Finance and Productivity Committee Chairs Report

The Dudley Group NHS Foundation Trust

Committee Chair: Lowell Williams

31st July 2025	
Integrated Performance Report – Month 3 2025/26	Reasonable Assurance
Winter Plan	Partial Assurance
ED Redesign	Substantial Assurance
Ambulance Handovers	Partial Assurance
EPRR Core Standards Submission	Substantial Assurance
Finance Summary – Month 3 2025/26	Partial Assurance

31st August 2025	
Black Country Pathology Service	Partial Assurance
Divisional Deep Dive – Surgery, Womens and Childrens - Productivity	Substantial Assurance
Divisional Deep Dive – Surgery, Womens and Childrens - Financial	Partial Assurance
Industrial Action Debrief	Substantial Assurance
Finance Summary Month 4, CIP Performance and Workforce Update	Partial Assurance
Procurement Performance	Substantial Assurance

Meeting held on 31st July 2025

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE

- The Committee was concerned that the Winter Plan presented a financial risk to achieving this years budget.
- The continued challenge for ED triage and ambulance handovers remained a concern.
- The committee expressed concern around the lack of a fracture liaison service in the Dudley Borough due to the current unavailability of funding.
- The Trust faces a shortfall of £17.3m of Cost Improvement Programmes, noting the ongoing work to mitigate this.

MAJOR ACTIONS AGREED

- The Black Country Pathology Service remained as a matter arising on the agenda.
- The Winter Plan and Length of Stay item would remain as a standing item for focus on reducing the bed base and improving flow.
- The committee requested a deep dive report focused on screening programmes
- It was asked for the remit of the Infrastructure Committee to return when clarified.

POSITIVE ASSURANCES TO PROVIDE

- There was a continued strong performance on elective pathways and cancer.
- Good progress was being made on the ED redesign project.
- The Trust had self-assessed EPRR compliance as substantial which was an improved position from partial assurance in 2024.

DECISIONS MADE

- The committee agreed the submission of the Winter Plan to the ICB acknowledging the financial risks.
- The committee agreed the fee of £187.5k for Newton Consultancy to undertake a four-week diagnostic subject to ICB and NHSE approval.
- The agenda mapping and support for BAF development was approved for the new Infrastructure Committee.
- The committee agreed the full write off of £171,920 as a bad debt to MW Phillips Pharmacy with no detriment to financial to the Trust financial position.
- The Care Navigation Centre business case comprising an investment of £445k per annum was approved.

Meeting held on 31st August 2025

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE

- Financial risks remain around; CIP delivery at £12.6m, non-recurrent costs, workforce costs particularly in bank and cash resilience.
- Concern was noted around the development and implementation of recurrent CIP in Surgery, Womens and Childrens division.

MAJOR ACTIONS AGREED

- No formal actions were commissioned.

POSITIVE ASSURANCES TO PROVIDE

- There was an overall strong operational performance and favourable league table ranking.
- The division presented a comprehensive deep dive into Surgery, Women and Childrens providing good levels of grip and control.
- Effective management was seen during the recent resident doctor's industrial action.
- Financial performance is slightly better than plan year to date.
- Procurement is overdelivering savings and benchmarking in the top quartile.

DECISIONS MADE

- The committee approved the process undertaken by the costing team in the National Cost Collection Exercise.
- The committee approved in principle the outline operating and financial model for the Elective Hub, noting a £1.9m gap and interdependencies.
- The committee approved the new resus staffing business case with annual costs in region of £770k.

Quality Committee Chair's Report

Committee Chair: Professor Liz Hughes

29 July 2025	
Integrated Quality Report	Partial Assurance
Discharge Improvement Work	Reasonable Assurance
Perinatal Quality Surveillance Report	Substantial Assurance
Learning from Claims Report	Reasonable Assurance
Performance Against Workforce Forecast	Reasonable Assurance
PSIRF Oversight Report Q1	Substantial Assurance
Developing Workforce Safeguards Compliance	Substantial Assurance

26 August 2025	
Integrated Quality Report	Partial Assurance
Corporate Risk Register	Reasonable Assurance
Quality Impact Assessment Updates	Reasonable Assurance
Patient Safety Specialist Report	Substantial Assurance
Discharge Improvement Work	Partial Assurance
Chief Nurse & Medical Director Report	Substantial Assurance
Perinatal Quality Surveillance Report	Substantial Assurance
Performance Against Workforce Forecast	Reasonable Assurance
Biannual Safer Staffing Review Report - Nursing	Reasonable Assurance
Clinical Nurse Specialist Staffing Review	Reasonable Assurance

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE	MAJOR ACTIONS AGREED/WORK UNDERWAY
• Fragility of the Mental Health Act Administration service contracted from Walsall Healthcare NHST. • Current Midwifery vacancy level is at 14.0 WTE, with 13.4 WTE jobs offered to newly qualified midwives due to qualify in September and October 2025. Bank utilised in the short term to mitigate the gap. Midwifery Support Worker vacancy is currently 9.0 WTE; all recruited into and start dates are being arranged. • Current inability to fully meet the MIS Year 7 - Maternity and Neonatal Voices Partnership (MNVP) safety action due to a lack of national funding. • Increase in clinical negligence claims, however robust reviews via GIRFT process or divisional reporting channels. • Increase in incidents to open TES areas due to continued flow and challenge for ambulance offload requirements. Discharge lounge closed as an inpatient area and now resumes as originally intended. • Work ongoing to improve current low compliance with second assessment for VTE to link with discharge planning. • Downward trend for sepsis in ED with work ongoing to improve quality and safety oversight. • Vital Signs Q1 target achieved as part of Quality and Safety Delivery Plan. However, further work is ongoing to improve overall compliance. • Stillbirth rate increased to 3.48 per 1,000 births in July. A Deep Dive to understand the booking process is underway, with interim solutions in place to monitor impact and outcomes. • Increase in complaints, with no themes or trends. Divisional review ongoing to explore how early intervention can prevent complaints as well as exploring nursing support at the front door to support early resolution.	• Discussions underway with the Chief of Medicine regarding repeated deferment of the Chest Pain Pathway paper; the Committee will await an update via the Risk & Assurance Group Highlight Report. Subsequently the report was received in August. • Digital work ongoing across ICB and all providers to consider joint contracts for the Patient Administration System and Electronic Staff Record. • Monthly oversight meetings and Deep Dive approach with IPC team to review provision of cleaning across the organisation. • Quality & Safety Delivery Plan on track to meet end of year objectives; 4/11 Green, 7/11 Amber. Informatics capacity and funding required to support Community Voices impacting on development. Additionally, Patient safety Framework review may potentially impact delivery. • REACCT and Care Transfer Hub models launched and showing positive impact, with reductions in delayed discharges and early evidence of improved patient flow. Clinical Criteria to Treat and Discharge (CCTD) and HITWAFE ward standardisation workstreams increased compliance with Estimated Discharge Dates to 85% across inpatients, strengthening transparency and MDT discharge planning. Digital Bed Management System now live with full integration, providing real-time visibility of bed capacity and supporting operational flow. • 6 risks currently under the remit of the Quality Committee to be reassigned to the Corporate Risk Register for the Joint Infrastructure Committee; agreed with the Executive Leads for the risks and the Executive Leads for the receiving Committee.
POSITIVE ASSURANCES TO PROVIDE	**DECISIONS MADE**
• Improvements in complaints backlog further to responsiveness improvement plan.	• The assurance level for BAF Risk 1 remains as positive. Previous recommendation to Board to reduce risk score to 9, meeting the target level. No known risks to sustain target level. • The Committee reviewed, discussed, and approved the following documents:

• Reduction in Trust acquired pressure ulcers; the Committee agreed on partial assurance due to the difficultly predicting pressure ulcers reported during winter pressures. • Improvements in Safeguarding Level 3 mandatory training; 84% in June 2025 compared to 70% in May 2025. • Significant improvements noted in Diabetes Care and Insulin Safety indicated by fewer related incidents. • Perinatal mortality data remains stable, all below national rates. • National Maternity and Neonatal Review announced by the Secretary of State noted; plans developed for each element identified in the metrics outlined. • Significant assurance of Developing Workforce Safeguards Compliance. Of the 12 DGFT safe care standards, 9 are fully compliant and 3 are partially compliant. • No evidence of the current workforce reduction plan compromising quality and safety. • Sustained improvement for Learning from Deaths; SHMI and HSMR remain stable within expected range. • Substantial assurance with the agreed PSIRF policy and plan for Quarter 1 with a reduction in unplanned responses. • Digital Team highly commended at HSJ Awards for work in conjunction with Surgery Hero. • Second cycle of CQC Self-Assessment enabled robust gap analysis and areas for improvement. • Recent CQC engagement meeting showcased improvements to the Imaging Department, with substantial evidence available to support the Imaging CQC ratings. • NHS England Chief Nursing Officer has announced a Graduation Guarantee for all newly qualified nurses and midwives. The Trust awaits further guidance from the ICB regarding a system wide implementation approach. Of note, this will have a financial and workforce impact. • Reduction in Hospital-Onset Healthcare-Associated infection cases for both CDI and BSI in Q1 2025/26. Under threshold for national C.diff rates.	- Organ Donation Annual Report - Terms of Reference: Discharge Improvement Group - for further review prior to approval • Following publication of Insightful Board guidance, Quality Committee papers to provide analysis of data submitted and reduce the overall size of the papers.

• Performance in care of ED Acutely Unwell Child improving with dedicated meetings and weekly assurance reports and SPC charts. • Positive assurance in relation to Quality Impact Assessments and Cost Improvement Programme. Separate themed QIA workstreams in relation to productivity and efficiency reviewed and approved. Current QIA template, used to measure risk and impact for service development and cost improvement projects, being reviewed and rewritten as well as Policy and SOP to align to national policy. • Trust's Patient Safety Strategy 2022-2025 superseded by Quality and Safety Delivery Plan 2025-2028. Closure of the strategy included assessment of outcomes against objectives; 5 priority areas and a total of 28 objectives of which 17 were fully met, 7 partially met, and 4 unable to deliver. Objectives partially met were incorporated into the Delivery Plan objectives. • Positive assurance from the Chief Nurse and Medical Director report reviewing Dr Penny Dash's review of safety across the health and care landscape; recommendations emulate the Trust's strategic objectives for the next 3 years, indicating a clear understanding of the changing landscape of the NHS. • UNICEF Baby Friendly (BFI) initiative team visited the Maternity Unit to reassess the service under the BFI Standards; received very positive feedback and passed just over 50% of the elements. Trust accreditation for BFI status remains; BFI team will work with the Trust to ensure the other 50% of elements are in an improving state to be achieved. • Increased acuity mitigated by Bank usage to maintain safety. Divisions to recruit into 15% of 22% relief and form part of the wards/clinical area establishment requiring Executive team agreement. • Assurance received from the latest nursing Safer Staffing review, with uplifts requested and approved for C3 and C1a and b, subject to funding identified. • Positive findings with Clinical Nurse Specialist Review to assess capacity and skill mix across specialities. Recommendations for implementation and evaluation generated to include a review of the data collection tool for future use. Recommendations and actions in progress. Secured £78,000	

from Research Regional Delivery Network to embed research across region and streamline services. • Good assurance on continued implementation of Martha's Law. • Good levels of assurance on work underway in matters relevant to their portfolio for Quality & Safety, Risk & Assurance, Discharge Improvement Work, Patient Experience including PALS and Complaints, Infection Control and Chief Nurse Senior Leaders Group.	

People Committee Chairs Report

Committee Chair: Catherine Holland

Committee Chair: Mohit Mandiratta (CH – a/l)

The Dudley Group NHS Foundation Trust

29th July 2025	
• The SWC divisional deep dive covered staff survey results, sickness absence, actions underway on mandatory training. The Committee took positive assurance on the actions being taken.	**Reasonable Assurance**
• Performance against workforce forecast - Month 3 saw a positive position	**Reasonable Assurance**
• ICan Project success, with substantial impact	**Substantial Assurance**

26th August 2025	
• Performance against workforce forecast – Month 4. Partial Assurance	**Partial Assurance**
• Safer Staffing Review provided Positive assurance on staffing levels using national tools and professional judgement.	**Reasonable Assurance**
• ESR, the optimisation of ESR at DGFT and the alignment of ESR processes between DGFT and SWBH provided reasonable assurance.	**Reasonable Assurance**

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE

July

- The Committee were mindful of the potential for industrial action across the organisation, not just by junior doctors.
- Workforce KPI's - the in-month sickness absence had increased, but the Committee was assured that comprehensive actions were in place. Good progress had been made on mandatory training. The 90% target for appraisals had been achieved.
- Issues with flexible working were noted, given the workforce reductions and impact on women in particular in terms of senior roles in medicine

August

- Concern over increase in sickness absence, which increased to 5.68% in July, despite significant actions in place. Noted that this was driven by a rise in long-term sickness, with Short-term sickness absence remaining static. Actions included increased occupational health appointments, focus on return-to-work interviews and targeted support for hotspot departments. There was a concern about winter pressures and sustainability of current interventions which needs to be monitored closely.
- Medical bank pay rates – there was concern at the potential collective action by medical staff to boycott shifts if the proposed changes to bank rates were introduced. Hannah White confirmed that all Trusts were required to carry out risk assessments and a firm system-wide position on rates was being co-ordinated.
- The workforce plan showed a negative variance of 60 WTE, with bank usage exceeding plan by 84 WTE – it was noted that industrial action had contributed to a medical bank increase.

MAJOR WORKS COMMISSIONED/ACTIONS AGREED

July

- Rachel Andrew and Jenny Glynn visiting Worcester University in August to discuss expectations of students coming into vacancies to ensure understanding of clinical environment.

August

- A risk assessment and EQIA would be completed when the proposed changes to medical bank rates were agreed.

POSITIVE ASSURANCES TO PROVIDE

July

- Workforce KPI's - good progress had been made on mandatory training. The 90% target for appraisals had been achieved.
- Workforce plan - assured that it was being actively managed, a big improvement had been made.
- The corporate risk register - progress around medical rostering would be monitored.
- Strategy Q1 repot - RAG ratings approved.
- Physicians Associates - more detail and in-depth discussion required at a future meeting.
- Recruitment and retention - good progress made, positive assurance provided.
- Band 2/3 - this is on track with the back pay payment date planned as September 2025.
- The SWC divisional deep dive covered staff survey results, sickness absence, actions underway on mandatory training. The Committee took positive assurance on the actions being taken.
- ICan project - the Committee thought this was an outstanding project with huge impact.

August

- Workforce KPI's - vacancy rates had reduced from 10% to 9%, with improved turnover and retention and high compliance with mandatory training (93.56%) and appraisals (92%) which were positive trends for workforce stability.
- ESR - the alignment of ESR processes between DGFT and SWBH were discussed, Karen Brogan highlighted the benefits of the increased expertise and team working. Andrew Harding, the Associate Director for Systems & Analytics, would also support further alignment and bring lessons learned from SWBH to inform DGFT's approach.

DECISIONS MADE

July

- Agreed that the BAF risk scores were appropriate. Agreed to retain BAF Committee assurance level as 'Positive' for the refreshed BAF 2.

August

- The Committee approved the Workforce Race Equality Standard (WRES) and the Workforce Disability Equality Standard (WDES) for publication.
- Due to the workforce challenges and increase in sickness absence the Committee agreed to change the BAF Committee assurance level to 'Inconclusive' for BAF 2.

• Safer Staffing Review provided Positive assurance on staffing levels using national tools and professional judgement. • Peter Lowe gave an update on the continuous improvement journey, detailing the integration of the Dudley and Sandwell improvement teams, standardisation of training, and progress on strategic projects such as community frailty interventions. • Positive updates were given on the ongoing work of the Equality, Diversity & Inclusion Steering Group and the Wellbeing Steering Group. • A positive update was received on Freedom to Speak Up detailing increased champion recruitment, engagement with the service and the launch of a new portal to improve accessibility. • NETS survey showed positive student experiences; midwifery response rate up 88%.	

Integration Committee Chairs Report

The Dudley Group NHS Foundation Trust

Committee Chair: **Vij Randeniya**

30th July 2025	
Community First VSA (Value Stream Analysis) Update	**Substantial Assurance**
Community Services Update	**Reasonable Assurance**
Primary Care Development Update	**Minimal Assurance**
Dudley Quality Outcomes for Health Framework	**Reasonable Assurance**
Health Inequalities update	**Substantial Assurance**
Communications & Engagement Update	**Substantial Assurance**

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE

30th July 2025

- Following the update on the Primary Care Development Plan and Dudley Quality Outcomes for Health Framework, the committee noted concern of the decision not to offer Dudley Quality Outcomes for Health framework in 2026/27 and the delay in the ICBs development of the risk stratification tool for the PCNs. These concerns are being raised with the ICB in a number of forums.

MAJOR WORKS COMMISSIONED/ ACTIONS AGREED

30th July 2025

- Following the update on Dudley Quality Outcomes for Health Framework, Lucy Martin agreed to present detailed end of year report on High Oak and Chapel Street in relation to the improved position in performance at a future committee.
- The committee requested that in future Communication and Engagement reports that we include areas that need improvement or feedback on what the Trust may not be doing so well at and how we are tackling this.
- Agreed that Stourbridge and Lye Primary Care Network would work with Care Navigation Centre team to test out the new model and the team would attend the next Dudley Primary Care Collaborative to talk through the work they are undertaking.

POSITIVE ASSURANCES TO PROVIDE

30th July 2025

- An update was presented on Community First VSA (Value Stream Analysis), which included updates on the Community Frailty Intervention teams, Care Home pilots, noting strong engagement across the system, and early indicators of positive impact in the pilot's test data. The committee received positive assurance on all the work ongoing.
- Positive assurance was received following the update on Community Services and how this aligns with the 10-year plan. The Care Navigation Centre (CNC) improvements include enhanced call pick-up times, electronic referrals, and SPoA expansion aligned with national guidance; updating the new phase 1 to have phonelines open from 6am – 10pm with a dedicated WMAS line.
- Positive assurance was received following the update on Health Inequalities, where Paul Singh provided an update on the last 6 months and progress made on tackling health inequalities by embedding equity in service planning, strengthening governance structures, and raising awareness through education and training.
- Following the update on Communications and Engagement update, Helen Codd shared the work ongoing within Dudley Young Health Champions on Marthas Rule. With Health Inequalities, looking to set up a bespoke area on the website or a podcast. Noting the recent attendance at Dudley Armed Forces Day and the benefit of face-to-face interaction, with over 600 members of the public participating. As well as this, noting the menopause café in Lye which had 160 women attend.
- The meeting was face to face at Provision House, this gave the charity a chance to listen into the committee meeting and then present to the committee. They explained the services they provide and provided a tour of the building.

DECISIONS MADE

30th July 2025

- The Integration Committee on the 27th of August was stood down due to high number of apologies received.

Infrastructure Committee Chairs Report

Committee Chair: **1/8/2025**

Day, month year	
IPA Gate 5 Review	**Substantial Assurance**
Governance Reporting Structure/ Mapping	**Reasonable Assurance**
3 Year Digital Plan	**Reasonable Assurance**
RACC Update	**Partial Assurance**

Day, month year	
3 Year Estates Plan	More work needed before assurance rating is assigned
Infrastructure Workshop 18/7/25 - Output	Assurance rating not applicable
Board Assurance Framework	More work needed before assurance rating is assigned

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE

- None

MAJOR ACTIONS AGREED

- RACC plan to be reviewed by Infrastructure Committee at the October meeting. (Proposal to bring forward a scheme that is more transformational, than a simple RACC replacement scheme, has been shared with NHS colleagues. Potential cost £150-200m.)

POSITIVE ASSURANCES TO PROVIDE

- IPA Gateway 5 Review – graded 'green' and positively commended by the Review Team.
- Workshop held on the 18/7/25 was well attended by colleagues from both Trusts and good (early) progress made re confirming 2025/26 priorities, longer term ambitions and immediate opportunities to share good practice and 'level up'.
- 3 year Digital plan well progressed – will be combined with Estates plan to create an overall Infrastructure Plan.

DECISIONS MADE

- Agreed vision statement for the work of the Infrastructure Committee (as discussed at the 18/7/25 workshop event and voted on by workshop participants).
- 3 year Estates plan being worked on and will be considered by the Committee in Q4. Estates plan will be combined with Digital plan to create an overall Infrastructure Plan.
- Infrastructure Plan will need to support the new Clinical Model as it evolves.

The Dudley Group NHS Foundation Trust

Paper for submission to Quality Committee on 29th July 2025

Report title:	CQC Self-Assessment Outcome Paper – cycle 2.
Sponsoring executive:	Martina Morris – Chief Nurse and Director of IPC
Report author:	Helen King – Deputy Compliance Manager

1. Summary of key issues

In 2024, the Black Country Provider Collaborative agreed to undertake a self-assessment across all four provider Trusts using the CQC Self-Assessment Framework. The primary objective of this programme of work is to ensure the quality standards set by the CQC are met and exceeded as a system. By working together, the Collaborative aims to identify strengths, share best practices and address areas for improvement. The Trust undertook an initial assessment during September to December 2024; the findings of which were reported to Quality Committee in March 2025 with a plan to repeat the exercise on a six-monthly basis.

The Trust has undertaken the second cycle of self-assessments aligned to the Trust's CQC registered core services during March to May 2025. Each core service lead(s) has examined and rated their service against the key lines of enquiry for each quality domain. The Compliance Team has supported and coordinated the programme. All assessment ratings have been presented at the June Quality and Safety Group meeting and have been subject to Executive Director-led confirm and challenge meetings during June and July 2025.
The Primary Care core service team had undertaken an initial self-assessment of the two GP practices as part of this exercise. However, this was not finalised as resource was redirected to support preparation for an announced CQC inspection; they will be included in further self-assessment rounds.

This report shares the final ratings assigned ahead of sharing with the Black Country Provider Collaborative. The report also highlights the caveats and challenges encountered in the second round of assessment and how the process will be strengthened for the third cycle.

The vast majority of core services rated themselves as Good. The assessment has enabled a robust gap analysis, and all core services have identified areas for improvement. The process of bringing the assessments together has enabled the identification of themes of improvement across Trust core services; providing opportunities for a Trust-wide improvement ahead of system wide opportunities.

Areas assessed as Requires Improvement are:

- Medical Care (Safe, Effective and Well-led)
- Surgery (Safe and Well-led).
- Services for Children and Young People (Safe and well-led).
- Outpatients (Safe and Well-led).

Self-ratings in Medicine, Surgery and Services for Children and Young People represent a reduction in rating compared to the CQC inspection in 2019 and 2023. It is important to recognise that the self-assessment is a snapshot in time reflective process and is one of many tools utilised for assurance and improvement purposes. Due to updates in the self-

assessment process, it is likely that services are rating themselves more accurately than in the initial round; and changes in ratings reflect this; rather than a decline in the quality of care.

In line with the Black Country Provider Collaborative, the next set of assessments will take later in the year (September/ October 2025), exact dates are yet to be agreed.

The second round of assessments will be subject to internal audit commencing in September 2025; any learning from this will be help strengthen the assessment process and associated assurances.

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	**X**
Improve health and wellbeing	**X**

3. Report journey
Individual core service assessments have been presented at: - Quality and Safety Group – June 2025 - Executive Director meetings – June/July 2025 - Joint DGFT and SWBH Board development session – July 2025 (to provide update)

4. Recommendation(s)
The Quality Committee is asked to:
a) To gain assurance from this proactive assessment and plans to repeat this exercise in a more robust and timely manner
b) To note areas of good practice and areas of improvement in both the findings and the process
c) To agree for the ratings to be shared with the Black Country Provider Collaborative

1. BACKGROUND

The Care Quality Commission (CQC) utilise a Single Assessment Framework to assess all service types across the health economy. The assessment framework is aligned to each of the CQC core services. The Black Country Provider Collaborative have agreed to undertake a self-assessment across all four provider Trusts using the assessment framework. The primary objective of the collaborative self-assessment is to ensure that the system meet and exceed the standards set by the CQC. By working together, the Collaborative aim to identify strengths, share best practices and address areas for improvement across the system.
The CQC self-assessment is separated into 5 key questions (domains) to replicate the core service framework and method of inspection used by CQC. The assessments have been completed by the service leads and relevant staff with the expertise of the core services and regulated activity performed.

This report shares the findings of the second cycle of self-assessment across all 10 core services delivered by Dudley Group. The GP Practices that joined the Trust in October 2024 have also started their CQC self-assessment tool; however, due to a CQC inspection were unable to complete their review in time for submission with this paper.

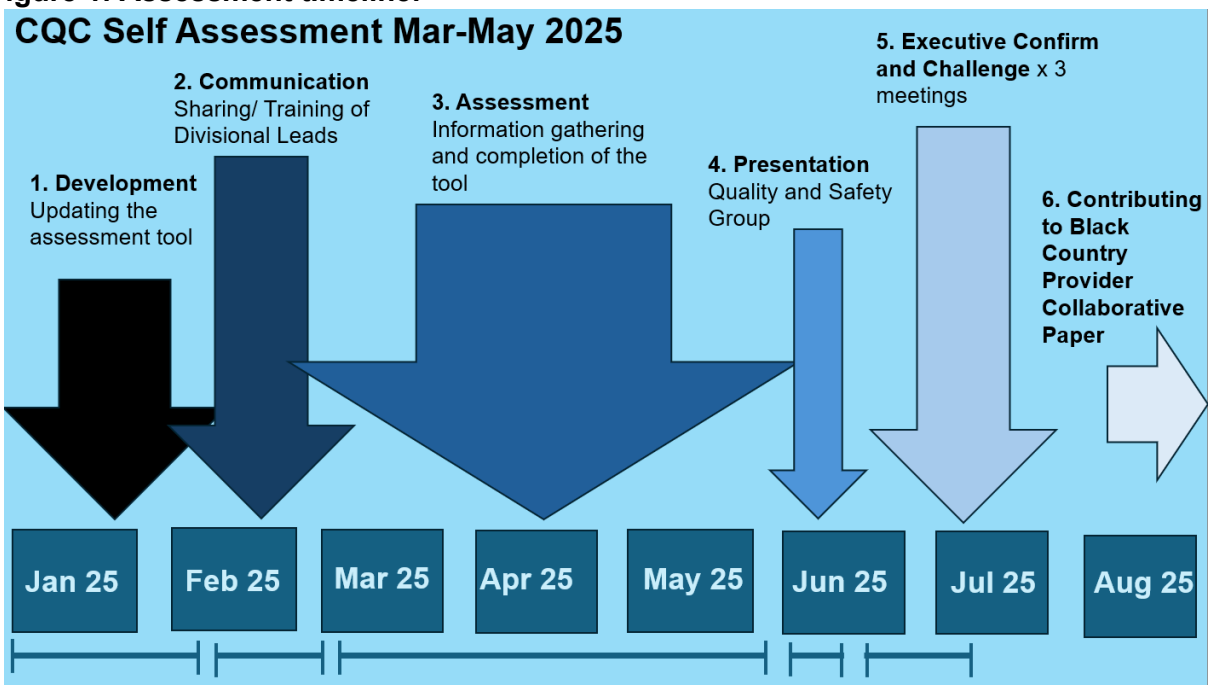
The Dudley Group 2nd Round of Self-Assessment

The Trust formally launched the second cycle of self-assessment through meetings with divisional leaders in February and early March 2025; all relevant stakeholders were invited to meet with the Compliance Team to discuss the process and requirements. Significant preparatory work had been undertaken by the Compliance Team ahead of these meetings; working with the other providers within the Black Country Provider Collaborative, with a particular focus on aligning our assessment tool with that used by Sandwell and West Birmingham.

Updates made to the assessment tool since the previous assessment round included additional clarity in defining quality statements within each key question (domain). This should support services with their understanding of CQC expectations, facilitating a more accurate assessment and rating. A scoring tool was also adopted in line with the CQC approach. Each quality statement is rated from 1-4 (1 ‘inadequate’; 2 ‘Requires Improvement’; 3 ‘Good’; 4 ‘Outstanding’).

A broad process plan was created to describe the key stages of the exercise (Figure 1).

Figure 1: Assessment timeline:



2. FINDINGS

All 10 core services have completed the self-assessment process and have assigned ratings in line with the CQC quality standards. Please see Appendix 1 for high level findings for each core service.

- Table 1 below illustrates the ratings assigned by the 10 core services across the Trust, following the initial self-assessment (Sept-Dec 2024).

- Table 2 below illustrates the ratings assigned by the 10 core services across the Trust, following the second self-assessment (Mar-May 2024).

- Table 3 below illustrates the ratings given to the Trust following CQC inspection activity during 2019 to 2023.

Table 1: Self-assessment ratings from Round 1 (Sept-Dec 2024)

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency Services	Good	Good	Good	Good	Good	Good
Medical care (including older people's care)	Good	Good	Good	Good	Good	Good
Surgery	Good	Requires Improvement	Good	Requires Improvement	Good	Requires Improvement
Critical care	Good	Good	Good	Good	Good	Good
Maternity	Good	Good	Good	Good	Good	Good
Services for children and young people	Requires Improvement	Good	Good	Good	Good	Good
End of Life care	Good	Good	Outstanding	Good	Good	Good
Community	Good	Good	Good	Good	Good	Good
Outpatients	Good	Good	Good	Requires Improvement	Good	Good
Diagnostic imaging	Good	Good	Good	Good	Good	Good

Table 2: Self-assessment ratings Round 2 (Mar-May 2025)

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and Emergency Services	Good ↔	Good ↔	Good ↔	Good ↔	Good ↔	Good ↔
Medical Care (including older people's care)	Requires Improvement ↓	Requires Improvement ↓	Good ↔	Good ↔	Requires Improvement ↓	Requires Improvement ↓
Surgery	Requires Improvement ↓	Good ↑	Good ↔	Good ↑	Requires Improvement ↓	Requires Improvement ↔
Critical Care	Good ↔	Good ↔	Good ↔	Good ↔	Good ↔	Good ↔
Maternity	Good ↔	Good ↔	Good ↔	Good ↔	Good ↔	Good ↔
Services for Children and Young People	Requires Improvement ↓	Good ↑	Good ↔	Good ↑	Requires Improvement ↓	Good ↔
End of Life Care	Good ↔	Good ↔	Outstanding ↔	Good ↔	Good ↔	Good ↔
Community	Good ↔	Good ↔	Good ↔	Good ↔	Good ↔	Good ↔
Outpatients	Requires Improvement ↓	Good ↔	Good ↔	Good ↔	Requires Improvement ↔	Good ↔
Diagnostic Imaging	Good ↔	Good ↔	Good ↔	Good ↔	Good ↔	Good ↔

Table 3: Current CQC ratings (from inspections)

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires Improvement	Good	Good	Requires Improvement	Good	Requires Improvement
Medical care (including older people's care)	Good	Good	Good	Good	Good	Good
Surgery	Requires Improvement	Good	Outstanding	Good	Good	Good
Critical care	Good	Good	Good	Requires Improvement	Good	Good
Maternity	Good	Good	Good	Good	Good	Good
Services for children and young people	Requires Improvement	Good	Good	Good	Good	Good
End of Life care	Good	Good	Good	Good	Good	Good
Community health services for adults	Good	Good	Good	Requires Improvement	Good	Good
Outpatients	Requires Improvement	N/A	Good	Good	Requires Improvement	Requires Improvement
Diagnostic imaging	Inadequate	N/A	Requires Improvement	Requires Improvement	Inadequate	Inadequate

Overall, the vast majority of the Trust core services have rated themselves as Good across the quality domains. Services that have rated themselves lower than that assigned by the CQC in their last inspection include:

Medicine:
Self-rated as **Requires Improvement** for safe, effective, responsive and overall.
In the previous round of self-assessment medicine rated themselves as Good across all key questions (domains).
CQC rated the service as Good in all areas in 2019.

Key concerns listed include:

- Improvement requires on Sepsis observations and treatment.
- Discharge safety work is ongoing.
- Medicines management improvement work ongoing.
- Nutrition and hydration scores are poor.
- Ongoing corridor care in use.
- Poor response times to complaints.

Surgery:
Self-rated as **Requires Improvement** for Safe; Well-led and Overall.
In the previous round Surgery rated themselves as Good for Safe and Well-led and Requires Improvement for Effective and Caring.
CQC rated the service as Requires Improvement for Safe, Outstanding for Caring and Good in all other areas, and overall, in 2019.

Key concerns listed include:

- Poor understanding of the chaperone policy.
- Resuscitation training compliance is below Trust standards.
- Poor overall compliance to mandatory training by medical workforce.
- Improved Sepsis management however still not meeting Trust targets.
- Poor compliance with bed rail assessment training.
- Serious concerns identified by trauma network peer review.
- Increased waiting list times for surgery.
- Discharge planning.
- Only one Professional Development Nurse for a number of directorates,

Outpatients:
Self-rated as **Requires Improvement** for Safe and Responsive.
The service rated themselves as Good for Safe in the previous self-assessment round (July-Sept 24) and Requires Improvement for Responsive. CQC rated the service as Requires Improvement for Safe but rated Responsiveness as Good in 2019.

Key concerns listed include:

- Capacity and demand staffing review is required.
- Ophthalmology backlog- currently being reported through Risk and Assurance.
- Appropriate off-site cover to support the deteriorating patient.

CYP:
Self-rated as **Requires improvement** for Safe and Well-led.
In the previous round the service rated themselves as Requires Improvement for Safe but Good for Well-led.
In the previous CQC inspection (2023) they were rated as Requires Improvement for Safe but Good for Well-led.

Key concerns listed include:

- NPSA bed rail improvement plan ongoing
- Continuation of hybrid working system for C2 (Digital vs Paper)
- Increased awareness and understanding regarding Martha's Rule
- Additional oversight currently required in the form of the Acutely Unwell Child group with assurance reporting to Risk and Assurance Group
- Poor staff surveys from C2
- The need to improve the management of risk actions and PaediCRID incidents

All core service ratings have been discussed with the Divisional leadership teams, shared at Quality and Safety Group and have been subject executive director led confirm and challenge sessions; where the core service leaders presented their rationale for the ratings.

2.1 Improvement Opportunities
Through the collation of the 10 core service assessments, it became apparent that there are learning opportunities at the core service level, Trust wide and across the system. Examples are detailed below.

Core service level:
Good Practice

- The use of medical and nursing huddles to share learning from incidents and complaints quickly and efficiently
- The use of interpreters
- Sustainability projects (from Critical Care)

Improvement Points

- Team awareness of financial constraints and the importance of improved productivity
- Local work plans to link into the new Trust strategy

Further detail on each core service assessment findings in terms of good practice and improvement areas are shared in Appendix 1

Trustwide:

- The need to work cross-divisionally to ensure that patients care is efficiently managed and patients can be discharged safely.
- Patient led services with the patient voice heard during meetings on a regular basis.
- Ensuring the accessibility and multi-lingual availability of patient information.
- The use of electronic dashboards to support quality care provision.

System-wide opportunities:

- The use of virtual wards, with access to multi-lingual services (in children's services).
- Quad leadership training to provide a solid leadership for services.
- System support with EPR access/ Badgernet for maternity represents an opportunity for risk reduction/improvement.

Themes identified across all core services will be shared at the system level to facilitate wider analysis and to link services with good practice to those that may require additional support/input.

3. REFLECTIONS ON ASSESSMENT PROCESS

The second round of assessment has been timelier than the first cycle, reflective of staffs' increased confidence/ familiarity with the process, as well as recognising the importance of the assessment.

Following the process changes made for the second round, further feedback from staff has been sought. One core service has requested that the information saved in the assessment tool remains within the next tool; to avoid having to re-start the whole process, and just update the outcome measures etc. Staff have also found presenting the draft outcomes of their assessments at Quality and Safety Group useful; as feedback provided in this forum helped to validate or influence their ratings, when benchmarked against other services.

Several leads have shared how they are utilising the tool as a 'live' document, updating this and the associated ratings as they gather new evidence, and actions/assurances are being generated.

Importantly, leads have advised that the tool enabled them to explore gaps they had not considered previously and this in turn will shape future workplans.

Caveats in process:

Although a standard assessment process was promoted through training and supportive meetings, there were several variabilities across the approaches and methodologies utilised across the core services:

- There have been variable levels of engagement with the completion of the assessment documents, resulting in variabilities in the robustness of evidence available to support the assessment statements. Core service leads advised that the capacity to undertake the assessment was the main limiting factor.
- End of life core service leads utilised an existing self-assessment method. Although the assessment was broadly translatable, they did not use the new framework; and evidence was not saved into the purpose built repositories.
- Larger core services such as medical care, community service, etc, which have numerous specialities/localities, were unable to effectively review every aspect of the core service, whereas more contained services, such as Critical Care, were able to robustly assess all elements of the service.
- Although the assessment tool and process aim to standardise ratings, subjectivity cannot be completely eliminated.

3.1 Strengthening the Assessment Process:

On a Trust and system level, feedback is being utilised to continually shape and strengthen the assessment tool. As new information is released from the CQC, the tool will be up-dated accordingly. The use of cross system peer reviews is also under discussion.

This second cycle of assessment has enabled the up skilling of staff involved and testing of methodologies, as a result subsequent cycles will be completed in a timelier manner. There is an ongoing discussion taking place regarding the next cycle in line with the Black Country Provider Collaborative, which will be starting around September/October 2025, with realistic time frames built in, along with support for services, particularly as this period will see the start of winter pressures.

Primary Care will be included in the next round of self-assessment to ensure that all Trust core services are captured. The recent CQC inspection will support the evidence required to accurately self-assess.

Work is ongoing to support teams to use the self-assessment tool provided by the Compliance Team, to ensure that the process and outcomes are standardised, across the Black Country. Advice and support will also be provided for services to enable them to save their evidence into repositories; this should be a multidisciplinary process; as it is evident that in previous rounds the work has generally been completed by nursing teams.

A guidance document is being created to support teams to understand why the process is necessary and how to repeat the process in the most effective way possible.

In September 2025, the self-assessment process will be audited by Trust internal auditors, learning from this will be included in subsequent rounds to improve assurance levels.

NB: This process has replaced the previous core service report that has been previously utilised by Dudley Group and presented at Quality and Safety Group biannually.

4. FOR DISCUSION AND CONSIDERATION

Committee are asked to gain assurance from this cycle of assessment in terms of the strengthened assessment process, the understanding of gaps and opportunities for improvement.

Committee are also asked to agree for Trust ratings to be shared with the Black Country Provider Collaborative to enable the next phrase of shared learning and theme analysis.

Appendix 1 Core Service Findings Overview

Core Service	Positive Findings	Improvement points (level of improvement required)
Urgent and Emergency Services	-Compliance to mandatory training for P1 and P2 -Transfer sheets audit 100% -Twice daily nurse and medical huddles documented -ED Clinic well established for follow ups -Fundamentals of care audit now underway -Extended learning of middle grade nurses -Good bereavement care given by teams -Posters in different languages available throughout departments -Being green information board -Monthly meeting with mental health partners -Learnings from incidents are shared at medical and nursing handovers	-Nursing vacancies and delays in recruitment -Nursing and CSW staffing regularly below agreed staffing levels -Long stays for patients awaiting mental health admissions -Work required to collect injury and violence data -NIC needs to be more identifiable in department -Improvement plans to be more regularly reviewed
Medical Care	-National benchmarking ongoing in different directorates -MDT approach to care Named nurse and consultant for adults and paediatric safeguarding to support teams in ED -Leadership development for matrons and deputy matrons -First Coronary Care to be nationally accredited in GSF -Nurse led bleep holder service for stroke patients -JAG accreditation for Endoscopy and Cardiology -AI in use in stroke and secretarial roles -Endoscopy part of green endoscopy scheme	-Adult resuscitation training at 76% -Concerns regarding discharge process- improvement ongoing -Continued improvement with e-obs compliance required -Delays in response to complaints -Implementation of TERP documentation -Improve knowledge and process around patients presenting with self neglect -Fast track discharges -Provision of specialist equipment for bariatric patients

	-Renal Kidney Network oversight reduced -Translator service available for immediate response -Development of community care navigation centre -Appraisal compliance	-Embed e-consent within medicine -Reduction in bank rates -Environmental sustainability -7 day working across aspects of MDT -Risk management QIA documentation
Surgery	-Quality confirm and challenge meetings held on a monthly basis -Weekly improvement huddle in gynaecology -Implementation of focus weeks- such as ulcer prevention and care/ falls etc -Referrals via sunrise for continuity of care -Launch of e-consent -Thematic review of diabetes -NOF improvement group demonstrated improvement in clinical effectiveness -Bespoke training initiated for DOLs -Dementia and learning disability champions across Division -Bespoke patient information leaflet -Electronic dashboard in ESH	-Timely Eobs -Compliance of sepsis screening, although improving -Poor understanding of chaperone policy -Mandatory training completion by medical workforce -Storage cupboards for medicines remain inadequate -Resuscitation training compliance <80% -Compliance with bed rails assessment training -Trauma network peer review identifying serious concerns regarding training for nurses and AHPs. -Large number of complaints received -Delays in accessing timely clinic appointments -Extended waiting lists/ times for surgery -Only 1 PDN for directorates
Critical Care	-Positive learning culture -Adherence to GPICS safe staffing -Education programme and development opportunities -Collaborative working across MDT -Follow up clinic established	-Input from parent teams for medical patients -Greater understanding of DOLS required -Greater adherence to IPC guidance -Delays in stepping down wardable patients-national outlier -Access to EPR for visiting teams

	-Positive feedback from patients/ families and low complaints/PALS -Excellent staff wellbeing support/ engagement -Timely management with incidents/ complaints -Patient forum to support service user led improvement -Several sustainability projects ongoing Good engagement with critical care network	-Lack of Physiotherapy provision -Staff knowledge to support mental health care for patients -Greater engagement with patient diaries -Availability of information in other languages -Involvement from parent teams and complex discharge
Maternity	-Good compliance with mandatory training (maternity specific) -Learning shared internally and wider within the LMNS -Maternity Incentive Scheme Year 6 achieved -Saving babies live care bundle achieved and assured by LMNS -Full participation in national audits -Improved mortality rates -Complaints well managed -Excellent bereavement service -Maternity Safety Champions at executive level -Family hubs launched across borough -EDI lead midwife driving focus on healthcare inequalities -Quad leadership training undertaken -Strong improvement culture	-Difficulty recruiting community midwifery posts -Challenges filling bank shifts -Safeguarding training below Trust standard -Maternity EPR still a barrier to share information across the system -Information not readily available in an accessible format -Limited MNVP in place -Staff survey results for medical staffing below trust average
Services for Children and Young People	-Consistently good mandatory training compliance -Engagement in neonatal and children's networks -Baby diary utilised on NNU to support FICare -NNU achieving safe staffing and QIS much improved	-Staff survey for C2 and medical secretaries below Trust standard -Robust management of risk actions and PaediCRID incidents

	-CAMHS assessment and support reducing admissions and LOS -Better collaboration with Paediatric ED and surgery teams -Children's services strategy -Evidence of responsiveness (Merry Hill, Family Hubs, Health Inequalities) -Multi-lingual access to paediatric virtual ward -Successful medical workforce recruitment -Innovation encouraged	-NPSA bed rail improvement plan for CYP- never event -Increased awareness and understanding of Martha's rule required -Ward cleaning audit for Mitie and Trust scores low -Acutely unwell assurance reporting -Greater research portfolio required -Improvements requires for NNU and C2 parents offer -Information available in other languages -Improve engagement with learning disabilities team -Outlier for HbA1c status
End of Life Care	-7 day working -Nacel Results -Implementation of GSF -Active audit programme -50:50 cancer: non-cancer in acute referrals -EOLC strategy in place -Level 2 priority training -MDT working demonstrated including working with the LD team	-Review of datix/ incidents required (local) -Fast track discharge actions (Trust) -Epaccs-ICB 6 monthly report to Trust EOLC group -GSF metrics transition from sunrise document to flowsheets (further work required) -Additional work with chaplaincy (local) -Fast track discharge added to risk register -Psychology contract under review -Support from mortuary required for additional learning (Trust)
Outpatients	-Mandatory training compliance -Chaperones trained and available with posters to inform patients -Learning from incidents shared Directorate wide	-Staff review required (local) -Improve FFT responses (local) -Improve senior cover for off sites and review SOPs relating to deteriorating patients (local) -Patient flow for ophthalmology (local)

	-Health records are managed in line with NHSE record management code of practice -Increase in Greatix -Learning from complaints discussed at weekly meetings and disseminated to teams -Good use of interpreters	-Ensure all SOPs and guidelines are up to date -Large number of complaints
Community	-Community deteriorating patient; infection control and safeguarding training target met -Lone working devices implemented -Community capacity process -Clinical audit plan in place (17 planned audits) -Daily huddle for capacity -Single point of access for services	-Patient autonomy risk assessment under review -SIT/ DOC pilot roll out required to support patient engagement -To implement continuous learning and improvement practice monitoring -Holistic checklist for district nurse teams to be relaunched -concern regarding community representation at NICE meeting-baseline to be reviewed and potential risk raised -Improved participation in research required -Improved FFT feedback required -KPIs not met for waiting time across some AHP services
Diagnostic Imaging	-Robust IR(ME)R procedures -Trust mandatory training and compliance to radiation safety legislation >90% -Manned observation areas -Strengthened staffing	-IR(ME)R structure within wider Trust (Trust) -Persistent facility-based incidents lowering IPC rating (Trust) -Staff awareness of DoLs (Local) -Move to electronic/ paperless communications (Trust)

	-Medicines Management- dedicated pharmacy technician -Consent processes up to date -Mental health champions with DoLs information available -Patient centred service -Good communication with patients during examinations -Active learning from complaints -Accessible service for all patients -Shared vision and values -Collaborative working with strong relationships with GPs and neighbouring Trusts	-Sewage flooding within department -Auditing of outcomes from interventional radiology -Improve outcomes of staff satisfaction survey -Improvement in shared learning from complaints -Improved referral guidance required (launch of iRefer) -Full roll out of 'your imaging' to access documents and reduce paper -Team awareness of financial constraints and importance of improved productivity

Department of Health & Social Care

NHS

Application to take part in the National Neighbourhood Health Implementation Programme

All fields in this document should be completed. THE QUESTIONS AND YOUR ANSWERS CONSTITUTE THE CRITERIA UPON WHICH YOUR APPLICATION WILL BE JUDGED

Applications should be emailed to england.neighbourhoodhealthserviceteam@nhs.net by 8 August 2025.

Place details

1. Current ICS your Place is part of: Black Country

2. Full name of the Place on which the project will focus

(please include details on footprint including population size, local authority alignment and number/configuration of any integrated neighbourhood teams):

Dudley Metropolitan Borough Council (DMBC) is a unitary authority and has been a member of the West Midlands Combined Authority since 2016.

DMBC provides essential services like housing, education, and social care to over 323,495 residents (2021 Census) across 24 wards, operating under a "no overall control" political leadership.

The Dudley GP Practice Registered Population is greater at 343,161 patients with the differences between the two, important for planning healthcare services and understanding local demographics.

In Dudley, 26% of the Lower Super Output Areas (LSOAs) fall within the 20% most deprived in England. This equates to 52 / 201 areas. 28.1% of Dudley residents live in areas that are within the 20% most deprived. Consequently, for many years partners have taken a multi-faceted approach focusing on targeted interventions, community engagement, and addressing the root causes of deprivation. This involves leveraging data, tailoring services, and fostering collaboration across various sectors.

Despite efforts by all partners outcomes remain poor in comparison with other parts of the West Midlands and within England in some significant areas that are pertinent to the partnership.

Childhood Development: In 2022/23, 40% of Dudley's children screened at 2-2½ years did not achieve a good level of development, which is substantially higher than the national average (21%). This gap has widened over recent years, with clear inequalities by deprivation and ethnicity emerging early in life.

Healthy Life Expectancy: Dudley residents, particularly those in more deprived areas, experience lower healthy life expectancy (the number of years lived in good health). This means people are living longer, but a greater proportion of their lives are spent in poor health. The healthy life expectancy in Dudley was 62.9 years for males and 62.7 for females (2020), which is lower than the national average.

General Poor Health: The 2021 census revealed that 6% of Dudley residents reported being in "bad or very bad" general health - higher than the national average of 5.4%. This highlights a significant portion of the population experiencing poor overall health

Prevalence of Chronic Diseases: Dudley has a higher recorded prevalence of conditions such as hypertension 18%, diabetes 7%, chronic kidney disease, chronic heart disease 4%, cancers 2%, respiratory illnesses 9%, and depression 18% compared to national averages.

Unpaid Carers and Disability: A notable proportion of the population provides high levels of unpaid care (5.4%), and 8.3% were classed as disabled in 2021, indicating a significant burden of health challenges on individuals and families.

Health Behaviours: Higher rates of adult and child obesity, 26.3% of year 6 children are obese, and lower levels of physical activity, contribute to poor health outcomes in the borough.

These poor outcomes are often rooted in the wider determinants of health, such as income, employment, education, housing, and access to services. DMBC and its partners are working to address these inequalities through various strategies, including the Financial Wellbeing and Mitigating Poverty Strategy and through the 3 Health and Wellbeing Board Goals addressing School Readiness, Cardiovascular Disease and Cancer Screening. The Dudley Health and Care Partnership (DHCP) have 7 shared KPIs:

1. Emergency admissions to hospital for people aged over 65 per 100,000 population
2. Average length of discharge delay for all acute adult patients
3. Long-term admissions to residential care homes and nursing homes for people aged 65 and over per 100,000 population
4. Speech Language and Communication development at 2-2.5 years development check
5. Dementia diagnosis rate
6. Controlled hypertension & diabetes
7. Early cancer detection

For several years Dudley has been working on neighbourhood work as part of the NHS England New Care Models Vanguard Programme. Efforts to support primary care colleagues, the creation of multidisciplinary team working, and integrated neighbourhood teams have been recognised and are highly regarded. In line with the 10 Year Health Plan we will enhance what is already established.

Dudley has 6 Primary Care Networks geographically aligned to the DMBC. PCNs work together to provide proactive, personalised, and integrated care, bringing services closer to people's homes and address the changing health needs of the population.

At a partnership level Kings Fund identify three distinct approaches to neighbourhood working.

- The NHS version focuses on coordinating health and social care services.
- The local government version involves broader multi-agency collaboration to support vulnerable individuals and families with complex needs.
- The community-led version empowers residents to tackle their own issues by leveraging local strengths and assets.

To explore how Dudley's neighbourhoods interconnect and work together and how this can be improved to deliver the 10 Year Health Plan, the Dudley Health and Care Partnership ran a workshop on July 23rd attended by over 100 residents, professionals, volunteers and wider stakeholders.

Overarching Concepts were:

· Community as the Delivery Model - community-led solutions, trusted connectors, place-based investment

· Neighbourhoods as Ecosystems - interaction of physical, social, health, and economic factors

· Flexible - each neighbourhood's identity and needs are distinct, based on how people move, live, and engage—not rigid boundaries

We will use this insight to inform our plans for the future.

Within our 6 PCN's Dudley has 11 established, standardised integrated neighbourhood teams.

Our Integrated Neighbourhood Teams (locally named Community Partnership Teams [CPTs]) have evolved from Multi-disciplinary Teams to Integrated Care Teams that include dedicated leadership, care co-ordination and voluntary sector social prescribers which enable the teams to look at the whole needs of the person, not just their health requirements. Individuals who were previously socially isolated were connected back into their local communities; small non-health related problems were resolved, which then gives confidence to individuals and reduces their utilisation of healthcare (up to a 30% reduction in primary care visits); patients report how their quality of life has improved; and many now contribute more by being part of social groups and thus adding social value back into their community. Our CPT/INTs are demonstrating improved patient outcomes and a reduction in A&E attendances and conveyance by West Midlands Ambulance Service.

As part of the Community Mental Health Transformation Programme, Primary Care Mental Health Teams have been established and will form the foundation of mental health support within the Community Partnership Teams which will be complimented by Consultant Psychiatrists/CNS for people with complex mental health requirements.

3. Neighbourhoods within the Place

(please include whether each neighbourhood has a clinical lead, managerial lead and admin support identified):

Clinical Leadership to Dudley Place: Dr Lucy Martin

Managerial Lead: Kat Rose

Support: Sally Cornfield

Brierley Hill PCN Clinical Lead: Dr Ruth Tapparo

Brierley Hill PCN Managerial Lead: Anneka Page

Brierley Hill PCN Admin Support: Amanda Coyle

Dudley & Netherton Clinical Lead: Dr Sarah Fung

Dudley & Netherton Managerial Lead: Samson Arishe

Dudley & Netherton Admin Support: Amanda Coyle

Halesowen Clinical Lead: Dr Royce Chan

Halesowen Managerial Lead: Katie Arnold and Sadie Meredith

Halesowen Admin Support: Amanda Coyle

Kingswinford & Wordsley Clinical Lead: Dr Balraj Mavi

Kingswinford & Wordsley Managerial Lead: Radhwan Hoque

Kingswinford & Wordsley Admin Support: Lubna Somra

Sedgley, Coseley & Gornal Clinical Lead: Dr Girish Narasimhan

Sedgley, Coseley & Gornal Managerial Lead: Ella Thompson

Sedgley, Coseley & Gornal Admin Support: Amanda Coyle

Stourbridge, Wollescote & Lye Clinical Lead: Dr Richard Evans

Stourbridge, Wollescote & Lye Lead: Suzanna Ball

Stourbridge, Wollescote & Lye Admin Support: Mearr Anderson

In addition, Dudley funds 11 Community Partnership Team (INT) Clinical Leads

4. **Chief Executive and Local Authority Chief Executive who will act as the co-sponsors:** (full name, title and contact details)

As a requirement of this application, systems will be expected to:

- fund a co-ordination function for each neighbourhood (named clinical lead, managerial and administrative support)
- provide essential backfill for staff and similar expenses (travel, accommodation, venues) to participate in the National Neighbourhood Health Implementation Programme
- provide enabling support to progress Neighbourhood Health e.g. analytical support (see FAQs)
- provide a Neighbourhood Health implementation coach and project lead

Balvinder Heran, Chief Executive, Dudley Metropolitan Borough Council, Council House, Priory Road, Dudley, DY1 1HF balvinder.heran@dudley.gov.uk

Mark Axcell, Chief Executive, NHS Black Country ICB, Black Country ICB, Civic Centre, St Peter's Square, Wolverhampton, WV1 1SH m.axcell@nhs.net

5. **Mayoral combined authorities**

If you are in a mayoral combined authority, please confirm that the mayor is aware of and supportive of your proposal.

Dudley Council has been a member of the West Midlands Combined Authority since 2016, which provides strategic leadership and coordination for certain functions across the wider West Midlands area. Dudley Council retains responsibility for most local government functions.

The West Midlands Mayor Mr Richard Parker is aware and is in support of the Dudley proposal.

6. **Neighbourhood Health implementation coach and project lead:**

(full name, current role and contact details)

Each Place will need to supply a person who has existing improvement, collaboration and leadership skills and is able to work with their own initiative (see role description in the FAQs). They will be assigned full time for 12 months to act as the local Place coach, as part of the national network of Neighbourhood Health project leads, supported by the national team.

Joanne Taylor, Strategic Commissioning and Transformation Lead joanne.taylor21@nhs.net

Joe has been leading this work in Dudley for over 8 years via an existing Community Partnership Team Transformation Group with all partners organisations represented. A Project Team is already in place to support Joe and cover leave etc. Dudley's Chief Integration Officer is an executive level position at The Dudley Group NHS Foundation Trust's (DGFT) and is vice chair of DHCP, ensuring the voice of partnership is heard and our mission of "Community First; Hospital only when necessary is recognised and embedded at Board level across health and care.

Place background information

Your application in local context

Please specify the following on this application form **(strictly no attachments or presentations)**.

7. Does your Place have a devolved budget from the ICB? If so, how is this organised and what scope of services does it cover? (max 150 words)

Yes. The ICB has delegated responsibility to its Dudley Managing Director for the commissioning budgets relating to the following out of hospital/neighbourhood health services:-

- Community services for adults
- Community services for children
- End of life/palliative care
- Intermediate care
- Voluntary and community sector services

This includes services forming the health element of the BCF.

This delegation is exercised through a joint ICB/Council Integrated Commissioning Committee.

The scope of services provided the basis for evolving into provision by an IHO.

8. Do you have existing data sharing agreements between the constituent statutory organisations in this application, and if so, what do they cover? (max 150 words)

- Relevant agreements in place to support current ways of working at population health management level and inter-organisational direct patient care.
- Agreements support Community Partnership Teams (Integrated Neighbourhood Teams).
- Plan to revisit agreements and map current position in August for potential adoption of new ways of working with NHS Digital Cohorting Team.
- Black Country ICB developing tools for population health management, including data sharing agreements for patient-level data.
- Active discussions with Local Medical Committees (LMCs) across the Black Country.
- Section 251 agreement being progressed by the ICB.

9. Do you have a risk stratification tool rooted in primary care data that would enable you to identify the adults with multiple long-term conditions and rising risk within the Place that will be the focus of this early work? Please describe (including if you have a section 251 agreement for use of linked patient level data for population health i.e. for both direct care and secondary use)? (max 150 words)

- Our CPT/INT Teams are working NHS Digital Cohorting as a test case to develop a risk stratification approach – future potential to be applied nationally.
- BCICB has a PHM approach that models current and future condition / comorbidity progression in diabetes, including associated service use and costs - approach will inform strategic commissioning (service demand management / cost avoidance).
- BCICB will work with PCNs to pilot population cohort searches.
- All GP practices, Trusts and Social Care have signed up to the Shared Care Record.
- Practices signed up to National Direct Enhanced Services which incentivises proactive care planning, targeted interventions, digital / data infrastructure. Practices use tools / analytic platforms to support PHM, risk stratification and segmentation.
- Condition specific CPT/INTs utilise risk stratification approaches to identify cohorts for management.
- Post pandemic (in line with NHS England guidance) we identify and prioritise patients at higher risk of CVD for their NHS Health Check.

10. Describe any existing forum for CEOs of the different statutory organisations and partners (e.g. VCSE, providers) in your Place that meets regularly to support the implementation of Neighbourhood Health (ways of working, function, responsibilities, frequency). (max 150 words)

Forum	Way of Working	Function	Responsibilities	Frequency
Health and Wellbeing Board	Statutory Committee	• Forum where political, clinical, professional and community leaders come together to improve the health and wellbeing of the population and reduce health inequalities.	• Production of the JSNA. • Produce and oversee delivery of joint health and wellbeing strategy.	Quarterly
Health and Care Partnership	Collaborative arrangement	• Effective use of the combined resources through proposing budget utilisation to the Integrated Commissiong Committee. • Integration and Collaboration	• Arranging and delivering health and care services. • The Board Executive Group is the "engine room" of the Partnership • Delivery of health and care elements of the HWBB strategy. • Shared priorities include Neighbourhood Health	Monthly
Forging a Future Executive	Collaborative arrangement	• Oversight of Dudley Borough Vision "Forging a future for all" (2030)	• Ensure progress against 7 aspirations which cover the wider determinants of health • Provides oversight of the strategic boards in Dudley	Quarterly

11. Describe existing examples of integrated working in your Place or Neighbourhood and the results obtained. (max 500 words)

<table>
<tr><th>Example</th><th>Results</th></tr>
<tr><td>Community Partnership Teams (INTs)</td><td>• ICB BI evaluation demonstrated intervention group had 279 emergency admissions less than a random matched Control Group, reducing the current yearly growth (2% per annum) by one third.
• Care home residents registered with Trust Practices:
  • Sustained reduction in-patient admissions per week - 77.9 to 68.6.
  • Sustained reduction in ED attendances - 100.1 patients per week to 89.4.</td></tr>
<tr><td>Family Hubs Integrated First 1001 Days Teams - personalised care</td><td>• Statistically significant increase in infants totally/partially breastfed / reduction in infants receiving no breast milk as part of a coordinated programme to give every child the best start in life.</td></tr>
<tr><td>Integrated Falls Prevention Pathway – structured medication reviews (SMR)</td><td>• Evaluation of 554 SMR's for care home residents (at risk of fall) - 703 medicines were stopped,129 were reduced.</td></tr>
<tr><td>Primary Community Secondary Care Interface Group – senior clinical leadership group</td><td>• Integrated pathway redesign / unintended consequences considered at outset
• Principles of Collaboration embedded
• Improved relationships</td></tr>
<tr><td>Dudley CVS's High Intensity User Service supports vulnerable adults with frequent ED use</td><td>• In 2023/24 113 individuals supported saving the NHS £593,000 by reducing unnecessary hospital admissions.</td></tr>
<tr><td>Life in Lye - combines asset-based community development, co-production to address wider determinants of health/ increase access to services, at neighbourhood level. System partners work alongside residents, traders and VCSE groups.</td><td>• Improved awareness of / access to services (Roma community),
• Professionals supported to recognise and address barriers to access/Increase in community-led activities
• Greater collaboration/community insight
• Community of practise and coaching for community leaders - supporting people to think and act as one 'system'.</td></tr>
<tr><td>Integrated Primary Care Pharmacy Team (embedded in GP Practices)</td><td>• Increased efficiency / productivity,
• Enables a focus on PHM through medicines optimisation e.g. lipid optimisation in cardiovascular disease</td></tr>
<tr><td>Adult Social Care Project Team -provides independent Social Workers undertake Social Care Assessments to enhancing effectiveness bed provision.</td><td>• Steady reduction in the average length of stay to an average of 30 days at the end of March 25, and during 2025/26 averaging 26 days.
• Previously LOS in pathway 3 was higher than national targets / number of placements exceeding a stay over of 10 weeks.
• Improved flow / outcomes from community beds have a positive financial impact</td></tr>
<tr><td>Joint Community Palliative Care Team – EOL support for patients that meet the NHS Continuing Healthcare criteria.</td><td>• Comprehensive package of care to patients who choose to be cared for in their own home.
<table><tr><td colspan="5">Number of End-of-Life patients supported per year</td></tr><tr><td>2020</td><td>2021</td><td>2022</td><td>2023</td><td>2024</td></tr><tr><td>865</td><td>912</td><td>747</td><td>768</td><td>793</td></tr></table></td></tr>
<tr><td>WorkWell - support residents with health conditions / disabilities to find or retain employment to boost their wellbeing.</td><td>• 168 residents started – 42% from CORE20
• 26% have completed a plan</td></tr>
<tr><td>Community Frailty Intervention Team</td><td>• Comprehensive geriatric assessment to people identified with risk factors contributing to frailty.
• Right services at the right time to prevent escalation / unnecessary admission to hospital.</td></tr>
<tr><td>Right Care, Right Person</td><td>• Joint development of MOUs / aligned crisis policies
• 23% reduction in Section 136 MHA detentions from November
• £800k in system savings, improved patient outcomes through least restrictive pathways</td></tr>
</table>

12. What do you hope to achieve from being part of the National Neighbourhood Health Implementation Programme? (max 150 words)

- Embed culture and capability to deliver a Neighbourhood Health service.
- Measurable impact on health outcomes/patient experience, and service sustainability by using shared metrics and evaluation methods
- Better access for patients through Hub working with adjustments for speciality need, mental health etc.
- Reduction in waiting times through hub working - provide access, specific appointments for need areas, co-ordinated and clear safeguarding processes.
- Health needs and education to be addressed.
- Expanded workforce.
- GP directorship in the progress of neighbourhood health services with GPs working at scale with a left shift of funding
- Opportunity to test/refine new approaches to PHM, workforce planning and partnership working, ensuring they are practical and scalable in our local context
- Faster growth for proactive, community-based care and successful initiatives
- Access to national best practices and solutions, check and challenge
- Align local efforts with national priorities to influence national direction of travel
- Deeper collaboration with partners and NHSE
- Engaged stakeholders, especially our residents
- Enhanced capacity for change within neighbourhood teams by addressing structures and policies but also culture and leadership.

13. What will you contribute to the National Neighbourhood Health Implementation Programme that other Places can learn from? Please provide details of the specific interventions that have delivered results. (max 200 words)

- Mature model / standard operating procedure / contractual mechanisms for Community Partnership Teams (INTs) including Community Pharmacy.
- Acute Respiratory Infection Hub – same day primary care access hub. NHSE exemplar.
- Dudley Quality Outcomes for Health – local primary care contract delivers improved population outcomes
- Contractual mechanism to embed neighbourhood model with primary care
- DGFT provides acute, community and two primary care contracts (GMS & APMS)
- Approach to collaboration at a place / system through our Primary Care Collaboratives and the BC Primary Care Transformation Programme

Learning from:

- Voluntary sector commissioned social prescribing within our PCNs enhancing social, economic, environmental well-being. Ring fenced funding enables social prescribers to connect people to funded groups, addressing frequent GP attenders' needs.
- Our approach to Primary Care Research
- Dudley Engagement Group, a monthly meeting with over 100 members from a broad range of stakeholders.
- "I-Can Dudley" award-winning programme - recruits local unemployed people into NHS with LA Social Care roles with career pathways from health into hard to fill social care roles
- BCICB commissioning of DGFT via a Good and Services Contract
- Award winning care examples from our Integrated Primary Care Pharmacy team

14. How will you reach, engage and improve outcomes for the 20% most deprived population as identified by the Index of Multiple Deprivation (IMD)? (max 200 words)

- Via Integrated Neighbourhood Hubs coproduced with our residents
- Using existing tools to identify cohorts i.e. diabetes supported by fully engaged primary care teams who are keen to reduce health inequalities / engage with patients / improve outcomes
- Expanded reach of CPT/INTs via a proactive approach and a PHM response.
- Our voluntary and community sector is embedded in our partnership; through direct service delivery, building community relationships, and advocating for systemic change they reach residents that statutory agencies are unable to.
- GP lead for health inequalities supported by PCN health inequalities leads, using analysis of local patient health records, identify patients living in areas with higher IMD to provide reasonable adjustments to overcome barriers preventing engagement.
- Area-based Local Authority Community Development Workers have extensive networks and trusted relationships in neighbourhoods, enabling reach / engagement of those most at risk of poor health outcomes.
- Innovative neighbourhood approaches are enabling greater collaboration and embedding strength-based approaches such as asset-based community development, co-production around the wider determinants of health and increasing access to services.
- 0-19 service developed caseloads using the principle of universal proportionalism. Data demonstrates improved outcomes; learning shared via Commissioning Community of Practice to commissioning our Neighbourhood services in this way.

15. How will you share learning within your System? (max 200 words)

- We disseminate info through seminars, master classes, workshops, partner networks (LGA, ADASS, ADCD, ADPH), use of DGFTs research capacity etc.

- Collaborative working is firmly embedded within the BC, with opportunities to share learning and best practice. We formally meet monthly as an Action Learning Set allocating specific time for staff to learn and share and collaborate daily across the system via shared digital platforms, using NHS Learning Hub for resources and discussions.

- BCICB Out of Hospital Programme Board will provide robust governance reporting arrangements to ensure accelerated learning is embedded across our system. We share dashboards and case studies to inform decisions.

- We share learning through a Commissioning "Community of Practice."

Partners are active members of the following Collaboratives:

- Dudley Primary Care
- Mental Health/LDA
- BC Primary Care
- BC Provider

- Coproduction is core to our transformation. On 23/07/25 the Partnership hosted a workshop exploring the 10-Year Health Plan and its vision for neighbourhood health hubs. Over 100 attendees from all partners, including resident took part in a vibrant and collaborative session. Ideas and feedback shared during this event will shape the future of neighbourhood health. We will continue to engage with all stakeholders in this way to share learning.

16. Please tell us about any other enablers you have implemented or are progressing to support sustaining or scaling neighbourhood working. For example, shared digital patient record, pooling of resources or estates, supporting GPs to work at scale and the development of neighbourhood and multi-neighbourhood providers, left shift of funding, training and development, Neighbourhood Health approaches with other specific population cohorts. We would be grateful if you could provide specific information on any local assets you have already that could support meeting the commitment to have a Neighbourhood Health Centre in every community, as set out in the 10 Year Health Plan. (max 300 words)

- Dudey has strong GP leadership embedded within our CPT/INT model with dedicated sessional arrangements.
- Dudley PCC have approved a Primary Care development plan, and conversations have started regarding neighbourhood and multi-neighbourhood providers.
- DGFT provide two GP Practices with associated services including research and have supported turnaround of practices in difficulty, and bespoke support offers to each local practice request.
- Well established Clinical Pharmacist workforce to allow streamlined care
- The Black Country ICSs SHCR platform enables unified access to patient records across all providers, supporting joint care planning and decision making across INTs to deliver timely informed care, supporting segmentation and risk stratification for targeted interventions.
- Patients with lived experience have coproduced group clinics for fibromyalgia using ARRS and DGFT specialists to support resilience and reduce inappropriate use of GP appointments
- Family Hubs have paediatric neurodiversity clinics – moved out of hospital to an environment more suitable to family's needs
- Diagnostics and other services at places our communities already go - shopping centre.
- Multiple buildings, estates and assets - providers are already co-located enabling opportunities for multi-disciplinary working.
- Community Diagnostic Centres will provide the infrastructure to support further expansion of community-based diagnostics and care.
- Dudley Improvement Practice Team provide a strong quality improvement framework to support the programme. A 'Hospital to Community' improvement programme has already commenced.
- CPT/INT leads are working with NHS Digital to map CPT/INT pathways to identify areas where digital support can improve outcomes and make efficiencies - working with the Cohorting Team to test ways to identify patients to identify patients at risk of developing long-term conditions.
- GPs offer personalised neighbourhood-based support services

Assets:

- 5 Family Hubs
- Voluntary, Community and Faith Organisations
- Community Development Workers
- Strong mature partnerships / engaged stakeholders
- Analytical & Technical support

17. Please list any other national pilots or initiatives you are involved in. (max 150 words)

- Family Hubs/Start for Life
- Sport England – Place Change Makers
- National Frailty Improvement Collaborative
- WorkWell
- Volunteer For Health
- National GIRFT Further Faster 20 Programme
- NHSE Validation Sprint - Waiting List Validation
- Community Diagnostic Centre (CDC) being delivered

18. Please identify any particular aspects of Neighbourhood Health (in addition to the initial shared priority of adults with LTCs and risking risk) that you are particularly interested in developing or contributing to (either specific population cohorts, or enabling agendas such as financial flows, digital, workforce, estates, supporting GPs to work at scale and the development of neighbourhood and multi-neighbourhood providers). (max 150 words)

- Supporting the 10yr plan with shift of resource – supporting GPs to work at scale
- Dudley's "Community First" commitment is driving transformation. Plans to shift financial resources to neighbourhoods - reactive to proactive care.
- Already commenced discussion with residents/communities
- CPT/INT leads partnering with NHSE to integrate digital resources into INTs for improved patient care, efficiency, and communication, with process mapping scheduled for August 4th.
- Established frailty and end of life pathways

- Shift from disease to prevention by testing innovative solutions for behavioural change and supporting people to better self-manage / through early intervention.
- GPs with special interest offering services / co-clinics with consultants
- Improving health literacy

- Expand Children's CPT/INTs to include children missing in education / emotional health and wellbeing alongside physical health.
- Care Home CPT/INTs currently cover 2/3rd of Care Home residents - will scale this to offer the service to all residents.
- Adolescents with addiction - working with education.

Declaration

This is to be completed by all CEOs (or equivalent) and PCN clinical directors in each constituent organisation in your Place.

We collectively agree to:

- endorse this application to join the National Neighbourhood Health Implementation Programme
- support the Place team to deliver the objectives of the programme
- contribute to nationwide learning, sharing and capability building for Neighbourhood Health

We commit to the continued implementation of Neighbourhood Health, including assisting other Places in subsequent phases of the work.

1.

Constituent organisation	Dudley MBC
Name and role	Balvinder Heran, Chief Exec.
Signature	
Date	30/7/2025

2.

Constituent organisation	Black Country ICB
Name and role	Mark Axcell, CEO
Signature	
Date	5.08.2025

PCN – Brierley Hill

Name and role	DR. RUTH TAPPARO PCN CD.
Signature	
Date	30/7/25.

PCN – Dudley & Netherton

Name and role	DR. SARAH FUNG DNPCN CD
Signature	
Date	23.7.25

PCN – Halesowen

Name and role	ROYCE CHAN
Signature	
Date	29/7/25

PCN CD – Kingswinford & Wordsley

Name and role	Dr BALRAJ MAVI - CLINICAL DIRECTOR
Signature	
Date	31/07/2025

PCN CD – Sedgley, Coseley & Gornal CLINICAL DIRECTOR

Name and role	Dr. GIRISH NARASIMHAN
Signature	
Date	28/07/2025

PCN CD – Stourbridge, WOLLESCOTE & LYE

Name and role	DR RICHARD EVANS SWLPCN CD
Signature	
Date	23/07/25

Dudley Health and Care Partnership (LA & ICB CEOs on page 11)

Chair – Dudley Council for Voluntary Services

Name and role	Andy Gray Chief Executive
Signature	
Date	28th July 2025

Vice Chair – The Dudley Group of Hopsitals NHS Foundation Trust

Name and role	Kat Rose Chief Integration Officer
Signature	
Date	28. July. 2025

The Dudley Group of Hopsitals NHS Foundation Trust

Name and role	DANE WAKE, CHIEF EXECUTIVE.
Signature	
Date	28 July 2025

Black Country Healthcare NHS Foundation Trust

Name and role	MARSHA FOSTER CEO
Signature	
Date	1st AUGUST 2025

Chair of the Dudley Primary Care Collaborative

Name and role	RACHAEL THORNTON CHAIR LPCC
Signature	
Date	30/7/2025.

Healthwatch Dudley

Name and role	Jason Griffiths Chief Officer
Signature	
Date	28th July 2025

West Midlands Combined Authority Mayor – support for Dudley NNHIP Application

Name and role	Richard Parker, Mayor of the West Midlands
Signature	
Date	5th August 2025

Neighbourhood Health Maturity Self-assessment

June 2025

If you have any enquiries about this pack, please contact the Community Care Team
england.communityhealthmidlands@nhs.net

Neighbourhood Health Maturity Self-assessment

Briefing

Purpose	The purpose of this tool is to support your System level self-assessment of your current level of maturity with regards to Neighbourhood Health. It will also be used to support dialogue between yourselves and the Regional Programme in terms of joint actions and support, alongside learning from across the Midlands Region where there is identified good practice.
Scope	The self-assessment should be carried out at System Level, focusing at either Place and/or Neighbourhood level, and INT/MDT and Service coverage in relation to the total population of the System. For this baseline assessment your responses should focus on the 2 to 4 % of Complex Patients (Adult and CYP) that are at risk of long-term admissions to either Hospital or Care Homes.
Timeline Checkpoints	Systems are asked to complete a baseline self-assessment, using the criteria set out in this document to determine the current level of maturity, by end-of June 2025 and return via the Midlands Regional ROC by 12:00, on the 24th July 2025. The Self-assessment will be re-run, late Q3/early Q4.
Measuring outcome	The baseline assessments will be used to agree a programme of support with the Regional Hospital to Community (H2C) Programme, and to assess progress at year-end.

Neighbourhood Health Maturity Self-assessment

Briefing continued

2025/26 Delivery Requirements, as set out in the National Neighbourhood Health Guidelines

- Standardisation and scaling of the initial 6 components

- Agree locally what specific impacts systems will seek to achieve during 2025/26, including as a minimum:
  - improving timely access to general practice and urgent and emergency care
  - preventing long and costly admissions to hospital
  - preventing avoidable long-term admissions to residential or nursing care homes

- Supporting adults, children and young people with complex health and social care needs who require support from multiple services and organisations

- NHS England » Neighbourhood health guidelines 2025/26
- NHS England » Guidance on neighbourhood multidisciplinary teams for children and young people
- NHS England » Standardising community health services

Neighbourhood Health Maturity Self-assessment

Briefing continued

Points to note in completing this tool

1. The Maturity Framework is structured to follow the Core Components and Enablers of the Neighbourhood Health Guidance. It is recognised that there maybe some overlap between the statements within the core components and Enablers that have been developed. This is inevitable when viewed via an implementation perspective and should be used to reinforce the co-dependencies between components and outcomes
2. Selection of the self-assessed level of maturity is a judgement, not an absolute decision. Systems will find that they have many elements across the maturity continuum, supported by local evidence. What is important, is that in completing the assessment, systems have a clear view on the actions they need to take to progress implementation, alongside the support that would be beneficial from the Regional Programme. Whilst helpful for your system to acknowledge maturity across the continuum, the focus of year 1 is to fully meet the ‘starting’ maturity for the identified population of 2-4% implementing INT/MDTs
3. Your final ‘judgement’ of maturity in this baseline assessment should be determined in relation to the 2025/26 specific requirements,. The framework will facilitate a wider assessment in future years, following publication of the ’10 Year Plan for Health’
4. When completing the assessment, please outline the local evidence you have used to determine your judgement in relation to Maturity.
5. Prior to submitting your completed assessment, please ensure that it has been moderated across the organisations and functions involved in implementing Neighbourhood Health

Neighbourhood Health Maturity Self-assessment

These are the six core components of a successful neighbourhood as per the Neighbourhood guidance.
Each neighbourhood can assess themselves against the **six core** components and the **four Enablers (***System Architecture and model of care, Workforce, Clinical and professional leadership and Digital***)** and score themselves on a scale of “Starting”, “Progressing”, “Achieving” and “Excelling”. The outcome can be demonstrated as a spider diagram to demonstrate the areas of strength and required improvement.

Population Health Management

A single, consistent system-wide population health management method needs to be applied to segment and risk stratify populations based on complexity and forecasted resource use to enable robust prioritisation processes for effective resource allocation for the greatest impact on health and wellbeing outcomes. These analytical approaches need to be complemented with wider quantitative and qualitative insight into groups that might be under-represented in NHS datasets.

MDT

Established MDTs at the neighbourhood and PCN in place in collaboration with community health, mental health, adult social care services and PCNs. Some neighbourhoods are built around PCN footprints.

Urgent neighbourhood services

Systems have standardised and scaled urgent neighbourhood services for people with an escalating or acute health need, ensuring urgent community response and hospital at home (virtual ward) services are aligned to local demand and work together to deliver a co-ordinated service.

Modern general practice

General practices are delivering the modern general practice model, to deliver improvements in access, continuity and overall experience for people and their carers. o streamline the end-to-end access journey for people, carers and staff, making it quicker and easier to connect with the right healthcare professional, team or service.

Integrated intermediate care

Systems are delivering time limited rehabilitation, reablement and recovery services (integrated intermediate care) taking a therapy-led approach working in integrated ways across health and social care and other sectors.

Standardising community health services

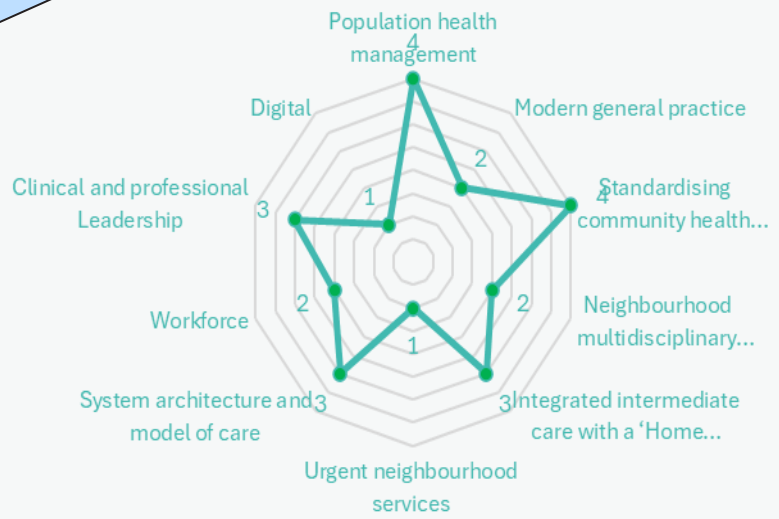
ICBs and providers are using the Standardising community health services publication (covering NHS-funded specialist support for people with physical health needs and neurodevelopmental services for children and young people) to ensure funding is used to best meet local needs and priorities.

Neighbourhood Health Maturity Self-assessment

Each neighbourhood can assess themselves against each component and score themselves on a scale of:
1: “Starting”
2: “Progressing”
3: “Achieving”
4: “Excelling”
The outcome can be demonstrated as a spider diagram to demonstrate the areas of st… …d required improvement.
An example has been shown below.

Component	Maturity level	
Population health management	4	Excelling
Modern general practice	2	P… …g
Standardising community health services		…celling
Neighbourhood multidisciplinary teams (MDTs)	2	Progressing
Integrated intermediate care with a ‘Hom… …proach	3	Achieving
Urgent neighbourhood services	1	Starting
System architecture and … …are	3	Achieving
Workforce	2	Progressing
Clinical … …ssional Leadership	3	Achieving
Digital	1	Starting

Example



The diagram provides an overview of the component level at a glance.

Neighbourhood Health Maturity Self-assessment *(Complete Following Assessment)*

Each neighbourhood can assess themselves against each component and score themselves on a scale of:
1: “Starting”
2: “Progressing”
3: “Achieving”
4: “Excelling”
The outcome can be demonstrated as a spider diagram to demonstrate the areas of strength and required improvement.

Capability	Maturity level
Population health management	1
Modern general practice	2
Standardising community health services	2
Neighbourhood multidisciplinary teams (MDTs)	4
Integrated intermediate care with a ‘Home First’ approach	3
Urgent neighbourhood services	2
System architecture and model of care	3
Workforce	2
Clinical and professional Leadership	4
Digital	1

This will be generated for you following submission

The diagram provides an overview of the component level at a glance.

Neighbourhood Health Maturity Self-assessment

Neighbourhood Health Maturity Self-assessment					Dudley's INTs are called Community Partnership Teams
Six core components and enablers	**Starting**	**Progressing**	**Achieving**	**Excelling**	**Local/System Evidence**

Population health management	• Have one consistent PHM approach and analytical tools in place.
	• Have information governance, data sharing and processing arrangements in place to ensure that data is shared safely, securely and legally.
	• Able to segment and risk stratify population data.
	• All available data can be broken down into neighbourhood and place level
		All the preceding characteristics plus:
		• Have a person-level, longitudinal, linked dataset across primary, acute, community and social care encompassing data from:
		  • General practice and wider primary care
		  • Community health services
		  • Mental health
		  • Acute care
		  • Social care
		  • Public health
			All the preceding characteristics plus:
			▪ Use advanced analytical tools (*including segmentation to identify inequalities*) and approaches to improve care
			▪ Have a cross-system intelligence function providing support to all levels of the system.
				All the preceding characteristics plus:
				• Apply a single consistent system-wide PHM method to ICB analytics platforms to segment and risk stratify populations, based on complexity and forecasted resource use.
				• Dataset to have broadened to include data components from: Local or central government including employment, education, safeguarding, *voluntary services* and housing status
				• Developed multi-disciplinary analytical and improvement teams to ensure a data driven approach to development on interventions, focussing on prevention and reducing health inequalities.
				• Dataset to have broadened to include data components from:
				  • Local or central government including employment
					• **STARTING (ICB Colleagues to add)**
					• Lead for PHM in place and a Dudley "Population Health Management and Inequalities Steering Group" that reports to the Dudley Health and Care Partnership and Health and Wellbeing Board. Below the PHMISG is an "Analytical and Technical" subgroup. Terms of Reference supplied.
					• The PHM Lead is a core member of the Community Partnership Teams (Integrated Neighbourhood Teams) Transformation Group.
					• We do not have a systematic population segmentation risk stratification tool in place however risk stratification is used in specific disease areas (Diabetes, Palliative Care and Respiratory) by the Community Partnership Teams (CPTs) and within practices.
					• There are IG issues and data sharing agreements are not in place across the ICB – timeline for this is April 2026
					• Meanwhile the ICB is developing searches which Dudley GP Practices have put themselves forward to pilot.

Neighbourhood Health Maturity Self-assessment

Neighbourhood Health Maturity Self-assessment					Dudley's INTs are called Community Partnership Teams
Six core components and enablers	**Starting**	**Progressing**	**Achieving**	**Excelling**	**Local/System Evidence**
Modern general practice	▪ ICB has established a Primary/Secondary Care interface group with a named SRO ▪ ICB supporting practices to participate in local and national services to redirect avoidable secondary care patient contact to general practice/community providers ▪ All practices have all 3 (Online consultation, Cloud based telephony and walk in) channels available to patients to access general practice and patients are informed of how their enquiry will be managed at the first point of contact ▪ ICB has identified practices to participate in the national Practice Level Support programme to implement modern general practice ▪ ICB starting developing approaches to reducing unwanted variation across their practices	**All the preceding characteristics plus:** ▪ Primary/secondary care interface group meets regularly with participation from primary care and secondary care (clinical and non-clinical) ▪ 90% - 100% of practices signed up to participate in local/national services to redirect avoidable secondary care patient contact to general practice/community providers ▪ Practices have all 3 channels available to access general practice and are regularly reviewing data regarding patient contacts to improve access and align practice capacity to demand. ▪ Practices are promoting self service, self referrals and digital pathways to patients as appropriate. Triage processes and care navigation are in place but may need further development/refinement. ▪ Peer Ambassadors have been appointed and are being facilitated by the ICB to support practices ▪ ICBs have an understanding of the learning from practices attending the national PLS programme and have started to identify mechanisms to share the learning.	**All the preceding characteristics plus:** ▪ Primary/secondary care interface progress resulting in patients being seen in an appropriate setting by primary/secondary care clinicians. ▪ Increase in the number of patients using self-referral services, an increase in the use of advice and guidance service by general practice and delivery of EHCH DES specification. ▪ All practices working towards modern general practice and have OC open during core hours for both admin and clinical requests. Mature care navigation and triage processes are in place and being maximised for Pharmacy First pathways and digital self service. Continuity of care is a consideration for all appointments ▪ GP Dashboard metrics indicate MGP model in place and show improvements over time. HIS patient satisfaction and continuity of care metrics show improvement over time. ▪ Peer Ambassadors providing targeted support locally to practices to implement MGP and supporting local development programmes ▪ Co-ordinated approach to sharing the learning from practices that have participated in the national PLS programme	**All the preceding characteristics plus:** ▪ Cultural shift within acute trusts where primary/secondary care protocols adopted across acute trusts ▪ Reducing demand through developing models ▪ ICB capturing qualitative information highlighting benefit to patients and primary/secondary care. ▪ All practices have implemented all elements of modern general practice as indicated by GP Dashboard metrics. All practices have OC open during core hours for both clinical and admin requests and capture structured information about the patient's presentation, population segmentation and risk stratification of the patient into a single workflow. ▪ Mature Peer Ambassador programme providing support to practices to implement MGP ▪ Local learning networks. ▪ ICB using data and intelligence including patient measures including any local survey work with Health watch/CQC/patient insights, National GPPS/ONS Health Insight Survey Data/Patient complaints information. ▪ Staff satisfaction measures through national and local staff survey.	**Progressing** • Dudley has a Primary, Community, Secondary Care Interface Group which was established in 2021, terms of reference attached. • The PCSCIG has a Workplan (attached) and is the forum for pathway integration and agreement of the best sharing of workload lead by the Primary, Community and Secondary Care Interface Manger employed by DGFT. • A Dudley Primary Care Development Plan has been agreed with routine reporting to the Primary Care Collaborative, Dudley Health and Care Partnership and DGFT Integration Committee. •All practices are working towards modern general practice. •We currently have 4 practices participating in the Practice Level Support programme to implement modern general practice. A further 2 practices have expressed interest to participate in the next cohort. •Review meetings taken place in June 2025 to confirm current position of PCNs against Capacity

Neighbourhood Health Maturity Self-assessment

Neighbourhood Health Maturity Self-assessment					Dudley's INTs are called Community Partnership Teams
Six core components and enablers	**Starting**	**Progressing**	**Achieving**	**Excelling**	**Local/System Evidence**
	• Local needs, priorities & inequities for Community Health Services for children & adults (CHS) are starting to be identified and understood • The provision of core CHS services across Neighbourhood footprints has been mapped and discussions are taking place regarding commissioning of services to ensure equity of access, and appropriate service provision for the identified demand • Commissioning intentions for Neighbourhood Health services integrates both NHS and Local Authority provision, wider system partners and providers, and the voluntary and third sector • Work is beginning on improving collaboration & joint decision-making to improve outcomes, patient experience & to support the shift of activity from hospital to community • Current commissioning arrangements including contract management frameworks, alongside service provision, is being reviewed to deliver management of patients outside of the acute setting where appropriate, including those with escalating care needs in line with the Neighbourhood Health guidance • The Neighbourhood Health commissioning strategy is in development with the involvement of all system partners • The system is aligning the workforce & financial data against its draft Neighbourhood Health strategy	**All the preceding characteristics plus:** • Population health management analysis is being used to identify demand at a Neighbourhood level alongside opportunities for shifting care to a community setting where appropriate • New outcomes-based service specifications that align with the agreed system strategy are in development • Through the established Neighbourhood based working and integration, improvements in services are being identified and implemented • Work is progressing across health & local authority strategic partners/providers to develop collaboration & joint decision-making to improve outcomes, patient experience & to support the shift of activity from hospital to community • The system has identified and is now actioning any changes to Commissioning arrangements and contracts that are needed to deliver the required service to meet identified demand within it's established neighbourhoods • Neighbourhood Health and performance of wider Community Services are integrated within the overall System Performance Assessment Framework, and are available as a single / shared set of metrics derived from the Federated Data Platform (FDP)	**All the preceding characteristics plus:** • Commissioned services, at Neighbourhood level, are designed meet the locally identified priorities & Health inequities for those populations • Standardised, equitable & accessible integrated community health services (including all documented elements of planned care) are designed, commissioned & delivered effectively, with patients, carers and families, to meet the needs & priorities of their population. • Services at a Neighbourhood level have been integrated across Health and Local Authorities, focused on outcomes, including patient experience, that achieve the shift from Hospital to Community • A cohesive and effective neighbourhood health commissioning strategy is in place, integrating relevant elements across 111, UEC and UCR and recognising the need for services 24/7. • Ongoing Contract Management, underpins provider accountability and shared resources aligned with the agreed outcomes within each defined Neighbourhood • CHS activity workforce & financial data is aligned with Standardising Community Health Services guidance's categorisation of services.	**All the preceding characteristics plus:** • An exemplary neighbourhood health commissioning approach, developed and driven by all strategic partners • Excellent collaborative leadership across health & local authority partners • Effective co-production & proactive work to anticipate & understand the current & future needs of children & adults. • Innovative use of funding • Community health services are seamless & are used as exemplars for other areas, demonstrating clear improvements in outcomes • Community health services provide excellent patient, family/carer & staff experience & outcomes • Core service provision is understood & described in detail, enabling flexibility & innovation.	•STARTING • All adult community services cover the populations 16 years and above and are aligned with CYP specifications and focus on ensuring as much activity takes place in the Community wherever possible. • The core community services within the CPT model have all been mapped and aligned to the PCN footprint, needs analysis has been undertaken to ensure resources reflect demand. The wider service mapping of all Community services is outstanding at this stage. • A draft commissioning specification for Integrated Neighbourhood Teams (Dudley Community Partnership Teams) is currently awaiting formal approval to be included within all provider contracts • Joint decision making on clinical services takes place at the Primary, Community, Secondary Care Interface Group • Hospital to Community Improvement Programme commenced in April 2025 supported by DGFT's Dudley

Neighbourhood Health Maturity Self-assessment

Neighbourhood Health Maturity Self-assessment

Dudley's INTs are called Community Partnership Teams

ore ponents enablers	Starting	Progressing	Achieving	Excelling	Local/System Evidence
	• You have developed a model, which has been piloted in at least 1 neighbourhood • The approach has been evaluated following dynamic implementation on a specific cohort of patients based upon Population Health analysis • The INT/MDT includes Local Authority Colleagues, alongside Acute, MH and Primary Care Colleagues, and Third Sector • The holistic care plans are developed to take account of the patient voice, with patients participating in the plan development	**All the preceding characteristics plus:** • There is an agreed, system level expansion plan to achieve 100% of the same INT/MDT approach across the system for the initial cohort • The capability to access the Shared Care Record is in place across the system and all INT/MDT Participants can access this • Plans have been developed to modify the approach for different cohorts, as identified by Neighbourhood Level PHM analysis • Workforce plans to enable staff to move between Care Setting are at an early stage of agreement	**All the preceding characteristics plus:** • Each Neighbourhood has an active INT/MDT • The Neighbourhood Population has been segmented and stratified to identify the cohorts of patients that would benefit from proactive management within the Community/Primary Care setting • All patients have a documented 'Personalised Care and Support Plan'/'Advance Care Plan', accessible via the Shared Care Record • For Palliative and End of Life Care patients the MDT have developed the Advance Care Plan / Respect Plan • Service availability (to deliver the agreed plan) is sufficient to cover a 7 day service	**All the preceding characteristics plus:** • There is a reduction in the utilisation of unscheduled care / A&E Attendances for the target cohorts of patients • There is an increase in the use of Community/Primary Care based Urgent Care • The system has local mechanisms for monitoring achievement of outcomes • The workforce has the capability to utilise remote technologies to support patients in their own home	**STARTING** •The neighbourhood model (Community Partnership Teams) has been in place in Dudley for several years, which identifies and proactively manages people with complex co-morbidities including frailty. •The CPT Operating Model (attached) was approved in June 2024 and is currently being refreshed in light of recent changes in Dudley and to reflect the NHS 10 year plan. •11 CPTs are geographically aligned to the PCNs with additional pan Dudley CPTs which are condition specific. •An accelerated transformation programme has been in operation over the last 2 years to drive improvements •Local investment in Clinical leadership, social prescribing and dedicated care co-ordination has been in place for a number of years which supports the model. •The core team includes representation from GP practices, Intermediate Care Team, community nursing, local authority

Neighbourhood Health Maturity Self-assessment

Neighbourhood Health Maturity Self-assessment					Dudley's INTs are called Community Partnership Teams
Six core components and enablers	**Starting**	**Progressing**	**Achieving**	**Excelling**	**Local/System Evidence**
Integrated intermediate care with a 'Home First' approach	▪ MDT discharge planning including rehabilitation requirements starts on day of admission ▪ Joint decision-making between Health and Social Care at point of discharge ▪ Clear information across the whole system on commissioned bedded capacity for Pathway 2 (Community-based rehab) ▪ System level criteria is established for discharge Pathway 2 (community-based rehab) • Criteria is established at system level for discharge Pathway 2 beds aligned to national policy and rehab complexity scores (2a, 2b, 2c,2d). • Clear roles and responsibilities established between CTHs and INTs • Evidence of Therapy led provision in intermediate care • Identification of gaps / opportunities for step-up care (based on 'avoidable hospital admission information')	**All the preceding characteristics plus:** • Referral links between Care Transfer Hub (CTH) and Integrated Neighbourhood Teams (INTs) • Clear information across the whole system on commissioned P1 services, that enable a Home First / Intermediate Care approach • Home first approach embedded across acute and community in-patient discharge teams • System level performance assessment framework (PAF) that incorporates the intermediate care framework outcomes (KPIs) • Joint EPR that supports rehabilitation/intermediate care within community settings (specifically the patients own home) • Neighbourhood MDTs to agree 'pull' criteria to support discharge	**All the preceding characteristics plus:** ▪ Accurate integrated reporting of intermediate care ▪ System level performance framework that identifies all instances where Home First was not achieved (at point of admission or discharge) ▪ Case management approach in some areas e.g. complex discharge patient ▪ Evidence of increase in step-up activity (with corresponding decrease in acute / step-down provision) ▪ Aligned Demand and Capacity across all provision ▪ Digital technology are supporting the joined-up provision of IC across health and care	**All the preceding characteristics plus:** ▪ Embedded case management approach across integrated teams (including IDTs). INTs safely 'pulling' patients home ▪ Ability to evidence and celebrate how the Home First approach is embedded as business as usual (shift from hospital to community) ▪ Evidence showing avoidance of long-term admissions jointly between health & social care ▪ Evidenced adequate community/Step Up provision commissioned in line with PHM analysis re: demand ▪ People discharged to appropriate setting on Discharge Ready Date (through effective discharge planning) ▪ Monitoring of outcomes including patient experience (intermediate care) embedded at Neighbourhood, Provider, Commissioner levels	**Progressing** • We have established Transfer of Care Hub with several touch points throughout the day to enable joint decision making for discharge. • There is a clear understanding of the capacity of pathway 1 discharges and the mitigations during surge, work is underway to embed Home first for all discharges. • Care navigators work across primary and secondary care, identifying people for discussion in CPTs as required. Further work is required to embed the referral process but CPTs firmly embedded. • Capacity and demand modelling completed for BCF planning but in current development for a near time model for use across all partners. • Neighbourhood MDTs in place, 'pull' criteria' to be agreed. • Discharge planning starts on admission in most cases, working with acute trust to ensure this happens in all

Neighbourhood Health Maturity Self-assessment

Neighbourhood Health Maturity Self-assessment					Dudley's INTs are called Community Partnership Teams
Six core components and enablers	**Starting**	**Progressing**	**Achieving**	**Excelling**	**Local/System Evidence**
Urgent neighbour	SPoA are in place but require further work to optimise the opportunity and meet minimum specifications including: • one SPoA number for each ICB • Ambulance 'stack' is visible and reviewed (hear and treat) • Call Before Convey in place (see and treat) • UCR provision is aligned with existing demand at a rate of 180 per 100k pop.. • Step-Down and step-up VW provision meets national minimum standards • Step-up VW provision is being explored and enhanced to facilitate ED avoidance for identified cohorts of patients (frailty) • SPoA can facilitate referrals from GP, NHS111, care Homes and Ambulance Service as a minimum • SPoA should operate for a minimum 12hrs per day (working towards 24hrs)	**All the preceding characteristics plus:** • Data capture to improve understanding of potential demand across urgent services and how this aligns with existing workforce/skills/capabilities/capacity • Provision of community step-up VW in place, and ED attendance is avoided • Digital enablement is commencing • Communication across all services exploring opportunities to collaborate and integrate • Majority of the minimum requirements for SPoA are being met. • Pathways are being explored through the lens of Frailty to ensure all service provision required is in place, optimised and adds value to the patient. • Reduce the various referral points to streamline access to the most appropriate service at the earliest part of the patient journey including alternatives to ED	**All the preceding characteristics plus:** • Collaboration between the CTH and SPA to align accessible services and streamline access and data collection. • Progressing towards working 24/7 • Wide range of health and social care professionals can access the SPoA where triage, streaming, referral is required • SPoA can directly book patients into appropriate services in a timescale that meets their presenting need (same day/next day) • Digital enablement is progressing at pace, with access to SCR, Care Plans, Respect forms, recent clinical records etc, that will aid clinical decision making • Care Homes (with/without nursing) will have streamlined access into SPoA to provide clinical advice and facilitated response from suitable services so that staff avoid calling 999 where not clinically appropriate	**All the preceding characteristics plus:** ▪ Mature (potentially combined/integrated) SPA/CTH operating 24/7, and at scale across defined geography with a single access route/number ▪ Access to SPA/CTH available to any health and social care professional, and selected patients, where clinically beneficial ▪ Ability to triage, coordinate and access all urgent care services to avoid ED attendances or readmissions where clinically safe to do so – regardless of where the patient resides (own home/care home) ▪ Aligned D&C across all urgent pathways (acute and community) including as a minimum, UCR, step up/down VW, Medical & Frailty SDEC, UTCs, diagnostics, falls – supported by access to social care, pharmacy, voluntary sector etc ▪ The use of robust accurate data to closely monitor service provision, utilisation and access	PROGRESSING •UCR is well established with current model operating 8-9pm (7 days a week) •Pilot during Winter to extend working hours to 12pm – learning to inform any future business case for expansion •SPoA can take calls from GP, NHS111, care Homes and Ambulance Service. Self-assessment completed in the Autumn - attached •Call before convey is up and running – piece of work to establish appropriateness of referrals •Extensive promotion to both Primary Care and Care Home has taken place which has seen an increase in calls and utilisation. •Discussions taking place between DCH and ARI hub for more appropriate direction of people •Virtual Wards – mobilisation of six areas ••Respiratory ••Complex nutrition ••Frailty ••Acute Medical ••Heart Failure

Neighbourhood Health Maturity Self-assessment

Neighbourhood Health Maturity Self-assessment					Dudley's INTs are called Community Partnership Teams
Six core components and enablers	**Starting**	**Progressing**	**Achieving**	**Excelling**	**Local/System Evidence**
System Architecture and model of Care	• System has defined and agreed its Neighbourhoods • System partners have been identified • There is a developed shared vision and outcomes • There are agreed accountability arrangements • There is clear leadership, organisational and clinical, setting the direction	**All the preceding characteristics plus:** • Roles and responsibilities across partners has been identified • There is clear governance arrangements and lines of accountability between Neighbourhood and Place. • There is a clear plan for evaluation and roll out of the Neighbourhood Model • Minimum of 60% of system population is covered by Neighbourhoods where INTs/MDTs are established for Adults and Children in line with Neighbourhood Health guidelines. • INTs are in operation for the specific cohorts (comprising Adults and CYP) as stipulated in the 25/26 Neighbourhood Health Guide requirements.	**All the preceding characteristics plus:** ▪ All ICB geography (100%) is operating with a Neighbourhood Health model ▪ The system has established collaboration between providers both NHS and non-NHS. ▪ There is an embedded improvement approach where learning is being shared and acted upon	**All the preceding characteristics plus:** • There are full integration both horizontally and vertically at their Neighbourhoods. • There is a clear delivery programme for each Neighbourhood. • INTs are in operation for PHM analysis identified demand / patient cohorts (comprising Adults and CYP) • Evaluation is showing benefit to patients and a cohesive and cost-effective model of care.	PROGRESSING • The system has defined neighbourhoods with CPTs aligned to PCNs. However, we are hosting a Neighbourhood Health coproduction workshop on July 23rd with our residents to agree this (or at least start the discussion). • System partners will also attend the workshop so we can have a collective view of role and responsibilities and agree the governance. • The Dudley Health and Care Partnership already has an agree vision, priorities and outcomes with an integrated dashboard reporting on 7 KPIs – plan on a page attached. • Governance for Dudley Place has been agreed – changed in light of the 10 year plan to be incorporated over the coming year. • The Dudley Group NHS Foundation Trust is the host of the Health and Care Partnership and has a good and services contract with the ICB. • The draft service specification for INT (CPTs in Dudley) is currently

Neighbourhood Health Maturity Self-assessment

Neighbourhood Health Maturity Self-assessment					Dudley's INTs are called Community Partnership Teams
Six core components and enablers	**Starting**	**Progressing**	**Achieving**	**Excelling**	**Local/System Evidence**
Workforce	▪ There is an established shared vision with defined clear goals for integrated neighbourhood teams, shared with ICBs, Local Authority and local providers ▪ The system has built early engagement and buy-in from all professionals across specialties and services ▪ Work is progressing on developing a shared culture and set of values that support collaboration and patient-centred care ▪ A focused workforce mapping exercise has been started to map existing workforce capacity, skills and capabilities across all partners and providers in a bottom-up approach. ▪ Distributed leadership capability is starting to be built across neighbourhood teams ▪ There is an agreed approach to ensuring skills and tools are in place for staff to safely work across organisational boundaries in a pilot area. ▪ There is multi-professional working with clearly defined roles and shared accountability ▪ There is an outline organisation development plan which describes how to bring teams together ahead of service delivery. ▪ Establish feedback loops and support continuous learning	**All the preceding characteristics plus:** ▪ Staff involved in pilots are engaged and are actively involved in building the local neighbourhood service model to optimise the use of services, including wider primary care, general practice, mental health, community health services, neighbourhood MDTs and social care services. ▪ Opportunities for learning are identified to inform roll-out of other MDTs from service delivery evaluations. ▪ There is a broader organisational development plan with identified metrics and deliverables ▪ Workforce leadership across organisations have a shared vision to inform future expansion plans	**All the preceding characteristics plus:** ▪ There is an established shared culture and set of values that support collaboration and patient-centred care across all stakeholders and participants in Neighbourhood MDTs/INTs ▪ Workforce leaders across organisations have an agreed joint expansion plan linked to the agreed service delivery model understanding future supply and technology requirements ▪ Staff are enabled to utilise skills and tools to safely work across organisational boundaries in each neighbourhood ▪ There is joint training and staff rotation for neighbourhood teams in operation	**All the preceding characteristics plus:** ▪ Ways of working and integrated processes support learning and continuous improvement. ▪ There is a defined workforce model and plan that articulates the future activity shift from hospital and community that fully takes account of population health needs and requirements. ▪ There is future years plan for joint training and staff rotation across all services ▪ There are identified barriers and opportunities to better enable productive integrated working with a supply training and education plan in development to support delivery	STARTING • Dudley Health and Care Partnership has a clear vision, priorities and plan. The attached slides and 2 previous years annual reports shares the journey partners have taken together to get to this point • Partners agreed to a shared set of values and behaviours. • A series of workshops and events have taken place to ensure buy in from professionals, to include the voluntary sector. An event is planned for July 23rd to coproduce Dudley's model for neighbourhood health. This will also map skills, capacity and community assets • Multiprofessional working is embedded in our partnership, demonstrated via the Better Care Fund and the award winning ICAN employment project that spans both the LA and the NHS. Find out more here • Statutory organisations are enabling multi-professional learning by enabling access to training and tools for the whole partnership workforce and volunteers via the Dudley Improvement Practice

Neighbourhood Health Maturity Self-assessment

Neighbourhood Health Maturity Self-assessment					
Six core components and enablers	**Starting**	**Progressing**	**Achieving**	**Excelling**	**Local/System Evidence**
Clinical and professional Leadership					• Each of our eleven CPTs have a leadership structure in place which is either via a direct employment route or via a contractual arrangement with the PCN. • Associated JD's, job plans and specifications and regularly updated to ensure CPTs development is maintained as a focus • The CPT leads report directly to manager responsible for on-going development of the CPT model and there are monthly leads discussions in place.

