal	P Massey
4.	15:30pm	Menopause support session focus for 2025	Verbal	All
5.	15:40pm	Any Other Business	Verbal	All
6.	15:50pm	Reflections of the meeting	Verbal	All
7.	15:55pm	Close of meeting and dates of next meeting(s) TBC		



**DUDLEY WOMEN'S
HEALTH HUB
MENOPAUSE CAFE**

**WED 7TH
MAY** | **2:30PM
UNTIL
4:00PM** | DUDLEY
FAMILY HUB,
SELBORNE RD,
DUDLEY
DY2 8LJ

To find out more or book your space, please email
dgft.place.comms@nhs.net or ring Jessica Colley on
07854845052

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[Drawing]

Perimenopausal and Menopausal Risk Assessment

Name:		Position:		
Ward/Department:		Division:		
Date:				
Details of work activities:				
Hazard	Risk	Suggested actions	Risk Rating	Additional Control Measures
Manual Handling/ Lifting and carrying/Stretchin g and reaching	Hormonal changes during menopause (reduction in collagen in connective tissue) can cause stiffness in the ligaments and tendons which can make affected staff more prone to manual handling injuries.	-Ensure manual handling training is up to date -equipment to be available to reduce risk of manual handling equipment -Manual handling risk assessments -SHAW (referral) if required -Staff can self refer to Physio if required for any MSK issues -Are there opportunities to switch to lighter or different duties?		
Ergonomic/ DSE postural problems	Hormonal changes during menopause and perimenopause may increase the risk of ergonomic issues, headaches and fatigue	-Ensure a display screen equipment assessment has been carried out and is within its 2 year review period -Encourage breaks from the screen, carry out another task where possible to break up screen time -Arrange regular comfort breaks for meetings that last over an hour		



Achievements

Goal 4 – all staff have access to preventative wellbeing support and education to support their physical and mental health.

- SISU health booth pilot – approx. 1,000 health checks
- First Trust wellbeing week 2024
- Over 40's health checks offered
- Regular promotion of health education / awareness





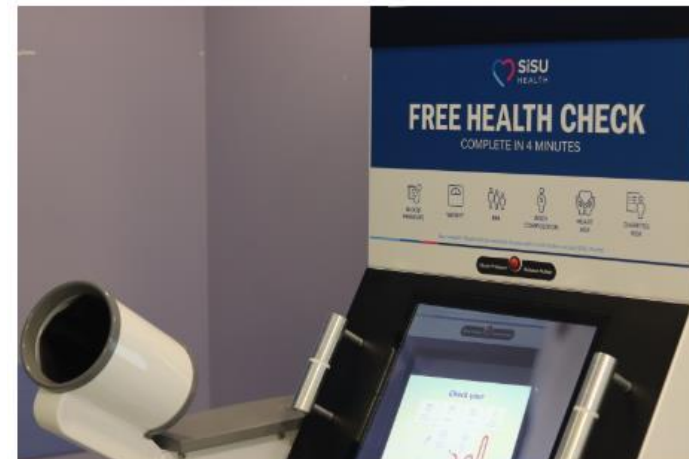
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Timetable of Events Wellbeing Week 2024



Wednesday 6 th November		
9:00am – 12:00pm: BHSF Room 3, CEC (Drop ins) <small>24/7 support that is confidential and tailored to you to include: health and wellbeing advice, critical incident advice, support for those with care responsibilities.</small>	9:00am – 12:00pm: Cost of Living - Dudley Council Lecture Theatre, CEC (Drop ins) <small>Showcasing a range of support available to the community ranging from national initiatives to help with everyday essentials</small>	10:00am – 18:00pm NHS over 40's Health Checks Action Heart Gym, Seminar Room <small>Please allow 50 mins for your health check. We will operate a diary system for the day. To book a health check, employees can call 01364 456111 ext. 1470. We can accept walk in's subject to availability.</small>
<div>Action Heart drop in tours Drop in gym tours will be available all week between 10am – 5pm. Simply drop in and take a tour with one of the gym team.</div> <div>SISU Health booth You can also drop in to complete your SISU health check all week, the health check machine will be at Action Heart gym until the end of November, when it will then move to a community site.</div>		



Achievements

Goal 5 – all staff feel safe and valued in their working environment. The working environment should not only reach but exceed the minimum standard of what is acceptable for our diverse NHS people.

- Staff room upgrades, due for completion Summer 2025
- Healthy food options reviewed with nutrition and hydration group – including delivery service for staff
- Getting the basics right – promoted by wellbeing champions



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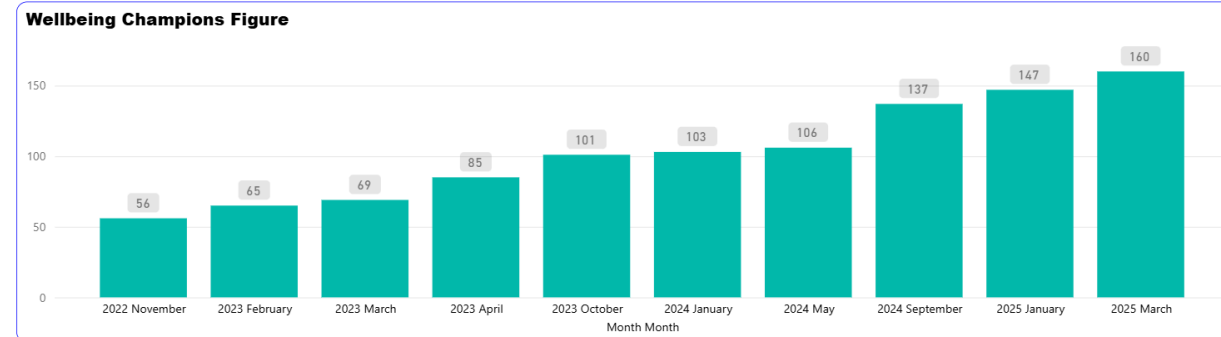
Achievements

Goal 6 – the importance of wellbeing is effectively communicated across the organisation

- Regular promotion of wellbeing events / education / awareness sessions
- Regular promotion of wellbeing support offer (wellbeing Business Partner visible across organisation)
- Wellbeing champion role – active recruitment (approx. 160 champions in post)
- Wellbeing webpages streamlined – phase 2 launch soon with new SharePoint



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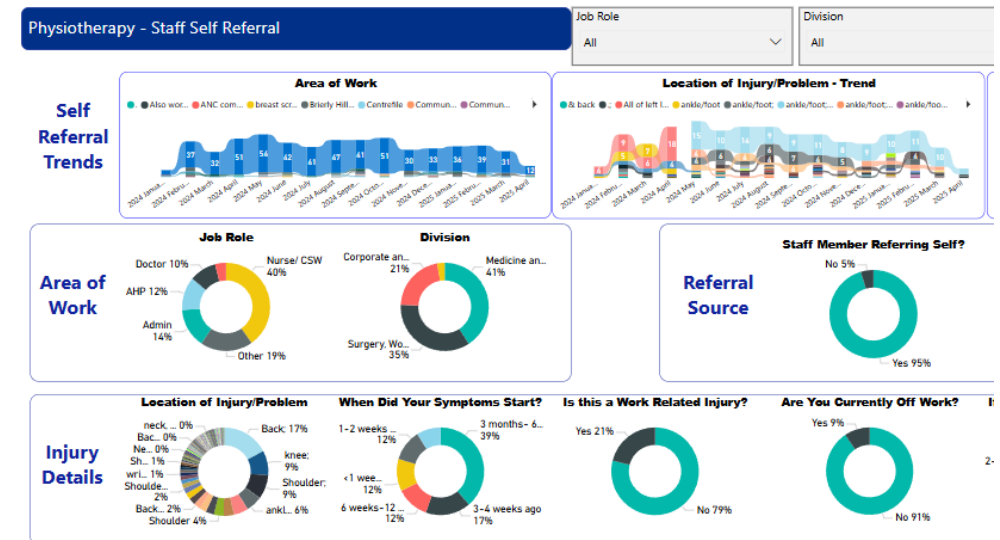
Achievements

Goal 7 – Staff wellbeing is a focus at senior leadership level and our managers are supported to ensure a wellbeing culture is adopted across the organisation.

- Wellbeing discussed at Board level, active engagement
- Wellbeing Steering Group representation further established and regularly reviewed (wellbeing dashboard embedded)
- Trust Wellbeing Guardian actively promotes and supports staff wellbeing at Board level



The Dudley Group NHS Foundation Trust



Goal 8 – Staff wellbeing is a focus at senior leadership level and our managers are supported to ensure a wellbeing culture is adopted across the organisation.

- Appropriate training, awareness and support is provided to management and support functions across the organisation.

WELLBEING TWO

- Understand the importance of the wellbeing conversation & how to have a good and meaningful wellbeing conversation.
- Recognise when people need support with their wellbeing.
- Understand how the workplace impacts on our wellbeing and how developing a supportive wellbeing focused culture and role modelling is critical.
- Develop a wellbeing plan at local level and understand the role of the wellbeing champion within this.



What helps you stay well at work? <ul style="list-style-type: none">○ Lunch breaks○ Exercise in the day○ Seeing natural light○ Communicating with others	
Are there any situations that may trigger you whilst working? <ul style="list-style-type: none">○ Conflict at work○ Changes to workload○ Deadlines○ Feedback○ Trying to progress work○ Working in isolation	
What can be done to support you and help minimise your triggers? <ul style="list-style-type: none">○ Catch ups○ Flexible working patterns○ Understanding changes to workload	

Deepening our commitment: Embedding staff wellbeing across the Trust



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- 1. Shift to proactive wellbeing**
- 2. Embed wellbeing in core operations**
- 3. Leadership and culture: building resilience**
- 4. Sustain and integrate wellbeing**



What is in the pipeline?



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Strategic Improvements

- Engage with staff and networks to review and update wellbeing strategy
- **Clear Wellbeing KPIs**
Defining success, tracking impact
- **Smarter Data & Dashboards**
Enabling insight-led decision-making
- **National Funding Bid**
For debriefing, MHFA, and health checks

Support Services & Resources

- **New EAP Service**
Enhanced access & quality of support
- **'Phase 2' Wellbeing Hub Launch**
Improved SharePoint access to resources
- Bid for **national funding project** to launch new initiatives

Inclusive, Staff-Focused Culture

- **Menopause Policy Launch**
Recognising and supporting our colleagues lived experience
- **Financial Wellbeing Offer**
Guidance, tools, and better support
- **Recruitment of Place-Based Champions**
Local voices, embedded support across teams

- ✓ **Collaborating with Sandwell will be crucial in driving sustainable change across both organisations. We'll work together on key projects where practical, ensuring shared expertise and resources for long-term impact.**



What our staff are saying?



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NHS Foundation Trust

Staff member, who has recently come back from long term sick leave for a serious illness

I have been with the Trust for 17 years this July and wanted to express how grateful I am that our Trust has Wellbeing as a permanent agenda item. When I was first appointed, wellbeing was not something that was looked after by the individual at home. Personal wellbeing discussions or problem sharing at work was not seen as 'the done thing'.

I think what has been great to see is the shift of understanding and behaviour. We have moved from a place where a staff member deals with their personal issues privately to a place where an individual can expect to come to work and have a supportive workplace. From personal experience I know this really helped a person like myself who has recently returned to work after long term sick leave. It has been amazing to return to work as a whole person, the good, bad and ugly, as opposed to leaving your problems at the door.



What our staff are saying?



The Dudley Group
NHS Foundation Trust

Undergrad team with a focus on student placement wellbeing (Ruth, Wellbeing Champion)

Without a doubt one of the best organised placements. Ruth is the best UGC I have met. Sorted out all issues I had and also checked up on me and ensured there wasn't anything she could do to help in addition. (This was again a student with a personal issue who I supported)

The undergraduate team here have been so lovely and genuinely made this the best placement I've had all year. Thank you so much for all you've done and to Ruth who's been the most supportive undergraduate coordinator I've ever experienced.