Dudley's INTs are called Community Partnership Teams

Neighbourhood Health Maturity Self-assessment

Neighbourhood Health Maturity Self-assessment | Dudley's INTs are called Community Partnership Teams

Six core components and enablers	Starting	Progressing	Achieving	Excelling	Local/System Evidence
Digital	• Integrated neighbourhood teams (INT) to have agreed data sharing agreement that enables shared care planning • Members of the integrated Neighbourhood teams (INTs) to have digitalised records • Robust digital maturity mapping across integrated Neighbourhood teams (INT) to ensure an adequate or minimum level of infrastructure is in place to support cross setting working • The INT/MDT is using minimal data from all participants including primary, community and acute providers as part of care planning • There is retrospective reporting re service utilisation and performance • The INT is using manual processes, e.g. paperwork, phone calls etc in their delivery of services to patients • Patient self-management through assistive technologies is limited, e.g. passive patient portals • Limited/pilot programmes utilising remote monitoring and online consultations for patients	**All the preceding characteristics plus:** • The capability to access the Shared Care Record is in place across the system and all INT/MDT Participants can access this • Digital Capability to co-ordinate care across an integrated neighbourhood team i.e., scheduling, remote consultation • Basic EPR interoperability between providers; beginning to include social determinants data • Basic digital referral systems; limited communication between teams • Self-management, patients receive digital reminders, educational content • Online consultations available as part of INT/MDT support, but not embedded in care pathways • Manual tracking of avoidable admissions; periodic reporting	• **All the preceding characteristics plus:** ▪ Integrated Shared care record accessible across settings (primary, acute, community); includes behavioural and social data ▪ Predictive models identify patients at risk of admission; alerts for care teams ▪ Shared digital care plans with coordinated task management across teams ▪ Interactive tools for self-management; remote monitoring/ communication with care teams ▪ Remote monitoring for high-risk cohorts with guidelines for follow-up ▪ Dashboards showing KPIs: admission rates, response times, care plan adherence ▪ Live Data reporting across MDT within INT ▪ Regular Data validation process in place ▪ Joint model of care implemented across INT that is supported by Digital	• **All the preceding characteristics plus:** • All members of the INT reporting via Federated Data Platform (FDP) • Information regarding care provided by all members of the INT available via NHS APP • Digital infrastructure interoperable and accessible across a patient's pathway within an INT provider • Real-time data exchange; predictive dashboards; full interoperability with regional/national systems • AI-driven dynamic risk scoring; integration of unstructured data (e.g. notes, wearables); outcomes inform prevention strategies • Real-time shared workflows; automatic triggers for care team intervention; performance tracking • Personalised engagement (PEPs, full access to NHS App functionalities, chatbots, virtual care); real-time feedback from patients; equity-aware engagement analytics • Proactive intervention based on continuous data streams (e.g. wearables, home devices); virtual ward • Real-time dashboards with drill-down capabilities; predictive and prescriptive analytics on system-level and patient-level metrics	STARTING **(ICB Colleagues to add)** Dudley perspective: • A dedicated EMIS template has been developed to ensure data is captured succinctly following intervention with the CPT. • Although currently community teams don't have a dedicated EPR they are trialling a community portal which will allow linkage to both acute and primary care EPR systems • A shared care record is in operation across the ICB footprint

Neighbourhood Health Maturity Self-assessment

System Level Actions and Opportunities

Actions – Dudley is taking 2025/2026

Dudley's INTs are called Community Partnership Teams

- We are developing a Community Navigation Centre which will act as the single point of access from primary care and care homes.
- Care Home Pilot – wrap around care at the residents home
- Transfer of Care Hub
- Social Prescriber in the Discharge Team

Opportunities – future support required by the system (ICB)

Dudley's INTs are called Community Partnership Teams

- Risk stratification is our key priority to enable our CPTs to become proactive rather than reactive
- Digital maturity is required to enable clinicians to share information "real time" and enable coordinated, integrated care – this includes non-NHS providers too.
- OD will be required to ensure that integrated teams are working effectively and efficiently and that patient care is optimised

Introduction

The National Infection Prevention and Control board assurance framework ('the frame
respond using an evidence-based approach to maintain the safety of patients, services
provision in England and can be used to provide assurance in NHS settings or settings
used by organisations to ensure compliance with infection prevention and control (IPC

The purpose of the framework is to provide an assurance structure for boards against
in the National Infection Prevention and Control Manual (NIPCM), the Health and Soci
other related disease-specific infection prevention and control guidance issued by UK

The aim of this document is to identify risks associated with infectious agents and outl
should be given to adopting an integrated systems approach for individuals at greater

Providers, ICBs, and regional teams collaborating to implement best practice in infecti
developing pathways based approaches across healthcare systems; ensuring AMR forr

The framework should be used to assure the executive board or equivalent, directors
the assessment of the measures taken in line with the evidence based recommendatic
criterion outlined in the Health and Social Care Act 2008: code of practice on the preve
support improvement and patient safety. The adoption and implementation of this fr
providers must demonstrate compliance with the Health and Social Care Act 2008. Thi

If the criterion is not applicable within an organisation or setting for example, ambula

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 infect

ework') is issued by NHS England for use by organisations to enable them to
s users, staff and others. The framework is for use by all those involved in care
where NHS services are delivered. This framework is not compulsory but should be
C) standards (unless alternative internal assurance mechanisms are in place).

which the system can effectively self-assess compliance with the measures set out
al Care Act 2008: code of practice on the prevention and control of infections, and
Health Security Agency (UKHSA).

line a corresponding systematic framework of mitigation measures. Consideration
risk of ill-health from infection and AMR, including:

ion prevention and control, AMR prevention, and infection management;
ms part of organisational prevention plans.

of infection prevention and control, medical directors, and directors of nursing of
ons of the NIPCM (or whilst the NIPCM is being implemented) including the relevant
ention and control of infections. The outcomes can be used to provide evidence to
amework remains the responsibility of the **organisation and all registered care**
is requires demonstration of compliance with the ten criteria outlined.

ance services then select not applicable option.

Our Patients
Our People
Our Place

ACCESSIBILITY COMPLIANT

NHS
The Dudley Group
NHS Foundation Trust

Paper for submission to the Public Board of Directors on 11th September 2025.

Report title:	Clinical Nurse Specialist Staffing Review
Sponsoring executive / Presenter:	Martina Morris Chief Nurse Dr. Gail Parsons Director of Research and Innovation
Report author:	Dr. Gail Parsons

1. Summary of key issues

An assessment of the capacity and skill mix across specialities Trust wide was required to compile a validated register of Clinical Nurse Specialists (CNSs).

A validated regional assessment tool, supported by The Black Country Provider Collaborative, for uniformity was used to calculate the time allocated to specific aspects of work (Cassandra Tool, Jackson and Leary, 2015).

A register of 112 individuals were identified with a response rate of 54% of CNSs completing the data collection process.

Recommendations for implementation and evaluation have been generated to include a review of the data collection tool for future use, due to limitations of the tool.

2. Alignment to our Vision

Patients: Deliver right care, in the right place, at the right time	**x**
People: Be a brilliant place to work and thrive	**x**
Place: Build innovative partnerships to improve the health of our communities	**x**

3. Report journey

Peoples Committee and Trust Board

4. Recommendation(s)

The Quality Committee is asked to have an awareness of the review and the impact on delivering a high-quality service to all patients.

5. Impact reflected in our Board Assurance Framework (BAF)

BAF Risk 1.0		Failure to deliver the right care, in the right place every time
BAF Risk 2.0		Failure to ensure Dudley is a brilliant place to work and thrive
BAF Risk 3.0		Failure to build innovative partnerships to improve the health of our communities
BAF Risk 4.0		Failure to remain financially sustainable in 2025/26 and beyond
BAF Risk 5.0		Failure to achieve operational performance requirements & deliver strategic objectives
BAF Risk 6.0		Failure to take sustained action on infrastructures that enables strategic objectives

June 2025

The Dudley Group NHS Foundation Trust

Clinical Nurse Specialist Review

Executive Summary

A review of the Clinical Nurse Specialist (CNS) service was undertaken during a six-month period. Each CNS was invited to attend a virtual meeting to introduce the aims of the review. An introduction to the Cassandra Tool App, which was identified as the tool to capture data collection was discussed, along with a 'step by step guide' to completion. A further virtual meeting was scheduled for ongoing support.

Data Collection Responses

A register of 112 CNS names and designated specialities were generated.

61 CNSs completed the data collection process (54% response).

Findings

Details from the Cassandra Tool were generated with pie charts and graphic data populated from the Tool. The data was collated to reveal categories of interventions relating to time spent on various tasks.

Conclusion

The overall responses to the completion of the Cassandra tool were well received by those CNSs wishing to 'showcase' their role with examples of excellent models of practice.

In contrast, there were expressions of anxiety and apprehension from others to complete the tool, as they were concerned about the vulnerability of their job roles with the current financial constraints.

Support and reassurance were provided throughout the process, with one-to-one guidance, virtual meetings in groups, provision of a 'step by step' guide to completing the tool and in some instances, inputting of data from a hard copy record to the digital platform.

The representative sample of data allows for recommendations to be reviewed, implemented and evaluated for this important group of specialist nurses, working across a variety of specialities across the organisation.

Recommendations

1. For the next CNS review, a thorough assessment of available tools should be completed prior to selection, with preference given to one which is able to capture all parts of the role without extensive additional workload to the CNSs.

2. Consider providing dedicated sessions with the CNS group, allowing all participants to discuss any insights or key information they believe should be considered for the review and the wider service provision across the organisation.

3. CNSs should be supported to complete structured annual reviews that demonstrate the impact of their work. These reviews would not only provide evidence of their contributions to patient outcomes and service improvement but also help identify opportunities within each specialty to align future practice with the Trust's strategic objectives.

4. Those CNSs with a blended band role should be provided the opportunity for job evaluation, to provide further clarity of the role and clear boundaries of practice.

5. Clarity in relation to banding and title along with uniformity should be defined with job descriptions clearly reflecting the complexity of the role.

6. A review should be conducted to identify those CNSs who wish to become non-medical prescribers, and that they be actively supported in pursuing this advancement for the added value to patient care.

7. Consideration for responsibility allowance for non-medical prescribers as opposed to the individuals seeking a review of their banding should be explored.

8. Implementation and evaluation of a structured support and professional development plan for CNSs which can be tailored to the individual.

9. Consider inclusion of a senior clinician that is aware of CNSs job role that can appraise performance and development along with line managers.

10. An assessment of the CNS's current role, for example, whether they are running nurse-led clinics independently or alongside a doctor, can help inform a tailored development plan to enhance their capacity and capability for leading independent clinics and increasing clinic capacity.

11. All CNSs to consider having their own clinic template that accurately records the number of patients they are reviewing within each clinic session. This will allow for accurate funding allocation and income generation e.g. ensuring the correct tariff is applied to new/follow up patient review.

12. Consideration for multi-professional tariff when attending Consultant clinics with Specialist Nurse input.

13. The data generated from the Cassandra Tool should be used to evaluate the complexity of the patients seen by CNSs, as this may support appraisal objectives, for example, identifying cases involving multiple simultaneous interventions, which indicate higher complexity.

14. Consider increasing CNS virtual consultations/clinics for appropriate patients, offering choice.

15. Consider opportunities to collaborate with community teams to extend the specialist knowledge and skills of CNSs across both acute and community settings, thereby enhancing continuity of care.

16. Consider a service evaluation within each speciality, reviewing the psychological support provided by the CNS role, to assess whether current service needs are being met.

17. Consider whether non-clinical administration could be completed by administrative support staff, allowing the CNS to allocate more hours to clinical duties and patient contact – explore use of AI.

18. Explore opportunities for CNSs to be available within the ward areas as opposed to primarily within the out-patient setting.

19. CNS roles to explore opportunities for clinical hub 'clinics' for screening and prevention of health conditions, in relation to NHS 10 year plan – Hospital to community, from sickness to prevention.

20. Clear definition of the role of the CNS, level of qualification and training.

Introduction To the Review

A review of the Clinical Nurse Specialist (CNS) role is required to assess the capacity and skill mix across specialties Trust wide at annual intervals. The provision of a robust record of all roles across specialties is also required. A validated 'Tool' which can be considered for use in the evaluation of time spent on specific areas of work is also required.

The 'Tool' identified within The Black Country Provider Collaborative Region, to ensure uniformity of the evaluation process is the Cassandra Tool (Jackson and Leary 2015). This Tool aims to evaluate the time spent on each of the six main themes:

case management, clinical administration, non-clinical administration, physical, psychological and social elements.

Background

Senior nurse/allied healthcare professional leaders from surgery, medicine and Place divisions were identified. Each senior leader identified CNSs within their divisions. The reporting line of responsibility for each CNS was identified as the Matron or Directorate Manager for the specialty.

The names of CNS's were cross referenced with the organisational digital platform 'Allocate' for authenticity. A register of CNSs within The Dudley Group NHS Foundation Trust is now available, consisting of 112 staff.

Proposal

All CNSs were invited to attend a meeting via 'Teams', to introduce the purpose of the CNS review and the Cassandra Tool. The opportunity to ask questions was encouraged and ongoing support made available.

A 'champion' trainer was identified in each division to ensure good guidance was available for the completion of the Tool. A total of 70-100 hours is the recommended minimum period for everyone to capture their work. The Cassandra Tool matrix can provide 'rapid work sampling' by demonstrating evidence to show the care (intervention), the context, whom it is being delivered to, and the gaps in patient contact time.

The Cassandra App or alternatively a hard copy of the Tool was selected by each CNS as a personal choice for recording data/activities.

Capturing High Quality Data

Given the detailed data in relation to one episode or task carried out by the CNS, it is recognized that time taken to record the episode/intervention is indeed time not able to be spent on patient care or additional interventions. To ensure accuracy, it is recommended that an independent observer is available to capture the data at the 'real time' of the intervention without any delay in

beginning the further interventions. The independent observer will understand the Tool, be able to record the activity in real time and collate the time spent without delay.

The Data Collection Tool

The tool used was the Cassandra App tool which asks the CNSs to provide a record of the interventions completed between 70-100 hours. This required a printed chart which was physically carried with the CNS where they would tick every time an intervention was completed during this time.

Support provided included virtual 'teams calls' to discuss the expectations and importance of completion, emails with directions and a "how to guide" (see appendix 1) was created for easy-to-understand explanation of what was required. Several limitations were identified with the tool.

Initially, it was thought that the tool lacked the ability to save data, preventing users from maintaining an electronic record of their work and resulting in a reliance on paper-based collection, a method prone to omissions and added complexity to the process. Additionally, three separate and slightly different data collection tools (spreadsheets) were available on the website. This created confusion among CNSs about which version to use, often leading to the need to re-evaluate data if the incorrect tool had been selected.

Following this feedback, the tool's creator, Professor Alison Leary, Deputy President of the Royal College of Nursing and a leading expert and Professor in Healthcare Modelling, was contacted. Professor Leary confirmed that the website will be updated to align the various data collection tools into a single, streamlined version.

Furthermore, despite Job descriptions often including research, management and teaching, most specialist nurses spend most of their time in clinical practice. Those that do spend time researching or teaching or in management are requested to separate this time from the time recorded.

The tool lacks a mechanism for evaluating the outcomes and impact of CNS practice, which arguably provides a more meaningful measure of value than task frequency alone. Few CNSs currently complete annual reviews that capture the outcomes and impact of their work, an important gap, as such documentation could provide a more robust demonstration of their value to the organisation beyond task-based metrics.

Several CNSs successfully completed their reports independently, within the set deadline, and to a high standard. This highlights their strong problem-solving abilities and professional autonomy. Others required varying levels of support. All were offered the opportunity for one-to-one guidance, which was well received by many of the group. This opportunity was taken to discuss their work on an individual basis and allowed for some rich qualitative information.

There was significant anxiety surrounding the purpose of the CNS review, with concerns that it was being driven by the organisation's current financial constraints. Furthermore, several CNSs expressed appreciation for the opportunity to highlight their contributions to patient care.

Recommendations:

1. For the next CNS review a thorough assessment of available tools should be completed prior to selection, with preference given to one which is able to capture all parts of the role without extensive additional workload to the CNSs.

2. Consider providing dedicated sessions with the CNS, allowing all participants to discuss any insights or key information they believe should be considered for the review.
3. CNSs should be supported to complete structured annual reviews that demonstrate the impact of their work. These reviews would not only provide evidence of their contributions to patient outcomes and service improvement but also help identify opportunities within each specialty to align future practice with the Trust's strategic objectives.

Results of data collection using The Cassandra App

61 responses were received from both Medicine (46 responses) and Surgery (15 responses) CNSs, 9 out of 61 were only partially completed. One CNS was unable to provide the data due to compassionate leave and there has been no responses received from the remaining CNSs.

All graphic information was generated from the Cassandra Tool App, following individual CNS data input.

Chart 1: Pie Chart indicating responses for each speciality

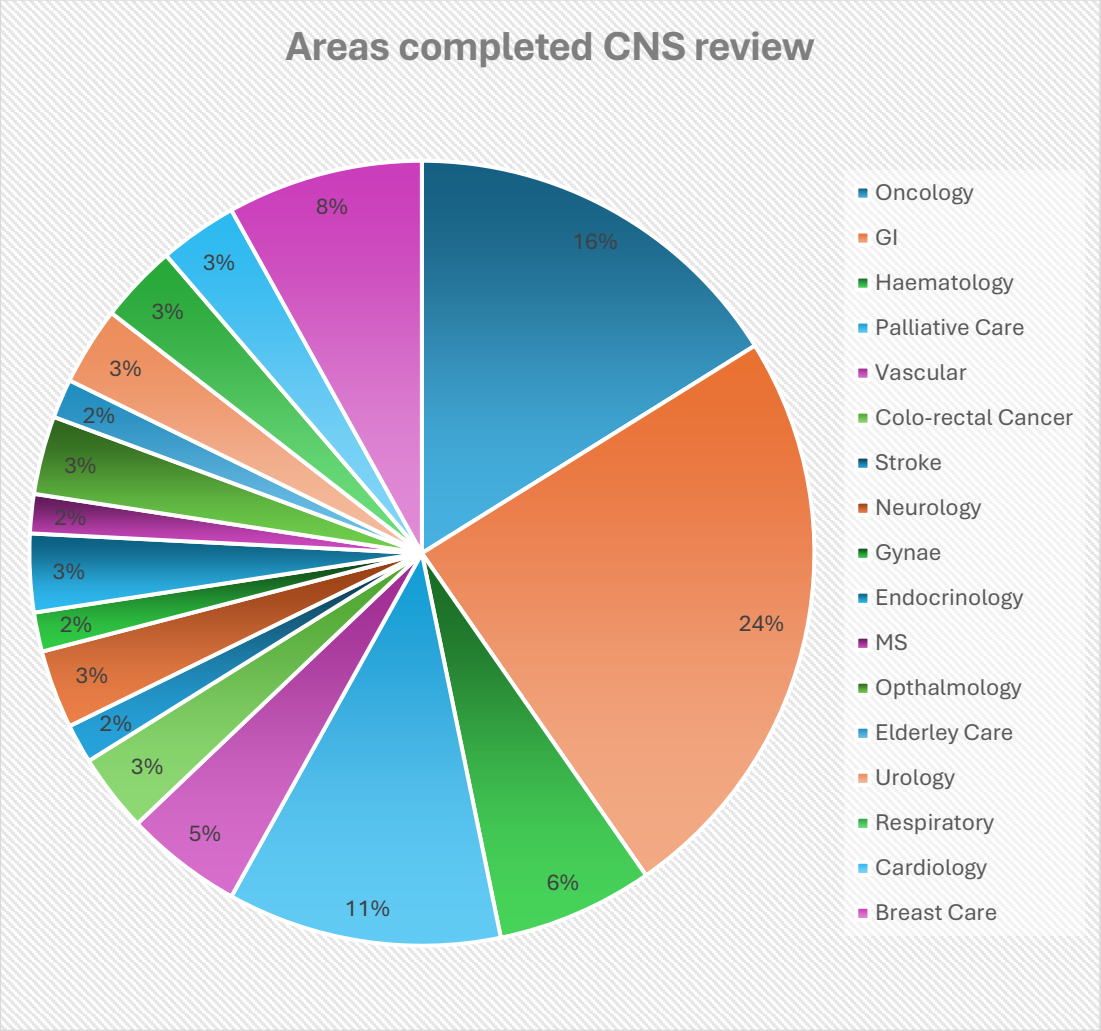


Chart 2: Pie Chart indicating responses for Divisions

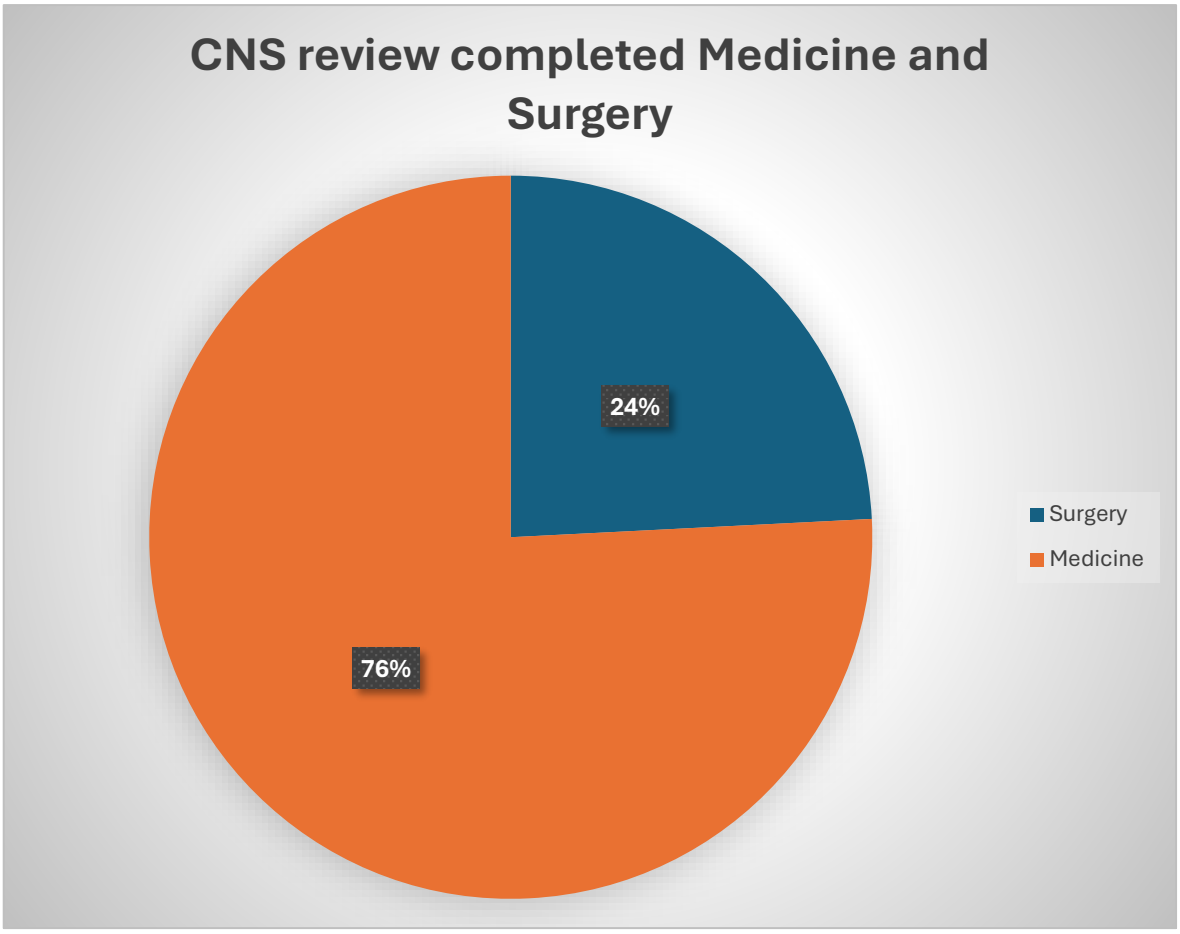
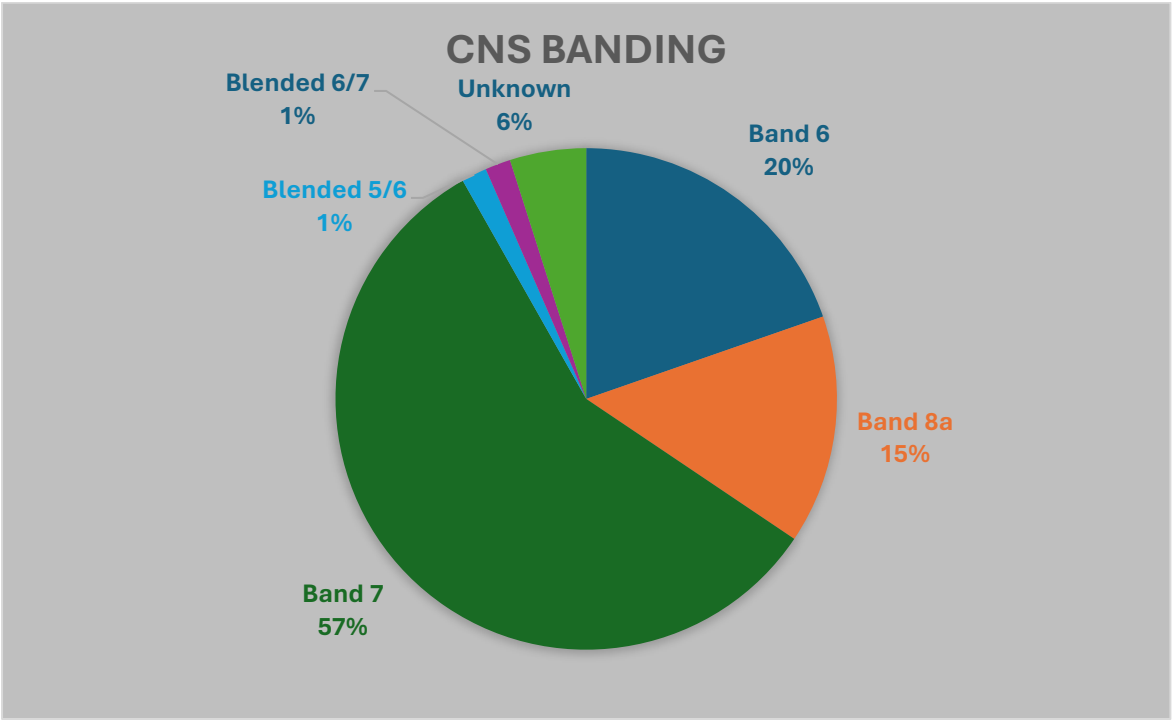


Chart 3: Pie Chart indicating CNS Banding allocation



Agenda For Change Banding

Banding allocation varies between a blended band 5/6 role to Band 8a.

The highest number of CNSs are band 7 (35/61) 57.4%,

Band 6 (12/61) 19.7%

Band 8a (9/61) 14.8%

In addition, there were two individual CNSs who reported that they have a blended banding role of a band5/6 and band 6/7.

Three individuals did not confirm their Agenda for Change banding.

Recommendation:

4. A blended band role can undermine role clarity, professional development and fairness, unless it is carefully designed with clear boundaries, structured progression, and appropriate support mechanisms. Job evaluation should be considered for blended band roles for individual clarification for the affected CNSs.

Job titles

70.5% (43/61) of job titles contain “Clinical Nurse Specialist”. The data shows there are varying job titles. The absence of standardised job titles for similar roles can lead to inconsistency in expectations, responsibilities, and scope of professional practice. There are inconsistencies with job responsibilities and banding within our CNS group.

Recommendation:

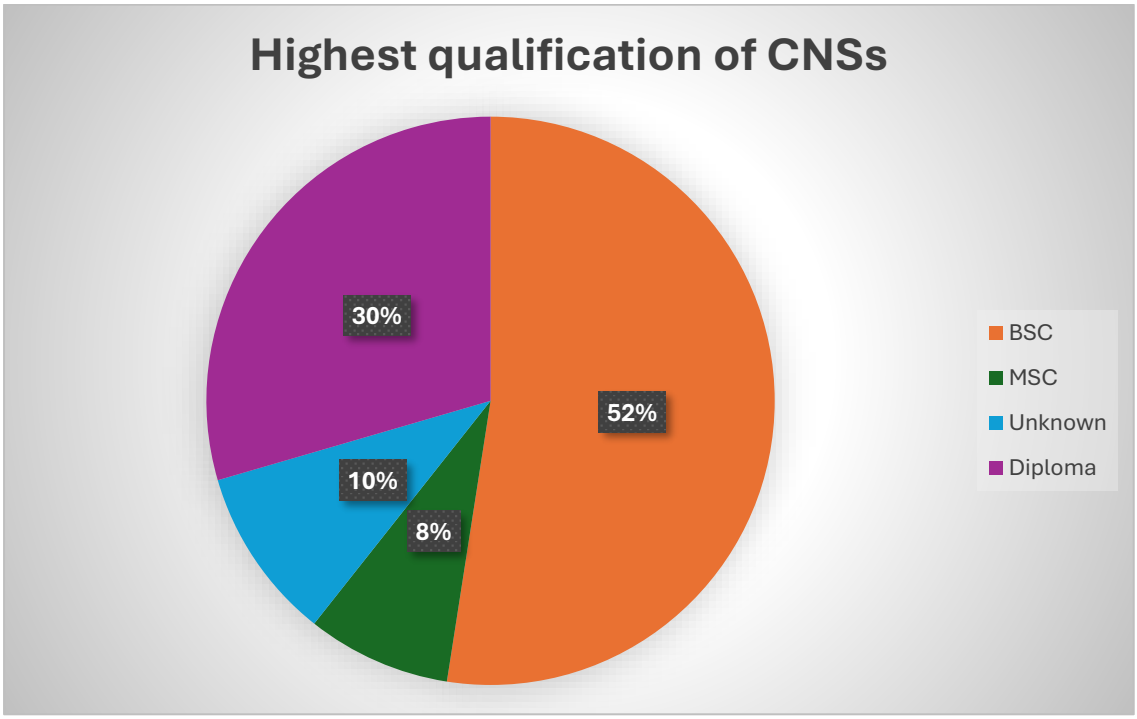
5. Clarity in relation to banding and title and uniformity with job description.

Skills and Qualifications

There are a range of highest qualifications across the organisation with the most common being Bachelor of Science 52.4% (32/61), Diploma 29.5% (18/61), Master of Science 8.2% (5/61), and missing data 9.8% (6/61).

Data revealed 13.1% (8/61) of CNSs are currently working towards a higher qualification. This indicates a good foundation in undergraduate qualifications.

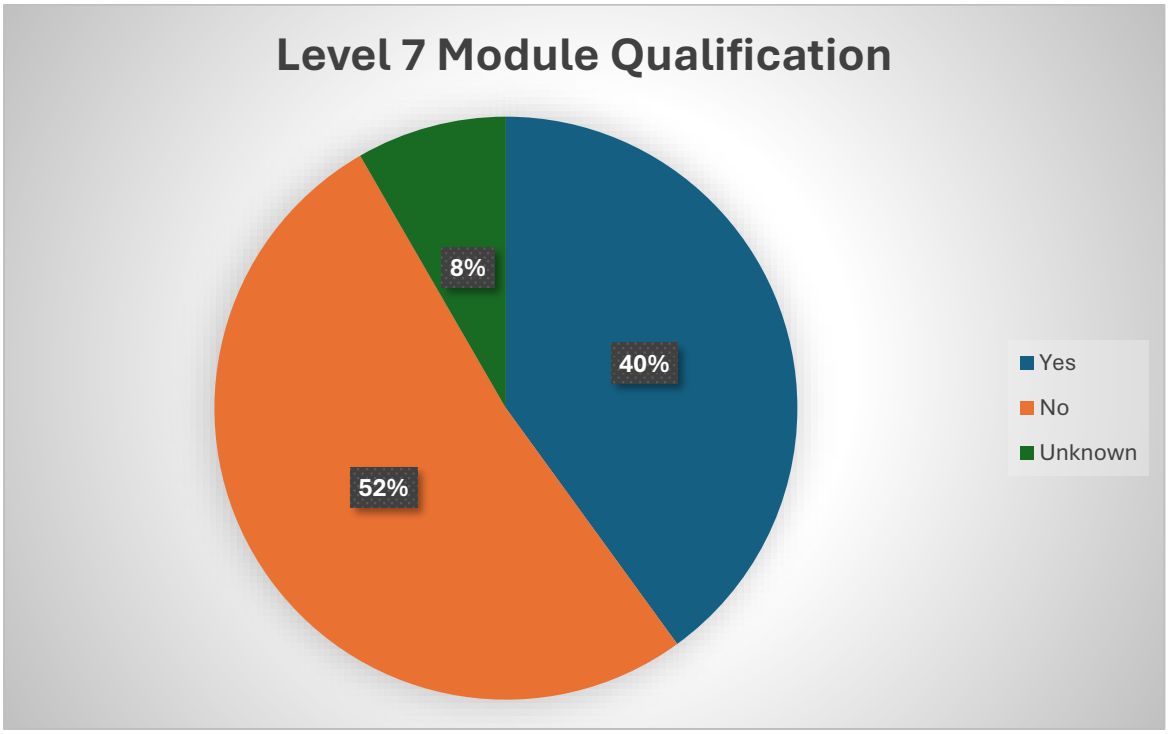
Chart 4: Pie Chart indicating highest qualifications of CNSs



50% (31/61) of CNSs hold qualifications at degree level (Level 6),

indicating a strong base for specialist clinical expertise.

Chart 5: Pie Chart indicating percentage of CNSs with level 7 qualifications



Independent prescribing

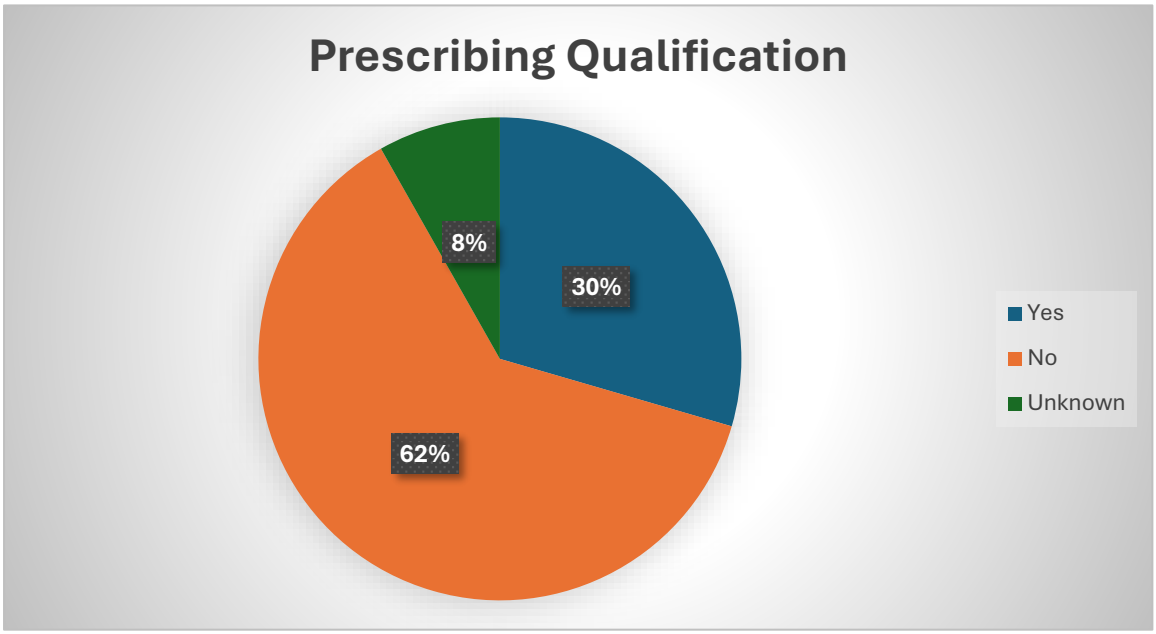
29.5% (18/61) are currently independently prescribing, as opposed to 62.3% (38/61) that do not have this skill. A further five individuals did not respond to this section of data collection.

Some CNSs have reported facing challenges in securing support, both financial and time away from work, to undertake prescribing qualifications. However, enabling CNSs to prescribe offers significant benefits, including improved access to timely and appropriate care, greater efficiency within clinical pathways, and more effective use of their specialised expertise.

Recommendation:

6. A review be conducted to identify CNSs who wish to become prescribers, and that they be actively supported in pursuing this advancement for the added value to patient care.
7. Consideration for responsibility allowance as opposed to the individuals seeking a review of their banding on successful completion of non-medical prescribing course and able to demonstrate regular use of this area of practice.

Chart 6: Pie Chart indicating percentage of CNSs with prescribing qualification



Professional Development:

A CNS shared an insightful perspective, stating, "We are a nurse when it suits, and a doctor when it suits." In addition to this there was an opportunity to meet a group of five CNSs where it was possible to gather some qualitative data. This statement was used to reflect the dual roles many CNSs navigate, balancing nursing duties with advanced clinical responsibilities. They were keen to point out the versatility and adaptability required in the CNS role, where they must shift between providing hands-on care and making complex clinical decisions. They also explained this ambiguity has led to stress and professional identity conflicts.

Despite the challenges posed by role ambiguity, few CNSs reported having regular appraisals or clinical supervision sessions with both their line manager and their supervising doctor.

Recommendation:

8. A structured support and professional development plan for CNSs will reduce ambiguity.
9. Consider a senior clinician within the speciality that is aware of CNSs job role and can appraise performance and development along with line managers.

Nurse led clinics

Several CNSs reported that they attend medical-led clinics as opposed to leading their own nurse-led clinic. In some cases, nurse-led clinics are cancelled if a doctor is not available, as these clinics often run alongside doctor-led sessions. In contrast, CNSs who demonstrate a higher level of autonomy operate fully independent clinics that do not require a doctor to be present.

The number of clinics reported ranges from 0 to 10 per week, highlighting significant variation in specialist roles and the expectations associated with them. It is also important to note that the term “clinic” is interpreted subjectively by CNSs. The duration of each clinic was not specified, indicating that reporting to have 10 clinics per week could refer to shorter sessions rather than full-length clinics. This may also indicate that the specialty places a greater emphasis on clinical work, potentially at the expense of the other three pillars of advanced practice: research, leadership, and education.

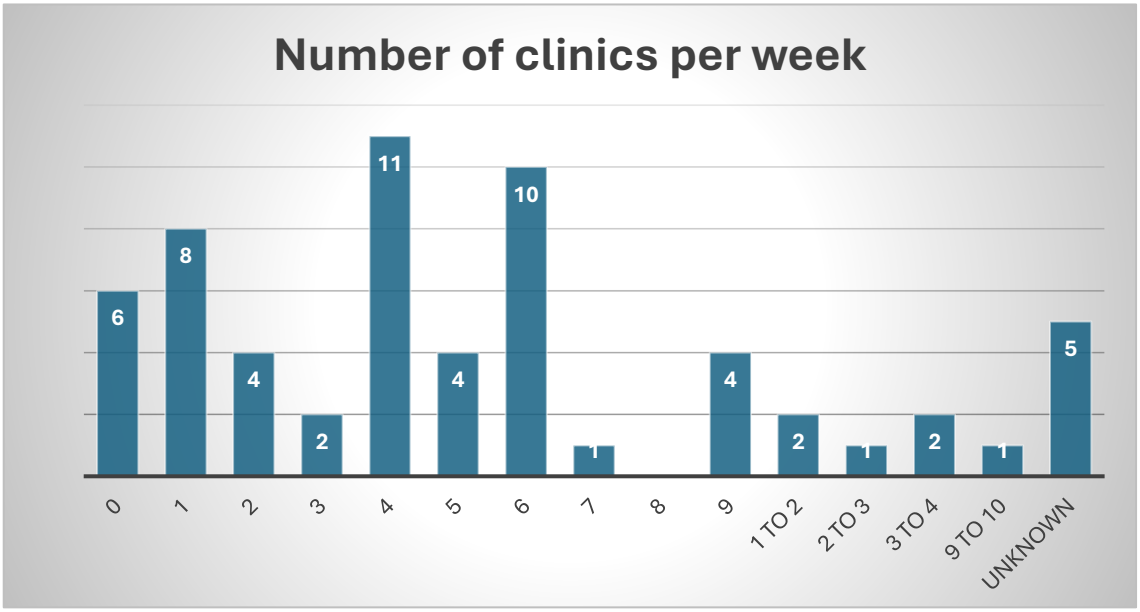
Recommendations:

10. An assessment of the CNS’s current role, in particular, detail of out-patient clinics, whether nurse-led or in conjunction with a doctor/consultant or part of the multidisciplinary team.

11. All CNSs to consider having their own clinic template that accurately records the number of patients they are reviewing within each clinic session. This will allow for accurate funding allocation and income generation e.g. ensuring the correct tariff is applied to new/follow up patient review.

12. Consideration for multi-professional tariff when attending Consultant clinics with Specialist Nurse input.

Chart 7: Number of CNSs and number of clinics per week



Interventions

CNSs would document each intervention completed within the allocated 70–100 hours. It is important to note that interventions are often carried out concurrently, and a higher frequency of simultaneous interventions may be indicative of the complexity and intensity of the work

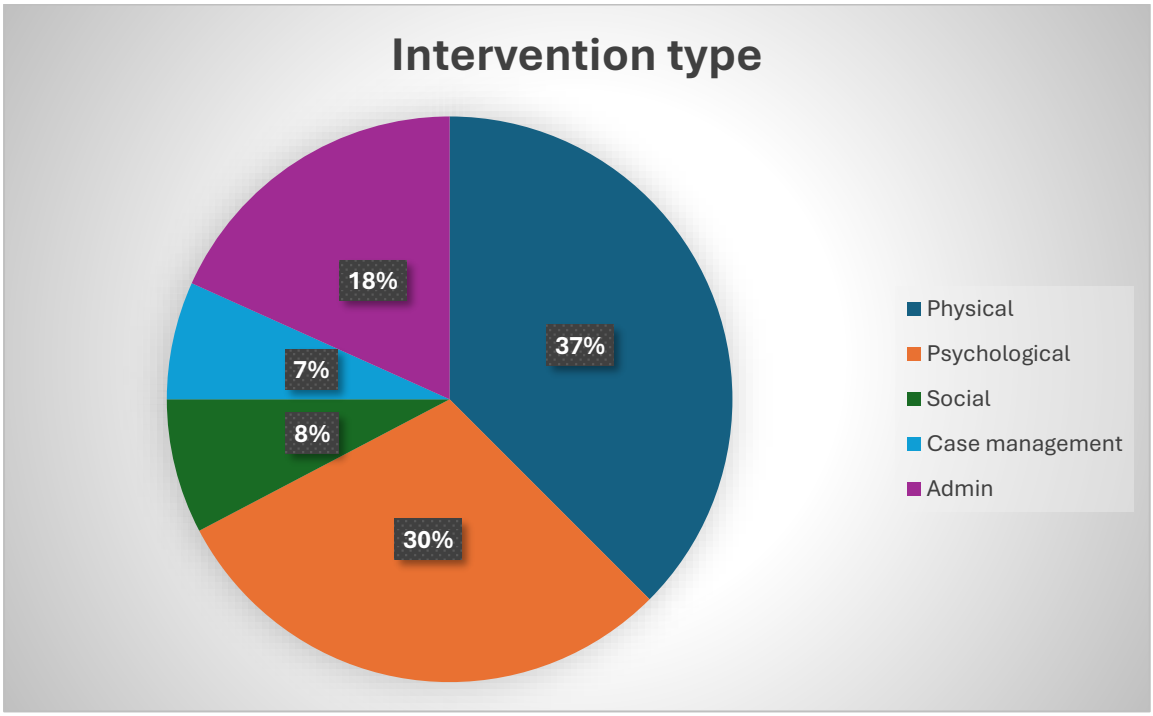
involved. The most common intervention was physical which was 39% of all the interventions, followed by psychological 31%, social 8% and administrative work being 19%.

The interventions are further divided into subcategories.

Recommendation:

13. Data should be used to evaluate the complexity of the patients seen by CNSs, as this may support appraisal objectives, for example, identifying cases involving multiple simultaneous interventions, which indicate higher complexity.

Chart 8: Pie chart indicating type of intervention; physical, psychological, social, case management, administration.



Work Setting

The majority of CNSs completing the data collection tool carried out interventions in the out-patient setting (21%), specifically reviewing patients attending follow-up appointments. Telephone consultations followed at 19%, whilst both inpatient and outpatient new patient visits each made up 15%. Specialist areas represented 17%, community settings 8%, and virtual reviews 5%.

There are significant variations in the settings where CNSs work, depending on their area of specialisation. Only a small number of CNSs provide care across all settings which is beneficial for healthcare integration, holistic care and improved care coordination. Several only work within one or the other (inpatient or outpatients) due to individual service demands.

A significant proportion of CNS work was carried out through telephone consultations, which were described as complex and challenging by several of the CNSs. However, no CNS reported receiving formal training or being aware of national guidance on telephone consulting,

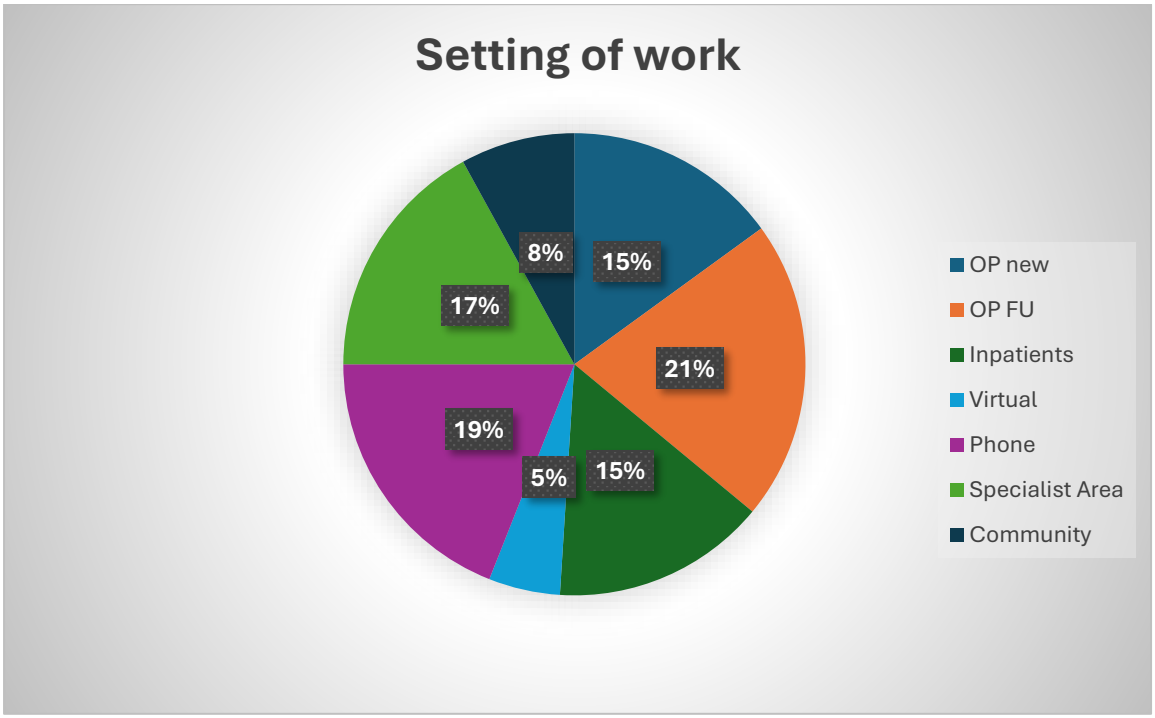
highlighting a gap in preparation for a key method of clinical delivery. Activity was not always captured.

Virtual consultations accounted for only 5% of all interactions. Given the NHS's current focus on reducing hospital attendance and associated costs, there is a clear opportunity to increase the use of virtual consultations. Shifting more appointments to remote formats could help align services with national efficiency goals while maintaining accessibility for patients.

Recommendations:

14. Consider increasing CNS virtual consultations/clinics
15. Consider opportunities to collaborate with community teams to extend the specialist knowledge and skills of CNSs across both acute and community settings, thereby enhancing continuity of care.

Chart 9: Pie Chart indicating CNS setting of work



Physical interventions

The number of interventions is calculated based on how often a specific intervention is completed within a defined number of practice hours. For example, if 100 hours of practice were assessed, the intervention count reflects how many times a particular task was performed during that period. In the case of physical assessments, for instance, CNSs completed the intervention an average of 92.5 times within those 100 hours.

The most common physical intervention was being physical health assessments 92.5, symptom management (65), promoting self-management (65), requesting investigations (53), symptom generalist care (41), performing procedures (29), and physical rescue interventions (18).

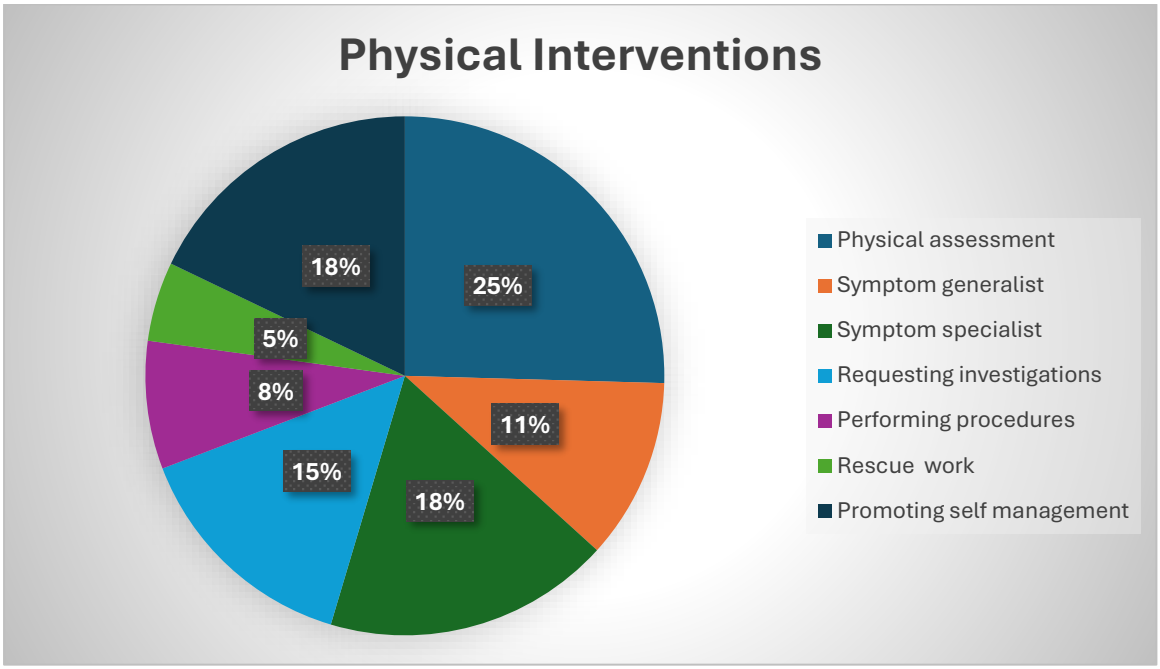
This data highlights CNSs' central role in ongoing patient care and symptom management, with a focus on proactive health assessments. However, less common interventions like procedures and rescue interventions suggest potential areas for specialised training. Additionally, the emphasis on self-management underscores the CNSs' role in empowering patients and improving quality of life.

Performing Procedures (29) and Physical Rescue Work (18): While less frequent, CNS involvement in these areas ensures that they can provide expertise in complex or urgent situations. Many CNSs perform procedures and emergency interventions, playing a proactive role in preventing unnecessary inpatient admissions. This aspect of their work is often highlighted by CNSs as a key and impactful component of their role.

Some CNSs have job plans that are entirely centred around advanced clinical skills or tasks that have traditionally been performed by medical staff. In such cases, their job titles may not align with the conventional definition of a "CNS."

For CNSs to operate at their full potential, it is important that the interventions they perform are balanced and aligned with their specialised skills. If their role becomes too focused on routine assessments or symptom management, they may be underutilised in more complex areas where their expertise is most needed. Conversely, delegating more routine work could free them up to focus on specialised care, which can have a significant impact on patient outcomes.

Chart 10: Pie Chart indicating physical interventions separated by type of intervention



Psychological interventions

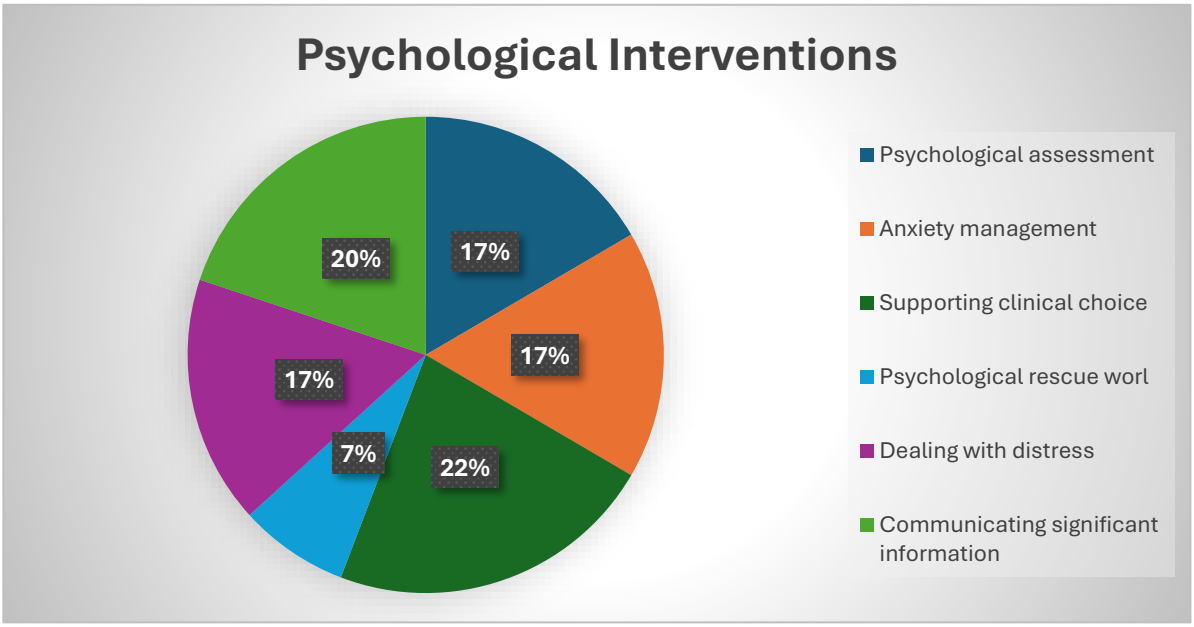
Psychological interventions formed a significant part of the CNSs' role, encompassing a range of supportive activities. These included psychological assessment (60), anxiety management (61), support with clinical decision-making (81), psychological rescue work (27), managing patient distress (61), and communicating significant or sensitive information (72). These interventions highlight the CNSs' involvement in supporting mental and emotional well-being, assisting in critical decision-making, and providing compassionate communication.

CNSs across the Trust are frequently relied upon to provide essential psychological support and management. Their expertise in building strong, trusting relationships with patients enables them to effectively navigate and manage even the most challenging situations.

Recommendation:

16. Consider reviewing the psychological support available to CNS patients to assess whether current services adequately meet their service needs.

Chart 11: Pie Chart indicating psychological interventions separated by type of intervention

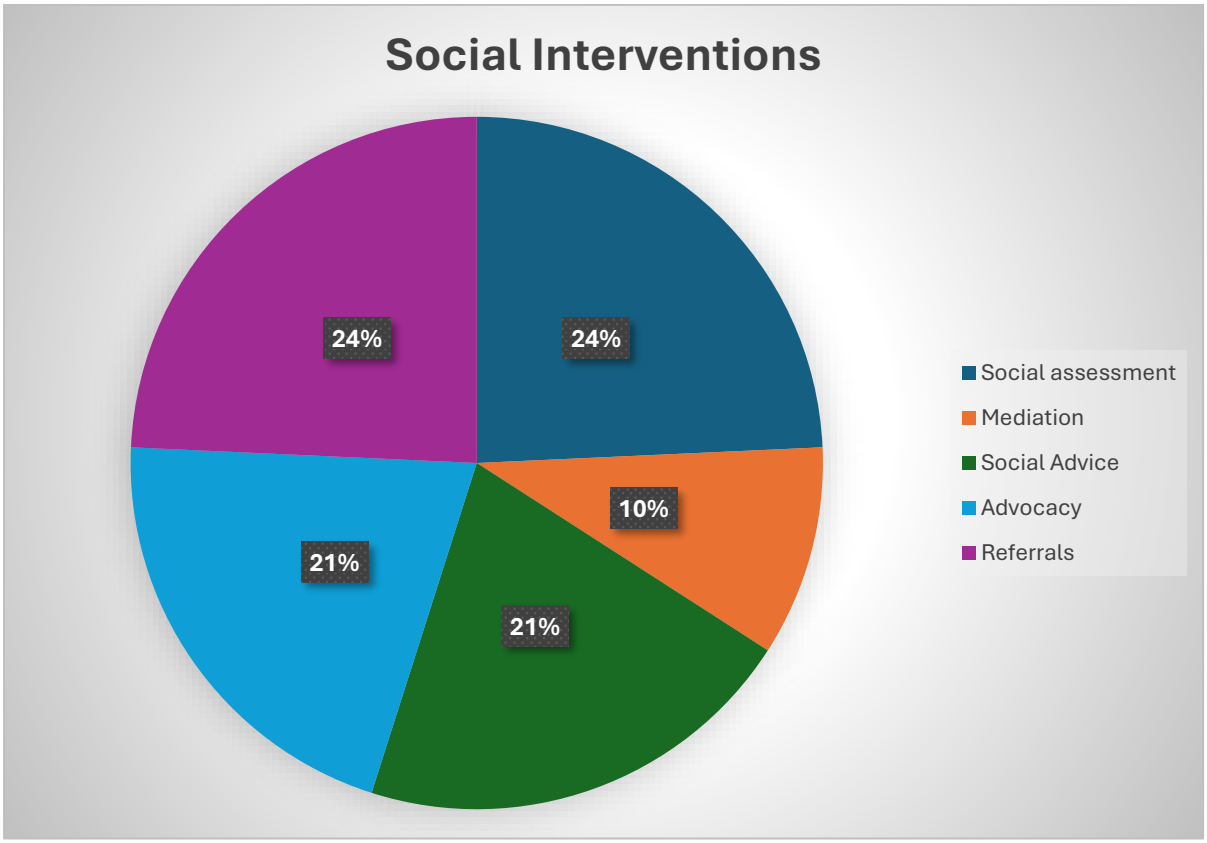


Social Interventions

Social care provided by CNSs includes social assessments (42) and referrals (42), which are the most common services, indicating their role in evaluating and directing patients to appropriate resources. Referrals encompass various types, with safeguarding referrals being a particularly important and critical aspect of patient safety. Advice (36) and advocacy (36) are also significant, reflecting the CNSs' support in navigating care options. Mediation (17) is less frequent, highlighting its more specialised role in resolving disputes or conflicts. Some CNSs report a high volume of mediation tasks, which they find challenging and stressful. This

suggests a potential need for additional support or training in mediation skills to reduce stress and improve effectiveness in handling such cases.

Chart 12: Pie Chart indicating social interventions separated by type of intervention



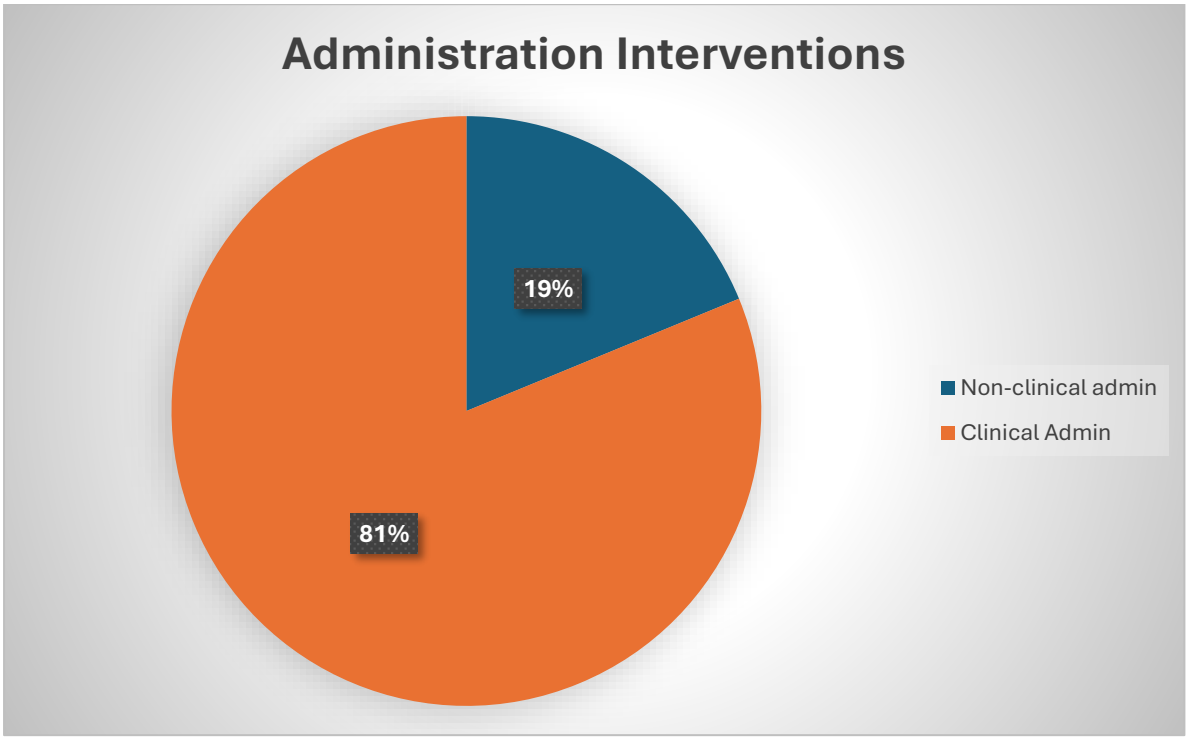
Administrative work

A significant amount of non-clinical administrative work (37) was carried out by CNSs', which could potentially be handled by administration support staff and release clinical capacity. Clinical administration was recorded 160 times and refers to tasks that could not be delegated to others.

Recommendation:

17. Consider whether non-clinical administration tasks could be completed by administrative support allowing the CNS to focus on specialist clinical duties.

Chart 13: Pie Chart indicating clinical and non-clinical admin work completed by CNSs



Conclusion

The overall response rate allowed for rich data to be collated, which revealed important findings for future development and improvement. An increase in response rate will be encouraged for future reviews.

The Cassandra Tool App was recommended for use, and generally it was useful in generating specific aspects of time spent on activities. There were, however, aspects of time spent teaching or carrying out research activities which were only captured by free text as opposed to a specific amount of time spent on those activities.

There is a need for structured support, development plans, career progression and formalising the appraisal process. The appraisal process would benefit the inclusion of a clinician who is aware of the role responsibilities and is able to discuss aspects of the role in detail and in response to the needs of the service.

The recommendations should be implemented with a robust action plan and evaluation of the actions should take place at agreed intervals.

Appendix 1- How to use Cassandra tool sent to all CNSs.

“How to” quick guide

Start

Print Tool
→ Print the tool from Cassandra™ App - Apollo Nursing Resource, www.apollonursingresource.com/showing-how-i-spend-my-time/cassandra-app/#

Start Clock
→ Collect between 70–100 hours of practice

Track Activities
→ Tally each intervention and the setting it was completed

Data Input
→ At the end of 70–100 hours, input the data (in numbers which signifies to many times you have completed the intervention during your practice hours) into the tool on www.apollonursingresource.com/showing-how-i-spend-my-time/cassandra-app/#

Generate Results
→ Press "Generate Results" to produce graphs of time spent on activities/area

Document Results
→ Copy the graphs into a Word document and add narrative on tool usage. Combine with cover sheet (see appendix 1) to complete report.

Send Report
→ Email the report to gail.parsons1@nhs.net

End

Note

Please be aware the Cassandra tool does not save your data. It is therefore, recommended that you input the complete data set (70-100 hours) once completed (rather than as you go along). It will only be visible to yourself (the data is not shared elsewhere).

Why?

CNSs are experts at treatment planning, vigilance and rescue work. The organisation wishes to showcase your practice as a diverse team of CNSs. It is an opportunity to show the complexity of your work and the value you bring to your patients.

The results will be combined to identify themes in practice and opportunities and/or investment where appropriate e.g. CNSs completing own non-clinical administration

tasks has previously been discussed therefore, data may be used to inform changes in service delivery to allow for additional clinical time which may be patient facing.

Who?

If you have Clinical Nurse Specialist in your job title.

When?

As soon as possible.

Problems/questions/concerns?

Reach out to: Gail Parsons Director of Research, Consultant Nurse and Izzie Gibson (CNS Nutrition), E.Gibson5@nhs.net

More detailed explanation below:

Why undertake activity analysis

Clinical Nurse Specialists undertake a range of tasks every day. Recording every one of them would be an impossible task – it would take up all your time. But being able to demonstrate to someone else how you spend your time is valuable. It can help show the complexity and specialist nature of your role (although methods such as Job Planning and the Service Summary are preferable) and help you see whether there are tasks (such as non-clinical administration) which does not necessarily require your high degree of expertise.

What is the Cassandra matrix?

Cassandra is a simple data collection tool to help you show how you spend most of your working time. It is based on a much larger and more complex database of specialist nursing activity called Pandora, which has been used by thousands of clinical nurse specialists to record their activity. Pandora recorded nine pieces of information about each event – including the length of time it took, why and how it happened, and the outcome. Using a technique called ‘data clustering’ to identify from Pandora the most common things that happen in specialist practice. New learning about the complexity of the work is now in Cassandra. Cassandra gives you a representative picture of how you spend your time, without having to record nearly as much information. Cassandra doesn’t record all your activity - just most of it. It also records the activity most associated with either income or savings if you work in an acute NHS Trust. Cassandra will represent your work accurately if you each record about 70-100 hours of work. This will give a picture of what you do most of the time. Despite being included in certain job descriptions, very few specialist nurses spend little time doing research, formally teaching or management. If you spend large chunks of time teaching, researching or managing, subtract that time and record it separately.

How to collect data

On the Cassandra™ App - Apollo Nursing Resource you will find the Cassandra Matrix waiting for you to input your data. Most people find it easiest to complete a data collection sheet each day and record information as they go along. To get a reasonable picture of your activity you will need to collect 70-100 hours of work. You can do this in days or hours over a few weeks, or you could record half days, different days of the week etc. until 70 hours is reached. 70 hours is the minimum you can collect, and it should be a representative spread of your work (for example, do not collect data only on Tuesdays unless you only work one day per week). Cassandra captures what nurses do (interventions) and where they happen (context). Each time you perform interventions simply tick the box according to what interventions you provided and where.

For example, symptom control in outpatients.

At the end of the data collection, add up the scores and transfer them to your personal spreadsheet on the website. They should be typical working weeks (e.g. not the week between Christmas and New Year). If you have days dedicated to research or formal teaching (which are not recorded by the Cassandra tool) then just leave these days out. The spreadsheet for each individual nurse has some basic automatic analysis in it already, which you can see straightaway.

How do I see my data?

You will be able to see the totals as you input them. When you have input the 70-100 hours' worth of data from your sheets simple press the generate report page. You will see several pie charts and graphs that show you how you spend your time. Once the report has been generated you can either save the document or copy and paste it into a word document.

What do I do with the data?

Once the data has been generated it should be put into a word document with some narrative about how you used the tool e.g. examples of practice.

How do I know what boxes to tick?

Cassandra captures what nurses do (interventions) and where they happen (context) to form a sample of work. You need to tick a box each time you perform an intervention this means for most people that each patient encounter will consist of several interventions.

The interventions are grouped into five main types:

1. Physical interventions
2. Psychological interventions
3. Social interventions
4 Case management
5. Administration

Based on the Pandora dataset we know that, when averaged out over many occurrences, each intervention type typically takes around the same amount of time. Therefore, by

analysing enough interventions, you can demonstrate how you divide your time over a typical year. Here are some of the Interventions and explanations from the literature-if you would like to know more, please contact us using the form on the Apollo website.

Physical assessment- This refers to physical assessments of patients.

Be sure to think about the assessments you do. They might be generalist or specialist e.g. undertaking an assessment requiring specialist expertise for example, in rheumatology this would include joint assessments and specialist scoring.

Symptom control – generalist- This refers to general symptom management not requiring specialist expertise, for example, if a patient asked you to advise on a problem not related to your specialism.

Symptom control – specialist giving advice on symptoms or treating (including prescribing or recommending medicines) requiring specialist expertise e.g. in Multiple Sclerosis related pain. Requesting investigations e.g. bloods, urine tests, radiology Performing procedures e.g. carrying out a bladder scan, infusions, joint aspirations, siting a stoma-it is also worth making a list of your specialist procedures for your service summary or annual report.

“Rescue work” is based on work by Silber et al (1992), which explored what would happen if a situation was not rescued. In this situation it refers to an intervention where a specialist nurse intervenes to prevent a situation deteriorating further perhaps leading to avoidable harm or to unscheduled care. The issue which resulted in the rescue work can be a deterioration of physical symptoms, a medicines issue or an iatrogenic problem (an adverse consequence resulting from a medical intervention) for example you might pick up the early signs of a chest infection or see something is incorrectly prescribed or not prescribed at all. Nurses use vigilance all the time to perform rescue work.

Promoting self-management-These are the interventions you might use such as health promotion and education which lead to eventual self-management by patients and carers.

Psychological Assessment refers to the assessments offered at NICE level 2. These are generally the interventions listed below such as active listening, helping to ‘meaning make’ or address issues of biographical disruption (loss of identity for example) this might also include a referral for more intensive interventions i.e. a psychologist or counsellor.

Anxiety management.

For most specialist nurses this is creating a safe space to explore fears and anxieties in relation to the illness or specialism.

Supporting clinical choice and meeting information needs.

Assessing & meeting information needs using specialist knowledge of the group, exploring choices for example product choices or drug therapy, psychological rescue work See ‘rescue work’ above. Anxiety rescue work might arise where a patient had been given misinformation or no information or rescue work because of the specialism is altered body image.

Dealing with distress.

The distress caused by the condition or its consequences Communicating significant news This could include news about diagnosis, progression of disease etc.

Social assessment.

An assessment of the patient’s social situation.

Mediation of relationships.

This is the process of adaption to often long-term illness where the specialist nurse might negotiate or talk to relatives/significant others. This could include supporting family carers in their response to their family member.

Advice (social)- Any kind of social advice including housing/financial/benefits This could include completing forms for patients.

Referral e.g. OT, physio, SALT, dietician, tissue viability, continence, orthotics/podiatry, any medical consultant including GP, health visitors/community nurses, nursing/care home, pain team, maternity services/midwife, neurophysiology, audiology, ophthalmology, sexual dysfunction, psychologist, psychiatrist, CPN or for counselling / relationship counselling / talking therapies. Safeguarding, workplace/employer, educational are some examples.

Advocacy/Brokering is where you might negotiate or speak up for a patient. This might be in an MDT meeting or ward round for example if you are aware of patients' thoughts on a particular area such as chemotherapy. The brokering aspect is when you negotiate appropriate or faster care for example negotiating a CT scan or other clinical care such as a referral to a new consultant.

Nonclinical administration e.g. booking an outpatient appointment, answering the phone and taking a message for someone else, typing letters, chasing routine results, preparing clinic notes, i.e. secretarial work e.g. dictating a letter to a GP, checking blood results.

Contexts

The contexts are the most common places where specialists work– or where work arises from. The Cassandra tool identifies the following contexts.

- Inpatient
- Outpatient new
- Outpatients follow up
- Paper/virtual clinic/MDT meeting
- Telephone clinic/response
- Specialist area (you can define this for example endoscopy)
- Community

We can add more if there are other settings where you regularly work and want to record. There is no 'office' context. If you do something in the office, you still need to tick the sheet – but put it under the context where the activity arose from

Tips on completing the boxes

The more detail you can collect the better - for example if you are recording a clinical encounter, you may do five or six things within it - make sure they are all recorded.

• Don't worry about whether each intervention takes a little time or a lot – that is all taken care of in the database which underpins Cassandra.

• If you do the same intervention multiple times for the same patient within the same consultation, only tick each box a maximum of one time. For example, even though you might do three ‘specialist physical assessments’, looking at spasticity, skin tone and continence, just tick the box once.

• Sometimes it will be difficult to know exactly which box to tick, but don’t spend too much time worrying about it – just use your best judgement. The following examples may help. In 2013 Cassandra was used by some Multiple Sclerosis specialist nurses to look at their activity you might find these examples useful in terms of recording yours.

These examples were put together for the GEMMS project by Amy Bowen and Geraldine Mynors (2014).

Example 1.

Helen receives a call from a patient who thinks she may be having a relapse of her MS. This is what she does, and what she ticks – all in the context ‘telephone’: Tasks done on the call boxes ticked Intervention (row) Context (column) Finds out from the patient what her symptoms are, listens carefully and makes a judgement.

Physical assessment – specialist telephone recommends that the patient comes up to a nurse led clinic so that her symptoms can be assessed and care given.

Rescue work telephone gives the patient some advice over the phone on how to recognise a true relapse and how some infections can be mistaken for relapses.

Supporting clinical choice and meeting information needs.

Manages anxiety, telephone advises the patient on how to manage her symptoms until her clinic appointment.

Symptom control - specialist telephone tries to put the patient through to clinic appointments, but as they are constantly engaged, makes the appointment on the PAS system herself.

Administration – non- clinical telephone writes about the phone call and the plan of action in the patient’s notes Admin - clinical telephone (originated by clinical phone call)

Example 2

Miriam undertakes a home visit and finds the patient not coping well at home. His partner is overstretched and depressed, and some respite care is needed. This is what she does, and what she ticks – all in the context ‘community’ & “telephone”:

Tasks done on the call boxes ticked intervention (row) Context (column) Assesses the patient’s physical symptoms.

Physical assessment – specialist community listens to the patient’s anxiety about how difficult things are at home, and the carer’s concerns.

Psychological assessment.

Dealing with distress

Community.

Advises on some possible options for respite care

Advice (social)

Manages anxiety. Community Back at the office. Contacts a respite centre to see whether they would be able to take the patient for a few days.

Referral (social) Telephone calls the patient's carer back to explain what is on offer and how the respite care would work, jointly decides on how to proceed.

Supporting clinical choice and meeting information needs. Telephone Calls the care home back to confirm the arrangements

Admin - clinical Telephone Calls patient transport to arrange the transfer

Admin – non-clinical Telephone Phones the patient's GP to explain what has happened and ask the GP to follow up Admin – clinical Telephone Writes to the patient's GP to confirm the plan of action Admin - clinical Community (originated in community).

Information Taken From:

Leary, A. (2012) Guide to using the Cassandra matrix. An activity analysis tool for the Specialist nursing community. Available from GuidetousingCassandraNov13.pdf.

Appendix 2- front sheet for CNS review.

Specialist Nurse Skill Mix Review Summary

January-May 2025

Name- **Service-**

Title- **Current Banding-**

Brief description of your role within the service	
Number of nurse led clinics	
Average number of patients per clinic	
Data capture period in hours	
Total number of physical interventions	
Total number of psychological interventions	
Total case management interventions	
Toal administration interventions	
Research involvement	
Formal teaching	
Other	
Qualifications- Please highlight those you hold currently	Master's degree [Healthcare related] BSc degree [Healthcare related] Independent prescribing qualification Specialist training **(please list)** Relevant postgraduate specialist qualification Management experience Budgetary management Workforce planning PHD RCN Accredited
Comments	

Responsible to-

Accountable to-

Who attends your annual appraisal?

Do you have your 360-degree evaluation?

References

Jackson, C, Leary, A. (2015) The Cassandra Project: Recognizing Multidimensional Complexities of Community Nursing for Work force Development: Phase 2 Report. Canterbury Christ Church University.

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Silber, J. H., Williams, S. V., Krakauer, H., & Schwartz, J. S. (1992). Hospital and patient characteristics associated with death after surgery: A study of adverse occurrence and failure to rescue. *Medical Care, 30*(7), 615–629.

Our Patients
Our People
Our Place

NHS
The Dudley Group
NHS Foundation Trust

Paper for submission to the Public Board of Directors on 11th September 2025.

Report title:	Infection Prevention & Control Board Assurance Framework
Sponsoring executive / Presenter:	Martina Morris, Chief Nurse and Director Infection Prevention & Control
Report author:	David Shakespeare, Deputy DIPC Hannah White, IPC Matron

1. Summary of key issues

This briefing will update the Infection Prevention & Control Strategic Group on Trust compliance with the NHS England Infection Prevention & Control Board Assurance Framework (updated April 2025).

There remain significant concerns regarding methodology and standards of environmental cleaning. Some IPC policies are out of date, however there is a plan to review and ratify updated versions.

2. Alignment to our Vision

Patients: Deliver right care, in the right place, at the right time	**X**
People: Be a brilliant place to work and thrive	
Place: Build innovative partnerships to improve the health of our communities	

3. Report journey

Infection Prevention & Control Group 30.07.25

4. Recommendation(s)

The Quality Committee is asked to

a) Note the current assessment of compliance with the Infection Prevention & Control Board Assurance Framework and associated workstreams.

5. Impact reflected in our Board Assurance Framework (BAF)

BAF Risk 1.0	X	Failure to deliver the right care, in the right place every time
BAF Risk 2.0		Failure to ensure Dudley is a brilliant place to work and thrive
BAF Risk 3.0		Failure to build innovative partnerships to improve the health of our communities
BAF Risk 4.0		Failure to remain financially sustainable in 2025/26 and beyond
BAF Risk 5.0		Failure to achieve operational performance requirements & deliver strategic objectives
BAF Risk 6.0		Failure to take sustained action on infrastructures that enables strategic objectives

Is Quality Impact Assessment required: No

Is Equality Impact Assessment required: No

Paper for submission to the Quality Committee on 26th August 2025
Infection Prevention & Control Board Assurance Framework

1. Introduction

NHS England (NHSE) issued a revised version (V5) of the Infection Prevention & Control (IPC) Board Assurance Framework (BAF) in April 2025. This version supersedes earlier versions of the BAF, which was originally created to assist Trusts in focussing on arrangements to manage Covid-19.

The current version covers the wider general IPC provision inclusive of the prevention & control of all Healthcare Associated Infection (HCAI) and the arrangements and mechanisms the Trust has in place to optimise keeping patients safe through infection prevention. The BAF covers current practice based on the National Infection Prevention & Control Manual for England. Available at:
NHS England » National infection prevention and control manual (NIPCM) for England

The BAF is therefore aimed at providing an additional level of assurance to the Board, that arrangements are in place to keep patients safe with respect to good and effective IPC and to highlight gaps in assurance, which require further action.

The framework is aligned to the 10 components of the Hygiene Code as part of the Health and Social Care Act 2008, and forms evidence of compliance against fundamental standard for safety (Regulation 12), under the CQC regulated activities.

NHS England has developed this framework to help providers assess themselves against the guidance as a source of internal assurance that quality standards are being maintained. It also allows for the identification of any areas of risk, and the mitigation and corrective actions taken in response. It is for this reason the tool was recommended as a method of assurance to Trust boards and organisational committees to demonstrate that there is a systematic review of compliance.

The tool was first published by NHSE in May 2020 with further updates issued leading to the current version 5. Available at:
NHS England » National infection prevention and control

As this tool reflects national policy and provides a systematic method for review of practice the Chief Nurse has asked that this be completed for the Trust and be presented through the Trust Infection Prevention & Control Group and onwards to the Quality Committee.

2. Legislative Framework

The legislative framework is in place to protect service users and staff from avoidable harm in a healthcare setting. NHSE have structured the framework around the existing 10 criteria set out in the code of practice on the prevention and control of infection (The Hygiene Code), which links directly to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The Health and Safety at Work Act 1974 places wide-ranging duties on employers, who are required to protect the 'health, safety and welfare' at work of all their employees, as well as others on their premises, including temporary staff, casual workers, the self-employed, clients, visitors and the public. The legislation also imposes a duty on staff to take reasonable care of health and safety at work for themselves and for others, and to co-operate with employers to ensure compliance with health and safety requirements.

Robust risk assessment processes are central to protecting the health, safety and welfare of patients, service users and staff under both pieces of legislation. Where it is not possible to eliminate risk, organisations must assess and mitigate risk and provide safe systems of work. In the context of HCAI and seasonal respiratory infections, there is an inherent level of risk for NHS staff who are treating and caring for patients and service users; and for the patients and service users themselves in a healthcare setting. All organisations must therefore ensure that risks are identified, managed, and mitigated effectively. This tool facilitates the identification of compliance and risk in relation to infection prevention and control.

3. Board Assurance Framework

The BAF is based on the 10 components of the Hygiene Code as outlined in the Health and Social Care Act 2008 (updated 2015).

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.
2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.
3. Ensure appropriate antimicrobial use to optimize patient outcomes and to reduce the risk of adverse events and antimicrobial resistance.
4. Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/medical care in a timely fashion.
5. Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people.
6. Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection.
7. Provide or secure adequate isolation facilities.
8. Secure adequate access to laboratory support as appropriate.
9. Have and adhere to policies designed for the individual’s care and provider organizations that will help prevent and control infections.
10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection.

The Infection Prevention & Control Team led by the Deputy Director of Infection Prevention & Control and IPC Matron lead on a continuing review of compliance with the Board Assurance Framework against the standards with each component part being rated a level of compliance. The IPC Team continue their practice mindful that best practice in IPC is founded in compliance with the Hygiene Code and challenges to compliance should be recognised and reflected in the BAF and subject to plans and actions for improvement.

Input to complete the assessment is also drawn from key stakeholders including the Trust Infection Control Doctor / Consultant Microbiologist, Estates and Support Services Teams and the Occupational Health and well-being service.

The levels are:
o Compliant
o Partial compliance
o Non-compliant

4. Assessment of compliance

The Trust maintains compliance in all aspects of the BAF but declares partial compliance due to challenges in relation to some areas:

1. Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risk their environment and other users may post to them.

1.4 They implement, monitor and report adherence to the National IPC Manual for England.

Narrative / action: Some Trust IPC policies are out of date. There is a plan to update the policies and receive them at the Infection Prevention & Control Group by September 2025.

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.

Narrative / action: The IPC Team is currently considering how to improve the investigation of community onset hospital associated (COHA) cases. These are cases where the specimen date is less than 3 days of admission (where admission day is day 1) and where the patient was discharged from the Trust in the last 28 days.

The IPC Team is also investigating how to increase surveillance of surgical site infection from the current basic minimum of one module (category of surgery) per quarter per year.

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

2.1 There is evidence of compliance with National Cleanliness Standards. Available at:

NHS England » National standards of healthcare cleanliness 2025

Narrative / action: The Trust soft services contractor is currently working on revised cleaning specifications with a view to presenting to the Trust and negotiating cost changes. There is no agreed proactive deep clean programme and efficacy audits raise ongoing concerns about the standard of cleaning in place. The IPC Team is contributing to a deep dive exercise in cleaning methodology and standards.

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 cleaning standards.

Narrative / action: There is ongoing concern around supervision of domestic staff and the execution of training in cleaning techniques. The Trust Facilities Contract Manager is leading a deep dive exercise into cleaning methodology, techniques and training with a view to working with the Trust soft services contractor to help bring about sustained improvements.

2.4 There is monitoring and reporting of water and ventilation safety, this must include a water and ventilation safety group and plan.

Narrative / action: The Trust does not currently have an in-date water safety plan. The Water Safety Group is currently undertaking work around this to put a plan in place. This does not mean that management of water systems is compromised and there is clear evidence of appropriate action for example in response to adverse sample results. The building level *Pseudomonas aeruginosa* risk assessment requires updating and this is being overseen by the Authorising Engineer for Water and the Water Safety Group.

2.9 Food hygiene training is commensurate with the duties of staff as per food hygiene regulations.

Narrative / action: An external Environmental Health audit in June 2025 resulted in a 3-star rating out of 5. This is concerning for a hospital facility and action is being followed up by the Estates Team with a view to improving hygiene standards.

3. Ensure appropriate antimicrobial stewardship to optimise service user outcomes and to reduce the risk of adverse events and antimicrobial resistance.

Narrative / action: No significant challenges to compliance with section 3.

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.

Narrative / action: No significant challenges to compliance with section 4.

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.

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.

Narrative / action: The IPC Team will develop revised signage and ensure it is in place in admitting areas prior to seasonal increases in the incidence of respiratory infections (by October 2025).

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.

6.5 All identified staff are fit tested as per Health and Safety Executive requirements and that a record is kept.

Narrative / action: The Health and Safety Team manage fit testing at the Trust. There are dedicated fit test trainers within the Divisions. There is a plan to request support from the Divisions to release staff to undertake fit testing to increase compliance. Compliance with fit testing is difficult to monitor as there is no centralised recording of fit tests undertaken. There is a plan to record fit testing completion on ESR.

7. Provide or secure adequate isolation facilities.

Narrative / action: No significant challenges to compliance with section 7.

8. Provide secure and adequate access to laboratory/ diagnostic support as appropriate (including systems and processes ensure that pathogen specific guidance and testing in line with UKHSA are in place.

Narrative / action: No significant challenges to compliance with section 8.

9. Have an adhere to policies designed for the individuals care and provide organisations that will help to prevent and control infections.

9.1 Policies and Procedures in place.

Narrative / action: Some IPC policies are out of date. Plan for review and receipt of outstanding policies at the Infection Control Groups in August and September 2025.

10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection. Includes that 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.

Narrative / action: No significant challenges to compliance with section 8.

5. Recommendation

The Quality Committee is asked to: Note the current assessment of compliance with the Infection Prevention & Control Board Assurance Framework and associated actions and workstreams.

David Shakespeare
Deputy DIPC
August 2025

Appendix 1 – Board Assurance Framework

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Performance KPI's

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August Report (July 2025 Data for National Performance & June 2025 Data for Cancer & VTE)

Karen Kelly, Chief Operating Officer

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Constitutional Performance

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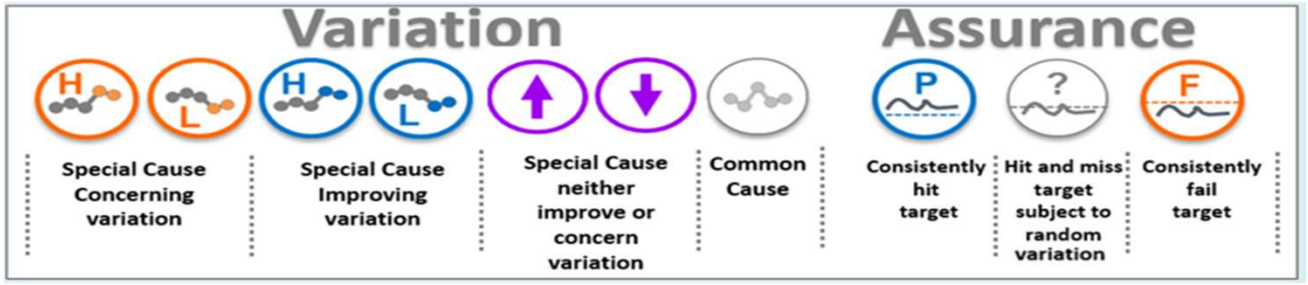
Constitutional Standard and KPI		Target	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	In-month Target		
Emergency Access Standard (EAS)	Combined 4hr Performance	78.0%	79.9%	83.6%	81.2%	81.9%	81.9%	78.1%	77.8%	78.7%	80.5%	78.3%	79.1%	79.8%	78.4%	78.0%	H	?
Triage	Triage - Ambulance	95.0%	90.7%	90.3%	91.0%	85.3%	87.4%	84.9%	86.3%	86.2%	89.5%	90.3%	90.7%	88.5%	86.1%	N/a		F
Triage	Triage - Major	95.0%	70.7%	75.6%	67.9%	60.3%	63.0%	58.6%	63.7%	62.2%	67.9%	74.9%	73.7%	73.8%	69.3%	N/a		F
Triage	Triage - Paediatrics	95.0%	72.7%	82.3%	62.1%	53.5%	61.7%	58.6%	63.1%	65.9%	75.2%	81.2%	80.2%	89.0%	89.4%	N/a	H	F
Triage	Triage - Minors	95.0%	58.1%	53.2%	57.9%	74.2%	65.6%	63.9%	73.3%	66.1%	73.7%	72.6%	72.2%	71.1%	74.8%	N/a	H	F
Referral to Treatment (RTT)	RTT Incomplete	92%	58.6%	57.2%	57.5%	58.3%	59.2%	58.2%	58.7%	58.9%	59.9%	61.4%	62.2%	63.2%	63.1%	61.1%	H	F
Diagnostics	DM01 - Diagnostics achieved within 6 weeks	85%	88.3%	86.3%	86.2%	89.2%	90.4%	85.8%	85.2%	87.8%	86.5%	85.5%	84.1%	87.1%	88.4%	91.0%	H	?
VTE	% Assessed on Admission	95%	99.1%	99.2%	99.1%	99.1%	99.1%	98.9%	98.7%	98.9%	98.8%	98.7%	98.8%	98.8%	N/a	N/a		P



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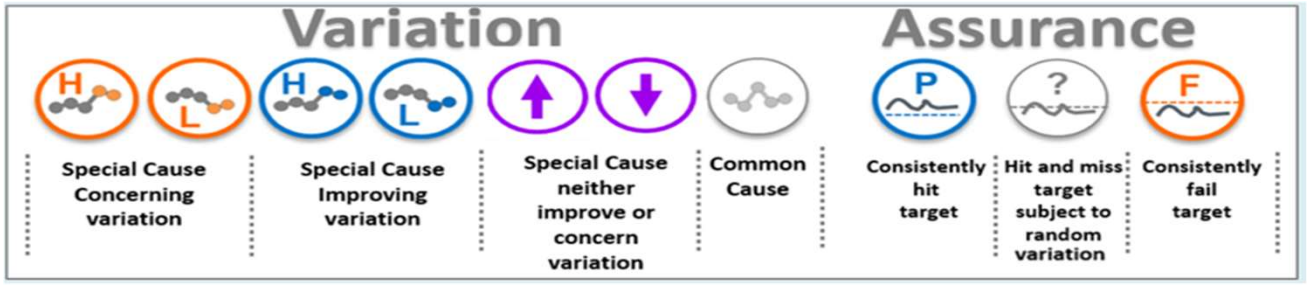
NHS Oversight Framework

The Dudley Group
NHS Foundation Trust

NHS Oversight Framework		Target	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	In-month Target		
Elective	Percentage of patients waiting less than 18 weeks (absolute performance)	92.0%	58.6%	57.2%	57.5%	58.3%	59.2%	58.2%	58.7%	58.9%	59.9%	61.4%	62.2%	63.2%	63.1%	61.1%	H	F
	Percentage of patients waiting less than 18 weeks (performance compared to plan)											-1.0%	-0.6%	-0.1%	-0.7%	n/a		?
	Percentage of patients waiting over 52 weeks		3.9%	4.3%	4.2%	3.3%	2.4%	2.2%	2.3%	2.0%	1.5%	1.8%	1.7%	1.0%	0.6%	0.7%	L	F
	Percentage of patients waiting over 52 weeks for community services											0.40%	0%	0%	0%			?
Cancer	Percentage of urgent referrals to receive a definitive diagnosis within 4 weeks	77%	81.6%	83.6%	82.0%	81.2%	81.9%	84.2%	81.6%	87.3%	86.5%	84.6%	77.7%	78.0%	n/a	n/a	L	?
	Percentage of patients treated for cancer within 62 days of referral	85%	74.4%	72.6%	71.7%	76.6%	71.1%	80.7%	75.2%	70.2%	71.7%	76.4%	74.3%	76.2%	n/a	n/a		F
Urgent and Emergency Care	Percentage of emergency department attendances admitted, transferred or discharged within 4 hours	78.0%	79.9%	83.6%	81.2%	81.9%	81.9%	78.1%	77.8%	78.7%	80.5%	78.3%	79.1%	79.8%	78.4%	78.0%	H	?
	Percentage of emergency department attendances spending over 12 hours in the department		9.3%	6.1%	8.9%	9.5%	9.9%	12.3%	12.4%	11.3%	9.2%	10.2%	8.7%	7.4%	9.0%	8.2%		F
Effectiveness & Experience of Care	Urgent community response 2-hour performance	70%	85.0%	84.0%	79.0%	81.0%	75.0%	76.0%	78.0%	77.0%	85.0%	87.0%	89.0%				H	P



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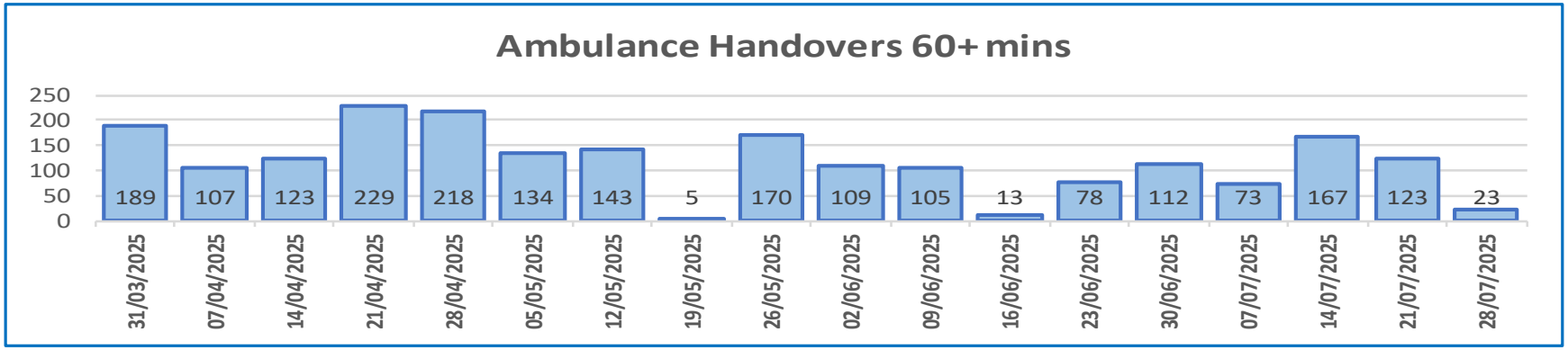
Ambulance Handovers 60+ Mins

The Dudley Group
NHS Foundation Trust



Performance

This month's activity saw 10,333 attendances. This has increased when compared to the previous month of June with 9,917.

11 out of the 31 days saw >350 patients, with 1 of those days reaching >400 patients.

3,231 patients arrived by ambulance; this shows an increase from the 2,904 ambulances that attended last month.

469 of these offloads took >1hr (14%). This is a decrease in our performance when compared with last month's performance of 11%

Over the month, the average length of stay (LOS) in ED was 206 mins for non-admitted patients and 409 mins for those waiting for a bed following a decision to admit. This represents a decline in performance compared to last month where the LOS was 196 mins and 373 mins, respectively.

Action

- We continue to use RAT for all ambulance patients to ensure assessment, treatment and medication are given quickly
- New REACCT project due to begin in August, including collaboration with the clinical transfer hub and discharge facilitators to enable early identification and discharge of medically fit patients.
- Additional trolley capacity now in place to ensure offloads can happen promptly at the ambulance entrance- Implemented and Operational, Corridor case utilised as and when required, when staffing allows.
- 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

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ED Performance

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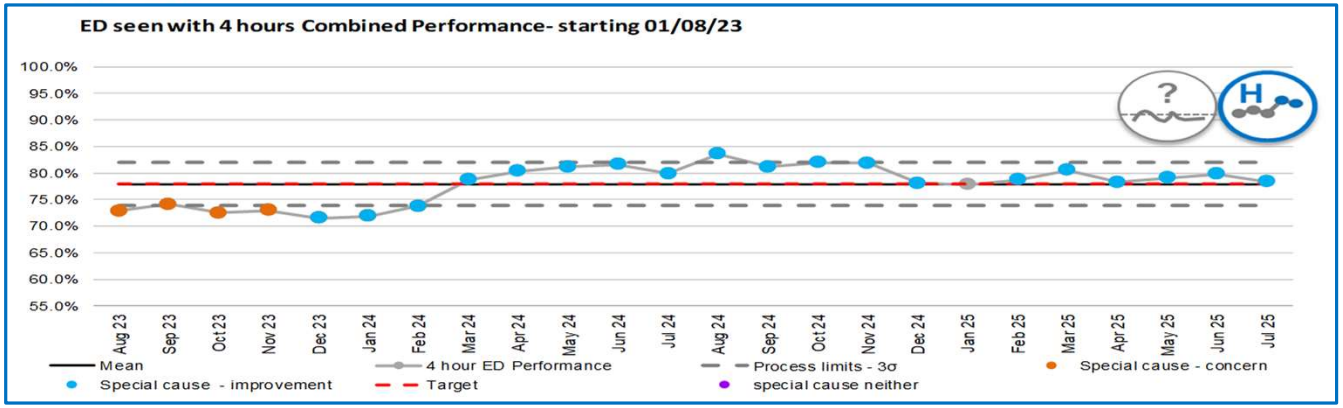

Latest Month 78.4%	Latest Month 96	4th for July 2025
EAS 4 hour target 78% for Type 1 & 3 attendances	DTA 12 hour breaches – target zero	DGFT ranking out of 13 West Midlands area Trusts

Performance

RHH ED performance for July was 3rd among trusts within the Black Country and 4th among trusts within the Midlands, despite high ambulance and walk-in attendance when compared to our regional neighbours.