The undergrad team were always very nice and helpful. They made my time at Russells Hall a lot better. (This was a student who needed wellbeing support for a personal issue she was going through)



What our staff are saying?



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NHS Foundation Trust

General wellbeing champion feedback

Staff actively having wellbeing conversations and seeking out the opportunity to speak to wellbeing champions

Wellbeing champions offering local initiatives such as wellbeing sessions (holistic therapies, wellbeing conversations, exercise, adding wellbeing as agenda item to meetings etc.)

Physical spaces in the hospital being dedicated to staff wellbeing (wider than the staff room project)



What did NHS England say?



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NHS Foundation Trust

“We were impressed with the Trust’s early engagement with the NHS People Plan and the work that had already been undertaken prior to the People Promise Programme launch.”

“We were pleased to see how the Trust has threaded the people promise through all the work undertaken before the programme and how you are now focusing on areas where you need to support further improvements.”

“We were impressed with all the wellbeing work and the importance the Trust places in this work and how it runs through and links to all the people promise themes.”



How do you think leadership can support?



Community First: Value Stream Analysis (VSA) 2025 Outcomes and Strategic Integration Report

1. Executive Summary

This report presents the findings and future directions following the Community First Value Stream Analysis (VSA) conducted from 31st March to 4th April 2025. The VSA aimed to redesign community-based health and care pathways with a shared ambition:

"Wouldn't it be great if people had access to the right health and care support in their community that allowed them to stay in their own home."

By March 2026, community-first pathways will be in place, delivering early interventions and reducing unnecessary hospital visits.

During the event, stakeholders from across Dudley's health, care, and voluntary sectors co-produced a future state for community care that prioritises prevention, self-care and early intervention. Five key personas guided our mapping exercises, spotlighting existing system gaps and opportunities. Eleven priority projects were developed during and after the event, each aligning with the Trust's Strategic Planning Framework (SPF) and measures of success.

Section 4 lists the projects with aim statements and named leads. More detail about each is given in the appendices.

3 of the 11 will benefit from smaller-scale implementation events which are now being planned:

- | | |
|-------------------------------|---------------|
| • Care Homes | 02-06 June |
| • Community Partnership Teams | 14-18 July |
| • Pain pathway | 13-17 October |

Governance for the Community First activity will be via Integration Committee (DGFT) and Dudley Health & Care Partnership Board (Dudley Place)

The following table summarises the contributions these projects make to the delivery of the Trust Strategic Planning Framework.

Self-Referral Pathway: Strategic Alignment Overview

	VSA/SPF Links															
	Strategic Objectives			Multi-year commitments					In Year Objectives 25/26						Metrics	
Improvement Cells	Our Patients	Our People	Our Place	Shift care from hospital to community	Value our people	Make best use of our resources	Improve speed of access to planned care	Develop thriving partnerships	Implement Care navigation centre	Implement a new model of care for urgent and emergency care	Develop an anti-bullying, anti-discrimination culture	Establish an elective hub in the south of the Black country	Transform outpatient services	Transform corporate services	Outcome Metric	Assurance Metrics
Self-Referral Pathway	DIRECT	INDIRECT	DIRECT	DIRECT		DIRECT		DIRECT	DIRECT	INDIRECT			DIRECT	INDIRECT	• Increased self-referrals	• Reduce unnecessary bed days • Reduce planned care leaving our system • Overall patient experience score (OPES)
Community Navigation Centre	DIRECT		DIRECT	DIRECT				DIRECT	DIRECT				INDIRECT		• Number of calls triaged and resolved appropriately • Reduced re-attendance • First-time resolution rates	• Reduce unnecessary bed days • Overall patient experience score (OPES) • Staff survey results
Social Prescribing Discharge	DIRECT		DIRECT			INDIRECT				INDIRECT					• Reduction in readmissions • Reduction in length of stay • 100% of eligible patients have a social support plan	• People die in their preferred place • Reduce unnecessary bed days
Social Care Discharge Team	DIRECT	INDIRECT				DIRECT				DIRECT					• Reduction in failed discharges • Reduced over-prescription of care/equipment • Improved therapist capacity	• Reduce unnecessary bed days • Overall patient experience score (OPES)
Jean Bishop Centre	DIRECT		DIRECT	DIRECT				DIRECT							• Reduction in ED attendances • Reduction in unnecessary medication • Improved carer support and patient satisfaction	• Reduce ED attendances • Patient experience
Chronic Pain Pathway	DIRECT					DIRECT							DIRECT		• 30% reduction in GP attendance	• Reduce planned care leaving the system • Overall patient experience score (OPES)
Patient Passport	DIRECT							DIRECT					INDIRECT		• Reduction in ED visits • Enhanced patient/staff experience	• Reduce unnecessary bed days • Reduce ED attendances
Access to Step-up Beds	DIRECT		INDIRECT	DIRECT						DIRECT					• 2-day LOS (max) • Reduction in unnecessary admissions • Increased discharges to usual place of residence	• Reduce unnecessary bed days • Reduce ED attendances
Children & Young People	DIRECT		DIRECT	DIRECT									DIRECT		• Increased patient/carer satisfaction • Reduced WNB and school/work absence • Reduced acute hospital use	• Overall patient experience score (OPES) • Reduce unnecessary bed days
Care Home Pilot	DIRECT		DIRECT			INDIRECT		DIRECT		INDIRECT					• Reduced 999 calls and ED admissions • Increased timely access to advice • More care in familiar settings	• People die in their preferred place • Reduce unnecessary bed days

These projects will be governed through the Integration Committee and tracked through the Dudley Health & Care Partnership Board. Each workstream includes specific metrics aligned with Dudley's strategic goals and national targets, such as reducing unnecessary bed days, improving experience and strengthening system integration.

2. Background and Context

The VSA was facilitated by Dudley Improvement Practice and included partners across the health, social care and voluntary sectors.

Shifting care from hospital to community is a central theme of the NHS Long-term Plan. The focus of the value stream is on preventing avoidable admissions, delivering more care closer to home and empowering individuals through proactive, personalised care models. The Community First initiative reflects this national ambition and brings it to life locally through practical redesign of services around people, not buildings.

Within the 2025-2028 DGFT Strategic Planning Framework, this shift has been embedded as a core principle. The Trust recognises that sustainable improvements in patient outcomes and experience will come from an integrated, place-based model of care delivery, driven by collaboration across acute, community, primary care, local authority and voluntary sectors.

Attendees were asked two key reflective questions at the start:

What does Community First mean to you?

- People being at the centre of the service
- Future planning for wrap-around services to help people live independently
- Same day diagnostics for community practitioners
- Prevention of avoidable hospital admission
- Access and navigation to all services for all practitioners

What are your hopes for the week?

- Breaking down invisible barriers
- Care delivered in the right place by the right practitioner
- All services working together
- Real change: identify blocks and waste
- Listening to the voices and experiences of our population

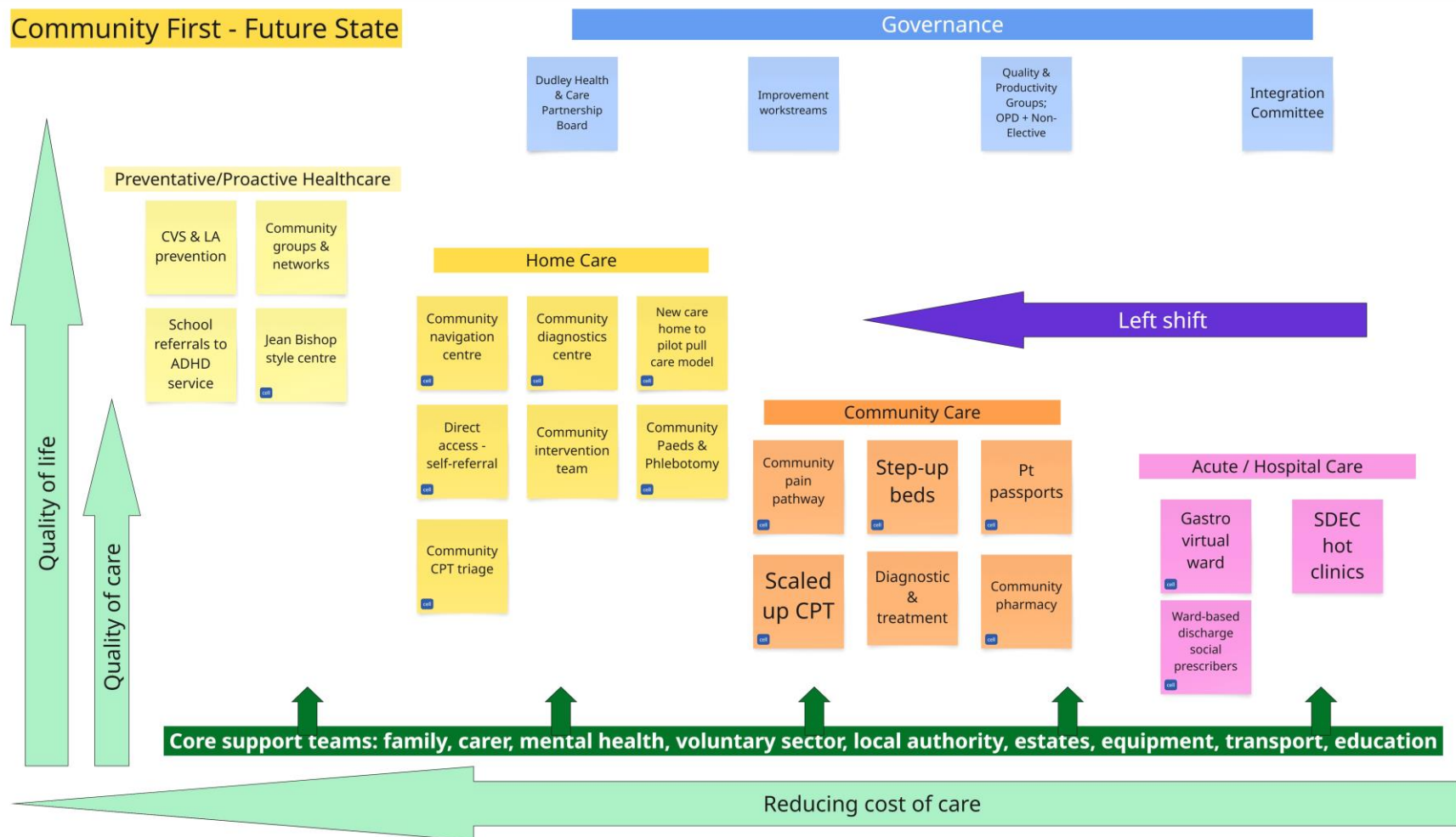
The improvement approach involved five persona-based process maps that allowed delegates to understand current states:

1. Betty – Elderly woman whose care fell through system gaps
2. Abigail– Young woman and frequent attender
3. CJ – Child awaiting ADHD diagnosis
4. Joyce – Care home resident
5. Jim – Adult with unmet social care needs

3. Future State Map

A co-designed map was produced that represents a vision that shifts the focus from acute to proactive, community-based care—referred to as the “left shift.” Each element on the map was built by consensus, aligning with the themes of the week. The layout captures key innovations—such as self-referral pathways, community diagnostics, step-up beds and proactive/preventative CPT teams—positioned to enhance quality of care and life, reduce hospital demand, and lower overall system costs. Governance and enablers like the Dudley Health and Care Partnership, improvement workstreams, and core support services were included to reflect how this future state will be underpinned and sustained.