ED 4hr Performance for July is 78.40%

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.
- New REACCT project due to begin in August, including collaboration with the clinical transfer hub and discharge facilitators to enable early identification and discharge of medically fit 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

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ED 4 Hour Waits Benchmarking

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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

July 2025

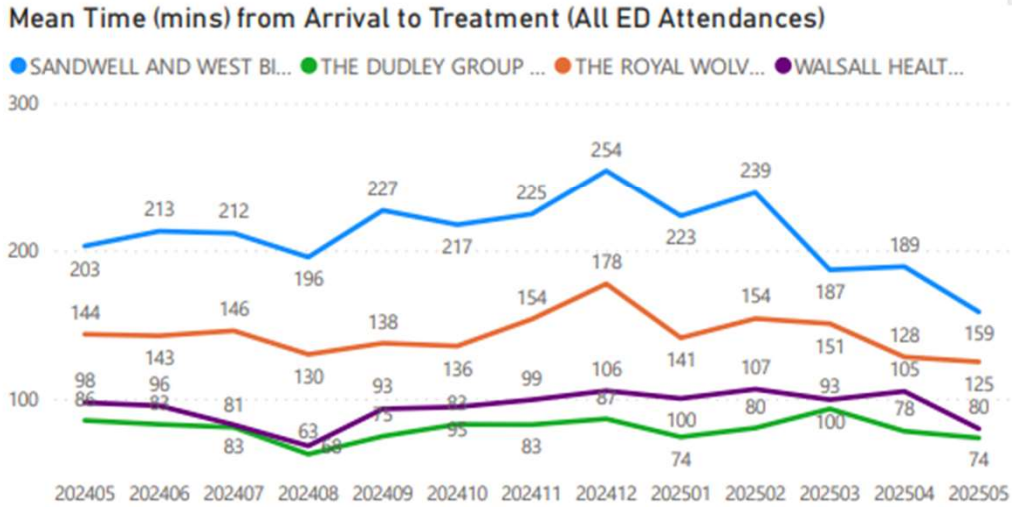
Latest Refresh
14/08/2025 10:07:38

Name	Value	National Rank
Birmingham Women's And Children's NHS Foundation Trust	87.04%	3
The Royal Wolverhampton NHS Trust	81.91%	16
Sandwell And West Birmingham Hospitals NHS Trust	78.86%	28
The Dudley Group NHS Foundation Trust	78.39%	31
South Warwickshire NHS Foundation Trust	78.31%	32
Walsall Healthcare NHS Trust	77.03%	42
George Eliot Hospital NHS Trust	76.07%	46
University Hospitals Coventry And Warwickshire NHS Trust	74.15%	64
University Hospitals Of North Midlands NHS Trust	70.86%	87
Wye Valley NHS Trust	70.80%	88
Worcestershire Acute Hospitals NHS Trust	66.45%	99
University Hospitals Birmingham NHS Foundation Trust	64.17%	104
The Shrewsbury And Telford Hospital NHS Trust	52.84%	120

DGH

Ranking out of 122 Trusts

Source: Daily EAS - Power BI



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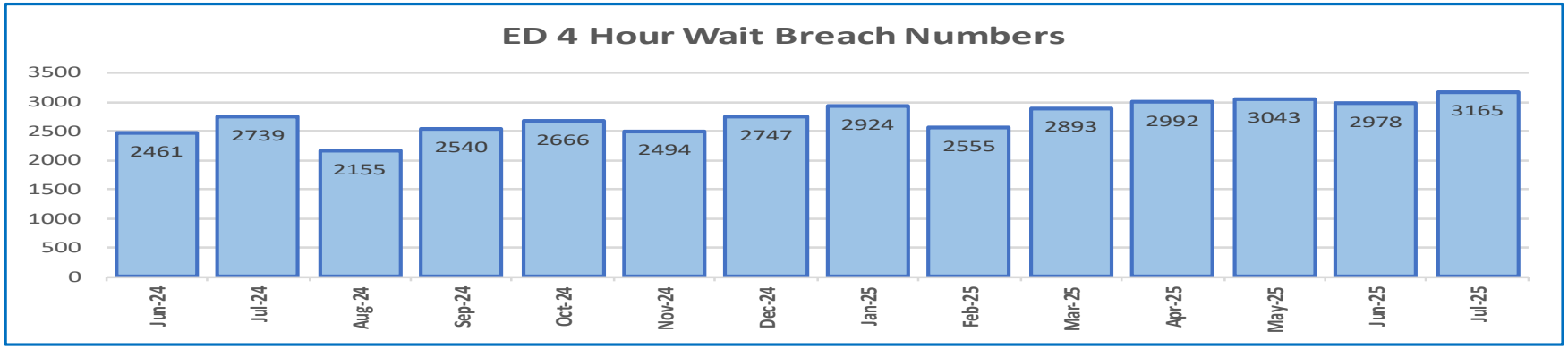
ED 4 Hour Wait Number of Breaches

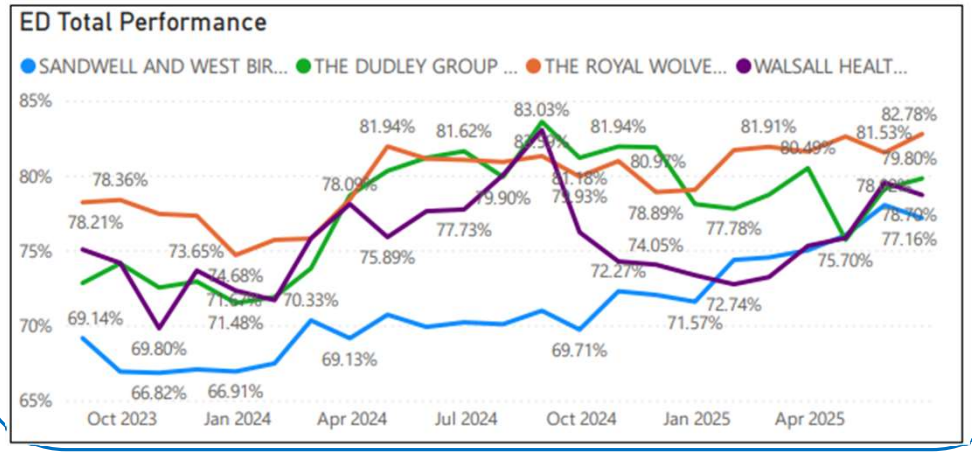
The Dudley Group NHS Foundation Trust



Date	No. Breaches
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
Apr-25	2992
May-25	3043
Jun-25	2978
Jul-25	3165

Performance

ED remains 3rd in the black country and in the top 30 nationally



Action

The ED performance for July was at 78.40% 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.
- Organisational agreement that specialties must take patients directly and not wait to assess them in ED.
- Extra Validation resource.

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12hr Waits – Plan vs Actual

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**Awaiting confirmation of data to be included

Performance	Action

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Discharge Ready Date (DRD)

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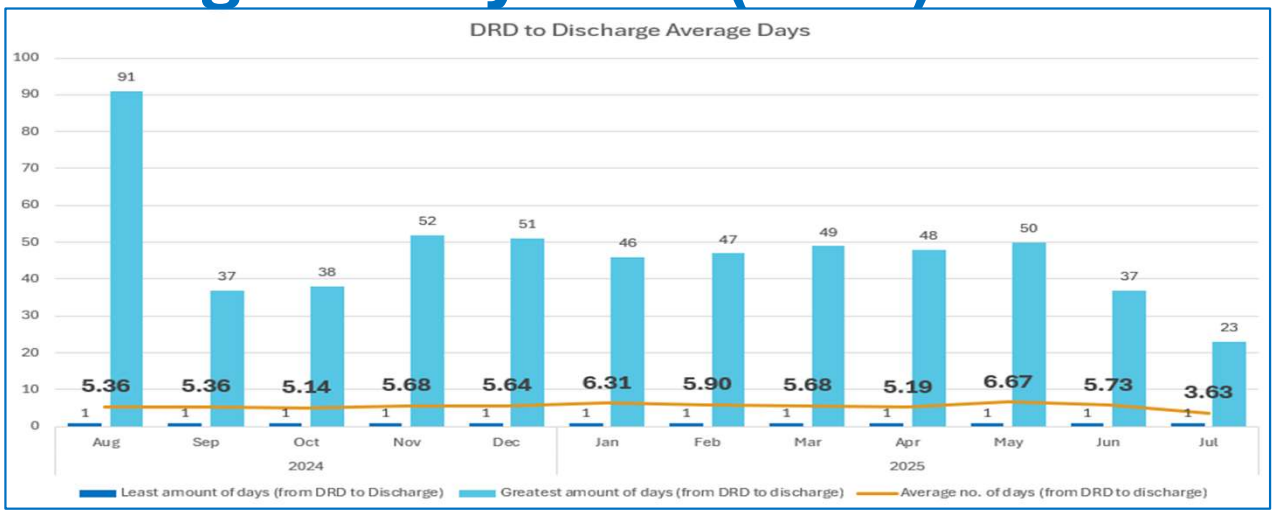

Performance

In July, performance improved significantly, with the average days from Discharge Ready Date (DRD) to discharge reducing to 3.63 days, compared to the 5–6 day trend seen earlier in the year. This demonstrates the positive impact of strengthened discharge planning and closer collaboration with community partners. However, it is important to note that this improvement has been underpinned in part by the increased use of bridging care for Pathway 1 patients. While this has supported timely discharges and sustained patient flow, it has also created a growing financial pressure for the Trust. An organisational decision is now required regarding the longer-term sustainability of this model, with discussions needed at system level to determine whether a shared commissioning approach can mitigate ongoing cost risks.

Action

The priority action is to sustain the improvement seen in July by embedding the practices that drove the reduction in delays. This will include ensuring all wards set and update Estimated Discharge Dates (EDD) within 24 hours of admission, with daily monitoring by the Care Transfer Hub to track patients approaching readiness. A clear escalation process must be followed for any patient exceeding three days post-DRD, with senior review to unblock barriers. Strengthened collaboration with community partners is also essential to secure timely packages of care and placements, supported by proactive brokerage and early equipment ordering. Governance oversight through weekly reporting will provide visibility of performance, enabling rapid identification of slippage and assurance that the July trajectory is maintained.

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EMS Level for last month

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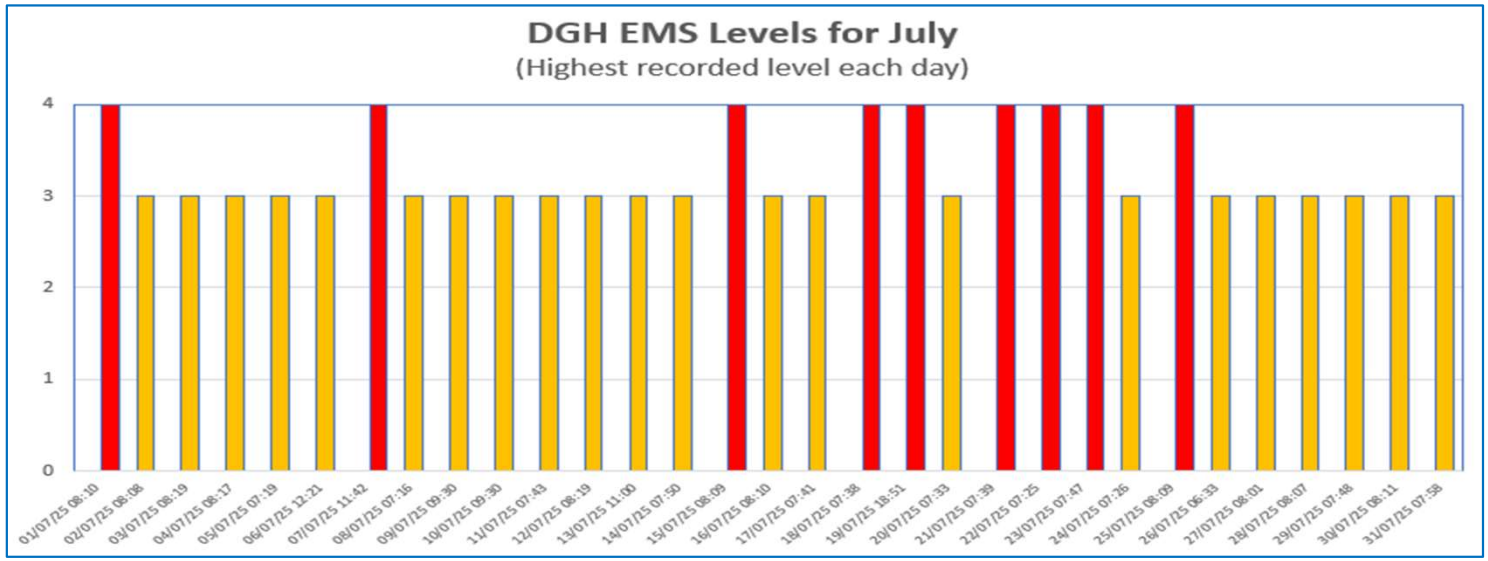
NHS Foundation Trust



Performance

EMS Levels 4 during July.

3,231 patients arrived by ambulance; this shows an increase from the 2,904 ambulances that attended last month.

469 of these offloads took >1hr (14%). This is a decrease in our performance when compared with last month's performance of 11%

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

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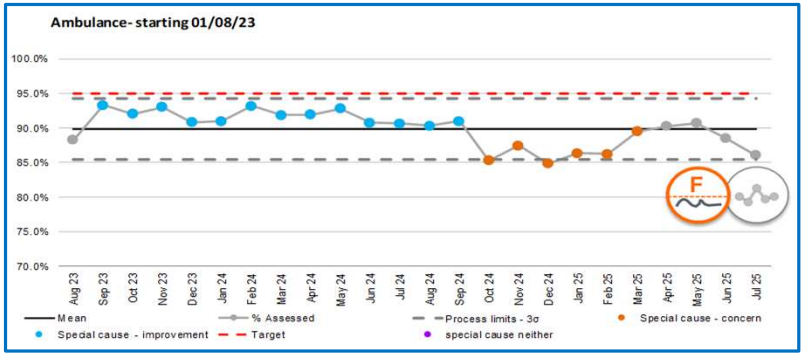
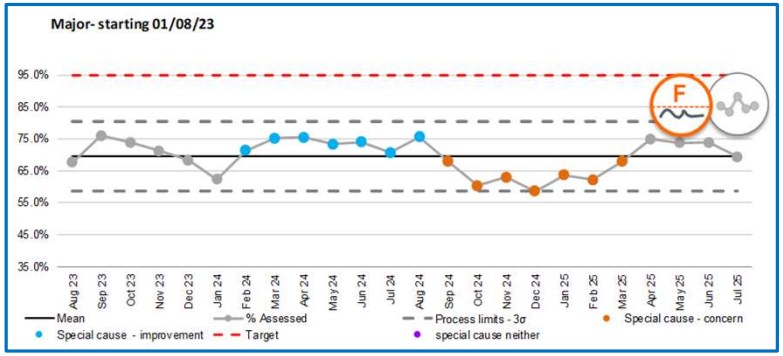
ED Triage

The Dudley Group
NHS Foundation Trust



Latest Month

86.1%



Latest Month

69.3%

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

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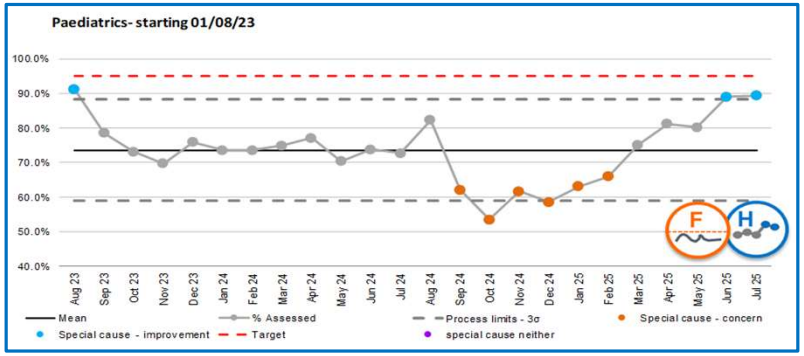
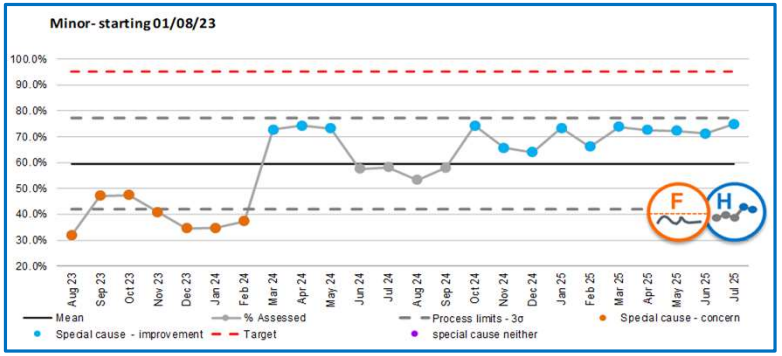
ED Triage

The Dudley Group
NHS Foundation Trust



Latest Month

89.4%



Latest Month

74.8%

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.

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Cancer

The Dudley Group NHS Foundation Trust

	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25
28 Day Combined (77%)	81.6%	83.6%	82.0%	81.2%	81.9%	84.2%	81.6%	87.3%	86.5%	84.6%	77.7%	78.0%
31 Day Combined (96%)	94.1%	89.9%	90.8%	93.1%	92.1%	93.9%	88.9%	93.2%	93.6%	96.6%	93.7%	97.1%
62 Day Combined (85%)	74.4%	72.6%	71.7%	76.6%	71.1%	80.7%	75.2%	70.2%	71.7%	76.4%	74.3%	76.2%

Latest Month	Latest Month	Latest Month
78.0%	97.1%	76.2%
28 Day FDS waits – Target 80%	31 Day Combined - Target 96%	62 Day Combined - Target 75%
Operational Plan Jul 25 – 82.0%	Operational Plan Jul 25 – 94.8%	Operational Plan Jul 25 – 72.3%

Performance

*All cancer data reports two months behind. Data included is up to and including June 2025:

28-day Faster Diagnosis Standard (FDS)

- Achieved 78% against national target of 77% (March 2026 national target is 80%). Increased focus on individual tumour site pathways to achieve monthly plans submitted to NHSE and for performance to be sustained. Performance has improved following work undertaken with teams in Gynaecology and Skin to create additional capacity.

31 day combined

- 31 day combined achieved 97.1% against national target of 96%.

62 day combined

- Achieved 76.2% against national target of 75% by end of March 2026 (this target does not supersede the 85% constitutional standard but set to support tiering measures for cancer performance). Monthly plans submitted to NHSE to be met and performance sustained.

- Gynae and skin tumour sites most challenged. Colorectal 62 day combined performance is area of focus.

- Performance reviewed at system Tiering Calls with NHSE.

Action

28-day FDS

-Performance to be sustained. Forecast shows achievement of monthly plan from July 2025.

31 day combined & 62 combined

- Gynae and skin capacity most challenged. Extra slots have been provided for both tumour sites and shows an improved position from July onwards.
- Urology continues to improve. Prostate straight to test pathway commenced and completion of LATP training for urology nurses with plan to expand once competency logs complete.
- Colorectal CTC reporting times are under review with Radiology clinical leads to improve if possible.
- New Cancer Waiting Times guidance changes from July 2025 issued by NHSE and implemented.
- Urology and Gynae CDC pathways to be implemented during 2025/26 following approval of funding by NHSE.
- Recent regional benchmarking shows the Trust has the smallest total backlog as a proportion of overall PTL (with exception of Birmingham Women's and Children's NHS Foundation Trust)

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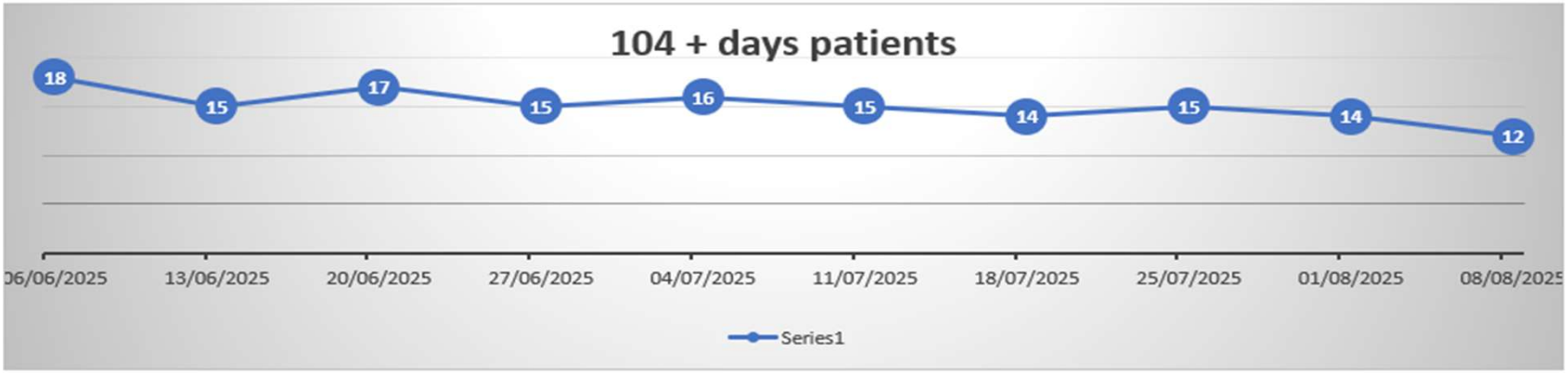
Cancer Performance – 104 Day – Harm Review

The Dudley Group NHS Foundation Trust



Latest Week (08/08/25)

12

All 104 week waits

Target - 10 Patients

Performance

- Of the 12 over 104 days patients, the most challenged tumour sites are Skin, Urology and Colorectal.
- 10 of the 12 have treatment plans / treatment dates. Those without treatment plans were awaiting surgery dates, best interest meetings or further investigations.
- In June we treated 19 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.
- Engage with Urology, Gynaecology and colorectal team to monitor Kidney patient's waiting over 62 day's to stop tip in's over 104 days.

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Cancer Benchmarking

The Dudley Group NHS Foundation Trust

28-Day Faster Diagnosis Standard vs Planning Trajectory

	Apr-25		May-25		Jun-25		Jul-25		Aug-25		Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Target
	Plan	Actual	Plan	Actual	Plan	Validated	Plan	Unvalidated	Plan	Unvalidated	Plan	Plan	Plan	Plan	Plan	Plan	Plan	25/26
	28-day																	
WHT - FDS	82.4%	87.4%	83.6%	84.1%	85.9%	85.6%	85.8%	86.6%	85.2%	83.6%	85.1%	86.0%	86.2%	82.7%	82.7%	83.1%	83.2%	80%
RWT - FDS	80.0%	80.0%	80.0%	80.1%	80.1%	80.0%	80.0%	76.7%	80.1%	74.7%	80.1%	80.1%	80.1%	80.1%	80.2%	80.3%	80.3%	80%
DGH - FDS	82.0%	84.6%	83.0%	77.7%	83.0%	78.0%	82.0%	82.1%	83.0%	86.1%	82.0%	82.0%	83.0%	82.0%	82.0%	82.0%	83.0%	80%
SWB - FDS	76.8%	73.4%	77.8%	68.8%	77.5%	77.5%	78.0%	73.2%	77.8%	76.2%	78.6%	79.3%	78.5%	79.3%	79.1%	79.6%	80.1%	80%

31-day CWT Trust Trajectory Progress

	Apr-25		May-25		Jun-25		Jul-25		Aug-25		Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Target
	Plan	Actual	Plan	Actual	Plan	Unvalidated	Plan	Unvalidated	Plan	Unvalidated	Plan	Plan	Plan	Plan	Plan	Plan	Plan	25/26
	FDS-day																	
WHT -31d	96.6%	98.8%	98.1%	98.1%	100.0%	96.2%	97.6%	96.8%	96.8%	87.5%	100.0%	97.5%	100.0%	97.3%	97.4%	97.4%	100.0%	96%
RWT - 31d	91.8%	90.5%	92.4%	91.3%	93.5%	93.6%	93.9%	89.9%	94.8%	78.8%	95.6%	96.0%	96.0%	96.2%	96.1%	96.1%	96.2%	96%
DGH - 31d	94.2%	96.6%	94.4%	93.7%	94.5%	97.1%	94.8%	94.0%	94.9%	92.6%	95.0%	95.1%	95.5%	95.7%	95.6%	95.7%	96.0%	96%
SWB - 31d	96.5%	89.0%	96.7%	93.9%	96.4%	92.8%	96.4%	94.4%	96.6%	95.8%	96.1%	96.8%	96.5%	96.6%	96.3%	96.2%	96.4%	96%

62-day CWT Trust Trajectory Progress

	Apr-25		May-25		Jun-25		Jul-25		Aug-25		Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Target
	Plan	Actual	Plan	Actual	Plan	Validated	Plan	Unvalidated	Plan	Unvalidated	Plan	Plan	Plan	Plan	Plan	Plan	Plan	25/26
	62-day																	
WHT - 62d	79.4%	78.1%	79.4%	83.1%	80.0%	80.3%	75.7%	69.9%	75.7%	61.5%	76.6%	76.1%	76.7%	75.4%	76.4%	76.7%	76.0%	75%
RWT - 62d	70.5%	69.6%	70.6%	71.3%	71.9%	72.2%	71.9%	52.2%	72.8%	38.2%	73.5%	75.3%	75.4%	75.4%	75.2%	75.2%	75.2%	75%
DGH - 62d	71.4%	76.4%	71.6%	74.3%	72.2%	76.2%	72.3%	80.6%	73.0%	80.6%	73.1%	73.6%	74.1%	74.2%	70.0%	74.5%	75.3%	75%
SWB - 62d	73.3%	73.6%	71.8%	66.5%	72.3%	68.1%	73.0%	74.0%	77.1%	70.6%	73.3%	73.8%	71.4%	72.0%	72.7%	74.5%	75.4%	75%

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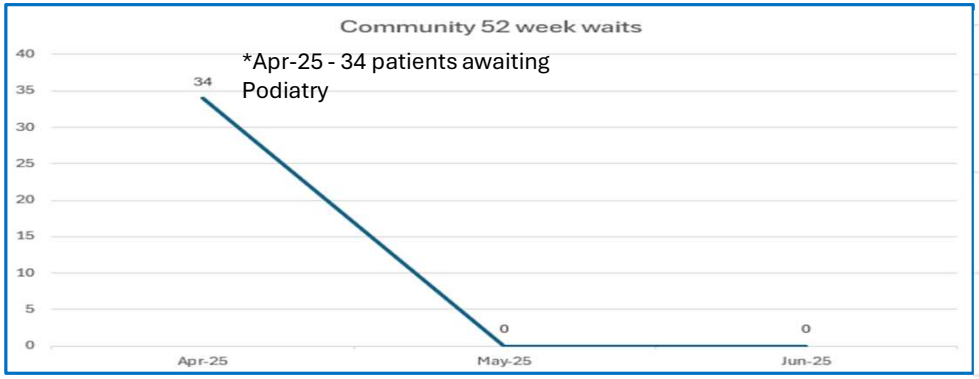
Community 52 Week Waits & UCR 2 Hour Target

The Dudley Group NHS Foundation Trust



UCR 2 Hour Target	TARGET	Apr-25	May-25
TOTAL Number of UCR 2 HOUR REFERRALS RECEIVED		720	764
Number of 2-hour UCR referrals that achieved the 2-hour standard		626	680
% of 2-hour UCR referrals that achieved the 2-hour standard - SEEN IN 2 HOURS	70%	87%	89%

Performance

Community 52 Week Waits

- Improved position with no patients waiting over 52 weeks.
- Podiatry currently no patients waiting over 18 weeks

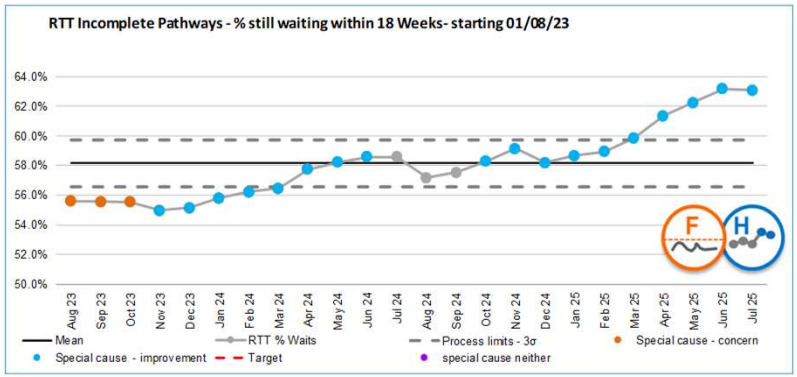
UCR 2 Hour Target

- Urgent Care Response 2 hour target >70% met for the last 2 years. Last nationally reported data was 89% for May (680) visits.

Action

- Continual monitoring of waiting times and review of demand and capacity
- Upskilling of staff within MSK and nail surgery to improve resilience within the service.
- Improvement actions in progress for administration process to manage data submission in line with Primary submission

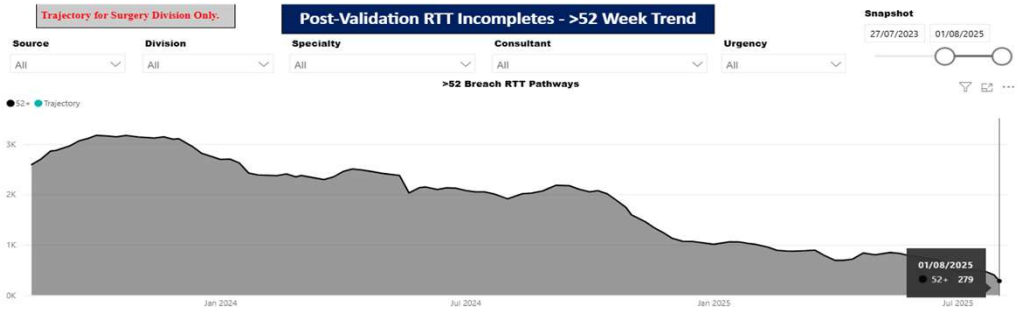
RTT Performance



Latest Month

62.9%

RTT Incomplete pathways target 65%



Taken from: RTT Incompletes - Post Validation Analysis - Power BI Report Server

Performance

Performance against the 18-week RTT standard has shown continued improvement, with 62.9% of patients treated within 18 weeks. This position is 1.4% ahead of trajectory.

For 52-week waits, a revised trajectory was agreed through the annual planning process, extending delivery to the end of Q2. At the end of July, the position was 279 patients against a planned 277, which is two ahead of trajectory. Corrective actions are in place to recover this position and achieve zero 52-week breaches by the end of September.

There were no 65-week breaches reported in July.

The total waiting list size has plateaued, with a reduction of 374 patients since the beginning of the month. However, the list remains 3,200 patients above plan, equating to a 7% variance. Communications have been circulated to GPs to provide reassurance around SWBH provision, and specialty-specific action plans are being developed for areas with the highest growth in referrals and waiting list size.

Participation in the NHSE validation sprint (Sprint 2, commenced 7th July) continues to deliver positive results. The Trust is already 3,800 clock stops ahead of its baseline position, with £33 received per additional clock stop. The sprint has now been extended into September 2025

Action

The specialties currently identified as high risk for 52-week delivery are Gynaecology and Trauma & Orthopaedics.

In Gynaecology, the principal risk relates to long waits for first outpatient appointments. To address this, three locum consultants commenced in August, each with significant outpatient commitments in their job plans to target the longest waits. In addition, Consultant Connect has been engaged to provide enhanced triage for patients not yet allocated a first appointment. This has resulted in 28% of referrals being returned to GPs with a detailed management plan. Insourcing began in August and is expected to significantly reduce the patient tracking list and decrease the time to first outpatient appointment.

In Trauma and Orthopaedics, the main risk relates to delays for inpatient treatment. To mitigate this, weekend operating lists have been planned for August. Mutual aid has been offered by RWT and WHT for hands, hips and knees, although uptake of this support has so far been limited.

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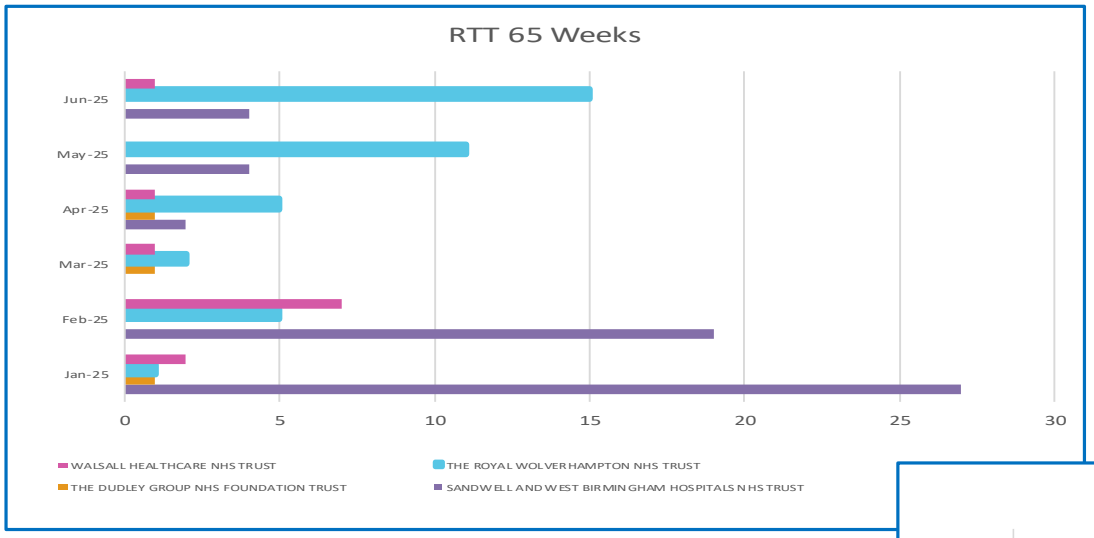
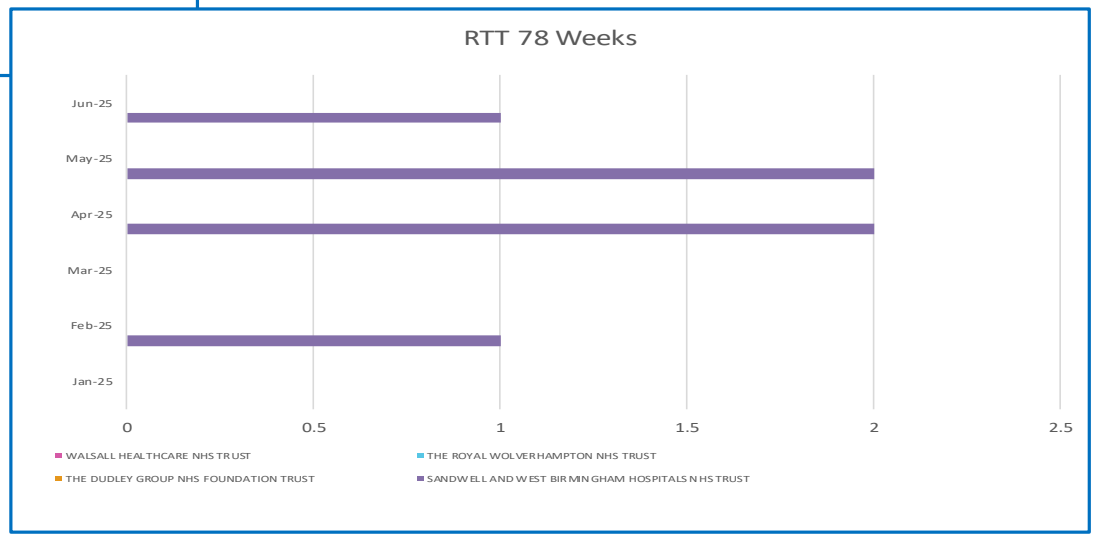
RTT Benchmarking

The Dudley Group NHS Foundation Trust





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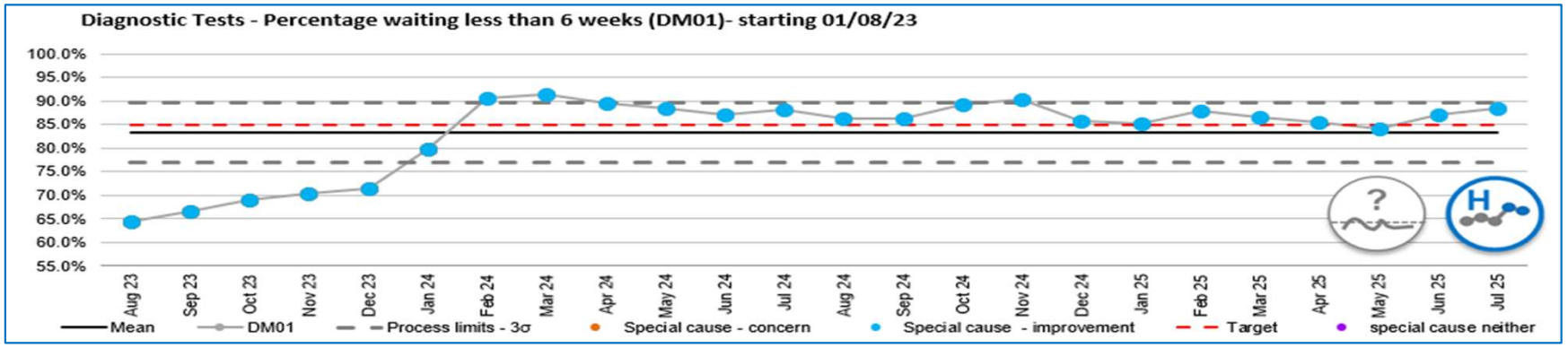
DM01 Performance

The Dudley Group
NHS Foundation Trust



Latest Month

88.4%

DM01 combining 15 modalities - target 85%

Performance

- DM01 for July continues to improve with performance of 88.4% compared to 87.1% in June. Backlog and number of 13+ week waits has reduced from 263 last month to 192.
- Sleep Studies recovery now commenced. July improved to 45.99% and further improvement at pace expected during August and September to clear backlog by revised date of October.
- MRI, Dexa, Endoscopy and Cardiology are all performing at 96% or above and Non-Obstetric Ultrasound performance has improved from 93% in June to 97% in July.
- Audiology is performing well at 94.59%, an improvement compared to 90.83% last month.
- CT is currently challenged and all 160 breaches over 6 weeks were cardiac. Total CT waiting list continues to remain relatively low. Action plan in development to support recovery.
- Patients waiting between 6 and 12 weeks are an area of focus. Diagnostic activity plan for 2025//26 submitted to ICB and actively monitored.

Action

- Sleep Studies equipment and additional workforce providing extra capacity. Staffing challenges in June and July have impacted recovery plan and revised trajectory will clear 6+ week backlog by October 2025. Sleep Studies to commence at Corbett CDC in September. Suitable space for further respiratory services to commence at Corbett CDC is in progress.
- CT cardiac demand vs capacity exercise undertaken. Imaging clinical leads scoping opportunities to create additional capacity and optimise scanning slots where possible. Further request for system mutual aid. Midlands Cardiac Imaging Task and Finish Group meeting scheduled for September.
- Cystoscopy reported small number of breaches over 6 weeks and data validation has been completed.

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DM01 Benchmarking

NHS
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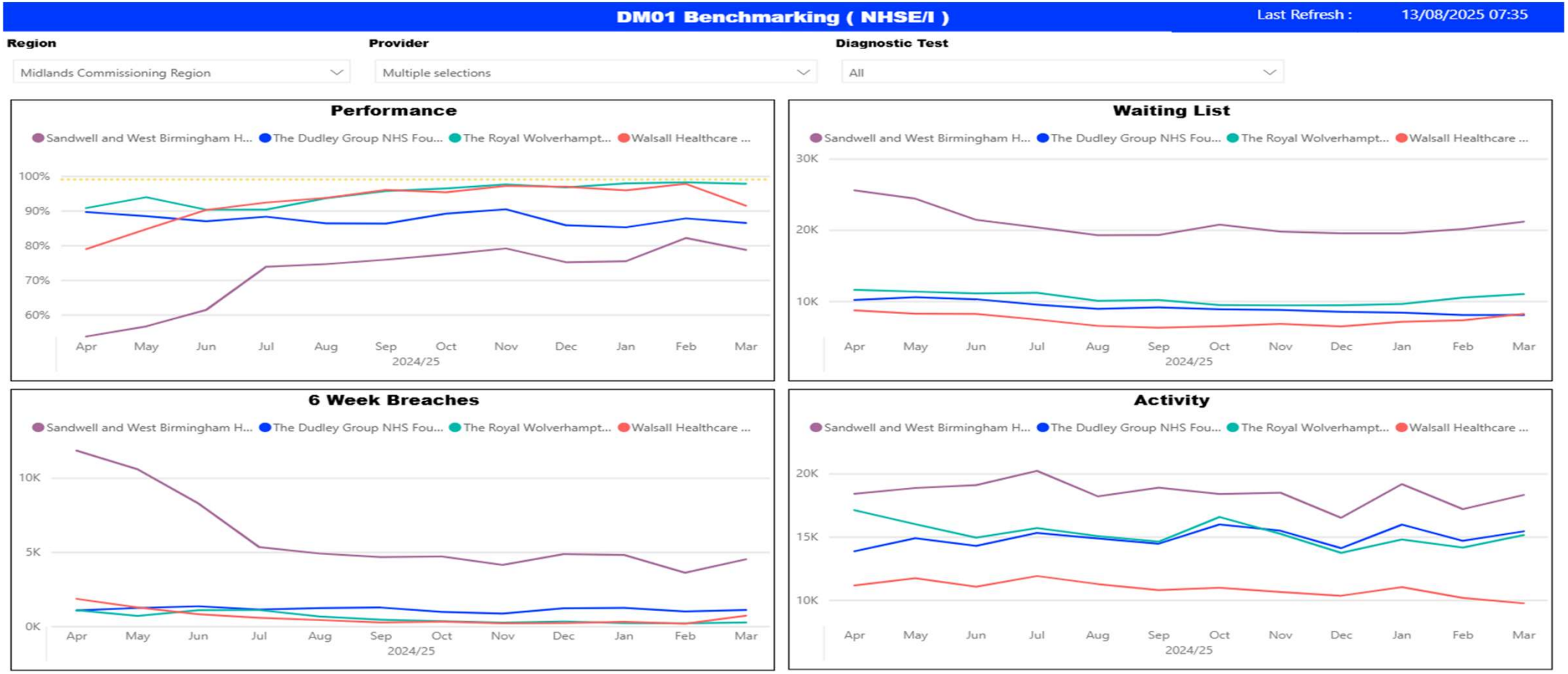

Source: [Imaging Cardiology CRIS Dashboard - Power BI]

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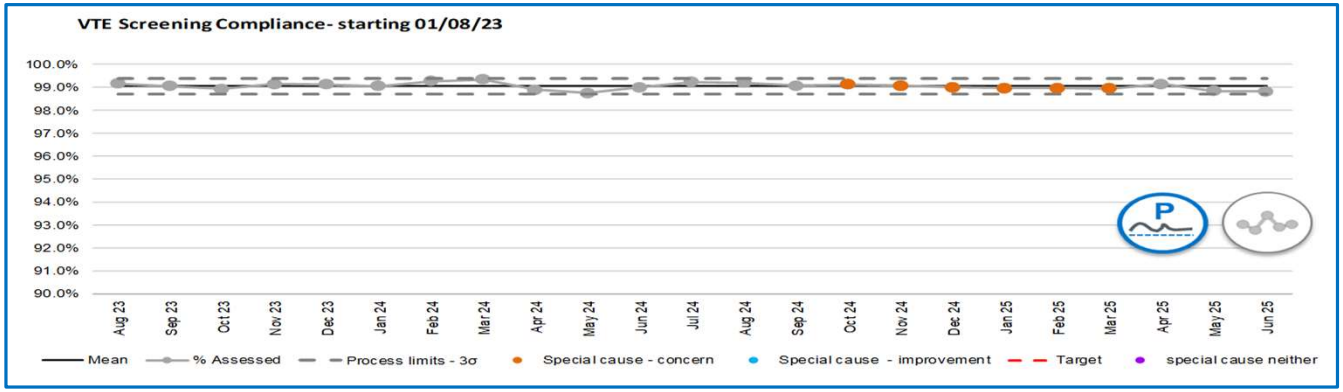
VTE Performance

Please note: VTE figures now run 1 month in arrears

The Dudley Group NHS Foundation Trust



Latest Month	Latest Month	Latest Month
98.8%	99.3%	98.6%
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.

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Screening Programmes

NHS
The Dudley Group
NHS Foundation Trust

Description	Comments	Reference	From	On Mat Dashboard	Target	Q1	Q2	Q3	Q4
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	Karina Lloyd, BCO AAA Screening	No	Acceptable: ≥60.0% Achievable : ≥95.0%	16.67%	29.41%	47.80%	62.50%
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	BSP-S03a	Joanne Essex	No	Acceptable: ≥70.0% Achievable : ≥80.0%	69.00%	77.00%	68.31%	
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	Jo Malpass / Sharon Turner	No	>=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	Newborn Screening KPI Submission	Yes	To be Set	0.70%	1.20%	0.50%	
NHS FASP Trisomy screening 2023/25	Indequate samples for Downs/Edwards/Patau screening a) Quadruple samples	FA4	Newborn Screening KPI Submission	Yes	To be Set	0.70%	2.00%	0.80%	
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)	Mel Bullas, Antenatal and Newborn Screening KPI Submission	Yes	>=99% Green 95%-99% Amber <95% Red	99.80%	99.90%	100.00%	
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)	Mel Bullas, Antenatal and Newborn Screening KPI Submission	Yes	>=99% Green 95%-99% Amber <95% Red	99.80%	99.90%	100.00%	
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)	Mel Bullas, Antenatal and Newborn Screening KPI Submission	Yes	>=99% Green 95%-99% Amber <95% Red	99.80%	99.90%	100.00%	
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	Mel Bullas, Antenatal and Newborn Screening KPI	No	Thresholds are not set for this metric	81.00%	80.00%	75.00%	
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	Mel Bullas, Antenatal and Newborn Screening KPI Submission	Yes	>=75% Green 50%-75% Amber <50% Red	43.20%	50.10%	52.50%	
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)	Mel Bullas, Antenatal and Newborn Screening KPI Submission	Yes	<=1% 1%-2% Amber >=2% Red	0.80%	1.00%	1.10%	
NHS Newborn Hearing Screening 2023/24	Coverage	NHSP-S01 & KPI NH1		Yes	>=99.5% Green 98%-99.5% Amber <98% Red	98.50%	98.40%	98.90%	
NHS Newborn and Infant Physical Examination screening 2023/24	Coverage	ANNB NIPE NP1		Yes	>=97.5% Green 95%-97.5% Amber <95% Red	96.60%	95.90%	97.10%	
NHS Newborn and Infant Physical Examination screening 2023/24	Timeliness	ANNB NIPE NP3		Yes	>=95% Green 90%-95% Amber <90% Red	85.20%	91.40%	54.90%	
Child Vision screening commenced in September						Not Yet Avaialble			

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Kitemark Explanation

NHS
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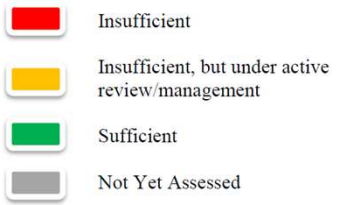
Element	Definition
Timeliness	The time taken between the end of the data period and when the information can be produced and reviewed. The acceptable data lag will be different for different performance indicators. Data should be captured as quickly as possible after the event or activity and must be available for the intended use within a reasonable time period. Data must be available quickly and frequently enough to support information needs and to influence the appropriate level of service or management decisions.
Monitoring	The degree to which the trust can drill down into data in order to review and understand operational performance. 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
Completeness	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.
Validation	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. Final validation is classified as sufficient where validation has been completed and where the indicator has received final approval from responsible individuals.
Audit	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.

Element	Definition
Reliability	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. 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.
Relevance	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.



Click HERE for full kitemark explanation & policy

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Quality KPIs – August 2025 (July 2025 Data)

Martina Morris Chief Nurse
Dr Jonathan Odum Medical Director

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Contents/Icon Key

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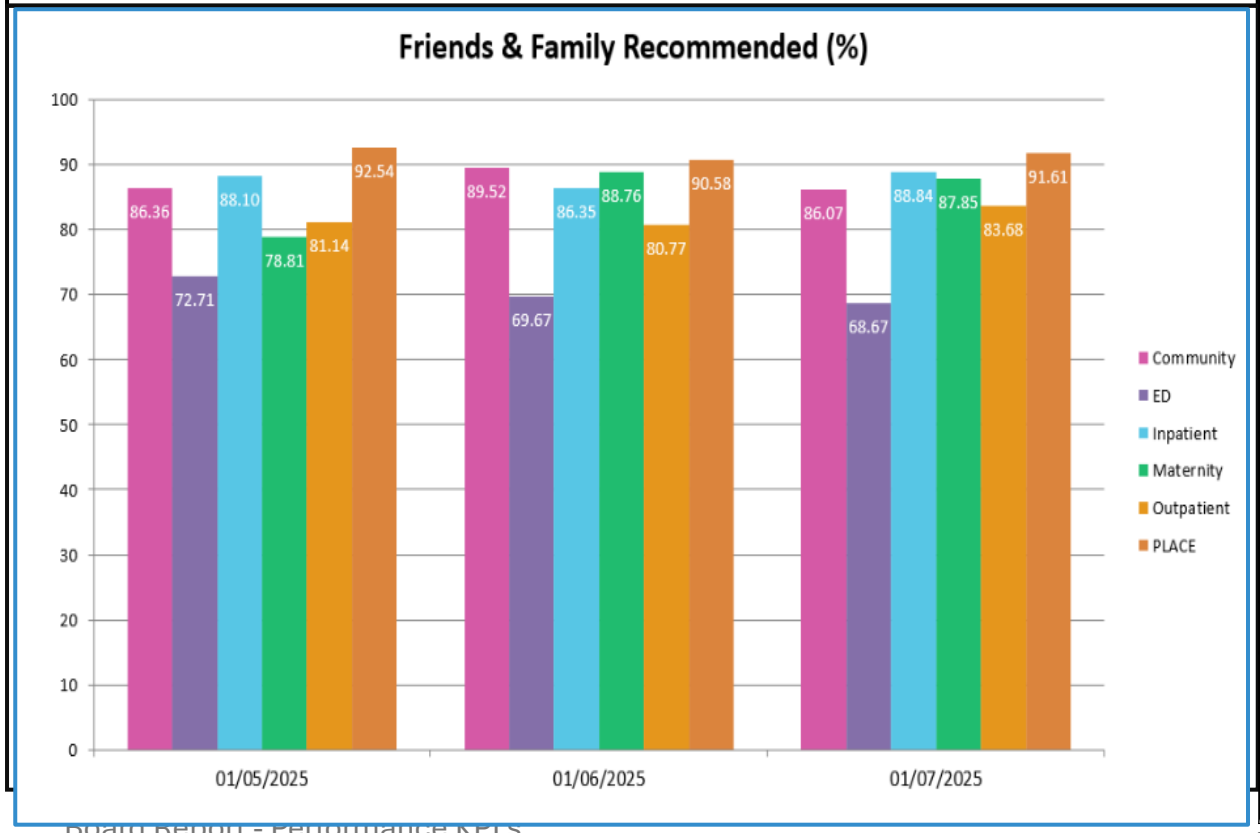
Friends and Family - Recommended

The Dudley Group NHS Foundation Trust

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.

Date	July 2025
Trust Performance	See Graph
Performance Target / KPI	Above national average/% positive scores are increasing



What are the charts showing us

Overall, 81% of respondents have rated their experience of Trust services as 'very good/good' in July 2025, no change from the previous month. A total of 6% of patients rated their experience of Trust services as 'very poor/poor' in July 2025, no change from June 2025.

In June 2025, the percentage very good/good scores for the A&E Department remain the lowest at 69% (a decline from the previous month at 70%). The 'very poor/poor' scores for the A&E Department have seen a small increase this month at 14% (in comparison to 13% in June 2025).

Maternity received the highest positive ratings in July 2025 at 88%. The percentage very good/good scores have improved for the Maternity and Inpatient departments in July 2025. Community have seen a decline in percentage positive scores in July 2025 at 86% in comparison to 90% in June 2025.

Areas Impacting on Compliance

FFT percentage very good/good scores remain below the national average for all divisions. Community have seen a decline in percentage positive scores in July 2025 at 86% in comparison to 90% in June 2025.

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

To note the improvement in percentage 'very good/good' scores for the Maternity and Inpatient Department, and a decrease in the number of patients rating their overall experience as 'very good/good' in Community.

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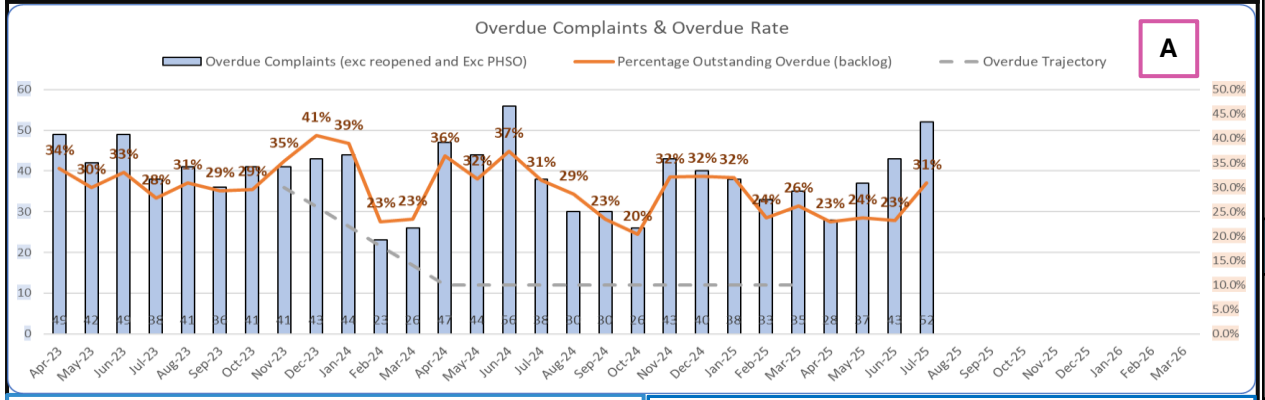
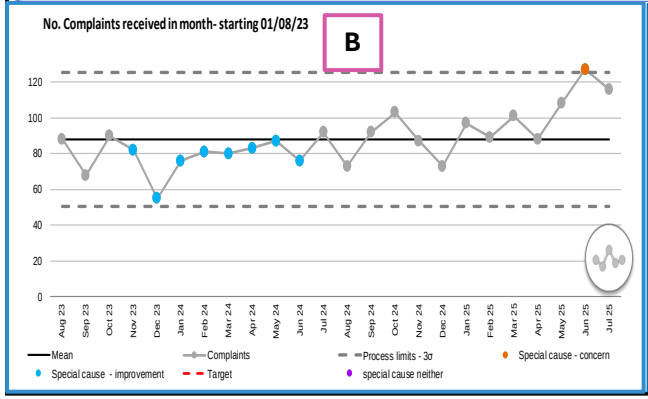
Complaints

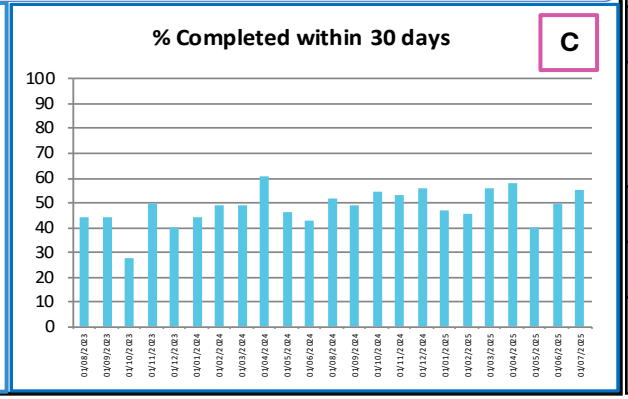
The Dudley Group NHS Foundation Trust

Background	*Monitoring compliance against complaint responses*

Date	July 2025
Trust Performance	A) 52 & 31% B) 116 C) 56%
Performance Target / KPI	49.3% against KPI of 90% response rate







What are the charts showing us

In July 2025, PALS received 328 concerns, 13 comments and 156 signposting contacts totalling 497 compared to 468 in June 2025. The main theme being appointment delays and cancellations. 8 PALS concerns were escalated to a complaint.

The Trust received 116 new complaints in July 2025 compared to 127 for June 2025. Of the 127 complaints received, all were acknowledged within 3 working days. The main theme for complaints for July 2025 was patient care.
Response rate (KPI is 90% response rate):

- The Trust closed 136 complaints (excluding Ombudsman cases (no Ombudsman cases closed for July 2025) compared to 108 in June 2025. All complainants are given a 30-working day timeframe. Of those 136 closed, 73 (53.6%) were closed within 30 working days.
- Not including re-opened complaints and Ombudsman cases, there were 126 complaints closed (first response) and of those 126 complaints, 70 were within 30 working days (55.5%), which is an increase of 5.5% on last month's response rate of 50% (first response complaints).
- For only first response written complaint responses (this excludes reopened complaints, LRMs, Ombudsman cases), there were 124 complaints closed, 70 of those 124 complaints were closed within 30 working days with the response rate being was 56.4% (increase on last month being 52.1%)

As of 31 July 2025, there were 192 complaints open in total (this includes reopened complaints and Ombudsman cases) with 76 in backlog (39.5% in backlog). There were 168 complaints open (excluding reopened complaints and excluding Ombudsman cases) with 52 of those in backlog (30.9%). Of those 168 complaints; 9 are local resolution meetings, 30 are with complaints (including those in the final stages of review), one is awaiting external records, and 128 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). There have been a large number of complaints received for May, June and July 2025. June received the most complaints ever recorded for the Trust.

Mitigations / Timescales / Blockers

The team have an escalation process in place bringing overdue complaints to the attention of the associated director. The team are currently reviewing complaints where poor responses have been received to offer training to those who may require this. The team have also started using an after-action review form to ask complainants for their feedback on learning and if they can share suggestions for improvement which will then be shared with services.

Risk Register – no longer on the Risk Register

Key Points to Note

A large number of complaints have been received, and this will potentially impact the number of complaints that may breach.

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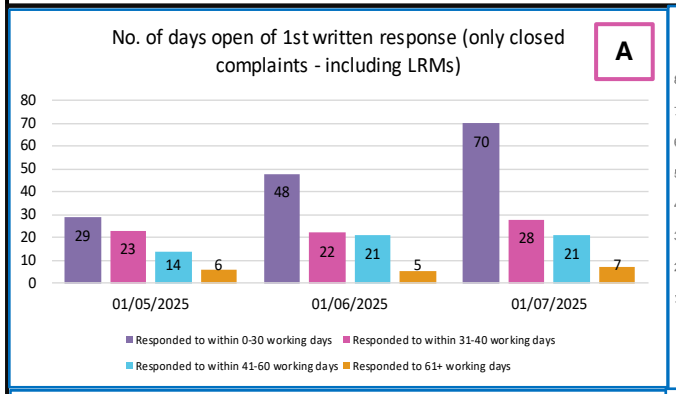
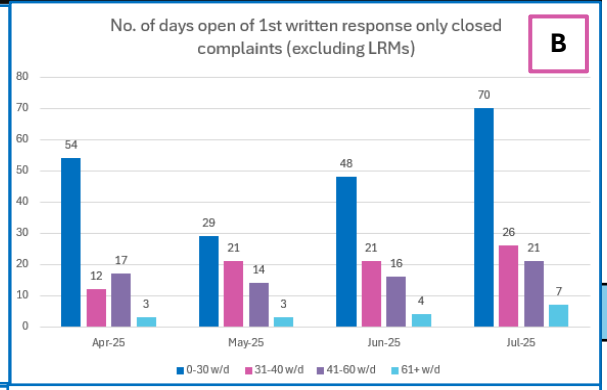
Complaints

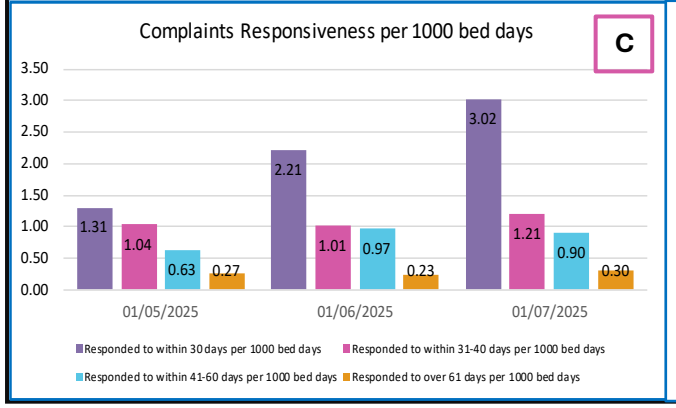
The Dudley Group NHS Foundation Trust

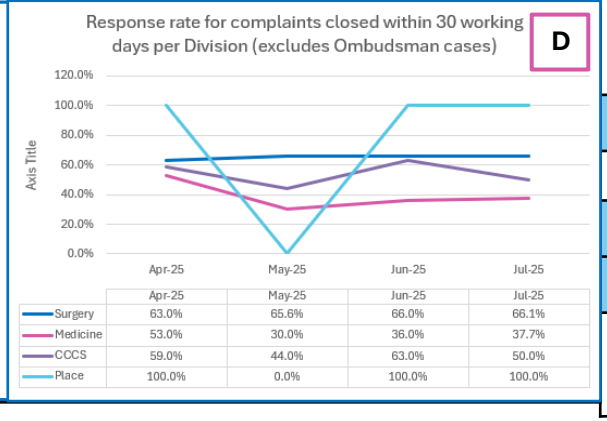
Background	*Monitoring compliance against complaint responses*

Date	July 2025
Trust Performance	A) 70 complaints closed within 30 working days
Performance Target / KPI	90% response rate within 30 working days









	Apr-25	May-25	Jun-25	Jul-25
Surgery	63.0%	65.6%	66.0%	66.1%
Medicine	53.0%	30.0%	36.0%	37.7%
CCCS	59.0%	44.0%	63.0%	50.0%
Place	100.0%	0.0%	100.0%	100.0%

What are the charts showing us

Chart A shows the Trust continues to respond to a large proportion of complaints within 30 working days. However, it does show this responsiveness had decreased in May but has started to increase again in June and July. This is good to note, given the large volume of new complaints received in May, June and July 2025 and the challenge of responding to an increased number complaints within 30 working days.

Not captured in chart A is the number of days open for first response complaints excluding LRMs. Table B highlights this information. As you can see, this does not alter the number of complaints open 30 working days, but it does show that the two LRMs closed in July were responded to within 40 working days.

Chart C captures the complaints responsiveness per 1000 bed days. When reviewing the overall patient activity for June (current estimate reported as 31,666 for community patient activity and 86,261 for inpatient activity, total as 117,927), the patient activity v.s complaints activity (new complaints) for July 2025 is 0.09%. At the end of 2024/25 this was 0.07% same as 2023/24.

Chart D shows the response rate for complaints closed within 30 working days per Division. The responsiveness has improved for Surgery and Medicine Divisions only slightly when compared to June 2025.

Areas Impacting on Compliance

Areas of impact- Responding to complaints by division within 20 working days due to clinical commitments, the large volume of complaints received for May, June and July. The average number of complaints for 2024/25 increased to 87 complaints per month from 79 in 2023/24 and for quarter 1 2025/26, the average is now 108 complaints per month. The average for per months for Q2 2025/26 so far is 121 per month (or 28.5 per week).

Mitigations / Timescales / Blockers

A complaints responsiveness report is to be reviewed putting forward an improvement plan.

Risk Register – no longer on the Risk Register

Key Points to Note

A complaints responsiveness report is to be reviewed putting forward an improvement plan.

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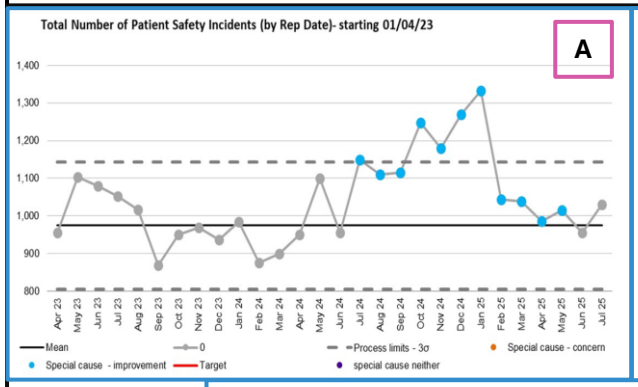
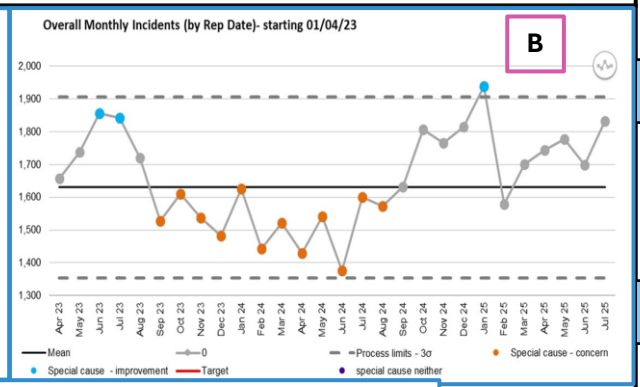
Incidents

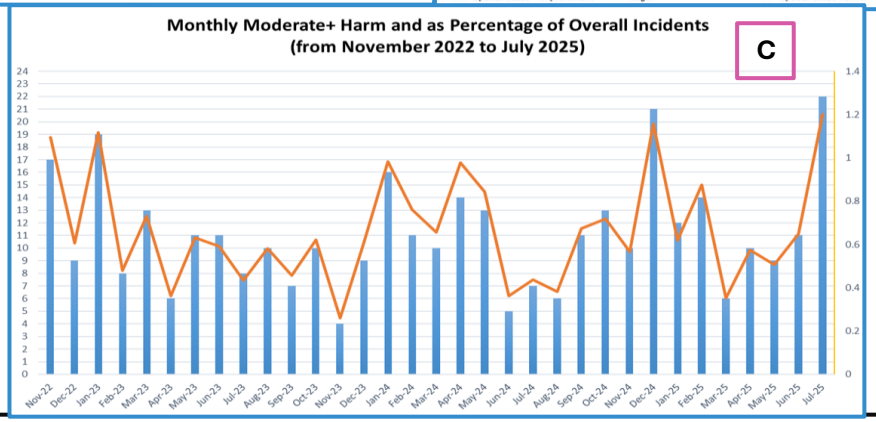
The Dudley Group NHS Foundation Trust

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

Date	July 2025
Trust Performance	A) 1031 B) 1832 C) 1.20% (22)
Performance Target / KPI	N/A







What are the charts showing us

The overall number of incidents reported in July has increased; this increase represents an overall upward trend in reporting since February 2025. The monthly number is above the rolling average and within expected limits/natural variation.

The number of patient safety incidents reported in July has also increased; reporting is above the average but within natural variation.

The number of incidents reported to result in significant harm in July (moderate/severe/death) **are still under review** and are likely to reduce following incident review and investigation. Historical monthly data sets have been refreshed which demonstrate that monthly harm levels (numbers of incidents and percentage) consistently fall following review with harm remaining low (less that 1% of incidents resulting significant harm).

Areas Impacting on Compliance

The changes in overall incident and patient safety incident reporting is likely to reflect natural variation with no significant concerns or trends. 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 July 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

n/a

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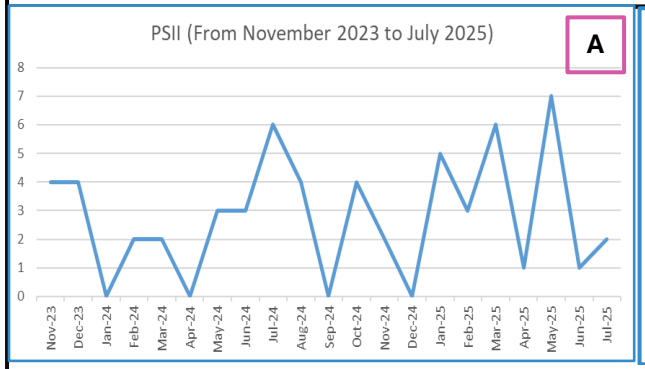
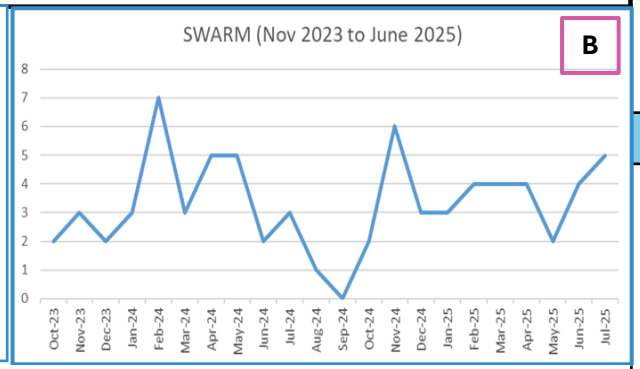
Incidents

The Dudley Group NHS Foundation Trust

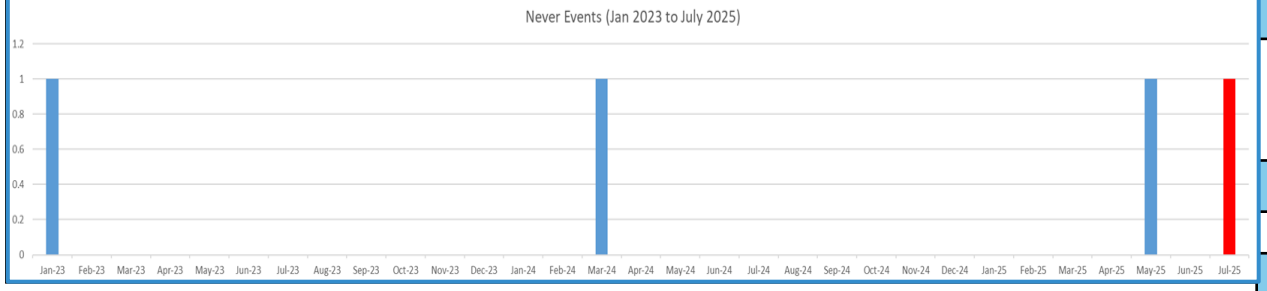
Background	Incident reporting and patient harm monitoring is an essential approach for monitoring safety and the learning culture of an organisation

Date	July 2025
Trust Performance	A) 2 B) 5
Performance Target / KPI	N/A





Doc Compliance (12 Months)	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Total
Compliant	7	4	11	8	16	26	10	10	10	9	10	9	130
In Progress													0
Total	7	4	11	8	16	26	10	10	10	9	10	9	130



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 2 new PSII/ full investigations launched in July; representing a small increase in reporting compared to June.

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 5 new Swarm reviews commissioned in July; reporting remains fairly consistent with previous period.

There was one new Never Events reported in July which accounts for one of the PSII in Chart A. This incident involves the removal of an unintended facial lesion by the Dermatology Service at Corbett Hospital; the intended lesion was left in situ. An immediate review has been undertaken of the incident and system factors explored. Duty of Candour has been undertaken and the patient has been re-booked to have the xcorrct lesion removed.

Statutory duty of candour compliance is being closely monitored to ensure appropriate enactment can be evidenced. There are no breaches in compliance.

Areas Impacting on Compliance

The PSII reported during this period relate to different service and different incident types.

The Never Event investigation is underway; access to clinical photography has been raised as an area for further review and strengthening in the initial review and will be a focus of the ongoing investigation.

The second PSII relates to an incident raised by the Paediatric Critical Care network and relates to care delivered in February 2025. Following the transfer out of a 17 month old child, the Trust have been asked to explore missed opportunities to identify infection and administer antibiotics sooner. An external specialist opinion has been sought as part of our investigation process. This is currently underway.

5 Swarms have been commissioned; these include three delays in scan results being discussed at MDT or with the appropriate team (all 3 involve different specialities) . The findings of the swarm reviews will be collectively reviewed to ascertain an common themes in learning

Wider theme analysis is captured in the quarterly PSIRF reports

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. Response timeframes are a challenge, the number of ongoing responses and staff availability to attend investigation meetings impact negatively on the Trust's timeliness.

Risk Register

nil

Key Points to Note

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Safer Staffing - Dashboard

NHS
The Dudley Group
NHS Foundation Trust

Date	July 2025

Safer Staffing Summary **Jul** Days in Month 31

Ward	Day RN Plan	Day RN Actual	Day CSW Plan	Day CSW Actual	Night RN Plan	Night RN Actual	Night CSW Plan	Night CSW Actual	RN Day %	CSW Day %	RN N %	CSW N %	Sum 24:00 Occ	Actual CHPPD Registered	Care staff	Total
B1	129	99	59	54	63	63	61	45	77%	92%	100%	74%	412	4.49	2.76	7.25
B2(H)	123	95	194	181	87	84	180	173	77%	93%	97%	96%	732	2.93	5.68	8.62
B2(T)	124	97	152	123	93	78	128	117	78%	81%	84%	91%	725	2.90	3.98	6.88
B3	196	174	191	178	189	178	160	154	89%	93%	94%	96%	1,156	3.58	3.45	7.03
B4	228	178	249	211	188	184	191	173	78%	85%	98%	91%	1,311	3.24	3.52	6.76
B5	248	190	166	146	238	220	103	95	77%	88%	93%	93%	1,016	4.96	2.78	7.74
B6	97	73	73	57	62	62	73	66	75%	78%	100%	90%	493	3.21	2.99	6.20
C1 A	127	127	149	115	93	90	124	116	100%	77%	97%	94%	742	3.43	3.75	7.17
C1 B	129	131	152	132	93	86	117	109	102%	87%	92%	93%	735	3.46	3.85	7.31
C2	260	226	65	53	273	228	61	50	87%	81%	84%	82%	480	11.12	2.51	13.63
C3	217	210	426	372	186	168	411	390	97%	87%	90%	95%	1,607	2.82	5.58	8.40
C4	210	187	68	62	124	100	62	71	89%	92%	81%	115%	679	4.93	2.26	7.19
C5 A	124	88	140	131	97	89	115	102	71%	94%	92%	88%	742	2.89	3.77	6.66
C5 B	162	140	125	106	155	147	95	95	86%	85%	95%	100%	736	4.58	3.28	7.86
C6	97	95	95	84	93	93	71	64	98%	88%	100%	90%	564	3.92	3.15	7.08
C7	219	166	191	167	156	148	193	183	76%	88%	95%	95%	1,113	3.31	3.78	7.09
C8	259	234	224	186	217	206	185	171	90%	83%	95%	93%	1,334	3.87	3.22	7.09
CCU_PCCU	252	225	63	52	217	215	36	32	89%	82%	99%	89%	791	6.54	1.27	7.82
Critical Care	538	406	124	88	519	394			75%	71%	76%		438	21.92	2.42	24.34
AMU	550	502	465	407	496	509	465	439	91%	88%	103%	94%	2,494	4.76	4.07	8.83
Maternity	850	776	263	183	527	500	155	123	91%	70%	95%	79%	1,271	9.61	2.82	12.42
MECU	93	91	34	33	93	93			98%	98%	100%		219	10.08	1.66	11.74
NNU	392	282			267	236			72%		89%		441	14.06	0.00	14.06
TOTAL	**5,622**	**4,794**	**3,667**	**3,122**	**4,526**	**4,172**	**2,986**	**2,770**	**85%**	**85%**	**92%**	**93%**	**20,231**	**5.10**	**3.46**	**8.57**

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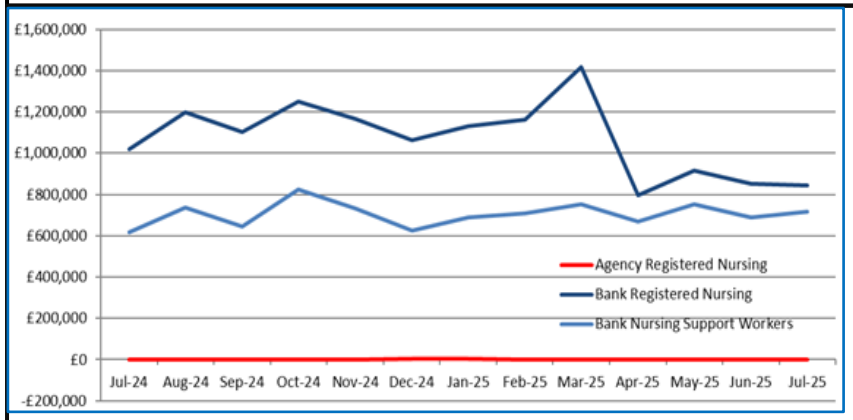
Safer Staffing

The Dudley Group
NHS Foundation Trust

Background

Date	July 2025
Trust Performance	A) B)
Performance Target / KPI	N/A



A - Bank Usage

B – Top 10 depts. using Bank & Agency, July 2025

Area	Nursing Vacancy %	Agency Registered Nursing	Bank Registered Nursing	Bank Nursing Support Workers	Grand Total
Emergency Department Nursing	23%	£0	£86,484	£51,628	£138,111
Ward AMU 1	21%	£0	£36,982	£42,076	£79,058
Ward AMU 2	6%	£0	£30,742	£37,933	£68,675
Ward C8	17%	£0	£25,386	£34,968	£60,354
Maternity Unit	3%	£0	£36,464	£15,526	£51,990
Ward B4	12%	£0	£22,766	£28,139	£50,905
Ward C3	17%	£0	£6,654	£41,718	£48,373
Ward C7	17%	£0	£22,551	£24,342	£46,893
Ward AMU Assessment	23%	£0	£27,844	£18,894	£46,738
Discharge Lounge	2%	£0	£29,001	£17,182	£46,183

What are the charts showing us

- Safe staffing % and CHPPD slightly lower in July 25 compared to June. 25 for days for nights remain the same
- Comparing the CHPPD with peers based on the Model hospital
- July 25 data – Nursing/Midwifery - Trust – 5.2 / peers 4.9, Care support worker – Trust 3.6 /peers 3.8
- Chart A – show a slightly increase CSW bank use in June 25, RN's remain the same
- Table B - bank remains high increase with increase vacancy rates especially in ED and Medical emergency wards . Also, due to the bank being utilised in the TES areas in ED and the additional beds on AMU1/2 requiring additional staff.

Areas Impacting on Compliance

Unfunded additional capacity in AMU 1&2 with 10 additional beds and TES area in ED continues to be utilised.
Discharge lounge is now back to the orginal purpose following the made event

Mitigations / Timescales / Blockers

TES areas continues to be utilised on a regular base's due high capacity demands in both ED x-ray and the corridor.

Risk Register

Key Points to Note

- Safer staffing report for June, 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 –
Student Nurses qualifying between Feb & Sept 25 -130 who have been on placement in the trust, 22have been offered jobs with the trust but we have 108 Nursing students who are still looking for jobs

Our Patients
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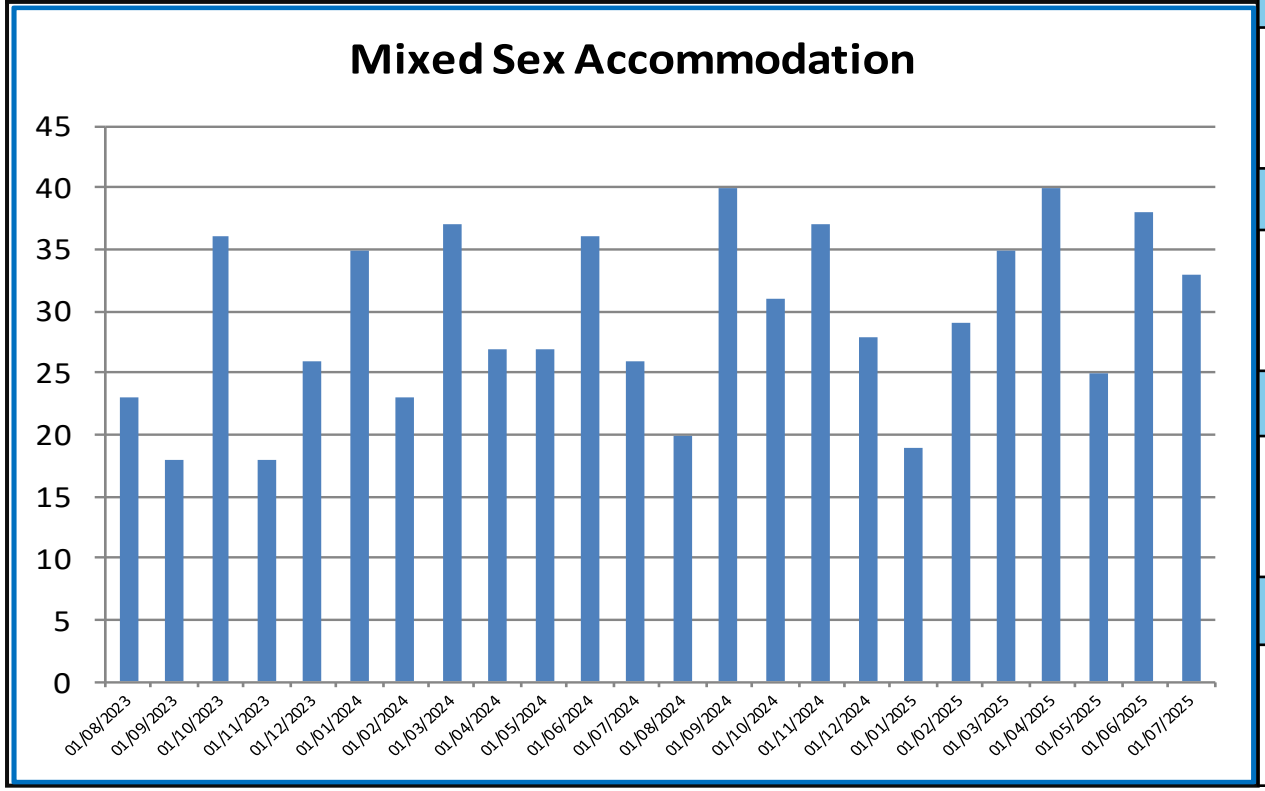
Mixed Sex Accommodation

The Dudley Group NHS Foundation Trust

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

Date	July 2025
Trust Performance	33
Performance Target / KPI	0



What are the charts showing us

Mixed sex breaches have seen an decrease in July 2025 to 33.

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.

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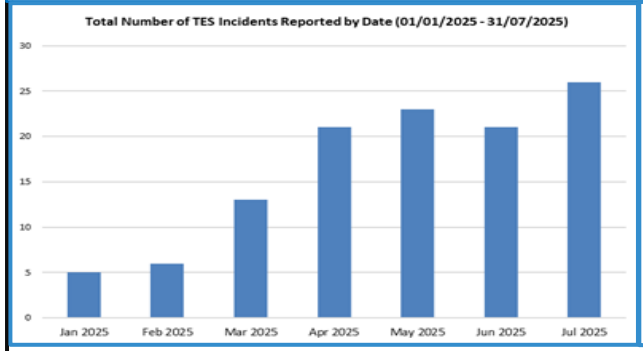
Temporary Escalation Space (TES) Incidents

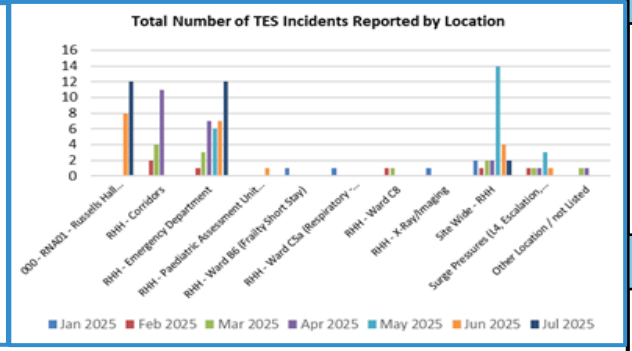
The Dudley Group NHS Foundation Trust

Background

Date	July 2025
Trust Performance	See Graph
Performance Target / KPI	

Figures provided within this table are taken from the 'Temporary Escalation Spaces (TES)' section of the UEC Daily sitrep which is submitted externally	Month						
Metric	**Jan-25**	**Feb-25**	**Mar-25**	**Apr-25**	**May-25**	**Jun-25**	**Jul-25**
The Number of Patients in Temporary Escalation Spaces within ED	8	3	7	25	31	24	18
Total Temporary Escalation Space beds occupied	0	28	2	23	22	14	18
Total adult general and acute Temporary Escalation Space beds occupied	0	28	2	23	22	14	18
Total paediatric general and acute Temporary Escalation Space beds occupied	0	0	0	0	0	0	0





* The above 2 charts and below table relate to Datix reporting/records. Incidents reported as 'Surge Pressures/Other Location/Russell's Hall Hospital' relate to Site Wide TES incidents

	Number of TES Incidents Reported	Risk Assessment Completed	Investigation Completed on Datix
Jan 2025	5	5	5
Feb 2025	6	6	6
Mar 2025	13	13	13
Apr 2025	22	22	21
May 2025	23	23	23
Jun 2025	21	20	21
Jul 2025	26	23	6

What are the charts showing us

The number of Temporary Escalation Space (TES) incidents reported during July 2025 has increased (26) when compared to the previous month (21). There has been a significant increase in the number of incidents reported since January 2025, showing an upward trend. The incidents reported in July were related to TES spaces opened Site Wide (53.8%) and the Emergency Department (46.2%).

Areas Impacting on Compliance

Reduction in divisional patient discharge resulting in lack of flow through ED and adherence to WMAS offload times.
There has been an increase in compliance of TES risk assessments being completed and updated into Datix, this needs to increase further to capture all incidence.

Mitigations / Timescales / Blockers

Admin trained within the capacity Team to ensure timely upload of paper TES assessment documents to be attached to Datix. Further work to include TES assessment document within Datix rather than paper format.
Patients in TES areas meet criteria. Corridor patients in ED have had ED Triage and RAT assessment to be deemed suitable for temporary area.
Number of patients additional on ward areas and in ED are highlighted at every capacity meeting.

Risk Register

Datix Risk ID – 2573 Temporary escalation spaces in operation due to lack of flow through the organisation

Key Points to Note

TES SOP now includes corridor care and has been submitted for ratification. Post NHSE visit in April 2025 the corridor was advised to be utilised to decrease ambulance delays.
Informatics creating report to show all patients with location of TES, ED corridor and holding beds on ward areas with time stamps, to enable accurate data and LOS of patients held in temporary areas. Report will be added from July 2025 onwards. AMaT quality audits commencing 1st July for TES areas.

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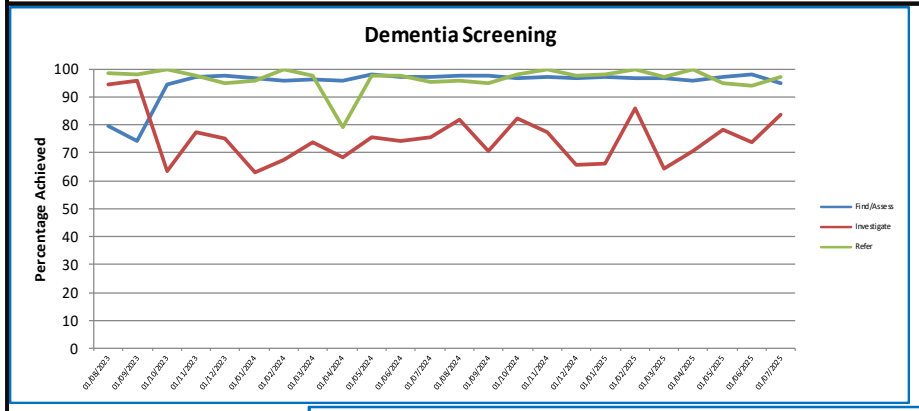
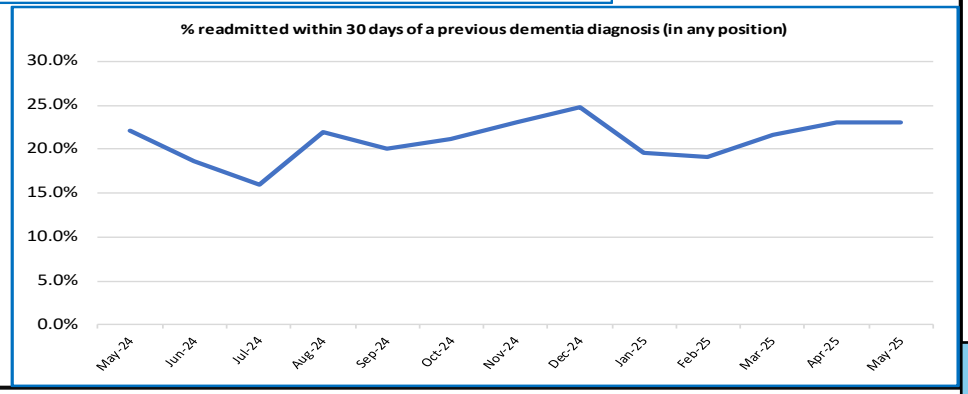
Dementia

The Dudley Group NHS Foundation Trust

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.*

Date	July 2025
Trust Performance	Find) 95.08% / Investigate) 83.67% / Refer) 97.22%
Performance Target / KPI	90%





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 (Find, Assess, Investigate and Refer).
The "Find" completed by the wards is compliant at 95.08 %, which is a reduction on the previous month of 97.87%.
The Dementia and Delirium Team who complete the "Investigate" is non-compliant at 83.67% but is an increase on last month which was 72.92%. This is a 10.75% improvement. The chart is trending at a gradual incline. The Dementia and Delirium Team who "refer" the patients that they have investigated is compliant at 97.22%.
The second chart shows the number of patients with dementia who were readmitted within 30 days of discharge. The latest available data is for May 2025 where there is an flattening of data for readmission.

Areas Impacting on Compliance

The Dementia and Delirium Team has been increased by an addition of a Nursing Associate working 0.80 WTE who commenced their post 20.04.25. Their impact with compliance levels appears to be having an impact due to the increasing investigate levels. It is anticipated that the increased contacts will continue. Feedback has been given to the team about addressing compliance levels.
It should be noted that the dementia and delirium team complete work and contacts that are not counted as part of the FAIR data, but still contribute towards patient care. This includes:

- Completing DoLS paperwork (this is part way through hand over to the Safeguarding Team), but the Dementia and Delirium team still support heavily with C3 and FMNU, which includes inputting the DoLS application and ongoing review – due to cease 18.08.25)
- Educating staff about restrictive interventions and the need to apply for a DoLS
- Support in ED will not be part of the FAIR assessment work
- Supporting with complex patients' multiple times of the week will impact on data collection
- Providing training to clinical staff about dementia and delirium will impact on FAIR data
- Responding to ward bleeps and calls to support the ward and patient care
- Educating and directing staff on the delirium pathway
- Supporting patients under 75 with queries of dementia
- Telephone calls to family members
- Communication with family members on the ward
- Fact finding to support with diagnosis of dementia where this is suitable

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 data patterns for the previous 12 months demonstrate a differing pattern. There is an increase in August 24 for readmissions, these then continue to increase during autumn and winter. They peak in December and then reduce before increasing steadily from February. There are clearly many factors that contribute to readmission rates.

Mitigations / Timescales / Blockers

The request to increase the 0.8 WTE nursing Associate post to 1.0 WTE in line with a staff member from another team reducing their hours has been agreed. The date that this becomes live needs to be confirmed, but will positively impact the Investigate data.

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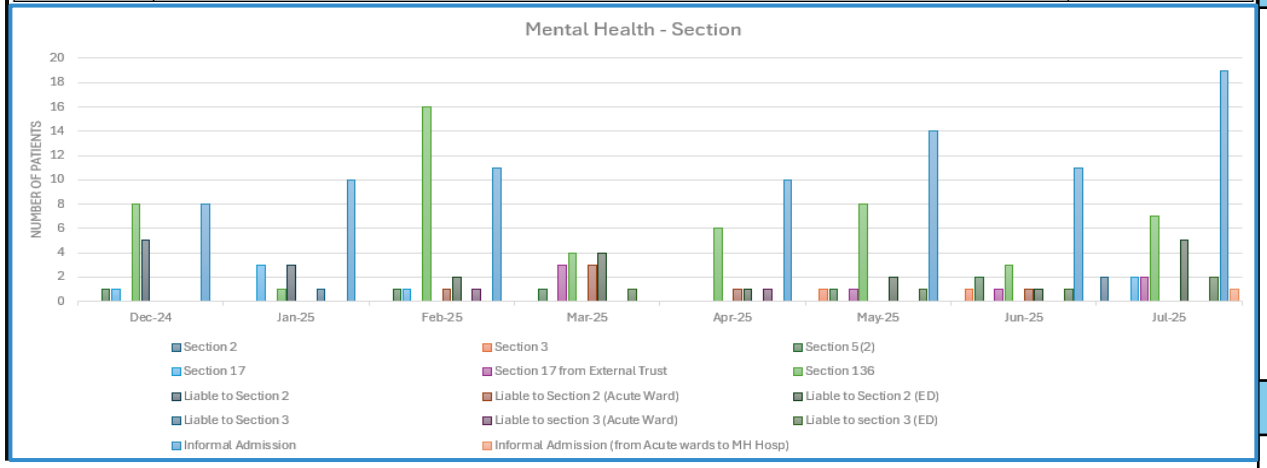
Mental Health

The Dudley Group NHS Foundation Trust

Background	*Data explores use of the Mental Health Act (MHA) 1983 within the inpatient Trust.*

Date	July 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
Jul-25	Section 2 to DGFT - 2 x discharged to a MH hospital bed from C7	2
Jul-25	Section 17 from external Trust - Section 2	2
Jul-25	Section 17 from DGFT - Local leave within Trust grounds for both patients on C7	2
Jul-25	Informal admission required from ED to MH Hosp	19
Jul-25	Informal admission required from Acute wards to MH Hosp - On AMU and discharged to a MH hospital	1
Jul-25	Section 136 - Discharged home x 4, Informal x3	7
Jul-25	Liable to Section 2 (ED)	5
Jul-25	Liable to Section 3 (ED)	2



What are the charts showing us

There has been 2 patients detained to DGFT on a section 2 due to their dual poor physical and mental health in relation to eating disorders. Both patients were transferred to mental health hospitals on their section 2 when medically fit. One patient was not transferred until 07.08.25 and so will impact August data. Both patients were granted section 17 leave to move within the hospital and its grounds to support contact with family and friends as part of their recovery and were a positive addition to their care. Both patient's detention followed the escalation process before the detentions to the hospital were accepted.
There were 2 patients admitted to the hospital who were on section 17 leave from a MH hospital due to their physical health needs. One was transferred back to a mental health hospital. The other was discharged from their section 2 and remains in the hospital under a DoLS.
There have been no patients liable to be detained within the acute wards of the hospital. However, there has been 1 patient who has been an informal or voluntary patient, admitted for physical health reasons and then awaiting an inpatient mental health bed on an informal basis.
There has been 7 section 136's in ED which is an increase from June 25. 2 of the patients were CYP, both of which were the same patient on 2 separate occasions and they were discharged home with CAMHS support for both. 4 of the patients were discharged home (including the CYP), 3 were admitted to mental health hospital on an informal basis. None of the patients detained under a section 136 had physical health needs, all were in ED as the local MH place of safety places were full.
There has been 19 patients in ED requiring an informal or voluntary admission to an MH hospital, this is an increase on the previous month. There were 5 patients in ED who was liable to section 2, and 2 that were liable to be detained on section 3, these numbers are an increase on previous months. These sections would become live when admitted to an MH hospital.

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 reviewing ED data on the new Power BI database 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. Section 5(2) training is accessed via a QR code and so pre-booking does not need to take place. Attendance for this training has been very low, often with no staff attending. There was no training available for 2 weeks over July and August due to the MHA Administrator being on leave.
There has been no compliance issues with the use of the MHA during July.
There has been the absence of the purchased MHA Administrator service from 25.07.25 - 8.08.25 due to them being on leave and the other MHA Administrator being on long term sickness. This resulted in the MHA Administrative role falling to the Lead for Mental Health and Complex Vulnerabilities. One patient detained to the hospital was supported to appeal against their detention as per their rights, leading to a Tribunal needing to be arranged. Due to the patient transferring to a mental health hospital, the tribunal took place at a MH hospital. All the arrangements and reports required for this were organised within the Trust.

Mitigations / Timescales / Blockers

Risk Register

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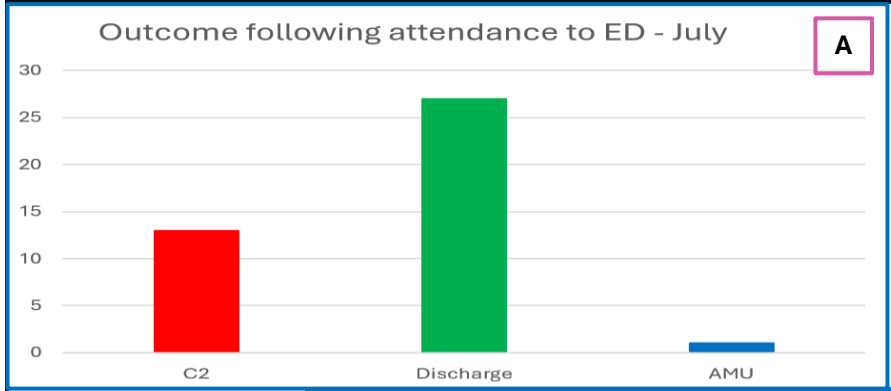
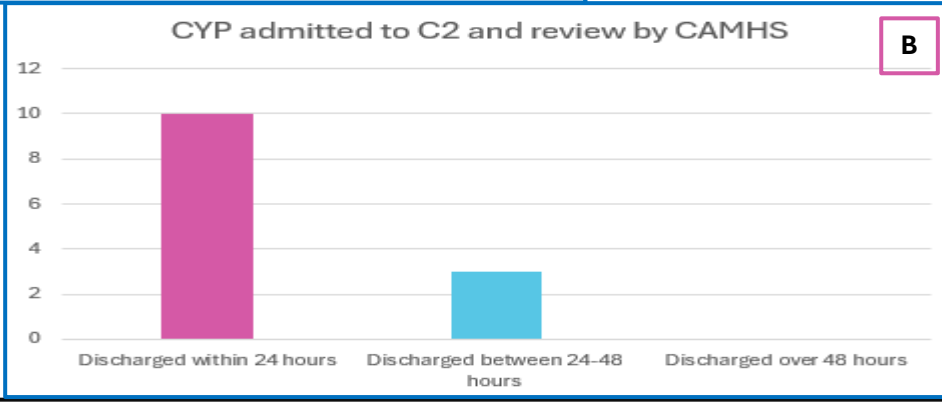
Mental Health - CYP

The Dudley Group NHS Foundation Trust

Background	*A review of Children and Young People with attend the Trust with mental health concerns*

Date	July 2025
Trust Performance	A) C2,13 D/C, 27 AMU, 1 B)<24, 10 24-48, 3 >48, 0
Performance Target / KPI	CQC compliant





What are the charts showing us

Chart A details that during July, 41 children with mental health concerns attended the Trust. Of which, 27 CYP were reviewed within Paediatric ED and were discharged. The remaining 14 went to Children's Ward (13) or to AMU (1). This information includes all attendances and does not differentiate if they attended multiple times.
Paediatric ED were able to discharge 27 CYP when they were medically fit, who didn't require admission to the trust. There were also 6 self-discharges during July, which includes advising staff that they didn't want to wait (completing DAMA form) and leaving before being seen (not completing DAMA form). There was 1 CYP that attended who had a section 136 in place (attended on 2 x separate occasions due to this) and 1 CYP was accompanied by police who was not on a section 136.
C2 saw 15 CYP being admitted following review within paediatric ED. CYP that were discharged within 24 hours of admission equates to 10. Those that remained for 24-48 hours equates to 3. There were 0 CYP that remained on C2 for over 48 hours.
All children were discharged when they were medically fit. The children within ED (20) that didn't DAMA, returned to their usual place of residence. All 13 children that were admitted to C2 were discharged to their usual place of residence following a review on the ward and a follow up appointment being made.

Areas Impacting on Compliance

Mental health reasons for CYP attending ED in July include the below, with some patients attending with more than 1 reason:

- Deliberate self-harm
- Overdose
- Suicidal ideation
- Behavioural concerns

July data is comparable to previous months. Overdose, suicidal ideation and deliberate self-harm remain the main reasons for attendances over the past 3 months.
School has now finished, which means no examinations, or peer pressure which could effect the mental health of the CYP. Consideration still needs to be considered for home/family life and out of school influences which may be affecting their mental health.
Children were discharged when they were medically fit and had been reviewed by a member of the CAMHS team and a community plan put in place.

Mitigations / Timescales / Blockers

July identifies that the 16-17 age range had the most attendances. This corresponds with finishing school and/or college.
This should also be reviewed looking at the gender of attendees. July has seen a 50% increase in the number of males that have attended with mental health concerns. Females continue to be the main gender that attends the Trust with mental health concerns, but there has be a decrease compared to June.
CYP who attend the Trust outside of Dudley include Sandwell (9), Wolverhampton (6). South Staffordshire (1) and Worcester (1). Sandwell patients are continuing to have a greater representation within the Trust. This may be due to RHH being closer to patients homes then then new 'MET' hospital that has been built. It must be considered that many of those CYP who live on the boarders of Dudley, may find that RHH is closer to them than the MET. Therefore, if an ambulance is required to bring them to hospital, they will bring them to their closest one, even if there is only 0.5mile in the distance.

Risk Register

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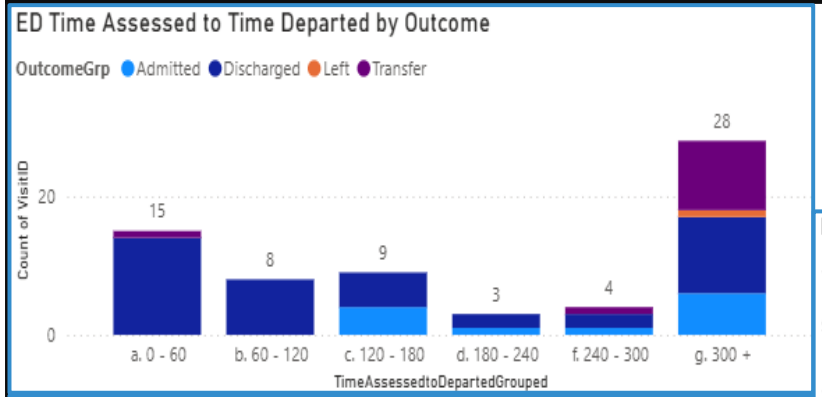
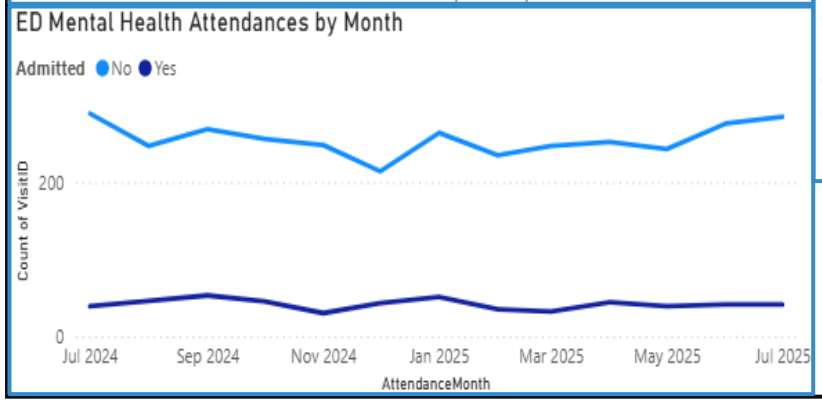
Mental Health – ED

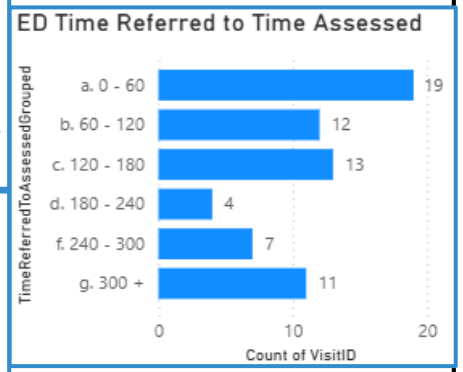
NHS
The Dudley Group
NHS Foundation Trust

Background	*Review of patients with mental health concerns attending ED, including assessment wait times and admission/discharge wait times*

Date	July 2025
Trust Performance	A) B) C)
Performance Target / KPI	CQC compliant







What are the charts showing us

Chart 1 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 MH hospitals and assessments requiring admission within DGFT.
Chart 2 details the waiting time for patients to be seen by Mental Health Liaison Services. This indicates that 66 patients were seen outside of the 1-hour timeframe directed by Core-24 guidance. This is an increase from 47 for July.
Chart 3 details that there is a consistent low number of patients who require admission to the Trust due to mental health needs. There has been an increase in he number of patients who do not require admission from May 2025.

Areas Impacting on Compliance

For patients awaiting admission to a MH hospital from ED, there have been the following wait times in July:
- 1 male patient waited 7 days
- 3 patient waited 2 days
- 7 patients waited 1 day
- The other 13 patients waited from 3- 23 hours

For patients admitted to the hospital:
- 1 patient waited over 6 days for transfer once MOFD from AMU (informal patient)
- 1 patient waited over 7 days for transfer once MOFD from AMU (informal patient)
- 1 patient waited 3 days for transfer once MOFD (section 2 patient)

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:
- The time of assessment of patients in data does not match actual documentation
- The time of referral for a patient to MHLS is not clear in terms of time completed and time picked up by MH services
- Sunrise pulls the data from notes entries that does not match activity in real time

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, reduced staffing numbers in the MHLS team impacts on their ability to see patients within the required time frames and on other occasions, the rational for the delays are not known/not documented.

Mitigations / Timescales / Blockers

It would be helpful to review the data for the number of contacts that MHLS has in ED and the acute wards each month, to identify if these remain consistent or if the work load is increasing. This would provide context to the above data review. This data would be different to the "mental health attendance by month" as this is a broad stroke approach to this data group and are not necessarily in contact with MHLS.

Risk Register

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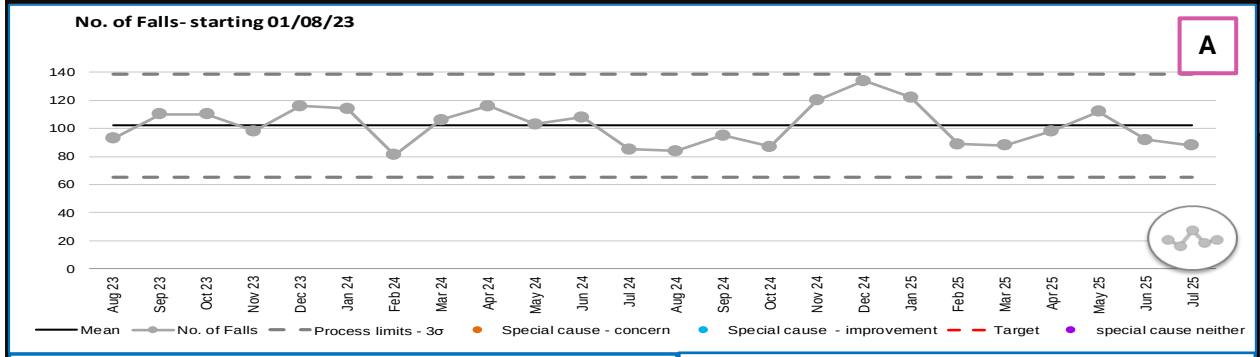
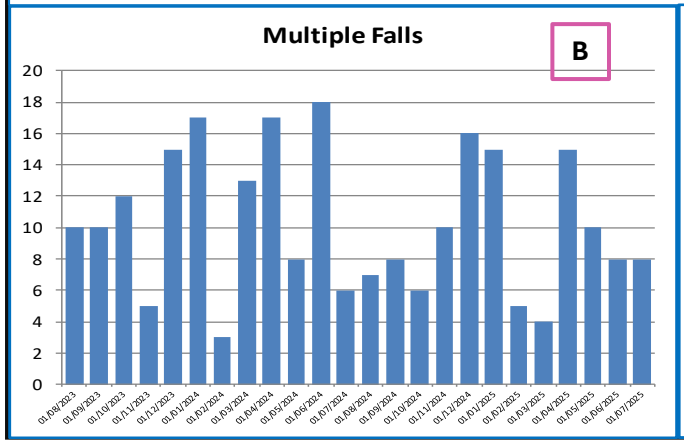
Falls

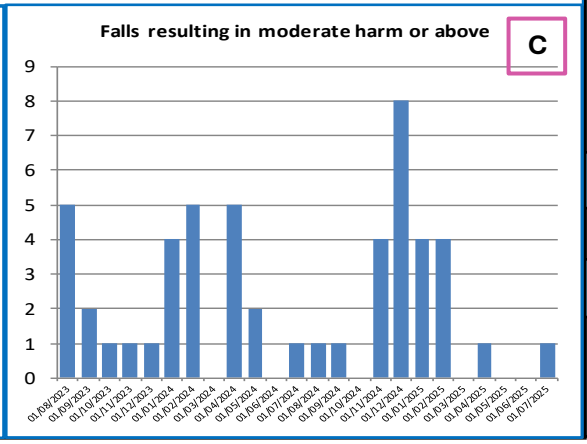
The Dudley Group NHS Foundation Trust

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.*

Date	July 2025
Trust Performance	A) 88 B) 8 C) 1
Performance Target / KPI	







What are the charts showing us

The overall number of inpatient and recurrent falls remains low and stagnant from June to July. There were 2 After Action Reviews(AAR) incident reported in July. 1/2 incidents reported as Moderate harm and 1/ 2 incidents reported as low harm. The overall number of AARs reported in July have decreased from 5 AARs reported in June to 2 AARs reported in July.

Areas Impacting on Compliance

- Additional capacity and demand
- Completing risk assessment on admission

Mitigations / Timescales / Blockers

- Bedrail policy for acute, inpatient and community final consultation for Trolley risk assessment
- Updated Trolley risk assessment introduced to accommodate paediatric and atypical patients in Theatres/Day case, ED peadiatrics and Paediatric Assessment Unit(PAU) .
- Safe use of bed/trolley rail training compliance 50% across Medicine and Surgery. Community safe use of bedrails training commenced in late June , compliance yet to be published.
- Bedrail and bed lever risk assessment for the community approved at R&A, community to commence training on 17/6/25
- Weekly compliance report shared with Divisional Chief Nurses/AHP as an overview for assurances and to help with achieving >90% by the end of October.
- 7/9 actions completed on Falls Single Improvement Plan, 2 outstanding actions are partially met.
- ETOC and EDDM to collaborate with Falls Single Improvement Plan as part of Thematic review 4 in preventing deconditioning.

Risk Register

There are no risks related to falls

Key Points to Note

June e-learning module for bedrails and bed levers has been launched to accelerate training compliance to be above trust target. E-learning module available on the Falls Prevention trust Hub page also, accessible through Learning and development.

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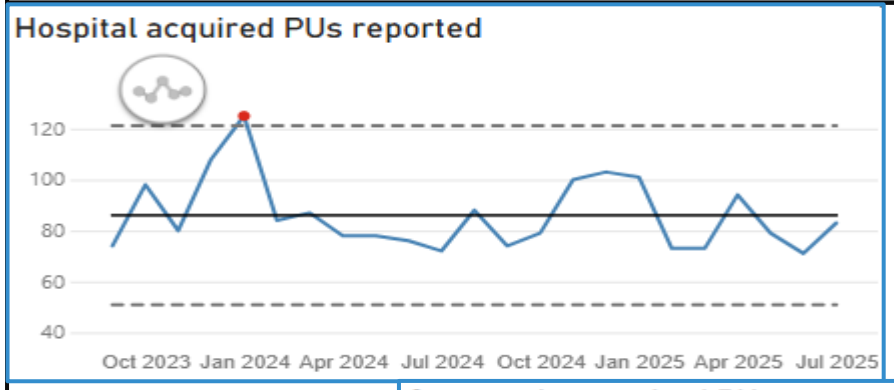
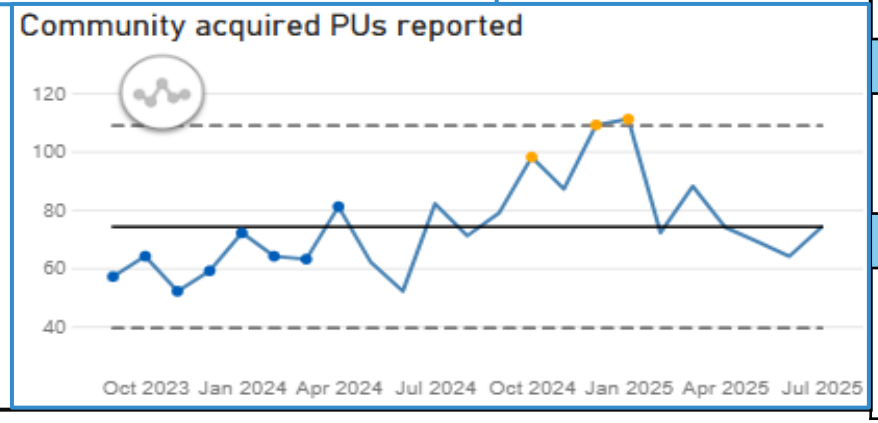
Pressure Ulcers

The Dudley Group NHS Foundation Trust

Background	Trend against pressure ulcer prevention performance

Date	July 2025
Trust Performance	See chart
Performance Target / KPI	





What are the charts showing us

There has been an increase in all Trust acquired Pressure Ulcers (exc MASD and external) from June where we saw 135, to July where we had 157. Both acute and community have seen an increase in month, acute had 83 acquired pressure ulcers and community had 74 acquired pressure ulcers.
We continue to work collaboratively with system partners to explore opportunities to further drive down pressure ulcers.
Informatics are exploring how they can pull a report for patients that are acquired a PU who were long stays in the ED department.

Areas Impacting on Compliance

Workforce challenges.
Capacity and demand

Mitigations / Timescales / Blockers

Purpose t migration onto Sunrise continues. Multiple meetings held with IT team. The wound assessment chart and dressing plan will also be included as a part of this change. Community have own IT team with which Purpose t has been shared.

Risk Register

Workforce limitations on risk register has been reviewed and closed although still some challenges. B6 due to start September. B7 on LTS. B2 interviews due to take place next week for Equipment store assistant.

Key Points to Note

The Tissue Viability team received 95 referrals for the community and 290 for the hospital. 187 equipment installations took place in the acute. Staff have been reminded not to send equipment out of the trust if possible due to cost and time required to locate.

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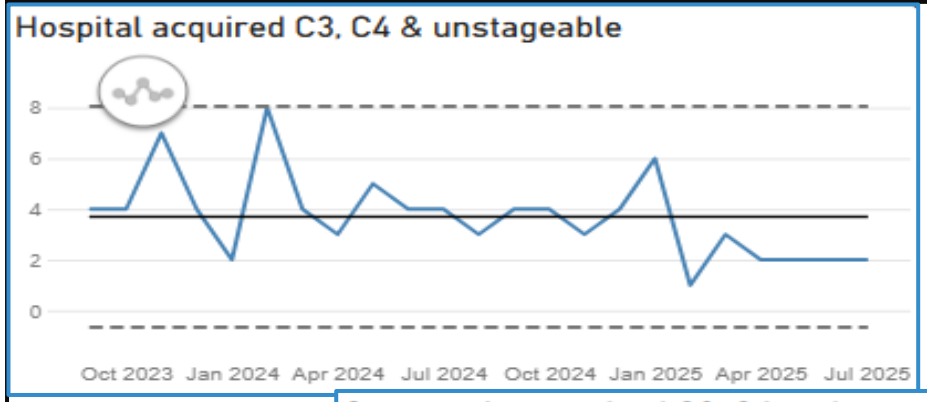
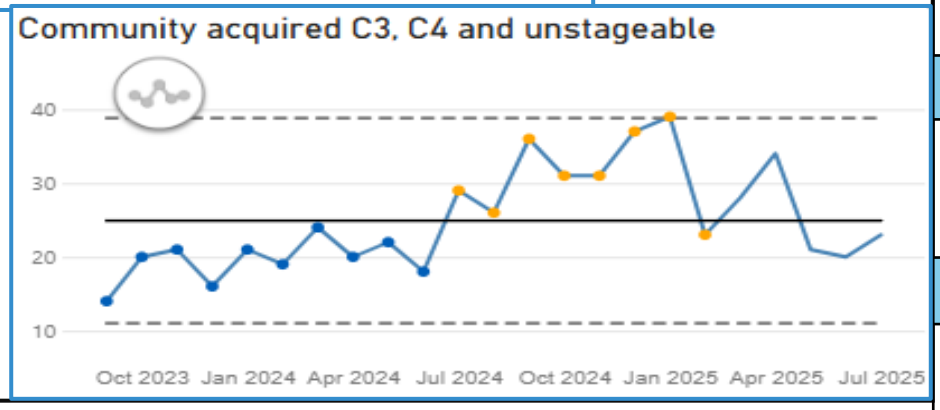
Pressure Ulcers

The Dudley Group NHS Foundation Trust

Background	Trend against pressure ulcer prevention performance

Date	July 2025
Trust Performance	See chart
Performance Target / KPI	





What are the charts showing us

There were 2 unstageable pressure ulcers in acute in July and no category 3 or 4s which is positive, 11 Deep Tissue Injury (DTI), and 17 category 2), 18 moisture associated skin damage (MASD).
Community had 4 category 3 and 3 category 4, 16 unstageable, 29 Category 2 & 22 DTI), 34 MASD.

Areas Impacting on Compliance

as per slide 17

Mitigations / Timescales / Blockers

As per slide 17

Risk Register

As detailed on previous slide

Key Points to Note

TV service provision continues across hospital and community and full program of education planned and in process of delivery. Meeting tba with education lead to have ELFH modules available for trust staff to utilise.

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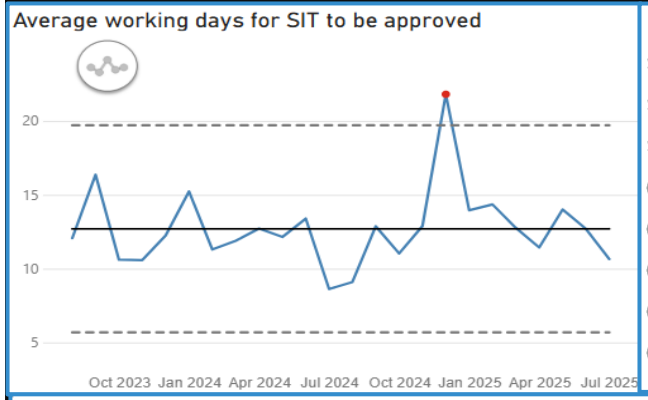
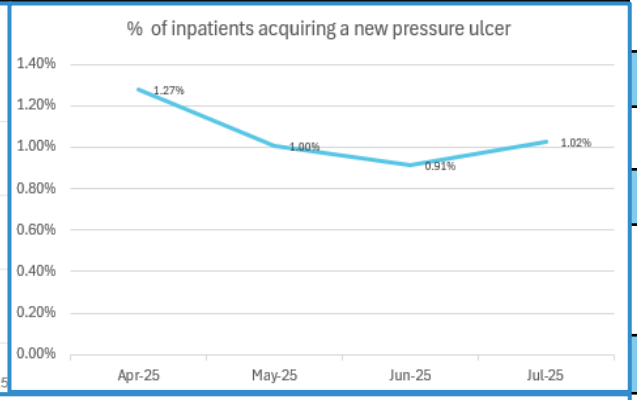
Pressure Ulcers

The Dudley Group NHS Foundation Trust

Background	Trend against pressure ulcer prevention performance

Date	July 2025
Trust Performance	See chart
Performance Target / KPI	





What are the charts showing us

Of the 157 PU incidents reported, 32 resulted in the completion of a short investigation tool (SIT) which were presented at the Pressure ulcer Group (PUG). The average working days for SITs to be approved is approx.10 days between reporting and approval. 22 of these were agreed to be no harm and 10 low harm, 0 were deemed moderate or severe harm. Key themes were inaccurate risk assessment and equipment delays.

Areas Impacting on Compliance

Workforce challenges across all teams and capacity issues

Mitigations / Timescales / Blockers

Each reported category 3, 4 and unstageable pressure ulcer is reviewed by the pressure ulcer group (PUG) to determine level of harm.

Risk Register

As detailed on previous slide

Key Points to Note

Equipment spend in community remains high due to a variety of reasons. The tender for supply and management of community beds, mattresses and cushions and hospital pressure reducing/relieving equipment has been published. Key stakeholders have been invited to review company submissions against the specification and will also attend the product demonstrations/presentations in August.

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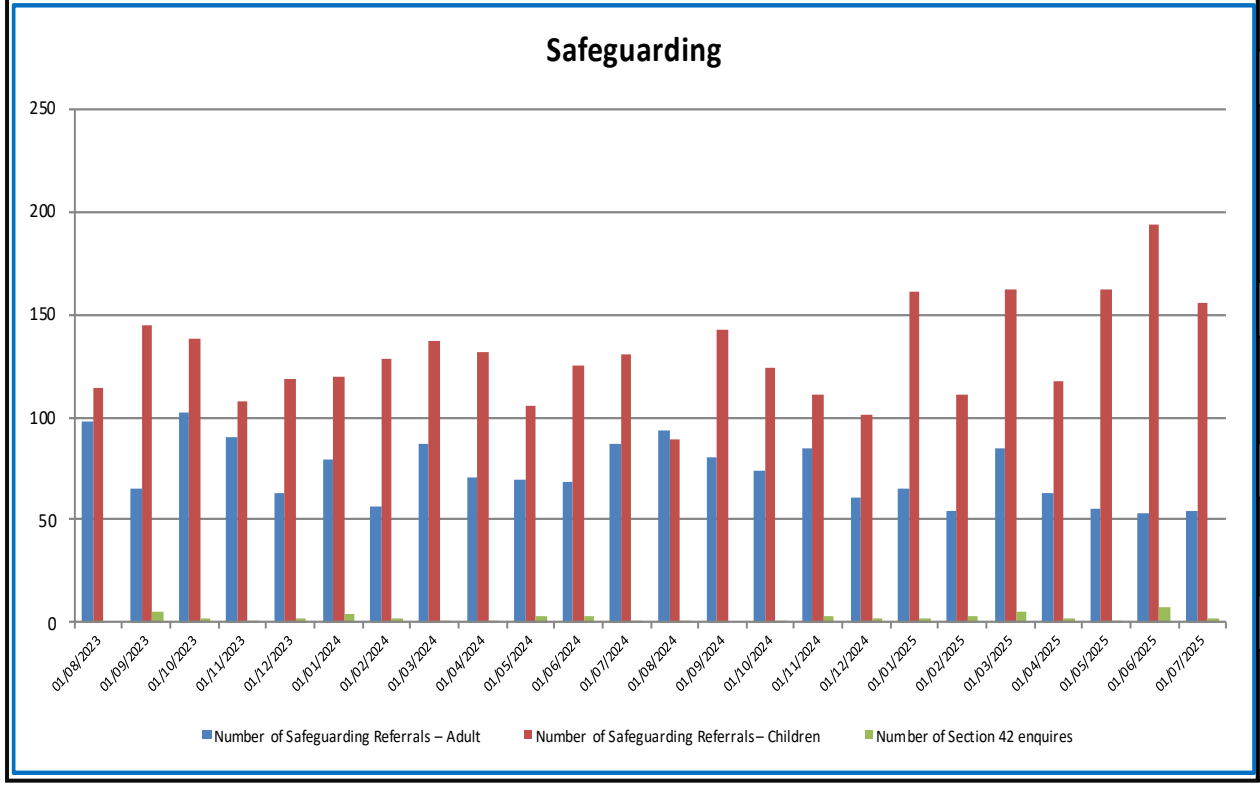
Safeguarding

The Dudley Group NHS Foundation Trust

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*

Date	July 2025
Trust Performance	Adult) 54 / Children) 156 / Section 42) 2
Performance Target / KPI	



What are the charts showing us

The charts provide information regarding the number of safeguarding referrals for children and adults. The number of safeguarding referrals for adults is static. Safeguarding referrals for children has decreased which is in line with the decrease in paediatric attendances to the Emergency Department. There have been 2 S42 enquiries raised regarding concerns of care provided by the Trust.

Areas Impacting on Compliance

There were 15 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 has increased by 50% compared to the number missed last month. The ED Deputy Matron is identifying staff who are responsible for missing these and speaking with individuals directly to remind them of think family principles. Safeguarding Children Level 3 training is now at 85% Trust wide. This is a significant improvement. The organisational training compliance for safeguarding training is being updated daily to provide an accurate and up to date compliance record for actions by divisions to be taken around non-compliance.

Mitigations / Timescales / Blockers

The safeguarding team undertake checks of all attendances of CYP in ED and for adults attending with risk vulnerabilities of MH/DA and substance misuse. The SG team will identify any missed opportunities to safeguard and communicate this to senior staff and ensure appropriate referrals are made.

Risk Register

Key Points to Note

Any missed opportunities and themes in relation to safeguarding children are also monitored and discussed at the weekly Acutely Unwell Child meeting where there is representation from the ED and Paediatric Ward.

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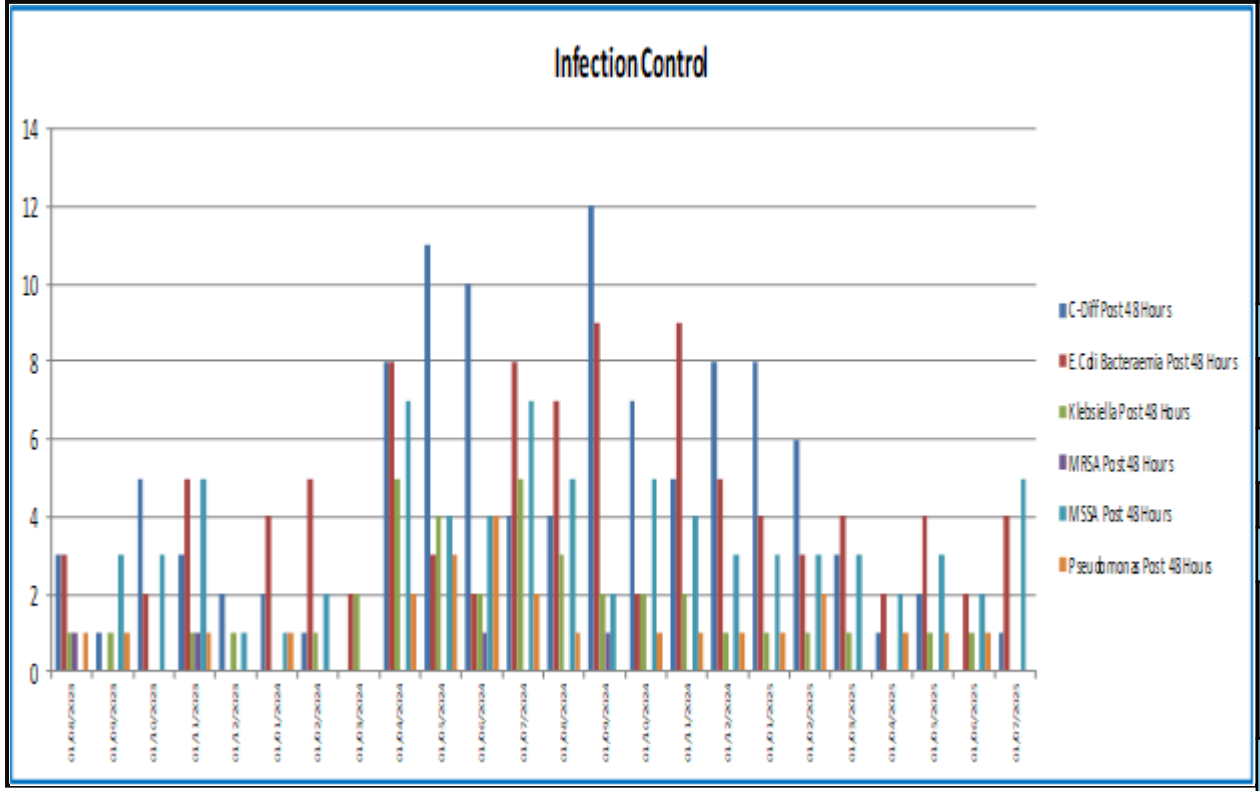
Infection Control

The Dudley Group NHS Foundation Trust

Background	IPC Healthcare Associated Data

Date	July 2025
Trust Performance	Threshold for blood stream infections for 2025/2026
Performance Target / KPI	HCAI reportable infections



What are the charts showing us

The objectives for 2025/26 have been released and are reflected in the table below. Although all thresholds were exceeded for 2024/25, CDI has been reduced from 73 to 72 (DGFT reported 97 2024/25), and E. coli from 75 to 68 (DGFT reported 79 2024/25), while Pseudomonas and Klebsiella remains the same. We have raised our concerns regarding the challenging reduction of the thresholds via NHSE.

	2025/2026 Threshold	HOHA July	COHA July	Cumulative Total 25/26
CDI Toxin	72	1	4	23
E. coli	68	4	9	30
Klebsiella	19	0	1	7
Pseudomonas	12	2	1	7
MSSA	N/A	5	2	20
MRSA	0	0	0	0

HOHA – Hospital onset healthcare associated (Sample taken 48 hours after admission)
COHA – Community onset Healthcare associated (Sample taken within 48 hours of admission but had been discharged from the same trust in the past 28days)

In line with the PSIRF Agenda the IPC team carry out post infection reviews on all HOHA cases. Common themes and learning outcomes are identified and shared amongst relevant teams and via IPCG
We have a reduction in our HOHA cases for CDI and BSI for Q1 of 2025/2026 with 22 cases compared to 44 cases for Q1 of 2024/2025

Areas Impacting on Compliance

A cleaning and disinfection of the environment policy has been agreed however not yet implemented by PFI partners
Bare below the elbow and Hand Hygiene continues to be challenging throughout the trust.

Mitigations / Timescales / Blockers

The Trust has adopted the PSIRF response to HCAI looking for themes and trends – 6 Monthly review of going to Q+S Group September 2025

Risk Register

3 risks on IPC risk register

- New HCID PPE training not being implemented by March 2025 due to limited training spaces available– MMUH have kindly offered to train 6 members of DGFT who will them train the trust.
- Dirty beds and equipment being left in corridors continues to be an issue – discussion re if should remain on IPC risk register or be moved to a corporate risk
- Temporary escalation space in ED remains with hand wash facilities only available in patient toilet. Hand gel is available.

The trust cleaning risk is being reviewed in relation to cleaning standards across the trust this will now be a corporate risk

Key Points to Note

The Trust reported 0 outbreaks during June
Due to all thresholds being exceeded for 2024/2025 the IPC team are developing a BSI improvement plan for 2025/2026 to run alongside the existing CDI improvement plan.
Alongside the trusts collaboration with MMUH the DDIPC and Data Analyst from MMUH will be supporting the IPC team at DGFT two days a week

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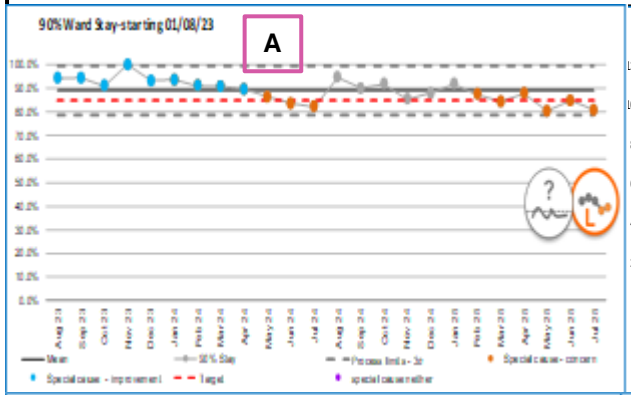
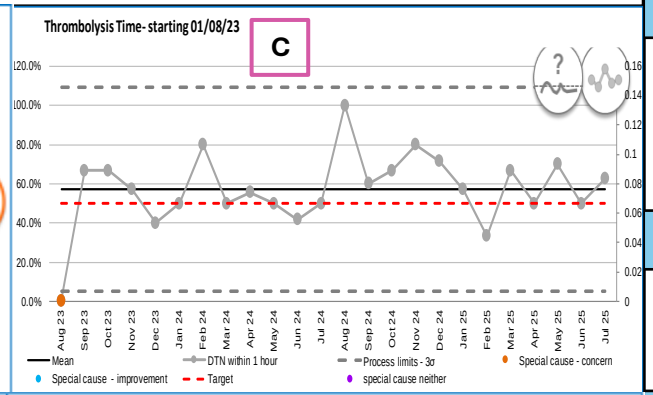
Stroke (latest 2 months are provisional)

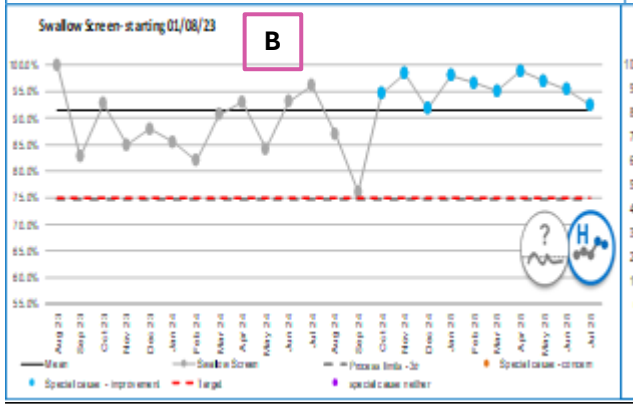
The Dudley Group NHS Foundation Trust

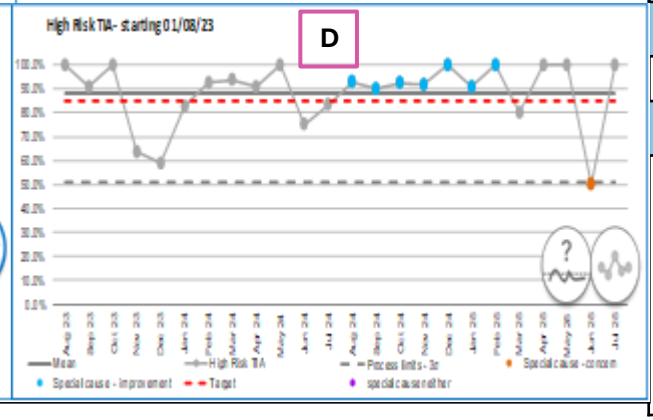
Background	Progress against National Stroke targets

Date	May 2025 / June 2025 / July 2025
Trust Performance	May Validated **A)** 80.5% **B)** 96.9% **C)** 70.0% **D)** 100% Jun/Jul Unvalidated **A)** 84.8%/80.9% **B)** 95.3%/92.5% **C)** 50.0%/62.5% **D)** 50.0%/100%
Performance Target / KPI	85% / 70% / 50% / 85%









What are the charts showing us

Chart A shows that 90% ward stay achieved 80.5% in May and is non-compliant with the 85% target.
Chart B shows that swallow screen performance is compliant with the 70% performance target in May (96.9%) and achieved SSNAP level A
Chart C shows that thrombolysis was compliant with the 50% performance target in May and achieved 70%.
Chart D shows that the HR TIA performance is compliant with 85% target in May and achieved 100% which is a SSNAP level A.

Charts C-D show that all areas are compliant with the SSNAP targets in May 25.
* **June and July data is currently unvalidated and is provisional.**

Areas Impacting on Compliance

Chart A 90% Ward stay is Non-Compliant; 15 patients did not spend 90% of their stay on the stroke ward in May 25 due to the following reasons below:

- 3 patients were transferred to ITU due to high acuity
- 1 Patient transferred to other speciality for review due to other co-morbidities (Complex patient)
- 11 patients were admitted to AMU wards prior to being admitted to the stroke ward due to not initially presenting with symptoms of stroke or no stroke beds available at the time of admission.

Mitigations / Timescales / Blockers

- PDSA test; Consultant presence in ED 8am – 8pm from 1st Sept 25 (currently reviewing cons job plan to accommodate a trial for 1 week) to support with key decision making and to ensure the right patients, receive the right care at the right time in the right location.
- Stroke team to continue to work closely with the site team to ensure efficient flow on Stroke ward.

Risk Register

Currently on Risk register: 1925 Inability to achieve A rating in SSNAP

Key Points to Note

Please see the link below which includes the list of new SSNAP key indicators along with our % Median scores from Oct – Dec 24 & Jan – Mar 25, National figures have also been included. The Data is not validated yet whilst provisional data has been shared rules /compliance against metrics has still not been agreed and shared.

SSNAP has not confirmed all the requirements yet hence why it has not been published via SSNAP nationally. We are in the process of updating our local reporting to reflect the new Key Indicators and due to the changes to the SSNAP Key Indicators/Webtool we currently don't have visibility of performance figures for Local Trusts. We are anticipating that they will be shared next quarter.

SSNAP - New Key Indicators (with scoring).xlsx

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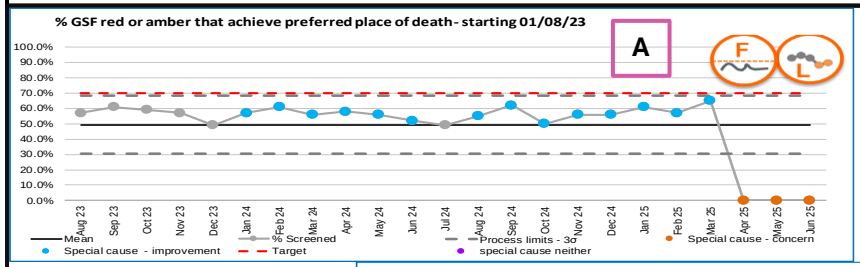
Gold Standards Framework (one month in arrears)

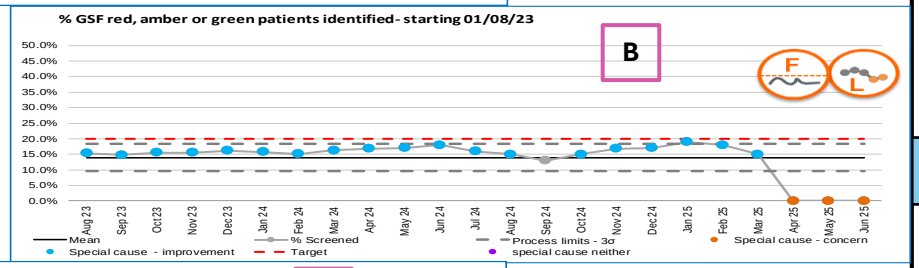
The Dudley Group NHS Foundation Trust

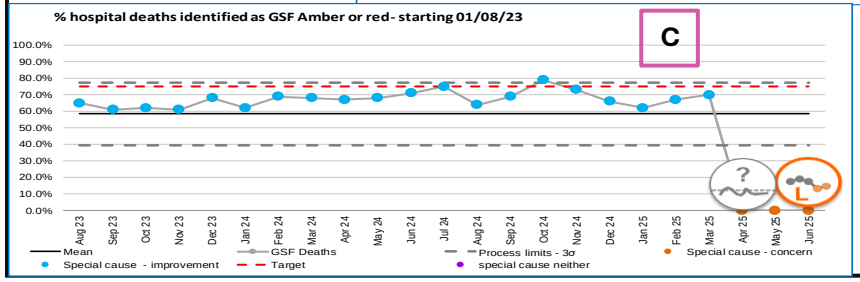
Background	KPI based on Nacel and Nice Guidance

Date	May 2025 (one month behind)*
Trust Performance	A) 65.0%/ B) 15.0%/ C) 70.0%
Performance Target / KPI	70%/20%/75%



*Due to the switch from the GSF document to flowsheets on Sunrise in April 2025, validated data is not available past March 2025





What are the charts showing us

During the migration to the new flowsheets, we are now validating the data and are not currently able to report on data from April 2025 onwards. Once the data is validated this will be provided retrospectively. We are meeting regularly with the data analyst. All configuration issues have now been resolved. Discussed at Trust EOLC group and agreed raise risk.

Areas Impacting on Compliance

Need for continued education on the wards – time taken for specialist palliative care team
Divisions invited to the Trust end of life care group to support implementation across the Trust
Successful GSF accreditation AMU 1 and 2, C1b, B2 hip and re-accreditation C7

Mitigations / Timescales / Blockers

- GSF flowsheet is now on Sunrise and replaced the GSF document–
- Please note therefore, during the migration to the new flowsheets and validation of metrics we are not able to report April 2025 figures. Once we have validated the data this can be provided retrospectively.

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
GSF data – planning to raise a risk following agreement at Trust EOLC group

Key Points to Note

Need to engage with divisions to improve identification of GSF patients
Fast track on the risk register and regular agenda item on Trust EOLC group
Successful GSF accreditation AMU 1 and 2, C1b, B2 hip and re-accreditation C7

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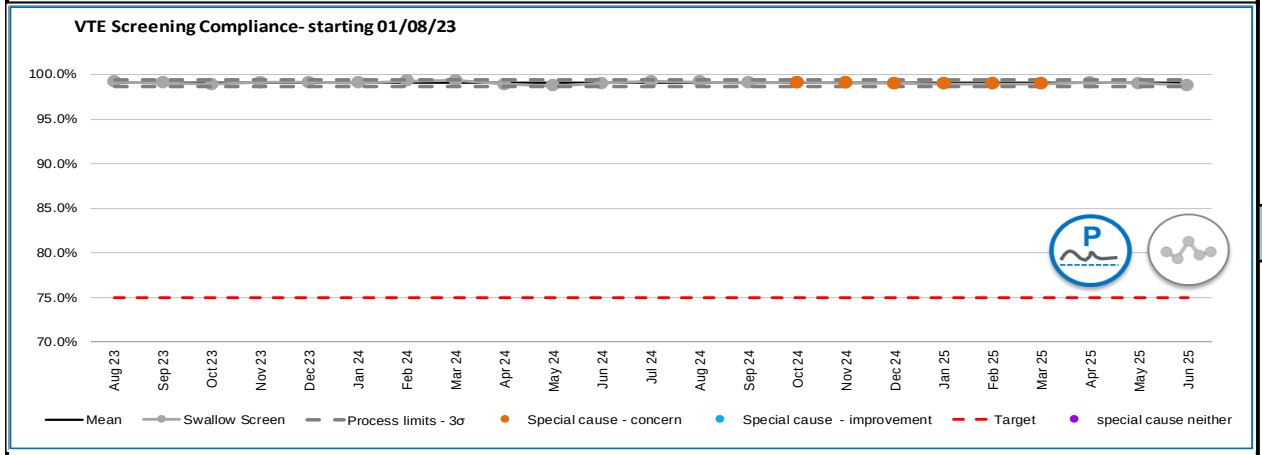
VTE (one month in arrears)

The Dudley Group NHS Foundation Trust

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

Date	June 2025
Trust Performance	98.8%
Performance Target / KPI	95%



First Assessment +/- 12 hours from Admissions

MonthYear	Total	IRA	CRA	Total RA	% Compliance
01/03/2025	14678	3154	11354	14508	98.84
01/02/2025	13534	2905	10488	13393	98.95
01/01/2025	14951	3207	11591	14798	98.97
01/12/2024	13830	3015	10677	13692	99.00
01/11/2024	14335	3097	11105	14202	99.07

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

MonthYear	Total	IRA	CRA	Total RA	% Compliance
01/03/2025	1084	111	1	112	10.33
01/02/2025	1070	103	1	104	9.71
01/01/2025	1205	104	1	105	8.71
01/12/2024	1154	132	0	132	11.43
01/11/2024	1169	125	0	125	10.69

What are the charts showing us

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

Areas Impacting on Compliance

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- 31/03/2025 - 189 cases of Hospital associated thrombosis 51 cases potentially preventable
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.

•VTE Improvement project pilots planned in medicine and surgery with support of DIP team to look at mapping VTE process, identifying problems and potential improvements which may reduce number of potentially preventable HAT

Risk Register

*P*otential 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(PSIRF) biannually to identify common issues 3 reviews highlight same issues
- Work being undertaken to develop metrics to monitor progress with HAT
- VTE Improvement project pilots planned in medicine and surgery with support of DIP team to look at mapping VTE process, identifying problems and potential improvements which may reduce number of potentially preventable HAT
- Mandatory training was updated and this is now live on learning and development page

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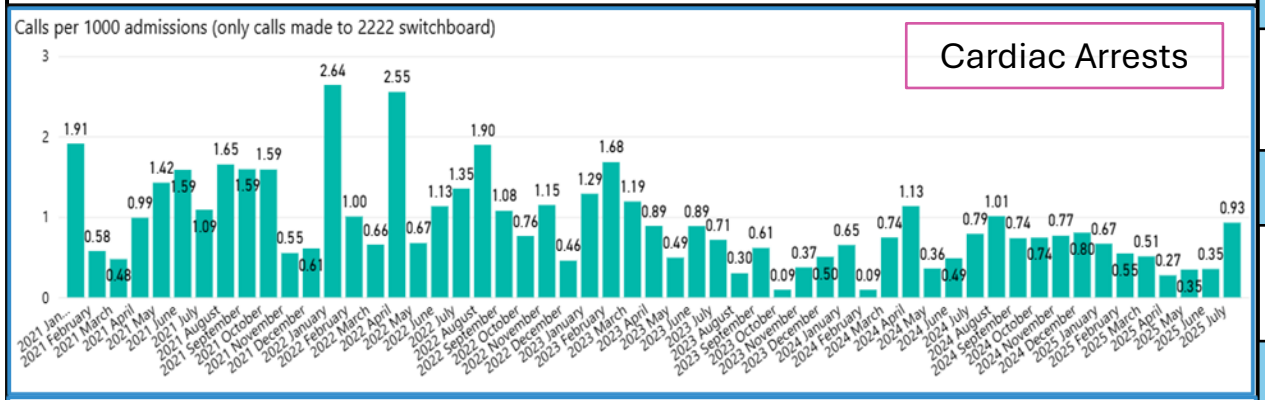
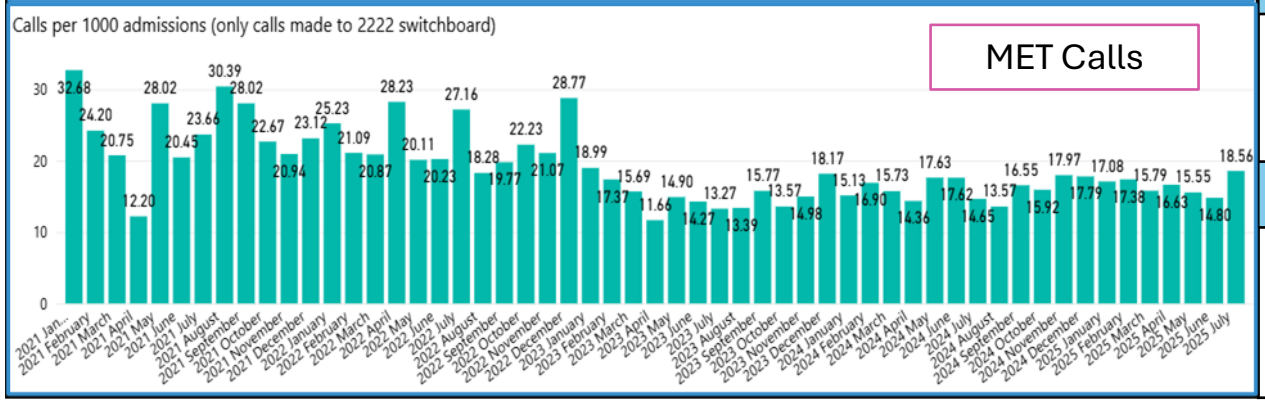
Cardiac Arrests / MET Calls

The Dudley Group NHS Foundation Trust

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

Date	July 2025
Trust Performance	Cardiac arrests 0.93 /MET calls 18.56
Performance Target / KPI	N/A





What are the charts showing us

July had the highest number of cardiac arrests since August 2024. Of the 11, only one occurred within the recent industrial action. Three patients were transferred to Critical care, one to MECU, one stayed in the monitored area of AMU & two stayed on their surgical wards, the remaining four did not get a return of spontaneous circulation.
There have also been the highest number of medical emergency calls/1000 admissions since January 2023, 34 of these within the industrial action period.

Areas Impacting on Compliance

A decrease from 40.18% to 36.09% (of 1294 inpatients) had a documented treatment, escalation & resuscitation plan (TERP) in July, of which 86.94% of the documents contained DNACPR decisions (31% of all inpatients) and 13% were for full active treatment (5% of all inpatients). This reduction is robust planning may help to explain the sudden increase in cardiac arrest and medical emergency calls for this month.

Mitigations / Timescales / Blockers

- 56% of patients triggering on the deteriorating patient pathway (DPP) received a senior clinical review within 60 mins of trigger in July, decreasing from 61% in June.
- 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

- July has seen the highest number of cardiac arrests (11) since August 2024
- 34 medical emergency calls and one cardiac arrest occurred within the industrial action.
- July has seen the highest number of medical emergency calls/1000 admissions since January 2023
- The decrease in TERP documents for July may help to explain the increase in 2222 calls due to no documented plan being present.

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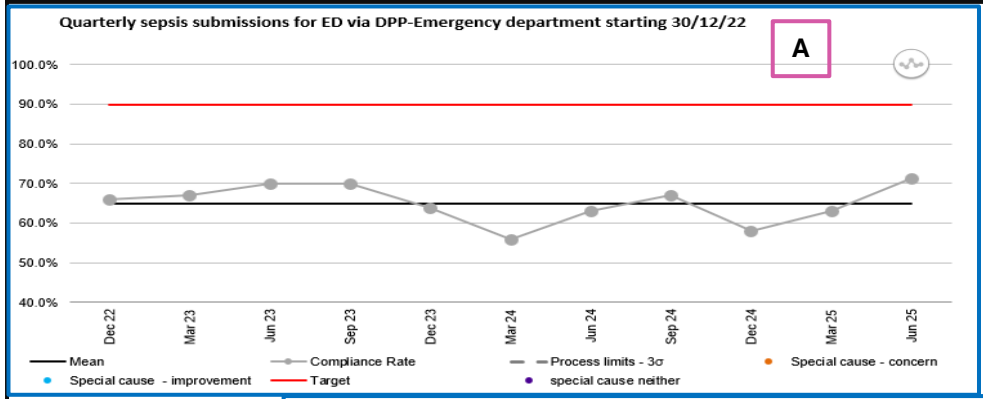
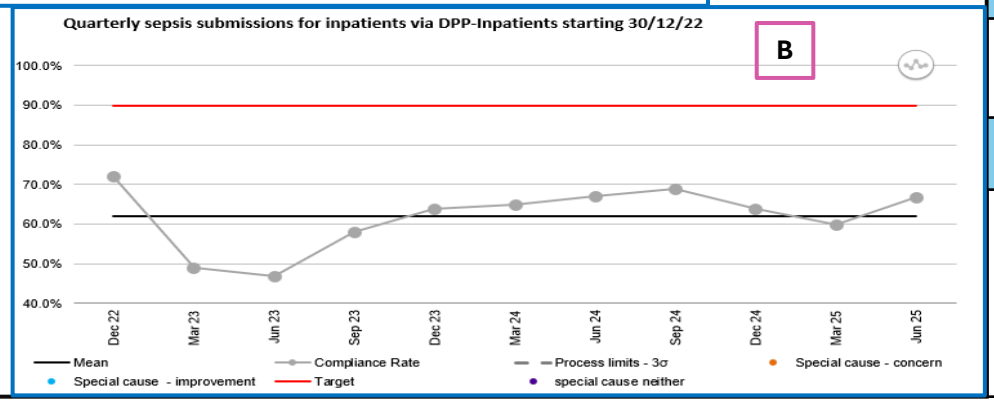
Sepsis

The Dudley Group NHS Foundation Trust

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

Date	July 2025 (Q1 2025/2026)
Trust Performance	A) 71.3% B) 66.8%
Performance Target / KPI	>90%





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 <=1hour of time zero (71.3%)
B) in-patients who undergo sepsis screening and who, where screening positive, receive IV antibiotic treatment <=1hour of time zero (66.8%)

Areas Impacting on Compliance

- A drop in compliance for administration of antibiotics by 10% in July to 63% for ED will have a negative impact on the Q2 quarterly submission
- An increase in compliance by the inpatient areas by 18% to 78% for July will positively impact upon the inpatient submission for Q2

Mitigations / Timescales / Blockers

- The improvements across the organisation in the timeliness of undertaking vital signs & charting at the point of care is also positively impacting the compliance of the timeliness in undertaking a sepsis screen for patients triggering on their early warning score in the inpatient areas.

Risk Register

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

Key Points to Note

- The change in patient wellness questions within the vital signs chart to the national wording for Martha's rule has triggering the requirement for more senior clinical reviews and sepsis screens in the front door admission areas than previously expected or experienced through July.
- The sepsis improvement work by the trust and AQUA has won its category in the HSJ awards for "Recognising and responding to the deteriorating patient" the project will be undertaking a 10 min presentation on 16th September at the congress in Manchester.

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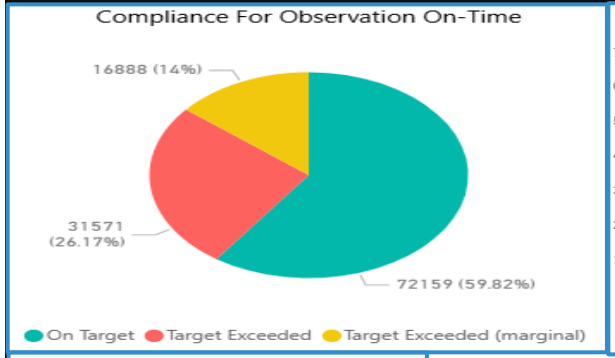
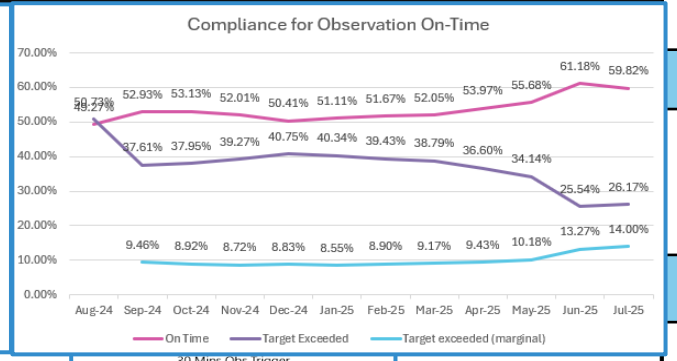
Vital Signs Compliance

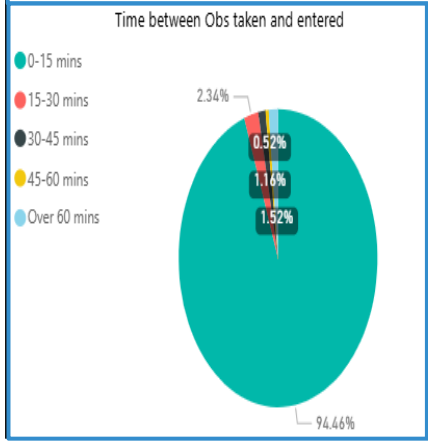
The Dudley Group NHS Foundation Trust

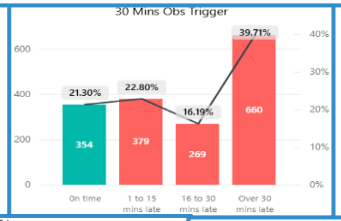
Background	Vital signs should be documented at the point of care (within 6 mins of recording) and frequency according to risk level from early warning score (EWS)

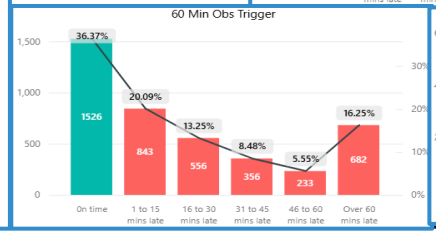
Date	July 2025
Trust Performance	59.82% on target/94.46% in 0-15mins
Performance Target / KPI	Vital signs recorded on time(via EWS risk level)

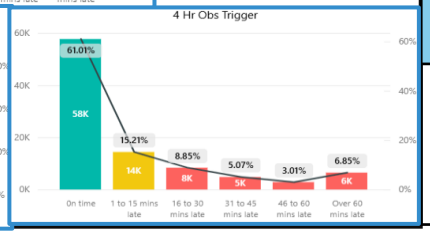












What are the charts showing us

- The compliance for observations (vital signs) on time demonstrates a decrease in compliance from 61.18% to 59.82% of all vital signs recorded in July.
- The clinical risk dictates the frequency required for vital signs set out by national guidelines (NEWS2, NPEWS, MEOWS) and will change depending on the latest score.
- **High clinical risk**, 30 min vital signs = 21.3% (NEWS2 ≥7, NPEWS≥9 & MEOWS=red) a decrease from 22.56% in June.
- **Medium clinical risk**, 60 min vital signs = 36.37% (NEWS2 5-6 or single trigger 3, NPEWS 5-8 or single trigger 4, MEOWS 2+ ambers, healthcare or patient/parental concern) a decrease from 37.15% in June.
- **Low clinical risk**, 4 hourly vital signs = 61.01% a decrease from 62.41% in June.

Areas Impacting on Compliance

- Martha's rule patient wellness questions launched across the early warning score in the organisation in July. This initially impacted on the admission areas as patients are asked how they are feeling and how are they feeling compared to yesterday or the last time we asked. These questions are mandated for the first set of vital signs in a day shift and a night shift. In ED, SDEC and ESH this is asked on the admission vital signs and initially caused an increase in patients requiring a senior clinical review.

Mitigations / Timescales / Blockers

- Four areas are currently being targeted for education by DPT as requested by the eObs task & finish group, safety huddles and deep dives by their leads to determine what common themes are found in delays as these are different for each area (B2, B4, C1 & CCU).
- C5 station 2 are piloting a new digital display board to replace the handwritten white boards and increase timeliness of vital signs.

Risk Register

ASM2413, UC2350

Key Points to Note

- Digital team are configuring and testing the automation of a NEWS2 of 0 to a frequency of 12hrly.
- Martha's rule (Call for concern) was activated for 12 patients in June across 6 clinical areas, a decrease from 16 in June.
- Patient wellness questions launched.

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Quality KPI Dashboard

The Dudley Group NHS Foundation Trust

Background	Monitoring of key patient care quality indicators

Date	July 2025
Trust Performance	AMaT RAG: Red <84%; Amber 84.1% – 89%; Green >89.1%
Performance Target / KPI	>89.1%

Audit	Frequency	Compliance over last 6 periods					
Tissue Viability SKIN audit (CQUIN 12)	M	97.3%	97.4%	96.6%	96.9%	97.7%	96.9%
Hand Hygiene '5 moments' audit (v2)	M	98.7%	99.2%	97.8%	99.0%	98.6%	98.6%
Infection Prevention and Control Audit	M	Non	88.9%	71.4%	96.5%	96.1%	96.9%
Matron In Patient Audit	M	89.8%	88.7%	89.9%	89.4%	89.1%	90.6%
Matron Audit - Out Patient Areas	M	95.4%	96.6%	96.6%	97.4%	97.7%	97.4%
Lead Nurse In Patient Audit	M	93.4%	93.7%	93.9%	92.9%	93.6%	94.7%

What are the charts showing us

Priority 1 audits on AMaT are maintaining a green RAG rating.

Areas Impacting on Compliance

- Nursing Quality Review IP flowsheet is not completed on Sunrise every shift. Work is in progress to amalgamate this flowsheet with the activities of daily living document to reduce duplication of information for staff. Draft version has been circulated for further discussion.
- E-obs not completed within 30 minutes. Weekly report is now sent to Lead Nurses and Matrons to monitor progress and share good practice. Task and finish group meetings continue. Trust wide targets for compliance set within the Quality and Safety delivery plan Q1 target met (60%). Q2 target is 60-65%.
- AMaT audit actions not completed as expected. Lead Nurses being required to work clinically to support patient care has a direct effect on the administration side of audit completion.

Mitigations / Timescales / Blockers

- Monthly quality reviews with Matrons and Lead Nurses at Division level to monitor performance.
- Quality Working Group continue to monitor AMaT data monthly to ensure Divisions are taking appropriate action and to share good practice identified .
- 10 additional beds on AMU and 4 trollies 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

- E-obs working group launched 'Let's get E-Ob-sessed' awareness event throughout July 2025 to increase awareness with observations being completed on time. Quality and safety delivery plan: E-Obs Q1 target for improvement met.
- Clinical accreditation for inpatient wards is in progress. 13 wards have been assessed to date, 9 of which have been awarded 'working towards clinical accreditation' status. The remaining 4 wards assessed are awaiting discussions regarding their level of award at Quality Working Group and Clinical Accreditation Board.

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Chief Nurse Dashboard (Inpatient areas only)

The Dudley Group NHS Foundation Trust

Date	July 2025

WardGroup	Budget WTE	Contracted WTE	Vacancy %	Sickness %	All Unavailability %	Parenting	All Unavailability	Total CHPPD	Mandatory Training %	%FFT Inpatient, Good & VeryGood	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	215.6	193.1	10.4%	4.7%	22.5%	10.5	43.5		95.0%		12	5	3	1	0		1	53%
CCU	54.1	48.1	11.1%	6.1%	23.0%	1.8	11.1		92.3%		4	0	0	2	0			46%
Critical Care	119.1	125.1	-5.0%	5.2%	31.9%	10.8	39.8		94.8%	71%		0	0	1	0			57%
Discharge Lounge	11.9	10.9	8.2%	2.0%	24.4%	0.9	2.7		88.3%	91%	1	0	0	2				11%
ED	188.3	160.9	14.5%	7.4%	31.0%	10.1	49.8		95.2%		44	1	0	0				87%
ESH	73.1	72.0	1.5%	5.3%	24.9%	3.3	18.0		92.8%		4	1	0	0	1			49%
FMNU	44.6	42.1	5.5%	3.3%	20.9%	0.9	8.8		96.2%		2	0	0	0	0			21%
Maternity	164.9	161.2	2.2%	7.3%	31.0%	8.2	50.0		94.2%		6				0			48%
MECU	21.4	19.6	8.6%	5.1%	16.4%		3.2		97.4%		1	0	0	0		1		34%
Neonatal Unit	62.0	57.5	7.3%	3.2%	27.7%	2.5	15.9		96.9%	78%								
Renal Unit	38.1	35.3	7.2%	6.7%	25.6%	1.8	9.0		96.2%									21%
SDEC	71.0	65.2	8.2%	6.4%	25.2%	0.9	16.4		96.7%	98%								60%
Ward A2										100%								84%
Ward B1	29.4	30.4	-3.6%	3.9%	22.0%	2.7	6.7		100.0%	87%					0			64%
Ward B2 Hip	49.6	48.1	3.1%	8.0%	23.2%	1.5	11.1		94.6%	50%		0	0	0				27%
Ward B2 Trauma	41.7	39.9	4.3%	6.2%	26.2%	0.9	10.5		96.1%	100%	1	1	0	4	0			36%
Ward B3	62.9	62.4	0.9%	5.7%	24.5%	2.2	15.3		93.2%	83%	3	0	0	8	0			60%
Ward B4	77.5	76.6	1.1%	7.6%	27.9%	2.8	21.3		93.4%	85%	5	0	0	5	0			45%
Ward B6	25.2	24.5	2.7%	9.3%	31.7%	1.8	7.8		97.7%			0	0	0	0			35%
Ward C1A	35.4	33.9	4.3%	4.3%	34.2%	4.5	11.6		91.7%	100%	1	0	0	0	0			30%
Ward C1B	38.1	33.7	11.5%	3.3%	21.1%		7.1		95.9%			0	0	0	0			23%
Ward C2	60.8	55.0	9.5%	4.1%	22.7%	1.0	12.5		90.2%	100%	4							72%
Ward C3	56.5	53.3	5.6%	5.4%	19.9%	1.3	10.6		92.7%	75%	2	0	0	0	0			29%
Ward C4	62.2	60.0	3.5%	8.7%	31.2%	3.8	18.7		92.3%		5	1	0	1	0			48%
Ward C5A	40.6	36.5	10.0%	7.9%	21.8%	0.9	8.0		95.3%	56%	1	0	0	1				40%
Ward C5B	46.0	42.7	7.3%	6.1%	26.4%	3.4	11.3		99.3%		4	1	0	1	0			41%
Ward C6	32.9	34.8	-5.6%	13.9%	31.8%	0.2	11.1		89.6%	70%					0			50%
Ward C7	63.1	59.2	6.1%	5.2%	25.7%	3.6	15.2		97.5%	89%	4	0	0	0	0			45%
Ward C8	80.9	72.5	10.4%	6.1%	24.5%	2.5	17.8		95.6%	91%	5	1	1	1	0			26%
Total	1,866.7	1,754.5	6.0%	6.1%	26.5%	85.0	464.8		94.6%	88%	109	11	4	27	1	1	1	52%

WardGroup	Hand Hygiene 5 moments audit (v2)	Infection Prevention and Control Audit	Lead Nurse In Patient Audit	Matron In Patient Audit	Tissue Viability SKIN audit (CQUIN 12)
AMU	97.4%	98.5%	97.4%	93.8%	100.0%
CCU	98.3%	98.6%	98.7%	83.1%	97.8%
Critical Care	n/a	n/a	n/a	91.1%	n/a
Discharge Lounge	96.7%	n/a	n/a	n/a	100.0%
ED	100.0%	93.1%	n/a	n/a	n/a
ESH	n/a	n/a	n/a	n/a	97.9%
FMNU	95.3%	n/a	98.7%	96.6%	95.1%
Maternity	100.0%	96.6%	n/a	n/a	n/a
MECU	100.0%	n/a	98.7%	86.8%	100.0%
Neonatal Unit	n/a	n/a	n/a	n/a	n/a
Renal Unit	98.7%	93.3%	n/a	n/a	n/a
SDEC	100.0%	100.0%	n/a	n/a	n/a
Ward A2	100.0%	n/a	n/a	n/a	n/a
Ward B1	100.0%	n/a	93.3%	93.1%	100.0%
Ward B2 Hip	82.1%	n/a	94.5%	89.5%	98.1%
Ward B2 Trauma	90.0%	82.1%	86.5%	88.3%	90.9%
Ward B3	46.7%	n/a	92.0%	86.4%	98.0%
Ward B4	93.8%	100.0%	93.8%	89.8%	93.8%
Ward B6	100.0%	n/a	n/a	95.1%	n/a
Ward C1A	97.7%	96.6%	n/a	94.9%	100.0%
Ward C1B	100.0%	96.6%	95.4%	96.6%	n/a
Ward C2	100.0%	n/a	n/a	n/a	n/a
Ward C3	100.0%	n/a	n/a	95.1%	n/a
Ward C4	97.7%	94.7%	n/a	96.6%	92.0%
Ward C5A	98.1%	100.0%	96.4%	85.0%	100.0%
Ward C5B	n/a	n/a	98.4%	85.2%	100.0%
Ward C6	98.0%	n/a	n/a	86.4%	96.6%
Ward C7	100.0%	87.0%	95.1%	89.5%	98.4%
Ward C8	94.7%	92.9%	91.9%	88.5%	97.4%
Total	97.2%	96.1%	95.2%	90.9%	97.6%

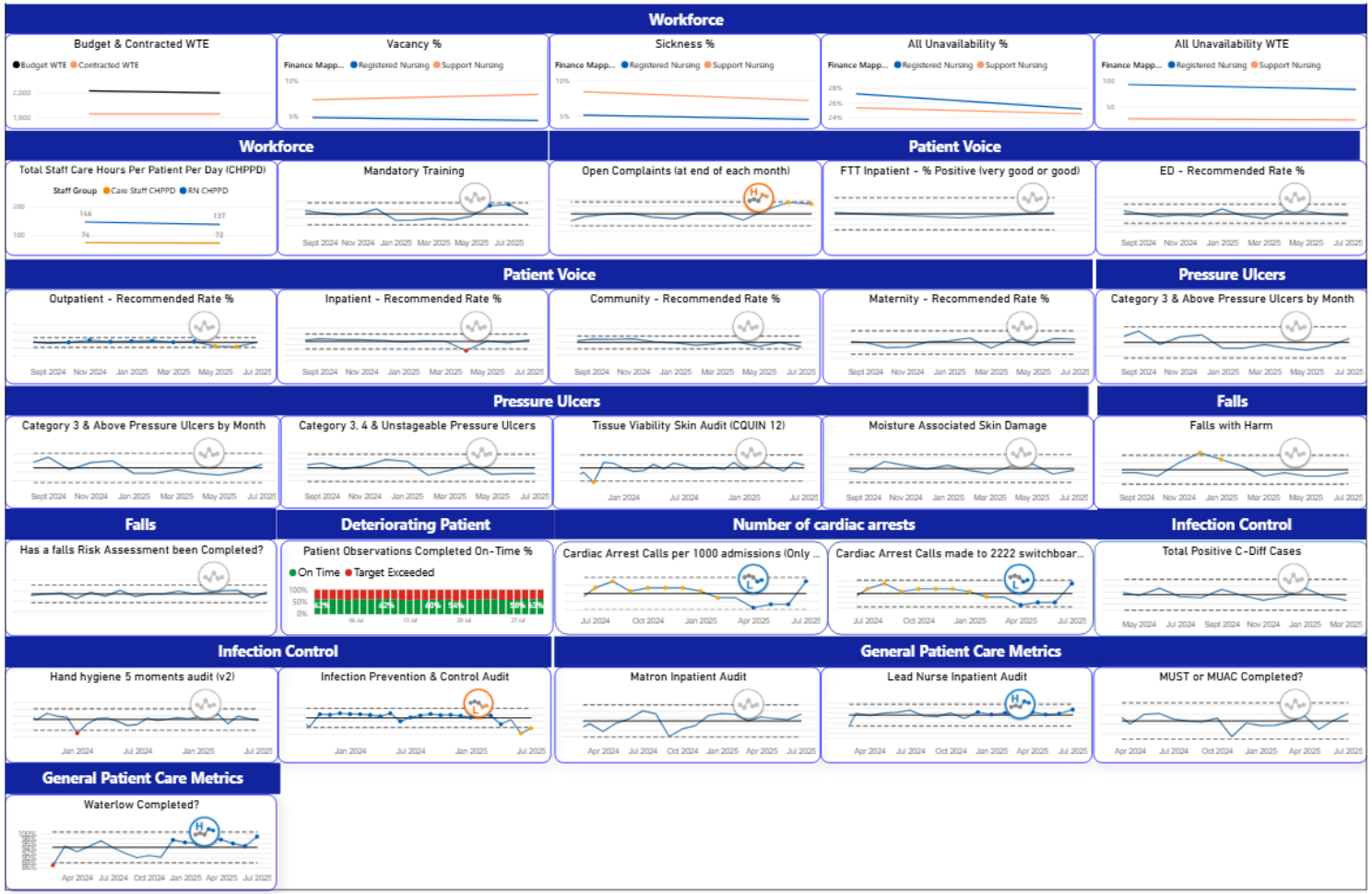
WardGroup	Has a falls risk assessment been completed?	MUST or MUAC completed	Waterlow completed
AMU	100.0%	95.0%	100.0%
CCU	100.0%	100.0%	100.0%
Critical Care	n/a	n/a	n/a
Discharge Lounge	n/a	n/a	n/a
ED	n/a	n/a	n/a
ESH	n/a	n/a	n/a
FMNU	100.0%	100.0%	100.0%
Maternity	n/a	n/a	n/a
MECU	100.0%	70.0%	100.0%
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	90.0%	60.0%	100.0%
Ward B3	70.0%	90.0%	80.0%
Ward B4	100.0%	90.0%	100.0%
Ward B6	n/a	n/a	n/a
Ward C1A	n/a	n/a	n/a
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	n/a	n/a	n/a
Ward C5A	100.0%	100.0%	100.0%
Ward C5B	100.0%	100.0%	100.0%
Ward C6	n/a	n/a	n/a
Ward C7	100.0%	100.0%	100.0%
Ward C8	90.0%	70.0%	100.0%
Total	96.7%	90.7%	98.7%

The data in this table reflects inpatient areas only

- Sickness absence has increased slightly from 5.4% in June to 6.1% in July.
- The task and finish group to review patient observations completed on time continues. The **'Let's get 'Ob'-sessed'** campaign ran between 1st – 31st July across the Trust to: Increase on-time observation compliance to at least 75% by end of Q4 2025/26; Improve understanding of why observations matter to patient care; Promote the correct use of digital recording systems. Weekly compliance reports are now sent to ward lead nurses and Matrons to enable monitoring progression with compliance. Q1 target of 60% was met.
- Matron inpatient audit 'E-Obs on time' question continues to contribute to red and amber overall audit results for some ward areas.
- An improvement in areas completing MUST/MUAC within 24 hours of admission is noted, with the overall RAG rating improving from amber in June to green in July.
- Several areas not completing the new infection prevention and control audit is noted. Divisional Chief Nurses have been asked to address this.

Chief Nurse Trends (All nursing/midwifery/AHP areas)

Date	July 2025



What are the charts showing us

- Vacancies for support staff show slight increase from June.
- Sickness absence continues to decline.
- Mandatory training continues to exceed target.
- Patient voice trends should be viewed in conjunction with slides 3 and 4.
- Pressure ulcer trends should be viewed in conjunction with slides 17,18 and 19.
- Falls trends should be viewed in conjunctions with slide 16.
- Category 3 and above pressure ulcers showing a slight rise. This should be viewed in conjunction with slides 17, 18 and 19.
- Deteriorating patient trends are daily compliance rates and should be viewed in conjunction with slides 25, 26 and 27.
- Infection prevention and control audit – there is an improvement in compliance since June.
- May and June MUST/MUAC and Waterlow compliances were noted to be absent in last month's report. Informatics have corrected this, and May, June and July are now shown on the dashboard, both metrics showing an improvement in compliance.

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Kitemark Explanation

The Dudley Group NHS Foundation Trust

Element	Definition
Timeliness	The time taken between the end of the data period and when the information can be produced and reviewed. The acceptable data lag will be different for different performance indicators. 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. Data must be available quickly and frequently enough to support information needs and to influence the appropriate level of service or management decisions.
Monitoring	The degree to which the trust can drill down into data in order to review and understand operational performance. 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
Completeness	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.
Validation	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. Final validation is classified as sufficient where validation has been completed and where the indicator has received final approval from responsible individuals.
Audit	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.

Element	Definition
Reliability	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. 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.
Relevance	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.

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

Click HERE for full kitemark explanation & policy

APPENDIX 1

Regional Maternity Heatmap

Data refreshed: 22/08/2025 14:35:09

Heatmap

Version: 2
Deployed Oct 2023

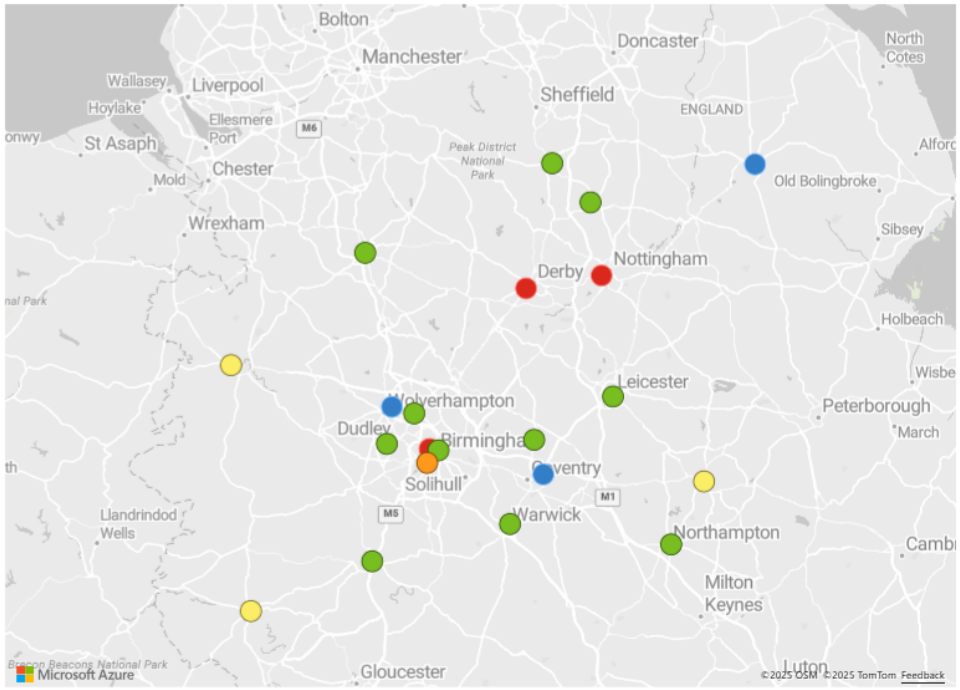
Region: Midlands

NHS England

Overall heatmap scoring key: >40, 36-40, 30-35, 20-29, <20

Region average score: **28.1**

Heatmap month: August 2025



Provider	Overall score
UNIVERSITY HOSPITALS OF DERBY AND BURTON NHS FOUNDATION TRUST	57.0
NOTTINGHAM UNIVERSITY HOSPITALS NHS TRUST	45.0
SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST	43.0
UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST	38.0
THE SHREWSBURY AND TELFORD HOSPITAL NHS TRUST	35.0
KETTERING GENERAL HOSPITAL NHS FOUNDATION TRUST	32.0
WYE VALLEY NHS TRUST	31.0
WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST	29.0
THE DUDLEY GROUP NHS FOUNDATION TRUST	26.0
BIRMINGHAM WOMEN'S AND CHILDREN'S NHS FOUNDATION TRUST	24.0
GEORGE ELIOT HOSPITAL NHS TRUST	24.0
SHERWOOD FOREST HOSPITALS NHS FOUNDATION TRUST	24.0
SOUTH WARWICKSHIRE UNIVERSITY NHS FOUNDATION TRUST	24.0
UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST	23.3
UNIVERSITY HOSPITALS OF NORTH MIDLANDS NHS TRUST	22.0
NORTHAMPTON GENERAL HOSPITAL NHS TRUST	21.0
CHESTERFIELD ROYAL HOSPITAL NHS FOUNDATION TRUST	20.0
WALSALL HEALTHCARE NHS TRUST	20.0
UNIVERSITY HOSPITALS COVENTRY AND WARWICKSHIRE NHS TRUST	18.0
THE ROYAL WOLVERHAMPTON NHS TRUST	17.0
UNITED LINCOLNSHIRE HOSPITALS NHS TRUST	16.0

Regional Maternity Heatmap

Data refreshed: 22/08/2025 14:35:09

Scoring

Region: Midlands

NHS England

Heatmap month: August 2025

Provider	Overall score	CQC Mat overall rating	Stake holder concerns	CQC S29a	CQC s31	Ext. ind. review	Coroner reg 28	Mat Oversight	MIS	CNST repay ment	Eth. DQ	CQC Mat Survey	SBL	Midw ives vac.	MSW vac.	Obs vac.	Unfilled roles	Snr L'ship not in post	Safety champs	Birthrate + (last 3 yrs)	Neonatal death rate	Perinatal death rate	Stillbirth rate
BIRMINGHAM WOMEN'S AND CHILDREN'S NHS FOUNDATION TRUST	24.0	1.0	1	0	0	0	0	0	0	0	0	4	4	1	0		0	0	0	0	5	5	3
CHESTERFIELD ROYAL HOSPITAL NHS FOUNDATION TRUST	20.0	1.0	1	0	0	0	0	0	0	0	0	0	2	3	4		0	0	0	0	3	3	3
GEORGE ELIOT HOSPITAL NHS TRUST	24.0	1.0	1	0	0	0	0	0	0	0	0	3	0	2	5		1	0	0	0	5	3	3
KETTERING GENERAL HOSPITAL NHS FOUNDATION TRUST	32.0	3.0	1	0	0	0	0	5	3	0	0	3	0	1	2		1	0	0	0	5	5	3
NORTHAMPTON GENERAL HOSPITAL NHS TRUST	21.0	3.0	1	0	0	0	0	0	2	0	0	3	0	1	2		0	0	0	0	3	3	3
NOTTINGHAM UNIVERSITY HOSPITALS NHS TRUST	45.0	3.0	7	0	0	5	0	5	0	0	3	3	4	3	5		0	0	0	0	1	3	3
SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST	43.0	3.0	4	5	0	0	0	3	2	0	0	3	1	3	4		0	0	0	0	5	5	5
SHERWOOD FOREST HOSPITALS NHS FOUNDATION TRUST	24.0	1.0	1	0	0	0	0	0	0	0	0	3	4	2	4		0	0	0	0	3	3	3
SOUTH WARWICKSHIRE UNIVERSITY NHS FOUNDATION TRUST	24.0	1.0	1	0	0	0	0	2	0	0	0	2	1	1	5		0	0	0	0	5	3	3
THE DUDLEY GROUP NHS FOUNDATION TRUST	26.0	1.0	2	0	0	0	0	0	0	0	0	4	1	1	4		0	0	0	0	5	5	3
THE ROYAL WOLVERHAMPTON NHS TRUST	17.0	1.0	2	0	0	0	0	0	0	0	0	3	1	1	1		1	0	0	0	1	3	3
THE SHREWSBURY AND TELFORD HOSPITAL NHS TRUST	35.0	2.0	3	0	0	0	0	5	0	0	0	3	4	0	1		1	5	0	0	5	3	3
UNITED LINCOLNSHIRE HOSPITALS NHS TRUST	16.0	1.0	0	0	0	0	0	0	0	0	0	1	3	1	3		0	0	0	0	1	3	3
UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST	38.0	4.0	6	0	0	0	0	5	0	0	0	5	4	2	1		0	0	0	0	5	3	3
UNIVERSITY HOSPITALS COVENTRY AND WARWICKSHIRE NHS TRUST	18.0	1.0	1	0	0	0	0	0	0	0	0	3	1	2	3		0	0	0	0	1	3	3
UNIVERSITY HOSPITALS OF DERBY AND BURTON NHS FOUNDATION TRUST	57.0	5.0	4	10	10	0	0	5	3	0	0	3	4	0	0		1	5	0	0	1	3	3
UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST	23.3	2.3	2	0	0	0	0	0	0	0	0	3	0	2	0		1	0	0	0	5	5	3
UNIVERSITY HOSPITALS OF NORTH MIDLANDS NHS TRUST	22.0	1.0	1	0	0	0	0	0	0	0	0	3	1	1	2		0	0	0	0	5	5	3
WALSALL HEALTHCARE NHS TRUST	20.0	3.0	3	0	0	0	0	0	0	0	0	3	1	1	0		0	0	0	0	3	3	3
WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST	29.0	1.0	1	0	0	0	0	2	0	0	0	3	3	1	5		0	0	0	0	5	5	3
WYE VALLEY NHS TRUST	31.0	1.0	1	0	0	0	0	2	0	0	0	3	4	1	4		1	5	0	0	3	3	3

APPENDIX 2

Paper for submission to the Public Board of Directors 11th September 2025

Report title:	Perinatal Quality Surveillance Report – response to the rapid Maternity and Neonatal review announcement by the Secretary of State for Health and Social Care and ask of Trust boards.
Sponsoring executive:	Martina Morris, Chief Nurse and Board Level Maternity and Neonatal Safety Champion
Report author:	Claire Macdiarmid, Director of Midwifery and Maternity Safety Champion

1. Summary of key issues

On the 23rd of June 2025, Sir Jim Mackey, Chief Executive of NHS England and Duncan Burton, Chief Nursing Officer for England, wrote to all Trust Chief Executives and informed them that there would be a rapid independent review into Maternity and Neonatal services nationally. They outlined that this would be undertaken between June and December 2025, and 10 NHS trusts would be selected for this investigation. These trusts are yet to be announced. In addition, alongside this, an independent Taskforce would be set up, led by the SoS H&SC to oversee actions required.

The letter, which was shared with Quality Committee members and Trust Board in June, asks every local NHS Board to undertake the following actions:

-Be rigorous in tackling poor behaviour where it exists. Where there are examples of poor team cultures and behaviours these need addressing without delay.

-Listen directly to families that have experienced harm at the point when concerns are raised or identified. It is important we all create the conditions for staff to speak up, learn from mistakes, and at the same time staff who repeatedly demonstrate a lack of compassion or openness when things go wrong need to be robustly managed.

- Ensure you are setting the right culture: supporting, listening and working, through coproduction, with your Maternity and Neonatal Voice Partnership, and local women, and families.

- Review your approach to reviewing data on the quality of your maternity and neonatal services, closely monitoring outcomes and experience and delivering improvements to both.

- Retain a laser focus on tackling inequalities, discrimination and racism within your services, including tracking and addressing variation and putting in place key interventions. A new anti-discrimination programme from August will support our leadership teams to improve culture and practice. This also means accelerating our collective plans to provide enhanced continuity of care in the most deprived neighbourhoods, providing additional support for the women that most need it.

This paper outlines current position across Maternity and Neonatal services at The Dudley Group NHS Foundation Trust (DGFT).

2. Alignment to our Vision	
Deliver right care every time	**x**

Be a brilliant place to work and thrive	
Drive sustainability (financial and environmental)	
Build innovative partnerships in Dudley and beyond	
Improve health and wellbeing	

3. Report journey
Quality Committee.

4. Recommendation(s)
a. The Quality Committee is asked to accept this report as current position against the required actions of the letter dates 23 June 2025.

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		Effectively manage workforce demand and capacity
Board Assurance Framework Risk 3.0		Ensure Dudley is a brilliant place to work
Board Assurance Framework Risk 4.0		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		Achieve operational performance requirements
Board Assurance Framework Risk 8.0		Establish, invest and sustain the infrastructures, applications and end-user devices for digital innovation
Is Quality Impact Assessment required if so, add date: N/A		
Is Equality Impact Assessment required if so, add date: N/A		

The Dudley Group
NHS Foundation Trust

Response to announcement of National Review of Maternity and Neonatal Services - June 2025

1. EXECUTIVE SUMMARY

1.1 On the 23rd of June 2025, Sir Jim Mackey, Chief Executive of NHS England and Duncan Burton, Chief Nursing Officer for England, wrote to all Trust Chief Executives and informed them that there would be a rapid independent review into Maternity and Neonatal services nationally. They outlined that this would be undertaken between June and December 2025, and 10 NHS trusts would be selected for this investigation. These trusts are yet to be announced. In addition, alongside this, an independent Taskforce would be set up, led by the SoS H&SC to oversee actions required.

2. BACKGROUND INFORMATION

2.1 The letter asks every local NHS Board to undertake the following actions:

-Be rigorous in tackling poor behaviour where it exists. Where there are examples of poor team cultures and behaviours these need addressing without delay.

-Listen directly to families that have experienced harm at the point when concerns are raised or identified. It is important we all create the conditions for staff to speak up, learn from mistakes, and at the same time staff who repeatedly demonstrate a lack of compassion or openness when things go wrong need to be robustly managed.

- Ensure you are setting the right culture: supporting, listening and working, through coproduction, with your Maternity and Neonatal Voice Partnership, and local women, and families.

- Review your approach to reviewing data on the quality of your maternity and neonatal services, closely monitoring outcomes and experience and delivering improvements to both.

- Retain a laser focus on tackling inequalities, discrimination and racism within your services, including tracking and addressing variation and putting in place key interventions. A new anti-discrimination programme from August will support our leadership teams to improve culture and practice. This also means accelerating our collective plans to provide enhanced continuity of care in the most deprived neighbourhoods, providing additional support for the women that most need it.

3. RESPONSE AND CURRENT POSITION – DGFT

1. **Be rigorous in tackling poor behaviour where it exists. Where there are examples of poor team cultures and behaviours these need addressing without delay.**

Assurance

Perinatal Culture and Leadership program (PCLP)
The Trust's perinatal leadership team commenced the PCLP back in 2023 and continue to work together collaboratively. The aim of the programme was to improve culture and communication between the two teams (Maternity and Neonatal), to enhance the quality improvement agenda and enhance leadership skills and knowledge. It then moved on stage 2 which was to listen to the staff by undertaking a SCORE survey which measures progress within the organisation and identifies areas that require targeted improvements. Culture coaches were trained and remain working with teams at the current time. The perinatal quad maintains their strong coordinated approach and real benefits in collaborative working can be seen.

Support from HR
All leaders in Maternity and Neonatal services are supported by HR colleagues to address poor behaviours and ensure that relevant processes are followed as required.

Maternity and Neonatal safety champions
The work of the Safety champions has enhanced the ability of the teams at all levels to escalate concerns. This may be the senior team requiring support to complete work through procurement, finance or estates, but also for clinical staff to meet the executive and non-executive colleagues to discuss the service and raise any concerns directly to them. This is in place alongside the Trust's Freedom to Speak Up role.

Regular visits / walkabout and Board to Ward approach

The executive and non-executive teams undertake regular walkabouts and Board to Ward visits which provide another opportunity for the teams to speak to the Trust's leadership team. The are announced and unannounced, including out of hours. Chief Nurse Senior team also undertake back to the floor and out of hour visits. Feedback from these visits is generated and shared with relevant leaders for action.

2. **Listen directly to families that have experienced harm at the point when concerns are raised or identified. It is important we all create the conditions for staff to speak up, learn from mistakes, and at the same time staff who repeatedly demonstrate a lack of compassion or openness when things go wrong need to be robustly managed.**

Assurance

7-day bereavement service

Dudley Group provides a 7-day service to bereaved families. This is achieved by enhanced training offered to staff to ensure they are familiar with bereavement policies and pathways. Maternity service also has an on-call manager 24/7 to ensure any concerns escalated by families that cannot be dealt with at ward level, can be escalated and heard at the time of the incident. The Bereavement team also seek the views of the families on two separate occasions as per PMRT requirements and follow this u with a debrief once the postmortem and investigation processes are complete. Complaints procedures are also coordinated into this approach as required.* To note Post mortem consent will become available 7 days per week from November 2025. This is undertaken next working day by the bereavement team, should a trained clinician be unavailable over weekends/bank holidays.

Senior leader involvement in incidents and MNSI cases

The Head or Director of Midwifery are involved in all PSII cases and identify any concerns or issues at the earliest opportunity. If serious gaps in care are identified, they meet with the families directly to undertake duty of candour. The communication is then taken over by the Maternity Patient safety specialist. For SWARM and PSII cases, there is an assigned Director lead. To nothe there have been no escalations made from HSIB/MNSI to the Trust, since they began investigating serious incidents.

Maternity Patient safety specialist in post and senior governance lead

Following recommendations from the Ockenden report, Dudley Group employed both a Patient safety specialist funded by maternity, who is part of the the corporate team to ensure a non-biased review of cases, as well as a governance lead with appropriate seniority to ensure full oversight of incidents, MNSI and complaints. This allows for robust triangulation of data, and themes and trends to be raised as early as possible to allow improvement to follow.

Obstetric, Neonatal and midwifery governance leads in place

This allows an MDT collaborative approach to reviewing incidents.

Trust's Complaint process oversight by the Head and Director of Midwifery

The Director and Head of Midwifery have oversight of all complaints at the point they are submitted to the organisation and on completion prior to being sent to the complainant. This ensures oversight of themes and any concerning incidents requiring further investigation.

Maternity and Neonatal safety champions

As part of regular presence within Maternity and Neonatal services, the champions speak to the families to obtain their views on their experience and raise any concerns, which are then immediately shared with the respective leadership team.

3. **Ensure you are setting the right culture: supporting, listening and working, through coproduction, with your Maternity and Neonatal Voice Partnership, and local women, and families**

Assurance

Maternity and Neonatal Voices Partnership (MNVP)

An MNVP is in place, hosted by Gateway, funded by the ICB. It is recognised across the Black Country that this does not fully fulfil the requirements of the Maternity Incentive Scheme and further mitigation is in place to mitigate this shortfall. Further funding has been offered to MNVPs during this financial year of around £19k to enhance the presence and collaboration. Dudley Group have limited user involvement and are working on how this can be enhanced and increased.

Working relationships with the MNVP at Dudley are positive, and regular meetings occur between the senior team and the coordinator for the service. Feedback is shared and acted upon. Governance processes are currently being strengthened.

Actions to take:

- Further work required on coproduction and development of MNVP processes, in collaboration with the Black Country LMNS.

4. **Review your approach to reviewing data on the quality of your maternity and neonatal services, closely monitoring outcomes and experience and delivering improvements to both.**

Assurance

Maternity and Neonatal services revised safety dashboard has been recently launched which is reviewed and challenged at Quality Committee bi-monthly and at Board three time per year.

Maternity have also recently refreshed their data set which allows data to be analysed and triangulated more thoroughly.

Monthly review of the Midlands Maternity Heatmap at Quality Committee (Trust Board bi-monthly) and action/escalations undertaken as required.

Actions to take:

- Further collaborative working between Maternity and Neonatal governance to align processes and data collection.
- Review against the Perinatal Quality oversight model (yet to be formally launched).

5. **Retain a laser focus on tackling inequalities, discrimination and racism within your services, including tracking and addressing variation and putting in place key interventions. A new anti-discrimination programme from August will support our leadership teams to improve culture and practice. This also means accelerating our collective plans to provide enhanced continuity of care in the most deprived neighbourhoods, providing additional support for the women that most need it.**

Assurance

Equality, diversity and inequality lead midwife is in post, making a very positive impact.

Inequalities dashboard has been developed for use across the perinatal services and is being modified to enhance the data available from this.

Changes in reporting in quarterly mortality paper to include inequalities, for analysis and action.

Inequalities are reviewed in all patient safety incident responses.

Modified Continuity of carer teams in operation for bereavement, social complexities and diabetes with more planned.

Neonatal death and stillbirth thematic review was completed in February 2024, including a deep dive into multiple inequalities. Actions taken since include development of an aspirin PGD and work across the region sharing learning on pregnancies from consanguineous relationships. Further information will follow once completed across the Birmingham and Solihull Integrated Care System.

Actions to take:

- Further development of data analysis and involvement in anti-discrimination programme when launched in August 2025.
- Full review of service to find further opportunities for Continuity of Carer.

4. NATIONAL DEVELOPMENTS

The Trust awaits further announcement from the national team of the trusts that will participate in the rapid review. Staff briefings have taken place at the Trust to ensure all staff are aware of the announcement and are supported, recognising the potential negative impact on them.

Maternity Outcome Signal system

The Trust is aware that as a result of the review, there will be increased availability to national data relating to mortality over the coming months as well as access to the The Maternity Outcomes Signal System (MOSS) tool. MOSS aims to identify signals about **potential** critical safety issues in maternity **intrapartum** care that could lead to adverse outcomes and is intended to be used as part of routine safety monitoring within the Perinatal Quality Oversight Model (PQSM).

MOSS is a signalling tool for use within a critical safety system. Implementing MOSS does not require the collection of any new data and uses existing routinely collected data on term stillbirths, neonatal deaths and brain injuries from the ‘Submit a Perinatal Event Notification’ (SPEN) service, also hosted by NHS England for the purpose of notifying national organisations (MBRRACE-UK, NHS Resolution and the Maternal and Newborn Safety Investigations programme at CQC) simultaneously

when adverse events occur. The purpose of MOSS is to identify signals about potential critical safety issues in maternity intrapartum care promptly, that could lead to an increase in adverse outcomes. This should prompt a rapid, locally led ‘critical safety assessment’ to make sure that the labour ward is operating safely, along with quick escalation and assurance through the Perinatal Quality Oversight Model.

5. RECOMMENDATION(S)

The Board is invited to accept this paper as current position against the required actions of the letter dates 23 June 2025. A further update will be provided once instruction/information has been received from the national teams with next steps.

Evidence to support initial assessment outlined in this paper is available in the monthly Perinatal Quality Report and a plethora of other resources such as MIS scheme evidence, 3-year delivery plan evidence.

Classification: Official

NHS England

To:
- Trust CEOs and chairs

cc.
- ICB CEOs
- Regional directors

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

23 June 2025

Dear colleague

Maternity and neonatal care

Today, the Secretary of State for Health and Social Care has announced a rapid independent investigation into maternity and neonatal services. He has also announced an independent taskforce, alongside immediate actions to improve care.

This announcement comes on the back of significant failings in maternity services in parts of the NHS and we need – with real urgency – to understand and address the systemic issues behind why so many women, babies and families are experiencing unacceptable care.

It is clear that we are too frequently failing to consistently listen to women and their families when they raise concerns and too many families are being let down by the NHS. There remain really stark inequalities faced by Black and Asian women and women in deprived areas. In addition, we continue to have significant issues around safety and culture within our maternity workforce.

These have been persistent issues over recent years, so we now need to act with urgency to address these. The vast majority of births in England are safe and we have teams providing good and outstanding maternity and neonatal care every day. However, the variation in quality and performance across the NHS underscores why we can't accept the status quo.

So, between now and December, the independent investigation will conduct urgent reviews of up to 10 trusts where there are specific issues. We'll meet with relevant leaders of several organisations over the next month and while there will be some challenging conversations, we are really keen to hear what more we can be doing to support you to go further and faster in improving maternity and neonatal care.

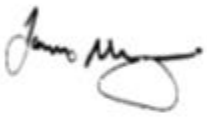
In the meantime, we ask every local NHS Board with responsibilities relating to maternity and neonatal care to:

- Be rigorous in tackling poor behaviour where it exists. Where there are examples of poor team cultures and behaviours these need addressing without delay.

- Listen directly to families that have experienced harm at the point when concerns are raised or identified. It is important we all create the conditions for staff to speak up, learn from mistakes, and at the same time staff who repeatedly demonstrate a lack of compassion or openness when things go wrong need to be robustly managed.
- Ensure you are setting the right culture: supporting, listening and working, through coproduction, with your Maternity and Neonatal Voice Partnership, and local women, and families.
- Review your approach to reviewing data on the quality of your maternity and neonatal services, closely monitoring outcomes and experience and delivering improvements to both.
- Retain a laser focus on tackling inequalities, discrimination and racism within your services, including tracking and addressing variation and putting in place key interventions. A new anti-discrimination programme from August will support our leadership teams to improve culture and practice. This also means accelerating our collective plans to provide enhanced continuity of care in the most deprived neighbourhoods, providing additional support for the women that most need it.

This is really challenging for all of us and the most important step we have to take to rebuild maternity and neonatal care is to recognise the scale of the problem we have and work together to fix it.

This will require us all to work together and this includes teams where care is outstanding where you will have a role to play in sharing best practice and supporting others to return their services to where their communities and staff want and need them to be. We hope you understand the importance of this and, as always, please get in touch if you want to discuss this ahead of the CEO call later in the week.



Sir Jim Mackey
Chief Executive

Duncan Burton
Chief Nursing Officer for England

Our Patients
Our People
Our Place

The Dudley Group NHS Foundation Trust

Paper for submission to the Executive Directors on 19th August, Quality Committee on 26th August, People Committee on 2nd September and Trust Board on 11th September 2025.

Report title:	Safer staffing review (nursing), including – Acute Assessment Areas, Acute inpatient wards, Children and Young People inpatient ward, Theatres, Neonates and Critical Care.
Sponsoring executive / Presenter:	Martina Morris – Chief Nurse and Director of Infection Prevention and Control
Report author:	Philippa Brazier – Associate Deputy Chief Nurse – Workforce and Professional Development

1. Summary of key issues

This report outlines the approach taken by the Trust to undertake safer staffing reviews, in line with national guidance (National Quality Board), and provides the outcome and recommendations for individual clinical areas from an establishment, skill mix, acuity coupled with professional judgement perspective.

Outcome:

- Validated safer staffing tools have been utilised for these reviews. In terms of SDEC, there are no validated tools available therefore the nationally available tools have been adapted to undertake the review.
- Overall, the safer staffing establishments remained in a positive position to provide and deliver safe, effective, high-quality care.
- No significant quality and safety concerns were identified by Divisional Chief Nurses based on their current establishments, although patient acuity has increasingly been challenging in some areas requiring additional temporary staff to maintain patient safety.
- A decision with regards to recruiting into the 15% of the 22% headroom/uplift has been made, which requires approval from the Executive team. Currently the 22% headroom/uplift is not applied to all clinical teams and is used inconsistently, which makes it challenging when aiming to drive the bank usage down.
- It is evident from the quantitative data that there is a disconnect between the tools recommended staffing establishments and the current funded staffing establishments, due to quantitative data collection issues. 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.
- The following table provides a summary of the clinical areas that have requested changes and if these were supported, subject to the Divisions identifying their required workforce reduction elsewhere, identifying funding to enact the change and completion of a Quality Impact Assessment (QIA).

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

June 25 SDEC	Requests suggested by ward leadership.	Changes supported by Division
AEC	Yes	yes
FAU	no	no
CAU	yes	yes
RAU	no	no
Oncology	yes	no
A2	no	no

June 25	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:

Establishment change requests following Divisional reviews:	
AMU 1	Keep the current establishment if unfunded beds close. If they remain open, then increase the establishment and budget.
AMU 2	Keep the current establishment if unfunded beds close. If they remain open, then increase the establishment and budget. To make SAM complaint, area requires an additional RN on LN, if beds remain open.
B6	Request an additional 1 WTE CSW on nights.

C3	Increase long day and long night CSW cover (1 WTE for each), which would reduce the overall temporary staffing use.
C1 A	Increase long day CSW cover (1 WTE) which would reduce the overall temporary staffing use.
C1 B	Request additional 1 WTE CSW on nights.
CCU	Increase night shift CSW by 1 WTE, this may be mitigated somewhat if CAU model is approved.
DL	Request additional 1 WTE RN cover during weekends to ensure safe medicines and safe discharges facilitation of patients.
B2 H	Additional 1 WTE CSW on nights.
B4	Opportunity for weekend staffing reductions - subject to a further review and QIA, with details to be confirmed.
Theatres	Operating theatres – reduction of 3.2 WTE (band 6 line) planned due to historical over establishment, including 100k saving on the supernumerary line.
CAU	Undertake a workforce review and a PDSA to attempt to in reach rather than have dedicated spaces. This may create opportunity for the 1.56 WTE band 5, 2.73 WTE band 2 and the 1 WTE band 6 to be released.
AEC	If CAU model works, expedite movement of a band 5 and 6 to AEC.

- For most 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. Further 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.
- Quality Impact Assessments will be completed by the Divisions to outline any risks and mitigations associated with this decision.
- Further work will be required to re-assess this depending on the plan with additional bed closures, non-elective workstream proposals and frailty work.
- Closure of all additional capacity areas, to maintain the reinstatement of the Discharge Lounge, which should positively impact on bank use.
- No current establishment changes are required for C2, PAU, ESH, C6 – recognising there are some significant ward moves pending, which may release workforce opportunities after the relocation.

Chief Nurse recommendations for establishment changes:

Workforce establishment increase:

- **C3** – an uplift is recommended for Band 2 Clinical Support Worker (CSW) 24 hours per day. The cleanliness support worker funding of 2.73 WTE available on C5a, could be utilised to fund this however there would still be a shortfall in funding 0.54 WTE. C3 has had a significant increase in patients' acuity with patients requiring enhanced and complex care. For example, during the data collection period, between 14-18 patients were on enhanced observations requiring 1:1 patient care. This permanent increase would improve are and mitigate against some of the bank expenditure.
- **C1a and C1b** would also benefit from an uplift of 1 WTE CSW on long day shifts, however there is currently no funding available although there are opportunities across the wider Division that may enable this. No significant quality and safety concerns have been raised in these areas associated with the current establishment, however patient acuity has been high and mitigated by Bank use.