Community First - Future State



4. Individual Project Overviews

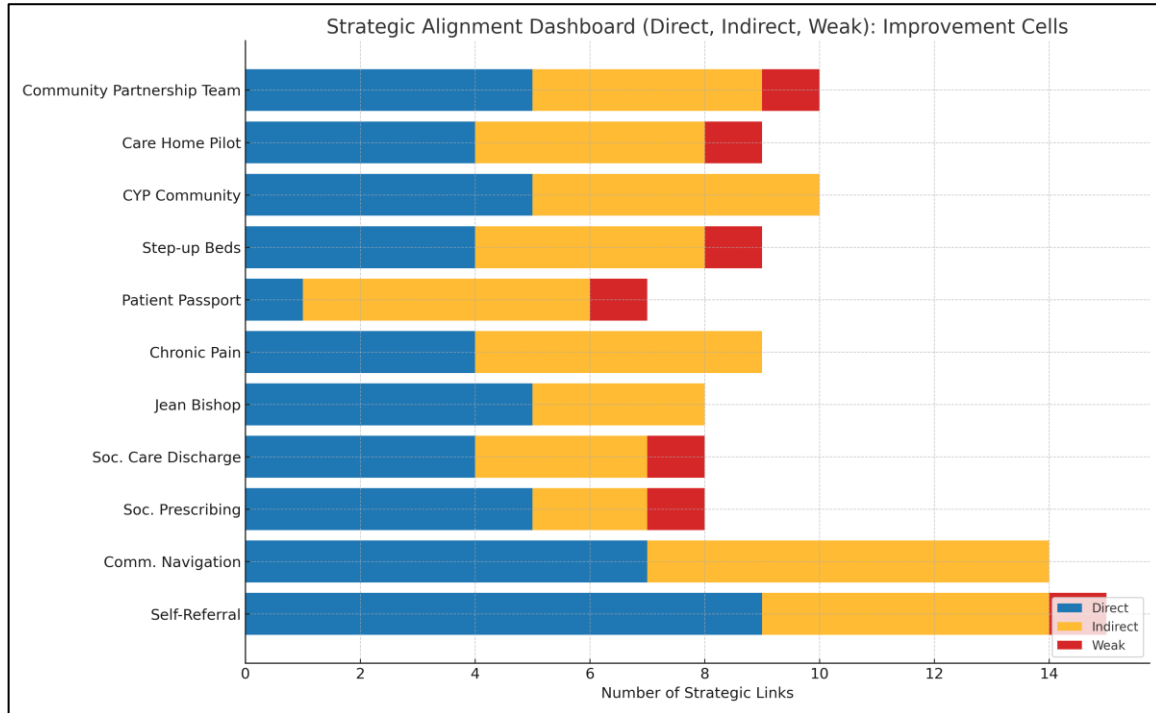
Project	Leads	Aim	Processes	Outcome Metrics	Timeline
Community Navigation Centre	Amandeep , Linda, Dr Ali, Lou, Bianca, Jo, Steve, Liz, Claire Towns	One single point of access for all care services in Dudley.	Electronic navigation, care navigators, triage, caseload management	Call outcomes, reduction in hospital admissions, patient satisfaction	By 31/03/2026
CPTs (Community Partnership Teams)	Sally Cornfield, Joe Taylor	Widen the reach of CPTs through proactive/ preventative working	Daily review of discharge data, Safe and well calls for vulnerable patients, Weekly GP-led ICT meetings for case discussion, Monthly MDT clinics with specialists for frail frequent attenders, Trialing of CYP (Children and Young People) CPTs with audit and feedback loops	Reduction in readmissions within 30 days, Reduction in ED Attendances, Increased referrals to community services, Patient and Staff Satisfaction scores	By September 2025
Self-Referral Pathway	Helen Blakemore	Direct patient access to services without GP attendance	Portal/APP facilitation, staff/patient training, triage, monitoring, video consults	Increased self-referrals, reduced inappropriate appointments, fair access	By September 2025
Social Prescribing as part of discharge	Kate Green	Support patients post-discharge using voluntary and community services (VCS).	MDT approach, patient identification, coaching for independence	Readmission rates, social support plan coverage	By March 2026
Social Care Discharge	Sharon Symonds,	Integrate therapy and	Early POC (Package of	Fewer failed discharges,	Ongoing

Team	Sally Cornfield	care planning early in hospital stay.	Care) start, therapy assessments, integrated team	reduced access visit times	
Jean Bishop Centre	Dr Martin, Karen Hanson	A “one-stop-shop” for older people to receive holistic care outside hospital.	Referrals, assessments, population health BI	Reduced ED visits, improved care plans	Draft model by July 2025
Timely Step-Up Beds	Jenny Cale, Dr Vedutla	Avoid unnecessary hospital admissions through short-stay community care.	Assessment, referral coordination, governance	LOS under 7 days, ED avoidance	By Oct. 2025
Children & Young People Community	Karen Anderson	Relocate 75% of paediatric phlebotomy and gastroenterology to community hubs.	Clinic booking, risk assessments, comms	Friends/family survey, WNB rate, wait times	By 30th Sept 2025
Care Home Pilot	Dr Lucy Martin	Provide more treatment in care homes, reducing hospital admissions.	Treatment plans, observation sharing	ED admissions, place of death, patient satisfaction	By October 2025
Chronic Pain Pathway	Kelly Houseman, Anneka Page	Reduce GP attendance among chronic pain patients by 30%.	Recruitment, peer support sessions	GP reduction, PROMS improvement, cost effectiveness	By April 2026
Patient Passport	Mick Marson, Dr John Frost	Provide clear community management for patients frequently attending with disordered gut-brain interaction.	Passport design, IT implementation	Reduced ED use, satisfaction scores	By Sept 2025

Full versions of Cell Sheets can be found in the Appendices. The Cell Sheet for CPTs is currently still under development.

5. Strategic Alignment

The projects contribute to the delivery of the Strategic Planning Framework as follows:



6. Next Steps

- All project teams to submit detailed delivery plans by May 2025
- Initial pilot projects to begin by July 2025
- Further implementation events, focusing on 3 chosen cells, starting June 2025
- Regular reporting to the Integration Committee on project milestones
- Regular reporting into Dudley Health and Care Partnership Board
- Evaluation using success metrics by April 2026
- Embedding outcomes into Dudley's system transformation plan for 2026-2029

7. Recommendations for the Executive Team

1. Endorse the Community First VSA programme
2. Confirm project governance via Integration Committee and Partnership Board
3. Ensure visibility of Community First through the DGFT Board reporting structure
4. Champion cross-organisational cultural change towards integrated community-first care

8. Appendices

Appendix A: Self-Referral Pathway v



Leads

Helen Blakemore

Self referral process/direct access



Aim: Wouldn't it be great if patients could directly access services without contacting/attending their GP practice, freeing up 15% of GP appointments by September 2025 by offering a single point of access direct referral service

What does good look like?

Digital self referral service via a portal or app

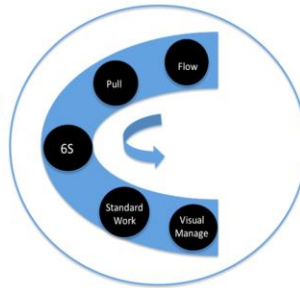
Standardisation of referral forms/eligibility criteria/consistency of offered service across Dudley

Collaboration of primary/secondary and social care services across Dudley

One shared care record

Inputs

Appointment data to measure baseline
Clinical and non-clinical staff to support
Patient communications/organisation communications
IT services/support
Training



Outputs

Better use of GP appointments
Improved patient journey
Time saving
Improved patient outcomes
Improve access and capacity

Metrics "In"

Number of appointments for self referral pathways
Most common types of referrals requested
Define which services can be self referrals
IT resource/support

Processes

Facilitate portal/APP
Training for staff and patients
Clinical triage support
Safety netting/monitoring
Video consultations/photo upload

Metrics "Out"

Reduction of inappropriate appointments
Increased self referrals
Time saving
Fair access
Release capacity



Integrated system with EMIS and secondary care
Efficiencies with pathways
Can be multi-lingual



Patient satisfaction
Follow-up system
Standardisation of pathway/services
Patient support and education



IT cost/development
Clinical staff cost
Pulled resource = cost effective
Patient/staff comms
Training



Better flow through pathways for patients and staff
Patients more in control
Less stress
Reduce capacity

Initial next steps

When will you meet?	w/c 14/4/25 to discuss pieces of work already happening in the division
Who will be there?	Helen Blakemore, Joe Taylor
Who is lead?	Helen Blakemore, Joe Taylor
What are the next steps?	Team up with whoever is already looking into this work within Place division

Appendix B: Community Navigation Centre



Community Navigation Centre



Leads

Amandeep, Linda, Dr Ali, Lou, Bianca, Jo, Steve, Liz, Local authority, mental health, voluntary services - CVS, Claire Towns

Aim: By 31/03/2026, Dudley will have one single point of access for all care services irrespective of patient location.

What does good look like?

Single point of access to community services
All patients and those caring for them, have accessibility to service
Will result in a reduction to unnecessary admissions to hospital and primary care
Have access to diagnostics in community point of care scans
Zero handoffs for patients/service users, getting it right first
Interoperability with other Backcountry SPA's and mental health services
24/7 access- triage Realtime, accessibility via different modalities e.g. phone digital
EPR accessible to all services

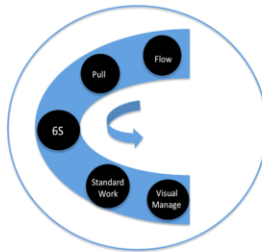
Inputs

Referring In

- Public health professionals
- WMAS, 111, Acute, GP
- Community teams, UTC
- ED
- Nursing and care homes
- Social care, voluntary sector

Clinical Pathways

- Medicine
- Surgery



Outputs

AOL, LTC, DCH, UCR, DN's
Podiatry, community rehab services
Care navigators, social care
Voluntary sector, virtual ward
Hot clinics, SDEC medical and surgical
GP's, access to community beds step up module
DOMS - phlebotomy, diagnostics
OBI, OPAT, ED, UTC
Community nursing

Metrics "In"

Call waiting time
Numbers accepted, abandoned, volume
Length of call
Meeting national data requirements for 'SPA'

Processes

Electronic call navigation system
Care navigators
Standard triage tool
Caseload management
Generalist and specialist

Metrics "Out"

Outcome e.g. sign posting - where to
Volume of calls to various services and organisations
Reattenders - patient ringing with same problem



Number of calls answered first time
Number of people receiving the right outcome
Reduction of admissions into hospital and primary care



One contract "right first time"
Patient & staff experience
Service user satisfaction



IT business case, EPR
Rota planning, 365 licences
Telephony system
Workforce

- Increased ophars
- Skill mix
- New rapid response

Equipment
Social workers
Travel, estates, consumables



Empowered workforce
Staff survey results
Sickness levels
Career progression
Staff retention

Initial next steps

When will you meet?	9/4/25 at PCN. Pre-meet/onboard DCHWG/CNCWG
Who will be there?	PCN - Steven Mann. DCHWG/CNCWG - Amandeep Tung-Nahal, Claire Towns, Bianca Mascarenhas, Paul Hudson, Dr Ali, Dr Rees, Linda Parkes, Joe Taylor, Lou Bleakley
Who is lead?	PCN - Steve Mann. Pre-meet - Amandeep Tung-Nahal
What are the next steps?	Engagement with primary care. Primary care/GPs to look at SWBH CNC Look at needs and outcomes - define priority pathways (governance), agree operating procedures, resource requirements, identify names, keep other services (location and facilities)

Appendix C: Social Prescribing as part of discharge



Leads

Kate Green

Social Prescribing as a Part of Discharge



Aim: By March 2026, we will have established a VCS non clinical model of support (as part of the discharge team) that enables people to live independently to avoid unnecessary hospital readmissions!

What does good look like?

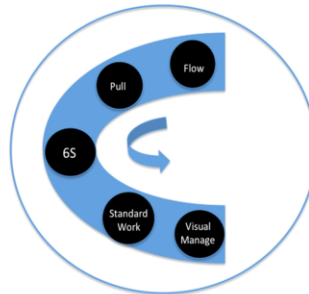
The revolving door for patients is avoided
 Patients are settled in their home environment
 There is a clear holistic plan for their wider social support needs
 At the point of discharge, the patient feels confident that their support needs will be catered for
 Living independently in their own home
 They have a sense of purpose and are fulfilling their potential
 Their basic needs are also met

Inputs

Trained social prescriber with skills, knowledge and understanding of the VCS
 Discharge date
 Discharge planning - which patients are in scope
 Colocation (in-person or virtual)
 Systems access - Sunrise
 Readmission data - where might we focus e.g. 65+
 Patient info
 Next of kin and family info

Metrics "In"

Number of patients discharged
 Number of eligible for service e.g. 65 & older
 Number that require social support



Outputs

Drop in readmission of those offered social prescribing
 A plan for their support needs
 Reduction in length of stay
 Daily check

Processes

MDT approach on the ward
 Identifying the patient list requiring social support
 Coaching/training/education to support selfcare and independence

Metrics "Out"

Percentage of readmission reduced
 100% have a social support plan
 Less than x admissions within 6 months



Number of referrals
 Where referrals are coming from
 Characteristics of those who achieve outputs



Patient feedback/experience
 Family feedback/experience
 Discharge team feedback/experience
 How many patients are appropriate



1x FTE social prescriber
 Cost of social prescriptions (e.g. contracts, commissioning, spot purchasing)



More cohesive
 Team without wall
 Improved collaboration
 Improved culture

Initial next steps

When will you meet?	By end of April 2025
Who will be there?	Kate Green, Sally Cornfield, VCS (dependent on gaps), discharge team
Who is lead?	Kate Green
What are the next steps?	Arrange first meeting. Explore gaps, needs and opportunities. Identify potential funding sources.

Appendix D: Social Care Discharge Team



Sharon Symonds, Sally Cornfield

Social Care Discharge Team



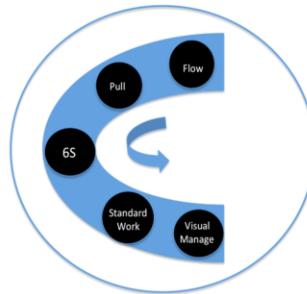
Aim: To reduce the over-prescription of care, number of readmissions and reduce length of stay by participating in ward rounds and identifying patients who require a package of care front of house by x% of the baseline

What does good look like?

Co-location of SCDT at the Trust, integrated with the discharge coordinators, offering therapy and the provision of care to inpatients and front of house

Inputs

Patients pulled via the ward rounds
Patients referred from discharge team (TOC)



Outputs

Package of Care
Therapy assessments and observations
Access visits when required
Early start of paperwork
Prescription and package of care & equipment
Signpost to support services (VCS)

Metrics "In"

SCDT
Office space

Processes

Acquire office space

Metrics "Out"

Reduction of people cancelling POC on day 1
Reduction of people inappropriately prescribing care
Reduction of people inappropriately prescribing equipment
reduce length of home access visit by 50%
reduce number of failed discharges
Reduce deconditioning on the ward
Improve capacity of DGFT therapists
Improve patient satisfaction



Reduce waste and inefficiencies
Integrated health and social care team



Patient satisfaction
Consistency
Time sensitive assessment



Neutral
Time for ward staff



Happier customers = happier therapists
Staff feel more in control
Staff feel more part of an integrated team
Environment for constructive challenge
Ward staff have released capacity
Less stress

Initial next steps

When will you meet?	15/4/2025
Who will be there?	Angela Hunt, Sharon Symonds, Wendy Malpass, Katy Hewitt, Rebecca Davies, Becki Benbow, Care Managers, Senior therapists
Who is lead?	Sharon, Angela and Katy
What are the next steps?	Discuss and present plans/rotas/accommodation

Appendix E: Creation of Jean Bishop Centre



Creation of a Jean Bishop Centre



Leads

Dr Martin (Champion), Karen Hanson

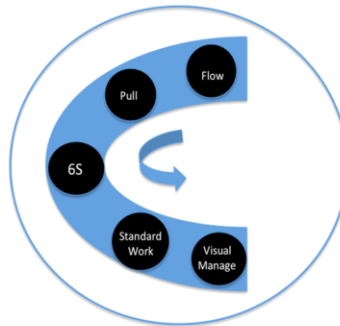
Aim: Holistic one stop shop for older people to be assessed for health and care, in a place that meets population need

What does good look like?

Providing citizens with the tools and assessments to facilitate long life, education, plans for their future! Either via a single centre or "pop up facility"

Inputs

- Scope premises
- Primary Care Practice link
- Care Co-ordinator/greeters
- Social prescribing
- Therapy
- Voluntary services
 - Home assessment
 - Finance support advise
 - Public health
 - Exercise tasters?
 - Food bank
- Pharmacy
- Diagnostics access
- Social care
- Referrals from CPT
- Hospice
 - Bereavement
 - Counselling
 - Social isolation
 - Advanced care planning



Outputs

- Named co-ordinator
- Clear assessment plan in a method chosen i.e. email, paper
- Use Merry Hill services, transport, free parking, restaurants, gyms, Holland Barret
- Findings = access via GP/CPT

Metrics "In"

- Risk stratification 65+ via CPT
- Target health inequality groups
- Identify a pilot PCN audience for resources, location etc
- Annual programme of pop ups!

Processes

- Referrals
- Assessments e.g. Advanced Care Plans
- BI - Population Health

Metrics "Out"

- Reduction of ED attendances
- GP reduction of unnecessary medication
- Improved career support
- Reduction in demands POC
- Patient experience/satisfaction



Draft model by July 2025

Initial next steps

When will you meet?	April to scope next steps and involvement.
Who will be there?	Karen Hanson, Lucy Martin, Primary Care, R Tapparo, Kate Green, Anneka Page, Jag Sangha
Who is lead?	Karen Hanson (initially)
What are the next steps?	Meet to define the need and potential pilot area.

Appendix F: Access to Timely Step-up Beds



Leads

Jenny Cale, Dr Vedutla

Access to Timely Step-Up Beds



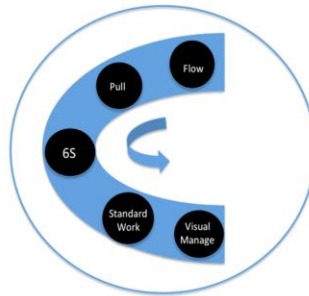
Aim: To create a short stay facility to avoid unnecessary attendance or admission to hospital

What does good look like?

Access to the time of need to enable further assessment, plans, support to facilitate patients to return to their usual place of residence

Inputs

Primary care
Clinical hub
Carers
Family
Nursing/Therapy/Social Care
Pharmacy
Commissioning



Outputs

Clear assessment plan to enable patient to return home
Co-ordinate onward referrals that can be undertaken in the community as appropriate
SOP

Metrics "In"

65+
Readmissions
0 LOS in hospital with 0 clinical intervention

Processes

Referral process/assessment
Clinical governance of patients
• who does it sit with?

Metrics "Out"

7 day LOS (max)
Reduction in ED attendance, admission, conveyance



Oct. 2025



How many people are discharged back home
How many unnecessary admissions we save



Reduction of time
£0 in money
Reduction in ambulance holds



Friends and family test
Staff survey
Improve MDT relationships

Initial next steps

When will you meet?	End of April TBC
Who will be there?	Jenny Cale, Dr Vedutla, Dr Ali, Lucy Martin, Wendy Malpass, Therapy representative
Who is lead?	Jenny Cale
What are the next steps?	Business case being drafted for next management to agree model for Ridge Hill. Initially need to agree that if this doesn't work, what is the alternative solution. Need to link with OBI and PI discussions.

Appendix G: Children & Young People in the Community



Children & Young People in the Community



Leads

Karen Anderson, Raghvinder Ram, Nicola Ruth, Becky Ward, Kellie Lennon,
Sian Annakin, Samantha Wilegoda

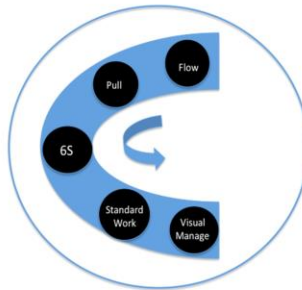
Aim: By the 30th September 2025, we will relocate 75% of both paediatric phlebotomy and paediatric gastroenterology services to the community health hub at merry hill centre.

What does good look like?

Out of school hours service
Family friendly location & amenities
Reduced wait times
Excellent transport links
Free parking
Normalise community settings for children and young people
Better patient experience

Inputs

Infrastructure (merry hill centre)
IT systems
Admin support
Specialist phlebotomists
Specialist CNS/Consultant
Risk assessments
Prescribing pharmacist
Primary care



Outputs

Increased patient and carer satisfaction
Reduction in hospital-based attendance
Reduction in WNB
Reduction in lost school/work time
Release space in acute trust

Metrics "In"

Identify Patients
Clinic identification (suitability)
Identify staff
Friends and family survey

Processes

Staff training
Booking
Clinic frequency
Internal/external comms
Building work on schedule

Metrics "Out"

Friends and family survey
WNB rate
Utilisation of clinics
Staff satisfaction survey
Waiting lists



Attendance
Increased flow
• reduced pathway wait
• Reduced clinic wait



Reduced wait times
Normalising healthcare
Reduced institutionalisation
Increased patient/carer/staff experience
Reduced missed education hours



Specialist time
Materials/IT
Receptionist
Reduced parking/transport cost



Patient survey (friend and family)
Staff survey
More relaxed environment

Initial next steps

When will you meet?	Tuesday 8th April or (HOC) Thursday 10th April
Who will be there?	Karen Anderson, Nicola Ruth, Samantha Wilegoda, Raghvinder Ram, Becky Ward, Sian Annakin, Kellie Lennon
Who is lead?	Karen Anderson
What are the next steps?	<ul style="list-style-type: none"> - Timeline based on current building schedule. - Training plan to upskill phlebotomists; phlebotomist skills & Paed resus skills - Logistics to move & availability of existing equipment, child friendly environment (toys, wall deco etc.)

Appendix H: Care Home Pilot



Care Home Pilot



Leads

Dr Lucy Martin, Ellen Kranting, ?Bianca, Dr. Tara Vedutla, Jenny Cale, Fiona Smith, Claire Towns, Rachel Gretton karen Hansen, Joe Taylor

Aim: To provide more home care and treatment for deteriorating care home residents by October 2025

What does good look like?