Workforce establishment reduction opportunities:

- **Theatres** have identified an opportunity for reducing 3.2 WTE of their Band 6 staff due to historical over-recruitment which is no longer required. In addition, a financial saving of 100k has been identified on the supernumerary line.
- A detailed review is to be completed on **B4** by the Divisional Chief Nurse, as there is believed to be a potential workforce reduction opportunity at the weekend.

2. Alignment to our Vision	
Patients: Deliver right care, in the right place, at the right time	x
People: Be a brilliant place to work and thrive	x
Place: Build innovative partnerships to improve the health of our communities	x

3. Report journey

- Executive team on 19th August 2025
- Quality Committee on 26th August 2025
- People committee on 2nd September 2025
- Trust Board on 11th September 2025

4. Recommendation(s)

The Executive team/QC and PC are 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) ET/QC and PC to debate and provide a view on the proposed skill-mix and establishment changes.

c) Trust Board is asked to receive the report for assurance.

5. Impact reflected in our Board Assurance Framework (BAF)		
BAF Risk 1.0	x	Failure to deliver the right care, in the right place every time
BAF Risk 2.0	x	Failure to ensure Dudley is a brilliant place to work and thrive

BAF Risk 3.0		Failure to build innovative partnerships to improve the health of our communities
BAF Risk 4.0	X	Failure to remain financially sustainable in 2025/26 and beyond
BAF Risk 5.0	X	Failure to achieve operational performance requirements & deliver strategic objectives
BAF Risk 6.0		Failure to take sustained action on infrastructures that enables strategic objectives
Is Quality Impact Assessment required if so, add date: TBC		
Is Equality Impact Assessment required if so, add date: TBC		

Safer Staffing Review – June 2025.

1. EXECUTIVE SUMMARY

The purpose of this report is to inform the Executive team, Quality and People Committees and ultimately the Trust Board of the outcomes of the June 2025 assessment of Nursing Safer Staffing using the Safer Nursing Care Tool (SNCT - Shelford Group 2023) where available, 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 (DWS - 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. The Trust completed its latest assessment against DWS for nursing, midwifery and Allied Health Professionals in June 2025.

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 hight 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 (relief) built into ward establishments is 22% (429 hours) per Whole Time Equivalent (WTE) staff member. It has been agreed by the Chief Nurse and the Deputy People Officer that 15% of 22% relief can be recruited into and will form part of the wards/clinical area establishment but this is not in place consistently across all areas and it requires Executive team agreement.

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 and we were due to hear the new recommended training beginning of April, but we still haven't heard for this to be updated in the trust. Other areas to be reviewed is the disparity with AHP staff protected time for CPD, that is not part of the Nurses allocated time.

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 is less than our partners within the Black Country Provider Collaborative. 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 latest staffing review undertaken Theatres, Neonates and Critical Care 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 data collection follows the same process as the inpatient ward areas, which includes data collection and professional judgement, then the divisional challenge and confirm meetings and finally challenge conversation with the Chief Nurse. No quality and safety concerns have been raised, and the service leads agreed to no changes in the establishments.

Our Same Day Emergency Care (SDEC) areas have not undertaken a staffing review for an extensive period and nationally there is no validated tool but the SDEC strategy 2024 NHS England states staffing should be safe, sustainable and appropriate to operate the service as a first-class service. As a Trust, we undertook a trial staffing review using professional judgment and an adapted SNST to gain the data, for AEC, CAU, RAU, FAU, A2 and Oncology assessment areas.

2. PROCESSES

The safer staffing review has been undertaken using the latest validated Safer Nursing Care Tool (SNCT), national guidance and adapted approach for SDEC. The overall data collection output when using the validated tools 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.
- Community nurse safer staffing tool (updated 2024) – the Trust's CNSST review is due to start for the first time September 2025.

The SNCT has been developed to help NHS Hospitals measure patient acuity and/or dependency to inform evidence-based decision regarding 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 (NSIs) 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 and Neonates process

In Critical Care the patient acuity and staffing levels are recorded twice a day 6am and 6pm and as part of safer staffing 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.

Operating Theatres process

In operating theatres, data is collected daily as 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 give an idea 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

SDEC process

In SDEC, the acuity data was collected for 14 days, twice a day at varying times through the two-week period to try and capture the flow of patients through these assessment areas. The use of professional judgment was part of this process reviewing elements like staffing levels, Nurse car sensitive indictors. In addition, a quality review was undertaken weekly in partnership with the designated ward nurse. This validation was undertaken by a senior professional who has been appropriately trained.

3. SKILL MIX

The minimum skill mix recommended by the Royal College of Nursing (RCN) is a ratio of 65/35 Registered Nurses/Clinical 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.

June 25	RN/CSW%		June 25	RN/CSW%		June 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			
B4	50/50		C6	50/50			

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 staff ratios to ensure any derogation is linked to planned model of care changes. This will be reflected in January's 2026 safer staffing review due to the recent implementation of the national changes of the unregistered workforce with the introduction of band 3 Higher care support workers in majority of our clinical areas and the impact this has.

The ratio of Registered Nurses to Clinical 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 ratio of RN/CSW falls short of the national standard. Whilst we are moving away from the ratios, many of the national documents still refer to them. Below provides an indication of what this means and how time this equates to.

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 11/2 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 nursing skill mix: British Associate Perinatal Medicine **(**BAPM) standards are:

Department	Nurse ratio
ITU	**1:1 Registered Nurse**
HDU	**2:1 Registered Nurse**
Special care and transition care	**1:4**

In neonates, Registered Nurses/Midwives must to 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 June 25 is in Appendix 6.

% Fill Rate	April 25	May 25	June 25
Registrant Day	86	88	86
Registrant Night	91	94	92
Non-Registered Day	87	88	87
Non-Registered Night	95	94	93

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 June 2025, the demand on services would not have allowed for a lower bed occupancy due to high capacity.

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 is 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	663	496	25.2
Hourly observations	2003	1245	37.85
4 hourly observations	97,829	40,284	58.82

Observations completed on time have increased slightly since the last review in January 25, actions are being undertaken to improve the compliance. Presently there is a pilot area on C5A, station 2 that has a tracking board to see the observations at a glance of when the observations are due. Other work undertaken has been with AMU1/B3/C2/C5 to review possible reasons for the delays, whether it is with training, IT issues etc, so far, a lot of evidence has shown it is around culture of recording the observation. Work will continue with several wards at a time to review each areas own issue and to support areas to action these.

Throughout the month of June there were 134 Medical Emergency Team calls.

Area	Number of MET calls	Area	Number of MET calls	Area	Number of MET calls
AMU1	10	**B4**	24	**C5A**	5 additional 4 not stating C5A or C5B
AMU2	5	**B5**	14	**C5B**	5
AMU3	1	**B6**	2	**C6**	6
AMUA	4	**C1A**	2	**C7**	11
B1	2	**C1B**	10	**C8**	8
B2 T	3	**C3**	2	**CCU**	2
B2 H	1	**C4**	7	**MECU**	1
B3	2	**DL**	0	**FMNU**	0
C2 paeds	2 paeds 1 adult				

Unplanned omission in providing patient medications

There were over 73 thousand late or missed medications throughout this data collection, compared to 64 thousand in January 2025 data collection. 14,301 were late (30 minutes or more after the directed time on the prescription) and 59,619 which were not performed. Due to the significant number of given medications, it is currently too challenging to create a stable report to give data on those which were given on time. As part of the quality and safety delivery plan for 2025/26 time critical medication is being focussed on, which should contribute to the improvement of late medication.

Nurse Sensitive Indicators

Nurse sensitive indicators (NSI) 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 reviewed 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 June 2025 there were 55 falls across the areas and 95 Pressure Ulcers reported through the DATIX system (to note the data extract at the end of June 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 January 2025, we have reduced both falls and pressure ulcers that was recorded on Datix.

PRESSURE ULCER DAMAGE					
June 25	**No PU**	**June 25**	**No PU**	**June 25**	**No PU**
AMU1	13	**B6**	2	**C7**	12
AMU2	14	**C1A**	0	**C8**	17
AMU3 (A4)	4	**C1B**	3	**CCU**	0
AMUA	8	**C2**	0	**DL**	0
B1	0	**C3**	2	**ESH**	9
B2H	6	**C4**	2	**MECU**	0
B2T	6	**C5A**	3	**FMU**	2
B3	18	**C5B**	8		

B4	19	**C6**	0		

FALLS					
June 25	**No Falls**	**June 25**	**No Falls**	**June 25**	**No Falls**
AMU1	4	**B6**	0	**C7**	4
AMU2	8	**C1A**	7	**C8**	4
AMU3 (A4)	3	**C1B**	5	**CCU**	0
AMUA	5	**C2**	1	**DL**	0
B1	0	**C3**	6	**ESH**	4
B2H	4	**C4**	2	**MECU**	0
B2T	1	**C5A**	4	**FMU**	1
B3	5	**C5B**	2		
B4	3	**C6**	0		

INFECTION PREVENTION CONTROL ESCALATIONS					
June 25		**June 25**		**June 25**	
AMU1	1 Covid 19 1 CDI 1 E-Coli	**B6**	1 E-Coli	**C7**	
AMU2	1 Covid 19	**C1A**		**C8**	
AMU3 (A4)	1 Covid 19	**C1B**		**CCU**	1 E-Coli
AMUA	1 Covid 19 1 CDI	**C2**	1 CDI	**DL**	
B1		**C3**		**ESH**	

B2H	1 CDI	**C4**	2 Covid 19	**MECU**	1 E-Coli
B2T		**C5A**		**FMU**	
B3		**C5B**	6 Norovirus		
B4	1 Covid 19	**C6**			

In addition to the above indicators, as a Trust we believe that the number of complaints which are received is also a strong indicator of nursing care and levels of staffing, throughout June there were 34 complaints, which has increased from January 25 that was 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 33 safeguarding referrals compared to January 25 in which there was 129, that is a significant reduction.

June 25	complaints	June 25	complaints	June 25	complaints
AMU1	2	**B6**	0	**C7**	3
AMU2	3	**C1A**	0	**C8**	3
AMU3 (A4)	0	**C1B**	0	**CCU**	0
AMUA	1	**C2**	5	**DL**	0
B1	1	**C3**	2	**ESH**	0
B2H	1	**C4**	1	**MECU**	0
B2T	1	**C5A**	2	**FMNU**	1
B3	1	**C5B**	4		
B4	3	**C6**	0		

June 25	No safeguarding	June 25	No safeguarding	June 25	No safeguarding
AMU1	3	B6	2	C7	5
AMU2	1	C1A	0	C8	1
AMU3 (A4)	0	C1B	0	CCU	0
AMUA	4	C2	5	DL	0
B1	0	C3	1	ESH	1
B2H	0	C4	0	MECU	0
B2T	5	C5A	0	FMU	0
B3	1	C5B	0		
B4	0	C6	0		

A breakdown of the nurse sensitive indicators per clinical area can be reviewed in Appendix 7.

6. Care Hours Per Patient Day (CHPPD)

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	April 25	May 25	June 25
Registered staff	5.21	5.23	5.16
Care Staff	3.56	3.84	3.50
Total	8.78	8.71	8.66

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 periods of the day more appropriately? Conversely the absence of administrative support staff such as ward clerks may increase nurses' workload at 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 appropriately, and ongoing training will be provided prior to the next review. 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

Individuals involved in the data collection and data assurance had to undertake training to ensure they were 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 remain in a positive position to provide and deliver safe, effective, high-quality care. 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 undertaken with a variety of senior clinical staff being asked to undertake, this time was difficult for identify staff due to the increase workload of Matron's working additional clinical shift, so some colleagues had to undertake additional areas per week to ensure all areas had a 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 7/8/9/10.

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.

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 are the collated detail ward level requests, Divisional Chief Nurse level asks and if 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 Confirm and Challenge
AMU 1	Keep current establishment if unfunded beds close, if they remain increase in budget required is required	Presently AMU1 - Based on SAM guidance would require 22 bed 1:6 plus a Nurse in charge 8 Monitored beds 1:4 that could increase to 1:2 based on acuity Plus, the present 4 extra beds on the ward unfunded. Lead nurse in charge of two areas, AMU and AMU assessment which is a breach of RCN guidance Extensive list of training requirements due to the specialty patients they manage, this takes staff away from ward area Predominantly band 3 CSW's rather than band 2, this allows for additional skill set to be utilised with the management of some more complex patients to be managed by the RN's No concerns with Nurse sensitive indicators Over the AMU areas the staff flexible based on the staffing levels and acuity **Recommendation** -Lead nurse in charge of two areas, AMU 1 and AMU assessment which is a breach of RCN guidance. This equates to 58 bed spaces and over 126 staff. Additional staffing if the extra beds remain open.	No current establishment changes to be enacted on AMU1, AMU2, A4 and AMUA – further work will be required to re-assess this depending on the plan with additional bed closures; NEL workstream proposals and frailty work.

Area	Ward/Department Request/Amendments	Divisional Chief Nurse (DCN) Outcome of Divisional Confirm and Challenge.	Chief Nurse Outcome of Confirm and Challenge
AMU2	If unfunded beds close to make the area SAM compliant, additional RN required on LN. If beds remain open a further increase in budget required.	AMU 2 - Based on SAM guidance of 30 beds day this requires1:6 ratio with Nurse in Charge. The at night 1:7 ratio with Nurse in charge Presently there are 6 additional unfunded beds on the ward. Current establishment 6 RN and 5 CSW on shift each day and 5RN and 5 CSW long night – this does not meet SAM guidance. Budgeted staffing drops by one RN at night however acuity and activity contradicts this drop, out of 486 admissions, 198 happened between 2000 and 0600, Current establishment 6RN and 5 CSW on shift each day and 5RN and 5 CSW long night – this does not meet SAM guidance. Due to the opening of the ED corridor, time taken to transfer patients between areas has increased significantly, often taking staff off the ward for up to 20 minutes at time. **Recommendation** - If unfunded beds close to make the area SAM compliant, additional RN required on LN. If beds remain open a further increase in budget required.	As above
AMU 3	Lead Nurse required to become RCN compliant.	Current staffing is in line with SAM guidance. Lead nurse band 7 temporarily supporting from AMU assessment leaving a gap both on AMUA and A4. **Recommendation** of a Lead Nurse required to become RCN compliant.	As above
AMU A	Keep current funded establishment within financial envelope. Lead nurse required to become RCN compliant.	Nationally recommended SAM guidance 1:4 ratio with a nurse in charge supernumerary to those numbers. Present staff - Ratio 6 RN and 5 CSW long day and long night. AMU assessment received 823 admissions into 22 spaces, 140 were discharged, 1 patient transferred to MECU, 2 to CCU. 667 patients transferred to ward areas.	As above

Area	Ward/Department Request/Amendments	Divisional Chief Nurse (DCN) Outcome of Divisional Confirm and Challenge.	Chief Nurse Outcome of Confirm and Challenge
		Since the last staffing review 2 cubicles have been removed for ED redesign however 1 side room now available and in use. Bedded area is located away from the nurse base and therefore always requires RN and CSW coverage. Keep current funded establishment within financial envelope. Lead nurse required to become RCN compliant. **Strongly disagree with the census data, there is clear cut national guidance regarding staffing of acute medicine assessment areas. There is a concern that the number of level 0 patients were recorded incorrectly**.	
B1	Agree with current establishment	The proposed establishment is reflective of the data collection and the tool being accurate. It is reflective of the acuity and activity within the area. The ward experiences a high turnover of patients, with most staying for 2–3 nights. Due to the nature of admissions, post-operative care, and the discharge processes, this turnover is significantly higher than in non-elective areas, and the responsibility for managing this workload falls under the Registered Nurse's (RN) remit. Following the recent rise in surgical site infections (SSI) for post-operative arthroplasty, the team has included a review of ward attendees in the ongoing action plan to minimise risks and ensure that the appropriate treatment and care plans are followed. In January and February, there were 50 ward attendees. Each patient is initially assessed by a Registered Nurse (RN), followed by an Advanced Nurse	No establishment changes have been agreed.

Area	Ward/Department Request/Amendments	Divisional Chief Nurse (DCN) Outcome of Divisional Confirm and Challenge.	Chief Nurse Outcome of Confirm and Challenge
		Practitioner (ANP) or doctor. Of the 50 patients, 31 required suture or clip removal and wound care There are no performance / gap issues within the workforce. Bank Fill rate is 100%. **Recommendation**- Keep current funded establishment.	
B2 H	Recommend changes	B2 Hip are 0.92 WTE over but it the review does not tell us if this is RN or CSW. On review of the data collection, it appears that some patients weren't assessed correctly. B2H has recently experienced a period where there has been no need to request additional support for patients with enhanced care needs, as their established staff have been able to manage due to lower patient acuity and requirements. Most of the patients on B2H would require additional intervention to mitigate risk and maintain safety at any one time. The ward team tend to mitigate and accommodate this risk within the current budgeted establishment. However, at night, the CSW establishment does reduce; this additional duty is requested via bank dependent upon acuity and a constant risk assessment. This patient group often become more confused at night. There are a number of best practice tariffs associated with management of hip fractures that also support the best patient pathway **Recommendation**- The 6th CSW at night. The decrease of RN at night is reasonable given the reduced amount of RN activity however, the patients dependencies for activities of daily living remain unchanged and the CSW numbers should reflect this.	No establishment changes have been agreed.

Area	Ward/Department Request/Amendments	Divisional Chief Nurse (DCN) Outcome of Divisional Confirm and Challenge.	Chief Nurse Outcome of Confirm and Challenge
		After consideration, the layout of the ward is not conducive with reducing the RN numbers during the day.	
B2 T	Remain the same	The only additional staffing requests are for 1-1 care or transfers to other hospitals that cannot be managed within the budgeted establishment. Average trauma patient LOS is 1-4 nights. Patients requiring intervention from specialist areas often have a much higher LOS due to the nature of the disease / condition and rehabilitation potential. The ward has seen a higher number of patients admitted with C-spine injury, requiring full spinal precautions which does increase the dependency The threshold for patients with confusion / agitation is variable and these patients are risk assessed, and 1-1 specialist care requested if required. This can be due to post op delirium as well as those patients with dementia. Nurses deliver specialist interventions such as PICC line care, VAC dressings, complex wound management, spinal precautions, following NORSE advice for those patients with traumatic injury and intensive rehabilitation; with a typical log roll taking 5-6 members of staff. **Recommendation**- Keep current funded establishment.	No establishment changes have been agreed.
B3		The ward is currently staffed to accommodate up to 4 patients in VASCU. However, as this is an emergency portal, it is not restricted to elective or post-operative patients. Consequently, the acuity level can increase significantly, and, at times, additional registered nurse staffing	No establishment changes have been agreed.

Area	Ward/Department Request/Amendments	Divisional Chief Nurse (DCN) Outcome of Divisional Confirm and Challenge.	Chief Nurse Outcome of Confirm and Challenge
		is necessary to ensure patient safety, particularly when patients are receiving multiple enhanced infusions. In partnership with Sandwell, there are plans to expand the vascular hub contingency to support Sandwell patients. This may necessitate additional staffing and a further staffing review to ensure that the expected demand is met. Due to the cancellation of the clinical skills passport and the ongoing training requirements for VASCU, could there be consideration across the division to support the employment of a PDN who has skills within critical care who can provide knowledge and training to staff to ensure they can safely complete the Level 1 competencies. Currently the Surgical division has as PDN as a 0.64. **Recommendation**- Keep current funded establishment.	
B4		The output from the data entry is significantly different from previous staffing review yet patient group remains largely the same. There were no patients requiring 2:1 enhanced observation during this data collection therefore that will have impacted the data. There is currently a risk on the risk register relating to the level 1 skill required to work in POCU – there is currently no training programme for nursing to support this training requirement. The ward does request additional RN support when the elective POCU list increases above 4 patients this is to ensure staffing is in line with Enhanced Care units staffing guidelines. Ward B4 often requires additional staffing due to patients requiring enhanced observations, during the data input for June 2025, the ward often absorb the extra requirements of staffing without additional staff	B4 – opportunity for weekend reduction in staffing (WTE TBC) – subject to a further review and QIA.

Area	Ward/Department Request/Amendments	Divisional Chief Nurse (DCN) Outcome of Divisional Confirm and Challenge.	Chief Nurse Outcome of Confirm and Challenge
		requests (in attempt to bring the bank spend down). This is risk assessed by the lead nurse and matron team. The ward profile document assessment contradicts the data within the acuity tool. Ward profile assessment suggests that the ward needs 5.9 WTE more whereas the acuity tool states 8.47 WTE less. **Consideration -** Currently the ward can staff for up to 4 patients in POCU, but at times this may be flexed to 5-6 patients. Where this is the case, an additional RN would be requested to maintain patients' safety and to comply with national standards for enhanced care units. With the ERF and collaborative efforts across Wolverhampton and Sandwell, the plan is to expand renal services, resulting in an increase in elective procedures, primarily nephrectomies, being routed through POCU. As a result, it is anticipated that POCU will be required to care for 5-6 additional patients more frequently soon. Due to the cancellation of the clinical skills passport and the ongoing training requirements for POCU, could there be consideration across the division to support the employment of a PDN who has skills within critical care who can provide knowledge and training to staff to ensure they can safely complete the Level 1 competencies. Currently the Surgical division has as PDN as a 0.64. The team are considering converting a band 6 to a PDN role. POCU staffing levels and competency is currently a risk for the division. In addition, POCU very rarely has level 1 patients admitted over the weekend. The matron team are reviewing alongside the consultant body, a Monday – Friday service with no emergency admissions – these would redivert to critical care. This in turn would then release staff / CIP	

Area	Ward/Department Request/Amendments	Divisional Chief Nurse (DCN) Outcome of Divisional Confirm and Challenge.	Chief Nurse Outcome of Confirm and Challenge
B5 (ESH)		Staffing establishment has not been increased to manage the increased number of patients attending ESH. The triage trollies, recliner chairs and tracker office have been used as additional patient spaces to support capacity on an almost daily basis, causing delay in triaging, assessments, patient care and treatment. An additional nurse has been requested to support this, though reliant on temporary staffing and is often unfilled. There has been an increased number of patients who require medical management within GAU, this cohort of patients require 1:1 registered nursing care during sensitive delivery and aftercare. Length of stay for this cohort of patients can vary from <1 day to 6 days. The request to increase nurse and medical cover is included in the business planning next year for GAU. **Consideration:** Within the current budget, there is not enough establishment to provide 7-day cover for the Surgical Bed Manager (SBM) role. There has been an increase within this years budget to cover day shift (07.00 - 19.30hrs), however the post is yet to be approved at VAR. There is no budget to cover overnight SBM, this is currently undertaken by the band 6 Shift Lead within ESH. However, the role and responsibilities do not change out of hours, resulting in poor staff morale and undermining decisions made by the SBM OOH. There is enough established budget to increase the SBM to 7 days a week. This is currently going through the VAR process. Matron is liaising with colleagues within the finance department to scope out costings to ensure equity within the service – a compliance review of the service recommended that senior support was required	No current establishment changes have been agreed for B5 (ESH), recognising there are some significant ward moves pending, which may release opportunities and create improved patient pathways and continuity of care.

Area	Ward/Department Request/Amendments	Divisional Chief Nurse (DCN) Outcome of Divisional Confirm and Challenge.	Chief Nurse Outcome of Confirm and Challenge
		on ESH out of hours. Matron is currently reviewing the job matching process, in keeping with similar departments within the Medical Division and band 7 SBM roles to ensure equity within the Trust nursing workforce. We would like to propose a 24/7 service with budget support from C6 to address the following - The current budget does not provide sufficient establishment to cover the Surgical Bed Manager (SBM) role on a 7-day basis. It is anticipated that the 2025/26 budget will include provision for day shift coverage (07:00 - 19:30 hrs). However, there is no budget allocated for overnight SBM coverage, which is currently being managed by the Band 6 Shift Lead within ESH. This arrangement creates challenges, as the role and responsibilities remain unchanged outside of regular hours, leading to diminished staff morale and undermining the authority of decisions made by the SBM during out-of-hours periods. To increase this role is a MUST DO for the division in the new financial year due to the ongoing discussions and future with community clinical hubs. Due to increasing number of attendances, the band 3 patient tracker role (currently covers 4 days / week) is required 7/7 to support flow and safety. We have received sufficient funding via the CNC to support an increase in patient tracker line with similar units and as identified in a recent Quality and Safety review, it is recommended that Band 7 (senior nursing) cover be provided 7 days a week. Currently, the Band 7 positions consist of the Lead Nurse and Clinical Lead Nurse, both of whom work clinically (managing a cohort of patients) for two shifts each per week. The Lead Nurse also works two shifts in a managerial capacity, leaving the Clinical Lead Nurse with senior oversight for 19 hours per week. There is no supervisory Shift Lead on ESH, as all staff are assigned a cohort of patients.	

Area	Ward/Department Request/Amendments	Divisional Chief Nurse (DCN) Outcome of Divisional Confirm and Challenge.	Chief Nurse Outcome of Confirm and Challenge
B6	Request additional CSW Long night	B6 currently funded for 16 beds but 17 are presently open. Skill mixes registered: unregistered 55:45 **Consideration** The move to C6 will create an additional 3 beds increasing the bed base to 19 beds. Whilst at present no additional request has been made for trained or CSW staff during the day, this will require consideration as the staffing establishment ratio would change from a 1:8 to a 1:9.5	No current establishment changes have been agreed on B6 (pending B6/C6 move).
C1A	Additional Band 2 overnight	Presently C1A - Skill mixes 50:50 registered: unregistered, 4:4 Long day 3:3 Long night. Band 2 – 3 ratio 30% band 2, 70% band 3 Additional patients placed on the ward on the back of definite discharges. Minimal evidence of additional patients overnight due to the layout of the ward. 55 requests for additional staff in June with 31 filled by staff bank. High number of complex mental health and learning disability patients with increasing acuity alongside this. Band 7 Lead nurse working at least one shift a week clinically and continues to backfill gaps in staffing throughout the week. **Recommendation-** Additional CSW long night – safeguarding issued regarding 1:1 support ads to mitigate against bank spend.	Uplifts are recommended for C1a and C1b for Band 2 CSWs – LD - however there is currently no recurrent funding available to fund this increase and the gap is mitigated by Bank use.
C1B	Additional CSW long night	Skill mixes 50:50 registered: unregistered, 4:4 Long day 3:3 Long night. Band 2 – 3 ratios requested 30% band 2, 70% band 3, although now considering 100 band 3 to support with the dialysis patients. Additional patients placed on the ward on the back of definite discharges. Minimal evidence of additional patients overnight due to the layout of the ward.	As above

Area	Ward/Department Request/Amendments	Divisional Chief Nurse (DCN) Outcome of Divisional Confirm and Challenge.	Chief Nurse Outcome of Confirm and Challenge
		55 shifts requested with 22 unfilled. 35 dialysed patients throughout June **Recommendation** - Additional CSW long night to reduce bank spend.	
C2	Happy with current establishment	Funded June 2025- 57.31 WTE (-2.6 WTE band 7s) We do support the new proposal given the demand and capacity challenges that influence the functioning of C2. Currently rostering 9 RN and 2 CSW per day although due to staffing challenges, it is not very often that there are 9 RN on duty. The unit do flex the staffing requirements to meet the demands of the service. Levels of dependency do appear accurate on the data collection. Matron has decided to continue to sense check and monitor compliance of safe care and the acuity data will be added to the handover daily moving forward. For the data collection in June, PAU was separated from the main census data collection to give a better plan to map out activity, demand, and acuity. Matron also plans to review from Partners In Paediatric (PIP) and compare the new proposed staffing to the PIP model and staffing tool. Since the opening of the Midland Met in October 2024 there has been an increase in patients for PAU/ C2 (See above data graph for Total Admissions). On discussions with caregivers, previously they were on the border/ in between RHH and Sandwell Hospital, however with the location of the Midland Met being Smethwick/ Birmingham RHH is now considerably closer therefore they are choosing to attend RHH. **Recommendation**- Keep current funded establishment.	No current establishment changes have been agreed for C2 and PAU, recognising there are some significant ward moves pending, which may release opportunities, improve patient care and associated pathways.

Area	Ward/Department Request/Amendments	Divisional Chief Nurse (DCN) Outcome of Divisional Confirm and Challenge.	Chief Nurse Outcome of Confirm and Challenge
C3	Additional Band 2 Long day and Long Night	During the period of data collection between 14-18 patients on enhanced observations **Recommendation -** Due to the ever-increasing number of confused and delirious patients do we need to convert a bay on station 3 to an enhanced support area (extension of FMNU). Scoping exercise underway. 0.96 on band four line to be moved to support CSW line Additional CSW LD and LN, this can be partially mitigated with some budget from C5 cleanliness support budget. Scope whether requirement for second FMNU station within C3.	An uplift is recommended on C3 for Band 2 CSWs – LD & LN (could use cleanliness support worker money of 2.73 WTE on C5a which we could potentially transfer over to nights on C3 and mitigate 2.19WTE, reduced due to special duty.
C4	Leave at current level	Skill mixes registered: unregistered 70:30 Long day 3:2 on ward 2:0 in isolation Long night 2:2 on ward 2:0 in isolation Staff require additional SACT training, this is an externally accredited training course which requires staff to attend one day per week for 6 months at a time. **Recommendation**- Keep current funded establishment.	No establishment changes have been agreed.
C5a	No changes requested	Band 6 (shared between a and b holds NIV bleep overnight to support the BTS target of starting NIV within 60 minutes of decision made to initiate NIV. This can remove them from the ward for extended periods of time especially if acutely unwell patients in Emergency department Routinely take additional patients to support with flow through the hospital. No concerns with Nurse sensitive indicators.	No establishment changes have been agreed.

Area	Ward/Department Request/Amendments	Divisional Chief Nurse (DCN) Outcome of Divisional Confirm and Challenge.	Chief Nurse Outcome of Confirm and Challenge
		Recommendation - Keep current funded establishment as C5a and C5b, MECU support each area based on acuity and staffing.	
C5b	Keep current funded establishment	Higher acuity of patients managed on RSU C5b, acute NIV patents and complex respiratory (Opti flow, CPAP, chest drains, tracheostomy) NCEpod guidance suggests a ratio of 1:2 for acute NIV however the department recognises that they have a mixture of acute and chronic NIV therefore accept a ratio of 1:4 Often takes an additional patient during the day to support with the flow in the hospital Multiple escorts to other trusts during census period due to oxygen demand and need for physiological investigations and management of pneumothorax patients at New Cross. No concerns with Nurse sensitive indicators. **Recommendation** - Keep current funded establishment.	No establishment changes have been agreed.
C6	Keep current funded establishment	Due to the planned amalgamation of C6 with B5 and the move of ESH-1 to the SDEC footprint, a further staffing review will be undertaken within this piece of work. There is a reduction of 3.31 WTE proposed based on the staffing review following January data input (although this is not categorised in RN / CSW split).	No current establishment changes have been agreed for C6, recognising there are some significant ward moves pending, which may release opportunities improve patient care and pathways.

Area	Ward/Department Request/Amendments	Divisional Chief Nurse (DCN) Outcome of Divisional Confirm and Challenge.	Chief Nurse Outcome of Confirm and Challenge
		There were 63 HOT clinics for June 2025. 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 was approved for the equipment, but staffing was not included in the case request. Therefore, the team cannot support the reduction in CSW workforce. **Recommendation** - Keep current funded establishment at present.	
C7	Keep current funded establishment	Present skill mix – CSW to RN ratio 45:55 both long day and long night. Air room within the ward utilised 28 out of 30 days during June, this increases bed base to 37 beds. Limits use of the air room for diagnostic procedures. 30 additional shifts requested, 22 filled and 8 unfilled. C7 has a built in additional CSW shift for long nights which is available for utilisation if there is a requirement to support with 1:1's. In June this was required every night. Often high acuity patients on the ward, having central line care, Picc line care, Complex cancer patients, and colitis patients. Band 6 PDN within the budget, mandatory training levels exceptionally good, PDN able to support where gaps in staff provision noted. **Recommendation** - Lead nurse in charge of discharge lounge alongside C8 which is a breach is RCN guidance. Otherwise, to keep current funded establishment.	No establishment changes have been agreed.

Area	Ward/Department Request/Amendments	Divisional Chief Nurse (DCN) Outcome of Divisional Confirm and Challenge.	Chief Nurse Outcome of Confirm and Challenge
C8	Staffing mix doesn't take into consideration bleep holders' role and period of time off the ward	National Stroke guidance HASU 1 : 3 ratio ASU 1 : 6 ratio Rehab 1 : 8 ratio with a co-ordinator of care for HASU/ASU Ratio CSW : RN 20/80 hyperacute 35/65 acute/rehab High increase of band 2 bank due to vacancies that in the process of recruited into Thrombolysed 25% of suitable patients, above national target of 20%, evidences the acuity of patients managed on the ward. Thrombolysis bed is ring fenced and therefore some of the census data will evidence that it is empty at time of collection. High number of complex neuro patients requiring complex care and interventional investigations. **Recommendation** - Keep current funded establishment.	No establishment changes have been agreed.
CCU	High number of complex neuro patients requiring complex care and interventional investigations.	Present skill mix- Skill mix registered: unregistered 80 : 20 CSW 1 : 16 on PCCU CSW 1 : 8 CCU (long day only) Clinical band 7 works x 1 clinical shift each week, with the remaining supervisory 2 unfunded beds which when require additional staffing to support according to the acuity of the patients within the unit and to ensure the BACCN guidance is met.	No establishment changes have been agreed, subject to CAU model approval.

Area	Ward/Department Request/Amendments	Divisional Chief Nurse (DCN) Outcome of Divisional Confirm and Challenge.	Chief Nurse Outcome of Confirm and Challenge
		Staffing census evidence at least one additional bed opened consistently throughout June. **Recommendation** -Additional CSW long night, this may be able to be mitigated somewhat if CAU model is approved.	
MECU	Recommend 1:2 ratio	Present skills mix - Skill mix registered: unregistered 75:25 3:1 Long day 3:1 long night Band 2-3 ratio band 3 100% 8 beds ward- Level 1a facility, RCN guidance suggests 1:4, although agreed 1: 3 due to layout of area and acute NIV patients who require 1:2 ratio NCEPOD Supports NIV bleep overnight, often taking staff off ward for hours at a time overnight Extensive training for staff means they are often off the ward to confirm competence. This results in the lead nurse covering those shifts. The lead nurse works 5 days per week to support this. Identified area to support tracheostomy and laryngectomy patients within medicine **Recommendation** -Keep current funded establishment.	No establishment changes have been agreed.
FMNU	Keep current staffing levels	High number of 1c patients with one patient noted to be a 1d, this patient was supported with Jo Day Alot of patients within the unit are independently mobile, this increasing requirement for additional staffing levels as previously agreed in last staffing review.	No establishment changes have been agreed.

Area	Ward/Department Request/Amendments	Divisional Chief Nurse (DCN) Outcome of Divisional Confirm and Challenge.	Chief Nurse Outcome of Confirm and Challenge
		Increased LOS due to long waits for pathway 3. Average LOS 12.1 days 10 incidents in June Themes violence and aggression patient on staff, predominantly linked to 2 patients in particular. Heightened security presence during this time. Admiral nurse based on FMNU where her caseload is predominantly based. **Recommendation** - Keep current funded establishment.	
DL	To keep as a discharge lounge	Data collected whilst the discharge lounge was functioning as a 24/7 bedded unit, however, plans in place to close beds and open as a day discharge lounge for same day discharges has now been enacted. Staffing budget and ledger currently aligned to lounge being open for same day discharges only. Funded 1RN 1 CSW Long day sat/sun 2RN and 2 CSW Long day weekdays. Opening hours 0700-1930 7 days per week. Would require additional RN for weekend days, review underway to understand whether this would need to be for a slightly different shift time. Lead nurse supports C8 and discharge lounge which is against RCN guidance. **Recommendation** - Additional RN during weekend days to ensure safe medicines management and safe discharge facilitation of patients.	No establishment changes have been agreed.

Area	Ward/Department Request/Amendments	Divisional Chief Nurse (DCN) Outcome of Divisional Confirm and Challenge.	Chief Nurse Outcome of Confirm and Challenge
Theatres	Agree with present establishment	The division would ask that the establishment remains the same. Currently meet AFFP guidelines and BADS guidelines. The department have reduced the number of apprenticeships ODPs – currently taking one per cohort. Theatres have not signed off the budget due to concerns with the anaesthetics and recovery staffing allocation. All other budgets have been approved. The disagreement stems from the absence of a STAR ODP and a dedicated recovery practitioner for each theatre per shift; this is not a concern however, as there are only 8 recovery spaces currently available. Although theatres serve a range of specialties, staff will rotate across areas to address staffing gaps, demonstrating a flexible workforce approach. Critical care nurses are also included in this staffing model. **For consideration for future service improvements/requirements:** · Bushy Fields requires two theatre sessions per week for ECT, which are currently unfunded (off site at BF). One ODP would be needed to support these sessions. · There are also plans to begin general anaesthetics in endoscopy; however, this activity is currently unbudgeted. · In addition, paediatric MRI services are not fully funded, with gaps in provision for the ODP, anaesthetist, and recovery support.	Operating theatres – reduction of 3.2 WTE (band 6 line) planned due to historical over establishment + 100K saving on the supernumerary line – QIA to be completed.

Area	Ward/Department Request/Amendments	Divisional Chief Nurse (DCN) Outcome of Divisional Confirm and Challenge.	Chief Nurse Outcome of Confirm and Challenge
		CIP: Over £100k from the supernumerary budget has been identified as a CIP (Cost Improvement Programme) saving. An additional 3.2 WTE will be CIP'd, and Finance are aware of this plan.	
NNC		Current establishment to maintain commissioned cots at 90%BAPM Lead nurses work clinically and each have 0.16WTE admin allocated Study time allocated for those undertaking QIS course- due to increase based on national guidance. Neonatal nursing staff should undertake the QIS course. 70% of workforce should hold this accredited qualification **Recommendation** - Keep current funded establishment.	No establishment changes have been agreed.
ITU		Current establishment to maintain 15 L3E beds Lead nurses work clinically and each have 0.16WTE admin allocated Study time allocated for those undertaking critical care course Critical care staff should undertake the national competency programme. 50% of workforce should hold accredited Adult critical care course **Recommendation** - Keep current funded establishment.	No establishment changes have been agreed.

The review has highlighted there is wider work which is ongoing looking at the location of current specialities, in particular, B5 (ESH) B6, C6, C2 and Paediatric ED and the options for relocation. 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
AEC	If CAU model works movement of band 5 and 6 staff to be moved to AEC.	First staffing review of SDEC, full period of data completed but was not very helpful mostly 0 and 1a but only snapshot of day Unit open from 0730-0030 Last patient accepted at 7pm and staff work staggered shifts until 22.30 Current staffing template is to cover a caseload of 40 patients Occupancy is frequently seen at over this figure 41-69 patients 12 midday to 6 pm is the busiest period of activity. Up to 150 patients a day are seen, over 31K patients were seen last year in a 12-month period. **Recommendation** - If CAU model works movement of band 5 and 6 staff to be moved to AEC.	No establishment changes have been agreed.
FAU		12 beds funded for Virtual ward, often operate at up to 150% capacity. Largely led by the ACP and CNS team. Referrals taken from ED but also focus on early supportive discharge from inpatient areas for example B6, C3 and FMNU. Direct WMAS pathway to the department to negate the need for some lower acuity patients to attend ED. X 2 ACP funded from FAU budget and therefore opportunity to back fill not currently available. 10 x POC available for use by the team, therefore riak appetite can be increased as risk of admission is reduced. Patients who hit these criteria often spend extended length of time in the department ensuring they are ready and safe to discharge. Average patient per day 10.	No establishment changes have been agreed.

		Support in the pre-operative assessment of patients who have a clinical frailty score above 5 by undertaking a full geriatric assessment. **Recommendation** - Currently remain same, if trust frailty model approved as part of the NEL workstream additional investment will be required. Part of winter plan is to increase virtual ward capacity to 30, this will require additional investment.	
CAU	Admin support may be required to help support cath lab activity to release clinical staff to perform clinical duties	No specific model for staffing BACCN suggest a senior qualified nurse for geographically diverse units or more than 6 beds. In reach model may release some band 2 hours to cover gap in CCU overnight CSW cover. Band 5/6 may be required to support the work remaining in AEC **Recommendation -** This team want to do a workforce review and a PDSA to attempt to in reach rather than have dedicated spaces, currently being worked through , this may create opportunity for the 1.56 WTE band 5, 2.73 WTE band 2 and the 1 WTE band 6 to be released.	No establishment changes have been agreed.
RAU	Team recommends no change but would support an ILD nurse as Dudley going to become a spoke centre (may be able to release some band 7 hours from Dras /VW to do this)	First staffing review full 14-day period of data collection Acuity data based on 6 chairs A 5-day service only Monday to Friday 8-8pm Acuity score 0 1 bay 4 chairs 2 SR's daily average of patients 6.4 (65 patients seen in 14-day period). This team support early facilitated discharge from c5, and offer routine and specialist respiratory bloods ABGs ARTP, Spirometry, pleural procedures, FeNO, short tern nebulisers, pulmonary rehab . **Recommendation** - Keep current funded establishment.	No establishment changes have been agreed.

Haem/ ONC	Slight increase on band 5 line to allow opening for 5 days.	5-day service; Monday – Friday 0730 – 1930 Currently sits within the c4budget with staff. Lead nurse (CNS) works 1 clinical shift each week. On current modelling, there has been an increase chair capacity to 8 from 6 however this would require some investment to allow these to be open every day. Huge development in treatment options for patients in recent years resulting in an ever-increasing requirement for the triage and treatment provision Telephone triage increasing exponentially against staffing levels **Recommendation** - Keep current funded establishment.	No establishment changes have been agreed.
A2 day case	Request an additional RN	5-day service; Monday – Friday 0800 – 2000. Funded for 14 chairs, average number of patients each day 30 – 40. Nurse to chair ratio depends on time of day and procedure being undertaken. On average provide 120-160 hours of treatment each day. Noted increase in demand for treatment, area often supports inpatient areas to discharge patients sooner by offering procedures such as paracentesis, as well as patients from SDEC who require on off treatments such as iron infusions. Space is now a concern for expansion of the service with the movement of surgical SDEC into the medical SDEC footprint. **Recommendation** - Keep current funded establishment.	No establishment changes have been agreed.

11. RISKS

Data integrity

Throughout our review period the full data collection period was not achieved in all areas therefore not capturing all the necessary data. We also need to improve where it states that a maximum 3 of the most senior ward staff, including the ward manager should identify the patient acuity, this was not the case on some wards and a variety of staff completed the data collection with no training.

The quality assurance process was followed with most areas being reviewed over 50% of the required ask, some areas did not achieve this on a weekly basis to ensure quality assure and validate data collection.

See Appendix 1 for action plan for areas to be addressed.

June 25	Data days collected (?/30)	Weekly QA numbers (?/4)	June 25	Data days collected (?/30)	Weekly QA numbers (?/4)	June 25	Data days collected (?/30)	Weekly QA numbers (?/4)
AMU1	28	3	B6	29	3	C7	30	2
AMU2	29	3	C1A	30	1	C8	28	4
AMU3 (A4)	27	3	C1B	25	3	CCU	29	4
AMUA	27	4	C2	25	1	DL	29	3
B1	29	3	C3	30	4	ESH	29	3
B2H	30	3	C4	26	3	MECU	26	2
B2T	30	3	C5A	30	2	FMU	30	3
B3	30	3	C5B	30	3			
B4	29	3	C6	26	3			

June 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	44.87	29.92	74.79	79.98	5.19	-5.54
AMU2	30	42.22	34.55	75.96	59.16	-16.80	-0.83

AMU3 (A4)	**12**	12.75	12.75	25.51	24.57	-0.94	-0.4
AMUA	**22**	20.28	16.59	36.85	61.03	24.18	
B1	**26**	17.74	11.83	29.57	30.41	0.84	1.16
B2H	**24**	19.68	29.52	49.2	50.12	0.92	-3.82
B2T	**24**	20.49	20.49	40.97	40.92	0.5	0.75
B3	**36**	36.72	18.69	66.76	64.74	-2.02	-3.06
B4	**48**	36.72	36.72	73.43	81.9	8.47	-5.9
B6	**16**	18.84	7.33	26.16	27.06	0.9	-1.49
C1A	**24**	29.95	29.95	49.65	38.9	10.75	-0.54
C1B	**24**	28.16	28.16	39.18	38.9	0.28	-0.54
C2	**47**	44.4	11.1	55.5	57.31	1.81	
C3	**36**	53.41	43.7	102.7	60.29	42.41	-1.7
C4	**24**	22.15	9.45	31.64	40.48	8.84	
C5A	**24**	44.46	29.57	42.56	39.44	-3.12	2.19
C5B	**24**	39.6	32.4	44.4	50.36	5.96	-1.54
C6	**19**	14.17	14.17	28.35	31	2.65	-3.31
C7	**36**	36.25	36.25	71.99	67.33	4.66	-0.19
C8	**44**	40.11	40.11	80.13	86.04	5.91	-2.59
CCU	**24**	29.57	7.39	36.92	59	22.08	
DL	**16**	16.83	11.22	28.05	10.84	17.21	-13.84
ESH	**26**	46.19	19.8	65.98	61.57	- 4.41	
MECU	**8**	11.75	3.92	15.67	22.52	6.85	-0.54
FMU	**16**	22.18	51.75	58.47	47.09	-11.38	-2.35

he 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.

12. NEXT STEPS

The proposed next steps are detailed following this review:

- Safer staffing reviews to be completed in the Emergency Department and Community.
- Further data collection and review of Adult Inpatient areas, Adult Assessment Units and Children and Young People areas to be undertaken as planned in January 2026.
- Further training sessions to be made available in December 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.
- Review the possibility of undertaking a staffing review in outpatient areas, following the competition of the review in the same day emergency care areas.
- Progress action plan associated with the Developing Workforce Safeguards gap analysis completed in June 2025.

APENDICES

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

	SNCT Red Rule	June 2025 Compliance	RAG		SNCT Red Rule	June 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 Associate 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 conduced 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 14th 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	

Data Collection Output At a Glance - Appendix 2a

Jun-25	Beds	Acuity 0	Acuity 1a	Acuity1b	Acuity1c	Acuity1d	Acuity2	Acuity3	Acuity BE	Data days collected (?/30)	Weekly QA numbers (?/4)	No complaints	No safeguarding	No Falls	No PU	Covid 19	Norovirus	CDI	E Coli	MRSA	Observations post target			Medicines Late/Unplanned ommission		RN/CSW%
																					L	M	H	Late	Unplanned Ommission	
AMU 1	35	0.85	13.57	13.17	1.32	0.21	5.10	0.00	0.75	28	3	2	3	4	13	1	0	1	1	0	2337	104	54	200	31	60/40
AMU2	36	1.37	17.65	12.27	4.10	0.00	0.34	0.00	0.06	29	3	3	1	8	14	1	0	0	0	0	2315	40	12	166	34	55/45
AMU3 (A4)	12	1.22	5.11	5.29	0.51	0.00	0.03	0.00	0.85	27	3	0	0	3	4	1	0	0	0	0	962	11	8	52	11	50/50
AMUA	22	5.14	10.51	3.51	0.48	0.00	0.14	0.00	1.18	27	4	1	4	5	8	1	0	1	0	0	688	40	26	71	14	55/45
B1	26	11.13	6.75	2.27	0.00	0.00	0.00	0.00	5.86	29	3	1	0	0	0	0	0	0	0	0	996	8	0	469	9	60/40
B2H	24	3.90	0.00	16.93	3.16	0.00	0.00	0.00	0.00	30	3	1	0	4	6	0	0	1	0	0	1295	6	4	452	11	40/60
B2T	24	8.20	0.03	14.33	1.33	0.00	0.00	0.00	0.10	30	3	1	5	1	6	0	0	0	0	0	1378	43	26	216	23	50/50
B3	36	4.46	1.23	26.66	1.10	0.00	1.76	0.00	1.23	30	3	1	1	5	18	0	0	0	0	0	1880	19	7	878	37	55/45
B4	48	3.72	26.79	9.93	3.83	0.00	0.17	0.00	0.82	29	3	3	0	3	19	1	0	0	0	0	2445	66	37	373	45	50/50
B6	16	11.44	0.20	3.93	0.79	0.00	0.00	0.00	1.18	29	3	0	2	0	2	0	0	0	1	0	1195	10	6	102	8	55/45
C1A	24	2.40	0.60	18.03	2.73	0.00	0.00	0.00	0.93	30	1	0	0	7	0	0	0	0	0	0	1422	11	0	170	10	50/50
C1B	24	1.36	0.56	17.44	0.80	0.00	0.00	0.00	0.76	25	3	0	0	5	3	0	0	0	0	0	1210	19	23	478	24	50/50
C2	47	26.60	1.64	0.52			0.00	0.00	14.08	25	1	5	5	1	0	0	0	1	0	0	6	0	0	0	0	80/20
PAU	11	7.16	0.12	0.00			0.00	0.00	3.72	25	1															
C3	36	4.73	0.86	15.76	13.66	0.00	0.00	0.00	0.70	30	4	2	1	6	2	0	0	0	0	0	1112	17	6	218	13	55/45
C4	22	2.57	11.50	7.46	0.00	0.00	0.03	0.00	0.42	26	3	1	0	2	3	2	0	0	0	0	1531	39	24	326	49	70/30
C5A	24	4.33	3.30	14.50	1.03	0.00	0.36	0.00	1.46	30	2	2	0	4	8	0	0	0	0	0	11525	48	23	243	21	60/40
C5B	24	3.44	2.89	16.55	0.65	0.00	0.58	0.00	1.86	30	3	4	0	2	7	0	6	0	0	0	1126	53	22	224	17	55/45
C6	19	10.35	0.38	6.93	1.07	0.00	0.00	0.00	0.00	26	3	0	0	0	0	0	0	0	0	0	1384	6	8	160	12	50/50
C7	36	4.51	4.96	25.00	3.12	0.00	0.00	0.00	1.38	30	2	3	5	4	12	0	0	0	0	0	2625	46	44	376	30	50/50
C8	44	6.89	3.75	30.60	1.62	0.00	1.17	0.00	0.92	28	4	3	1	4	17	0	0	0	0	0	2404	23	17	329	47	55/45
CCU	26	5.72	12.48	5.31	0.13	0.00	1.72	0.00	0.62	29	4	0	0	0	0	0	0	0	1	0	762	4	3	426	26	80/20
DL	16	2.58	0.62	12.24	0.03	0.00	0.00	0.00	1.44	29	3	0	0	0	0	0	0	0	0	0	4	0	0	8	0	60/40
ESH	36	19.21	7.00	9.78	0.25	0.07	0.32	0.00	1.35	29	3	0	1	4	9	0	0	0	0	0	2591	46	19	692	27	70/30
MECU	8	0.96	1.92	1.07	0.15	0.00	2.69	0.00	2.88	26	2	0	0	0	0	0	0	0	1	0	218	24	5	38	3	75/25
FMU	16	0.00	0.00	3.84	12.13	0.03	0.00	0.00	0.00	30	3	1	0	1	2	0	0	0	0	0	909	4	3	138	8	30/70

Data Collection Output At a Glance - Appendix 2b

Jun-25	Beds	RN/CSW%	Recommended WTE (Reg)	Recommended WTE NR	Recommended Overall Total	Funded budget Jan 25	Funded budget June 25	Diff FB is to Recc Over	Ward Profile Document WTE	Requests suggested by ward leadership.	Changes supported by Division	Change requested WTE	QIA requirement	
AMU 1	35	60/40	44.87	29.92	74.79	79.45	79.98	5.19	-5.54					AMU1
AMU2	36	55/45	42.22	34.55	75.96	59	59.16	-16.80	-0.83					AMU2
AMU3 (A4)	12	50/50	12.75	12.75	25.51	24.57	24.57	-0.94	-0.4					AMU3 (A4)
AMUA	22	55/45	20.28	16.59	36.85	61.06	61.03	24.18						AMUA
B1	26	60/40	17.74	11.83	29.57	30.58	30.41	0.84	1.16					B1
B2H	24	40/60	19.68	29.52	49.2	50.86	50.12	0.92	-3.82					B2H
B2T	24	50/50	20.49	20.49	40.97	44.06	40.92	0.5	0.75					B2T
B3	36	55/45	36.72	18.69	66.76	66.16	64.74	-2.02	-3.06					B3
B4	48	50/50	36.72	36.72	73.43	81.91	81.9	8.47	-5.9					B4
B6	16	55/45	18.84	7.33	26.16	27.06	27.06	0.9	-1.49					B6
C1A	24	50/50	29.95	29.95	49.65	38.9	38.9	10.75	-0.54					C1A
C1B	24	50/50	28.16	28.16	39.18	38.9	38.9	0.28	-0.54					C1B
C2	47	80/20	44.4	11.1	55.5	59.31	57.31	1.81						C2
PAU	11		11.1	2.8	13.9									
C3	36	55/45	53.41	43.7	102.7	60.29	60.29	42.41	-1.7					C3
C4	22	70/30	22.15	9.45	31.64	40.48	40.48	8.84						C4
C5A	24	60/40	44.46	29.57	42.56	42.3	39.44	-3.12	2.19					C5A
C5B	24	55/45	39.6	32.4	44.4	50.49	50.36	5.96	-1.54					C5B
C6	19	50/50	14.17	14.17	28.35	33.68	31	2.65	-3.31					C6
C7	36	50/50	36.25	36.25	71.99	67.33	67.33	4.66	-0.19					C7
C8	44	55/45	40.11	40.11	80.13	87.04	86.04	5.91	-2.59					C8
CCU	26	80/20	29.57	7.39	36.92	56.85	59	22.08						CCU
DL	16	60/40	16.83	11.22	28.05	10.85	10.84	17.21	-13.84					DL
ESH	36	70/30	46.19	19.8	65.98	73.92	61.57	-4.41						ESH
MECU	8	75/25	11.75	3.92	15.67	22.52	22.52	6.85	-0.54					MECU
FMU	16	30/70	22.18	51.75	58.47	47.09	47.09	-11.38	-2.35					FMU

the SHELFORD GROUP

Safer Nursing Care Tool (SNCT)

Safer Nursing Care Tool

Care level	Descriptor *Care requirements may include the following:*
Level 0 Hospital Inpatient Needs met by provision of normal ward cares.	• 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.	• 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: - 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.	• 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	• Patients requiring arm's length or continuous observation as per local policy.

Care level	Descriptor *Care requirements may include the following:*
Level 1d Patients who are in a STABLE condition but are requiring additional intervention to mitigate risk and maintain safety	• 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.	• 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: - 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.	• 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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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** • 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** • 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.
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** • Unaccompanied children • Established High Humidity, High Flow Nasal Cannula (HHHFNC) • 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** • 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 +/or 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** • 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 'specialing'

Safer Nursing Care Tool Acuity Data- Appendix 5

Jun-25	Beds	Acuity 0	Acuity 1a	Acuity1b	Acuity1c	Acuity1d	Acuity2	Acuity3	Acuity BE
AMU 1	35	0.85	13.57	13.17	1.32	0.21	5.10	0.00	0.75
AMU2	36	1.37	17.65	12.27	4.10	0.00	0.34	0.00	0.06
AMU3 (A4)	12	1.22	5.11	5.29	0.51	0.00	0.03	0.00	0.85
AMUA	22	5.14	10.51	3.51	0.48	0.00	0.14	0.00	1.18
B1	26	11.13	6.75	2.27	0.00	0.00	0.00	0.00	5.86
B2H	24	3.90	0.00	16.93	3.16	0.00	0.00	0.00	0.00
B2T	24	8.20	0.03	14.33	1.33	0.00	0.00	0.00	0.10
B3	36	4.46	1.23	26.66	1.10	0.00	1.76	0.00	1.23
B4	48	3.72	26.79	9.93	3.83	0.00	0.17	0.00	0.82
B6	16	11.44	0.20	3.93	0.79	0.00	0.00	0.00	1.18
C1A	24	2.40	0.60	18.03	2.73	0.00	0.00	0.00	0.93
C1B	24	1.36	0.56	17.44	0.80	0.00	0.00	0.00	0.76
C2	47	26.60	1.64	0.52			0.00	0.00	14.08
PAU	11	7.16	0.12	0.00			0.00	0.00	3.72
C3	36	4.73	0.86	15.76	13.66	0.00	0.00	0.00	0.70
C4	22	2.57	11.50	7.46	0.00	0.00	0.03	0.00	0.42
C5A	24	4.33	3.30	14.50	1.03	0.00	0.36	0.00	1.46
C5B	24	3.44	2.89	16.55	0.65	0.00	0.58	0.00	1.86
C6	19	10.35	0.38	6.93	1.07	0.00	0.00	0.00	0.00
C7	36	4.51	4.96	25.00	3.12	0.00	0.00	0.00	1.38
C8	44	6.89	3.75	30.60	1.62	0.00	1.17	0.00	0.92
CCU	26	5.72	12.48	5.31	0.13	0.00	1.72	0.00	0.62
DL	16	2.58	0.62	12.24	0.03	0.00	0.00	0.00	1.44
ESH	36	19.21	7.00	9.78	0.25	0.07	0.32	0.00	1.35
MECU	8	0.96	1.92	1.07	0.15	0.00	2.69	0.00	2.88
FMU	16	0.00	0.00	3.84	12.13	0.03	0.00	0.00	0.00

Date	June 2025

Safer Staffing Summary **Jun** Days in Month 30

Ward	Day RN Plan	Day RN Actual	Day CSW Plan	Day CSW Actual	Night RN Plan	Night RN Actual	Night CSW Plan	Night CSW Actual	RN Day %	CSW Day %	RN N %	CSW N %	Sum 24:00 Occ	Actual CHPPD Registered	Care staff	Total
B1	124	101	62	54	62	60	57	45	81%	88%	97%	78%	432	4.24	2.61	6.85
B2(H)	120	102	189	155	90	86	178	171	85%	82%	95%	96%	716	3.16	5.36	8.51
B2(T)	120	104	141	115	90	81	124	111	87%	82%	90%	89%	706	3.15	3.84	6.99
B3	188	174	185	167	180	178	158	150	92%	90%	99%	95%	1,112	3.72	3.42	7.14
B4	220	173	242	210	181	177	187	178	78%	87%	98%	95%	1,264	3.25	3.68	6.93
B5	240	188	160	147	230	217	96	86	79%	92%	94%	89%	1,007	4.93	2.70	7.64
B6	93	73	64	59	60	60	67	65	78%	92%	100%	97%	480	3.25	3.10	6.34
C1 A	123	126	147	108	90	90	119	112	103%	74%	100%	94%	712	3.55	3.72	7.27
C1 B	128	123	153	130	94	90	123	106	96%	85%	96%	86%	717	3.48	3.86	7.35
C2	262	222	65	58	267	222	59	56	85%	89%	83%	95%	445	11.73	3.00	14.73
C3	210	201	380	354	180	168	370	361	96%	93%	93%	97%	1,557	2.84	5.39	8.23
C4	200	157	69	62	120	94	63	73	78%	90%	78%	117%	651	4.51	2.40	6.91
C5 A	117	89	121	117	90	88	97	94	76%	96%	98%	97%	715	3.00	3.53	6.54
C5 B	157	140	122	110	150	148	91	90	89%	90%	98%	99%	707	4.78	3.40	8.18
C6	94	92	94	85	90	90	88	75	98%	91%	100%	85%	554	3.85	3.48	7.33
C7	208	169	182	166	150	137	180	166	81%	91%	91%	92%	1,072	3.35	3.71	7.06
C8	250	238	228	204	210	191	191	174	95%	89%	91%	91%	1,290	3.90	3.52	7.42
CCU_PCCU	241	224	60	52	210	210	30	27	93%	87%	100%	90%	744	6.85	1.27	8.12
Critical Care	521	363	120	86	510	358			70%	72%	70%		415	20.84	2.49	23.32
AMU	536	500	455	413	482	504	455	434	93%	91%	105%	95%	2,404	4.91	4.23	9.14
Maternity	822	740	256	181	510	498	149	113	90%	71%	98%	76%	1,206	9.86	2.85	12.71
MECU	92	91	33	32	91	89			99%	97%	98%		204	10.59	1.71	12.29
NNU	375	280			262	226			75%		86%		392	15.41	0.00	15.41
TOTAL	**5,442**	**4,671**	**3,526**	**3,063**	**4,400**	**4,060**	**2,882**	**2,687**	**86%**	**87%**	**92%**	**93%**	**19,502**	**5.16**	**3.50**	**8.66**

Nursing Sensitive Indicators – June 25- Appendix 7

Jun-25	Beds	Weekly QA numbers (?/4)	No complaints	No safeguarding	No Falls	No PU	Covid 19	Norovirus	CDI	E Coli	MRSA
AMU 1	35	3	2	3	4	13	1	0	1	1	0
AMU2	36	3	3	1	8	14	1	0	0	0	0
AMU3 (A4)	12	3	0	0	3	4	1	0	0	0	0
AMUA	22	4	1	4	5	8	1	0	1	0	0
B1	26	3	1	0	0	0	0	0	0	0	0
B2H	24	3	1	0	4	6	0	0	1	0	0
B2T	24	3	1	5	1	6	0	0	0	0	0
B3	36	3	1	1	5	18	0	0	0	0	0
B4	48	3	3	0	3	19	1	0	0	0	0
B6	16	3	0	2	0	2	0	0	0	1	0
C1A	24	1	0	0	7	0	0	0	0	0	0
C1B	24	3	0	0	5	3	0	0	0	0	0
C2	47	1	5	5	1	0	0	0	1	0	0
PAU	11	1									
C3	36	4	2	1	6	2	0	0	0	0	0
C4	22	3	1	0	2	3	2	0	0	0	0
C5A	24	2	2	0	4	8	0	0	0	0	0
C5B	24	3	4	0	2	7	0	6	0	0	0
C6	19	3	0	0	0	0	0	0	0	0	0
C7	36	2	3	5	4	12	0	0	0	0	0
C8	44	4	3	1	4	17	0	0	0	0	0
CCU	26	4	0	0	0	0	0	0	0	1	0
DL	16	3	0	0	0	0	0	0	0	0	0
ESH	36	3	0	1	4	9	0	0	0	0	0
MECU	8	2	0	0	0	0	0	0	0	1	0
FMU	16	3	1	0	1	2	0	0	0	0	0

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

Apr-25	Beds	Acuity 1a	Acuity1b	Acuity1c	Acuity1d	Acuity2	Acuity3
ITU		2.10	3.50	0.90	0.00	6.30	4.10

Apr-25	Beds	Acuity 1a	Acuity1b	Acuity 2	Acuity 3
NNU		3.90	4.90	1.50	0.80

Management Team - Theatres

	WTE Budget	WTE Contracted	Difference	Qualified Deficit	Hours Available	Qualified Deficit
Band 8	1	1	0		0	
Band 7	9	8.4	0.6		22.5	
Band 6	5.85	5.85	0		0	
Band 5	0	0	0		0	
Band 4	0	0	0		0	
Band 3	1	1	0		0	
Band 2	1	1	0		0	

DC Theatre CH Ward, Theatre & Recovery

	WTE Budget	WTE Contracted	Difference	Qualified Deficit	Hours Available	Qualified Deficit
Band 8	0.00	0.00	0.00		0	
Band 7	0.00	0.00	0.00		0	

Band 6	2.40	3.29	-0.89		-33.375	
Band 5	7.73	3.06	4.67		175.125	
Band 4	0.00	0.00	0.00		0	
Band 3	0.00	0.00	0.00		0	
Band 2	4.84	4.95	-0.11		-4.125	

Theatres Weekend Lists

	WTE Budget	WTE Contracted	Difference	Qualified Deficit	Hours Available	Qualified Deficit
Band 8	0.00	0.00	0.00		0	
Band 7	0.00	1.44	-1.44		-54	
Band 6	2.88	5.02	-2.14		-80.25	
Band 5	8.64	8.90	-0.26		-9.75	
Band 4	0.00	0.18	-0.18		-6.75	
Band 3	0.00	0.12	-0.12		-4.5	
Band 2	3.36	5.07	-1.71		-64.125	

Theatres T&O

	WTE Budget	WTE Contracted	Difference	Qualified Deficit	Hours Available	Qualified Deficit
Band 8	0.00	0.00	0.00		0	
Band 7	0.00	0.00	0.00		0	
Band 6	4.70	6.04	-1.34		-50.25	
Band 5	4.48	5.82	-1.34		-50.25	
Band 4	4.48	1.91	2.57		96.375	
Band 3	0.00	0.00	0.00		0	
Band 2	4.48	5.82	-1.34		-50.25	

Theatre Supernumerary

	WTE Budget	WTE Contracted	Differance	Qualified Deficit	Hours Available	Qualified Deficit
Band 8	0.00	0.00	0.00		0	
Band 7	0.00	0.00	0.00		0	

Band 6	0.00	0.17	-0.17		-6.375	
Band 5	0.00	1.07	-1.07		-40.125	
Band 4	0.00	1.00	-1.00		-37.5	
Band 3	0.00	0.00	0.00		0	
Band 2	0.00	7.28	-7.28		-273	

Theatres Recovery & Anaesthetics

	WTE Budget	WTE Contracted	Difference	Qualified Deficit	Hours Available	Qualified Deficit
Band 8	0.00	0.00	0.00		0	
Band 7	0.00	0.00	0.00		0	
Band 6	9.44	17.74	-8.30		-311.25	
Band 5	32.33	34.91	-2.58		-96.75	
Band 4	0.00	0.00	0.00		0	
Band 3	0.00		0.00		0	
Band 2	1.39	1.00	0.39		14.625	

Main Theatre Other Specialties

	WTE Budget	WTE Contracted	Differance	Qualified Deficit	Hours Available	Qualified Deficit
Band 8	0.00	0.00	0.00		0	
Band 7	0.00	0.00	0.00		0	
Band 6	5.46	4.71	0.75		28.125	
Band 5	6.79	9.18	-2.39		-89.625	
Band 4	0.00	3.48	-3.48		-130.5	
Band 3	0.00	0.00	0.00		0	
Band 2	5.46	12.91	-7.45		-279.375	

RHH Day Case Ward

	WTE Budget	WTE Contracted	Difference	Qualified Deficit	Hours Available	Qualified Deficit
Band 8	0.00	0.00	0.00		0	
Band 7	0.00	0.00	0.00		0	

Band 6	5.40	5.92	-0.52		-19.5	
Band 5	13.31	9.84	3.47		130.125	
Band 4	2.01	1.92	0.09		3.375	
Band 3	0.00	0.00	0.00		0	
Band 2	9.88	8.72	1.16		43.5	

RHH Day Case Theatre & Recovery

	WTE Budget	WTE Contracted	Difference	Qualified Deficit	Hours Available	Qualified Deficit
Band 8	0	0	0		0	
Band 7	0	0	0		0	
Band 6	8.3	8.48	-0.18		-6.75	
Band 5	14.91	8.34	6.57		246.375	
Band 4	0	1	-1		-37.5	
Band 3	1.34	1	0.34		12.75	
Band 2	6.06	6.89	-0.83		-31.125	

Theatres Emergency & Other

	WTE Budget	WTE Contracted	Difference	Qualified Deficit	Hours Available	Qualified Deficit
Band 8	0	0	0		0	
Band 7	0	0	0		0	
Band 6	14.22	15.92	-1.7		-63.75	
Band 5	12.91	8.44	4.47		167.625	
Band 4	0	1	-1		-37.5	
Band 3	0		0		0	
Band 2	16.03	13.7	2.33		87.375	

Jun-25	chairs	Recommended WTE (Reg)	Recommended WTE NR	Recommended Overall Total	Funded Budget - June 25	Diff FB is to Recc Over	Ward Profile Document WTE	Requests suggested by ward leadership.	Changes supported by Division	Change requested WTE	QIA requirement
		this is based on 24/7									
AEC	54	68.61	29.41	98.02							
RAU	8	8.3	3.56	11.86	6.46	5.4	-0.46				
CAU	8	8.39	3.59	11.98	13.73	-1.8					
FAU	8	9.24	3.96	12.98	16.7	3.72	5.6				
Heam/onc	6	6.19	2.6	8.84	13.53	-4.69					
A2	14	15.42	6.61	22.2	11.15	11.05	1.99				

12 HRS /7 DAYS just halfing the recomendation

34.3	14.7	49.01		
4.15	1.78	5.93	6.46	-0.53
5.9	2.53	8.53	13.73	-5.2
4.62	1.98	6.6	16.7	-10.04
3.09	0.99	4.42	13.53	-9.11
7.71	3.3	11.1	11.15	-0.5

Our Patients
Our People
Our Place

The Dudley Group NHS Foundation Trust

Paper for submission to the Board of Directors on 11th September 2025

Report title:	Learning from Deaths (Mortality Report)
Sponsoring executive / Presenter:	Dr Jonathan Odum, Interim Medical Director
Report author:	Dr P Brammer and Nuala Hadley

1. Summary of key issues

The Board of Directors is advised that the Learning from Deaths Report has been considered at the Quality Committee with appropriate scrutiny and challenge.

Assure

- Sustained improvement of perinatal/paediatric mortality
- Summarised Hospital Level Mortality Indicator and Hospital Standardised Mortality Ratio (SHMI/HSMR) remain stable and within expected range
- Structured Judgement Reviews providing assurance of good care for the trust

Advise

- CUSUM (Cumulative Sum control chart) alerts are early warning triggers, 4 alerts – 1 SHMI and 3 HSMR
- The Trust may observe some instability in the SHMI when Emergency Care Data Set (ECDS) coding is implemented.

Alert

- Fast track discharge on Risk Register

2. Alignment to our Vision

Patients: Deliver right care, in the right place, at the right time	**x**
People: Be a brilliant place to work and thrive	**x**
Place: Build innovative partnerships to improve the health of our communities	**x**

3. Report journey

Mortality Surveillance Group
Quality Committee

4. Recommendation

The Public Trust Board is asked to:

a) Be **assured** that mortality continues to improve and is within the expected levels

5. Impact reflected in our Board Assurance Framework (BAF)

BAF Risk 1.0		Failure to deliver the right care, in the right place every time
BAF Risk 2.0		Failure to ensure Dudley is a brilliant place to work and thrive
BAF Risk 3.0		Failure to build innovative partnerships to improve the health of our communities
BAF Risk 4.0		Failure to remain financially sustainable in 2025/26 and beyond
BAF Risk 5.0		Failure to achieve operational performance requirements & deliver strategic objectives
BAF Risk 6.0		Failure to take sustained action on infrastructures that enables strategic objectives
Is Quality Impact Assessment required if so, add date: No		
Is Equality Impact Assessment required if so, add date: No		

1. EXECUTIVE SUMMARY

The Board of Directors is advised that the Learning from Deaths Report has been considered at the Quality Committee with appropriate scrutiny and challenge.

SHMI is currently 98.29 and HSMR is currently 88.15. Both are now within the expected range, with HSMR as a positive outlier.

The work within the surgical division related to fractured neck of femur is ongoing and we continue to pursue sustained improvements through quality improvement work. Both Stroke and Fractured Neck of Femur are showing a decrease in SHMI with Stroke now at 98.97 and #NoF at 98.

Continued stability in perinatal mortality demonstrates that the work completed following the thematic review is fully embedded within the trust.

The Medical Examiner Service continues to be the largest source of referrals for Structured Judgement Review (SJR). Completed SJRs show a good quality of care and low level of avoidability. The Dudley Medical Examiner service is fully operational and all deaths within the Dudley Borough are undergoing a proportionate review each month.

The full report is located in the reading room associated with this meeting.

The Executive is asked to note the decreasing trend in SHMI and HSMR. It is likely that the improvement in HSMR / SHMI reflect an improvement in the denominator as well as quality of care and provides assurance in relation to previous alerts. Positive assurance related to quality of care includes SJRs output and falling HSMR with no weekend effect.

The progress against mortality related actions is reported via Quarterly Learning from Deaths reports submitted to Quality Committee and Trust Board.

Nuala Hadley and Dr P Brammer on behalf of Dr J Odum
27/08/2025

2. BACKGROUND INFORMATION

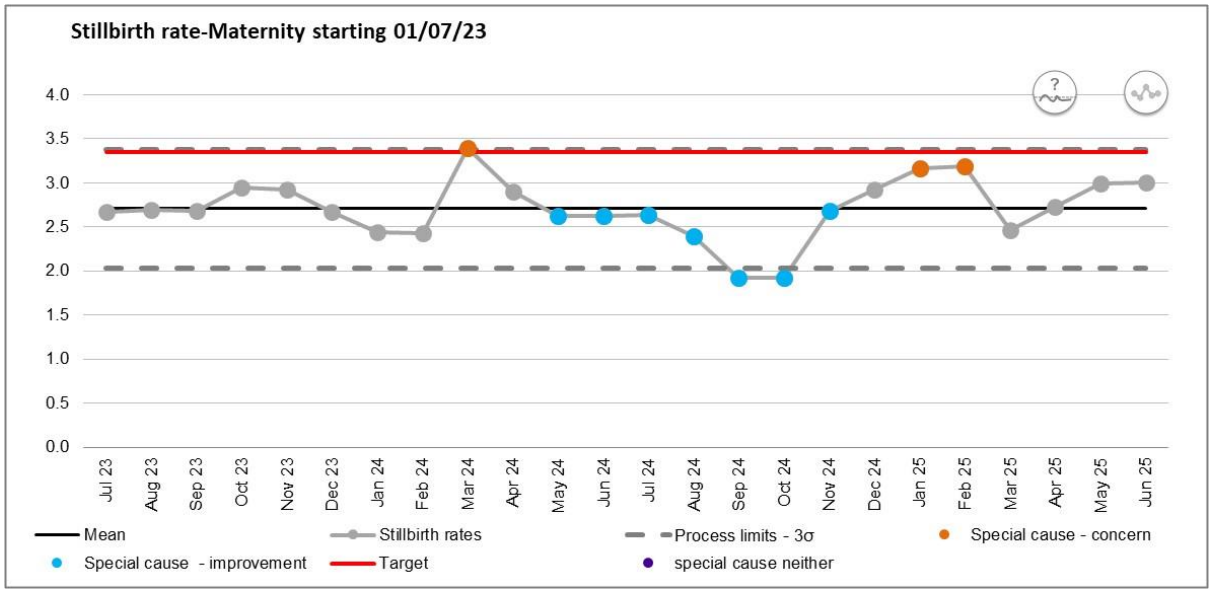
This report has been structured to review outcomes throughout the chronological life cycle from conception to end of life care.

2.1 Conception to Birth

2.1.1 Perinatal

Stillbirths
The National stillbirth rate is 3.35 (MBRRACE 2024) and it can be seen the crude stillbirth rate for Quarter 1 2025/2026 peaked in February 2025, but the rate has remained stable since.

		Crude Rate	National crude rate	Number of stillbirths
Quarter 2 2024/2025	Jul-24	2.63	3.35	0
	Aug-24	2.39	3.35	1
	Sep-24	1.92	3.35	0
Quarter 3 2024/2025	Oct-24	1.92	3.35	1
	Nov-24	2.68	3.35	3
	Dec-24	2.92	3.35	1
Quarter 4 2024/2025	Jan-25	3.17	3.35	1
	Feb-25	3.19	3.35	0
	Mar-25	2.46	3.35	1
Quarter 1 2025/2026	Apr-25	2.73	3.35	1
	May-25	2.99	3.35	1
	Jun-25	3.0	3.35	2



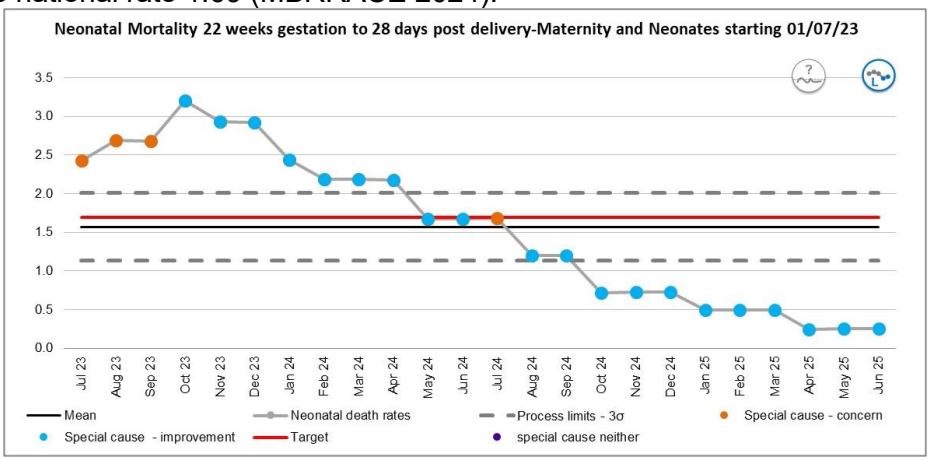
The above chart provides a comparison of the stillbirth crude rate and national rate. In Quarter 1 2025/2026 in April (2.73), May (2.99) and in June (3.0). There has been a slight increase in the number of stillbirths over the last few months which is being closely monitored. It has been identified that in some cases late booking may have contributed but there is ongoing work.

Neonatal deaths

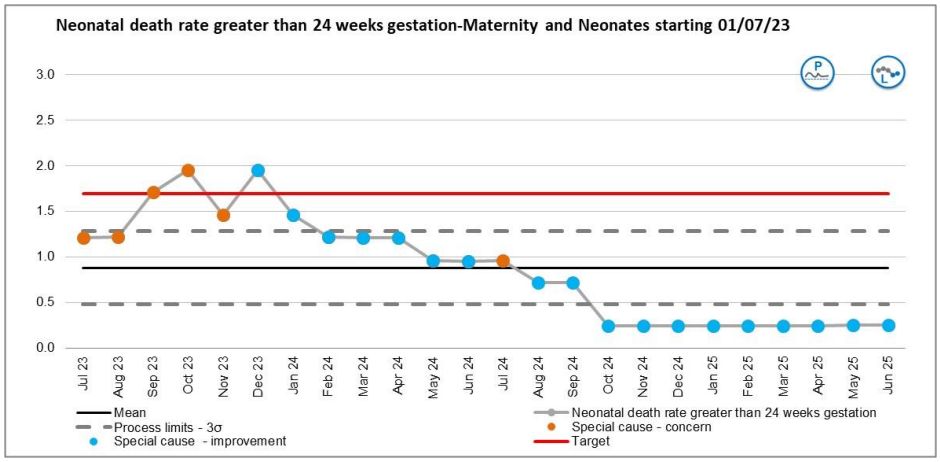
The National Neonatal Death (NND) rate is 1.69 (MBRRACE 2024), and the rate has remained statistically low during Quarter 1 2025/2026.

		Crude Rate	National Crude Rate	DGFT > 24 weeks gestation	Number of NND
Quarter 2 2024/2025	Aug-24	1.2	1.69	0.72	0
	Sep-24	1.2	1.69	0.72	0
Quarter 3 2024/2025	Oct-24	0.72	1.69	0.24	0
	Nov-24	0.73	1.69	0.24	0
	Dec-24	0.73	1.69	0.24	1
Quarter 4 2024/2025	Jan-25	0.73	1.69	0.24	0
	Feb-25	0.49	1.69	0.24	0
	Mar-25	0.49	1.69	0.24	0
Quarter 1 2025/2026	Apr-25	0.24	1.69	0.24	0
	May-25	0.25	1.69	0.25	0
	Jun-25	0.25	1.69	0.25	0

In Quarter 4 2024/2025 in April (0.24), May (0.25) and June (0.25) the crude rate is statistically lower than the national rate 1.69 (MBRRACE 2024).



MBRRACE (2024) neonatal death crude rate (1.69) only includes NND from 24 weeks gestation and when DGFT rate is recalculated including NND >24 weeks gestation the rates are April (0.24), May (0.25) and June (0.25) which is significantly lower than the national rate.

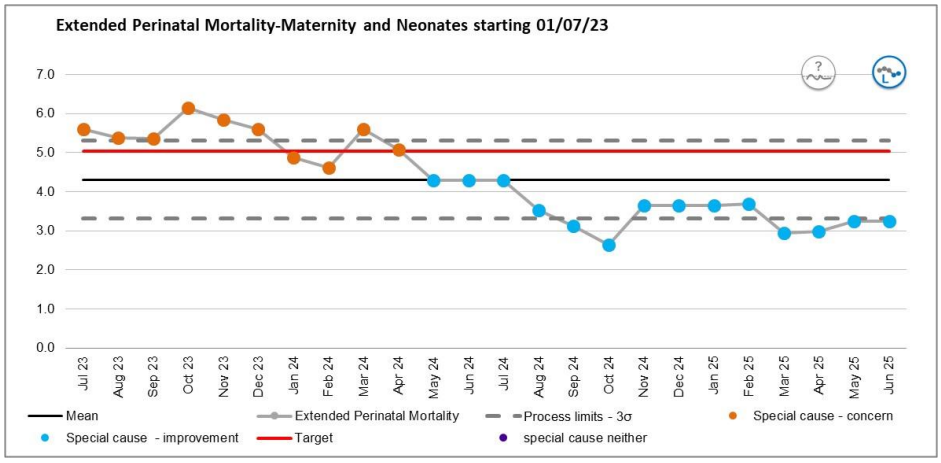


Extended Perinatal Mortality

The national extended perinatal mortality rate is 5.04 (MBRRACE 2024).

		Crude Rate	National Crude Rate
Quarter 2 2024/2025	Jul-24	4.3	5.04
	Aug-24	3.52	5.04
	Sep-24	3.13	5.04
Quarter 3 2024/2025	Oct-24	2.64	5.04
	Nov-24	3.65	5.04
	Dec-24	3.65	5.04
Quarter 4 2024/2025	Jan-25	3.65	5.04
	Feb-25	3.69	5.04
	Mar-25	2.95	5.04
Quarter 1 2025/2026	Apr-25	2.98	5.04
	May-25	3.24	5.04
	Jun-25	3.25	5.04

The extended perinatal mortality rates in Quarter 1 are April (2.98), May (3.24) and June (3.24). The extended mortality rate has remained below the national rate (5.04) over the last 12 months.



2.1.2. Paediatric

Child death notifications

Fig 1 Child death statistics include all 0–18-year-old deaths involving Dudley children and children who resided out of borough but who died from April 2025 in Dudley

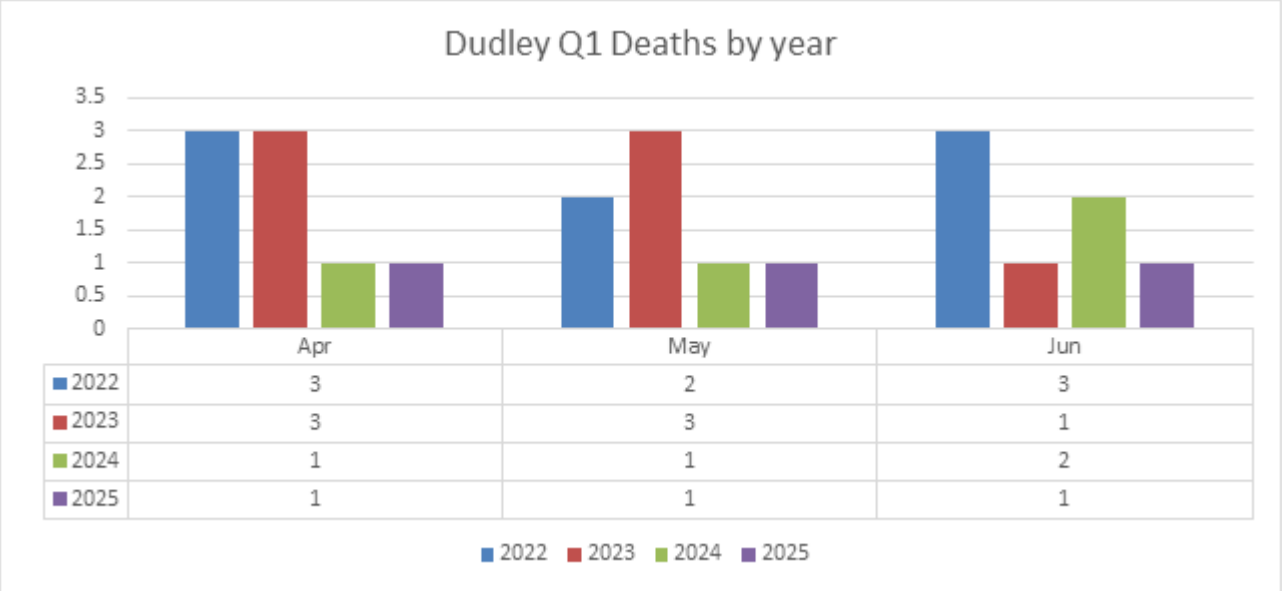
MONTH	Deaths in ED	Deaths in hospital	Previable/ Premature neonatal deaths	Deaths in Community	Dudley Deaths in other hospital / hospice	Deaths at RHH of children from other areas	Deaths of Dudley children	Cumulated Total including children from other areas
April			1		**1-NX**		1	1
May				**1-At home**			1	1
June					**1-BCH**		1	1

July								
Aug								
Sept								
Oct								
Nov								
Dec								
Jan								
Feb								
Mar								

Abbreviations
WV- Wolverhampton
S- Sandwell
NX- New Cross
BWH- Birmingham Womens Hospital
BCH- Birmingham Childrens Hospital
NNU- Neonatal unit
PICU- paediatric intensive care unit
RTC- road traffic collision
There are child deaths in the Emergency Department which include children who arrived CPR in progress and did not survive.

The above chart demonstrates deaths occurring at DGFT and Dudley neonates and children over a 12-month period.

In November, February and March there were no deaths of children at Russells Hall hospital who reside out of the borough or deaths involving Dudley children.



The above chart demonstrates the number of deaths each quarter involving Dudley neonates and children or deaths occurring at DGFT, noting the continued downward trend since 2023

In July NCMD published a thematic report into Learning from child death reviews on Palliative and End of Life Care Provision. The report included children who were very unwell, had congenital anomalies, cancer or other conditions that meant they were expected to die earlier than usual. The period the report covered was 1st April 2019 until 31st March 2022.

It was noted that there were higher numbers of deaths of children with and without a life limiting condition in the most deprived neighbourhoods in comparison to the least deprived neighbourhoods. The report and an action plan in response to recommendations has been included in the papers for members.

Recommendations to note include:

- Review commissioning arrangements to ensure all infants (including those who are preterm), children and young people with life-limiting conditions have 24-hour access to community nursing teams, specialists in paediatric palliative care, and other appropriate healthcare professionals as required, and especially at the end of life

- Ensure all bereaved families are allocated a key worker, in line with the Child death review statutory and operational guidance. The key worker post should be funded and embedded appropriately as per the guidance.

- Ensure all named medical specialists working with infants, children and young people receive and complete appropriate training in parallel planning and documenting advance care plans (e.g., the Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) form and the Children and Young Person's Advance Care Plan (CYPACP) document).

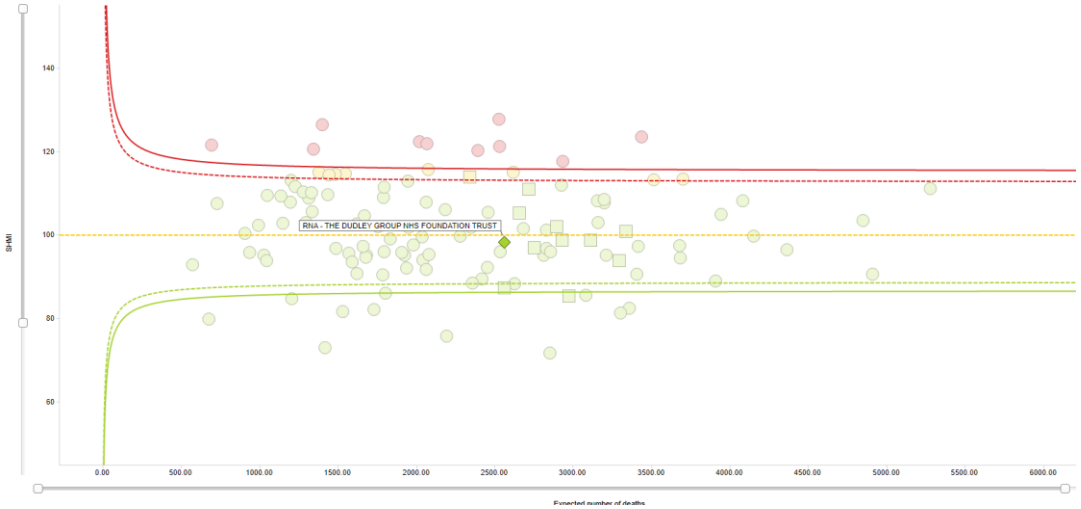
- Integrated Care Boards working with care providers looking after children with life-limiting conditions should ensure that the ReSPECT / resuscitation document is easily visible. In hospital trusts this might include adding it to the 'banner' bar of the electronic patient record.

- Ensure timely access to essential medications needed for the delivery of end-of-life care at home. This should include parenteral medication for subcutaneous infusions and medications needed off label or beyond their licence (as this is frequently the case in paediatric palliative care).

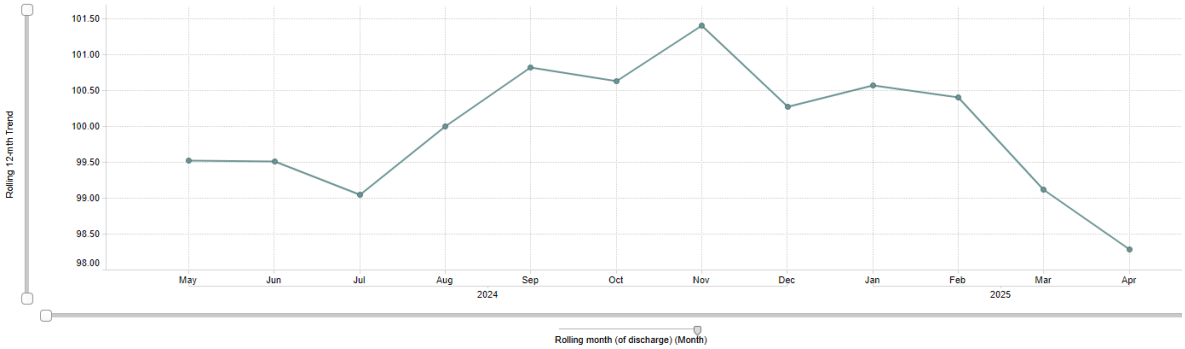
An action plan has been developed to respond to the recommendations

2.2. Adult Mortality

SHMI – May 24 to **Apr** 25 **=** 98.29

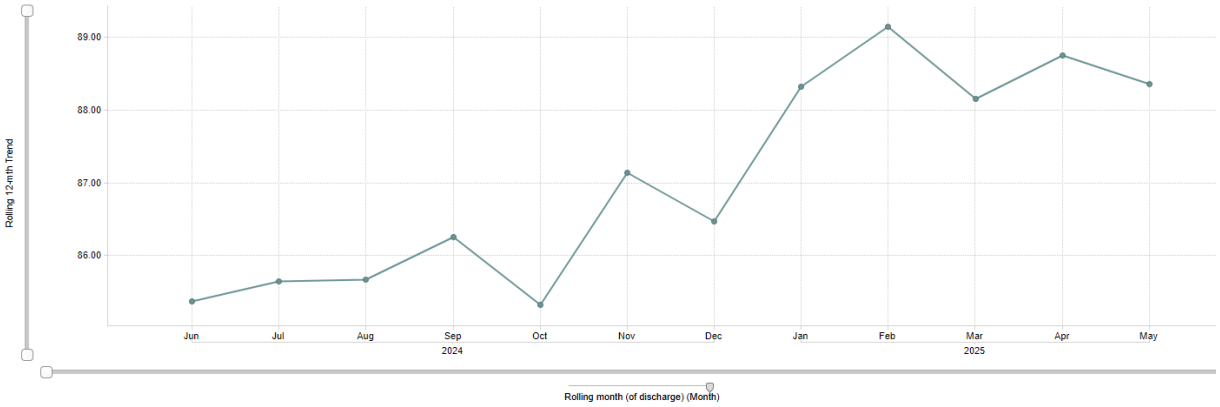


SHMI 12-month rolling trend



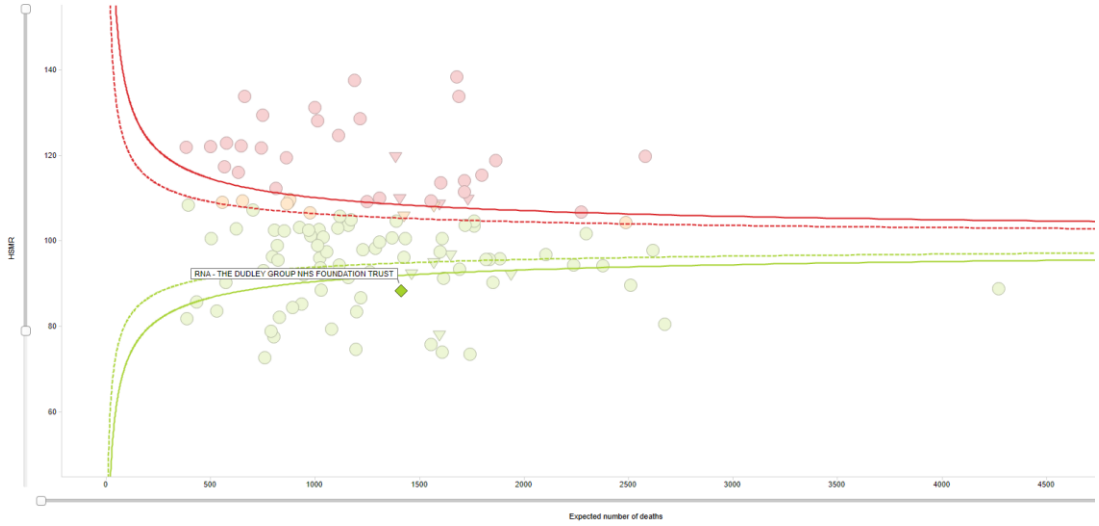
HSMR - Jun 24 **to May** 25 = 88.36

HSMR 12-month rolling trend



Although the HSMR appears to have had a very large increase since November 2024 the y axis scale is very small and the trust remains a positive outlier as shown in the national funnel plot

National Funnel Plot



CUSUM Alerts

CUSUM triggers are an early warning of potential further alerts.
Care must be taken when analysing the data as the alerts could be for a small number of patients.

Indicator Name	Period	Value	
Mortality Cumulative Summary Aggregated (HSMR) - 77 - Encephalitis (except that caused by tuberculosis or sexually transmitted disease)	March 2025	6.34	
Summary Hospital-Level Mortality Indicator (Monthly SHMI) - 11 :: 15 - Cancer of rectum and anus	May 2024 - April 2025	220.90	
Summary Hospital-Level Mortality Indicator (Monthly SHMI) - 71 :: 117 - Other circulatory disease	May 2024 - April 2025	173.32	
Summary Hospital-Level Mortality Indicator (Monthly SHMI) - 133 :: 244 - Other injuries and conditions due to external causes	May 2024 - April 2025	232.34	

VLADs for alerts - last 3 months

VLAD charts are used to show long-term trends in treatment outcomes. Here, we show the 'number of lives saved' against case number, where 'lives saved' is calculated as a running total of (expected number of deaths) – (observed number of deaths). For each case the risk of death is calculated using the same methodology as used in calculating the SHMI (HES-based) value.

SHMI Category	SHMI (12-months)	Discharges	Observed Deaths	Expected Deaths	Declining Cusum triggers (3-months)	Declining Cusum triggers (12-months)	Improving Cusum triggers (3-months)	Improving Cusum triggers (12-months)	Lives Saved
133 :: Other injuries and conditions due to ext...	245.66	124	15	6.11	1	1	0	0	-8.89
92 :: Biliary tract disease	142.78	899	29	20.31	1	1	0	0	-8.69

Groups having excess deaths (Top 10)

SHMI Category	SHMI (12-months)	Discharges	Observed Deaths	Expected Deaths	Declining Cusum triggers (3-months)	Declining Cusum triggers (12-months)	Improving Cusum triggers (3-months)	Improving Cusum triggers (12-months)	Lives Saved
71 :: Other circulatory disease	173.32	487	24	13.85	1	1	0	0	-10.15
89 :: Intestinal obstruction without hernia	137.65	241	34	24.70	0	0	0	0	-9.30
124 :: Intracranial injury	130.98	209	38	29.01	0	0	0	0	-8.99
6 :: Hepatitis, Immunizations and screening for...	149.48	713	25	16.72	0	0	0	0	-8.28
133 :: Other injuries and conditions due to ext...	232.34	127	14	6.03	1	1	0	0	-7.97
11 :: Cancer of rectum and anus	220.90	98	14	6.34	0	0	0	0	-7.66
67 :: Occlusion or stenosis of precerebral arter...	392.73	197	9	2.29	0	0	0	0	-6.71
8 :: Cancer of esophagus	148.66	51	19	12.78	0	0	0	0	-6.22
92 :: Biliary tract disease	130.11	893	26	19.98	0	0	0	0	-6.02
30 :: Secondary malignancies	113.53	214	49	43.16	0	0	0	0	-5.84

Whilst the numbers involved in some of these alerts is small, the mortality group are monitoring for any trends in these conditions. The intestinal obstruction group will fall into the remit of the EMLAP work and any improvement work is already in place. Secondary malignancy data has appeared on a regular basis over several years and a current audit of readmissions has shown cancer to be a major cause for admission. An audit of cancer of the rectum and anus is planned.

Changes to recording of emergency admission data

The current SHMI data includes all patients admitted to the Trust. The SHMI is governed by the observed number of deaths divided by the expected number of deaths for the variety of conditions contained within the SHMI data.

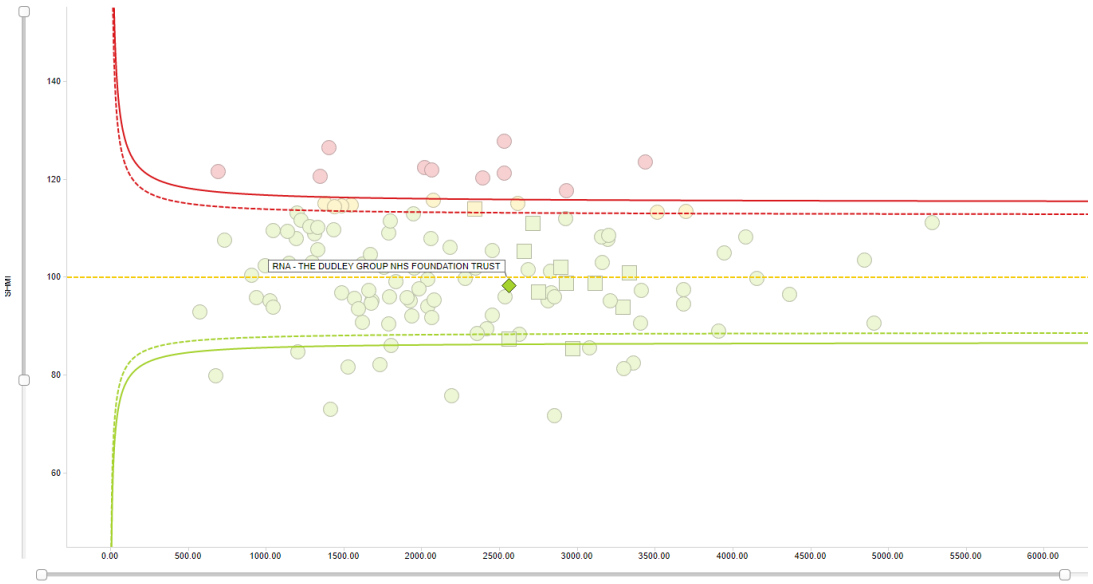
Nationally there has been a directive to record emergency admissions that have a 0-1 day stay within a separate Emergency Care Data Set (ECDS). The Trust has delayed this change to achieve stability following previous local data set changes. However, local Trusts are in the process of changing and it is likely that we will also make the change in the near future. This may impact on SHMI at some point following the change, as the reduction in recorded admissions will result in a reduction in the number of expected deaths thus altering the ratio.

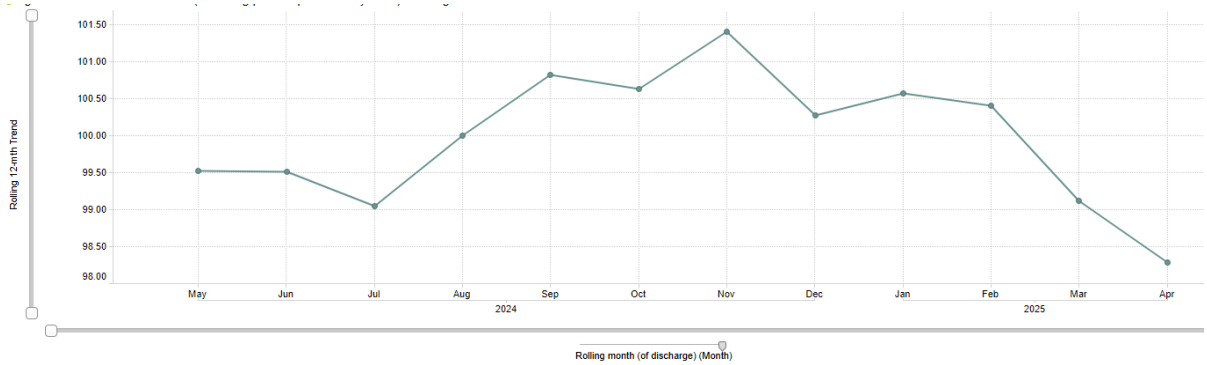
Nationally, Trusts who have made the change have found an impact on their SHMI data but as more Trusts change, the impact should lessen. The mortality group will provide updates when this change has been implemented.