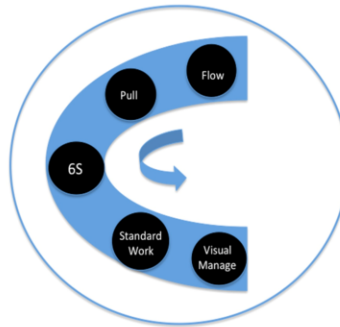
More residents get care in their familiar environment with family around

Avoid needless delays

Treatment is more promptly delivered

Inputs

Care home staff
EHCH team (Chapelst)
District nursing
Clinical hub
Care Home Education Team
Geriatrics & Hospice - Advice technology - Communication of observations
?CQC



Outputs

Reduced hospital admissions
Reduced 999 calls
Increased patient satisfaction
Increased family experience
Timely access to specialist advice
reduced duplication between staff
Increased trust between teams
Reduced wait for treatment

Metrics "In"

Numbers of patients admitted
999 calls/ ambulances out
Waiting time between calling for and receiving help
Hospital length of stay
Dying in preferred place of care
Patient experience

Processes

Holistic treatment plan
Doesn't need new document but agree on what it needs to contain
?Timing

Metrics "Out"

Reduced number of patient admitted
Reduced number of 999s/ambulances
Reduced number of help waiting time
Reduced hospital length of stay
Increased number of patients dying in preferred place of care
Increased patient experience



Counting

- Admissions
- 999s
- Waiting times
- Length of stay



Patient experience

- Via chapelst
 - Via care homes
- Dying in preferred place of care



Number + trust

Unless over 24 hours
7 days a week



Staff survey

Friends and family
Increased trust between teams

Appendix I: Chronic Pain Pathway



Leads

Kelly Houseman, Helen Blakemore, Anneka Page, Jag Sangha

Chronic Pain Pathway



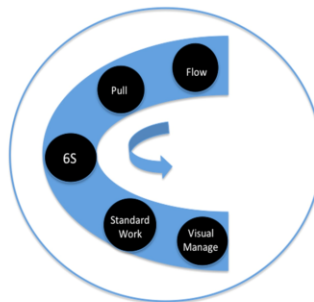
Aim: By April 2026, aim to reduce GP attendance by 30% amongst patients with between 10-25 visits in past 12 months with pain and fibro conditions

What does good look like?

- 30% reduction in GP attendance
- High patient engagement and attendance to peer support sessions
- Measurable improvements in self management/confidence and quality of life using PROMS (Patient Reported Outcome Measures) and PCS scale
- Seamless integration of CPT in delivery alternative care pathways
- Positive feedback from patients, staff of primary and secondary care

Inputs

- Data (appointment data)
- Patient identification
- Baseline of PROMS
- HR of CPT (including specialist)
- Patient comms
- Infrastructure (e.g. premises)
- Admin support



Outputs

- Reduce GP attendance
- Established peer support group
- Improved patient outcomes
- Enhance service integration
- Reduce medication reliance
- (Dependence forming medicines)

Metrics "In"

- Number of patients identified as HI users (10-25 ppts) in last 12 months with pain and or fibro
- Baseline PROMS
- Number of staff assigned
- Availability of space
- Number of patient comms
- Number of patient consent and responses

Processes

- Patient recruitment process (invite)
- Frequency of invites
- Frequency of sessions/CPT's
- Structure/schedule of sessions
- Involvement of CPT members
- Facilitation of sessions
- Referral/escalation process
- Feedback to practices - completion

Metrics "Out"

- Percentage of reduction in GP attendance
- Improvement of PROMS scores
- Attendance/retention levels
- Referrals to other services
- Patient feedback
- Cost effectiveness
- Staff feedback
- Reduction of referrals to pain management



- Attendance
- Patient recruitment target
- CPT efficiency's between roles
- Smooth running of sessions



- Patient outcomes (PROM)
- Satisfaction (Patient satisfaction)
- Service integration
 - High level of engagement



- Resource utilisation (time!)
- Cost effectiveness by reduction of GP appointment
- ?Venue costs



- Patient empowerment
- Staff engagement
- Team cohesion
- Primary/secondary collaboration

Initial next steps

When will you meet?	TBC
Who will be there?	Anneka Page, Kelly Houseman, Helen Codd, Joe Taylor, DIP, Dr Frost, Workwell, OT, Dietitian, SPCW, CC
Who is lead?	
What are the next steps?	PCN meeting at the end of April

Appendix J: Patient Passport



Children & Young People in the Community



Leads

Karen Anderson, Raghvinder Ram, Nicola Ruth, Becky Ward, Kellie Lennon,
Sian Annakin, Samantha Wilegoda

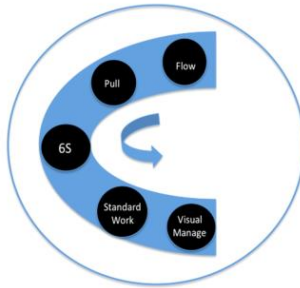
Aim: By the 30th September 2025, we will relocate 75% of both paediatric phlebotomy and paediatric gastroenterology services to the community health hub at merry hill centre.

What does good look like?

Out of school hours service
Family friendly location & amenities
Reduced wait times
Excellent transport links
Free parking
Normalise community settings for children and young people
Better patient experience

Inputs

Infrastructure (merry hill centre)
IT systems
Admin support
Specialist phlebotomists
Specialist CNS/Consultant
Risk assessments
Prescribing pharmacist
Primary care



Outputs

Increased patient and carer satisfaction
Reduction in hospital-based attendance
Reduction in WNB
Reduction in lost school/work time
Release space in acute trust

Metrics "In"

Identify Patients
Clinic identification (suitability)
Identify staff
Friends and family survey

Processes

Staff training
Booking
Clinic frequency
Internal/external comms
Building work on schedule

Metrics "Out"

Friends and family survey
WNB rate
Utilisation of clinics
Staff satisfaction survey
Waiting lists



Attendance
Increased flow
• reduced pathway wait
• Reduced clinic wait



Reduced wait times
Normalising healthcare
Reduced institutionalisation
Increased patient/carers/staff experience
Reduced missed education hours



Specialist time
Materials/IT
Receptionist
Reduced parking/transport cost



Patient survey (friend and family)
Staff survey
More relaxed environment

Initial next steps

When will you meet?	Tuesday 8th April or (HOC) Thursday 10th April
Who will be there?	Karen Anderson, Nicola Ruth, Samantha Wilegoda, Raghvinder Ram, Becky Ward, Sian Annakin, Kellie Lennon
Who is lead?	Karen Anderson
What are the next steps?	<ul style="list-style-type: none"> - Timeline based on current building schedule. - Training plan to upskill phlebotomists; phlebotomist skills & Paed resus skills - Logistics to move & availability of existing equipment, child friendly environment (toys, wall deco etc.)

Prepared by: Nick Conway & Jennifer Prior
Date: April 2025

Dudley Health and Care Partnership Update

Report for Further reading pack to Public Board on 8th May 2025

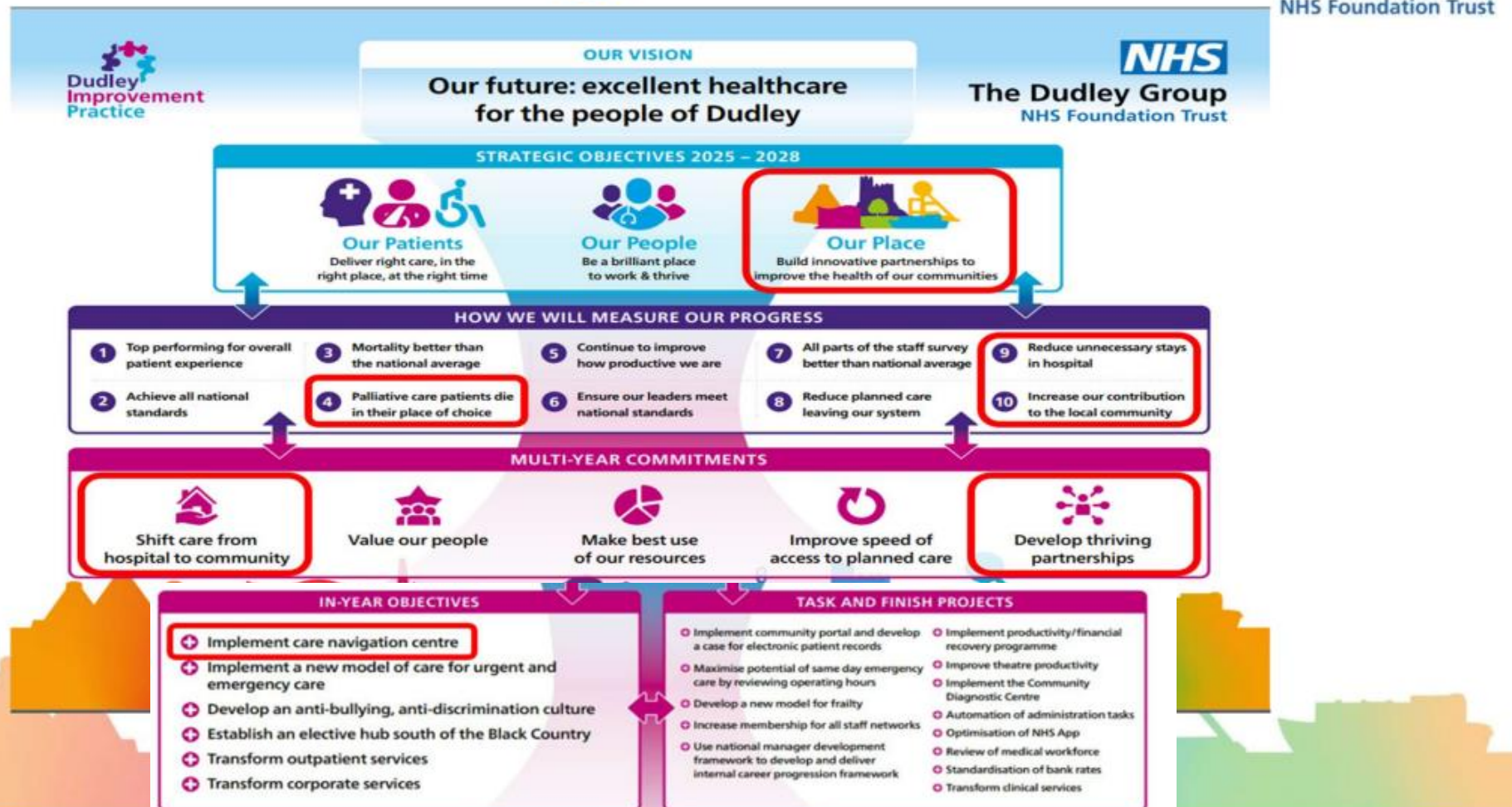
Areas marked in **RED** in further reading pack identify where Dudley Health and Care Partnership has shared objectives and outcomes.

Our Patients
Our People
Our Place

DGFT Strategy

NHS

The Dudley Group
NHS Foundation Trust



Progress report on implementing our strategy and annual plan 2024/25

Quarter 4: January – March 2025



This report provides an update on the implementation of the strategic plan 2021 – 2024 and the annual plan 2024/25.

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

Summary progress against strategy and objectives in the annual plan 2024/25

Goal, success measure and objective from annual plan	RAG rating	
	This quarter	Last quarter
Deliver right care every time		
Measures of success		
CQC good or outstanding		
Improve the patient experience results		
Achieve NHS constitution targets		
Objectives from the annual plan		
Reduce complaints by 15% compared to 23/24		
90% of complaints to be responded to in 30 days		
Increase responses to patient experience survey by 20%		
Reduction in incidents resulting in significant harm		
Standardised hospital mortality index (SHMI) better than England average		
Re-admission within 28 days better than England average		
Eliminate 65 week waits by September 2024 and reduce 52 week waits		
Improve productivity (reduce DNA rate to better than England average, increase PIFU to 5%, theatre utilisation 85%)		
Be a brilliant place to work and thrive		
Measures of success		
Improve the staff survey results to better than England average		
Reduce the vacancy rate to 7% or below		
Objectives from the annual plan		
Improve retention rates for nursing, midwifery and AHP groups		
Bullying and harassment – staff survey results better than England average		
Raising concerns – staff survey results better than England average		
Recommend trust as a place to work – staff survey results better than England average		
Drive sustainability		
Measures of success		
Reduce cost per weighted activity to better than England average		
Reduce carbon emissions (year-on-year decrease to achieve net zero by 2040)		
Objectives from the annual plan		
Deliver financial plan (deficit of £32.565m)		
Deliver recurrent cost improvement programme of £31.896m		
Reduction in use of bank by 25%		
Build innovative partnerships in Dudley and beyond		
Measures of success		
Increase proportion of local people employed to 70% by Mar-25		
Increase the number of services delivered jointly across the Black Country		
Objectives from the annual plan		
A total of 35 people into work via ICan (through jobs and skills hubs or paid work experience		
Improve discharge processes		
Improve health and wellbeing		
Measures of success		
Improve rate of early detection of cancers (75% of cancers diagnosed at stages I,II by 2028)		
Increase planned care and screening from disadvantaged groups		
Objectives from the annual plan		
Achieve acceptable coverage for breast screening (70%) and work towards achievable level (80%)		



Goal: Right care every time

Executive lead: Medical Director / Chief Nurse/ Director of Governance

Strategic measures of success

Measure of success and target	Current status	RAG	Summary of progress this quarter	Actions planned for next quarter
CQC good or outstanding	Trust CQC ratings unchanged during Q4		<p>There have been no new CQC inspections during Q4. During this quarter, an informal engagement meeting took place between Medical Director, Chief Nurse and the CQC relationship leads. No concerns were raised by the CQC at or after the meeting.</p> <p>The CQC self-assessments across the 10 core services have been finalised and approved. The self-assessment process for the Primary care core service is close to completion and is due to be presented to Quality and safety Group in Q1. Good progress has been made and with the integration of Primary care into Trust Governance process and other compliance related activities.</p> <p>Core service review of Critical Care has taken place (internal quality and safety review) – the report is being finalised for sharing in Q1.</p>	<p>The ratings and points of shared learning following the first cycle of CQC self-assessment will be shared with the Black Country Provider Collaborative. The second cycle of Trust self-assessments is due to commence in Q1.</p> <p>Finalisation of the Critical Care Core Service including the review findings and subsequent improvement work. Commencement of the next Core Service review - Children's services.</p> <p>Presentation of the Primary Care self-assessment at Quality and Safety Group.</p>

Improve our patient experience results to top quartile performance (England) by 2025	The first-cut results for the Children and Young People Survey 2024 were received in January 2025. These results are benchmarked against the other Trusts who used Picker as their preferred contractor to run the survey.		<p>The results remain under embargo and cannot be shared outside of the organisation.</p> <p>The full published results are expected on the CQC website in May 2025.</p>	
Achieve NHS Constitution targets (Referral to treatment, diagnostics, cancer, emergency access)	<p>February RTT position 59.21% vs 25/26 target of 64.2% by end of March 2026.</p> <p>February DM01 performance has improved and achieved 87.8%. The overall backlog of patients waiting to be seen is reducing month on month. NHSE target by end of March 2025 is to report zero 13 week breaches and 95% of</p>		<p>February has shown continued improvement in the RTT performance, with zero 65-week breaches reported for the month.</p> <p>52-week performance remains good. We continue to overachieve against our trajectory, with the end of January position being 743 pathways ahead of plan. By the end of March 26, we should have no more than 1% of patients on the waiting list waiting more than 52 weeks. Current position = 2%.</p> <p>Dexa, Endoscopy, Cardiology and Audiology are performing well at 95% or above. Sleep Studies, Cardiac MRI and Cardiac CT remain challenged. NOUS has seen a reduction in 6+ week breaches.</p> <p>Sleep studies achieved 49.2% in February. There is a recovery plan to increase capacity to improve this position by end of June 2025.</p>	<p>Operational plans are being worked on ensuring forecasts align with the improvement targets. This will provide information at a speciality level for directorates to develop action plans against revised expectations set out in 'Reforming Elective Activity for Patients' planning guidance.</p> <p>Short term recovery plan for sleep studies using bank continues. Plan to commence respiratory in CDC before end of March. Increased staffing and additional equipment will provide extra capacity. Recovery plan and trajectory will clear 6+ week backlog by June 2025.</p> <p>Cardiology and Imaging working in collaboration to increase capacity. Plan to increase number of unsupervised slots at RHH and consider number of additional supervised lists to support MRI and CT</p>

	<p>patients to be seen within 6 weeks.</p> <p>January - All cancer 28 Day FDS waits target 77% - achieved 81.5%</p> <p>January - 31 day Combined Target 96% - achieved 88.8%.</p> <p>January - 62 Day Combined Target 70% - achieved 74.9%.</p>		<p>Non obstetric ultrasound significantly improved from 87.68% in January to 93.18% in February.</p> <p>MRI has improved from 88.34% in January to 91.61% in February.</p> <p><u>28-day Faster Diagnosis Standard (FDS)</u> Performing well at 81.5% and remains above national target of 77%. Increased focus on individual tumour site pathways.</p> <p><u>31 day combined</u> 31 day combined achieving 88.8% against national target of 96%. Surgical and diagnostic capacity and BCPS reporting delays impact performance. 31 day trajectory to achieve 96% submitted to ICB. Renal and skin are tumour sites most challenged.</p> <p><u>62 day combined</u> Achieved 74.9% and remains above NHSE target of 70% by end of March 2025. (This target does not supersede</p>	<p>pressures. Apps training completed in February will provide additional capacity on new CDC CT scanner at Guest. RWT are providing mutual aid for very small volume of patients.</p> <p>NOUS performance has improved. Sonographer led head and neck lists will reduce reliance on consultant led lists. Additional consultant led lists are being scoped.</p> <p>Diagnostic performance is reviewed with NHSE on fortnightly system tiering call.</p> <p>A trajectory has been developed to reduce 13 week breaches to zero by end of March 2025 where possible.</p> <p><u>28-day FDS</u> Performance to be sustained. Forecast shows continued achievement. 31 day combined & 62 combined</p> <p>Gynae: remains challenged. ICB aware and the team are working on extra capacity.</p> <p>Skin: Nurse biopsy clinics begin 27th March 2025 to support diagnostics and low grade excisional biopsy capacity.</p> <p>Prostate – increased first OPA and biopsy capacity required for April. Extra capacity planned.</p> <p><u>BCPS</u> Urgent 10-day Histology: February 2025 was at 59% against national target 70%. The performance declined by 4% from January 25 due limited reporting capacity as a result of annual leave. E</p>
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	<p>February EAS 4 hour target 78% for Type 1 & 3 attendances – achieved 78.7%.</p>	<p>the 85% constitutional standard but set to support tiering measures for cancer performance).</p> <p>Late Tertiary referrals closely monitored. Primarily urology, colorectal and lung. Actions in place to reduce. Cancer performance is reviewed at Regional Performance Tier Calls with NHSE.</p> <p><u>February 4 Hour Target</u></p> <p>RHH ED Performance for February is 2nd best in the black country despite high ambulance and walk-in attendance when compared to our regional neighbours.</p> <p>We continue to validate performance and record reasons for each breach which is then explored by the ops team and the department tri.</p> <p>Last month's data have allowed for identification of themes and increased focus on these have been:</p> <ul style="list-style-type: none"> • GP letter patients straight to SDEC/Surgical SDEC • Agree new streaming template with UCC for patients with letters to go direct to Speciality <p>Altering the registration process for patients arriving by the front door.</p>	<p>Requesting is a at 47%, Compass pilot is due to go live once all SOPs and policies have been ratified at relevant committees and Gastro continue to work through the technical issues. Urgent requesting remains at 55% and is being addressed via weekly task and finish group.</p> <p><u>4 Hour Target</u></p> <p>Deputy Matrons are further highlighting 4hr performance whilst on clinical floor to teams.</p> <p>Continued scrutiny that GP letters are being directly streamed to appropriate area to avoid being booked into ED.</p> <p>Focus now on NHSE's 5 priority ED improvement initiatives: -</p> <p>Streaming & Redirection.</p> <p>Rapid Assessment & Treatment (RAT).</p> <p>Maximising UTC use.</p> <p>Improving Ambulance Handover process Reducing the time in department.</p>
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			<p><u>February Ambulance Handovers</u> This month's activity saw 8,402 attendances. This has decreased when compared to the previous month of January with 8,790.</p> <p>16 out of the 28 days saw >300 patients.</p> <p>2747 patients arrived by ambulance; this shows a decrease from the 3031 ambulances that attended last month.</p> <p>430 of these offloads took >1hr (16%). This shows an increase in performance when compared with last month's performance of 20%.</p> <p>Over the month, the average length of stay (LOS) in ED was 217 mins for non-admitted patients and 469 mins for those waiting for a bed following a decision to admit. This represents an improvement when compared to last month where the LOS was 215 mins and 481 mins, respectively.</p>	<p><u>Ambulance Handovers</u> We continue to use RAT for all ambulance patients to ensure assessment, treatment and medication are given quickly.</p> <p>New front door model proposed, presence of AMU doctor, ED medic, receptionist, ambulance tracker, and triage nurse to streamline patient flow and improve efficiency. This is still under review, currently being scoped with divisional management.</p> <p>Escalation of ambulances without a plan to offload at 30mins to Site Team with additional role cards to link AMU & Site teams based on the Kings College Model - Continues to be in progress.</p> <p>Additional trolley capacity now in place to ensure offloads can happen promptly at the ambulance entrance - Implemented and Operational.</p> <p>Streamers and triage nurses continue to utilise pathways as early as possible and sit out suitable patients to free up ambulance - We continue to utilise pathways to allow efficient ambulance offload.</p> <p>Designated ED Tracker monitoring ambulance offloads/pinning. Regular escalation to both halo, site, ops management and NIC - Ongoing monitoring and regular escalation in place.</p> <p>ED operational escalation bleep initiated through office hours and point of contact for urgent escalations - This is currently in use.</p> <p>Requirement for all CAT 3 ambulances to contact Dudley Clinical Hub, even if already presented at</p>
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				<p>hospital, to explore potential community-based interventions and avoid any unnecessary hospital admissions - In progress, on-going work to streamline communication and ensure full implementation.</p> <p>Utilise TES space (four additional beds) to support patient flow and alleviate ambulance handover delays - TES space staffed by site team, with NIC identifying suitable patients.</p>
Objectives from the annual plan				
Objective	Current status	RAG	Summary of progress this quarter	Actions planned for next quarter
Reduce complaints by 15% compared to 2023/24	<p>At the end of 2023/24, the Trust had received 956 new complaints. To reduce this figure by 15% for 2024/25, an anticipated number of new complaints received would be 812 for 2024/25.</p> <p>During Q4 2024/25, the Trust received 287 new complaints. With an average of 95 complaints per month for that quarter.</p> <p>The total number of complaints received for 2024/25 is 1053, this an 10.1% increase on 2023/24.</p>		<p>During Q4, 2024/25 there were 287 new complaints received. In comparison to Q4, 2023/24, there were 237 new complaints received; this is an increase of 21% for the year quarter comparison.</p> <p>In 2023/24, 956 complaints were received compared to 1053 for 2024/25. This is an increase of 10.1% increase.</p>	The complaints team continue to offer an informal approach (PALS route) to address concerns where applicable to reduce the number of formal complaints received.