2.2.1 Improvement work

Fractured Neck of Femur – The improvement group are currently looking at:

- Informatics have built a Power BI to enable the group to monitor and identify the areas that need to be improved. Early indicators are showing that the average time to theatre has risen to just over 37 hours and the main reason for a delay in theatre is due to insufficient capacity.
- The pathway document has been reviewed and some comments received by the group that need to be included.
- The group are now working at identifying areas where work now needs to be focused – designated bed and reconfiguration of ward to accommodate #NoF patients in a timely manner.
- Current SHMI is 98





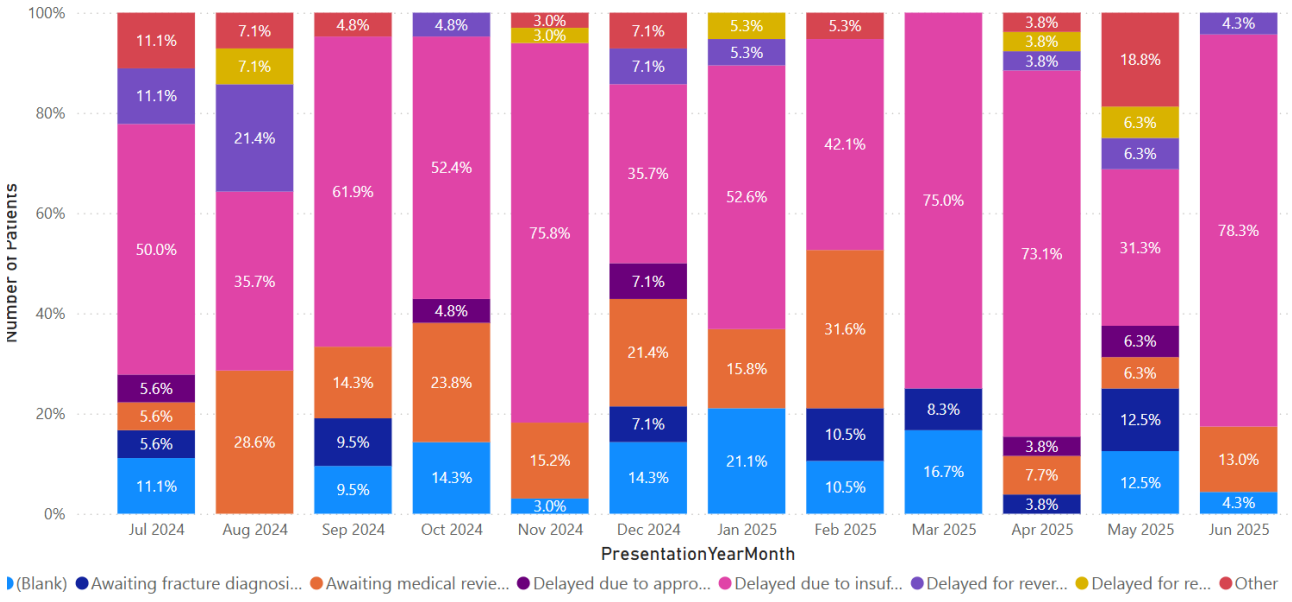
National Hip Fracture Database continue to improve. When the improvement group commenced there were 4 areas where it did not meet the national target, currently there are two areas. Currently the trust does not meet the admission to specialist ward within 4 hours due to patients not having a Fascia Iliaca Block and being moved to the ward on time, it also is below average for prompt surgery. This is highlight within the trusts dashboard shown below which demonstrates that the main delay to theatre is due to an insufficiency in theatre capacity

KPI overview: RUS. Russells Hall Hospital

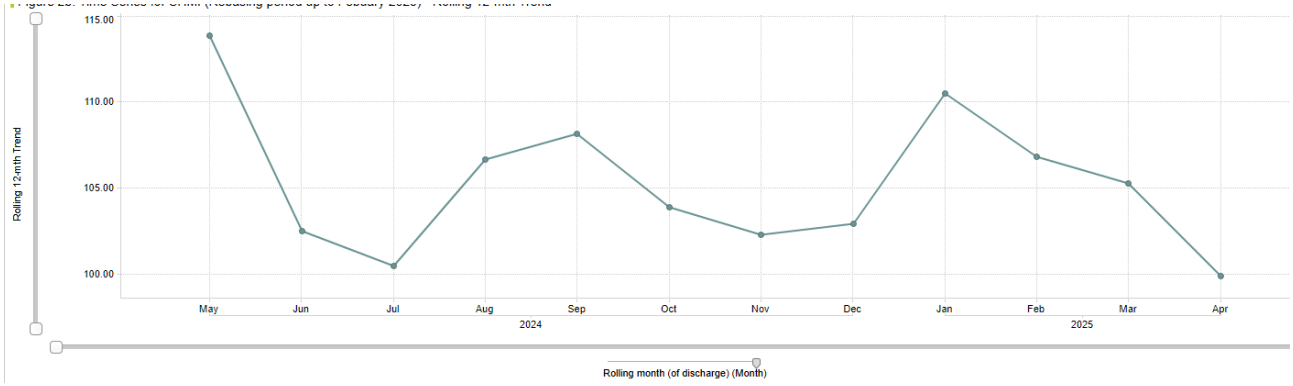
Annualised values based on 578 cases averaged over 12 months to the end of June 2025, except KPI6 and KPI 7 which are delayed to allow for follow up data to be included.

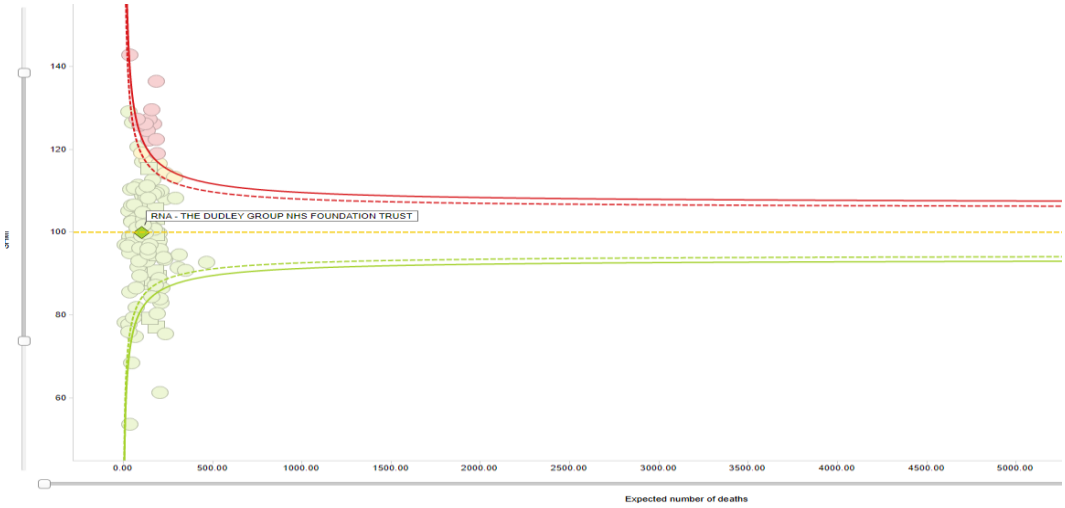
0. Admission to specialist ward	1. Prompt orthogeriatric review	2. Prompt surgery	3. NICE compliant surgery
1%	99%	53%	77%
NHFD overall: 9%	NHFD overall: 89%	NHFD overall: 57%	NHFD overall: 70%

4. Promptly out of bed	5. Not delirious post-op	6. Return to original residence	7. Bone medication
82%	73%	76%	75%
NHFD overall: 82%	NHFD overall: 68%	NHFD overall: 75%	NHFD overall: 56%



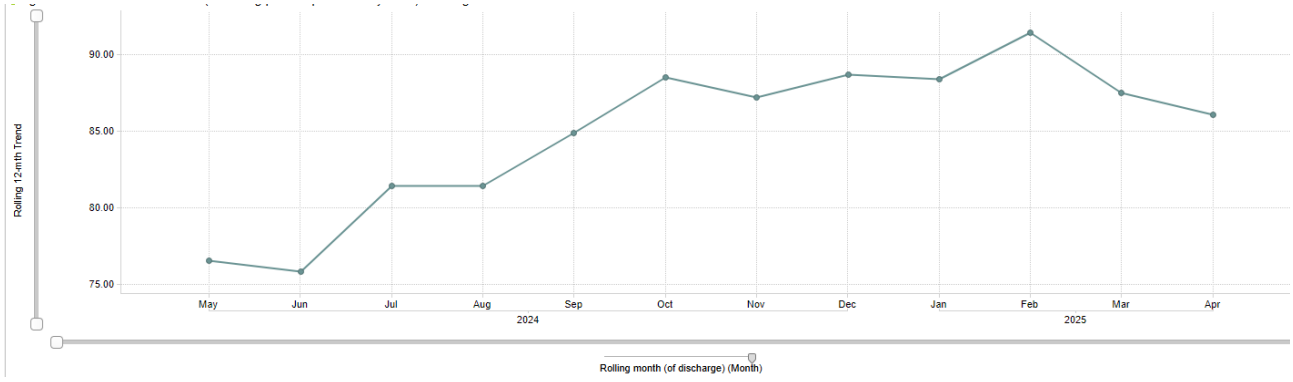
Acute Cerebrovascular Disease – The SHMI for acute cerebrovascular disease has been elevated for a number of months but as can be seen in the figure below it has steadily decreased, the current SHMI is 99.87. The validation of patient notes is now embedded into the Stroke Team and Coding Department, and this has had a significant impact on the SHMI. The stroke team are also ensuring that the data entered onto SSNAP is accurate and reflects the patients correctly.





National Funnel Plot

Septicaemia Mortality – There is continual monitoring of the trust Septicaemia SHMI – current SHMI is 86.04. AQUA data is providing positive assurance that patients are receiving the appropriate treatment during the appropriate time scales.



2.3.1 Learning Disabilities

Deaths in Trust of people with a learning disability: March 2025 - 0 Deaths

Month	Deaths in Hospital	Reported to LeDeR
May 24	1	1
June 24	2	2
July 24	2	2
August 24	2	2
September 24	1	1
October 24	1	1
November 24	1	1
December 24	1	1
January 2	2	2
February 25	2	2
March 25	0	0

The team are currently working to establish a new Action Plan formed around feedback and learning from LeDeR. The first phase of this plan will see us attending ward rounds whenever possible to ensure that information such as One Page Profiles and SALT Guidelines are thoroughly handed over to the relevant staff.

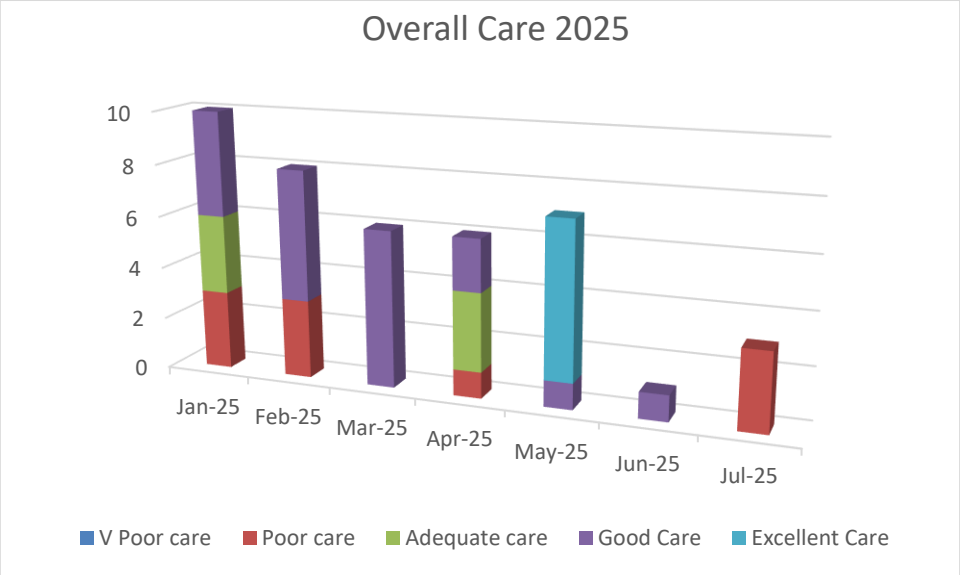
2.3.2 End of Life

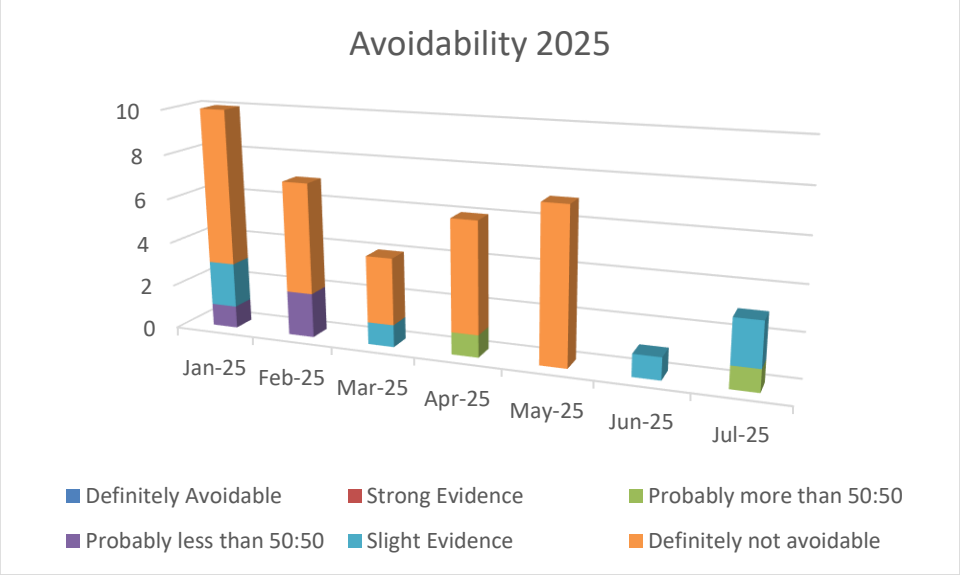
- Wards B2 (st 3 and 4), AMU 1 and 2, C1b – achieved accreditation
- C7 achieved re- accreditation and nominated ward of the year
- Paper accepted for publication BMJ Palliative and supportive care
- Working with B4, B3 to support GSF implementation
- MECU and community heart failure team planning on applying for GSF accreditation in 2026
- 5 wards planning on applying for GSF re-accreditation in 2026 – C3, FMNU, CCU, C8 and critical care and rapid response community team
- Fast track discharge on risk register – July and August 2024 because 48 hours standard not met 166 excess bed days
- GSF metrics data following switch from document to flowsheet is in the process of being validated so will be delay in providing the data for April 2025 onwards until validated and data analyst prioritising work but complex - risk raised following discussion in Trust EOLC group July 2025
- The following risks have been raised by the group –
- Risk Register
    - COM 2024 Inadequate GSF data inputting on Oasis for EOL patient
    - COR 2423 Due to variability to respond to Fast Track Palliative Discharge patients are not reaching their preferred place of care in a timely manner resulting in a breach in the Gold Standards Framework which could potentially lead to a poor experience for patient and their family.
- Pending risk added to log - Wider metrics data not available within Power BI to support the validation of data for the identification of GSF patients

2.4. Assurance

Structured Judgement Review

Currently for 2025 there have been 54% of the referrals reviewed and 82% show adequate to excellent care. All cases identified with very poor/poor care were escalated for a Structured Judgement Review by the Patient Safety Team following a DATIX.





Medical Examiner Service

The Medical Examiners service has consistently reviewed 100% of deaths in the previous 12 months. The statutory start date for community deaths was 9th September 2024 and whilst there is a marked increase in the total number of deaths reviewed the service is still maintaining 100%.

Coroners Inquests

The Trust has noted reducing numbers of Coroner's inquests. In April 25 the Trust was issued with a regulation 28 notice (PFD). This relates to the death of a patient following a discharge where no arrangements were put in place to ensure a care pack was started. The Trust are completing an action plan and response to the coroner. The lead medical examiner undertakes a review of all PFD notices nationally to find applicable learning ahead of any NPSA alerts.

Future Work Planning

Continued focus on specific clinical conditions with high SHMI particularly #NOF and stroke.

Continued work on EMLAP pathways to review and improve processes. This is based on incident reporting data rather than specific SHMI alerts. We are planning a systematic review of other condition specific SHMI areas where we feel there is scope for improvement.

We will be seeking assurance of mortality processes related to the implementation of ECDS (Emergency Care Data Set) coding.

We are also undertaking work on readmissions within the last 90 days of life where we have seen an increase over the last 12 months. The broad data suggests coded diagnoses of pneumonia and cancer as being predominant causes along with extreme frailty though more work is needed.

3. RECOMMENDATIONS

The Executive is asked to note the decreasing trend in SHMI and HSMR. It is likely that the improvement in HSMR / SHMI reflect an improvement in the denominator as well as quality of care and provides assurance in relation to previous alerts. Positive assurance related to quality of care includes SJRs output and falling HSMR with no weekend effect.

The progress against mortality related actions is reported via Quarterly Learning from Deaths reports submitted to Quality Committee and Trust Board.

Nuala Hadley and Dr P Brammer on behalf of Dr J Odum
27/08/2025

Glossary

SHMI	Summarised Hospital Level Mortality Indicator	ECDS	Emergency Care Data Set
HSMR	Hospital Standardised Mortality Ratio	MBRRACE	Mothers & Babies – Reducing the Risk through Audits and Confidential Enquiries
AQUA	Advanced Quality Alliance	NND	Neonatal Death
VLAD	Variable Life Adjusted Display	SUDIC	Sudden Unexpected Death In Childhood
SJR	Structured Judgement Review	CCS	Clinical Classification Service
ME	Medical Examiner	OPCS	Office of Population Censuses and Surveys
KPI	Key Performance Indicator	NHFD	National Hip Fracture Database
SSNAP	Sentinel Stroke National Audit Programme	SAS	Specialty and Specialist Doctors
NPSA	National Patient Safety Alert	LeDeR	Learning from Deaths Review
EmLap	Emergency Laparotomy	GSF	Gold Standards Framework

SALT	Speech and Language Therapy	CUSUM	Cumulative Sum control chart

The Dudley Group NHS Foundation Trust

Winter Plan 2025/26

Table of Contents

1. Background and Winter 24/25 review

1.1 Background and learning

As previously highlighted in the paper to Board in March 2025 the winter period of 24/25 posed significant challenges to services, particularly Urgent and Emergency Care (UEC) manifesting as long Ambulance handover delays, prolonged 4 hour and 12 hour length of stay patients in the department for admitted pathways all exacerbated by high proportion of patient with no criteria to reside and overall poor discharge numbers daily.

To recap on the lessons highlighted in that paper which is included in Appendix 2:

1. Adherence to the organisational plan is important: Continuing to work with a community focus

2.Plan according to and independently of ICB for winter pressures: We are using data and information from last year to produce internal modelling alongside collaborative modelling with the ICB.

3. Build in Supersurge Capacity: This is the reason for including a 'buffer' in our preparations this year.

4. Improve Clinical Engagement: There has been wide, multi-professional and organisational involvement this year.

5: Focus on the Quality Impact: The key performance indicators for monitoring of the plan this year include a focus on quality.

1.2 Performance

1.2.1 Urgent and Emergency Care 4 Hour Standard

Despite the significant pressure that the Trust was under, 4 hour performance was maintained for the non admitted what did we end year end in March with % pathways with performance significantly reduced for 4 hour performance for patients on admitted pathways. However DGFT ended the 24/25 year placed 1st of 23 providers in the Midlands region and 12 out of 122 national acute providers. As part of the achievement of improved performance the Trust was awarded £1m capital monies as the 9th most improved nationally.

The table below demonstrates the 4 hour performance at the Trust, during the winter months from October 2024 to end of March.

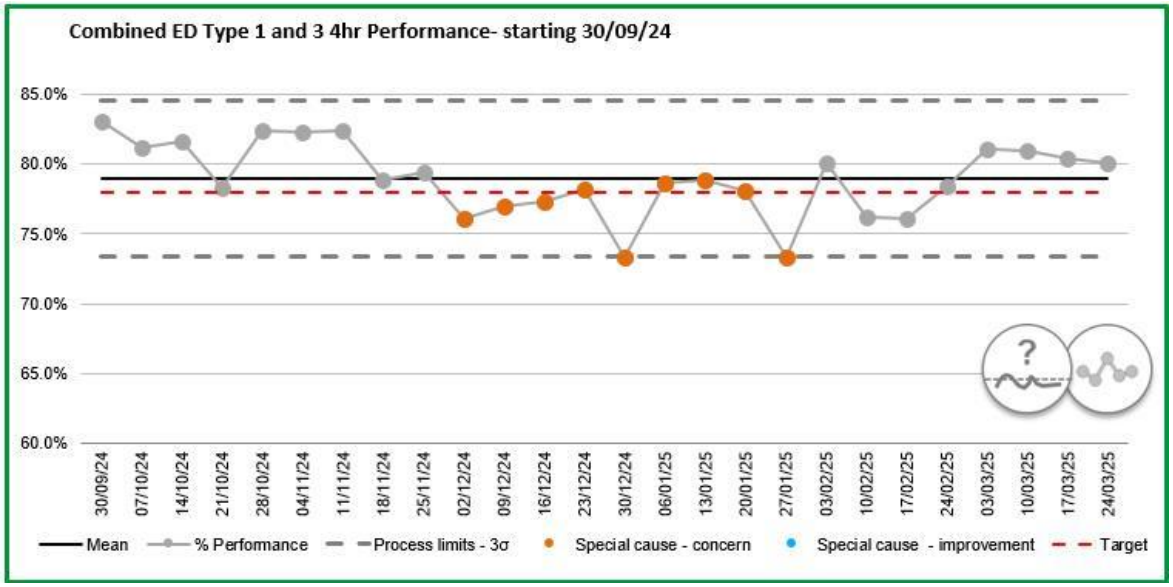


FIGURE 1 (ABOVE): 4 HOUR PERFORMANCE OVERALL WINTER 24/25

Non-admitted pathways support the performance and it is acknowledged that there is further work needed in admitted pathways, hence the mitigations contained within this plan to ensure patients are admitted to the bed base quicker in their journey. See figure 2 and 3 below demonstrating the variation between pathways and performance alongside our Black Country peers.

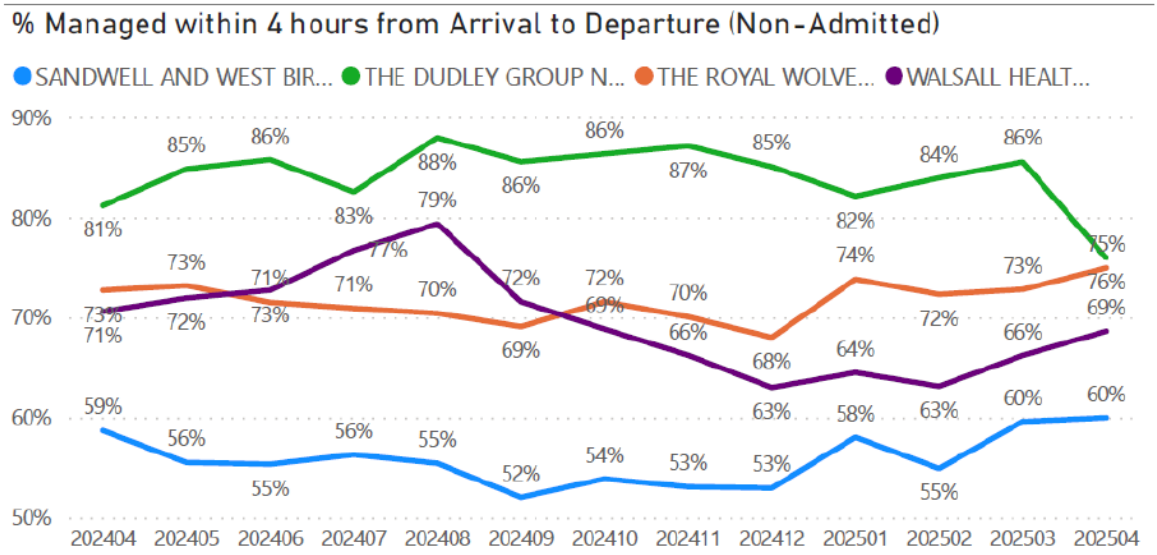


FIGURE 2 (ABOVE): 4 HOUR PERFORMANCE APR 24-APR 25 NON-ADMITTED

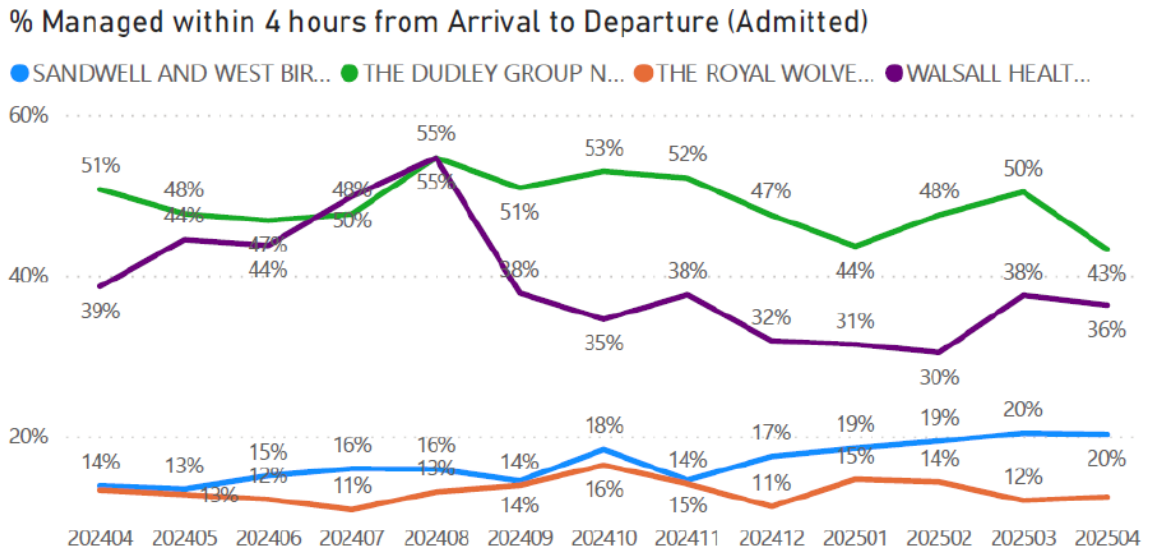


FIGURE 3 (ABOVE): 4 HOUR PERFORMANCE APR 24 - APR 25 ADMITTED

1.2.2 Ambulance Handover

Prolonged Ambulance handovers also remain a concern within the Trust, having improved in recent weeks overall but particularly challenging during the winter period with an average of 1 in 3 Ambulances going over the hour. The Trust have recognised that this is an unacceptable position and have commended for seeking support and advice from the National and Regional teams. This is ongoing and supports work and actions relating to not only the winter plan but ongoing sustainable improvement. The figure below demonstrates ambulance handover delays of greater than 60 minutes.

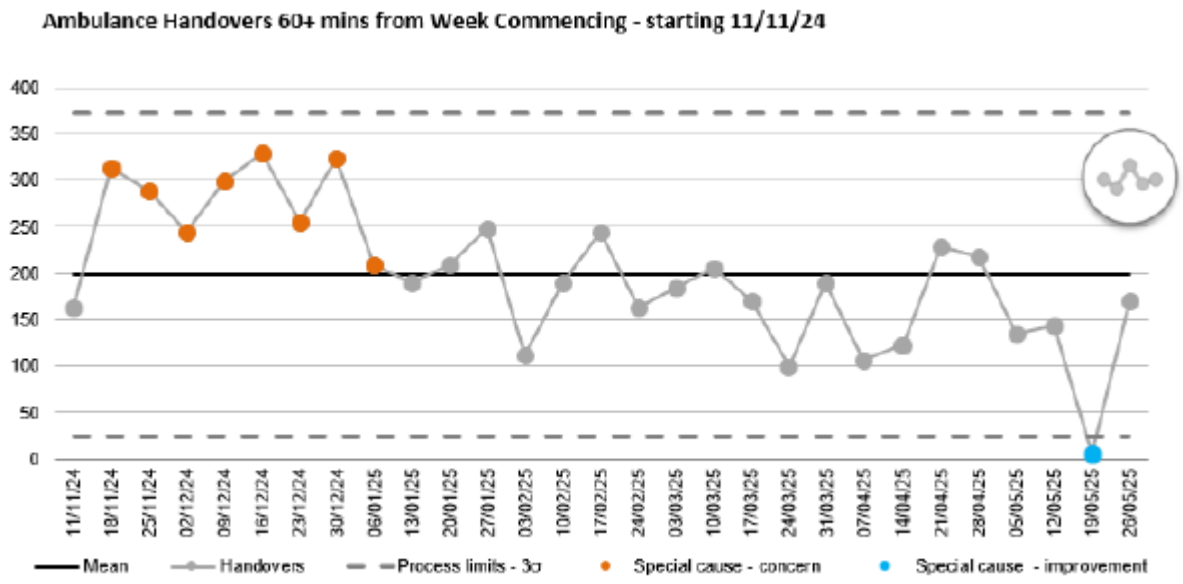


FIGURE 4 (ABOVE): AMBULANCE HANDOVER GREATER THAN 60 MINUTES

1.2.3 Bed Occupancy

Analysis of the data demonstrates that bed occupancy levels were the main contributory factor to this drop in performance between the admitted and non-admitted pathways and also contributing to the cause of prolonged Ambulance offloads. Occupancy at DGFT remained high throughout the winter period being persistently higher than 98% compared to the other Trusts across the Black Country. DGFT had a higher number of patients with no criteria to reside in the Acute Trust than our peers, and this is a key focus of the plan this year, both internally and working collaboratively with our partners in social care to improve this.

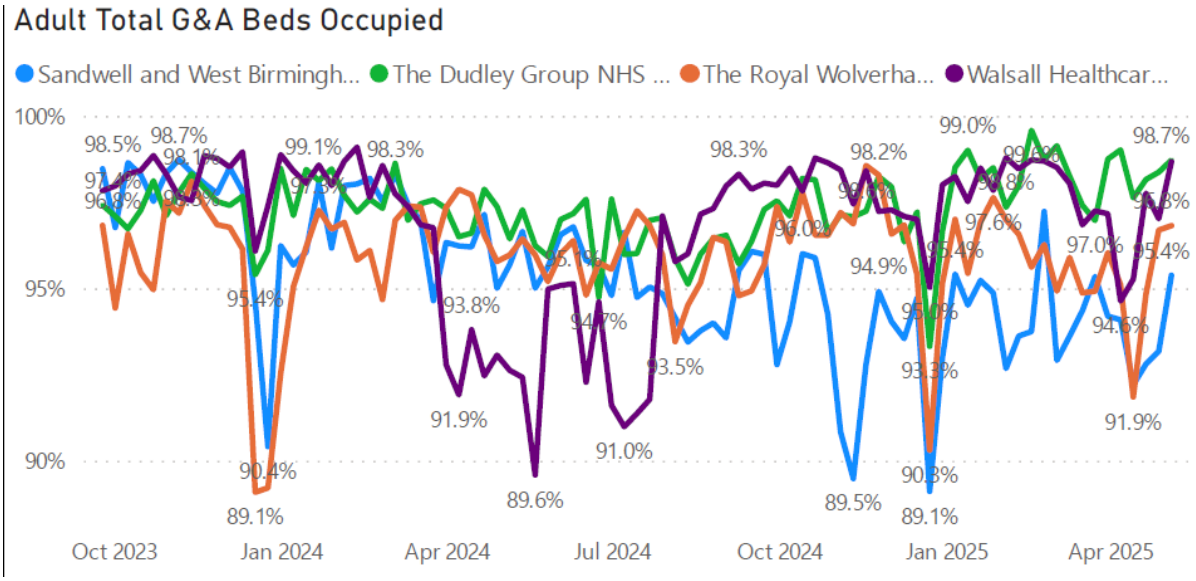


FIGURE 5 (ABOVE): BED OCCUPANCY ACROSS THE BLACK COUNTRY ACUTE TRUSTS

Mitigation during winter 24/25 included the conversion of the discharge lounge to 16 inpatient beds, the conversion of a large proportion of Same Day Emergency Care (SDEC) to 26 inpatient beds, the addition of 10 inpatient beds in to the Acute Medical Unit (AMU) and the creation of 3 spaces in the Emergency Department (ED) Xray area as a Treatment Escalation Space (TES) to relieve pressure in the ED. The conversion of SDEC in particular had a detrimental impact on the flow out of the ED exacerbating the long waits in the department and long Ambulance holds, this is not an option that will be considered this Winter as strongly advised during a supportive visit from NHS England. In addition to these bedded areas there

have been additional patients placed in ward areas pending discharges leaving the Trust. Risk assessments have been completed for all of these as when required and a standard operating procedure is in place for the use of allocated TES.

1.2.4 External reviews

The Trust has been commended by our regional NHSE team for recognising the difficulties currently being faced in our UEC pathways and for seeking review proactively. Reviews by the NHSE UEC team, Getting it Right First Time and ECIST have been carried out. The key findings from these reviews are being worked in with closely tracked action plans. The key points are:

- Requirement for improved decision making for medical patients overnight
- Need for a designated space for Ambulance offload
- Need to upscale the virtual wards in all areas
- Key focus on improving frailty pathways
- Increased acuity in Same Day Emergency Care and more patients to remain in primary care
- Need to ensure that the number of patients out of bed and dressed daily is increased to reduce deconditioning

The Trust will be working with delivery partner Newton from August until October to support the non-elective workstream. This is expected to reinforce the initiatives already highlighted in this plan ensuring that there is resilience during the period.

2. Modelling for Winter 25/26

2.1 Internal Modelling

The analysis undertaken of the activity requirement for Winter 24/25, including the impact of the opening of the Midland Metropolitan University Hospital and the increased number of patients from Sandwell postcodes to DGFT which is now included as our business as usual, has a shortfall of **71.5** beds for the winter 25/26, this includes the nationally anticipated increase in UEC activity of 4.3%. 41 of these beds are a shortfall throughout the year based on the current activity levels throughout the year, thus the mitigation is 71.5 but the specific causation of winter applies to 30.5 of these. The Trust did not increase the bed base as a result of the increase in patients from the Sandwell population as the focus was to be on community services and treating patients closer to home.

However, the Trust worked in collaboration with Sandwell and West Birmingham NHS Foundation Trust (SWBH) to develop a joint Stroke rehabilitation unit at Rowley Regis Hospital of 11 beds. This has proved beneficial and successful.

It is important to note that due to our Ambulance handover delays DGFT was supported by strategic conveyancing by WMAS to other Black Country Trusts, this placed additional pressure upon UEC departments in these organisations and is something that DGFT need to avoid in the coming winter. The data has demonstrated that on average between October 2024 and March 2025 105 patients per month were conveyed to other Black Country Trusts, 3.5 arrivals per day equating to an additional demand of 1.45 patient admissions at DGFT to eradicate strategic conveyancing. This will mean that DGFT needs an additional **24 beds** for the period between October and March.

FIGURE 6 (ABOVE): STRATEGIC CONVEYANCING TO AND FROM DGFT

The complete demand modelling overall represents a shortfall, pre mitigating actions within the winter plan to be at **95** inpatient beds**.** The Trust is aware of the variation in activity across the winter period and will plan to mitigate for 100 beds to allow for fluctuations.

2.2 ICB Modelling

The modelling from the ICB supports the modelling undertaken by the Trust. This was made available on 23rd June 2025. The ICB highlights a bed deficit of 79 beds not inclusive of the impact of strategic conveyancing. The modelling demonstrates, as shown in the graph below, that the most significant pressure will be felt in the New Year period 25 into 26 where the Trust will exceed the maximum bed availability inclusive of all additional beds open at maximum surge last year with a normal bed base of 630. As demonstrated there is a constant demand throughout winter that the Trust will be at greater than base occupancy over the entire period.

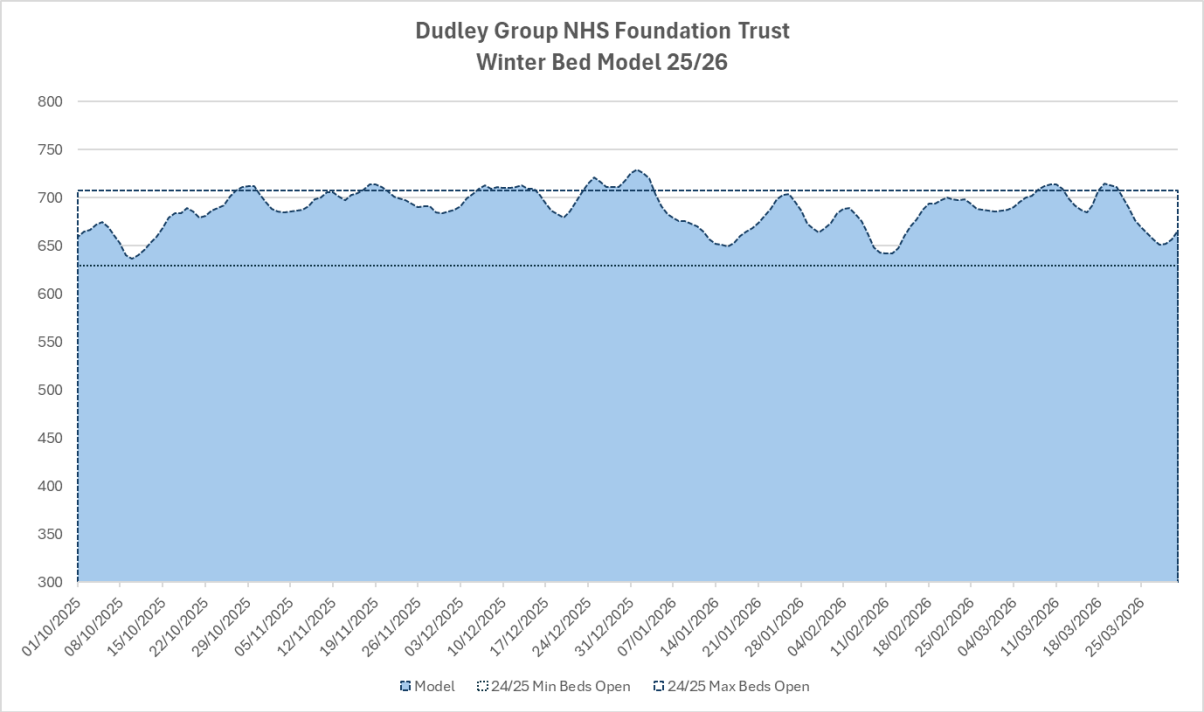


FIGURE 7 (ABOVE): ICB MODELLING FOR WINTER 2025/26

3. Winter planning approach 2025/26 and Current Performance

3.1 Urgent and Emergency Care Plan 25/26 – Key deliverables

A collaborative approach has been taken with the development of the winter plan 25/26 to meet demand, initially internally with a multi-disciplinary approach and subsequently with partners from Public Health, Social Care, West Midlands Ambulance Service, Voluntary Sector and Primary Care. This culminated in a face to face event on 25th June 2025 to finalise the winter plan in time to meet the nationally agreed planning time scales for this year.

With continued pressure into the summer months on our emergency portals the Trust has been working closely with the Urgent and Emergency Care Getting it Right First Time (GiRFT) team, Emergency Care Improvement Support Team (ECIST) and voluntarily attending the Midlands Region UEC Tier Call to draw the benefits of shared learning and improvement ideas from the other acute trusts across the patch.

The Urgent and Emergency Care Plan 2025/26 was published by NHS England (NHSE) and the Department of Health and Social Care (DHSC) on Friday June 6th and outlined the following as being key requirements of the winter plan, all of which have been included in the plan this year. The table below demonstrated current performance against the key UEC targets, we continue to perform well on 4 hour and 12 hour performance but challenged with respect to Ambulance handover.

UEC Plan 25/26 Priority	MAY 2025 Performance	MAY 2025 Trajectory	MARCH 2026 Trajectory
A minimum of 78% of patients who attend an A&E to be admitted, transferred or discharged within 4 hours	79.82%	80%	78%
Eradicating last winter's lengthy ambulance handover delays to a maximum handover time of 45 minutes	46 minute average	30 minute average	45 minute max handover as per UEC plan
Reducing the number of patients waiting over 12 hours for admission or discharge from an emergency department compared to 2024/25, so that this occurs less than 10% of the time	9%	10%	10%

FIGURE 8 (ABOVE): CURRENT UEC PERFORMANCE AGAINST TRAJECTORY

Additional priorities include

- Set local performance targets by pathway to improve patient discharge times, and eliminate internal discharge delays of more than 48 hours in all settings
- Improve vaccination rates for staff and eligible patients – last year delivered 38.4% for staff vaccination with a target of 43.5% this year.
- Increase the number of patients receiving care in primary, community and mental health settings

A focus has been placed on attendance avoidance, ensuring that those patients who do attend are treated on the correct pathway with admission avoided where appropriate. For those patients who are admitted to ensure there are no delays in their inpatient pathway and that timely discharge is achieved at the end of their stay. For that reason not all of the DGFT winter plan interventions are directly aligned to bed demand reductions but will assist in the reduction of pressure at the emergency portals reducing the risk of delayed Ambulance offloads and improved 4 and 12 hour performance.

4. Overall winter mitigations and timeline

4.1 Overview

The main key change and driver to the Trust managing winter pressures this year is reducing occupancy and avoiding the need for patients to attend hospital when an alternative care pathway would be better suited to their need.

The launch of the Care Navigation Centre will enable health professionals to be signposted to the most appropriate service for the patient.

To reduce occupancy within the Trust there is a plan to strengthen the census reviews with learning shared from Sandwell and West Birmingham NHS Foundation Trust who have seen length of stay reductions as a result of using this census

There is also the intention (if funding agreed) to continue with the Trust commissioned bridging service which allows patients on pathway 1, to be discharged to their place of care ahead of their allocated package of care commencing (Local Authority).This means that those who are allocated care commencing on future dates do not wait in the acute bed base. In essence as an Acute Trust the days will be bridged to allow the patient to be discharged. The cost for this is currently £52k and ongoing would be £23k per month and sits as a cost pressure within the Trust. Although a cost pressure this is less expensive than if the patient has remained in the Trust (cost per week £850 cf >£2k per week in hospital)

4.2 Reduction of LOS

The Chiefs of Service in bed holding Divisions will have a robust monitoring process through the Medical Service Heads and Clinical Service Leads to set targets to reduce length of stay. The expectation is for all areas to meet or exceed the national average length of stay by specialty in acute providers, this will be monitored on a weekly basis via the length of stay dashboard and outliers reviewed. Reporting into the Divisional and to Trust Operational Meeting. The table below outlines the key specialities across the Trust and their comparative length of stay excluding same day discharge, those in red exceed the national average and will be the first in focus.

Speciality	DGFT LOS	National Average
General Surgery	6.53	5.78
Urology	4.58	4.48
Breast Surgery	3.5	3.91
Colorectal Surgery	6.67	5.98
Upper GI Surgery	11	5.56
Vascular Surgery	10.17	13.4
Trauma and Orthopaedics	9.31	11.68
ENT	1.72	3.36
Ophthalmology	1	5.36
Oral Surgery	5	3.13
Plastic Surgery	4.91	4.21
Paediatric Surgery	3.33	4.34
General Internal Medicine	8.3	8.88
Gastroenterology	8.54	8.84
Endocrinology	11.08	10.13
Haematology	11.54	10.08
Cardiology	5.4	7.03
Stroke Medicine	10.01	12.17
Respiratory	10.69	9.31
Renal Medicine	10.41	10.0
Neurology	3	10.87
Paediatric Medicine	2.85	2.57
Elderly Care	11.99	12.15
Gynaecology	2.76	2.34

FIGURE 9 (ABOVE): LENGTH OF STAY BY SPECIALTY

If the specialities that are currently adversely outlying when compared to their national benchmark were to achieve reduction to the national level and all others remained at the same level then **13** beds would be released across the Trust when same day discharges are excluded.

4.3 Planned improvements supporting mitigations

Below is the current position of planned improvements that will support our winter mitigations. The accelerated timeline of the plan this year allows for these mitigations at DGFT to continue to be developed and tested in preparation for winter, for that reason there may be variation as we approach winter and further improvements can be made. Although some of these plans may release capacity for winter, they do all form part of the planned winter mitigations included in a subsequent table.

Implementation Date	Mitigation	Expected impact	Cost to DGFT	Lead
By July 2025	Launch of the Care Transfer Hub (Pilot already underway in June 2025)	Improved real time joint working ensuring patients are placed on the correct discharge pathway and reduction in avoidable delays. Appropriate escalation across health and social care.	Nil additional cost	Gregg Marson, Associate Director for Discharge
July 2025	Rapid Emergency Assessment and Care Team pilot	REACT aims to reduce avoidable admissions by providing early, targeted assessments and interventions for patients attending ED. The team will work closely with medical, nursing, therapy, social care, and community partners to facilitate timely decision-making and support safe discharge pathways.	Nil cost – changed use of existing personnel	Anita Cupper – Programme Director for Capacity and Flow
July 2025	Implementation of fortnightly Multi-Agency Discharge Events (MADE)	Unblocking of discharge delays with multi-agency involvement over and above that offered by the Care Transfer Hub	Nil cost	Gregg Marson, Associate Director of Discharge
July 2025	Roll out of Electronic Bed State	Allows for real time movement of patients around the organisation improving timeliness of flow from ED and reducing Ambulance offload delays	Nil cost	Ravinder Sahota-Thandi, Interim Operational Chief Information Officer
By September 2025	Full review of all patients in care homes to ensure relevant RESPECT documents are available to prevent inappropriate	Attendance avoidance	Nil cost	Jenny Cale, Deputy Director of Operations PLACE

	conveyance into the Trust			
September 2025	Ridge Hill facility opens	If bed closures are deferred until early 2026 18 beds could be released as step down from acute trust.	£132k per month if reopened	Karen Hanson, Deputy Director of Integration
September 2025	Paediatric Emergency Department and Paediatric Assessment Unit co location go live	Release of 9 bed spaces on C2 which will form the winter resilience space for Paediatrics	£80k per month if reopened	Sara Davis, Divisional Chief Nurse SWC and Marie Banner, Interim Divisional Chief Nurse MIC
September 2025	Swap of wards B6 and C6, Surgical SDEC Co-locating with medical SDEC.	This will allow for improved access to Frailty through C6 footprint.	No cost impact	Sara Davis, Divisional Chief Nurse SWC and Marie Banner, Interim Divisional Chief Nurse MIC
October 2025	Implementation of a fully recruited care navigation centre (CNC) signposting patients to the most appropriate clinical service and away from ED where possible modelled on the Sandwell CNC	Attendance avoidance	Nil additional cost impact above already agreed investment	Amandeep Tung-Nahal, Director of Operations CCCS
October 2025	Acute Respiratory Infection Hub at High Oak Surgery opened. Appointment availability will be stepped up in December through to February from 4 hours to 8 hours per day. Pathways available for both Adults and Paediatrics (5300 appointments)	Attendance avoidance and increased availability of appointments for non-respiratory illnesses in primary care.	Nil cost to DGFT	Jenny Cale, Deputy Director of Operations PLACE
October 2025	Increase of 10 beds to the Frailty Virtual Ward over and	Step up and step down availability of 10 beds	£35k per month	Rory McMahon, Director of Operations MIC

	above the increase within the Non-Elective Workstream (30 to 40 beds)			
October 2025	Increase of 10 beds to the Acute Medicine Virtual Ward over and above the increase within the Non-Elective Workstream (30 to 40 beds)	Step up and step down availability of 10 beds	£90k per month	Rory McMahon, Director of Operations MIC
September – March 2026	Vaccination Programme for staff flu and Covid 24/25 Flu of employed staff 38.4% COVID employed staff 22.1%	It is unclear at this point which vaccines will be given to NHS professionals this year. We await information from national team.	Funds allocated each year to provide a roving team within budgeted position	Jo Wakeman, Deputy Chief Nurse

FIGURE 10 (ABOVE): WINTER PLAN MITIGATION TIMELINE

4.4 Bed mitigation overview for winter

Priority	Initiative	Bed Savings	Balance against -100	Risk/Cost
1	Predicted improvements to internal Discharge Pathways	20	**-80**	Required success of discharge improvement work
2	Improved escalation process with external partners for discharge delays	10	**-70**	Requires partnership working with out of area authorities
3	Increase of 10 beds to the Frailty Virtual Ward	10	**-60**	£35k per month
4	Increase of 10 beds to the AMU Virtual Ward	10	**-50**	£90k per month
5	AMU additional beds closed as part of NEL workstream	10	**-40**	£98k per month Current cost of the 10 additional beds on AMU 1 & 2
6	AMU A Bed closed as part of NEL workstream	16	**-24**	Cost £143k per month

7	PAU/ED co-location	9 (Paeds only)	**-15**	Cost £80k per month
8	Surge into Discharge Lounge Overnight	16	**+1**	Cost £58k per month

FIGURE 11 (ABOVE): BED MITIGATION OVERVIEW

4.5 Scenario analysis

	Bed deficit	Risks
Scenario 1: Do Nothing	95	• Inability to safely manage flow through the organisation. • Significant Ambulance offload delays • Need to place patients on corridor and utilise Treatment Escalation Spaces • Potential risk to patient safety
Scenario 2: No LOS reduction, surge areas opened but no support from partners in reducing number of patients with no criteria to reside	-27	• Increased staffing requirements that may not be met • Significant increase in cost • Patients will remain in bed base despite no medical or therapeutic need
Scenario 3: No LOS reduction but all surge areas and virtual wards at capacity and support from partners on discharge destinations for complex patients	+1	• Increased staffing requirements that may not be met • Significant increase in cost with no mitigation • Patients continue to stay greater than national LOS in similar settings
Scenario 4: LOS reduction but no surge capacity made available and no support for patients with no criteria to reside	-82	• Low cost • May increase the number of patients who have no criteria to reside as no community placement available resulting in reduced benefit
Scenario 5: LOS reduction and all mitigations currently in plan enacted	+14	• High Cost • Reliant on partners to support discharge of patients with no criteria to reside (number may be increased due to reduced LOS) • Surge beds may have a staffing requirement that is unable to be met

FIGURE 12 (ABOVE): SCENARIO ANALYSIS

There are risks associated with the above bed mitigations, discharge internal processes need to be managed robustly and the demands need to be supported by our partner organisations. The availability of surge capacity is reliant on the success of the work being undertaken in the Non-elective length of stay workstream and movement of activity off site with the reopening of closed beds. The reopening of any closed area will incur staffing costs and these are estimated in the table above.

The following schemes are currently being scoped:

- *Movement of minor injuries out of the ED to vacated therapy space*

- *Ridge Hill facility when opened could release 18 beds which could prevent the opening of the discharge lounge overnight as a mitigation*
- *Increased capacity on the Paediatric virtual ward*

4.6 7 day working

A review of seven day working across the medical division has been carried out and has confirmed that there is face to face consultant presence daily throughout the week and at weekends in all but one inpatient speciality and this is currently being addressed. A review by GIRFT has identified that a streamlining of ward round processes that would allow for an increased number of patients to be seen as part of the ward round and this is currently being worked on divisionally.

5.0 Financial Impact

Acknowledgement of the financial pressures currently being faced mean that the highest priorities of the plan are those which do not have a significant cost impact upon the Trust. Specifically the improvements to discharge planning and pathways, improved relationships and escalation pathways with partners both in and out of area, and improvements to length of stay.

The initiative of bridging packages of care for pathway one patients to allow them to leave the Trust the same day as they are made medically fit is proving to be effective and is something that would also be prioritised to continue as part of the plan this winter. This has a monthly cost of £23k and is included in all options.

Two scenarios have been worked up as part of the plan, Scenario 1 assumes that the impact of winter is felt from October and all mitigations are needs to be implemented immediately. The ICB modelling of activity distribution suggests that this is unlikely and is therefore the worst case scenario, each of the options is costed individually within the below table. The overall risk of worst case scenario is £3.18m.

Initiative	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Total
Bridging beds	£23,000	£23,000	£23,000	£23,000	£23,000	£23,000	£138,000
Predicted improvements to internal Discharge Pathways	£0	£0	£0	£0	£0	£0	£0
Improved escalation process with external partners for discharge delays	£0	£0	£0	£0	£0	£0	£0
Increase of 10 beds to the Frailty Virtual Ward	£35,000	£35,000	£35,000	£35,000	£35,000	£35,000	£210,000
Increase of 10 beds to the Acute Virtual Ward	£92,000	£92,000	£92,000	£92,000	£92,000	£92,000	£552,000
AMU additional beds closed as part of NEL workstream	£98,000	£98,000	£98,000	£98,000	£98,000	£98,000	£588,000
AMU A Bed closed as part of NEL workstream	£143,000	£143,000	£143,000	£143,000	£143,000	£143,000	£858,000
PAU/ED co-location	£80,000	£80,000	£80,000	£80,000	£80,000	£80,000	£480,000
Surge into Discharge Lounge Overnight	£58,000	£58,000	£58,000	£58,000	£58,000	£58,000	£348,000
	£529,000	**£529,000**	**£529,000**	**£529,000**	**£529,000**	**£529,000**	**£3,174,000**

FIGURE 13 (ABOVE): FINANCIAL MODELLING OF ALL MITIGATIONS THROUGHOUT WINTER

The second scenario has assumed the distribution of impact being in correlation to the ICB modelling, with options stepped up and down promptly in response to pressure increasing and decreasing at the front door. This option has an overall cost of £2.34m.

Initiative	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Total
Bridging beds	£23,000	£23,000	£23,000	£23,000	£23,000	£23,000	£138,000
Predicted improvements to internal Discharge Pathways	£0	£0	£0	£0	£0	£0	£0
Improved escalation process with external partners for discharge delays	£0	£0	£0	£0	£0	£0	£0
Increase of 10 beds to the Frailty Virtual Ward	£35,000	£35,000	£35,000	£35,000	£35,000	£35,000	£210,000
Increase of 10 beds to the Acute Virtual Ward	£92,000	£92,000	£92,000	£92,000	£92,000	£92,000	£552,000
AMU additional beds closed as part of NEL workstream	£98,000	£98,000	£98,000	£98,000	£98,000	£98,000	£588,000
AMU A Bed closed as part of NEL workstream		£143,000	£143,000	£71,500	£71,500	£143,000	£572,000
PAU/ED co-location		£80,000	£80,000				£160,000
Surge into Discharge Lounge Overnight		£58,000	£58,000				£116,000
	£248.000	**£529.000**	**£529.000**	**£319.500**	**£319.500**	**£391.000**	**£2.336.000**

FIGURE 14 (ABOVE): FINANCIAL MODELLING IN LINE WITH ICB ACTIVITY PREDICTION

6.0 Service level winter plan highlights

This section summarises the key points in the service level winter plans, the full versions are included in appendix 3.

6.1 Surgery, Women and Children

- Vaccination & Staffing: Focus on increasing vaccination uptake among staff and eligible patients to reduce seasonal illness, and manage annual leave to maintain staffing levels and minimise service disruption in Quarter 4.
- Urgent Care Access: Expand hot clinic capacity and explore a surgical virtual ward to provide timely urgent care, prevent unnecessary admissions, and support flow through Surgical SDEC and the care navigation centre.
- Elective Care Continuity: Protect elective throughput by increasing pre-winter activity using High Intensity Theatre lists, Paediatric Super Saturdays, and available theatre space in other Black Country Trusts.
- Daily Operations & Escalation: Introduce a clear SOP for daily capacity teams to support timely escalation, effective decision-making, and reduce pressure on the Emergency Department during surges.
- Discharge Planning: Embed estimated discharge dates and criteria-led discharge processes across services to support flow and reduce unnecessary inpatient stays.
- Paediatric Winter Readiness: Reinforce paediatric discharge planning, safe staffing, and complex care support, with a flexible surge plan for increased respiratory demand and potential expansion of the Paediatric Virtual Ward.

6.2 Community and Core Clinical Services (CCCS)

- Workforce Resilience: Core Clinical Services are focused on maintaining workforce resilience and operational flexibility, especially in diagnostics and clinical support services, to meet surge demands.
- Diagnostics Strategy: Diagnostic capacity (imaging, pathology, ultrasound, phlebotomy) is being expanded, with elective activity shifted to Guest and Corbett sites to protect emergency capacity at Russells Hall Hospital.
- Therapy and AHP Services: Allied Health Professionals and therapy teams are positioned for rapid assessments and early intervention to avoid admissions and support home recovery.
- Pharmacy Optimisation: Pharmacy will ensure timely discharge medication and medication safety through extended hours, streamlined TTO processes, and use of FP10s during OPEL 4 escalation.
- Mortuary Staffing Review: Mortuary services are reviewing staffing and leave planning to maintain service during winter peaks, with mutual aid protocols in place.
- Care Navigation Centre (CNC): CNC will go live in September 2025, coordinating care to reduce unnecessary ED attendances via triage, alternative care pathways, and a band 6 clinician in ED.

- CNC Referral Pathways: Referrals will be accepted from WMAS, primary care, NHS 111, and other professionals, with phase 2 including patient and carer referrals.
- New Clinical Pathways: CNC aims to streamline flow to hot clinics, SDEC, and Virtual Wards—e.g., creating a DVT community pathway and reducing ED visits.
- System Integration with WMAS: CNC strategy will align with WMAS's "Call Before Convey" model, focusing on care homes and primary care to avoid ED admissions.
- System-Wide Winter Readiness: Region-wide initiatives include a pilot Out of Hours UCR SPA, single point of access in the south, and collaboration with REACCT and CTH models to support discharge and community reintegration.

6.3 PLACE

- PLACE is focused on ensuring patients access the most appropriate primary care settings and are discharged promptly into suitable care environments.
- The division is actively developing the Care Transfer Hub to enhance discharge processes (Pathways 1, 2, and 3), improve patient outcomes, reduce delays, and strengthen system-wide collaboration.
- Weekly long-stay reviews will be introduced in community beds, alongside infection control liaison, to minimise delays and maintain bed availability.
- High Oak and Chapel Street GP surgeries will improve care navigation through enhanced receptionist training, promoting appropriate use of alternative services and digital options for non-urgent needs.
- The Acute Respiratory Infection Hub (ARI), launching in October with expanded capacity from December, will offer targeted appointments for respiratory symptoms, relieving pressure on GP services.
- A project ensuring all care home residents have appropriate RESPECT documentation will conclude by September 2025, reducing unnecessary hospital conveyance and supporting end-of-life care in the community.

6.4 Medicine and Integrated Care

- Ambulance Offload & Corridor Care: Meeting the 45-minute ambulance offload target and eliminating corridor care remains a priority, with delays linked to high bed occupancy and slow admissions.
- Dedicated Ambulance Handover Area: A section of the closed AMUA beds through the non-elective workstream will be repurposed to create a 6-bay handover zone and side room to improve triage and front-door flow.
- Increased ED Capacity: Minor Injuries relocation allows for 3 new ED assessment spaces, aiding patient stepdown despite space limitations preventing recliner chairs.
- Streamlined Clerking: A unified clerking document will reduce duplication, accelerate diagnosis, and support faster patient flow and turnaround.
- Mental Health Bay: A proposal to convert the ED intubation room into a dedicated Mental Health assessment bay is under review, improving care for MH patients.
- Reducing ED Attendances: The Community Navigation Centre (CNC) and other diversionary pathways may reduce attendances by around 80 patients/month, pending validation.
- Improved Specialty Referrals: Direct GP referrals to specialties will continue via Malling Health, with support needed from receiving areas to accept patients promptly.
- Discharge Lounge & RAT Model: A fully functional discharge lounge and continued use of the Rapid Assessment and Triage (RAT) model are vital for flow and capacity.
- Paediatric ED Performance: Sustaining 92% 4-hour performance in Paediatric ED through community partnerships, Band 7 nurse oversight, expanded Virtual Wards, and senior on-site presence.
- Short-Stay Admissions: Targeting a 0.4-day LOS reduction for overnight medical admissions through early senior review, timely AHP involvement, and enhanced EHR support.

7.0 Collaboration with system partners

7.1 West Midlands Ambulance Service, Emergency Response and Non-Emergency Patient Transport

The close working relationship between the Acute Trust and West Midlands Ambulance Service (WMAS) is paramount in importance this year and discussions around the winter plan have been ongoing. WMAS have committed to maximising the use of call before convey and urgent care response, utilising hear and treat where possible and focussing on timely discharge from hospital.
In order for us to best utilise the support for our winter resilience and to contribute to the resilience within particularly the non-emergency patient transport service is by ensuring that transport is booked at least the day before travel wherever possible, that transport is only booked ready for patients with medication available and that the correct mobility is arranged, minimising the number of stretcher transfers for patients who are able to sit. WMAS are also keen to work with us on earlier risk assessments for patients who are going to require transport home at the point of discharge so that this does not need to be carried out at the point of discharge causing unnecessary prolonged length of stay.

We are also planning to work more closely with the Hospital Ambulance Liaison Officer (HALO) with increased present from our out of hospital teams to direct patients to alternative services even on arrival wherever possible.

7.2 Voluntary Sector

The voluntary sector were represented at the planning session on 25th June and have committed to providing a directory of services to the Care Navigation Centre allowing direct access in to their support offer. There is also commitment of the sharing of communications material from the Trust around local faith and community groups supporting those that are sometimes harder to reach with conventional communication methods.

The Dudley voluntary services team are also keen to support the setting up of a volunteer led patient transport service and this will be explored prior to the winter.

7.3 Social Care & Dudley Metropolitan Borough Council

Dudley Metropolitan Borough Council (DMBC) Social Care is committed to a proactive and integrated approach to prevent avoidable admissions, support timely discharges, and enable recovery through person-centred care. Our priorities focus on early intervention, system collaboration, and maintaining operational resilience throughout winter pressures. The full plan is included in Appendix 4 and will be monitored through monthly one to ones between the Deputy Chief Operating Officer at Dudley Group and the Director of Adult Social Care at Dudley MBC.

1. Seven-Day Discharge Operations
We will maintain a fully staffed, 7-day social care discharge service

2. Timely and Flexible Care Offers
To minimise discharge delays, care packages will be secured swiftly, supported by flexible rotas and responsive services including evening and weekend coverage.

3. Escalation and Surge Planning
During periods of heightened system pressure, we will proactively bring forward planned discharges.

4. Medication Oversight
In partnership with health colleagues, we will support medication screening and reviews to prevent overprescribing and reduce medication-related readmissions.

5. Transfer of Care Hub (TOCH) Engagement
Social care will maintain a strong presence in the TOCH, contributing to integrated, patient-centred discharge planning.

6. Robust On-Call System
We will operate a reliable 7-day on-call system to support urgent social care needs and facilitate escalation when required.

7. Urgent Care Attendance Avoidance
Through our Urgent Care Attendance Avoidance Team, we will provide rapid response services 7 days a week.

8. Participation in System-Wide Initiatives
Social care will continue to engage in key system-wide initiatives such as Multi-Agency Discharge Events (MADE) and local development programmes.

9. Hospital Avoidance Beds
Five dedicated hospital avoidance beds will be used to support individuals with urgent social care needs in a non-hospital setting.

10. Access to Therapy Equipment
Access to essential therapy equipment, available 7 days a week

11. Support to FAU and ED
Responsive social care support will be available

8.0 Communications plan

A summary of the internal communications plan is included here, the full plan is included in Appendix 5.

Goal 1: Educate and inform the public to help reduce inappropriate unheralded ED and UTC attendance.

Goal 2: Support NHS staff and maintain operational effectiveness.

Goal 3: Maintain trust and clarity during periods of high pressure (crisis & incident communication).

9.0 Infection Prevention and Control

DGFT will continue to adhere to current up to date Infection Prevention and Control (IPC) guidance, with ongoing emphasis on staff and public compliance with fundamentals such as hand hygiene, bare below the elbow requirements for the staff. This will continue to be closely monitored, and non-compliance addressed. Established audits and monitoring processes will continue to identify any non-compliance early, hence focusing on prevention of infections.

The IPCT will continue daily ward rounds across acute medicine to assist with flow and patient safety, identifying patients who may require isolation and screening.

Screening:

- National guidance for COVID-19 remains unchanged.
- Influenza and RSV screening will recommence during the winter period in conjunction with local trends.

Isolation:

- Patients with the same diagnosis (viral respiratory infections or norovirus) may be co-horted in bays

Outbreaks will continue to be declared internally and externally as per the requirement, and meetings will be held in line with PSIRF to identify common themes and learning.

Cleaning and decontamination:

- Cleaning is continually reviewed alongside trends and a change to chlor clean will be considered for all cleans if there is a surge in infection prevalence or incidence. Correct application of the reviewed cleaning and decontamination policy will be monitored via the Infection Prevention and Control Group and escalated in line with the established process.

10.0 Staff Wellbeing and Support

Ensuring the wellbeing and resilience of our workforce remains a cornerstone of the Trust's Winter Plan. As winter pressures increase demand across the hospital, it is vital that we protect our staff from avoidable stress, burnout and the negative impact of prolonged operational pressure. This section summarises our proactive approach to supporting staff attendance, psychological safety, and sustainable working and is in full in Appendix 7.

Key Actions for Winter 2025/26:

- **Targeted Wellbeing Communications**
- **Launch of Enhanced Employee Assistance Programme**
- **Drop-In Wellbeing Spaces and Virtual Safe Rooms**
- **Mid-Winter Feedback and Responsive Planning**
- **Occupational Health Access Improvements**
- **Wellbeing Champions**
- **Promotion of Trust Wellbeing Offer**
- **A review of meetings and non urgent admin activity**

These measures reflect our commitment to creating a compassionate, responsive and sustainable workplace. By prioritising staff wellbeing, we strengthen the Trust's ability to maintain safe and effective care throughout the most challenging months of the year.

11.0 Winter vaccination plan

The staff vaccination programme will be operational throughout Q3 and Q4 2025/26, and it is not currently clear whether both, COVID-19 and Flu vaccines will be offered. Exact dates and detail of the roll out are yet to be agreed. We are cognisant that vaccine hesitancy affected vaccine uptake during 2024/25 and that current media coverage regarding the COVID-19 vaccine may affect the 2025/26 uptake, if made available. The full plan Is included in Appendix 8.

To ensure high uptake and effective delivery of the winter vaccination programme, the Trust will implement a comprehensive and targeted approach.

A robust communications campaign will underpin the programme, clearly outlining the benefits of vaccination—not only for staff themselves, but also for their families and the patients in their care. The campaign will also align with seasonal themes and key events, such as Christmas and Bonfire Night, to promote engagement and increase uptake through special vaccination events.

At present, national guidance on the scope of the 2025/26 winter vaccination programme is pending. The Trust will remain responsive to updates, including whether COVID-19 vaccinations will again form part of this year's delivery plan alongside flu.

12.0 Discharge improvement

In preparation for winter 2025/26, the Trust is implementing a system-led discharge model, aligned with Home First principles and national NHS guidance. The Care Transfer Hub will serve as the operational

anchor for this approach, ensuring real-time oversight of complex discharges, integrated escalation, and a consistent 7-day presence. The core aim is to reduce discharge delays, increase same-day discharge performance, and proactively manage flow pressures across all discharge pathways, working alongside patients Estimated Discharge Date to forward plan. The full summary is included in Appendix 9.

To strengthen whole-system discharge coordination, the Trust will implement a single community bed tracker for Pathway 2 and 3 capacity, accessible to all partners. This will enable real-time visibility of bed availability, streamline referrals, and ensure estimated discharge dates (EDDs) are jointly monitored and actioned. In parallel, the Trust will continue to utilise its bridging pathway (Subject to funding) to enable same-day Pathway 1 discharges for Dudley patients in collaboration with the Council. Where the discharge teams complete TOC forms and documentation by 2pm, same-day discharge will be facilitated. This will reduce unnecessary internal waits, minimise weekend discharge backlogs, and improve the patient and family experience.

The Care Transfer Hub will operate 7 days per week, providing consistent multidisciplinary oversight of patients who are ready for discharge. The key operational priority will be the elimination of hospital process-related delays, which remain the most frequent cause of extended stays—accounting for an average of 18–24 patients per day in winter 2024/25.

13.0 Surge plan

The mitigations within this plan aim to avoid surging into additional beds. In order to be resilient however it is imperative that we have the ability to meet increased demand for inpatient capacity when discharge and community settings, including virtual wards, are unable to support with the patients. There is also a requirement within the UEC Plan 25/26 that corridor care is eliminated. The surge will be carried out as demonstrated below, and will only be commissioned by the Chief Operating Officer in hours and the Director on Call out of hours.

The Trust will be avoiding the use of both Treatment Escalation Spaces (TES) and the corridor for the forthcoming winter, however, there needs to be the ability to respond safely at times of surges of activity with the Ambulance Service. For this reason the standard operating procedures for the safe utilisation of both of these areas will be refreshed in time for winter to ensure that if the areas were required to be used in extremis then it could be activated safely in partnership with the Executive team during working hours or the on call Director out of hours.

First would be the opening of the Additional Beds on AMU that should be stepped out of as part of the non elective workstream, then the reopening of the 16 spaces in AMU A and then the overnight opening of the discharge lounge as a final escalation. The opening of the discharge lounge may be mitigated by the opening of capacity in Ridge Hill but plans for this are yet to be finalised.

14.0 Leadership and Oversight

At the launch of the Urgent and Emergency Care Plan 2025/26, NHSE were clear that this was going to be a difficult winter ahead and that it may be schemes identified are new and don’t deliver in the way expected. They therefore need close management, leadership and oversight to ensure that they are delivering to expectation and to support rectification plans if this is not seen to be the case.

There will be daily huddles Monday to Friday with all clinical teams invited to ensure that our staff are well informed of the pressures of the day, receive timely feedback both positive and supportively critical with a real focus on ensuring that the site is running safely and effectively. Once per week these huddles will be widened to include primary care, social care, public health and the voluntary sector to review all of the mitigations we have in the plan and to identify any improvements that can be made as we move through the season.

The Chief Nurse, Medical Director and Chief Operating Officer maintain consistent and visible executive leadership within the Urgent and Emergency Care areas and across the Trust. This includes a regular presence in the areas, back to the floor which includes senior nursing, midwifery and Allied Health Professional leavers and out of hours visits providing additional support during times of extremis.

Colleagues from the wider executive team maintain consistent and visible leadership with support to operational teams on a daily basis. Board to ward visits including Non-Executive Directors are in place across the organisation with associated governance in place.

Real time information about the current status in the Emergency Department is available to Executive, Corporate and Divisional leadership and is monitored on an ongoing basis each day.

The Trust escalation level will be utilised to mobilise tactical and strategic command as necessary in addition to ensuring that there is daily executive oversight in the running of the organisation. Expectation will be that there is on call management representation from 12 midday until the Trust de-escalates.

Regular reporting will be provided to Quality Committee, Finance and Productivity Committee and the Trust Board to ensure that the Board are informed of the performance of the winter plan via the Integrated Performance Report and the Chief Nurse & Medical Officer Report.

15.0 Appendices

Appendix 1 – Contributors

Name	Role	Organisation
Adam Thomas	Group Chief Strategy and Digital Officer	DGFT/SWBH
Dr Ahmed Ismail	Clinical Director for Urgent and Emergency Care	DGFT
Alis Rasul	Directorate Manager Paediatrics	DGFT
Amandeep Tung Nahal	Director of Operations Community and Core Clinical Services	DGFT
Andy Gray	Dudley Community Voluntary Service	DGFT
Mr Babar Elahi	Chief of Surgery, Women and Children	DGFT
Becki Benbow	Assistant Team Manager – Dudley STAR	DMBC
Chris Benfield	Head of Analytics and Insight	DGFT
Chris Dinsdale	Interim Director of Operations Medicine	DGFT
Chris McAvoy	Senior Data Relationship Manager	DGFT
Dr David Pitches	Consultant in Public Health	DMBC
Deborah Vasey	Matron Cardiology and Emergency Department	DGFT
Dr Elizabeth Rees	Chief of Community and Core Clinical Services	DGFT
Gregg Marson	Associate Director Discharge Improvement	DGFT
Hannah Jones	Head of Communications	DGFT
Hannah White	Matron Infection Prevention and Control	DGFT
Hannah White	Head of People	DGFT
Helen Mallard	Lead Nurse for Site Operations	DGFT
Ian Chadwell	Deputy Director of Strategy	DGFT
Jack Richards	Deputy Chief Operating Officer	DGFT
Jayne Tranter	Deputy Divisional Chief Nurse Medicine	DGFT
Jean Pegg	Directorate Manager Acute Medicine	DGFT
Jenny Bree	Lead Nurse for Improvement	DGFT
Jenny Cale	Deputy Director of Operations PLACE	DGFT
Jo Wakeman	Deputy Chief Nurse	DGFT
Dr Joanne Taylor	Medical Service Head Emergency Department	DGFT
Joanne Malpass	Deputy Director of Operations Surgery, Women and Children	DGFT
Dr Julian Hobbs	Medical Director	DGFT
Karen Brogan	Chief People Officer	DGFT
Karen Hanson	Deputy Director of Integration	DGFT
Karen Kelly	Chief Operating Officer	DGFT
Kelly Pettifer	Director of Operations Surgery, Women and Children	DGFT
Laura Broster	Group Chief Communication Officer	DGFT/SWBH
Dr Lucy Martin	Chief of PLACE Division	DGFT
Maria Dance	Divisional Chief Allied Health Professional	DGFT
Marie Banner	Divisional Chief Nurse Medicine	DGFT
Martina Morris	Chief Nurse	DGFT
Michelle Brotherton	Director for Non-Emergency Patient Transport	WMAS
Dr Paul Hudson	Operational Medical Director	DGFT
Phil Atkins	Directorate Manager Emergency Department	DGFT
Dr Phil Brammer	Deputy Medical Director	DGFT
Dr Raj Uppal	Chief of Medicine and Integrated Care	DGFT

Rory McMahon	Director of Operations Medicine	DGFT
Ruckie Kahlon	Chief Pharmacist	DGFT
Sara Davis	Divisional Chief Nurse Surgery, Women and Children	DGFT
Sarah Knight	Head of Primary Care and PLACE Commissioning Dudley	BC ICB
Simone Smith	Head Corporate Resilience	DGFT
Steve Wheaton	Deputy Director of Operations Black Country ICB	BC ICB
Wendy Malpass	Team manager – Intermediate Care	DMBC

The Dudley Group NHS Foundation Trust

Appendix 2 – Lessons learned from Winter 24/25

Paper for submission to the Board of Directors on 18th March 2025

Report title:	Lessons Learned from The Dudley Group Winter Plan 2024/25
Sponsoring executive:	Karen Kelly, Chief Operating Officer
Report author:	Rory McMahon, Director of Operations, Medicine

Summary of key issues using Assure, Advise and Alert

Assure
The operational divisions at The Dudley Group have conducted a post winter review and thorough learning exercise, chronologically examining the planning and execution process of the winter plan 2024/25.

The lessons learned should form key maxims relating to future Winter Plans, and relate to securing robust capacity which can flex in times of extreme pressure for the coming winter 2025/26.

Advise
Lessons have been learned around forecasting, workforce, planning, and system resilience which are detailed within this paper

Alert
Winter 2024/5 was challenging for all at the Dudley Group. As with any process, however, value has been drawn from the review and reflection on last year's plan – and the ability to subsequently apply the learning to future processes to attain maximum efficiency.

For 2025/26 the national expectation as part of the new Urgent and Emergency Care plan is that all organisations and systems will need to have the winter planning signed off by the end of summer. The lessons learned included in this paper will be incorporated into the plan, alongside shared learning from our system partners and delivered to the Trust Board in September 2025.

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	**X**
Improve health and wellbeing	**X**

3. Report journey
18/3 – Trust Executive

4. Recommendations
The Public Trust Board is asked to:
a) **Review** and Discuss the performance of the winter plan 2024/25
b) **Review** and Discuss the performance of the trust's key metrics over winter
c) **Discuss and Accept** the Winter Plan Lessons Learned

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	X	Build innovative partnerships in Dudley and beyond
Board Assurance Framework Risk 7.0	X	Achieve operational performance requirements
Board Assurance Framework Risk 8.0		Establish, invest and sustain the infrastructures, applications and end-user devices for digital innovation
Is Quality Impact Assessment required if so, add date:		
Is Equality Impact Assessment required if so, add date:		

Report to Board of Directors

Lessons Learned from The Dudley Group Winter Plan 2024/25

Contents:

1. Executive Summary – High Level Lessons Learned

During the winter of 24/5, the trust planned to pilot a 'Community First, Hospital when necessary' approach to the management of acute admissions and thus bed pressures at DGFT.

The mitigations scheduled within the winter plan, for a number of reasons detailed within this paper did not provide the expected level of mitigation against the number of extra patients who presented at the trust

The following learning points have been identified following a review process:

Lesson 1: Adherence to the organisational plan is important. The decision to deviate from the community hub model piloted by Enfield, a decision which was made at Divisional level, compromised the effectiveness of the winter plan. The intervention was worth 39 beds, and paring down the model from a cost of £1.1m to £400k ultimately led to its abandonment, as the new, untested model did not work, and gave executives no choice but to stand it down.

Lesson 2: Plan independently of Integrated Care Board (ICB) for winter pressures. ICB modelling was, as openly acknowledged by the ICB, not entirely accurate – from the magnitude of the peak to the timing of the peak, to the geographical nature of the patients presenting at the front door. Partnership working and focus on local knowledge of past winters is crucial to getting this right next time.

Lesson 3: Build in Super surge Capacity. Optimised systems do not work at 100% operationalisation at all times. According to the Kings Fund, the optimal capacity position for a trust is 94.5% of the commissioned bed base. DGFT have spent all winter above 100% - and as of the date of writing, are at 98.5% even in summer months.

Future plans should include extra, unanticipated contingency capacity in this regard. All efforts, as per the advice from the NHSE national team led by Chris Morrow-Frost, should be made to avoid the bedding of SDEC. There is a further requirement to initiate a robust system approach to planning across all services, which and links to EPRR teams and other trusts. The trust's proposed move to a community-based model of care, specifically as part of a future AMRAT model, should offset this.

Lesson 4: Improve Clinical Engagement. The winter plan was operationally led, and did not sufficiently engage our clinicians at the trust; as a result valuable feedback was not ascertained and thus not acted upon. This is planned to be managed differently this coming year.

Lesson 5: Focus on the Quality Impact: there was insufficient focus on quality metrics within the plan – including not only the quality of environment delivered for patients, but also for staff. Our Chief Nurse, Martina Morris, has offered valuable guidance in this regard.

2. Summary of Winter Plan 2024/25

The winter plan was based on an ethos of community first; that is a range of interventions based in the community, virtual wards and a community hub offer that extended to care homes and ambulances.

During the summer of 2024, The divisions worked together in order to maximise admission avoidance to the DGFT bed base, and came within 15 beds of the assurance required by the ICB in terms of combined winter and Midland Metropolitan University Hospital (MMUH).

The Executive Committee and Board were sighted on the governance surrounding the development and reporting of the MMUH impact modelling and mitigations planning which informed the winter plan .

Figure 1: Winter and MMUH plan mitigations

The two pie charts above show the plan and gap relative to the 65 beds that the trust had internally calculated that MMUH would cause (as opposed to the ICB calculated total of 29); and the 76-bed gap the ICB had calculated to the winter plan. Both figures were to peak.

Distinct interventions included

- A 10-bed virtual acute ward
- 24 extra beds released through rationalisation of the community hub funding (above) ; i.e. the extra beds released due to lowering of the unit cost within the same cost envelope
- 15 beds released through adherence to the 35/20 Complex Discharge KPI; that is to say that the trust will achieve 35 complex discharges on a weekday, and 20 on a weekend day.
- 18-bed frailty virtual ward
- 11-bed estate at Rowley

The combined cost for both plans was anticipated to be £2,637k, with a notional split of £1,581k for MMUH and £1,057k for winter. Of this, £1.1m was badged against the most impactful scheme – community hub admission avoidance.

Divisional Interventions

In addition to the plan, each division identified during the winter and subsequently implemented a separate set of interventions to reduce bed occupancy. These included the below

a) Medicine Division

The medicine division bedded large sections of its surge and Ambulatory Emergency Care (AEC) Same Day Emergency Care (SDEC) areas, as well as installing ten extra curtained cubicles in AMU. In addition to this, between the hours of 8 and 6, a temporary escalation space, staffed by all divisions on a rota, was

devised in order to expedite offloads from ambulances within the mandated 45 minute timeframe. The trust used space as flexibly as possible to deal with the large extra number of patients required.

In addition to this the medical division participated into multiple deep dives into the ward and bed base in order to liberate every possible bed and aid flow. Acute medical in reach into ED occurred on a daily basis.

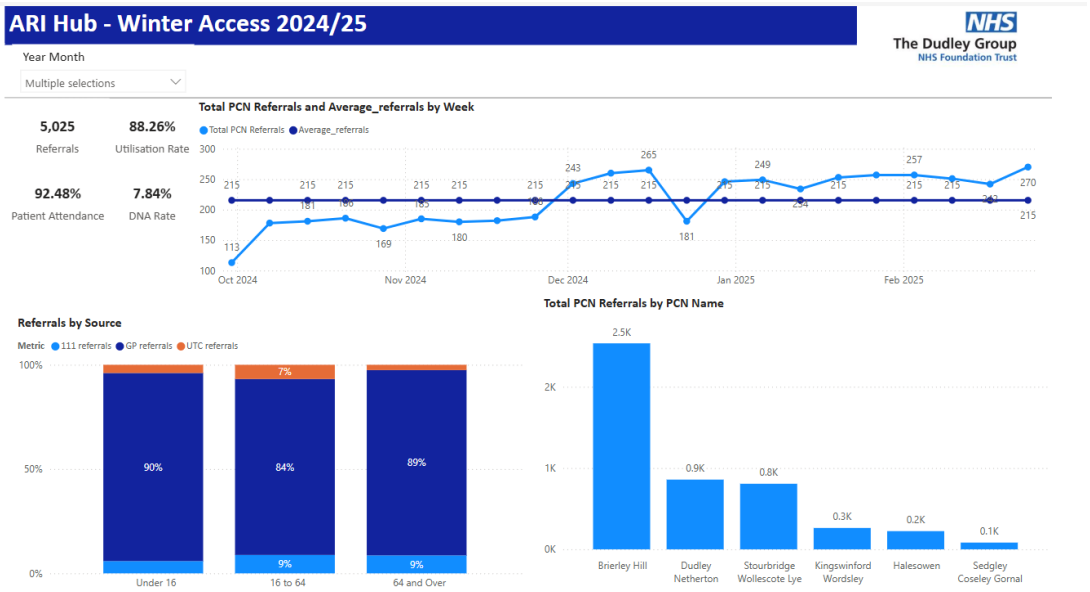
b) Surgery Division

The surgical division cleared beds to allow the trust to outlie to whenever possible. Space was used flexibly to house additional patients in the majority of ward areas.

c) Place Division

The Acute Respiratory Infection (ARI) Hub was commissioned between 1st October 2024 and 31st March 2025 to provide additional GP appointment capacity to support Dudley Place system resilience this Winter. The service operated Monday – Friday 9am – 1pm and Saturday 10am – 2pm between 1st October 2024 – 30th November 2024 and 1st March – 31st March 2025 providing an additional 192 GP face to face appointments each week. Then from 1st December 2024 to 28th February 2025 the service operated Monday – Friday 9am – 6pm, Saturday 10am – 2pm providing an additional 272 appointments each week with additional capacity over the Christmas bank holiday period. The service had direct referral pathways from Dudley GP practices and 111 with redirection pathways from both the UTC and Dudley Clinical Hub taking place.

Figure 15: Acute Respiratory Infection RI Hub Utilisation



d) Community with Core Clinical Services (CCCS) Division

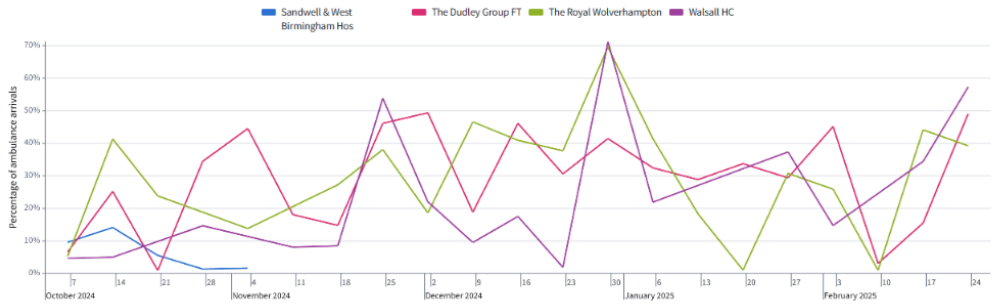
CCCS Division, to support the reduction of bed occupancy, and to support the discharge decision making at ward and board rounds. implemented the bringing forward of patients for CT scanning every evening (17.00-20.00) and revised the phlebotomy rotas where possible to ensure all wards had been attended by a phlebotomist by 12.00. The division also sought to increase the number of discharge facilitators in the Complex Discharge Team, to allow for one Discharge Facilitator per ward each weekday, and increasing workforce numbers at the weekend, to further strengthen ward based MDT working and aiding planning admission on discharge. The IV/OPAT team extended their services to enable the AMU VW to facilitate the continuation of IV treatment at home and support the reduction of the length of stay on AMU

3. Performance Context

The winter of 24/5 was a challenge clinically, operationally, and financially to the trust. The trust saw a high level of ambulance handover delays versus our Black Country partners, caused by high occupancy. This was in part driven by the opening of the Midland Metropolitan University Hospital (figure 4).

Figure 2: Ambulance Breaches over the hour versus Black Country partners, Winter 24/5

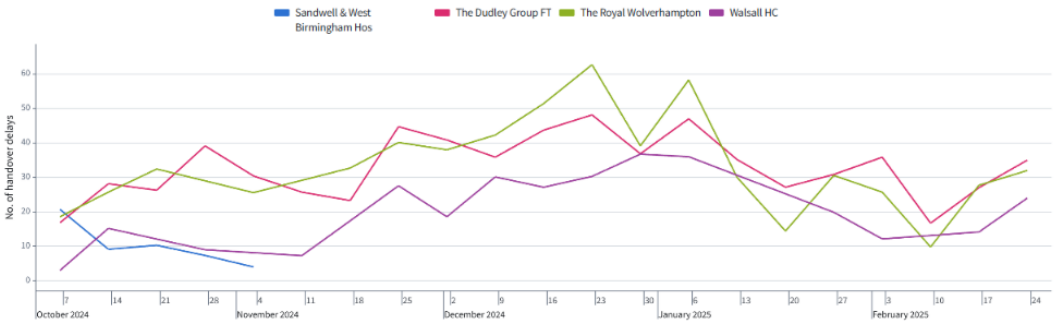
An average of one in every three ambulances at the trust went over the hour in winter 24/5.



NB: Sandwell data not available

Figure 2: Distinct number of ambulances breached by day, versus partners, Winter 24/5

Dudley were consistently worse than our partner trusts, when breaches are adjusted by bed base



NB: Sandwell data not available

There has been a sharp increase in ambulance attendances at RHH since the closure of Sandwell Hospital and the opening of MMUH in October 2024. Data shows that this has had a marked effect on the number of one-hour breaches occurring

Figure 4: Number of Ambulances, April 2024 to April 2025

NB – Average ambulances 96 per day pre MMUH; 102 post

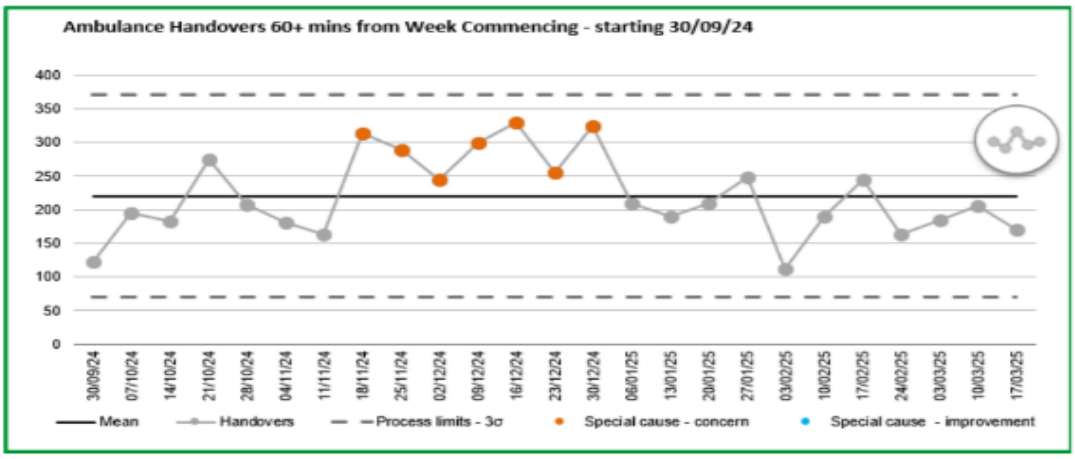
The below details from which postcodes those extra ambulances were constituted. This has now been addressed with a reallocation of Non-elective funds from MMUH to DGFT.

Figure 5: Constitution of additional ambulances

	Patient Postcode Areas			
	Dudley	Sandwell	Walsall	Wolverhampton
Baseline period pre-MMUH opening	65.27	15.97	1.50	2.22
7 Days post-MMUH opening	67.50	20.75	1.00	2.14
Increase/Decrease since Baselined	3.42%	29.96%	-33.33%	-3.36%

NB: summary: +2.23 Dudley Postcode, + 4.78 Sandwell Postcode, - 1.01 Remainder (BC & OOA)

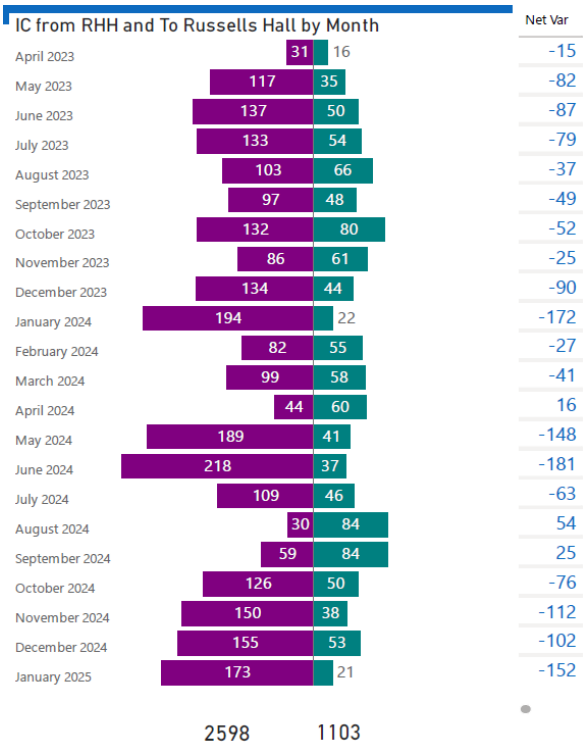
Figure 6: Ambulance handovers over the hour, winter 24/5



This performance was supported with an increase in strategic conveyance away from the Russells Hall site by West Midlands Ambulance Service. This placed additional pressure on our system partners and resulted in patients not always being placed in the hospital closest to their residence.

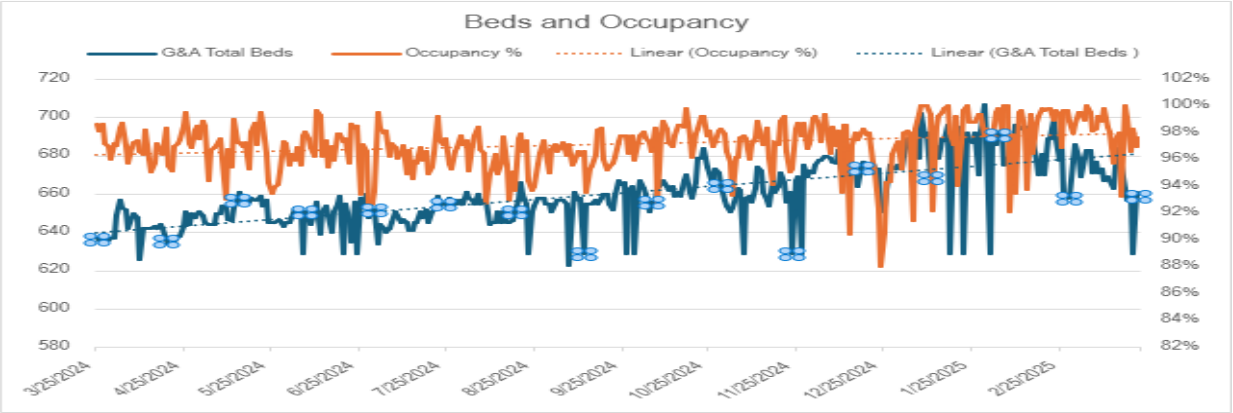
The opening of Surge beds also supported this performance, at a cost tothe trust over £300,000 per month during this period.

Figure 7: Intelligent Conveyancing and performance of RHH site in January 2025



This was driven by an increase in occupancy at the trust over and above the bed base. In the initial stages, SDEC and AEC as permanently bedded, and additional patients were in situ on wards where discharges had been identified for later in the day.

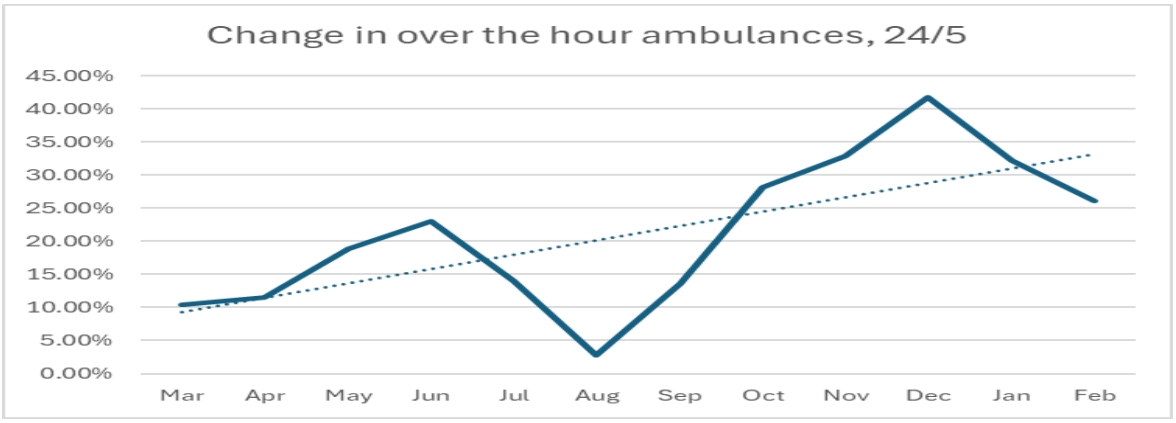
Figure 8: beds versus occupancy at DGFT, Winter 24/5



The trust has developed an occupancy scale (communicated to commissioners July 2024) which accurately predicted the levels of handover delay at the actual levels of occupancy.

Based on trust modelling, the trust could have expected between a 26% and 35% increase in over-the hour conveyances based on occupancy, and experienced 26, indicating an accuracy of prediction.

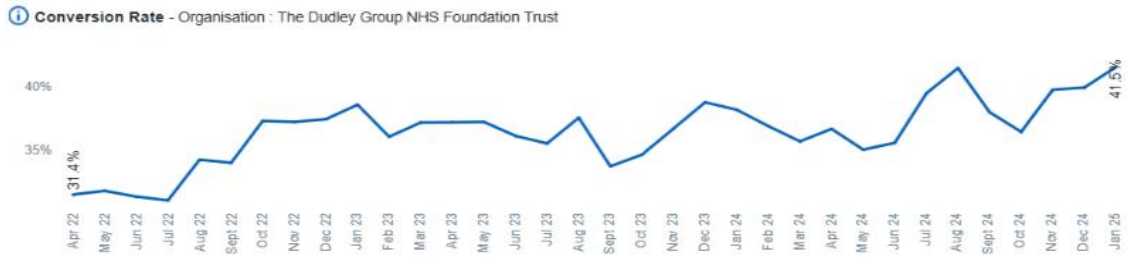
Figure 9: Change in over the hour ambulances, Mar 2024 to Feb 2025



Length of stay stayed fairly static throughout the winter period - However conversion rate rose (as it does every winter) to roughly 2% more than winter 24/5. This is roughly in line with the expected increase in acuity year on year of 1.5% DGFT has seen at the front door.

Figure 10: Conversion rate, ED (non UTC filtered) attendances, April 22 to Jan 25

Trust AVERAGE Occupancy	Handover Delays Over the Hour	Average 4 Hour Performance ED Only	Actual # over the hour delays per month	Source
95%	7%	76%	203	Actual
96%	14%	76%	406	Actual
97%	18%	75%	522	Actual
98%	22%	74%	638	Actual
99%	28%	74%	812	Actual
100%	31%	73%	899	Actual
101%	36%	73%	1032	Forecast Based on Volumes
102%	40%	72%	1166	Forecast Based on Volumes
103%	45%	72%	1299	Forecast Based on Volumes
104%	49%	71%	1433	Forecast Based on Volumes
105%	54%	71%	1566	Forecast Based on Volumes
106%	59%	70%	1699	Forecast Based on Volumes
107%	63%	70%	1833	Forecast Based on Volumes
108%	68%	69%	1966	Forecast Based on Volumes
109%	72%	69%	2100	Forecast Based on Volumes
110%	77%	68%	2233	Forecast Based on Volumes



Despite this, 4 hour performance stayed largely resilient, this is as a result of good performance in non-admitted pathways compensating for long waits for patients to be admitted into the bed base.

Figure 11: DGFT 4 hour performance by year, 2023/4/5

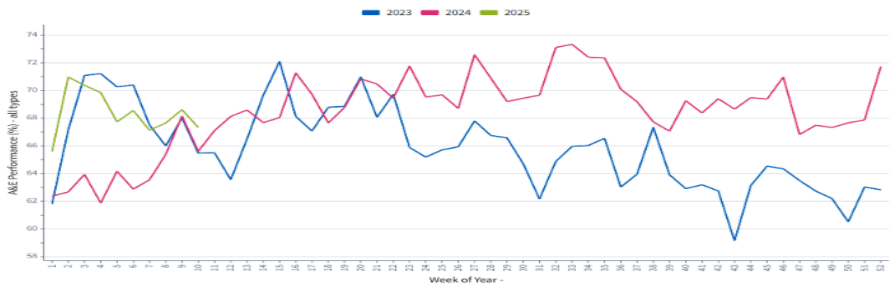
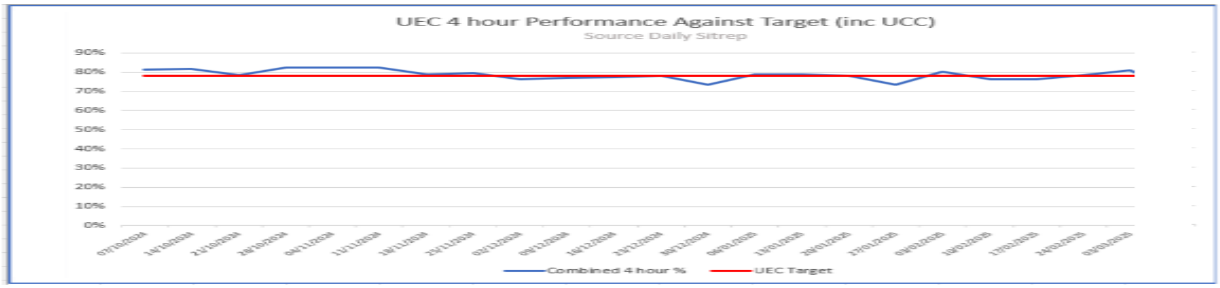


Figure 12: Performance vs Four Hour Standard



Urgent and emergency care (UEC) Performance was largely over or around the 78% standard, with the trust currently sitting at over 79.8% for the full year.

Patient Morale

Morale In ED in the period, according to the NHS' friends and family test was on average similar to the prior year

24/5 – ED Patient Morale

Emergency Department (% Very Good/Good)				
Oct-24	Nov-24	Dec-24	Jan-25	Feb-25
68%	69%	69%	74%	69%

Emergency Department (% Very Poor/Poor)				
Oct-24	Nov-24	Dec-24	Jan-25	Feb-25
17%	16%	16%	13%	15%

Emergency Department Mean Average Score	
Overall positive score	Overall negative score
70%	15%

23/4 – ED Patient Morale

Emergency Department (% Very Good/Good)				
Oct-23	Nov-23	Dec-23	Jan-24	Feb-24
69%	70%	70%	69%	72%

Emergency Department (% Very Poor/Poor)				
Oct-23	Nov-23	Dec-23	Jan-24	Feb-24
16%	14%	15%	16%	13%

Emergency Department Mean Average Score	
Overall positive score	Overall negative score
70%	15%

With Trust wide patient morale Scores following a similar, static pattern

24/5 – Trust wide Patient Morale

Trust Score (% Very Good/Good)				
Oct-24	Nov-24	Dec-24	Jan-25	Feb-25
82%	83%	83%	83%	82%

Trust Score (Very Poor/Poor)				
Oct-24	Nov-24	Dec-24	Jan-25	Feb-25
7%	6%	6%	6%	6%

Trust Mean Average Score	
Overall positive score	Overall negative score
83%	6%

23/4 – Trustwide Patient Morale

Trust Score (% Very Good/Good)				
Oct-23	Nov-23	Dec-23	Jan-24	Feb-24
82%	84%	83%	82%	83%

Trust Score (% Very Poor/Poor)				
Oct-23	Nov-23	Dec-23	Jan-24	Feb-24
6%	5%	6%	6%	6%

Trust Mean Average Score	
Overall positive score	Overall negative score
83%	6%

Staff Morale

Staff morale rose amongst ED nursing, but fell back amongst ED Medics

Figure 13: Staff Survey results, DGFT, versus prior years

Staff Survey Results Morale				
Department	**Trust Average**	**2024/5**	**2023/4**	**2022/3**
AMU 1	5.7	5		
AMU 2	5.7	6.3		
AMU Assessment	5.7	4.6		
ED Nursing	5.7	5.3	5	4.6
ED Paediatrics	5.7	4.9		
ED Minor Injuries	5.7	4.8		
ED Medical Staff	5.7	5	5.3	4.5

4. ICB Modelling

The ICB's modelling is below, at figure 14 Line C, below, indicated the required level of ICB assurance. The level of mitigation forecast was only marginally lower than this, and Line C was, for the majority of winter, around 35 beds clear of the level of anticipated activity at the Trust.