	The team have not achieved their target of a 15% decrease in the number of complaints received. The Trust has received 10.1% more complaints than 2023/24.			
90% of complaints to be responded to in 30 days	<p>The average response rate for 2023/24 was 42.8% for all complaints closed within 30 working days.</p> <p>The average response rate for Q4 2024/25 was 46.9%. The average yearly response rate was 47%, meaning there has been an increase in response rate for all complaints closed of 4.2% from 2023/24.</p>		<p>For Q4 2024/25, the Trust closed 304 complaints, 144 (46.9%) were closed (this is all complaints closed including reopened complaints) within 30 working days which is a decrease in the response rate from Q3, (2024/25) (50.3%) of 3.4%.</p> <p>The number of complaints closed for Q4 (2024/25) where there was a first response only (not including reopened and Ombudsman cases) was 264. Of those 264, 135 of those were closed within 30 working days. The average response rate of closed complaints where there is a first response only is 49.3%. This is a decrease from Q3 (2024/25) (54.5%) of 5.2%. The 2024/25 yearly average response rate for first response only complaints is 50.5%.</p> <p>This remains above the response rate for 2023/24 but is still not at 90% target response rate.</p>	Continue with escalation process in place which is showing an improvement in responsiveness from divisions.
Increase responses to FFT patient	There are no targets set for response rates under the new FFT guidance.		Overall, 82% of respondents have rated their experience of Trust services as 'very good/good' in February 2025, a	The patient experience team will ensure that monthly summary reports of the FFT are circulated within the

experience survey by 20%			<p>small decline since January 2025 (83%). A total of 6% of patients rated their experience of Trust services as 'very poor/poor' in February 2025, no change since the previous month.</p> <p>In February 2025, the A&E Department received the lowest percentage score for patients rating their overall experience as 'very good/good' at 69% a decline from the previous month (74%). The 'very poor/poor' scores for the A&E Department remain the highest of all departments at 15%, an increase of 2% since January 2025. Maternity received the highest positive ratings this month at 90%. Community have seen a decline in positive scores in January and February in comparison to the previous months where scores were above 90%.</p> <p>FFT percentage very good/good scores remain below the national average for all divisions.</p>	<p>Trust to include a breakdown of responses to the FFT by ward/clinic/department.</p> <p>Each department is to provide an update on the 'You Said We Have' actions and monitor scores to address any areas of concerns and identify good practice.</p> <p>FFT percentage very good/good scores are monitored through the divisional updates at the Patient Experience Group for assurance and to highlight action taken to improve scores at ward/department level.</p>
Reduction in incidents resulting in significant harm (moderate, severe, death)	<p>The percentage and number of incidents resulting in significant harm remains low. However, there was an increase in the numbers and percentage of incidents resulting in harm in December 2024 (reporting validated in January) This mainly</p>		<p>PSIRF response tools continue to be utilised and developed to review system-based factors contributing to incident occurrence.</p> <p>Single improvement plans are in place for several of the speciality areas including pressure ulcer and falls prevention. Work continues to strengthen the improvement work and monitoring forums in place.</p> <p>A programme of action effectiveness</p>	<p>Work to promote incident reporting through training and awareness raising.</p> <p>Work to further review and strengthen the improvement metrics to assess the impact of incident action plans to take place throughout 25/26.</p> <p>Focus on improvement themes and aligned quality improvement activity is planned for Q1; the occurrence of recurrent themes in learning through incident responses indicates a challenge for the</p>

	<p>pertains to an increase in the number of falls and pressure ulcer incidents resulting in significant harm. Overarching reporting numbers continue to improve with some seasonal variation as per previous Q4 positions.</p>		<p>checks are being undertaken to ensure actions have been embedded/sustained in practice and are having the desired impact. Work continues to promote reporting through up-dated training schedules.</p>	<p>organisation in terms of embedding impactful and effective change. The Dudley Improvement Practice are supporting this work.</p>
<p>Standardised Hospital Mortality Index (SHMI) (quarterly) better than England average</p>	<p>SHMI – Jan 24 to Dec 24 = 101.11 HSMR Jan 23 to Dec 24 = 86.38</p>		<p>Pathway specific improvement groups in place for #NOF, Stroke, EmLap and Sepsis. AQ bundles continue to be embedded. #NOF SHMI continues to reduce and is now at 111.</p> <p>Hospital at Night monitoring of the Deteriorating Patient Pathway dashboard proved successful during Q3 and Q3 and now business as usual providing timely clinical review.</p>	<p>Stroke audit due to be reported in April 2025 at Mortality Surveillance Group.</p> <p>Learning from Deaths reporting to Board on a quarterly basis.</p> <p>SJR panels meeting on a weekly basis and increasing support to PSIRF implementation.</p>
<p>Re-admission within 28 days better than England average</p>	<p>8.73% rolling 12 month. Decrease from previous reporting period but above national average of 8.01%. Peer average significantly higher at 9.27%</p>		<p>Ongoing review of readmissions at speciality level via divisional governance structure</p>	<p>Ongoing review of readmissions at speciality level via divisional governance structure</p>
<p>Eliminate 65 week waits by Sept 24 and reduce 52 week waits</p>			<p>52-week performance remains good. We continue to overachieve against trajectory, with the end of January position being 743 pathways ahead of plan.</p> <p>We are focused on achieving the 52-week standard for children and young</p>	

			people by the end of March 25, with 43 patients remaining in the cohort.	
Improve productivity (reduce DNA rate to better than England average, increase PIFU to 5%, theatre utilisation at 85%)	<p>Missed Appointments (DNA) Performance - January 6.5%.</p> <p>PIFU Performance – March 3.4%.</p>		<p><u>Missed Appointments (DNA)</u> Performance January 6.5% (Division Level: - CSS 7.9% - MIC 5.3% - SWC 7.2%).</p> <p><u>PIFU Performance</u> March (Division Level: - CSS 18.3% - MIC 2.9% - SWC 2.8%).</p>	<p>Missed Appointments (DNAs) - Trust trajectory 5% by March 2026. PIFU – Trust trajectory 6% by March 2026.</p> <p>Specialty Tri teams to weekly monitor performance via OPD Dashboard / Missing Outcome Dashboard / PIFU Dashboard against National 85th percentile. Ongoing actions / monitoring via weekly OPD efficiency & productivity / Divisional / ICB / National GIRFT Meetings.</p> <p>Additional workstreams related to Missed Appointments / PIFU / wider GIRFT programme: - Access Policy – adherence / patient letters. Adherence of GIRFT Further Faster Specialty Handbooks. Specialty learning & sharing good practice. Health Inequalities / Work Well National Programme until March 26 to support economic inactive patient groups. Digital OPD programme to commence April 25. Accurx Video Platform April/May 25. Pilot Digital Outcomes. Job Planning team objectives to include clinic templates / GIRFT programme. FU PTL validation.</p>



Goal: Be a brilliant place to work and thrive

Executive lead: Director of Operational HR

Strategic measures of success

Measure of success and target	Current status	RAG	Summary of progress this quarter	Actions planned for next quarter
Improve the staff survey results to better than England average by 2024/25	Results for 2024 remain at benchmark average for People Promises. Response rate is also on par with benchmark average.		Results have shown no significant change for 2024 and Trust remains in line with benchmark average for People Promises. 3 year trend remains positive – although need to maintain focus on engagement as this score has declined in 2024. Delivery of People Plan, People Promise actions and oversight through Being a Brilliant Place to Work group continues.	Ongoing delivery of communications, engagement and training plan to support delivery of anti-bullying and anti-discrimination policies and work programme. Delivery of year 3 of Dudley People Plan and delivery Journeys. Re-launch of MakeitHappen feedback loop.
Reduce vacancy rates to 7% or below	Vacancy rates have been consistently below the 7% target for 12 months.		Vacancies continue to be monitored through the Trust's KPI reports to People Committee and Board. There is a robust vacancy control process in place to ensure establishment is controlled.	Through the Being a Brilliant Place to work and thrive committee the focus continues to be on workstreams that support high retention rates to ensure vacancy levels do not increase.

Objectives from the annual plan

Objective	Current status	RAG	Summary of progress this quarter	Actions planned for next quarter
Improve retention rates for Nursing, Midwifery and AHP groups in particular retain 80% of our internationally recruited workforce	95% retention rate		Detailed analysis recently undertaken with regards to retention rates. 95% retention rate determined. Only 22 leavers out of 399 headcount.	Focus on supporting those who are maternity leave to ensure retention on return from maternity leave.
Bullying and harassment - experience of bullying from managers - staff survey results better than England average experience of bullying from colleagues: staff survey results better than England average	2024 Staff Survey results: Q16b discrimination from managers/colleagues - 9.25% (better than 2023 score of 9.82%) and better than benchmark average. Q14b experienced bullying and harassment from		The new Anti Bullying, Anti Discrimination Policy has been launched including communications plan in place and training and support for managers. Active promotion and cascade is underway. Hub page has been launched.	Launch training programme and ensure that all managers view policy briefing and undertake additional training. Identify teams to undertake bespoke targeted work and interventions and launch support package.

	managers – 10.30% (better than 2023 score of 10.77%) and at benchmark average. Q14c experienced bullying and harassment from colleagues – 18.48% (better than 2023 score of 18.68%%) and at benchmark average.			Further work to explore expanding our internal mediation service.
Raising concerns - I feel safe to speak up staff survey results better than England average	2024 Staff survey scores to I feel safe to speak up have declined in 2024 and this is a declining trend. It does reflect a national trend of decreasing scores. Q25e I feel safe to speak up about anything that concerns me 56.75% in 2024 (58.26 in 2023). Below benchmark average.		Ongoing delivery of Freedom to Speak Up plan including wider promotion of role and champions, development and recruitment of champions, engagement activity. Review of strategy commenced.	Ratification and launch of strategy. Ongoing delivery of FTSU actions within plan. Feedback from national Staff Survey to teams through MakeitHappen.
Recommend trust as a place to work staff survey results better than England average	2024 Staff Survey scores for this question have declined – 57.38% compared to 58.51 in 2023. This is marginally below benchmark but above the position from 2021.		Review of results to understand key areas of change – mainly around ability to make improvements or change happen and recommend for work and care. Ongoing delivery of People Plan and Journeys.	Launch of framework around Listen, Act and Feedback to improve visibility of actions and change happening within the organisation. Improved promotion of Being a Brilliant Place to Work Group and associated activities.



Goal: Drive sustainability

Executive lead: Director of Finance

Strategic measures of success

Measure of success and target	Current status	RAG	Summary of progress this quarter	Actions planned for next quarter
Reduce cost per weighted activity to better than England average by 2024/25	<p>Productivity metrics from Model Hospital for 2022/23 show that the overall trust position is in the third highest quartile. Medical and nurse staffing costs per WAU remain in the highest quartile.</p> <p>(New) implied productivity growth compared to 19/20 shows that trust is in the 2nd quartile nationally with a negative variance of 6.8% compared to the provider mean of -10.7%</p> <p>A basket of productivity metrics from Model Hospital (Appendix 2) shows a varied picture highlighting instances where the trust is already meeting benchmarks and where there is further work to do</p>		<ul style="list-style-type: none"> Trust engaging well with GIRFT Further Faster programme and showing improvement across the key metrics Productivity metrics based on more recent performance such as theatre utilisation, day case rates and length of stay continue to show improvement Productivity metrics are informing the development of cost improvement plans in the quality and productivity workstreams 	<p>Engage in the GIRFT programme Further Faster 20 focused on those trusts where there is greatest potential for waiting list reductions to improve health of working population</p> <p>Continued focus on productivity and efficiency through the quality and productivity workstreams</p>
Reduce Carbon Emissions (year-on-year decrease achieving net zero by 2040)	<p>Green Plan Refresh has been drafted.</p> <p>Proposed and planned estate work is due to achieve a 39% reduction to the building energy proportion of carbon emissions,</p>		<p>The Energy and Estates Group has received funding for Solar PV and LED lighting upgrades for the retained estates. This work along with lifecycle work and a Low-Temperature Hot Water Proposal from Mitie (de-steam RHH), it is estimated that</p>	<p>Launched the refreshed Green Plan.</p> <p>Establish Bathroom First with Pilot wards.</p> <p>Travel and Wellbeing events.</p>

	leavings 8% remaining for the 2032 interim target.		<p>emissions from building energy will be reduced by 39% by 2032, leaving 8% remaining to meet the interim NHSE target.</p> <p>The Trust is working with the Midlands Net-Zero Hub to develop a decarbonisation plan for the estate. Our estate is the largest source of emissions.</p> <p>Mitie have agreed to decommission the Nitrous Oxide Manifold.</p> <p>Work has begun on the Greener Clinical Transformation Challenge which is led by the Midlands team. In the Black Country the focus is on “Bathroom First” principles to improve patient care and reduce the demand on pulp products.</p> <p>Actions have also been embedded within the Quality Priorities.</p>	Decommissioning of Nitrous Manifold. Draft Estate Decarbonisation Plan from Midlands Net Zero Hub.
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Objectives from the annual plan