The reality was unfortunately markedly different. Almost immediately upon the closure of MMUH, the trust moved to open 57 surge beds, later increased to 67 once 10 extra beds were opened on AMU.

Line D (Figure 15) represents the number of beds at the trust actually opened during winter.

Figure 14: Dudley total and peak bed requirement and ICB assurance winter 24/5

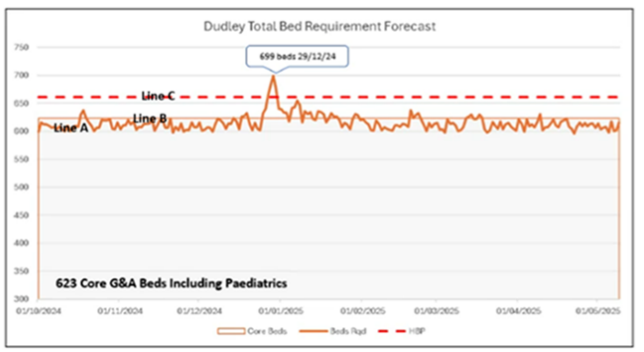
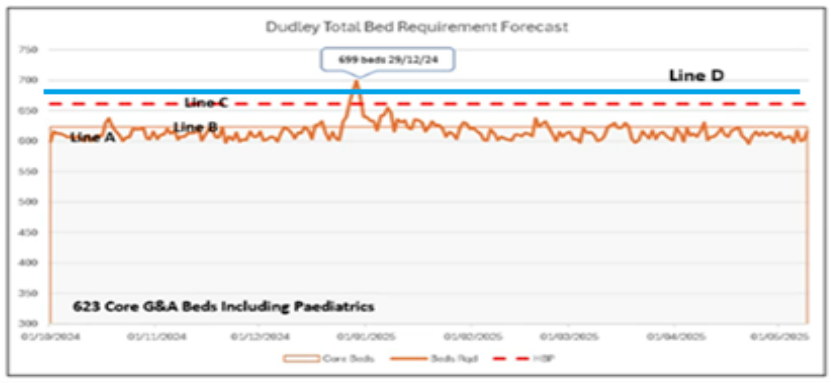
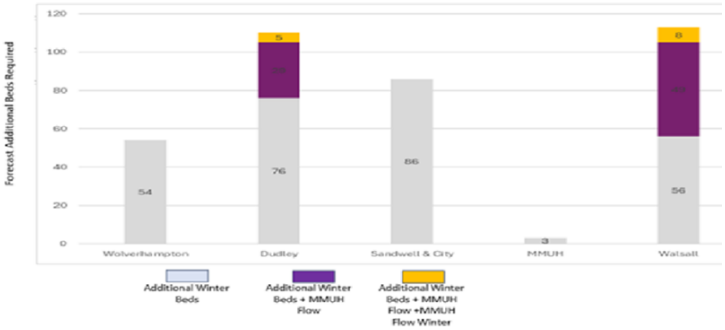


Figure 15: Beds open at trust, winter 24/5



The below graphic represents the ICB modelling of the peak, and cause attribution

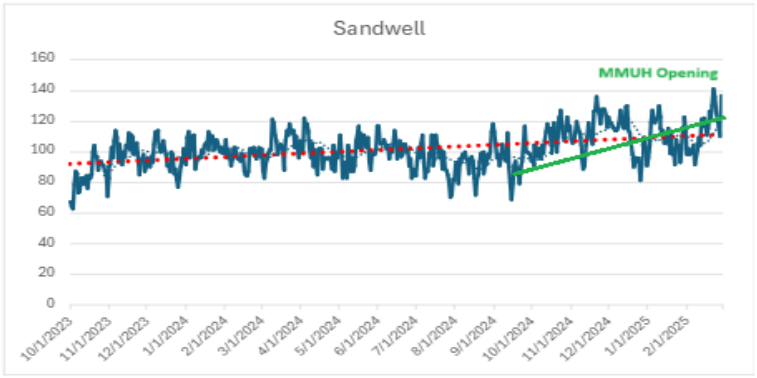
Figure 16: ICB peak modelling winter 24/5



The reasons for this include unanticipated Sandwell patients in the bed base, a low number of complex discharges, and a heightened number of MOFD in the bed base at DGFT. The above modelling RE: DGFT and MMUH impact was incorrect, as will be demonstrated below.

The below section details the patients which the winter plan was expected to mitigate against.

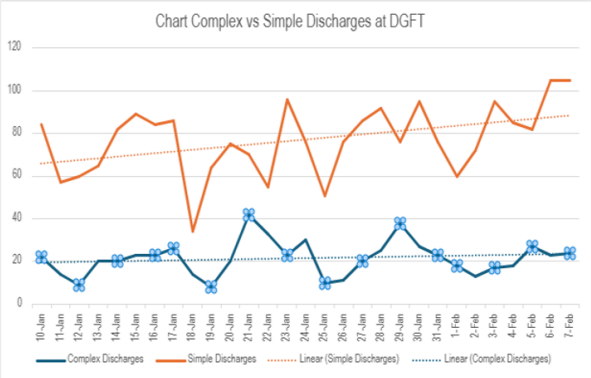
Figure 17: Sandwell patients in bed base pre and post MMUH.



- The data in figure 6 shows roughly 26 more patients in the bed base in the period Oct ’24 to feb ’25 – with a marked upward trend in that period compared to previously. Further data analysis showed
- The 'natural' rate of increase of Sandwell patients in the Dudley bed base (between 22/3 and 23/4, so no MMUH impact) is circa 5%.
- The rate between 23/4 and 24/5 (so MMUH Impact) is upwards of 25%
- Average 26 pts with a Sandwell Postcode in bed base more than 23/4 in 24/5
- Looking at Jan and Feb, the worst day was 19th February when we had 39 more Sandwell patients in the bed base
- This is a roughly 4.5% pressure on our bed base

Complex Discharges also significantly lagged the anticipated level (Data extract from report in feb), creating an Excess of MOFD. An excess of complex MOFD (Medically Optimised Fit for Discharge) at the Trust, which sits at between 23 and 27% (25% was the figure identified in the recent Trust census led by our Medical Director). The national average is 16.6%; An exemplar, such as our neighbour and ICB Partner Walsall, is 9-10%. This manifests in 50-60 extra MOFD within the Trust bed base, the causes of which (and the solutions to which) are multifactorial and involve multiple divisions and external agencies.

Figure 18: Complex versus simple discharges (Jan-Feb 2024/5)



5. Success and failure of interventions in Winter Plan

a) 10-bed virtual acute ward extension

This was successful, and was in fact over-capacity all winter. This facet of the mitigative plan was particularly successful at times of high congestion within ED; it was on occasion possible for consultants to discharge 4 patients at any one time from ED cubicles into the AMU virtual ward.

The board has now served its purpose and is likely to be shrunk back to a smaller number in order to make its continued running more financially viable for the trust.

b) 39 extra beds released through community hub funding of admission avoidance (above)

It was initially planned that the trust would look to replicate new model of care developed in Enfield whereby clinical teams with advanced skill sets would man the community hub 24 hours per day and link into an urgent community response team partially staffed by GP's and consultants which would go into care homes and realise the significant opportunity which the place division have subsequently calculated in preventing admissions from care homes.

This was initially costed at £1.1 million. The reason for this costing was to make the model commensurate with the Enfield model to achieve the number of visits and contacts necessary to prevent the admissions and thus to realise admission avoidance.

After looking into how this could be adopted, DGFT proposed an augmentation of the model. This reduced the funding envelope to £400,000. After a pilot, it was concluded that the model did not work as expected and was therefore stood down, This was crucial to the winter plan as it involved 35 beds worth of admission avoidance – that is nearly half the surge capacity of the trust.

The abandonment of this initiative ultimately led to the failure of the winter plan due to the disproportionate impact of this one intervention on the portfolio of mitigations

c) 15 beds released through adherence to the 35/20 Complex Discharge KPI; The trust will achieve 35 discharges on a weekday, and 20 on a weekend day.

The KPI for complex discharges to improve upon the MOFD position detailed earlier in this paper was not realised. Complex discharges did not improve from the pre winter position and thus no bed savings were made as a result of this initiative.

d) 8-bed frailty virtual ward

It was planned, as per instruction, the 18 bed frailty virtual ward extension must be staffed using bank. Unfortunately during the start of the winter period the frailty specialty suffered a number of long term absences within the band 7 nursing line. The directorate explored everything that it could in terms of the utilisation of staff from other trusts, but none were available.

e) Eleven bed estate at Rowley

The stroke rehabilitation estate at Rowley was opened on the 1st of February after extensive negotiation and recruitment into the roles. Although it is now open and full, the facility served to alleviate a small part of

the MOFD problem (patients waiting for pathway 3 packages of care), and the MOFD problem grew all winter and thus consumed this element of the mitigation without benefit.

6. Lessons Learned

Lesson 1: Don't deviate from the plan blueprint.

The key strength of the Enfield Model was that it would deliver proven outcomes - and that we had a contact at the Enfield team whom we could ask questions in order to iron out practicalities and take learning from. The revised plan did not realise the benefits required and therefore did not mitigate the number of beds required.

Lesson 2: Plan independently of ICB for winter pressures. modelling was incorrect – from the magnitude of the peak, to the timing of the peak, to the geographical nature of the patients presenting at the front door; our mitigations within our own community were not designed to mitigate Sandwell patients.

Going forward all winter plans should be formulated using a greater degree of collaboration, using trust data. DGFT did model what we felt MMUH related pressures would be and communicated them to the ICB in June of 2024, but this did not affect the ICB's modelling either in terms of magnitude or peak.

Assurance, cumulatively at trust level and not ICB level should just be the driving factor in creating robust winter plans going forwards bearing in mind the lessons learned regarding the inadequacy of ICB modelling in winter 24/5. DGFT are, subsequently, not the only trust to contest the modelling – Wolverhampton and Walsall have both requested learning exercises.

Lesson 3: Build in Supersurge Capacity

The DGFT Non-elective Workstream for 2025/26 has acknowledged this as a central pillar, and is building in winter resilience and capacity to new models of care.

Lesson 4: Improve Clinical Engagement.

By placing clinical leaders at the helm of winter planning, healthcare organisations can ensure that strategies are informed, practical, and focused on delivering high-quality patient care even under the strain of heightened demand.

The DGFT plan was operationally led, and more specifically led by the DGFT medical division. This deprived clinicians of the chance, in good time, to collaborate and grow solutions; True clinical leadership promotes collaboration between various specialties and departments, ensuring a comprehensive approach to addressing the complexities of winter demand, including emergencies, hospital admissions, and outpatient care.

Clinically led planning can also facilitate better communication among clinical teams, management, and support staff. This is crucial during winter months when circumstances can change rapidly; and teams are often better equipped to respond swiftly to crises or spikes in patient volume, as they can make informed, effective decisions that prioritise patient safety and care.

Lesson 5: Focus on the Quality Impact

Insufficient focus was placed upon quality metrics and KPIs in the DGFT 24/5 winter plan. This is important for a number of reasons.

Winter periods often come with higher demand due to seasonal illnesses, such as flu or respiratory conditions. KPIs focused on safety help ensure that patient care remains a top priority, reducing the risk of errors, accidents, or infections. They track vital aspects of patient care and safety, such as infection control rates, fall prevention, and medication errors.

Winter months can strain healthcare systems, leading to longer wait times and reduced satisfaction. KPIs that track patient satisfaction, waiting times, and quality of care ensure that the patient experience does not suffer even during peak times. By focusing on quality, trusts can maintain high standards of care and improve patient outcomes.

Appendix 3 – Service level winter plans

Surgery Women and Children

The Surgery, Women, and Children (SWC) division has developed a proactive and multi-faceted winter plan for 2025/26, designed to sustain safe and effective care across all its services during periods of peak demand. Priorities include increasing vaccination uptake among staff and eligible patient groups, particularly to minimise the impact of seasonal illnesses. Hot clinic capacity will be expanded to provide timely access to urgent care and prevent unnecessary admissions, while careful planning of annual leave will ensure even distribution across the workforce to reduce service disruption in Quarter 4.

A focus has been placed early on maintaining elective flow throughout the winter period but increasing throughput pre winter by maximising the use of high intensity operation lists (HIT), use of Paediatric Super Saturday events and usage of vacant theatre space in other Black Country Trusts to minimise any unexpected impacts on elective throughput as a result of winter pressure.

A standard operating procedure for the roles and responsibilities of the daily capacity team ensuring that escalations for surges in demand and capacity are dealt with in timely manner and there is effective decision making in these high pressure periods reducing the reliance on holding patients within the Emergency Department.

The division is working to increase the availability of hot clinic appointments, exploration of the introduction of a surgical virtual ward, to fully embed the usage of estimated date of discharge and criteria led discharge. Work is also underway to look at right-sizing the surgical SDEC to ensure that the department is fully prepared to cope with the demand realised from the care navigation centre.

Within paediatric services, the division is placing emphasis on maintaining flow and capacity, particularly during surges in respiratory presentations typical of the winter period. This includes reinforcing discharge planning processes and ensuring there is adequate escalation and support for children with complex needs. Paediatric pathways will be monitored closely to respond flexibly to seasonal demand, with a continued focus on safe staffing and effective service coordination. A surge plan is also being developed to increase availability of space on the Paediatric Virtual Ward, this may require a small capital investment for further remote monitoring equipment.

Community and Core Clinical Services

Within Core Clinical Services, efforts are being concentrated on ensuring workforce resilience and operational flexibility. Plans are in place to maintain staffing levels across diagnostic and clinical support services, with particular emphasis on deploying resources dynamically to respond to surge demand. Diagnostics, including imaging and pathology, will offer increased availability to support timely clinical decision-making and reduce delays in patient progression. This will include moving as much elective diagnostic activity to the Guest and Corbett sites to ensure availability for emergency and inpatient diagnostics to be carried out on the Russells Hall Hospital site. Additional inpatient ultrasound capacity is to be provided on Saturdays and the phlebotomy service will be reviewed to offer a seven day service with all blood samples collected by 11am. Allied health professionals and therapy services are also being positioned to provide rapid assessments and early intervention to prevent unnecessary admissions and support recovery at home where clinically appropriate.

The Pharmacy service will play a central role in sustaining patient flow during winter. Prioritisation is being given to medicines optimisation and the timely provision of discharge medications to prevent avoidable delays. The TTO (To Take Out) process is being streamlined with workforce plans designed to maintain extended pharmacy hours where required. This approach aims to ensure medication safety while supporting swift transitions of care across hospital and community settings. Where necessary outpatient services will be instructed to use FP10 prescribing forms when the Trust is on OPEL 4 to enable patients to access community pharmacies for dispensing of hospital outpatient medication allowing the pharmacy department to focus on the provision of medication for inpatients and prioritisation of timely medication for discharge.

The staffing model within the mortuary is being reviewed to ensure that there is a robust on call roster with annual leave having been taken evenly throughout the year to ensure that there are no staffing shortfalls

during Q4 when seasonal variations in death rates increase the uptake on mortuary services. There will also be a process to call for mutual aid across the system if required.

Care Navigation Centre is aiming to be operational by September 2025, with the objective of enhancing patient care coordination, minimising unnecessary hospital conveyances and attendances and providing alternative pathways to support urgent care response.

Impact from September 2025 of the project will concentrate on:

1. Referrals into CNC from WMAS, Primary care, NHS 111 and all health and care professionals, with Phase 2 opening to patients and carers.
2. Service Provision 12 hours 8 am - 9pm, 7 days a week including bank holidays, to include band 6 triage clinician – Nurse/Paramedic to be placed in ED.
3. Establish new pathways that can support patient flow from community services/Primary care to SDEC/Hot clinics and VWs and reduce footfall to ED e.g. DVT pathway within Community, direct step up into hot clinics/Virtual Ward's as clinically appropriate.
4. The CNC workstream will revise the strategy with West Midlands Ambulance Service (WMAS) concentrating on the 'Call Before Convey' model and focus on Primary Care and Care Homes to increase the utilisation of the Hub and prevent attendances and admissions into ED. Work is also underway to look at the provision of a single CNC across the Black Country hosted by Wolverhampton as currently offer a 24hour service provision.

In addition to this system wide schemes are also in development and should positively support winter readiness:

- Development of a single Out of Hours (OOH) UCR SPA in the Black Country to support review and safe stacking of patients on the CAD portal. Wolverhampton to host this OOH SPA with a pilot starting on 16th of June for the hours of 6.30-8am.
- Collaboration with Sandwell to develop a single point of access for the south in line with the single point of access for Wolverhampton and Walsall. Scoping has already started with 1st meeting being held with Sandwell on 20th June 25.
- Working with Sandwell to review provision of wider community services and cross border cover, including District Nursing services and IV therapy.
- To work with the Rapid Enablement, Assessment, Care, Coordination, Therapy and Treatment (REACCT) and Care Transfer Hub (CTH) models to ensure discharge pathways are set up with the CNC to facilitate turning patients around from front door and discharges back into the community.

PLACE

PLACE have focused on ensuring that patients are accessing care in the most appropriate facility in primary care where possible and also supporting patients to be discharged from the organisation in the most timely way possible into suitable care settings.

The division is contributing significantly to the development of the Care Transfer Hub supporting a more integrated approach to the management of pathway 1, 2 and 3 discharges aiming to improve patient outcomes, reduce delays and strengthen system collaboration. This will improve communication, accessibility and escalation across the whole of the local health and social care sector in relation to safe patient discharge.

Weekly long stay reviews will be implemented within community bed settings to ensure that delays are minimised alongside regular liaison with infection control to ensure good practice is maintained within these settings to ensure that bed availability is not impacted by closures as a result of infection outbreaks.

The GP services that fall within our management, High Oak and Chapel Street Surgery will be implementing improved training for reception teams to ensure that we are maximising care navigation and that GP appointments will be preserved for those patients that require them and that there is reinforcement

of patients accessing alternative professionals where appropriate including the Community Pharmacy, Opticians, Dental services and utilisation of electronic requests for non-urgent matters such as FIT notes and prescription requests. The Acute Respiratory Infection Hub (ARI) will be launched in October with increased capacity available from December onwards to provide appointments for patients with respiratory symptoms allowing them to be directed away from frontline GP appointments. The Urgent Treatment Centre and NHS 111 will be able to refer directly to this service.

A project to ensure all care home residents have appropriate RESPECT documentation in place where indicated will be completed by the end of September 2025. This will support patients who do not wish to be conveyed to hospital or are at the end of life with symptoms that could be well managed in the community are not inappropriately conveyed to hospital.

Medicine and Integrated Care

Meeting the 45 min standard for Ambulance Offload, meeting 12 hour performance and eliminating corridor care.

Reducing ambulance offload delays, 12-hour breaches (primarily linked to delays in admission), and the use of corridor spaces remains a key priority for the winter period. These issues are predominantly driven by consistently high bed occupancy. The Emergency Department (ED) will focus on the timely transfer of patients once a bed is allocated, and ensure efficient clinical ownership and turnaround within the department.

As part of the Non-Elective (NEL) workstream, 22 beds within AMUA will be stood down to facilitate the creation of a dedicated 6-bay ambulance handover area, with an additional side room. This initiative is designed to expedite triage and improve flow at the front door. Operational considerations, including staffing and safe clinical management of this space, require further planning and discussion.

Further capacity will be created through the relocation of minor injuries services to Therapies, allowing the ED to create three additional assessment spaces. While the addition of three trolleys will have a limited overall impact, it provides crucial extra assessment space and enables more efficient patient stepdown from Majors. Space constraints make the inclusion of 8 recliner chairs unfeasible.

To streamline clinical processes, a single clerking document will be implemented across ED. This will reduce duplication, support faster diagnosis and treatment, and improve bed turnover, ultimately helping to meet the 45-minute ambulance offload target.

A potential innovation under review includes converting the ED intubation room into a Mental Health (MH) assessment bay in partnership with Black Country Healthcare. This would provide dedicated, staffed space for patients awaiting mental health admission and prevent unnecessary delays.

The NEL workstream’s community hub and other diversionary initiatives are expected to reduce ED attendances by approximately 80 patients per month, according to the CCCS business case for the Community Navigation Centre (CNC). However, this figure is currently anecdotal, and no formal pilot or outcome data yet substantiates this projection.

ED will continue to redirect appropriate GP referrals directly to specialties from Malling Health Streamer. This requires commitment from specialty assessment areas to accept patients without additional pre-transfer investigations, which previously led to a breakdown in this pathway due to unrealistic expectations placed on Malling.

A fully operational discharge lounge remains a critical component in enhancing patient flow and reducing bed occupancy, with a direct impact on improving ambulance handover times and eliminating corridor care.

The Rapid Assessment and Triage (RAT) model will continue throughout the winter to identify patients suitable for streaming away from ED at an early stage.

Maintaining 4 hour performance for Paediatric Emergency Care

Paediatric ED has consistently maintained a four-hour performance of 92%. Sustaining this level will be achieved through close collaboration with the community division, with an emphasis on shifting care into the community and preventing default referrals to ED from other specialist services.

A clinical Band 7 nurse will continue to support flow and address any emerging capacity issues within the department.

Plans are in place to increase Virtual Ward (VW) capacity and expand existing pathways. A full review of current ED and Paediatric Assessment Unit (PAU) pathways is also underway, with the aim of identifying waste and inefficiencies.

Increased on-site senior presence, including a PAU consultant available from 09:00 to 21:00, will further support performance and decision-making.

Maintaining 4 hour performance overall

The trust has maintained performance above 79%, and will continue efforts to achieve the minimum standard of 78% throughout winter. ED will maintain strong clinical ownership and active tracking of patients approaching the four-hour breach mark.

Collaboration with Mental Health (MH) services remains a key focus, with internal escalation processes in place to prevent delays exceeding 24 hours. To enhance the interface with MH services, the trust will:

- Develop clear, standardised protocols for triaging and managing psychiatric emergencies.
- Ensure early involvement from MH providers upon patient arrival.
- Implement rapid screening tools to determine severity and disposition needs.
- Provide direct access to MH specialists, either on-site or remotely.
- Integrate mental health with real-time bed tracking via the new bed management system.
- Deliver regular staff training on MH conditions, de-escalation, trauma-informed care, and correct use of MH protocols.

A professional standards audit will be conducted to support quality and consistency in patient care.

Reducing length of stay for Emergency Medical Admissions staying one night

The trust is targeting a minimum 0.4-day reduction in length of stay (LOS) for patients with overnight medical admissions. This will be achieved through several key initiatives:

- Early senior clinical review (consultants or experienced registrars) within the first few hours of admission to accelerate diagnosis and care decisions.
- Timely involvement of Allied Health Professionals (AHPs), such as physiotherapists, occupational therapists, and social workers, to support early discharge planning. The REACT team is expected to play a significant role here, pending proof of concept and mobilisation.
- The new bed management system and integrated electronic health record (EHR) platform will support clinicians by prompting evidence-based pathways and discharge criteria.

Appendix 4: Social Care and Dudley Metropolitan Borough Council

Dudley Metropolitan Borough Council (DMBC) Social Care is committed to a proactive and integrated approach to prevent avoidable admissions, support timely discharges, and enable recovery through person-centred care. Our priorities focus on early intervention, system collaboration, and maintaining operational resilience throughout winter pressures.

1. Seven-Day Discharge Operations

We will maintain a fully staffed, 7-day social care discharge service, ensuring continuous support for safe and timely discharges via the Discharge to Assess (D2A) model. This will be underpinned by integrated working across preventive services, informal carer support, telecare, and reablement, all aimed at reducing reliance on long-term care and improving outcomes. A strong emphasis will be placed on staff wellbeing, with training, rest and recovery workshops, and active participation in seasonal vaccination programmes.

2. Timely and Flexible Care Offers

To minimise discharge delays, care packages will be secured swiftly, supported by flexible rotas and responsive services including evening and weekend coverage. A strengths-based approach to care planning will be prioritised, empowering individuals to regain independence as quickly and safely as possible.

3. Escalation and Surge Planning

During periods of heightened system pressure, we will proactively bring forward planned discharges. Through real-time data analysis and effective escalation protocols, we will work in close collaboration with health partners to ensure individuals ready for discharge are prioritised without compromising safety or quality.

4. Medication Oversight

In partnership with health colleagues, we will support medication screening and reviews to prevent overprescribing and reduce medication-related readmissions. Ensuring that all necessary reviews are completed before discharge is a core part of our safe discharge process.

5. Transfer of Care Hub (TOCH) Engagement

Social care will maintain a strong presence in the TOCH, contributing to integrated, patient-centred discharge planning. As the model evolves, we remain agile and committed to ensuring that social care perspectives are embedded in daily decision-making.

6. Robust On-Call System

We will operate a reliable 7-day on-call system to support urgent social care needs and facilitate escalation when required. Strong communication pathways with all system partners will be upheld to enable real-time coordination and problem-solving.

7. Urgent Care Attendance Avoidance

Through our Urgent Care Attendance Avoidance Team, we will provide rapid response services 7 days a week. Working alongside community health teams and GPs, this approach will prevent unnecessary hospital admissions by managing risk in the community and delivering timely interventions.

8. Participation in System-Wide Initiatives

Social care will continue to engage in key system-wide initiatives such as Multi-Agency Discharge Events (MADE) and local development programmes. This collaboration will drive system learning, service improvements, and shared accountability.

9. Hospital Avoidance Beds

Five dedicated hospital avoidance beds will be used to support individuals with urgent social care needs in a non-hospital setting. These placements offer an environment for stabilisation, assessment, and short-term recovery – helping prevent unnecessary admissions.

10. Access to Therapy Equipment

Access to essential therapy equipment, available 7 days a week, will be maintained to facilitate safe

discharges and ongoing recovery at home. Social care teams will work closely with therapy services to ensure timely provision and installation.

11. Support to FAU and ED
Responsive social care support will be available to both the Frailty Assessment Unit (FAU) and Emergency Department (ED). These interventions will enable front-door discharge where appropriate, reducing length of stay and easing pressure on acute services.

Appendix 5 – Communications Plan

Communications plays a key role during winter. Last year our Black Country communications community responded well, having a robust plan in place, detailing our approach, messages and target audiences. Together, we developed and localised communication toolkits which allowed for consistent and timely communications to patients, public, our workforce, primary care and wider stakeholders. This work was overseen by the Black country UEC Programme Board.

Building upon the success of that collaborative approach, in 2025/26 our Trust will work with the ICB and partners across health and care to maximise the reach of our messaging which will be tailored to achieve the following goals:

Goal 1: Educate and inform the public to help reduce inappropriate unheralded ED and UTC attendance.

- Seasonal Vaccinations: Promote uptake among vulnerable populations, work to dispel myths, reduce hesitancy and overcome messaging fatigue.
- Self-care messages: Encourage people to manage minor illnesses (like colds, sore throats) at home or through pharmacy.
- "Choose well" campaign to educate people on when to use A&E, UTC's (if standalone) NHS 111, pharmacies, or GPs.
    - Promote pharmacy first/minor ailment schemes including late night opening
    - Promote access to mental health care teams when an existing service user is in crisis
    - Promote 24/7 mental health helpline for Black Country residents who are or have a loved one who is struggling with their mental health
- Cold weather health advice: Provide tips to prevent cold-related illnesses and protect vulnerable individuals.
- Promote NHS 111 as a first point of contact for non-life-threatening issues.
- Work with local authorities, UKHSA, and other healthcare partners to ensure consistent and coordinated messaging (speak with 1 voice)

Goal 2: Support NHS staff and maintain operational effectiveness.

- Promote staff flu vaccinations to keep our workforce well.
- Support staff to improve discharges 'where best next'
- Support awareness of virtual wards and community pathways for admission avoidance
- Disseminate winter preparedness plans, staffing updates, and infection control protocols.
- Boost morale through recognition and support messaging.
- Provide up-to-date information during severe weather or service disruption.

Goal 3: Maintain trust and clarity during periods of high pressure (crisis & incident communication).

- Communicate clearly to those who need to take new actions.
- Maintain trust and confidence in the NHS during peak periods of demand.
- Coordinate messaging during extreme weather.
- Work with local and national media to manage expectations and reduce panic.

Media handling: We will take a proactive approach to media handling and will participate in a press briefing for late November with representatives from organisations across the system. The briefing will be an important opportunity to share how the system is working together to prepare for winter, as well as explain the external factors influencing pressures on the NHS to set expectations. Relationship building through this process will also support our ability to rapidly rebut inaccurate or misleading information. If needs arise, regular Q&A sessions can be established to ensure accurate messaging is featured in media reporting.

Branding: The development of a 'Think Which Service' brand in 2023, ensured a consistent look and feel across campaign messages related to winter, we will utilise this again this year but add to the products with new, engaging content.

Promotion: Whilst the ICB may have a small amount of advertising spend there is no discretionary funds identified at the Trust for any paid content or materials. Whilst this limits the marketing mix in terms of promotion we can still utilise the following channels.

- GP waiting room screens
- Trust and partner social media channels/ websites
- Local news outlets
- Our health and care workforce, volunteers, members and governors
- Local councillors and our networks of community, voluntary and faith-based partners
- Trust estate

Targeting & segmentation: Work is now underway to establish the target messaging and population segmentation. We are working with operational colleagues to understand key data sets to establish the key geographic, demographic and condition related issues that are contributing to the unheralded and inappropriate demands placed on urgent care services. This insight will support us to target our communication efforts at key messages to the right people to shift behaviours.

Example communication material that was demonstrated as successful last winter is planned for use again this year:

Image 1: Think Which Service Black Country branding

Image 2: pharmacy bags


NHS
Black Country
Think which service?
Common ailments and illnesses
Urgent medical help or advice that isn't life-threatening
Health advice and over the counter medicines
Symptoms that won't go away
Walk in or book an appointment via NHS 111
Life-threatening emergencies
999
blackcountryics.org.uk/think

Appendix 6 – Infection Prevention and Control Plan

DGFT will continue to adhere to current up to date Infection Prevention and Control (IPC) guidance, with ongoing emphasis on staff and public compliance with fundamentals such as hand hygiene, bare below the elbow requirements for the staff. This will continue to be closely monitored, and non-compliance addressed. Established audits and monitoring processes will continue to identify any non-compliance early, hence focusing on prevention of infections.

The IPCT will continue daily ward rounds across acute medicine to assist with flow and patient safety, identifying patients who may require isolation and screening.

Screening:

- National guidance for COVID-19 remains unchanged. All respiratory symptomatic patient cases will have a PCR test. Point of Care Testing (POCT) remains within the emergency setting and this is currently led by ED staff. If there is a significant surge in respiratory cases, the service provisions will be reviewed with the medical division.

- Influenza and RSV screening will recommence during the winter period in conjunction with local trends. A specific start date is yet to be agreed (this will include POCT).

Isolation:

- ED/AA isolation – following diagnosis, patients will be moved directly into single sideroom isolation with an ensuite bathroom, patients may be required to be moved to AA to assist with ED flow.

- Patients with the same diagnosis (viral respiratory infections or norovirus) may be co-horted in bays – patients will remain in their current speciality / settings where possible. In the event of a significant surge in respiratory cases, placement of patients maybe specific to an area / ward.

Outbreaks will continue to be declared internally and externally as per the requirement, and meetings will be held in line with PSIRF to identify common themes and learning.

Personal Protective Equipment:

- Viral respiratory infection prevalence is continually monitored. A surge in cases will result in a risk assessment lead by Director of Infection Prevention and Control (DIPC) in relation to FRSM wearing across trust. At present, FRSM is not mandated and is advised on a case-by-case basis.

- Health and Safety team are continually working towards staff being face fit tested – at present all divisions lead of face fit training.

- There are no current or expected supply issues regarding PPE stock.

Cleaning and decontamination:

- Cleaning is continually reviewed alongside trends and a change to chlor clean will be considered for all cleans if there is a surge in infection prevalence or incidence. Correct application of the reviewed cleaning and decontamination policy will be monitored via the Infection Prevention and Control Group and escalated in line with the established process.

Appendix 7: Staff Wellbeing and Support

Ensuring the wellbeing and resilience of our workforce remains a cornerstone of the Trust's Winter Plan. As winter pressures increase demand across the hospital, it is vital that we protect our staff from avoidable stress, burnout and the negative impact of prolonged operational pressure. This section outlines our proactive approach to supporting staff attendance, psychological safety, and sustainable working.

Key Actions for Winter 2025/26:

- **Targeted Wellbeing Communications**
  Regular, concise messages will be shared during peak pressure periods to promote self-care, encourage help-seeking, and signpost to resources. The new Employee Assistance Programme (EAP), which includes access to a dedicated support app, will be central to this campaign.
- **Launch of Enhanced Employee Assistance Programme**
  A new Trust-wide EAP will go live ahead of winter, offering confidential counselling and emotional support to all employees. The service will provide 24/7 access and flexible support channels, including digital options, ensuring timely and responsive help.
- **Drop-In Wellbeing Spaces and Virtual Safe Rooms**
  We will offer staff opportunities to decompress through drop-in wellbeing sessions and virtual "safe spaces." These will enable peer connection, reflection, and psychological decompression during high-pressure periods.
- **Mid-Winter Feedback and Responsive Planning**
  A short staff survey will be conducted mid-winter to understand how teams are coping and whether further support or adaptation is needed. This will allow for a real-time response to emerging issues.
- **Occupational Health Access Improvements**
  We have secured additional OH Physician capacity, meaning staff will experience improved access to appointments and faster, more effective occupational health support.
- **Wellbeing Champions**
  We will continue to develop and grow the network of wellbeing champions across divisions. These staff members provide localised peer support and act as conduits for wellbeing promotion and early escalation of concerns.
- **Promotion of Trust Wellbeing Offer**
  The existing suite of wellbeing tools and resources, available via the staff hub, will be promoted throughout the winter period to ensure high visibility and accessibility.
- **A review of meetings and non urgent admin activity**
  A review of meetings to reduce the length and attendance requirements from front line staff to maximise availability for all to provide front line patient care

These measures reflect our commitment to creating a compassionate, responsive and sustainable workplace. By prioritising staff wellbeing, we strengthen the Trust's ability to maintain safe and effective care throughout the most challenging months of the year.

Appendix 8: Winter Vaccination Plan

The staff vaccination programme will be operational throughout Q3 and Q4 2025/26, and it is not currently clear whether both, COVID-19 and Flu vaccines will be offered. Exact dates and detail of the roll out are yet to be agreed. We are cognisant that vaccine hesitancy affected vaccine uptake during 2024/25 and that current media coverage regarding the COVID-19 vaccine may affect the 2025/26 uptake, if made available.

To ensure high uptake and effective delivery of the winter vaccination programme, the Trust will implement a comprehensive and targeted approach. A bespoke, stand-alone vaccination team will be in place, comprising both substantive staff and bank support, dedicated solely to this programme.

All frontline staff, including those employed through Mitie, will be offered vaccination. A roving team will support accessibility by delivering vaccinations directly within clinical areas and across other Trust sites, reducing the need for staff to leave their work environments.

A robust communications campaign will underpin the programme, clearly outlining the benefits of vaccination—not only for staff themselves, but also for their families and the patients in their care. The campaign will also align with seasonal themes and key events, such as Christmas and Bonfire Night, to promote engagement and increase uptake through special vaccination events.

Progress will be monitored closely, with fortnightly compliance updates shared across the Trust to maintain visibility and momentum. In parallel, we will continue our focus on improving vaccination uptake among pregnant women, particularly in relation to flu and whooping cough, supporting the maternity service's public health responsibilities.

At present, national guidance on the scope of the 2025/26 winter vaccination programme is pending. The Trust will remain responsive to updates, including whether COVID-19 vaccinations will again form part of this year's delivery plan alongside flu.

Appendix 10: Community First Update

Community First: Strategic Improvement Programme Update

Date: 3 July 2025
Prepared by: Nick Conway & Jen Prior

Executive Summary

The Community First Value Stream Analysis (VSA) programme is progressing on schedule, with all 11 improvement cells now in delivery or planning. Key pilots Community Frailty Intervention Team(C-FIT) and Care Home) are launching in Q3 2025, supported by strong system engagement and early signs of impact. Risks are being actively managed, and a full evaluation will be presented in Q3.

1. Programme Overview

The Community First value stream analysis (VSA) is one of our strategic vehicles for transforming out-of-hospital care. The VSA took place in March 2025. Anchored in system-wide collaboration, it aims to reduce hospital demand by designing services around people and place. The event generated 11 active improvement cells (**Appendix 1**), each focused on shifting care upstream and delivering more proactive, integrated care in the community. All cells have now entered delivery or pilot planning phase.

2. Strategic Alignment

The VSA programme aligns directly with the Trust's 2025–28 strategic priorities:

Strategic Objective 1: Our Patients – Deliver the right care, in the right place, at the right time

- **Community Frailty Hub (C-FIT)**: Creating community-based integrated frailty response.
- **Social Care Discharge Team**: Reducing unnecessary care, readmissions, and hospital stays.
- **Care Home Pilot**: Providing early home-based support for deteriorating residents.
- **Timely Step-Up Beds**: Establishing short-stay community beds to avoid hospital admissions.
- **Patient Passport**: Improving care for frequent attenders experiencing DGBI.
- **Self-Referral Process**: Increasing direct patient access and reducing GP appointments.

Strategic Objective 2: Our People – Be a brilliant place to work and thrive

- **Community Navigation Centre**: Simplifying service access to improve staff efficiency.
- **Chronic Pain Pathway**: Supporting GPs and reducing demand on primary care.

Social Prescribing in Discharge: Empowering voluntary sector collaboration, enhancing staff satisfaction and partnerships.

Strategic Objective 3: Our Place – Build innovative partnerships to improve community health

- **Children & Young People in the Community**: Relocating paediatric services to community-based settings.
- **CPTs with Care Coordinators**: Developing neighbourhood-based partnerships and coordinated care teams.
- **Social Prescribing in Discharge**: Collaborating with voluntary sector to enhance community discharge support.
- **Community Navigation Centre**: Establishing a single-access point, strengthening integration and partnerships.

Multi-Year Commitments Supported:

Shift care from hospital to community (C-FIT, Step-Up Beds, Care Home Pilot, Children & Young People)

Value our people (Social Care Discharge Team, Chronic Pain Pathway)

Make best use of our resources (Community Navigation Centre, Self-Referral Process)

Improve speed of access to planned care (Timely Step-Up Beds, Self-Referral Process)

Develop thriving partnerships (Social Prescribing in Discharge, CPTs with Care Coordinators)

3. Improvement Event Progress Summary

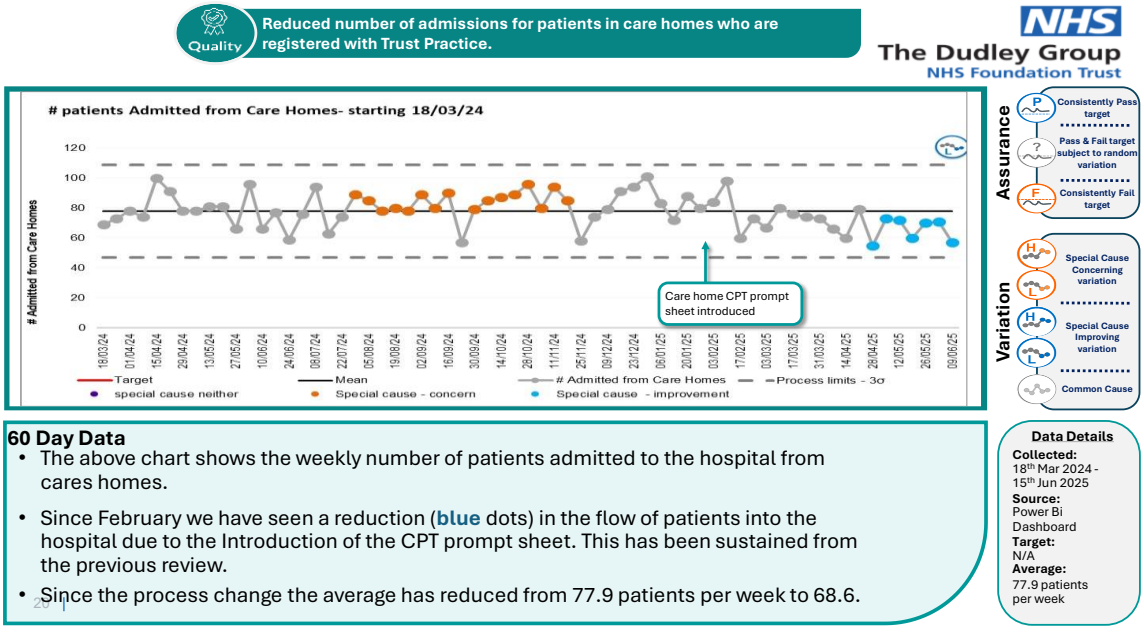
Activity	Date(s)	Status	Outcome Summary
Value Stream Analysis (VSA)	31st March – 4th April 2025	✅ Complete	11 system-level improvement projects identified.
Improvement Event #1 – Care Home Pilot	12-16th May 2025	✅ Complete	Design finalised; pilot launch scheduled for 1/09/2025.
Improvement Event #2 – Community Frailty Intervention Team (C-FIT)	7–11 July 2025	✅ Complete	Design finalised; C-FIT pilot established provisional date for launch 06/08/205
Improvement Event #3 – Community Partnership Teams (CPT)	13–17 October 2025	To commence planning August 2025	N/A

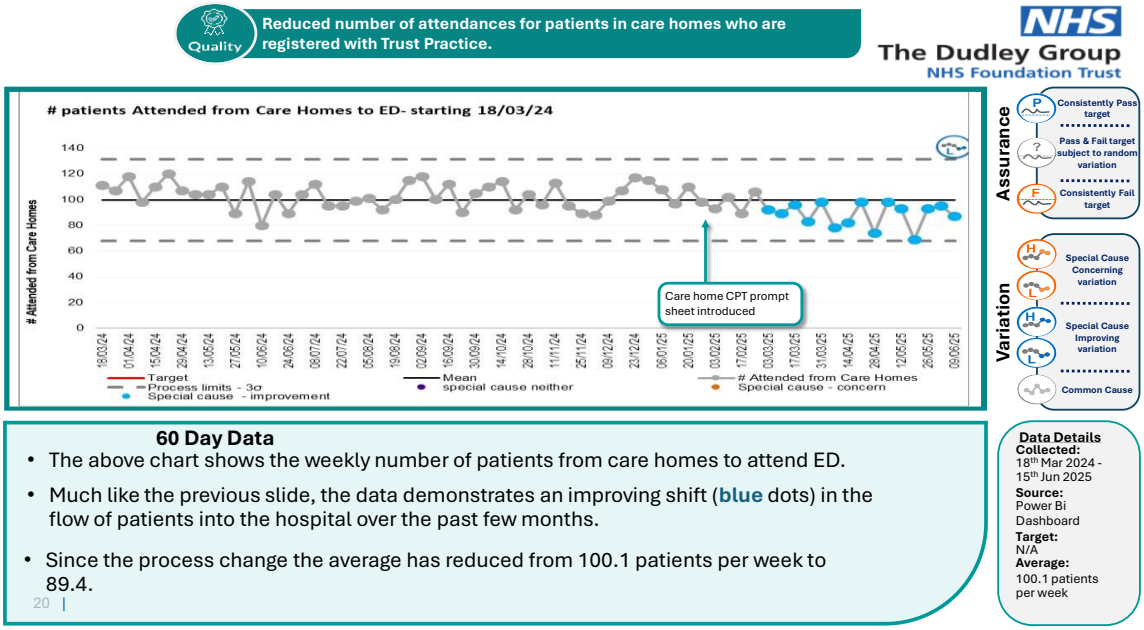
4. Key Highlights & early Improvements

System Engagement: Over 60 stakeholders involved across health, care, voluntary sector, and lived experience.

Data-Driven Design: Evidence of reduced care home admissions following initial prompt sheet test (figure 1 & 2).

Strong Foundations: Pilot teams and governance structures are in place to support delivery and monitor progress.





60 Day Data

- The above chart shows the weekly number of patients from care homes to attend ED.
- Much like the previous slide, the data demonstrates an improving shift (**blue** dots) in the flow of patients into the hospital over the past few months.
- Since the process change the average has reduced from 100.1 patients per week to 89.4.

20 |

Data Details
Collected: 18th Mar 2024 - 15th Jun 2025
Source: Power Bi Dashboard
Target: N/A
Average: 100.1 patients per week

5. Risks & Mitigations

Risk	Rating	Mitigation Strategy
Limited data access delays improvement planning	! Medium	Escalated to Informatics – resolution in progress.
90-day review cancelled due to power failure at Brierley Hill Health Centre. Potential loss of oversight of improvement projects and delays to updates	! Medium	New date booked for review.

6. Next Steps

• **C-FIT launch:** Pilot launch 6th August 2025. Commence testing and track data
• **Care Home Pilot Launch (Sept):** Commence testing and establish real-time evaluation framework.
• **Programme Evaluation:** Early indicators of impact to be shared in Q3 for Integration Committee and Dudley Care Partnership Board.

6. Appendices

Appendix 1. Improvement Cells

Cell	Aim	Lead(s)	Update Summary
Community Frailty Intervention Team (C-FIT)	Event completed July 7–11. To create integrated community-based response for frailty.	Karen Hanson	Second implementation even along the Community First Value Stream completed; action plan defined, owners allocated, interim actions underway. Provisional date for pilot launch 06/08/2025
Patient Passport	We aim to provide passports for patients with frequent attendance	Dr John Frost	Engagement progressing, Joe

	to hospital with symptoms of disordered gut brain interaction (DGBI). Frequency 3 or more visits in 6 months by the end of September 2025		Taylor involved; delivery planning ongoing.
Children & Young People in the Community	Relocate 75% paediatric services to Merry Hill by Sept '25.	Karen Anderson	Services confirmed (GI, ADHD, Respiratory, Epilepsy). Equipment/HEAT checks complete; phlebotomy support in scoping phase.
Social Care Discharge Team	Reduce unnecessary care, readmissions, and hospital stays by joining ward rounds and quickly identifying patients needing care packages early. Target: reduce by x% from baseline.	Sharon Symonds	14/5/25 Greg Marson leading Care Transfer Hub (CTHub), linking this project with wider agencies. CTHub presented to Execs. Reduced P3s.
Care Home Pilot	Home-based support for deteriorating residents by Oct '25.	Dr Lucy Martin	Pilot begins Sept 1; charter co-produced; executive and care association engagement underway; winter scale-up being explored.
Timely Step-Up Beds	Establish short-stay community beds to avoid unnecessary hospital admission.	Jenny Cale	Model approved; 18 beds identified; delivery planning initiated.
Chronic Pain Pathway	Reduce GP attendances by 30% for patients with chronic pain/fibro by April 2026.	Kelly Houseman, Anneka Page	Pilot scheduled with 2 PCNs; lived-experience group engaged.
Self-Referral Process	Free up 15% of GP appointments via direct access by Sept 2025.	Helen Blakemore	Pilot launching with maternity service; aligned with maternity pathway redesign.
Social Prescribing in Discharge	Establish Voluntary Care Sector-led discharge support model by March 2026.	Kate Green (CVS)	Proposal completed; funding being pursued; collaboration with Volunteering for Health initiated.
Community Navigation Centre	Create a single point of access for all services by March 2026.	Amandeep Tung-Nahal	Phase 1 soft-launched July 1; staffing in place; phase 2 expansion in planning; addressing GP engagement and data-flow risks.

CPTs with Care Co-ordinators	Develop neighbourhood-based Community Partnership Teams by March 2026.	Sally Cornfield	Awaiting risk stratification pilot; workshop scheduled July 23; ongoing CPT development work.

Appendix 11: Community Services Update

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NHS 10-Year Plan

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The NHS 10-Year Plan and the accompanying Performance Assessment Framework for 2025/26 outline a comprehensive set of Key Performance Indicators (KPIs) and metrics for community services and other NHS providers.

Key priorities:

- Prevention
- Personalised care
- Digital Transformation
- Workforce
- Integration
- Financial Sustainability

Key elements relevant to Community services:

- Hospital to Community – Shifting care closer to home
- Analogue to Digital – Embracing digital transformation
- Sickness to prevention – focusing on proactive, preventative care

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What Does the Plan Mean for Shifting Care from Hospital to Community?

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National Context

The plan commits to reducing hospital spend and expanding **Neighbourhood Health Services** , beginning in areas of greatest need. It introduces new GP contracts and calls for integrated, community -focussed care.

DGFT Strategic Alignment:

- **Shifting care from hospital to community** is the first of our commitments within the new strategy.
- Resources from **Dudley Improvement Practice** have been prioritised to support **'community first'** with a value stream analysis in April.
- Dudley has long-established **Community Partnership Teams** involving professionals from different agencies developing pro-active approach to care management. These are well -placed to evolve into **Neighbourhood health services.**
- We already provide **support and development to PCNs** via the Place division.
- A successful **Community Diagnostic Centre** has been running for the past 3 years.
- Planning has started to shift more outpatient care out of hospital starting with more services being provided from Merry Hill Centre and the Family Hubs.

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What Does the Plan Mean for Prevention & Population Health?

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National Context

The plan includes:

- National prevention accelerators for Cardiovascular Disease and Diabetes
- Genomics-based early detection
- Neighbourhood-led public health delivery
- Integration of employment advisers in care teams
- Targeted action to reduce health inequalities

DGFT Strategic Alignment:

- Our third strategic objective to 'build innovative partnerships **to improve the health of our communities** ' makes our commitment to prevention and population health explicit.
- Trust is a key partner in the Dudley Health and Care Partnership which has shared objectives to improve **vaccination and screening** and increase **local employment**.
- Colleagues in Place division already working with primary care on improving prevention for cardiovascular disease and diabetes.

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Performance – 10 Year Plan Metrics
Urgent Community Response (UCR): 2 -hour Response
Sustained performance above 70%national target

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UCR Performance

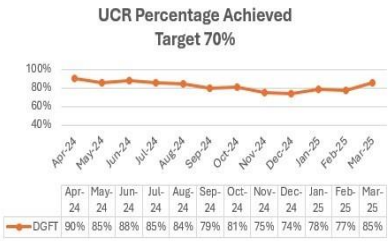
The service continues to maintain delivery of 70% KPI of referrals being seen within 2 hours of referrals

85% achieved in March 2025

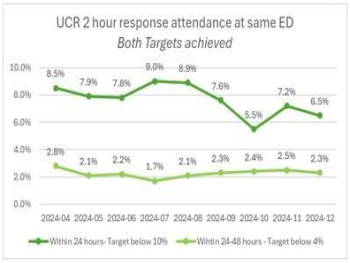
The no of ED Admissions within 24 & 24-48 hours of UCR intervention has been achieved and remains below defined targets

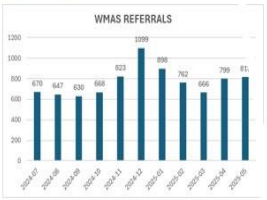
There was a small increase in All WMAS referrals in April & June

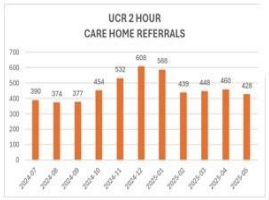
2 hour UCR referrals from Care Homes average around 443 per month over the last 4 months Feb-May 25



	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
DGFT	90%	85%	88%	85%	84%	79%	81%	75%	74%	78%	77%	85%







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Performance – Community services 52 weeks compliance – 10 Year Plan Metrics

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- Total of 4251 patients waiting for community services with the average mean wait of 10 weeks
- All services are meeting 52 weeks
- 90.2% of patients seen within 18 weeks

Service	Patients Waiting	0-1 week	1-2 weeks	2-4 weeks	4-12 weeks	12-18 weeks	18-52 weeks	52-104 weeks	>104 weeks	Mean Waiting Time Weeks
Neurology	50	0	5	8	27	6	4	0	0	6
DABBS (Continence)	744	92	40	122	228	153	109	0	0	14
Stroke	18	3	3	8	3	1	0	0	0	2
Speech & Language	83	6	12	23	30	11	1	0	0	10
Dietetics	139	0	5	26	85	21	2	0	0	17
Podiatry	721	1	99	123	205	120	173	0	0	13
CMAPS (MSK Physio)	2496	1791	14	18	205	342	126	0	0	12

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Performance Overview - Community services

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Service Type	Area	Compliance
Home based care	OBI/ Intermediate Care	OBI had an average of 109 referrals per month in April/May 34.5% of OBI contacts in May were 2 hour urgent and 19.3% same day On average 44 referrals per month (based on data December-May)
	District Nursing	Service report 2635 patients on the caseload in May 2025 On average the service has 14,800 contacts per month
	End of Life Team	On average the service has 340 contacts per month
Community Clinics	Referrals	Community Services received 102,000 referrals in 2024/25. Average of 8600 per month
	Wait Times	The total community waiting list is 4251 in May (Source: SITREP) 58% of these are CMAPS No patients are waiting above 52 weeks 9.8% of patients are waiting over 18 weeks
	DNA/Cancellation	DNA rates for Community services are all under 5% except for DABBS - Dudley Adult Bladder and Bowel Service at 5.9% in May 2025 Note: 5 less DNAs would meet 5% target
Attendance Avoidance - Navigation SPA	Call pick-up times	2721 - Number of calls to SPA in May This includes 109 for EOL Average speed to answer calls was 01:55 mins EOL average speed to answer calls was 01:11 mins 89.6% of calls were answered Of all calls received (including those declined) - 5.1% in May were signposted to ED 73.1% of calls WMAS on scene were diverted from ED

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Care Navigation Centre (CNC) – expansion of the current single point of access

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- Development of a Care Navigation Centre (CNC) is one of the priorities for Community services, as part of the non-elective workstream, shifting services from hospital to Community in line with the NHS10 year plan
- This involves expansion of the current Single Point of Access in the Dudley Clinical HUB, to increase capacity to take referrals (from 31,761 pa to an expected 43,446 pa) and direct patients to SDEC, hot clinics and virtual wards. This is expected to reduce attendance at ED by 11,685 per year and subsequent admissions to the bed base. This is made up of:

- Ambulance category 4 & 5 calls including from care homes diverted (1753 pa)
- Surgical walk-ins between 8am – 8pm diverted (9,932 pa)

- The investment does not increase the hours of availability but does increase capacity to take and process referrals. The CNC will support all patients living in Dudley regardless of whether they are registered with a Dudley GP or not.

- **Phase 1: 1st September 2025**

Referrals from WMAS, Care homes, Primary care, NHS 111, Local authority and any healthcare professional.

- **Phase 2 : January 2025 (date tbc)**

As above with inclusion of referrals from patients and carers known to community services (currently being picked up at individual service level so need co-locating to CNC to deliver a 'true' Single point of Access).

- **Communication Plan**

Working with Trust Communications department and Place division to develop a Comms plan to engage with Primary care and ensure utilisation of the CNC.
Care home engagement event planned for September 2025.

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Care Navigation Centre (CNC) – update

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Staffing:

- Recruitment: Community Navigator in ED 2.73wte advertised, 2.64wte recruited, 0.09wte remaining
- SPA clinician – 5.24wte advertised, 2wte recruited, 3.24wte remaining
- Total 3.33wte to readvertise
- Staffing rota completed and agreed with finance
- New & current starter training plan finalised

Benefits realisation:

- Closure of 16 beds overnight discharge lounge – interoperability with the Care Transfer Hub (CTH), to coordinate discharges and prevent admissions by optimising use of Community Services
- ED performance opportunity for 4hrs for Type 1 activity only: Maximum improvement opportunity 5.7%
- Ambulance Handover impact- average handovers in minutes saved (1,753 less in ED): Total opportunity 4.2%
- ED Community Navigator shadowing data w/c 19/06/25 for 5 days: 182 Patients reviewed - 20 patients of which could have been navigated from ED = 10.98%

Pathway development:

- Soft launch of the 'step up' pathways from CNC to AMU Virtual Ward and Heart Failure clinic live since 7th July 2025
- DVT pathway to go live for soft launch August 2025
- Surgical pathway – Emergency surgical HUB, Urology, – go live date 1st September 2025.
- Trauma & Orthopaedics, Gynaecology pathways to be set up following ESH and Urology. Initial meetings with clinicians planned for w/c 4th of Aug 2025

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Collaboration with community teams across the Black Country

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Out of Hours (OOH) West Midlands Ambulance Service(WMAS) referrals:

Since June a pilot has been running with Wolverhampton hostinga OOH single point of referral for WMAS referrals via the CAD (Computer Aided Dispatch) portal for all UCR teams across the black country between the hours of 6.30 8.00am. The Wolverhampton CNC triage referrals for all teams and advice or signpost and 'stack' referrals as appropriate so individual teams can review patients at start of the respective hours of service.

Single South CNC for patients and carer referrals:

- Currently working with Sandwell CNC to scope the development of a single CNC for the south of the borough (all Sandwell and Dudley residents) to accept referrals from patients and carers known to community services to support triage and signposting for treatment to the right services across Sandwell and Dudley
- Single point of access in Dudley currently supports the triage of out of area (Sandwell) referrals to signpost and reduce declined referrals.

Aligning performance reporting:

Working with Sandwell to align reporting of Community performance metrics, along with review of gaps in service provision and commissioning arrangements.

Shared Standing Operating Procedures (SOPs)/protocols:

Working with Sandwell and other UCR teams to align community pathways across the areas, sharing SOPs and policies and learning to ensure standardization of services across the black country where possible.

Appendix 12: Quality and Equality Impact Assessment

Quality Impact Assessment

Patient Safety

• Positive impacts: Strengthened discharge planning (Care Transfer Hub, MADE, bridging packages), commitment to avoiding corridor care, strong Infection Prevention & Control measures.

• Risks: High bed occupancy and reliance on temporary surge capacity may compromise safety.

• Mitigations: Robust risk register, executive oversight, SOPs for safe use of surge areas.

Clinical Effectiveness

• Positive impacts: Use of virtual wards, respiratory hubs, GIRFT/ECIST recommendations, benchmarking against national LOS standards.

• Risks: Dependence on productivity workstream delivery; failure to reduce LOS risks flow blockages.

• Mitigations: LOS dashboard monitoring, external support (Newton), divisional accountability.

Patient Experience

• Positive impacts: Reduced ambulance delays and ED waits, care closer to home (CNC, ARI hubs, voluntary transport).

• Risks: Surge use (e.g., discharge lounge) may affect dignity; communication barriers for vulnerable groups.

• Mitigations: Accessible comms plan, patient-centred discharge planning, voluntary/faith sector support.

Workforce & Operational Impact

• Positive impacts: Staff wellbeing initiatives (enhanced EAP, wellbeing champions, safe rooms).

• Risks: Reliance on bank/agency staff; financial constraints may limit mitigation delivery.

• Mitigations: Workforce planning in service-level plans, staff wellbeing embedded.

Equality Impact Assessment

Age

• Positive: Frailty and paediatric pathways strengthen support.

• Risks: Older people may be disproportionately impacted by delayed discharge.

• Mitigations: Bridging packages, care home RESPECT reviews, strong partnership with DMBC.

Disability

• Positive: Virtual wards and CNC reduce travel burden; pharmacy supports safe discharge.

• Risks: Patients with LD/complex needs may struggle with pathway changes.

• Mitigations: Ensure reasonable adjustments and LD liaison input.

Race / Ethnicity

• Risks: Language barriers may reduce engagement with CNC, ARI hubs, vaccination.

• Mitigations: Use voluntary/faith groups for communication, translation/interpreting provision.

Pregnancy & Maternity

• Risks: Winter surge could impact maternity and elective capacity.

• Mitigations: Protect elective throughput via early scheduling and ‘Super Saturdays’.

Health Inequalities

• Positive: CNC and ARI hubs support deprived communities.

• Risks: Digital exclusion if reliance on online access.

• Mitigations: Multiple access routes (phone, GP, WMAS referral).

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Workforce KPI Report
July 2025

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Summary

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Metric	Rate	Target	Trend	
Absence – In Month	5.68%	<=5%	↑	**Sickness Absence** In-month sickness absence for July 2025 is 5.68% an increase from 5.07% in June 2025. The rolling 12-month absence has increased to 5.36 in July 2025 from 5.35% in June 2025.
Absence - 12m Rolling	5.36%	<=5%	↑	
Turnover	6.66%	<=8%	↓	**Turnover** Turnover (all terminations) has decreased from 7.06% in June 2025 to 6.66% in July 2025. Normalised Turnover has decreased from 2.99% in June 2025 to 2.82% in July 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.
Normalised Turnover	2.82%	<=5%	↓	
Retention (12 month)	92.9%	>=80%	↑	**Retention** The 12-month retention rate has slightly increased to 92.9% from 92.8% last month
Vacancy Rate	9%	<=7%	↓	**Vacancy Rate** In July 2025 the vacancy rate decreased to 9%, down from 10% in June 2025.
Mandatory Training	93.56%	>=90%	↑	**Mandatory Training** Statutory Training increased from 93.45% in June 2025 to 93.56% in July 2025. Overall, it has remained above 90% target for a sustained period.
Appraisals	92%	>=90%	↑	**Annual reviews** The annual review window closed for reporting on 30th June. Final dashboards are now reflecting the completion rate at 92%, above target.

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Sickness Absence

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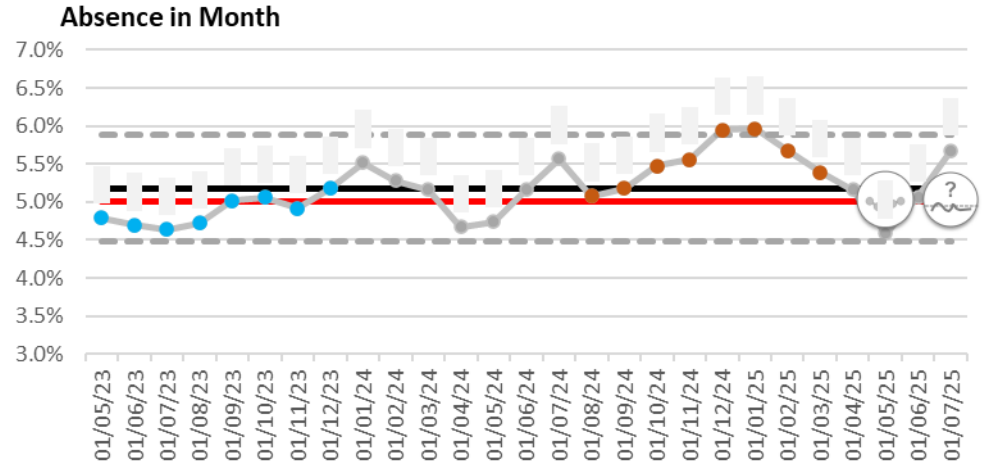
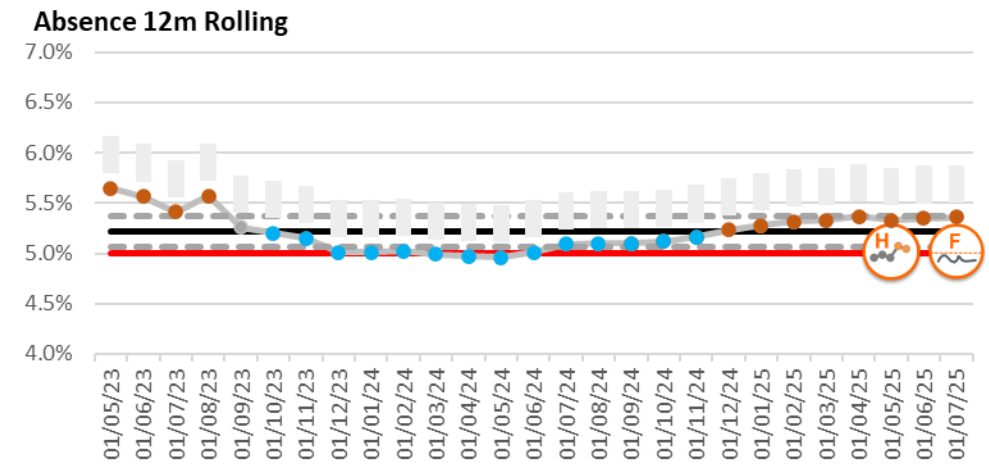




In-Month Sickness Absence

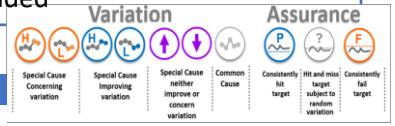
In-month sickness absence for July is 5.68%, an increase from 5.07 % in June 2025.

Rolling 12 M Sickness Absence

The rolling 12-month absence for July 2025 is 5.36%, compared with 5.35% in June 2025.

Assurance
There are a number of mitigations currently in place to support the continued reduction of absence:

- Sickness Reduction taskforce in place
- Recording sickness absence training continues to be delivered
- Focusing on ensuring return to work interviews are undertaken and recorded
- Dedicated managing absence section with guides and toolkits on the hub
- Targeted interventions in hot spot areas through coaching and intense support for managers in those areas
- Top 10 long term absences subject to confirm and challenge
- Enhanced OHP provision
- New EAP provider launched
- Wellbeing journey well embedded



	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25
Absence in Month	5.08%	5.18%	5.47%	5.56%	5.95%	5.96%	5.68%	5.39%	5.16%	4.59%	5.07%	5.68%
Absence 12m Rolling	5.10%	5.10%	5.12%	5.16%	5.23%	5.28%	5.31%	5.33%	5.37%	5.33%	5.35%	5.36%

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Long-Term and Short-Term Absence

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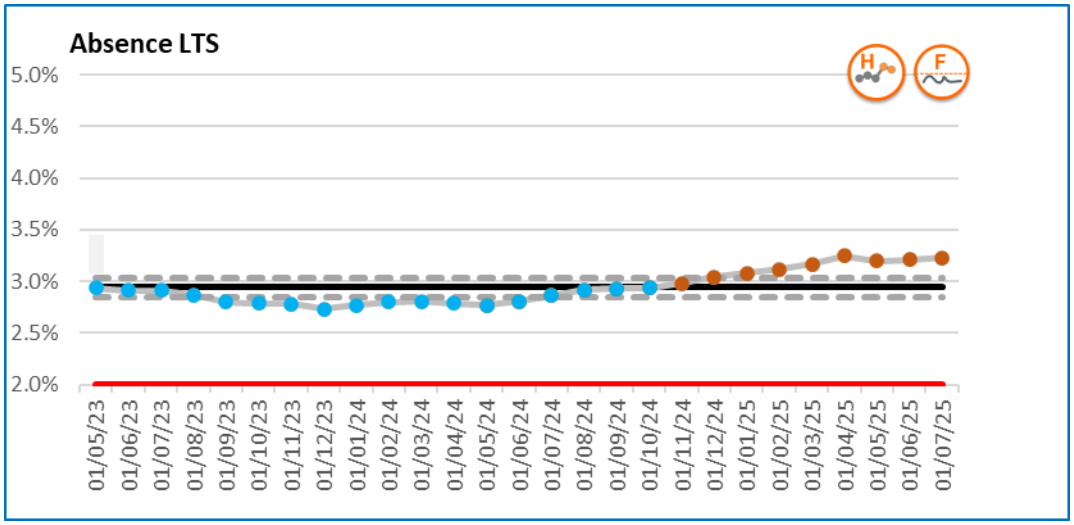

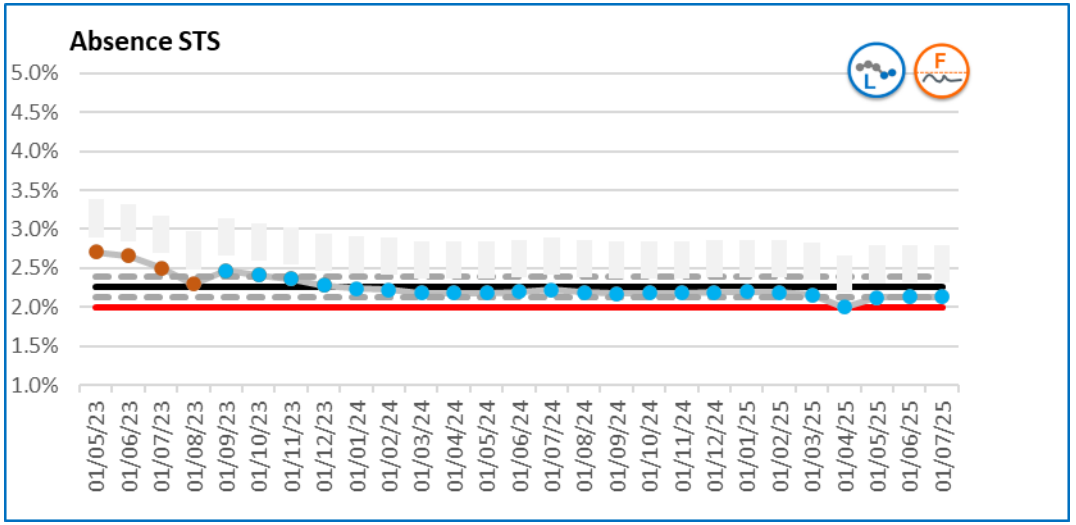

Long-term sickness absence has increased very slightly from 3.21% in June 2025 to 3.22% in July 2025. Short-term has remained static at 2.13%.

In July 2025 short-term absence accounted for 82% of all sickness absence episodes, with long-term absence (28 days +) accounting for 18% of absence episodes. Long-term absence accounted for 55% of all FTE days lost.

As of end of July 2025 there were 138 long-term absences open across the Trust.

- 120 cases are between 28 days and 6 months
- 14 cases between 6 months and 12 months
- 4 cases 12 months or more in length

What next

- Extending the Top 10 reviews to departments with – Top 10 FTE days lost, Top 10 highest number of episodes and Top 10 highest % - subject to confirm and challenge
- Review and rewrite of Trust policy
- Continued implementation of return-to-work compliance monitoring
- Spot sickness file audits by HR
- Promote new EAP service

	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25
Absence LTS	2.92%	2.93%	2.94%	2.98%	3.04%	3.08%	3.12%	3.17%	3.25%	3.20%	3.21%	3.23%
Absence STS	2.19%	2.17%	2.18%	2.18%	2.19%	2.20%	2.19%	2.16%	2.00%	2.12%	2.13%	2.13%

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Sickness Absence – Staff Groups

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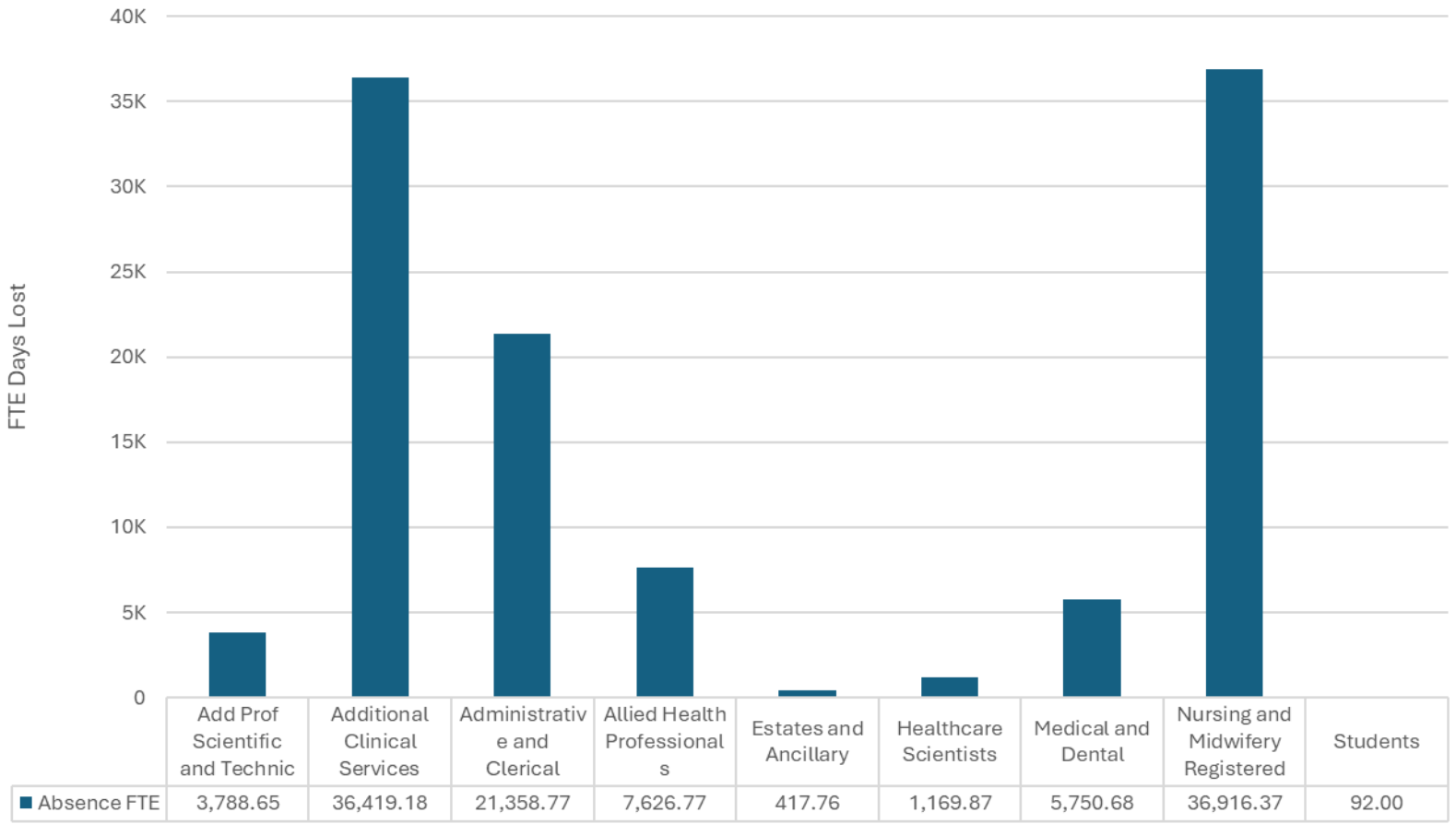

	Add Prof Scientific and Technic	Additional Clinical Services	Administrative and Clerical	Allied Health Professionals	Estates and Ancillary	Healthcare Scientists	Medical and Dental	Nursing and Midwifery Registered	Students
Absence FTE	3,788.65	36,419.18	21,358.77	7,626.77	417.76	1,169.87	5,750.68	36,916.37	92.00

Year-to-date Nursing and Midwifery and Additional Clinical Services have lost the most FTE days as a result of sickness absence. Proportionately admin and clerical staff have a high rate of sickness absence.

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Sickness Absence – Staff Groups

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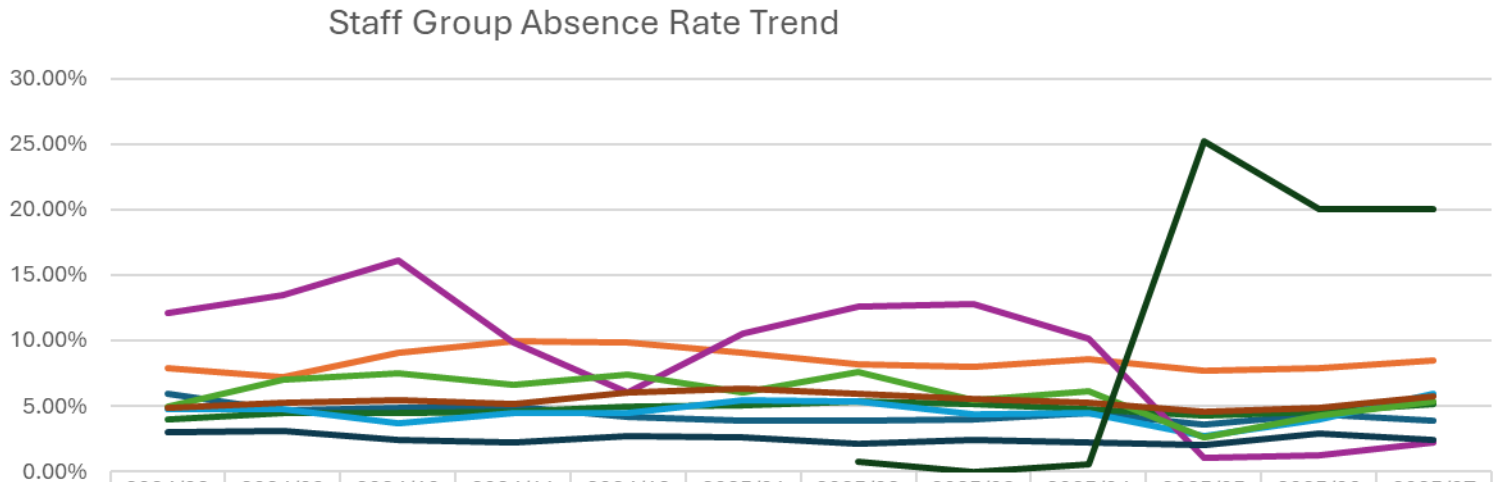

	2024/08	2024/09	2024/10	2024/11	2024/12	2025/01	2025/02	2025/03	2025/04	2025/05	2025/06	2025/07
Add Prof Scientific and Technic	5.97%	4.61%	4.89%	4.91%	4.18%	3.88%	3.88%	3.99%	4.46%	3.61%	4.41%	3.92%
Additional Clinical Services	7.86%	7.22%	9.08%	9.90%	9.84%	9.07%	8.19%	7.97%	8.57%	7.71%	7.84%	8.47%
Administrative and Clerical	3.93%	4.47%	4.42%	4.52%	4.91%	5.06%	5.32%	5.10%	4.74%	4.27%	4.60%	5.17%
Allied Health Professionals	4.76%	4.73%	3.70%	4.49%	4.49%	5.43%	5.37%	4.37%	4.45%	2.69%	4.02%	5.90%
Estates and Ancillary	12.10%	13.45%	16.07%	9.89%	6.05%	10.53%	12.55%	12.83%	10.13%	1.01%	1.27%	2.16%
Healthcare Scientists	4.93%	6.98%	7.44%	6.56%	7.44%	6.01%	7.60%	5.48%	6.15%	2.61%	4.30%	5.36%
Medical and Dental	2.96%	3.09%	2.37%	2.22%	2.67%	2.59%	2.14%	2.39%	2.21%	2.00%	2.90%	2.39%
Nursing and Midwifery Registered	4.82%	5.24%	5.42%	5.12%	5.99%	6.30%	5.97%	5.54%	5.28%	4.53%	4.90%	5.78%
Students							0.71%	0.00%	0.55%	25.16%	20.00%	20.00%

In July 2025 absence rates for all staff groups increased except for Medical and Dental and Add Prof Scientific and Technic.

The biggest increase was within Allied Healthcare Professionals and Healthcare Scientists.

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Reason for Absence

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Top 10 Absence Reasons by FTE Days Lost

Absence Reason	Headcount	Abs Occurrences	FTE Days Lost	%
S10 Anxiety/stress/depression/other psychiatric illnesses	839	1,093	27,374.07	24.1
S25 Gastrointestinal problems	2181	3,051	11,949.15	10.5
S13 Cold, Cough, Flu - Influenza	2421	3,209	11,839.04	10.4
S12 Other musculoskeletal problems	569	735	10,542.38	9.3
S99 Unknown causes / Not specified	679	889	7,393.21	6.5
S28 Injury, fracture	232	254	5,818.66	5.1
S11 Back Problems	353	412	5,534.59	4.9
S30 Pregnancy related disorders	267	715	5,513.86	4.9
S26 Genitourinary & gynaecological disorders	396	509	5,345.40	4.7
S17 Benign and malignant tumours, cancers	44	64	3,369.75	3.0

Top 10 Absence Reasons by Absence Days

Absence Reason	Headcount	Abs Occurrences	Abs Days	%
S10 Anxiety/stress/depression/other psychiatric illnesses	839	1,093	32,608	24.6
S25 Gastrointestinal problems	2181	3,051	13,617	10.3
S13 Cold, Cough, Flu - Influenza	2421	3,209	13,500	10.2
S12 Other musculoskeletal problems	569	735	12,505	9.4
S99 Unknown causes / Not specified	679	889	8,670	6.5
S28 Injury, fracture	232	254	6,949	5.2
S11 Back Problems	353	412	6,459	4.9
S26 Genitourinary & gynaecological disorders	396	509	6,313	4.8
S30 Pregnancy related disorders	267	715	6,195	4.7
S17 Benign and malignant tumours, cancers	44	64	3,879	2.9

- Anxiety/Stress/Depression/Other Psychiatric illness continues to be the top reason for absence that causes the greatest number of FTE days lost and Cough Cold Flu is the second highest reason.
- Cough, Cold, Flu is the top reason for absence that has the highest number of occurrences followed by gastrointestinal problems.
- The taskforce groups are working with areas that have high short-term sickness absence and reducing the number of episodes through ensuring managers have the tools, support and resources to manage sickness absence at the earliest opportunity.

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Absence Benchmarking

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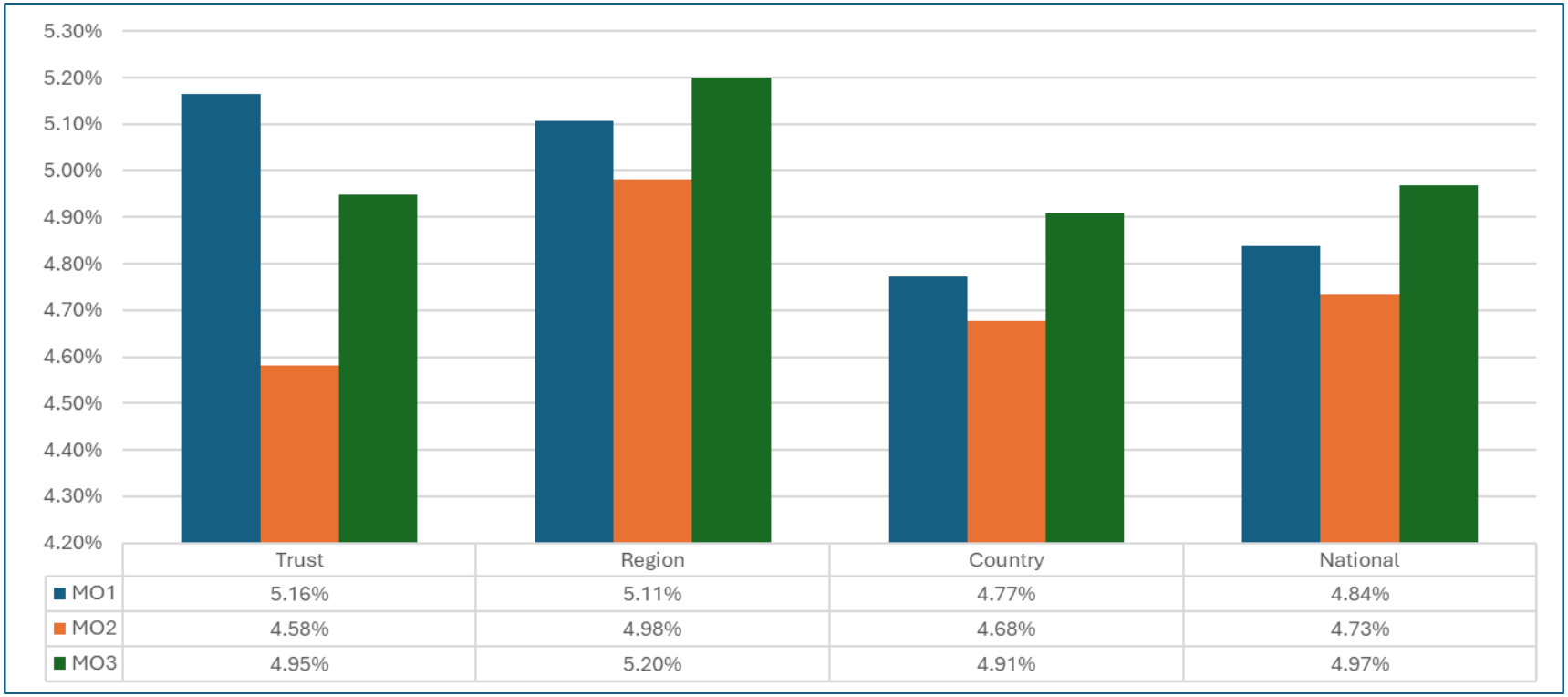

	Trust	Region	Country	National
MO1	5.16%	5.11%	4.77%	4.84%
MO2	4.58%	4.98%	4.68%	4.73%
MO3	4.95%	5.20%	4.91%	4.97%

- National and Regional benchmarking data is only available until end of June 2025.
- Due to local differences in timeframes and methods used for recording sickness absences, national and regional comparative data is subject to change. DGFT absence includes COVID related absences and is refreshed each month twelve months in arrears.
- In June 2025 (M03) the Trust's sickness absence rate was lower than the Region and Nationally, but higher than the Country.

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Recruitment/Vacancies/Turnover - TRUST

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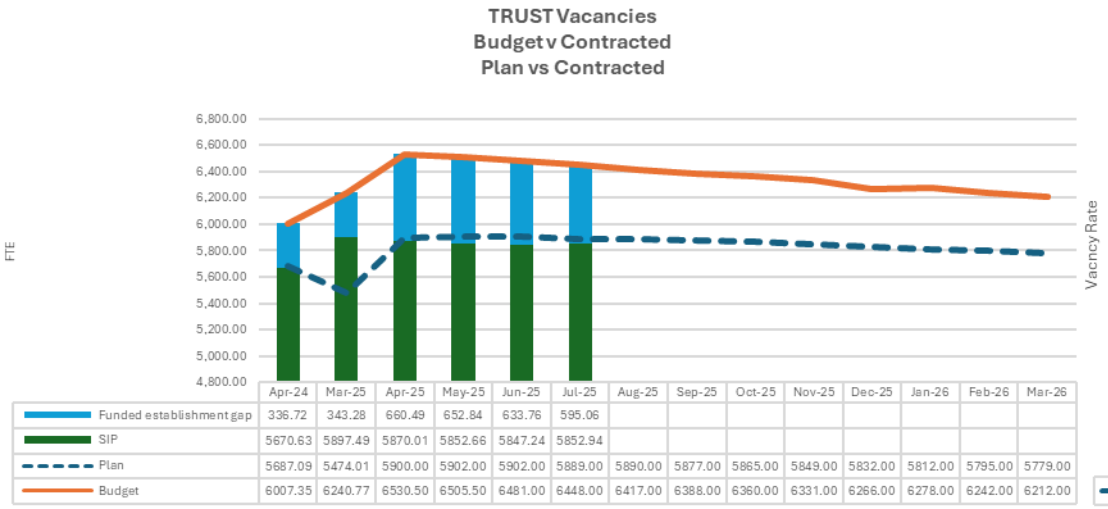
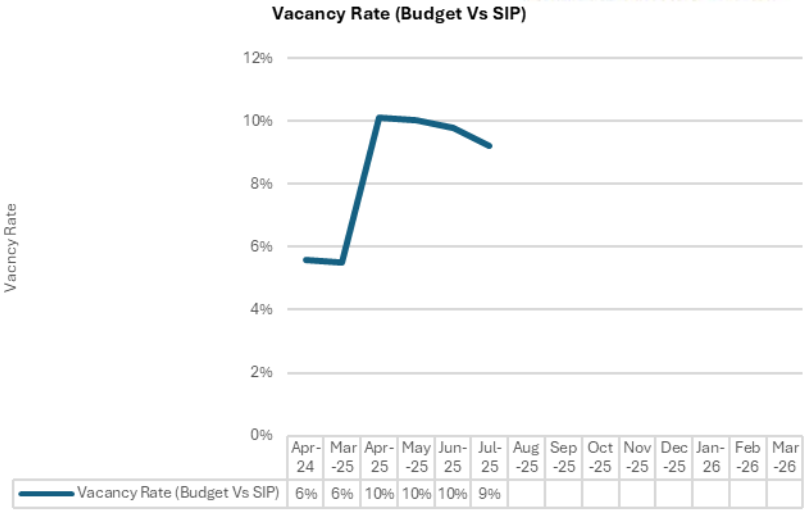
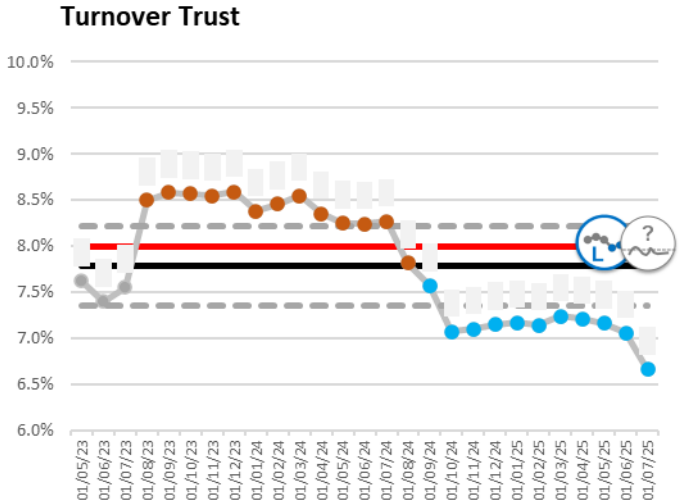
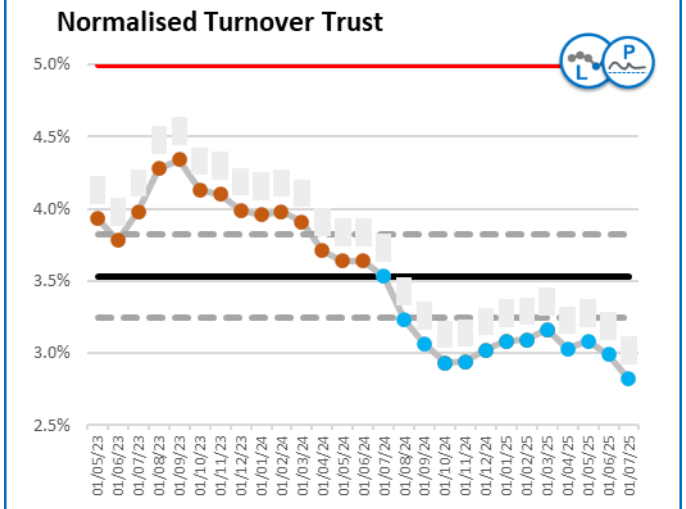


	Apr-24	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Funded establishment gap	336.72	343.28	660.49	652.84	633.76	595.06								
SIP	5670.63	5897.49	5870.01	5852.66	5847.24	5852.94								
Plan	5687.09	5474.01	5900.00	5902.00	5902.00	5889.00	5890.00	5877.00	5865.00	5849.00	5832.00	5812.00	5795.00	5779.00
Budget	6007.35	6240.77	6530.50	6505.50	6481.00	6448.00	6417.00	6388.00	6360.00	6331.00	6266.00	6278.00	6242.00	6212.00



	Apr-24	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Vacancy Rate (Budget Vs SIP)	6%	6%	10%	10%	10%	9%								





Contracted WTE staff has increased from 5847.24 WTE in June 2025 to 5852.94 WTE in July 2025.

For substantive staff this is 36.06 WTE below the workforce plan (less staff than we said we would have).

Total vacancies stand at 595.06 WTE in July 2025. This equates to a vacancy rate of 9%.

Overall staff turnover (rolling twelve months average) is at 6.66% with normalised turnover at 2.82% in July 2025.

	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25
Trust Turnover	7.82%	7.57%	7.07%	7.10%	7.15%	7.17%	7.14%	7.24%	7.21%	7.16%	7.06%	6.66%
Trust Normalised Turnover	3.23%	3.06%	2.93%	2.94%	3.02%	3.08%	3.09%	3.16%	3.03%	3.08%	2.99%	2.82%

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Recruitment/Vacancies/Turnover - Registered Nursing & Midwifery

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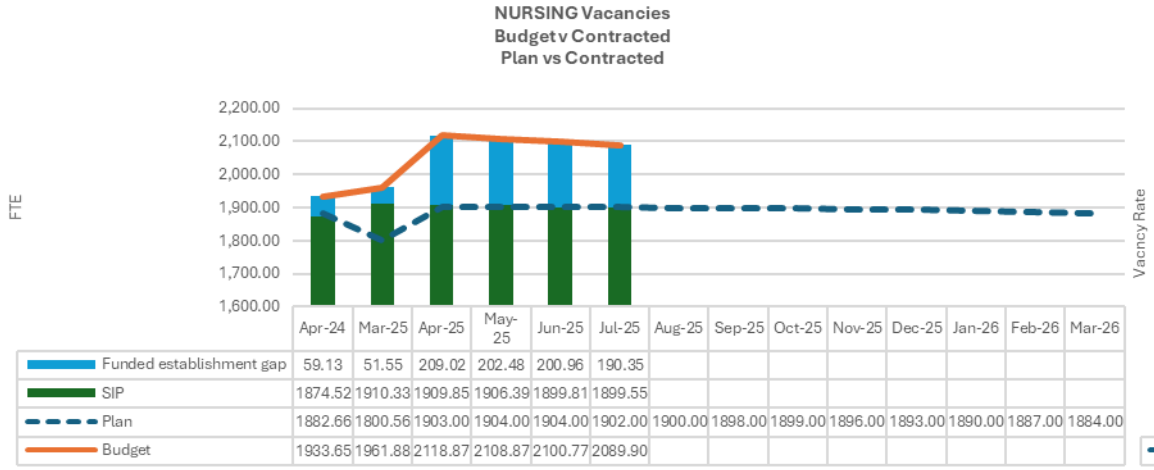
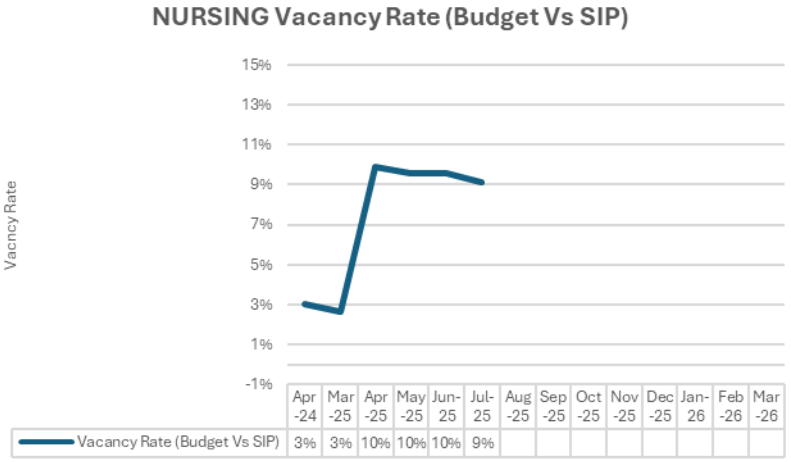
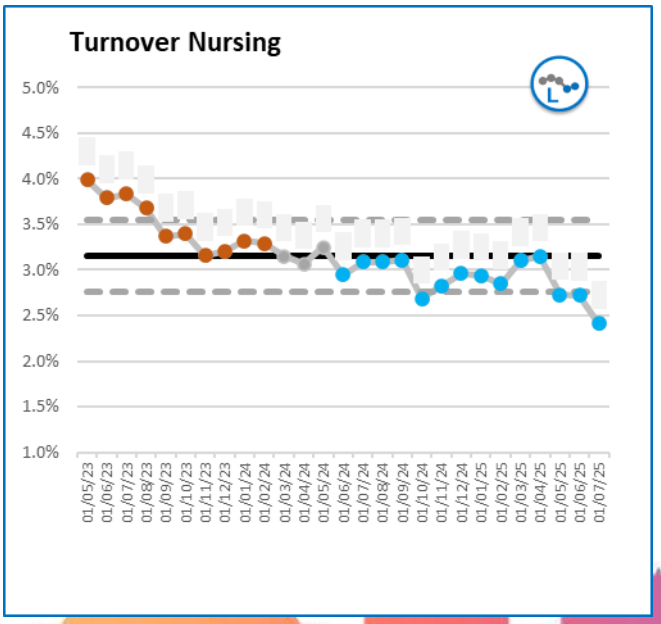
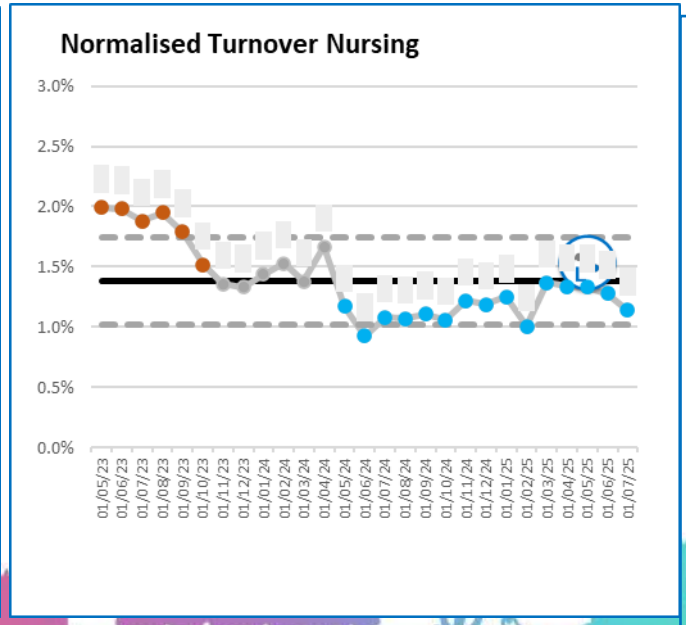


	Apr-24	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Funded establishment gap	59.13	51.55	209.02	202.48	200.96	190.35								
SIP	1874.52	1910.33	1909.85	1906.39	1899.81	1899.55								
Plan	1882.66	1800.56	1903.00	1904.00	1904.00	1902.00	1900.00	1898.00	1899.00	1896.00	1893.00	1890.00	1887.00	1884.00
Budget	1933.65	1961.88	2118.87	2108.87	2100.77	2089.90								



	Apr -24	Mar -25	Apr -25	May -25	Jun-25	Jul-25	Aug -25	Sep -25	Oct -25	Nov -25	Dec -25	Jan-26	Feb -26	Mar -26
Vacancy Rate (Budget Vs SIP)	3%	3%	10%	10%	10%	9%								





Contracted WTE for nursing and midwifery staff in July 2025 was 1899.55 WTE, compared with 1899.81 WTE in June 2025.

This is 2.45 WTE below the workforce plan (less staff than we said we would have).

The total nursing and midwifery vacancies reported stands at 190.35 WTE, which equates to a vacancy rate of 9%.

Staff turnover for nursing (rolling 12 months average) is at 2.41%, with normalised turnover at 1.14% in July 2025.