Objective	Current status	RAG	Summary of progress this quarter	Actions planned for next quarter
Deliver financial plan (deficit of £32.565m)	The year end accounts are in the process of being pulled together. The Trust fully expects the outturn to be within the target deficit position of £1.590m. Note that the plan has changed since the start of the year following the receipt of deficit funding from NHSE.		<ul style="list-style-type: none"> Challenge sessions held with Divisions to drive further improvement Reduced substantive staff numbers following vacancy freeze Improved ERF performance Further settlements with associate commissioners re diagnostics, UEC and passthrough drugs Continued grip and control on non-pay 	<ul style="list-style-type: none"> Continued grip and control into new financial year Agreement of contracts with associate commissioners Development of weekly monitoring for bank costs Implementation of system for WLI claims
Deliver recurrent cost improvement programme of £31.896m	<ul style="list-style-type: none"> Forecast position has improved with an expected £31.2m end of programme delivery expected at year 		<ul style="list-style-type: none"> Additional CIP with a YE forecast value of £210k provided by PLACE division 	<ul style="list-style-type: none"> New FIG template created to support the governance of the 2025/26 programme,

	<p>end. We have a £614k shortfall at month 11.</p> <ul style="list-style-type: none"> • 73% of the delivery Forecast is Recurrent at £22.98m. • 98% of PIDs have successfully passed through the QIA process to date with just 2 awaiting review. 		<ul style="list-style-type: none"> • Continued ERF overperformance especially within MIC. • 6 new governance workstreams being set up to lead and deliver productivity improvements in NEL & UEC, Elective, Outpatients, Temporary Staffing, Corporate & Commercial and Medicines. Each of these workstreams will report into FIG on a monthly basis. • Specialty annual planning templates have been returned and CIP Team continues to work with divisions to extract meaningful CIP and Transformation plans from these documents. 	<p>including target metrics as set by NHS E.</p> <ul style="list-style-type: none"> • Reporting of 2025/26 CIP Programme and identified GAP will be reported. • GIRFT metrics will be utilised to support the Outpatient and Elective workstreams to ensure measurable improvement trajectories are developed and monitored.
Reduction in use of bank by 25%	The Trust plan assumes 25% reduction in bank (156 WTE by end September 2024). The divisions have developed reduction trajectories		<ul style="list-style-type: none"> • February position 149.19 wte behind target but adjusted to 59.91 wte due to: <ul style="list-style-type: none"> - Surge Beds (34.29 WTE) - ERF delivery (47.13 WTE) - Midland Met/Winter (7.86 WTE) • Executive led confirm and challenge meetings • Additional bank controls • Initial March position shows significant deterioration, driven by annual leave. 	<p>Executive led confirm and challenge meetings</p> <p>Additional bank controls</p> <p>Performance monitoring through Finance Improvement group and Finance and Productivity Committee</p> <p>Move to weekly Exec monitoring</p> <p>Reduction in rates from 1st April</p>



Goal: Build innovative partnerships in Dudley and beyond

Executive lead: Chief Strategy & Digital Officer

Strategic measures of success

Measure of success and target	Current status	RAG	Summary of progress this quarter	Actions planned for next quarter
Increase proportion of local people employed to 70% by Mar-25	Current proportion remains at 68%. Change opportunities have been limited due to recruitment restrictions.		Continued delivery of ICan work placements and CSW programme. Exploring partnerships with organisations outside of Dudley Group and Dudley Council.	Developing links with Mitie to support increased access to local jobs.
Increase the number of services delivered jointly across the Black Country	The Trust continues to play an active role in the Dudley Health and Care Partnership with routine reporting to the Integration Committee established.		<ul style="list-style-type: none"> The 2024/25 operational planning guidance asked integrated care boards (ICBs) to “establish and develop at least one women’s health hub in every ICB by the end of December 2024 in line with the core specification, improving access, experience and quality of care.” In Dudley there were already strong foundations in both primary and secondary care, so our proposal built additional capacity in community-based settings across the Dudley borough closer to home for Menorrhagia (Heavy menstrual bleeding); Menopause; a Women’s Health Hub Educational Programme and Educational Programme for Primary Care Clinicians. In January we launched the Black 	<ul style="list-style-type: none"> Establish a Housing and Health Forum. Local partners have been commissioned to pilot WorkWell initiatives on a place footprint, and these will commence on April 1st, 2025. A second task and finish group addressing issues around discharge letters will commence in May. Partners have been invited to attend the “Community First” Value Stream Analysis with the Dudley Health and Care Partnership committed to provide oversight and assurance.

			<p>Countries Women's Health Hub in Dudley after securing funding from the ICB. The model aims to improve access to and experiences of care, improve health outcomes for women, and reduce health inequalities. We are offering nonclinical elements of the service at the heart of our communities in our Family Hubs to include menopause cafes.</p> <ul style="list-style-type: none">• Partners have considered and contributed to refresh of the Integrated Care Partnership (ICP) strategy and the roadmap to produce the Joint Forward Plan Strategic Summary. The ICP has refreshed its terms of reference and membership and moving forward Kat Rose (Chief Integration Officer) will become a core member going forward.• WorkWell, which provides early intervention to people who are experiencing barriers to gain or retain employment due to health conditions or disabilities, has been well received with 103 referrals received to date (03/03/24).• We continue to develop and improve the Primary, Community, Secondary Care Interface with 125 queries received and addressed in Q3 and 103 thematically analysed and prepared for discussion at task and finish groups. The better	
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			management of workload group has met with an action plan developed.	
Objectives from the annual plan				
Objective	Current status	RAG	Summary of progress this quarter	Actions planned for next quarter
A total of 35 people into work via ICan (through jobs and skills hubs or paid work experience)	54 people into work through the programme from paid work experience and CSW programme. 100 people into work through the into employment programme.		All candidates have now completed the programme and all programmes have now finished in Phase 1. Candidates who completed paid work experience but who have not yet secured work are being supported to access any vacancies that are suitable. Evaluation activity has been completed with interviews and economic impact analysis. Final ICan team away day to review the programme.	Confirm funding arrangements for Phase 2 – awaiting final funding and outcome documents. Planning programme activity once funding is confirmed. Finalise and publish evaluation of Phase 1.
Improve discharge processes (30 discharges per day from MOFD list, 90% of patients to be discharged within 24 hours once known to system partners, reduce number of incomplete discharges on the complex list – no more than 5% failed per day, 30% of In-patient's discharges are home for lunch for each RHH ward	Current KPIs set within the team are not being met although we have seen an improvement in the data over the last 6 months.		<ul style="list-style-type: none"> On average we are provided with 33 planned discharges daily with an average of 20 facilitated each day. To mitigate impact of MMUH and winter the KPI for the average number of discharges required has been revised to be 35 per day Mon-Fri and 20 per day Sat-Sun from August 2024. Incomplete discharges - main areas of concern were patients becoming medically unwell, transport and delays with medication. 	<ul style="list-style-type: none"> Work with IT to combine systems for live updates to support efficiencies with information on medication and transport status and prevent duplication



Goal: Improve health and wellbeing

Executive lead: Chief Operating Officer

Strategic measures of success

Measure of success and target	Current status	RAG	Summary of progress this quarter	Actions planned for next quarter
Improve rate of early detection of cancers (75% of cancers diagnosed at stages I, II by 2028)	In Q3 24/25 63% of cancer were staged at I or II. This figure is likely to be higher but due to breast cancer staging being incomplete we are unable to count those cancers. 33% of Lung cancer patients were staged at I or II out of 51 patients		<ul style="list-style-type: none"> Lung cancer screening is well established now and we have seen improvement in treatments times. Q4 will give us a better understanding of the impact on the staging of lung cancer patients. 	<ul style="list-style-type: none"> Improve breast cancer staging data Monitor impact of lung screening checks
Increase planned care and screening from disadvantaged groups (Breast screening uptake 70% or greater)	Missed outpatient appointments by deprivation quintile show that rates are over twice as high in the most deprived quintile compared to the least deprived (8.0% versus 3.7%)		<ul style="list-style-type: none"> Reduction of missed appointments being addressed in quality and productivity workstream and needs interventions that will address this discrepancy Childrens services have identified cohorts of patients where missed appointments are high and exploring options for addressing 	<ul style="list-style-type: none"> Implications of addressing health inequalities in elective care as highlighted in 'Reforming Elective Care' to be picked up by Health Inequalities Core Group

Objectives from the annual plan

Objective	Current status	RAG	Summary of progress this quarter	Actions planned for next quarter
Achieve acceptable coverage for breast screening (70%) and work towards achievable coverage (80%).	Uptake Q3 69.49%. Validated data Q4 Too early to publish credible results yet.		Q3 saw us in planning stages of the development of a video for the LGBTQ+ communities. This is currently paused due to the ICB lead on this project transferring to WMCA. It is hoped this the project will also transfer	The project with WMCA to improve uptake across the service by utilising a targeted approach with both first time invitees and perpetual DNA's will be introduced early April, once it has been understood what impact the extra workload will have on the admin team.

			<p>over as the importance of up to date material is recognised.</p> <p>Materials have been designed for 'Over 70's to encourage self-referral, since a common theme when the service attends events appears that many are unaware, they can still access the service. This is in its final stages prior to the Commissioners approval.</p> <p>Materials have been completed for leaflets aimed at the LGBTQ+ to reinforce inclusivity across the service, which needs to be signed off by the Commissioners.</p> <p>Cancer Champion Training has been condensed to one session due to the lead of this work stream transferring to the WMCA, putting further pressure on the ICB to deliver training.</p> <p>We are seeing an increase in uptake across all three areas, with a particular focus on Wolverhampton which continues to lag. This would be due to the diverse population, ranking as the 20th most deprived council area in England, and the largest proportion of Bilston's LSOAs in the top 10% most deprived in England.</p> <p>The project to develop a Cancer Screening Guide for Primary Care, to be utilised across the ICB, & to include City & Sandwell has been completed,</p>	<p>The relocation of the mobile unit to Stafford Street has been a success after negotiations with Dudley Council. This helps to target Dudley and Netherton PCN which has a lower-than-average uptake. Due to funding PH Dudley are reducing their advertising campaigns by utilising social media platforms as an alternative to the pharmacy bags previously used. They also noted feedback from beauty salons which expressed their dislike for advertising formats of screening materials in store, preferring to use their social media accounts instead.</p> <p>Events will focus on GP Practices, to engage with previous DNA's and first-time invitees, followed by a further event where feasible to cover current DNA's. This allows for a more targeted approach, in which GP's and Practice Cancer Champions can also engage with the Breast Service. Several previous events have allowed for staff training on the breast service, which allows for GP staff to signpost patients should the situation arise.</p> <p>The Cancer Bus returns to Dudley and Wolverhampton in April, and May with Staffordshire ICB. This sees an excellent footfall, and women being signposted to relevant agencies where needed.</p>
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			<p>this will focus on breast screening coding and GP uptake, the role of practice involvement by sharing best practice.</p>	<p>We hosted a successful event in Lye 2023 with over 120 females in attendance which will be repeated on May 10th, with The Mayor of Dudley, and local Councillor in attendance. The event this year will be split and men invited in the first half of the session. With stallholders from Bowel, Breast, AAA, and Lung Screening in attendance. Focusing on Breast Screening and targeting GP's due to be screened in June due to their previous uptake of 37%. Lye also has a large South Asian and Romanian population.</p>
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