	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25
Nursing Turnover	3.09%	3.11%	2.69%	2.83%	2.96%	2.94%	2.85%	3.10%	3.15%	2.73%	2.72%	2.41%
Nursing Normalised Turnover	1.07%	1.11%	1.06%	1.22%	1.19%	1.25%	1.01%	1.37%	1.34%	1.33%	1.28%	1.14%

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Recruitment/Vacancies/Turnover - Medical & Dental

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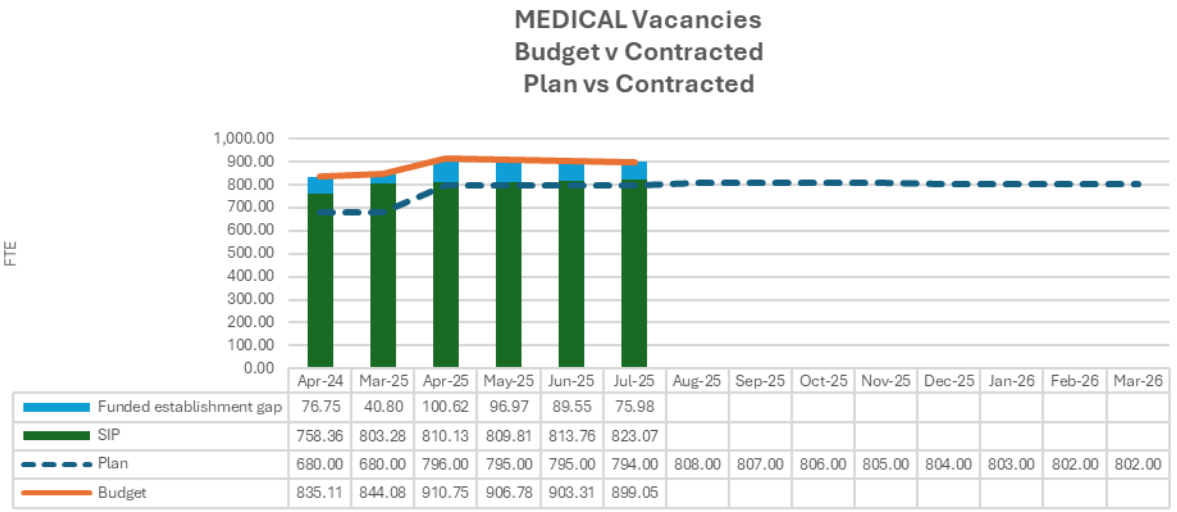
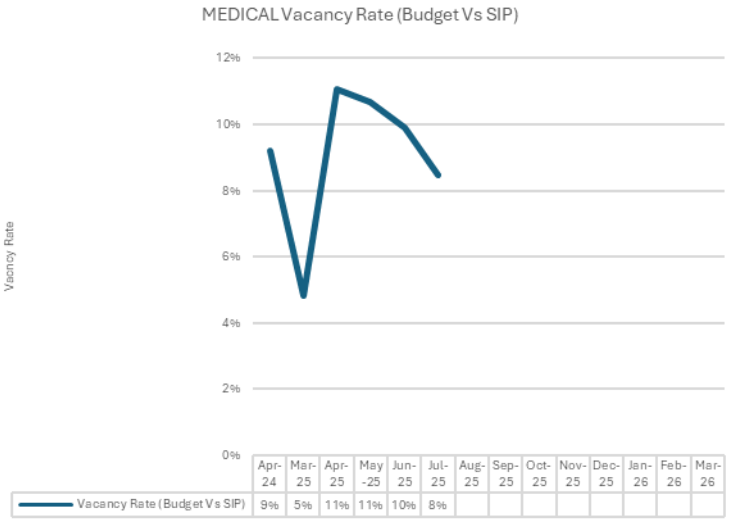
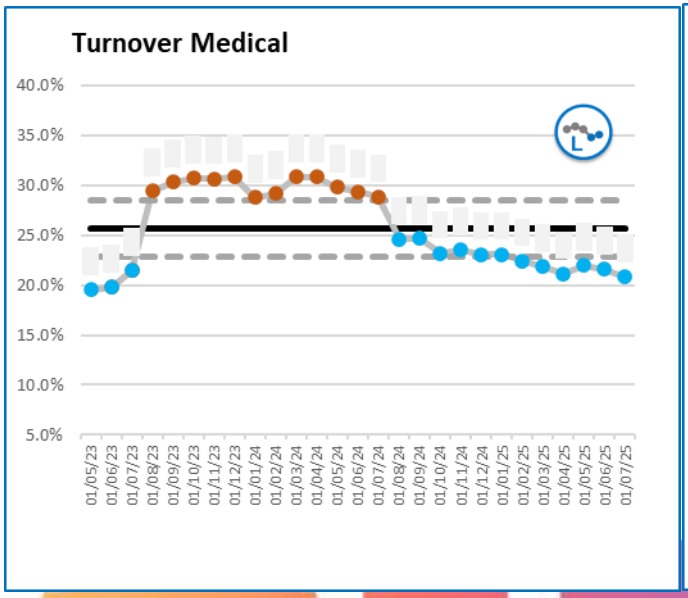
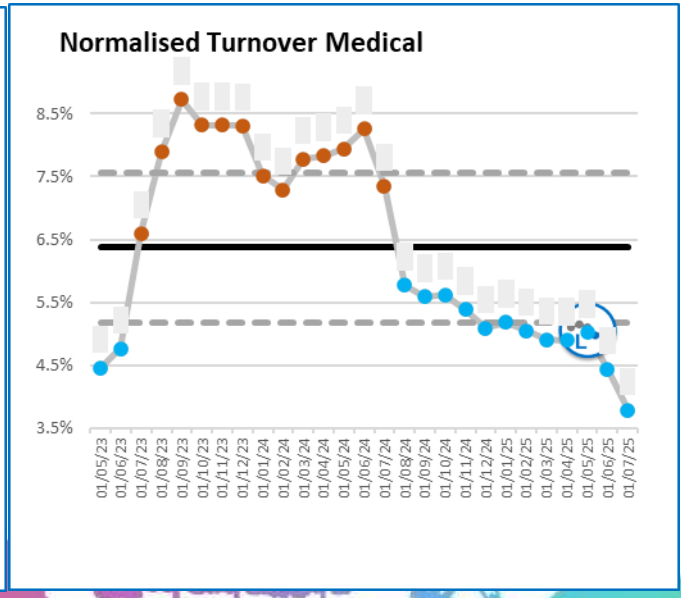


	Apr-24	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Funded establishment gap	76.75	40.80	100.62	96.97	89.55	75.98								
SIP	758.36	803.28	810.13	809.81	813.76	823.07								
Plan	680.00	680.00	796.00	795.00	795.00	794.00	808.00	807.00	806.00	805.00	804.00	803.00	802.00	802.00
Budget	835.11	844.08	910.75	906.78	903.31	899.05								



	Apr-24	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Vacancy Rate (Budget Vs SIP)	9%	5%	11%	11%	10%	8%								





Contracted WTE for medical and dental staff in July 2025 was 823.07 WTE, compared with 813.76 WTE in June 2025

This is 29.07 WTE above plan (more staff than we said we would have).

The total medical and dental vacancies stands at 75.98 WTE. The vacancy rate is 10%.

Staff turnover for medical and dental (rolling 12 months average) is 20.85% with normalised turnover at 3.79%. It should be noted that Deanery rotations are included in overall turnover.

	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25
M&D Turnover	24.64%	24.66%	23.21%	23.53%	23.08%	23.09%	22.43%	21.83%	21.13%	21.96%	21.59%	20.85%
M&D Normalised Turnover	5.77%	5.59%	5.62%	5.39%	5.09%	5.18%	5.05%	4.91%	4.90%	5.02%	4.44%	3.79%

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Recruitment/Vacancies/Turnover - Allied Health Professional

NHS
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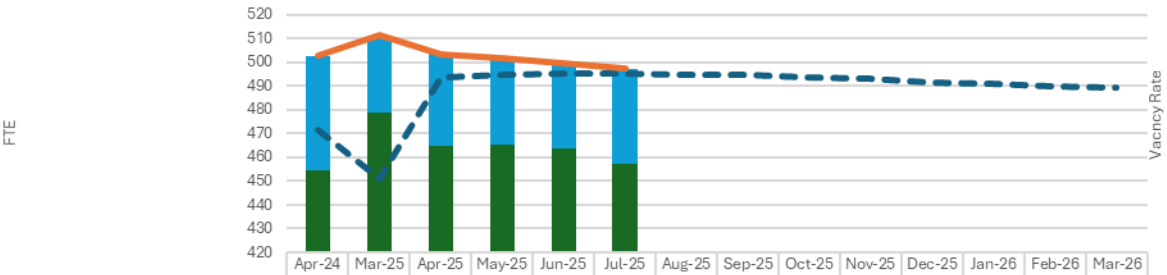
AHP Vacancies
Budget v Contracted
Plan vs Contracted

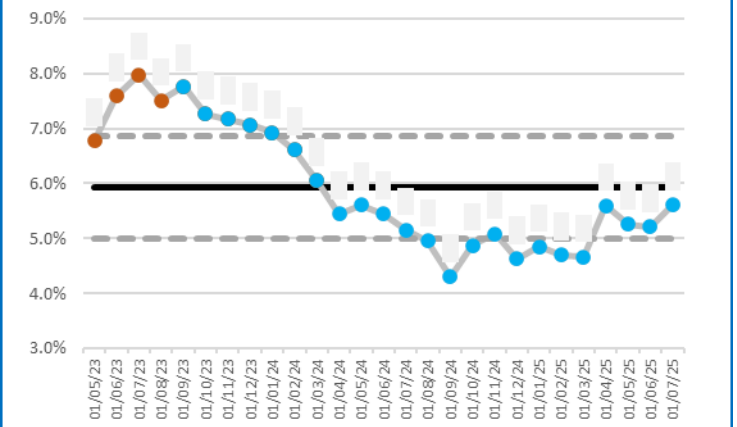


	Apr-24	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Funded establishment gap	48.14	32.25	38.93	36.39	36.13	40.14								
SIP	454.38	478.95	464.53	465.1	463.43	457.08								
Plan	471.59	451.22	493.4	494.7	495.3	495.3	494.7	494.7	493.4	492.8	491.5	490.9	489.6	489.3
Budget	502.52	511.20	503.46	501.49	499.56	497.22								

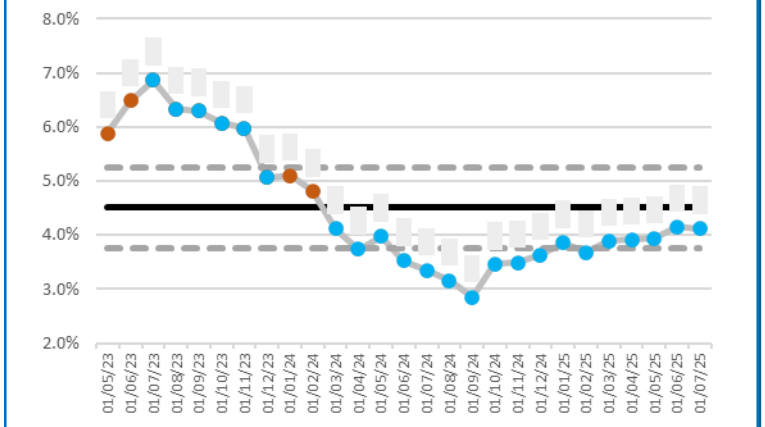
AHP Vacancy Rate (Budget Vs SIP)

	Apr -24	Mar -25	Apr -25	May -25	Jun -25	Jul- 25	Aug -25	Sep -25	Oct -25	Nov -25	Dec -25	Jan -26	Feb -26	Mar -26
Vacancy Rate (Budget Vs SIP)	10%	6%	8%	7%	7%	8%								

Turnover AHP



Normalised Turnover AHP



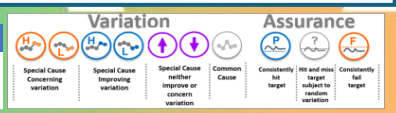
Contracted WTE for AHP's in July 2025 was 457.8 WTE, compared with 463.43 WTE in June 2025.

This is 38.22 WTE below the workforce plan (less staff than we said we would have).

The total AHP vacancies in July 2025 is 40.14 WTE this is a vacancy rate of 8%.

Staff turnover for AHP's (rolling 12 months average) is 5.61%, the normalised turnover is 4.12%.

	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25
AHP Turnover	4.95%	4.30%	4.87%	5.08%	4.63%	4.85%	4.70%	4.66%	5.60%	5.26%	5.21%	5.61%
AHP Normalised Turnover	3.16%	2.85%	3.46%	3.49%	3.63%	3.86%	3.68%	3.89%	3.92%	3.94%	4.15%	4.12%



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Starters and Leavers

NHS
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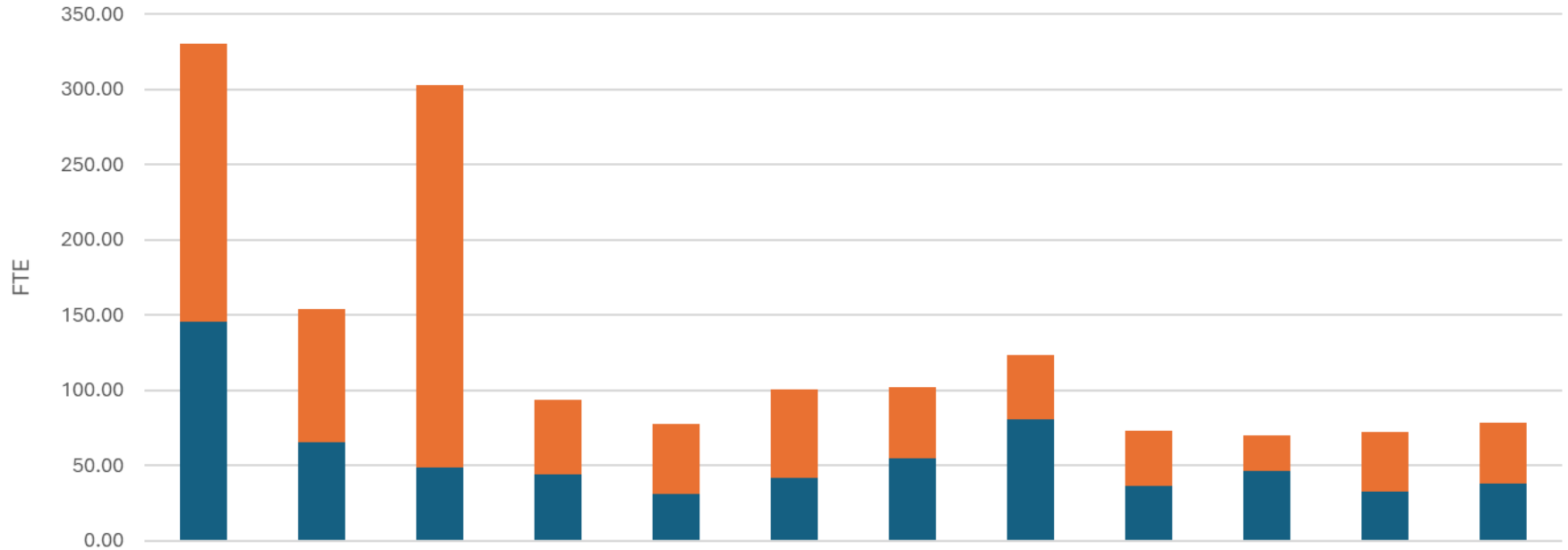
NHS Foundation Trust



	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25
Starters FTE	184.76	88.73	254.59	49.03	46.87	58.71	47.06	42.88	37.33	23.49	39.52	39.81
Leavers FTE	145.51	65.12	48.58	44.25	30.94	42.05	54.63	80.42	36.07	46.12	32.67	38.23

Starters vs Leavers

- This month we have seen more starters than leavers in July 2025.

Assurance

- The Trust's recruitment and retention journey is now ratified and will be socialised through a new sub-group of People Committee. However, recruitment to roles continues to be subject to grip and control / Vacancy Control measures, which means a greater emphasis on retention.

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Retention

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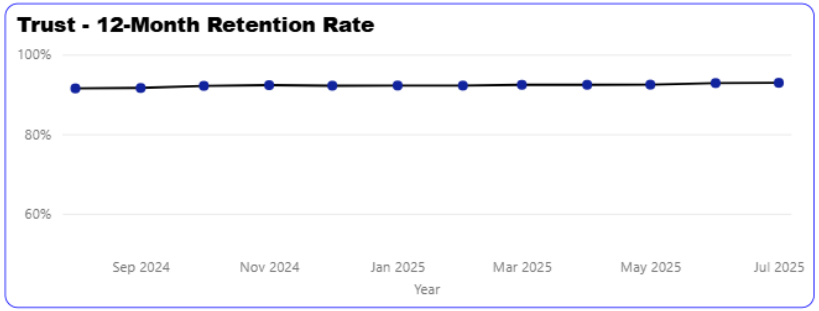
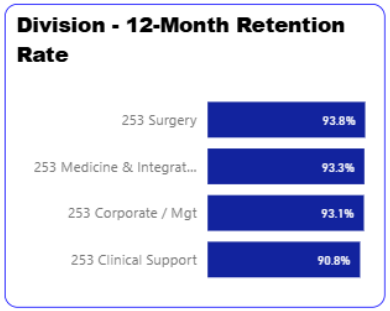
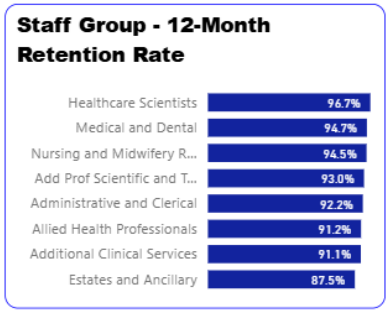
NHS Foundation Trust

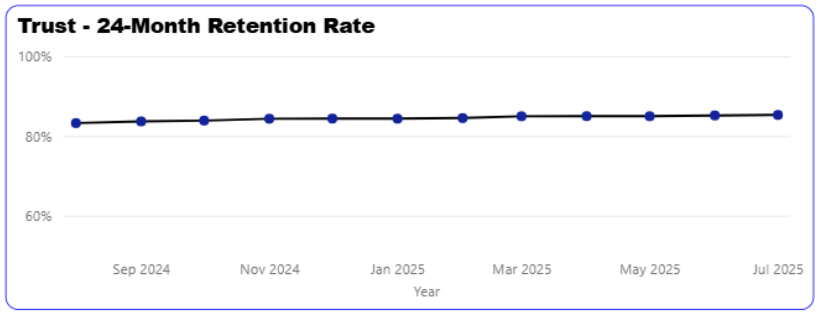


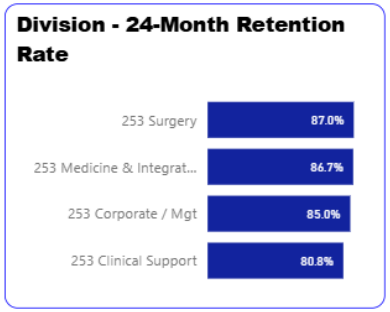


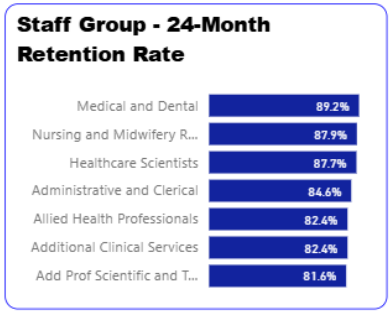


July 2025

12-Month	Trust 92.9%
24-Month	Trust 85.3%







The 12m retention rate has increased slightly to 92.9% in July 2025 from 92.8% in June 2025.

The division with the lowest 24-month retention rate is CCCS at 80.8% and both Additional Professional, Scientific and Technical staff and Additional Clinical Services are two staff groups with the lowest retention rates.

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Employee Relations

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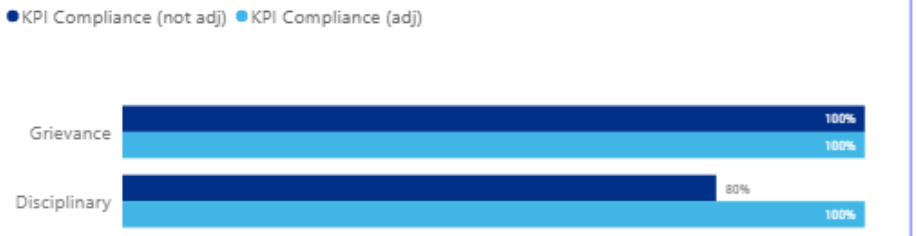
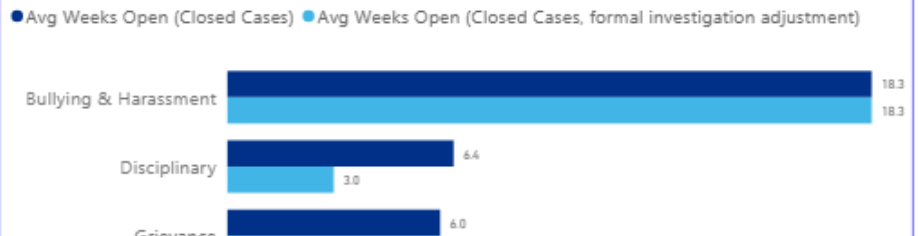
NHS Foundation Trust

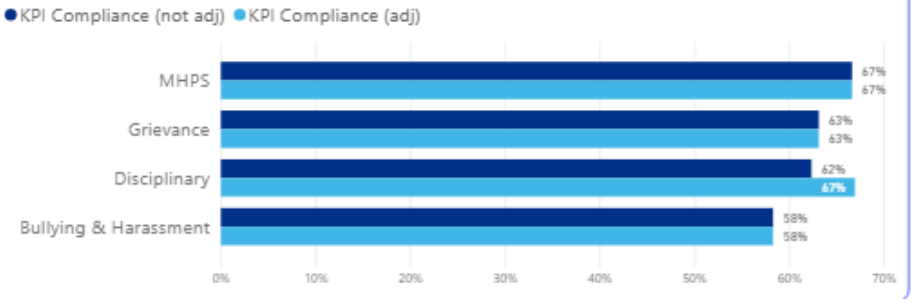
Last Month - KPI Compliance



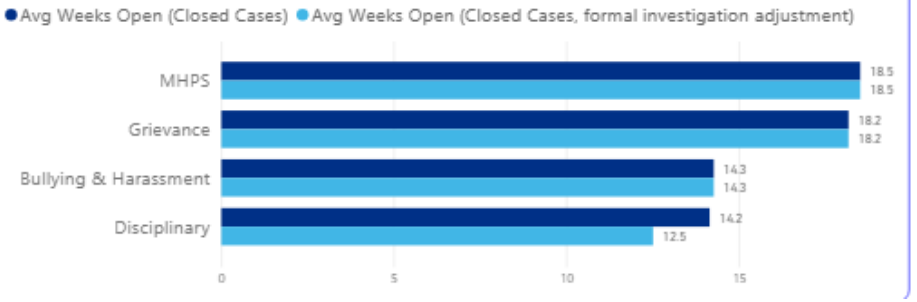
Last Month - Average Weeks



Last 12 Months - KPI Compliance



Last 12 Months - Average Weeks



Grievance 12 month KPI compliance has improved from 58% last month to 67% in July 2025. In July 2025 the lowest 12 month compliance was across bullying and harassment.

On average (over the last 12 months) Grievances and MHPS cases take longer than the suggested KPI of 12 weeks, both being slightly above 18 weeks as an average length.

Disciplinary takes the lowest number of weeks to complete an investigation, on average (over the last 12 months) this take 14.2 weeks (with fact finding) and 12.5 weeks (adjusted to date the investigation was commissioned)

The focus this year is around socialising the new Grievance and Bullying and Harassment policies to see both reductions in time taken but also reductions in cases porceedidng formally also.

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Agency and Bank Usage

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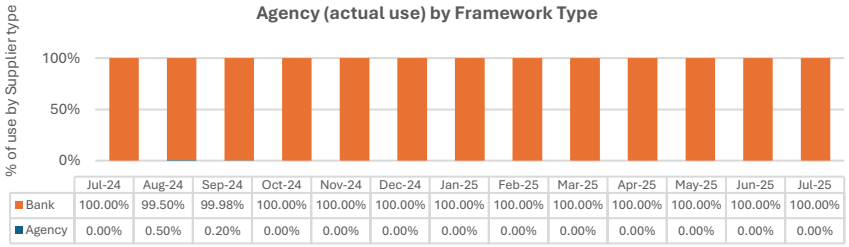
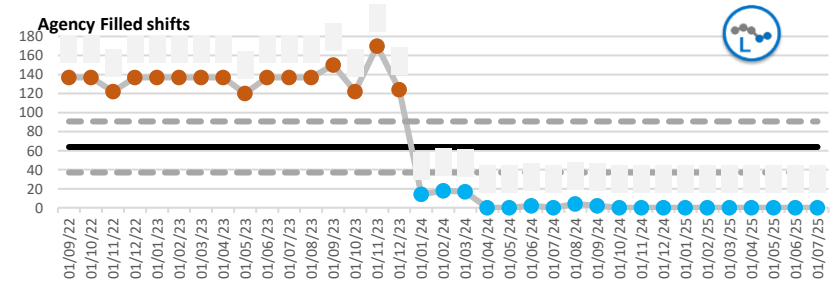
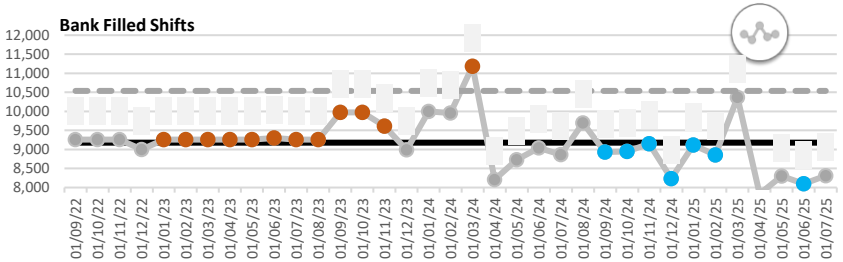
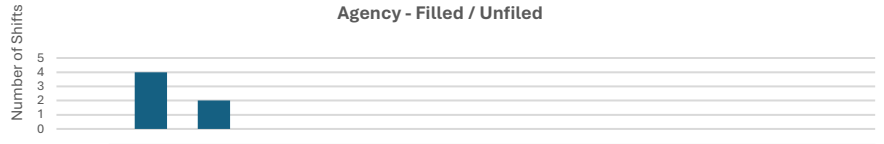


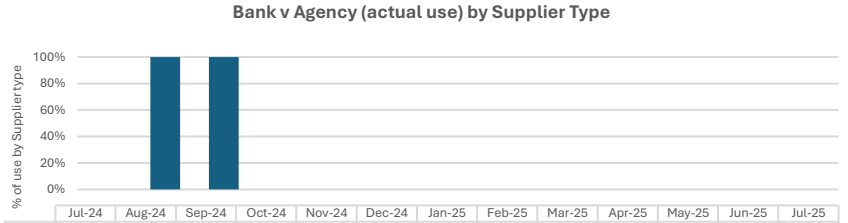
	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25
Bank	100.00%	99.50%	99.98%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Agency	0.00%	0.50%	0.20%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%



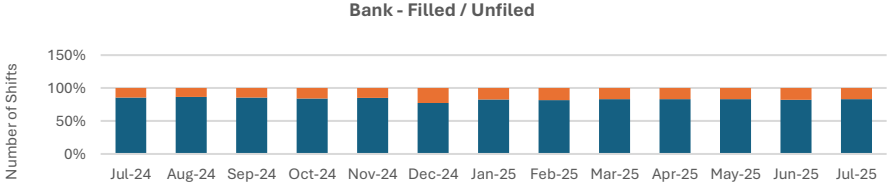




	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25
Unfilled Shifts	0	0	0	0	0	0	0	0	0	0	0	0	0
Filled shifts	0	4	2	0	0	0	0	0	0	0	0	0	0



	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25
NFW	0	0	0	0	0	0	0	0	0	0	0	0	0
FW	0	4	2	0	0	0	0	0	0	0	0	0	0



	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25
Unfilled Shifts	15%	13%	14%	16%	15%	22%	17%	18%	17%	17%	17%	18%	17%
Filled Shifts	85%	87%	86%	84%	85%	78%	83%	82%	83%	83%	83%	82%	83%

Bank fill rates have increased to 83% in July 2025, compared with 82% in June 2025. There continue to be no reported non-medical agency shifts filled via the centralised team.

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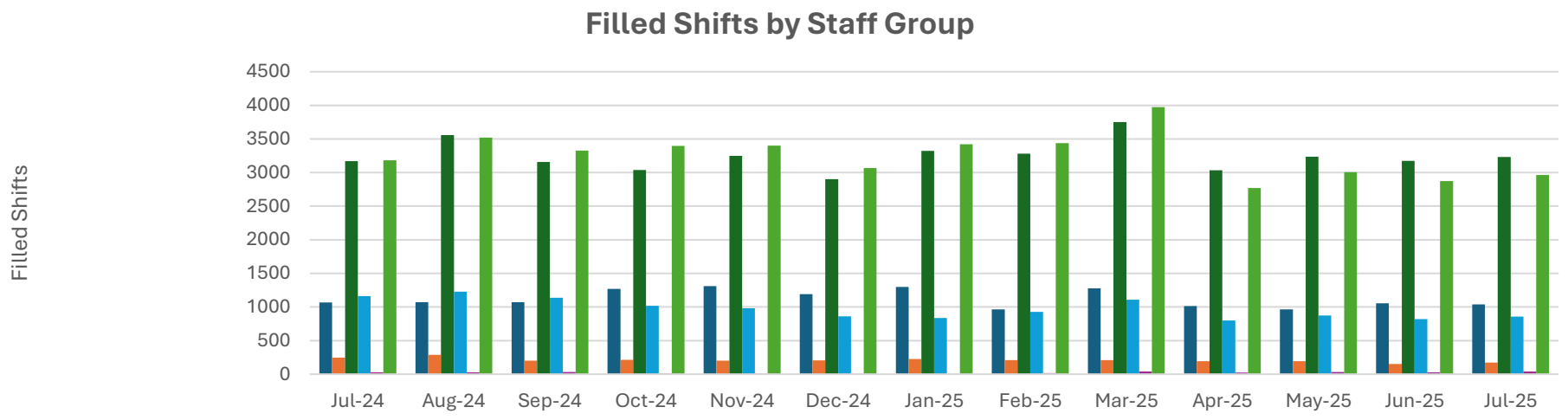
Bank Usage by Staff Group

The Dudley Group NHS Foundation Trust



	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25
A&C	1069	1073	1073	1268	1312	1193	1300	965	1276	1013	965	1053	1040
Add Prof Scientific and Technic	249	288	202	213	202	206	228	209	211	195	194	152	172
Additional Clinical Services	3168	3558	3156	3036	3247	2901	3323	3283	3753	3032	3234	3173	3231
AHP	1161	1229	1138	1019	979	861	838	929	1110	800	872	822	858
Healthcare Scientists	28	28	31	11	8	4	4	17	40	26	33	27	41
Nursing & Midwifery Registered	3184	3522	3326	3396	3400	3065	3420	3437	3975	2768	3004	2872	2963

- Admin and Clerical bank reduced from 1053 shifts in June to 1040 shifts in July
- All other staff groups increased between June and July in the number of filed shifts
- The largest increase was in Nursing and Midwifery registered in July

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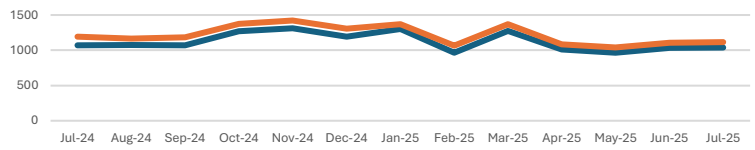
Bank Fill Rates

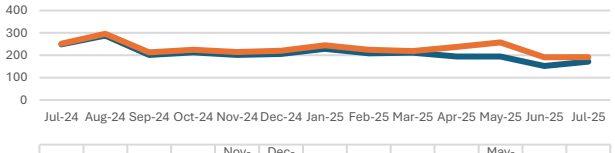
The Dudley Group NHS Foundation Trust

Bank A&C Filled / Requested



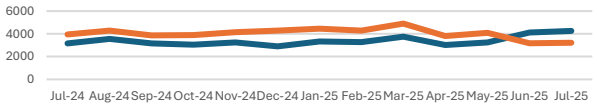
	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25
A&C Filled	1069	1073	1072	1268	1312	1193	1300	965	1276	1013	965	1033	1040
Total Request	1194	1166	1184	1373	1422	1308	1368	1065	1372	1084	1040	1105	1116

Bank Add Prof Scientific and Technic Filled / Requested



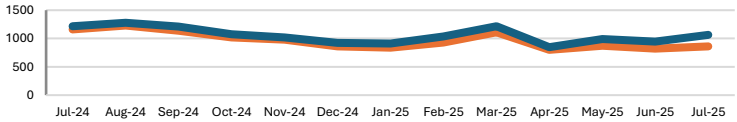
	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25
Add Prof Scientific and Technic Filled	249	288	202	213	202	206	228	209	211	195	194	152	172
Total Request	251	296	213	224	215	220	244	224	219	238	257	191	192

Additional Clinical Services Filled / Requested



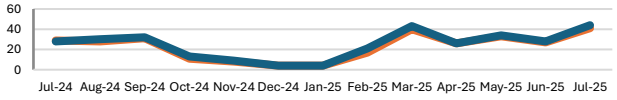
	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25
Additional Clinical Services Filled	3168	3558	3156	3036	3247	2901	3323	3283	3753	3032	3234	4119	4259
Total Request	3959	4293	3870	3904	4158	4275	4464	4289	4899	3820	4095	3173	3231

AHP - Filled / Requested



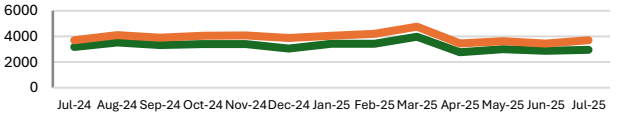
	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25
AHP Filled	1161	1229	1138	1019	979	861	838	929	1110	800	872	822	858
Total Request	1218	1278	1214	1074	1017	921	909	1037	1218	847	993	944	1062

Regsistered Filled / Requested



	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25
Healthcare Scientists Filled	29	28	31	11	8	4	4	17	40	26	33	27	41
Total Request	28	30	32	13	9	4	4	21	43	26	34	28	44

Regsistered Filled / Requested



	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25
Nursing & Midwifery Registered Filled	3184	3522	3326	3396	3400	3065	3420	3437	3975	2768	3004	2872	2963
Total Request	3712	4112	3907	4049	4066	3890	4056	4193	4761	3451	3641	3444	3701

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A&C Bank Use

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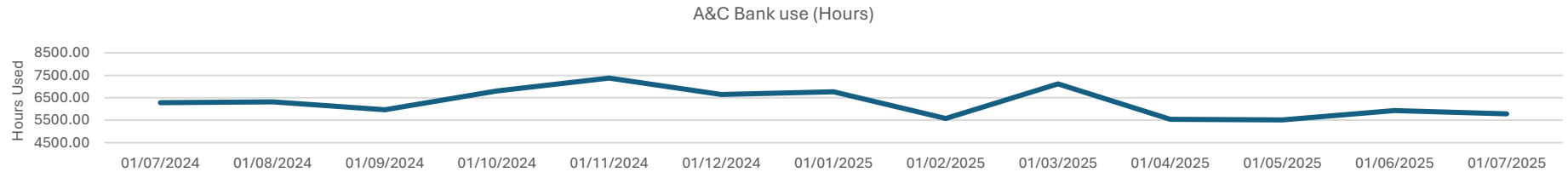
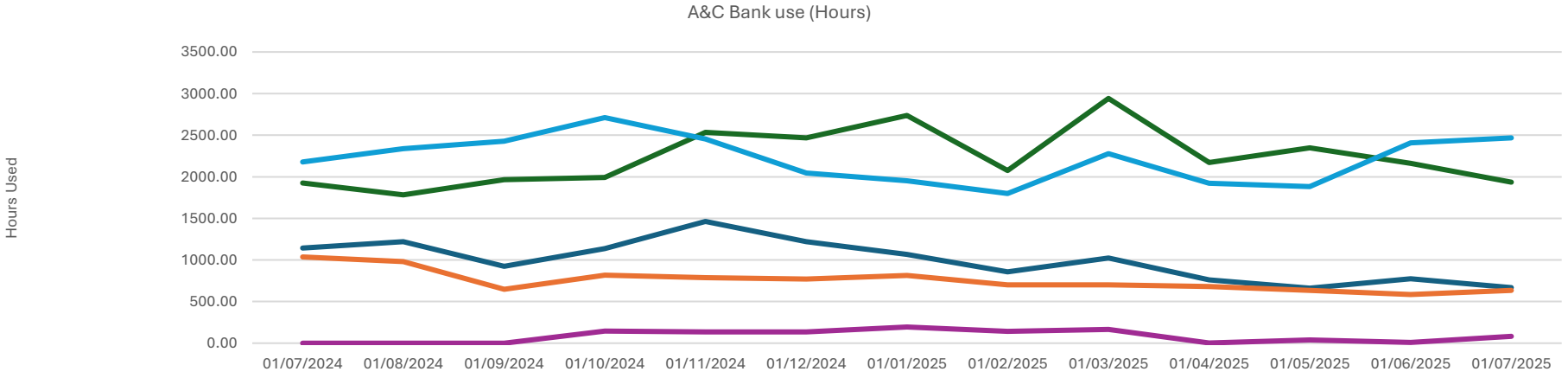


	01/07/2024	01/08/2024	01/09/2024	01/10/2024	01/11/2024	01/12/2024	01/01/2025	01/02/2025	01/03/2025	01/04/2025	01/05/2025	01/06/2025	01/07/2025
A&C	6283.42	6320.33	5962.47	6806.07	7375.88	6639.98	6764.63	5573.72	7112	5539.18	5513.65	5934.41	5784.55



	01/07/2024	01/08/2024	01/09/2024	01/10/2024	01/11/2024	01/12/2024	01/01/2025	01/02/2025	01/03/2025	01/04/2025	01/05/2025	01/06/2025	01/07/2025
Clinical Support	1143.58	1219.00	923.00	1137.67	1463.17	1220.33	1068.50	856.25	1024.41	760.50	661.42	772.74	668.50
Corporate / Mgt	1036.58	981.33	647.50	818.00	788.67	772.00	815.25	699.67	701.96	682.00	634.33	584.75	633.50
Medicine & Integrated Care	1924.41	1782.66	1963.92	1992.17	2534.92	2467.32	2735.88	2076.30	2941.88	2172.02	2346.90	2162.08	1934.03
Surgery	2178.83	2336.58	2428.05	2711.15	2453.88	2045.83	1950.50	1798.75	2279.13	1922.67	1883.50	2407.34	2467.52
Dudley Place	0.00	0.00	0.00	147.08	135.25	134.50	194.50	142.75	165.00	2.00	37.50	7.50	81.00

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A&C Bank use by Reason

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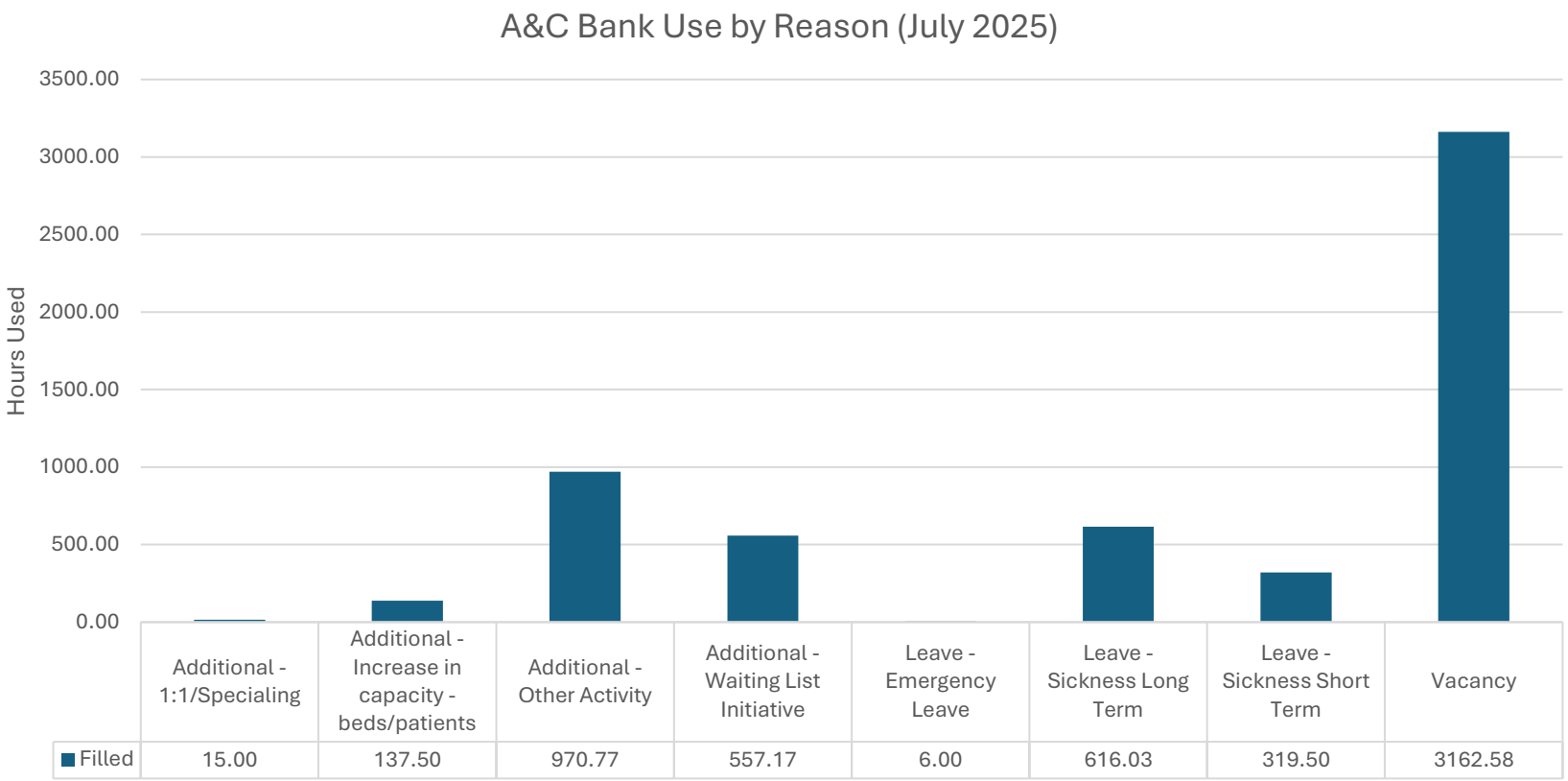

	Additional - 1:1/Specialing	Additional - Increase in capacity - beds/patients	Additional - Other Activity	Additional - Waiting List Initiative	Leave - Emergency Leave	Leave - Sickness Long Term	Leave - Sickness Short Term	Vacancy
Filled	15.00	137.50	970.77	557.17	6.00	616.03	319.50	3162.58

Bank requests in July continue to be primarily driven by vacancies, with secondary reasons being additional activity and sickness absence

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Rostering KPI

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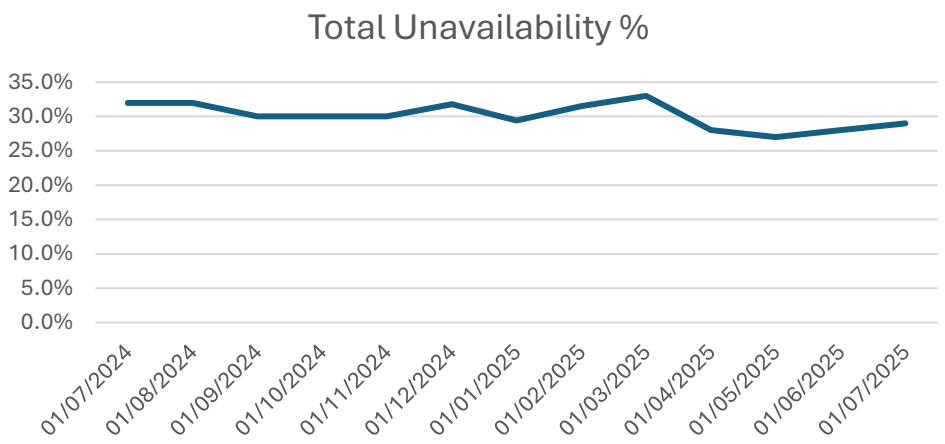
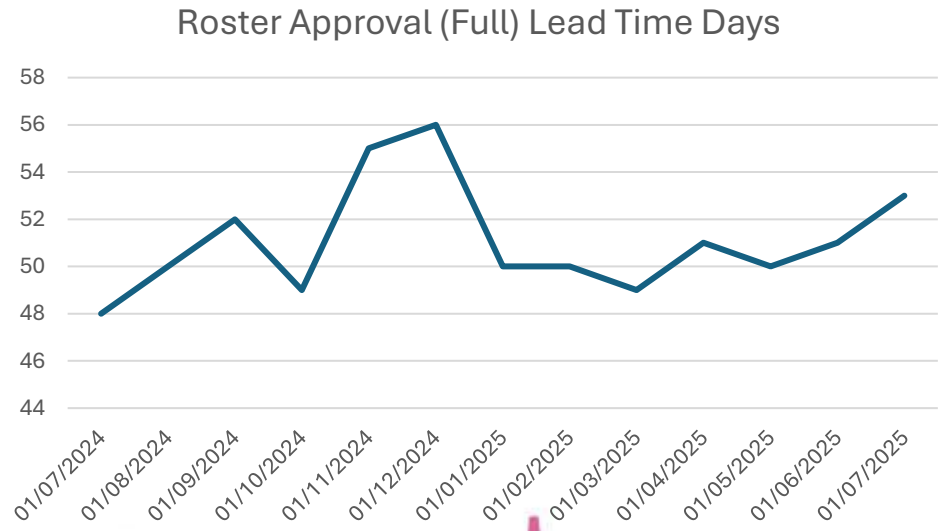


Unavailability is where staff are absent from their normal daily work but still consuming their contracted hours.

29%. Budgeted percentage is 22%.

If actual unavailability is higher than budgeted, then either costs will exceed budgets (e.g. backfilling absence with temp staff), or units will be short staffed.



The number of days between the full approval (publishing) of the roster and the roster start date. Short lead times generate staff morale issues due to poor notice of their roster, and higher temporary staffing usage or unfilled duties as there is less lead time for the bank to fill gaps.

53 Days. Trust target is 55 days, NHSE minimum is 42 days.

This is trending in the right direction. Confirm & Challenge meetings along with frequent e-mail notifications now being used to improve compliance.

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Rostering KPI

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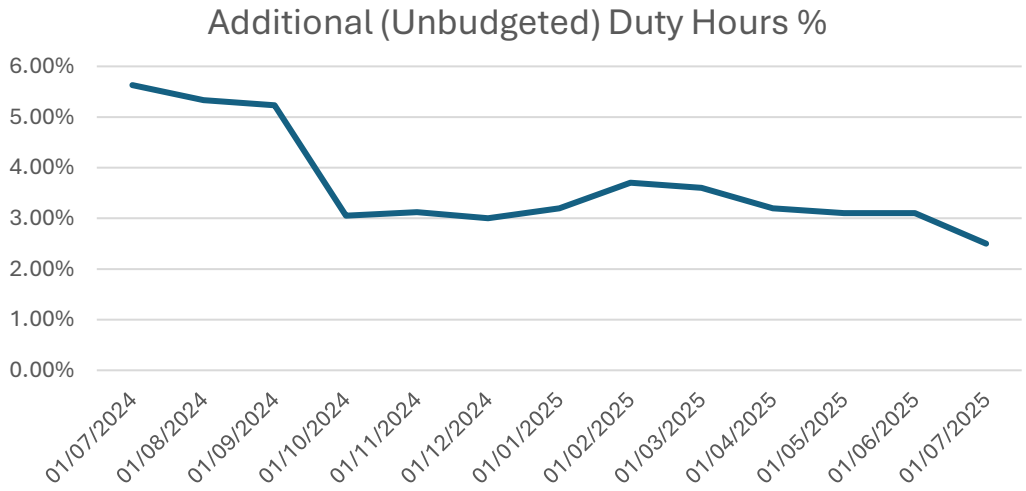
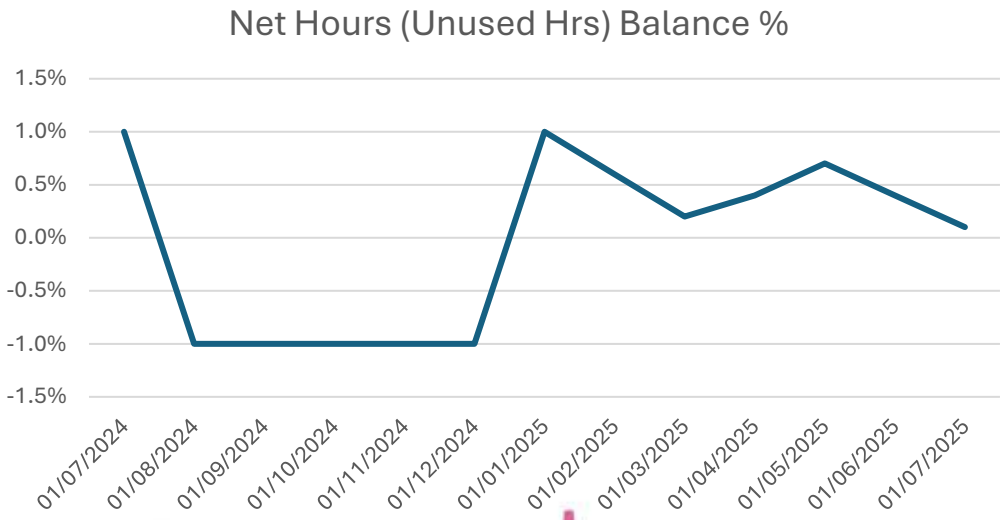


The % of assigned duty hours that are in addition to the budgeted demand e.g. 4 staff rostered when only 3 are budgeted. This may be due to legitimate increased demand (e.g. increased acuity)

2.5%. Departments with the highest percentage of additional duty hours are Discharge Lounge, Day Case Theatres , C3, B2 Trauma & C1

Most common reasons are Increase in Capacity,1:1 & WLI.



The % contracted hours left unused - e.g. if a staff member is contracted and paid for 150 hours but only works 144 hours there are 6 hours unused.

0.1%.

In January 2025 the Trust have implemented a rule that bank cannot be worked where there are hours owing.

Confirm and Challenge have discussed how to support managers to manage the operational pressures, alongside responsibilities to scrutinise rosters.

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Work Experience and Widening Participation

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ICan Dudley:
In 2025/26 ICan is being funded via 3 funding streams:

Adult Education Budget: will continue to fund Into Employment programmes. Funding is available for Clinical Support Worker novice programmes but there is a risk these will not be delivered due to lack of band 2 posts andcapacity to deliver in professional development team.

Youth Trailblazer: we have funding to provide 20x placements for 18-21 year old NEETs. Community engagement has commenced. Placements will be recruited in September and start in November.

Connect 2 Work: we will be supporting 40 unemployed people and 10 In-work, aged 18-29, with significant barriers in obtaining or sustaining employment on an intensive Supported Employment programme delivered predominantly 1-1. This will officially launch September.

T-Levels
•There are 7 Business Management and Administration students from Halesowen College undertaking industry placements with the Trust in (1 has dropped out).
•The Healthcare T-Level student programme will re-commence in September.

Ambassadors
There are 82 Careers Ambassadors in the Trust.

Work Experience:

•There were 10 dept-led placements that took place in July. Five were for th epurpose of gaining access to Higher Education and the other 5 were part of organised work experience through college.

•The Trust's annual medical work experience programme also took place across June and July which saw 50 students undertake a one-week programme specifically designed for those looking to apply for medical school.

Total placements – 60

Careers Education Information Advice and Guidance (CEIAG)
There were 300 face to face engagements during July and 150 online. This consisted of 3 large scale careers events, a virtual 'Meet the Expert' session to 150 secondary school pupils, and 2 1:1 careers advice and guidance conversations. A small team of Ambassadors taught a bespoke course to 55 students in years 7-9 at a local secondary school.
Total student engagements – 450

Work Related Learning
Behind the Scenes took place on 9th July at RHH and was attended by students from 3 schools (Summerhill School was a late cancellation).

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Apprenticeships

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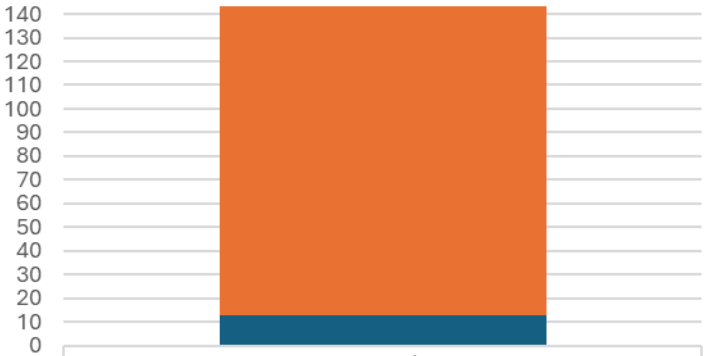
Apprenticeships - as of July 25

Number of Signups against year plan (146)



	Number of signups
Remaining signups	133
Sign ups	13

Total Active Apprenticeships : 216

Apprenticeship Levy	£
Expired Levy April 25	£29,290.18
Expired Levy May 25	£32,972.34
Expired Levy June 25	£22,421.32
Expired Levy July 25	£87,724.65

We currently have 49 pending enrolment from August onwards, with additional expected due to the final Senior Leader Level 7 intakes in October and December.

Apprenticeship activity and Levy Spend continue to be impacted by the recruitment freeze.

Sign up activity was low in Q1, and we achieved only 3 sign ups in July. Levy funding has expired during July linked to this reduction in activity.

However this this is expected to increase significantly by the end of Q2, driven by a surge of interest in level 7 Senior Manager apprenticeships before they end in December.

We are increasing the number of external apprenticeships being sponsored through our Levy Fund.

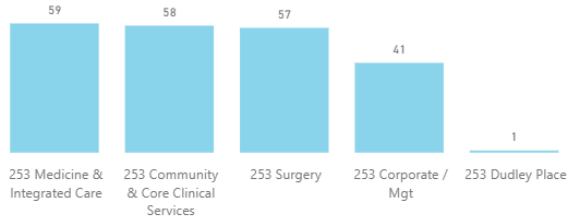
Work continues to promote internal apprenticeship opportunities to compensate for the lack of new apprentice opportunities.

It has been confirmed that level 7 funding will be available for certain clinical pathways including Advanced Clinical Practitioner and District Nursing which is welcome news.

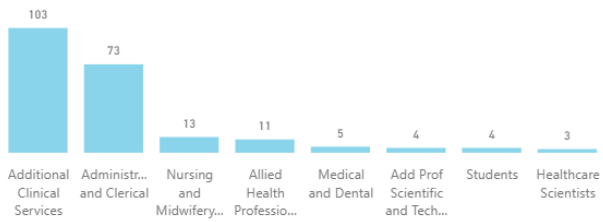
We are still awaiting news on other changes to the levy. .

Active Apprenticeships breakdown

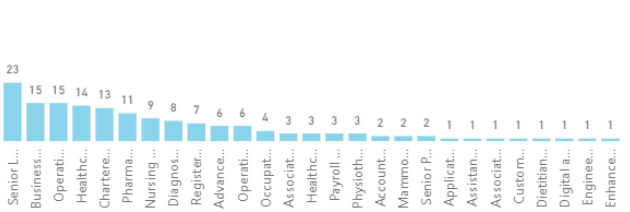
Division



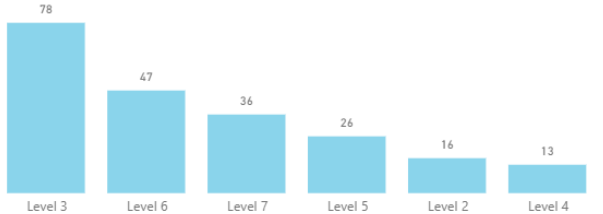
Staff Group



Programme



Apprenticeship Level



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Mandatory Training

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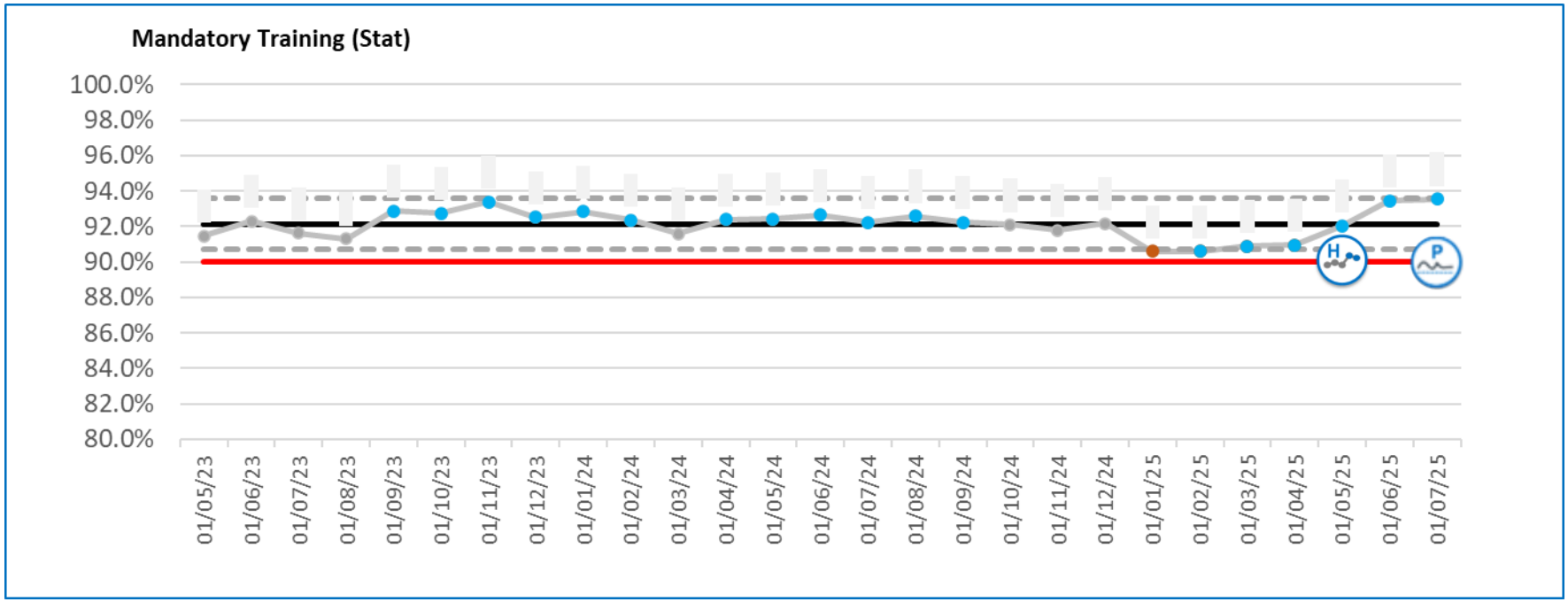

The overall rate for July has been maintained at above target with good improvements across all Divisions. Place is now at 86% - on track for above target performance by Q3.

	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25
Mandatory Training (Stat)	92.60%	92.22%	92.09%	91.79%	92.16%	90.60%	90.59%	90.88%	90.96%	92.04%	93.45%	93.56%

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Mandatory Training – Priority 1

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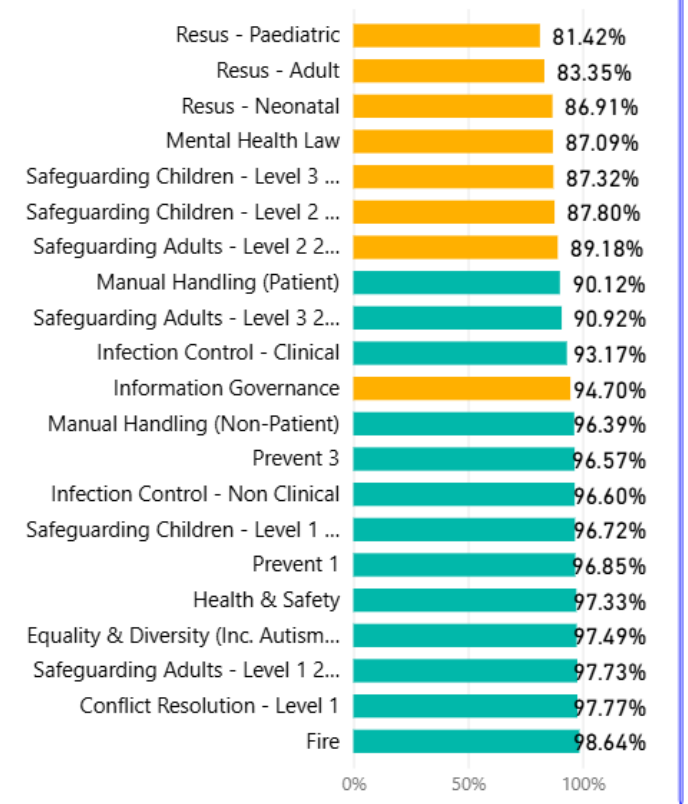
Month: July 2025	Trust	CCCS	Corporate	MIC	Surgery	Place
	93.56%	95.68%	95.55%	92.77%	93.18%	86.40%

Course Compliance



Depts by no. required to achieve 90%

Ward/Service (based selections)

Group5Description	Actual	No. to Target	%' tage
253 General Surgery Medical Staff Serv	472	77	77.37%
253 MOC Medical Staff Serv	400	42	81.46%
253 Medical Staff Cardiology Serv	223	37	77.43%
253 CHC & Intermediate Care Serv	265	34	79.81%
253 Medical Staff - Respiratory Serv	294	30	81.89%
253 Halesowen PCN ARRS Serv	169	29	77.16%
253 Medical Staff GP Medicine Serv	60	27	62.50%
253 Dudley & Netherton PCN ARRS Serv	190	24	80.16%
253 Cardiology Clinical Measurement Serv	449	21	86.01%
253 Medical Staff - GI Serv	205	21	81.67%
253 Medical Staff (Older People) Serv	249	21	83.00%
253 GP Clinical Leadership/Advisor Serv	120	20	77.41%
253 Medical Staff (Vascular) Serv	153	19	80.10%
253 Obs.and Gynae. Medical Staff Serv	439	18	86.58%
253 Med Secs - Endocrinology Serv	65	16	72.22%
253 Maxillofacial Surgery Medical Staff Serv	84	14	77.77%
253 Medical Staff Renal Serv	94	14	78.33%
253 Enhanced Care Home Team Serv	80	13	77.66%
253 Psychiatry Medics Rechg PCT Serv	85	13	78.70%
Total	**66,003**	**-2518**	**93.56%**

All Divisions are above target - except Place which is on track against plan.

There has been good progress across all subjects - with no red subjects in July.

Compliance remains a focus area following Divisional Deep Dives with actions in place to address both subject exceptions and any department challenges.

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Organisational Development

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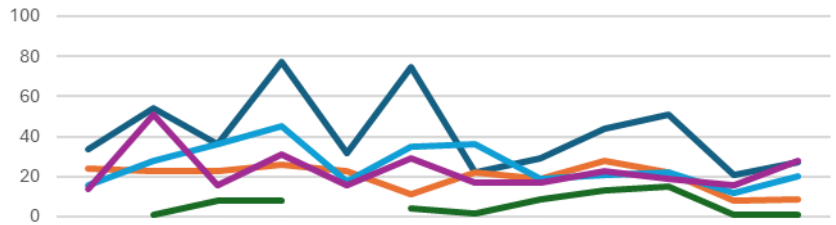
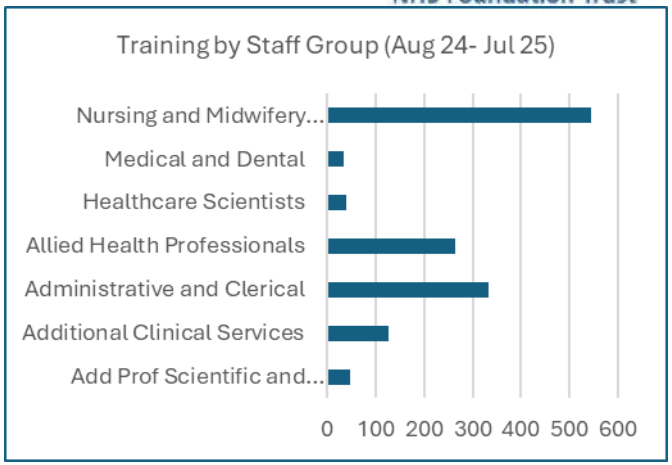


	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25
253 Community & Core Clinical Services	34	54	36	77	32	75	22	29	44	51	21	27
253 Corporate / Mgt	24	23	23	26	23	11	22	19	28	22	8	9
253 Dudley Place		1	8	8		4	2	9	13	15	1	1
253 Medicine & Integrated Care	16	28	36	45	18	35	36	19	21	22	12	20
253 Surgery	14	51	16	31	16	29	17	17	23	19	16	28



Course	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Grand Total
253 Resilience Training				8									8
253 Admin Essentials					14	12			7				33
253 Annual Review Training								21	68	52	4		145
253 Bespoke Training		10		16			4	6	4	9		7	56
253 Coaching	7		4	8		7	8			9	9		52
253 Communications 1	3	11	13	11	10	4		2		9		4	67
253 Communications 2	13		15	7	7	7	20		5		4	11	89
253 Flexible Working		5											5
253 Leading People at Dudley	8	4	3	7		4		4					30
253 Leading with Confidence Introduction		8	12		19		17		8				64
253 Living The Values		2	13	26		66	2	10		22	6		147
253 Local Induction Training	17			14			2						33
253 Managers Essentials	12	39	19	35	17	15	34	21	20	15	21	28	276
253 Organisational Awareness & Report Writing								2					2
253 Report Writing and Presenting					3								3
253 Resolving Conflict & Honest Conversations				4					4		5		13
253 Welcome 2 Dudley Induction	12	20	18	12	2	9	7	8		7	4	4	103
253 Wellbeing 1	12	6	14	11	10	5	1	8	8	6	5	8	94
253 Wellbeing 2	4	10		15									29
253 Wellbeing 2 - Team Wellbeing for Managers						7		11				7	25
253 Wellbeing Adhoc		36				18							54
253 Wellbeing Champions			8	8	5								21
253 Workforce Planning		6		5	2		4		5			16	38
Grand Total	**88**	**157**	**119**	**187**	**89**	**154**	**99**	**93**	**129**	**129**	**58**	**85**	**1387**

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Performance against 25/26 workforce plan – M4

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Month 4 Performance – Trust Overview

The Dudley Group NHS Foundation Trust

DGFT **Workforce Vs Plan 2025/26 (Actual / Forecast)** Note change in signage : -ve variance = adverse to plan

		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Substantive	Plan	5,900	5,902	5,902	5,889	5,890	5,877	5,865	5,849	5,832	5,812	5,795	5,779
	Actual	5,869	5,853	5,847	5,853	5,890	5,877	5,865	5,849	5,832	5,812	5,795	5,779
	Variance	31	49	55	37	0	0	0	0	0	0	0	0
Bank	Plan	542	529	516	501	487	474	476	463	415	436	428	415
	Actual	513	536	548	585	487	474	476	463	415	436	428	415
	Variance	29	-7	-32	-84	0	0	0	0	0	0	0	0
Agency	Plan	7	7	6	6	6	6	6	6	6	6	6	6
	Actual	13	17	10	19	6	6	6	6	6	6	6	6
	Variance	-7	-11	-4	-13	0	0	0	0	0	0	0	0
Total	**Plan**	**6,449**	**6,438**	**6,425**	**6,397**	**6,383**	**6,357**	**6,347**	**6,318**	**6,253**	**6,255**	**6,230**	**6,200**
	Actual	**6,395**	**6,406**	**6,405**	**6,457**	**6,383**	**6,357**	**6,347**	**6,318**	**6,253**	**6,255**	**6,230**	**6,200**
	Variance	**54**	**32**	**20**	**-60**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

- In Month 3, the Trust reported a negative variance of 60 WTE, with actual staffing at 6,457 against a plan of 6,397.
- Substantive workforce shows a positive variance of 37 WTE under a planned position of 5,889.
- The bank workforce shows a negative variance of 84 WTE against a planned position 501 WTE. At M4 bank usage is at 585 WTE, this is 84 WTE above plan and an increase of 37 WTE from M3. Nursing, Midwifery, AHP, Admin and Scientific and Technical remained broadly similar, with Medical and Dental bank increasing from 64 WTE in June to 102 WTE in July, the majority of which is attributed to supporting the industrial action and mainlining activity.
- Agency workforce shows a negative variance of 13 against a planned position of 6 WTE. Overall, agency remains very low with Trust with all usage relating to medical staff.
- Drivers of change for substantive staffing is the staggered effect of full vacancy freeze December and January and the ongoing impact of the Divisional and Executive vacancy control process with CEO sign-off.
- For Bank usage, there are improved reporting and additional controls in place – however there is still additional capacity driving additional bank usage, in addition to supporting the resident doctor industrial action from 25 July (7am) to 30 July (7am), spanning five days across NHS Trusts in England.

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Month 4 Performance – Medicine Division

The Dudley Group NHS Foundation Trust

Medicine Division **Workforce Vs Plan 2025/26 (Actual / Forecast)** Note change in signage : -ve variance = adverse to plan

		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Substantive	Plan	1,889	1,886	1,883	1,880	1,881	1,878	1,879	1,875	1,869	1,864	1,858	1,853
	Actual	1,875	1,866	1,870	1,876	1,881	1,878	1,879	1,875	1,869	1,864	1,858	1,853
	Variance	14	20	13	3	0	0	0	0	0	0	0	0
Bank	Plan	283	277	270	263	255	249	255	248	222	232	230	222
	Actual	278	283	279	307	255	249	255	248	222	232	230	222
	Variance	5	-6	-9	-44	0	0	0	0	0	0	0	0
Agency	Plan	3	3	3	3	3	3	3	3	3	3	3	3
	Actual	8	9	5	14	3	3	3	3	3	3	3	3
	Variance	-5	-6	-2	-11	0	0	0	0	0	0	0	0
Total	**Plan**	**2,175**	**2,166**	**2,156**	**2,146**	**2,139**	**2,130**	**2,137**	**2,126**	**2,094**	**2,099**	**2,091**	**2,078**
	Actual	**2,161**	**2,158**	**2,154**	**2,197**	**2,139**	**2,130**	**2,137**	**2,126**	**2,094**	**2,099**	**2,091**	**2,078**
	Variance	**14**	**8**	**2**	**-51**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

- Medicine divisional performance in month 4 shows a negative variance of 51 WTE against the total workforce planned position of 2,146
- Substantive workforce saw a positive variance of 3 WTE against a planned position of 1,881
- Bank workforce saw a negative variance of 44 WTE against a planned position of 263 WTE
- Agency workforce saw a negative variance of 11 WTE against a planned position of 3 – this is a significant increase.

- Key Risk - Performance over plan in July – there is a significant risk of not recovering this position against a reducing trajectory.
- Sustained reductions will be required to stay on track for March 2026.

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Month 4 Performance – Surgery, Women's and Children's Division

NHS
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Surgery Division **Workforce Vs Plan 2025/26 (Actual / Forecast)** Note change in signage : -ve variance = adverse to plan

		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Substantive	Plan	1,944	1,942	1,940	1,935	1,938	1,933	1,927	1,922	1,917	1,911	1,906	1,902
	Actual	1,964	1,961	1,955	1,960	1,938	1,933	1,927	1,922	1,917	1,911	1,906	1,902
	Variance	-20	-19	-15	-25	0	0	0	0	0	0	0	0
Bank	Plan	170	165	161	155	150	145	141	137	122	131	127	123
	Actual	152	161	175	178	150	145	141	137	122	131	127	123
	Variance	18	4	-14	-23	0	0	0	0	0	0	0	0
Agency	Plan	3	3	3	3	3	3	3	3	3	3	3	3
	Actual	5	8	5	5	3	3	3	3	3	3	3	3
	Variance	-2	-5	-2	-2	0	0	0	0	0	0	0	0
Total	**Plan**	**2,117**	**2,110**	**2,104**	**2,093**	**2,091**	**2,081**	**2,071**	**2,062**	**2,042**	**2,045**	**2,036**	**2,028**
	Actual	**2,121**	**2,130**	**2,135**	**2,143**	**2,091**	**2,081**	**2,071**	**2,062**	**2,042**	**2,045**	**2,036**	**2,028**
	Variance	**-4**	**-20**	**-31**	**-50**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

- SWC's divisional performance in month 4 shows a negative variance of 50 WTE against the total workforce planned position of 2,093.
- Substantive workforce saw a negative variance of 25 WTE against a planned position of 1,935 WTE
- Bank workforce saw a negative variance of 23 WTE against a planned position of 155 WTE
- Agency workforce saw a negative variance of 2 WTE against a planned position of 3

- Key Risk – Consistent underperformance across Months 1–4 poses a risk to achieving year-end targets.

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Month 4 Performance – CCCS

The Dudley Group NHS Foundation Trust

CCCS Division **Workforce Vs Plan 2025/26 (Actual / Forecast)** Note change in signage : -ve variance = adverse to plan

		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Substantive	Plan	1,210	1,216	1,221	1,220	1,221	1,221	1,217	1,214	1,211	1,206	1,203	1,199
	Actual	1,200	1,198	1,197	1,188	1,221	1,221	1,217	1,214	1,211	1,206	1,203	1,199
	Variance	10	18	24	32	0	0	0	0	0	0	0	0
Bank	Plan	75	73	72	70	69	66	66	64	58	60	58	57
	Actual	72	77	77	81	69	66	66	64	58	60	58	57
	Variance	3	-4	-5	-11	0	0	0	0	0	0	0	0
Agency	Plan	0	0	0	0	0	0	0	0	0	0	0	0
	Actual	0	0	0	0	0	0	0	0	0	0	0	0
	Variance	0	0	0	0	0	0	0	0	0	0	0	0
Total	**Plan**	**1,286**	**1,290**	**1,293**	**1,290**	**1,290**	**1,287**	**1,283**	**1,278**	**1,269**	**1,266**	**1,261**	**1,256**
	Actual	**1,272**	**1,275**	**1,274**	**1,269**	**1,290**	**1,287**	**1,283**	**1,278**	**1,269**	**1,266**	**1,261**	**1,256**
	Variance	**14**	**15**	**19**	**21**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

- CCCS divisional performance in month 4 shows a positive variance of 21 WTE against the total workforce planned position of 1,290.
- Substantive workforce saw a positive variance of 32 WTE against a planned position of 1,220.
- Bank workforce saw a negative variance of 11 WTE against a planned position of 70 WTE.
- No agency usage report

- Key Risk – Performance is tracking close to plan for July.
- Sustained reductions will be required to stay on track for March 2026.
- Bank usage remains above plan against a reducing trajectory, which provides a continued risk of non-delivery

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Month 4 Performance – Corporate Services

The Dudley Group NHS Foundation Trust

Corporate Division **Workforce Vs Plan 2025/26 (Actual / Forecast)** Note change in signage : -ve variance = adverse to plan

		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Substantive	Plan	680	680	680	676	672	668	665	662	659	656	653	650
	Actual	652	649	642	643	672	668	665	662	659	656	653	650
	Variance	28	31	38	33	0	0	0	0	0	0	0	0
Bank	Plan	11	11	11	11	11	11	11	11	11	11	11	11
	Actual	10	13	16	17	11	11	11	11	11	11	11	11
	Variance	1	-2	-5	-6	0	0	0	0	0	0	0	0
Agency	Plan	0	0	0	0	0	0	0	0	0	0	0	0
	Actual	0	0	0	0	0	0	0	0	0	0	0	0
	Variance	0	0	0	0	0	0	0	0	0	0	0	0
Total	**Plan**	**691**	**691**	**691**	**687**	**683**	**679**	**676**	**673**	**670**	**667**	**664**	**661**
	Actual	**662**	**662**	**658**	**660**	**683**	**679**	**676**	**673**	**670**	**667**	**664**	**661**
	Variance	**29**	**29**	**33**	**27**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

- Corporate divisional performance in month 4 shows a positive variance of 27 WTE against the total workforce planned position of 687
- Substantive workforce saw a positive variance of 33 WTE against a planned position of 676
- Bank workforce saw a negative variance of 6 WTE against a planned position of 11 WTE

- Bank usage remains above plan against a reducing trajectory, which provides a continued risk of non-delivery

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Month 4 Performance – Dudley Place

The Dudley Group NHS Foundation Trust

Place Division **Workforce Vs Plan 2025/26 (Actual / Forecast)** Note change in signage : -ve variance = adverse to plan

		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Substantive	Plan	177	178	178	178	178	177	177	176	176	175	175	175
	Actual	178	179	183	184	178	177	177	176	176	175	175	175
	Variance	-1	-1	-5	-6	0	0	0	0	0	0	0	0
Bank	Plan	2	2	2	2	2	2	2	2	2	2	1	1
	Actual	1	2	1	2	2	2	2	2	2	2	1	1
	Variance	1	0	1	0	0	0	0	0	0	0	0	0
Agency	Plan	0	0	0	0	0	0	0	0	0	0	0	0
	Actual	0	0	0	0	0	0	0	0	0	0	0	0
	Variance	0	0	0	0	0	0	0	0	0	0	0	0
Total	**Plan**	**180**	**181**	**180**	**180**	**180**	**179**	**179**	**178**	**178**	**177**	**177**	**177**
	Actual	**179**	**181**	**184**	**186**	**180**	**179**	**179**	**178**	**178**	**177**	**177**	**177**
	Variance	**1**	**0**	**-4**	**-6**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

- Place divisional performance in month 4 shows a negative variance of 6 WTE against the total workforce planned position of 180.
- Substantive workforce saw a negative variance of 6 WTE against a planned position of 178
- Bank workforce saw no variance against plan

- Key Risk – Consistent underperformance across Months 2–4 poses a risk to achieving year-end targets.
- Complexities in Primary Care-funded posts, hosted by DGFT, will impact delivery

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Month 4 – Key Actions

The Dudley Group NHS Foundation Trust

- Sickness absence:-
  - **Progress in June 2025**
  - In-month sickness absence: 5.07% (↑ from 4.59% in May)
  - Rolling 12-month absence: 5.35% (↑ from 5.33%)
  - Short-term absence: 83% of episodes
  - Long-term absence: 51% of FTE days lost
  - 123 long-term cases open (↓ 31 from April)

  - **Key Actions Delivered**
  - ESR training led to a 5% increase in recorded return-to-work meetings
  - New EAP service launched
  - Additional Occupational Health appointments added
  - HR audits in hotspot areas (e.g., ED Nursing, Pharmacy, Maternity, Imaging, Therapy) – includes return to work discussions, attendance at occupational health, follow up letters, etc. This is proving successful and response from teams is positive.
  - Long term sickness cases are reviewed as part of the assurance process monthly with the senior HR team.
  - The supporting attendance workstream continues to combine the work carried out by the HR team and the Wellbeing team.
  - Deep dive into days lost, sickness absence % rates and number of occurrences taking place to identify trends and evaluate work carried out in hot spot areas. The focus being to highlight top 5 areas within each division to explore how they are managing their long-term and short-term sickness.

- Right Shift, Right Band
  - Reports have now been issued consistently for five consecutive weeks and shared with both the Divisional Chief N and DDCN. The format remains dynamic and continues to evolve based on user feedback to ensure relevance and usability.
  - Between April and June 2025, the average number of flagged instances per month was 456. Following the introduction of reporting in July, this figure reduced significantly to 286.
  - Most flagged instances relate to Band 5 duties being paid at Band 6 rates. Bank assignments have been reviewed and updated accordingly, with divisional-level KPIs and reporting now in place to monitor compliance.
  - A system warning has been enabled to alert users when the assigned grade does not match the required grade. These alerts will be monitored and reported on to ensure continued oversight and accountability. Weekly reporting to commence 1st July, including reporting on improvement.

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Month 4 – Key Actions/Notes

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- Rates
  - AFC Bank rates are now reduced to the bottom of the pay band for all areas.
  - Pay rates were discussed by the Trust Executive Team, and negotiations were due to commence in January 2025. On 20 January 2025, the Trust had an agreed set of rates for resident doctors at the Trust, however a system rate card is now being progressed. System rates were presented to and approved at the JPC (Joint Provider Committee) in July 2025. It was also discussed at the BCPC Executive in August - The group agreed on a clear escalation framework for exceptions, requiring executive approval, and emphasised timely September implementation and strict compliance.

- Bank usage
  - Medical and Dental - Establishment of Medical Bank and Agency steering group – with key actions on developing reporting for establishment controls, enhanced usage controls, roster optimisation and development of agency exit plans. A review of resident doctor rates/negotiation within the system - to be agreed at BCPC and then approached with the LNC. Reviewing draft principles for temporary staffing usage.

  - Nursing, Midwifery, AHP and Technical - Establishment of Nursing, Midwifery and AHP Steering group - Key actions on developing weekly reporting, enhanced usage controls, roster optimization, Nursing, Midwifery, AHP deep dive completed.

  - Roster confirm and challenge meetings are being changed to prospective to scrutinise the roster, prior to publication. Weekly reporting with Executive level oversight

  - In comparison to 24/25 there has been a month-on-month reduction and across the 3 months, this gives an average 47 WTE reduction compared to 24/25.

  - At M4 bank usage is at 585 WTE, this is 84 WTE above plan and an increase of 37 WTE from M3. Nursing, Midwifery, AHP, Admin and Scientific and Technical remained broadly similar, with Medical and Dental bank increasing from 64 WTE in June to 102 WTE in July, the majority of which is attributed to supporting the industrial action and mainlining activity.

- Agency
  - Agency usage (all medical and dental) increased in M4 to 19 WTE from 10 WTE in M3, resulting in being 13 WTE over plan. As of M3, there was overspend of £275k to June. Agency usage was 0.8% of the total paybill.
  - The spend is spread across 10 specialties with high costs (>£50k spend) in Elderly Care, Paediatrics, ED, Rheumatology, Obstetrics and Anaesthetics.
  - Work is ongoing to agree exit strategies with Divisions. In addition, there is a requirement by the end of quarter 2 to ensure all rates paid are in line with agreed caps.

ACCESSIBILITY COMPLIANT

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Our approach to Freedom to Speak Up 2025 – 2028

Working to ensure we are a workplace where people are actively encouraged to speak up, feel safe to do so, where we listen to one another and action is taken to follow up and learn from concerns raised.

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Freedom to Speak Up matters

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Diane Wake – Chief Executive
Executive Lead for raising concerns

Leading this organisation, it is vital that we provide opportunities for our people to raise concerns where they arise – and for them to feel comfortable speaking up, with confidence that action will be taken and their voices being valued and recognised.

We have already made positive changes to raise awareness of how to speak up and how we respond to concerns raised.

Our delivery plan for Freedom to Speak Up activity outlines the next stages of action for us to increase awareness, improve safety for patients and experience of staff and ensure that we continuously learn from any concerns raised.

Catherine Holland
Non-Executive Lead for raising concerns

The NED role focuses on supporting the FTSU Guardian and promoting a speaking-up culture at the board level. The NED Lead provides guidance and oversight to the FTSU Guardian, ensuring they have the resources and support needed to carry out their role effectively.

Highlighting Trends and Emerging Issues:
The NED Lead can identify patterns or recurring concerns arising from the FTSU process and bring them to the attention of the board.

By fulfilling these responsibilities, the Non-Executive Director Lead plays a crucial role in creating a safe and open environment where staff feel empowered to speak up about concerns and contribute to a culture of continuous improvement.

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Executive Summary

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Purpose:

To foster a culture where all staff feel safe, supported, and empowered to speak up about concerns, ensuring their voices are heard, valued, and acted upon.

Key Goals:

Speak Up:	Increase awareness and accessibility of speaking up channels.
Listen Up:	Strengthen listening and engagement through training and active dialogue.
Follow Up:	Ensure timely, visible, and effective responses to concerns raised.
Ensure Learning:	Embed organisational learning from concerns to drive continuous improvement.

Expected Outcomes by 2028

- 90% of new starters trained in raising concerns within 3 months.
- 80%+ staff compliance with role-appropriate Speak Up training.
- 25% reduction in anonymous concerns.
- Increased staff confidence and satisfaction in raising concerns.
- A robust, visible network of trained champions and guardians across the Trust.

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Introducing Freedom to Speak Up

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Freedom to Speak Up is the term given to the policy and support arrangements that help us create an environment where people who work in our organisation are encouraged to speak up and be listened to where they have concerns about their work – this could be anything that gets in the way of them doing a great job.

The National Guardian's Office

The framework for Freedom to Speak Up was established in 2015 aimed to create a safe and supportive environment for staff to raise concerns and established the National Guardians Office in 2016. The goal of the Guardian's office is to make speak up business as usual by leading, training and supporting a network of Freedom To Speak Up guardians and champions whilst providing challenge on speaking up matters to the healthcare system. It provides a strategy framework, training and events for guardians and support national learning from concerns raised across the healthcare system

NHS England and Freedom to Speak Up

NHS England aims to ensure everyone working within the NHS feels safe and confident to speak up. They have created the national policy framework and continue to improve the quality of speaking up arrangements across the NHS by

• Evaluating concerns raised by people working within the NHS about the way NHS organisations operate; their cultures and the quality of care they provide.

•Providing a scheme for people that require support after they have spoken up.

•Using staff experiences; learning from the handling of speak up matters and best practice to form the basis of policy, guidance and resources. These further support leadership teams to improve operational arrangements around Freedom to Speak Up.

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Strategic Connections to Freedom to Speak Up

The Dudley Group NHS Foundation Trust

This Freedom to Speak Up framework aligns to delivery of the NHS People Promise and our Trust People Plan by creating ways for people to speak up, be listened to and action taken on their concerns.

Promoting Freedom to Speak Up will help us to support our people and deliver our Trust Strategy, particularly the objective of Being a brilliant place to work and thrive and our multi-year commitment to Value our People.

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Our Approach to Freedom to Speak Up 2025 - 2028

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The NHS People Promise commits to ensuring that "we each have a voice that counts, that we all feel safe and confident to speak up, and take the time to really listen to understand the hopes and fears that lie behind the words". Ensuring we are an organisation where people feel safe and supported to speak up, we can keep improving our services for all patients and the working environment for our staff.

We know some groups in our workforce feel they are seldom heard or are reluctant to speak up. This includes those from minority ethnic backgrounds, LGBTQ+ individuals, people with disabilities and those undertaking temporary employment such as bank or agency staff, We also know that junior staff, students and trainees can be hesitant to speak up due to concerns about authority and progression.

This delivery plan outlines our actions that make it easier to Speak Up, give confidence that action is taken and that our organisation learns from speaking up and listening with goals and outcomes identified for the next 3 years. The freedom to speak up service will work towards making speaking up business as usual throughout the organisation to enhance the work life of the healthcare workforce and improve the quality and safety of care.

The document will ensure the Freedom To Speak Up service within the Dudley Group NHS Foundation Trust is in line with The National Guardians Office 2024 Strategy.

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Our Approach to Freedom to Speak Up 2025-2028

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Supporting delivery against the key strategic goals of:

- Delivering the right care in the right place, at the right time
- Being a brilliant place to work and thrive
- Building innovative partnerships to improve the health of our communities

Our plan outlines how we will achieve our ambition to make speaking up business as usual and to ensure our people:

- Feel safe to speak up and remove any barriers to doing so
- Are confident they are listened to
- Trust that action is taken to follow up on concerns raised, and
- Know that our organisations learns from this

Speak Up	**Listen Up**	**Follow Up**	**Ensure Learning**
Ensure all staff understand how to raise concerns Increase and develop Champion Network	Ensure all staff have accessed the training for their role Increase listening and engagement activities	Ensuring action is taken in response to concerns raised Increased visibility of actions taken to address concerns	Develop systems to ensure organisational learning from concerns raised Build an effective network of guardians across our system

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Our Approach to Freedom to Speak Up 2025-2028

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Speak Up	Listen Up	Follow Up	Ensure Learning
Ensure all staff understand how to raise concerns Increase and develop Champion Network	Ensure all staff have accessed the training for their role Increase activity and impact of listening and engagement activities	Ensuring action is taken in response to concerns raised Increased visibility and confidence in actions taken to address concerns	Develop systems to ensure organisational learning from concerns raised Build an effective network of guardians across our system
Key actions to deliver our goals			
Deliver communications plan Recruit, retain and develop champions Ensure new starters access awareness information	Promote and monitor training completed by staff. Develop and deliver annual plan of engagement and listening activities	Develop clear operating standards Explore barriers to speaking up and implement actions to reduce these	Undertake the national reflection tool annually and increase scores Establish routine ways of measuring experience of speaking up
Measures of success			
Staff survey metrics Increasing number of champions and increase in champion activity	Training compliance Staff survey metrics Increase in reporting of concerns Increased programme of activity	Publication of standards and key performance indicators Monitoring performance against indicators Increased reporting from under-represented groups	

Speak Up

Ensure all staff understand how to raise concerns
Increase and develop Champion Network

Year 1	Year 2	Year 3
Increase staff awareness through delivery of communications plan. Agree KPI measure and method for staff awareness of raising concerns.	Review impact of activity through experience questionnaire/metrics. Adapt and deliver annual communications plan.	Review impact of activity through experience questionnaire/metrics. Adapt and deliver annual communications plan.
Ensure raising concerns is included in Welcome to Dudley with 25% of new starters accessing training within 3 months by Q4 20252/6	Ensure raising concerns is included in Welcome to Dudley with 50% of new starters accessing training within 3 months by Q4 2026/7	Ensure raising concerns is included in Welcome to Dudley with 90% of new starters accessing training within 3 months by Q4 2027/8
Expand network of champions by increasing and training a minimum of 10 additional champions by Q4 25/26	Expand network of champions to ensure representation of key departments and challenge groups with a minimum of 20 additional champions by Q4 2026/7	Expand network of champions to ensure representation of key departments and challenge groups with a minimum of 20 additional champions by Q4 2027/28
Deliver ongoing development for existing champions through annual event and quarterly network meeting	Review effectiveness of champions with performance measures around concerns raised and awareness activity delivered. Deliver ongoing development for existing champions (quarterly and annually)	Review effectiveness of champions with performance measures around concerns raised and awareness activity delivered. Deliver ongoing development for existing champions (quarterly and annually)

Listen Up

Ensure all staff have accessed the training for their role Increase activity and impact of listening and engagement activities		
Year 1	Year 2	Year 3
Achieve 25% compliance of staff undertaking Speak Up training appropriate to their role. Ensure 50% of Board members have completed Board level training.	Achieve 50% compliance of staff undertaking Speak Up training appropriate to their role. Ensure 100% of Board members have completed Board level training.	Achieve 80% compliance of staff undertaking Speak Up training appropriate to their role. Provide an annual update on raising concerns for Trust Board annually including learning from concerns.
Develop an annual plan of engagement and listening activities to provide baseline including champion activity.	Review impact of activity on core metrics (concerns raised and resolved, increased confidence in raising concerns in Staff Survey). Publish annual plan of engagement and listening activities increasing each year.	Review impact of activity on core metrics . Publish annual plan of engagement and listening activities.

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Follow Up

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Ensuring action is taken in response to concerns raised
Increased visibility and confidence in actions taken to address concerns

Year 1	Year 2	Year 3
Explore reasons for anonymous concerns and take action to reduce proportion of anonymous concerns annually.	Review impact of actions on anonymous concerns through reduction by 10% of anonymous concerns by the end of 2026/7	Review impact of actions on anonymous concerns through reduction by 25% of anonymous concerns by the end of 2026/7
Establish clear operating standards and timescales for reporting, action and feedback.	Ensure that performance standards reach 80% compliance.	Ensure that performance standards reach 80% compliance.
Publish case studies, quotes and data on raising concerns to improve visibility. Ensure experience of raising concerns data is shared bi-annually.	Increased number of published case studies, quotes and data alongside experience of raising concerns data bi-annually. Measure impact through staff survey metrics on confidence in raising concerns	Review impact of activity through staff survey metrics on confidence in raising concerns. Review and adapt approach depending on impact.
Explore barriers to speaking up in under-represented groups highlighted and develop an action plan to address barriers. Ensure data reporting baseline provides breakdown by categories to measure change.	Review impact of actions on reducing barriers from under-represented groups – measure activity completed to reduce barriers and review data reporting by categories. Target to increase reporting by 10% from under-represented groups.	Review impact of actions on reducing barriers from under-represented groups. Review with stakeholders actions and impact. Target to increase reporting by 20% from under-represented groups.

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Ensure learning

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Develop systems to ensure organisational learning from concerns raised Build an effective network of guardians across our system		
Year 1	Year 2	Year 3
Undertake national self assessment of Freedom to Speak Up to provide baseline	Develop and deliver actions to improve areas of focus from national self assessment to evidence of strength (4/5)	Undertake national self assessment of Freedom to Speak Up with improvements in scores to best practice (5/5)
Develop and deliver method of assessing experience of raising concerns.	Deliver and report bi-annually on experience of users raising concerns. Increase satisfaction from baseline around experience and outcome.	Deliver and report bi-annually on experience of users raising concerns. Increase satisfaction from Year 2 around experience and outcome.
Embed approach to data triangulation, themes and lessons learned from concerns raised and use data to target raising concerns training and awareness.		
Develop Dudley's role in the system guardian work including annual events at Board level and shared annual report on learning from concerns raised across the system.	Develop Dudley's role in the system guardian work including annual events at Board level and shared annual report on learning from concerns raised across the system.	Develop Dudley's role in the system guardian work including annual events at Board level and shared annual report on learning from concerns raised across the system.

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Measuring Success

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Year 1 - Develop	Year 2 - Embed	Year 3 - Review
• Complete self assessment by end of Q3 2025/26 • 25% of new starters complete raising concerns training within 3 months in role • Achieve 25% compliance of staff undertaking Speak Up training appropriate to their role. • Increase number of champions by 10 (current number plus 10) • Ensure 50% of Board Members have completed training for their role • Published operating standards and timescales for responding to concerns • Clear process for experience assessment for those raising concerns. Initial date to provide baseline. • National reflection tool completed to provide baseline	• National reflection tool completed with improved scores to best practice (4/5) • 50% of new starters complete raising concerns training within 3 months in role • Achieve 50% compliance of staff undertaking Speak Up training appropriate to their role. • Increase number of champions by 20 (current number plus 20) • Ensure 100% of Board Members have completed training for their role • Reduce percentage of anonymous concerns by 10% • Ensure that performance standards reach 80% compliance. • Increase satisfaction from baseline around experience and outcome by 10%	• National reflection tool completed with improved scores to best practice (5/5) • 90% of new starters complete raising concerns training within 3 months in role • Achieve 80% compliance of staff undertaking Speak Up training appropriate to their role. • Increase number of champions by 20 (current number plus 20) • Ensure 50% of Board Members have completed training for their role • Reduce percentage of anonymous concerns by 25% • Ensure that performance standards reach 100% compliance. • Increase satisfaction from baseline around experience and outcome by 25%

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Monitoring Delivery

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Data Sources	Responsibility	Frequency
• New starters completing Speak Up training on Induction - ESR	• Freedom to Speak Up Guardian with Organisational Development	• Quarterly – reported through Speak Up Steering Group
• Champion Numbers – ESR	• Freedom to Speak Up Guardian	• Quarterly – reported through Speak Up Steering Group
• Speak Up Training and Board Training – E learning for Health	• Freedom to Speak Up Guardian	
• Staff Survey Metrics	• HR Business Partner for Retention	• Annual reporting Quarter 4
• People Pulse results	• HR Business Partner for Retention	• Quarterly in Quarter 1, 2 and 4
• Anonymous Concerns reported through Speak Up data dashboard	• Freedom to Speak Up Guardian	• Annual reporting Quarter 4
• Case Studies	• Freedom to Speak Up Guardian	• Bi-annually
• National Self Reflection Tool	• Freedom to Speak Up Guardian	• Annually Quarter 3 through Speak Up Steering Group
• Data triangulation on Speak Up concerns, Datix, Patient Safety	• Freedom to Speak Up Guardian with Patient Safety team	• Quarterly reported through Speak Up Steering Group

Reporting arrangements
Reporting to Freedom to Speak Up Steering Group – Quarterly
People Committee – Quarterly
Trust Board - Quarterly

5. Leadership and Speaking Up Event Overview.

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Transforming Culture Through Leadership and Speaking Up Event 27th June 2025 Overview

We had 61 attendees in total including Guardians

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Opening address

Gary Crowe

Gary Crowe is the Deputy Chair at The Dudley Group and has been a non-executive director in the NHS for the last ten years, serving in three different provider Trusts in acute, community and specialist care.

Gary has experience from a variety of sectors including education, banking and finance, healthcare and management consulting. Gary has held various senior position in strategy, business transformation and risk and financial management as a director.

Most recently, Gary was a university professor of Innovation Leadership at University of Keele Management School and Loughborough University.

Our Patients
Our People
Our Place

The importance of listening to understand and organisational follow up.

NHS
The Dudley Group
NHS Foundation Trust

West Midlands Ambulance Service University NHS Foundation Trust
Black Country Integrated Care Board

Bethany Carter

Bethany qualified as a nurse in 2005. She is a highly experienced infection prevention (IP) specialist with a demonstrated experience of working in a variety of clinical settings and has a keen interest in compassionate and inclusive leadership, patient safety, education, human factors, and behavior change to influence good clinical practice.

On retiring from the military after a 17-year career, Bethany joined the Infection Prevention Team in Solent NHS Trust in January 2016. Her career at Solent saw her develop into the Head of IP role at the start of the SARS-CoV-2 pandemic. In September 2022, she took up the position of Lead Guardian for Freedom to Speak Up (FTSU).

In November 2023, Bethany took up her current position at the National Guardians Office as National Lead for Guardian Support and Policy, leading the Guardian Support and Policy team in providing guidance and support to Freedom to Speak Up guardians across England, including the development and implementation of training, guidance, and co-branded initiatives with partner organisations and stakeholders.

Prior to joining the NHS Bethany served in both the Royal Navy, where she qualified as a nurse, and subsequently as a Nursing Officer in the British Army. A career which spanned 17 years and saw her deploy on operations to Afghanistan and Sierra Leone where she worked as a specialist in the Ebola Virus Disease Treatment Unit.

Bethany is an ambitious and determined leader who has developed a set of operational and strategic, management and leadership skills. Her drive is intrinsically linked to her inherent caring nature, and she firmly believes in creating a culture of openness and transparency to improve and develop the wider workforce to ensure positive experiences and outcomes for both staff and service users.

"Not just one of those things" A black nurse's stance against racism and speaking up.

Michelle Cox

Michelle Cox is a distinguished nurse with over 30 years' experience in the NHS. Her extensive clinical background has been instrumental in shaping her commitment to promoting anti-racism practices within the healthcare sector.

In a landmark employment tribunal in early 2023, Michelle successfully challenged NHS England for race discrimination, harassment, and victimisation, underscoring the systemic challenges faced by many staff from the global majority within the NHS.

Beyond her work in the UK, Michelle has extended her expertise internationally through medical missions to Ghana and Sierra Leone. These missions focused on delivering community-based healthcare, sharing best practices, and supporting local healthcare professionals, reflecting her dedication to global health equity.

In recognition of her significant contributions to nursing and community healthcare, Michelle has been honoured as a Fellow of both the Royal College of Nursing and the Queen's Institute of Community Nursing. These prestigious fellowships acknowledge her dedication to advancing nursing practice and her efforts in fostering inclusive and equitable healthcare environments.


How did you feel after the workshop?
thoughtful
uplifted
disturbed
confused
supportive
humbled
sad
frustrated
committed
moved
hopeful
optimistic
enlightened
encouraged
inspired
informed
empowered
enthused
engaged
challenged
impacted
humble
energised
re-energised
happier
but more aware
safe space
brave


What were the key take away messages for you?
together we can do this
don't give up
confident in process
know your rights at work
speaking up is a big deal
empower to speak up
actively listen
to understand
escalate
challenge
relevance of roles
speak up
listen
be human
collaboration
bold
support
follow up
justice
apologise
speak-up
to listen
learning
comfort
change
be humble
act
leglislation
follow your instinct
be less defensive
importance of listening
allyship matters
racism can be very subtle
manage expectations
racism needs addressing

Our Values: Care, Respect, Responsibility

NHS
The Dudley Group
NHS Foundation Trust

GREEN PLAN 2025 - 2028

CONTENTS

EXECUTIVE FOREWORD

As a major acute and community healthcare provider, the Dudley Group NHS Foundation Trust recognises the significant environmental impact of delivering care to our communities. Like all large organisations, we consume substantial amounts of energy and water, generate waste, and are responsible for thousands of staff, patient, and visitor journeys every day.

Our vision is to deliver excellent healthcare for the people of Dudley. A key part of achieving this is working seamlessly with our partners to create healthier, fairer, and more sustainable communities. The Green Plan is a central driver of this ambition. It sets out how we will reduce our environmental impact across travel and logistics, asset management, climate adaptation, capital projects, sustainable models of care, procurement, and the use of natural resources.

Over the past four years, we have made significant progress in reducing our environmental impact and reducing our carbon emissions.

Some key achievements include:

- Secured almost £600,000 from the NHS National Energy Efficiency Fund to deliver LED lighting upgrades and solar panels in 2025. This is estimated to save 111 tCO_2e per year.
- Significant uptake of the free bus passes provided by National Express and Transport for West Midlands (TfWM). Over the last 12 months, more than 425 staff members have claimed the offer, totalling 15,861 bus journeys, which saves an estimated 5 tCO_2e by switching from car to bus.
- In November 2023, the Trust upgraded anaesthetic gas machines to newer models, providing data on gas use and enabling the Trust to move away from the Manifold supply. Working with PFI partners, the manifold was successfully decommissioned in July 2025, estimated to save 414 tCO_2e per year.
- Our Pharmacy Team has worked hard to establish the pharmacy returns scheme, where drugs from wards that aren't used by patients are re-dispensed by the pharmacy. This has saved £63,300 and saved 8.1 tCO_2e by returning over 2,300 drugs.
- The Trust has embedded sustainability through various methods, from preceptorship training, our Quality Priorities, all the way through to our annual Committed to Excellence ceremony, which has a dedicated Sustainability Award.
- The Trust has over 100 Green Team members who support delivering the Green Plan within their areas of work, be delivering their own projects to raise awareness. Heather Jones, on ICU, has engaged the whole department to form a small team delivering multiple projects which save time and money whilst reducing wastage. Such as their shift from 50ml syringes to 100ml propofol bottles saved 125 nurse hours, nearly 11,000 syringes, and £3,858.

Our Green Plan will measure success not only in reducing carbon emissions, but also in improving air quality, shifting travel behaviours, cutting single-use plastics, and building a more circular economy. Equally important are the wider benefits: healthier communities, reduced inequalities, and more resilient services. By embedding sustainability into decision-making and tracking progress against clear metrics, we will deliver benefits for patients, staff, and our local population. Our latest carbon report (2023/24) shows a 7% reduction in emissions since the 2019/20 baseline; down by 2,836 tCO_2e. To reach our 2032 Net Zero target, we must reduce emissions by a further 5.4% each year (2,148 tCO_2e). While NHS England has not set annual milestones, this benchmark helps us monitor progress and the pace of change required.

We remain committed to building on this success. As an anchor institution, we are proud to collaborate with partners such as Dudley Council, the West Midlands Combined Authority, Summit and Mitie, Transport for West Midlands, and others. Together, we are contributing not only to reducing carbon emissions but also to improving health, wealth, and regeneration across our region.

Looking ahead, this Green Plan will guide us in adopting more efficient and sustainable practices. Alongside it, we are implementing ambitious Net Zero Carbon plans, with a particular focus on transitioning to low-carbon energy and technology. Together, these programmes will embed sustainability into our daily operations, while inspiring and enabling our staff and patients to take part in this shared journey.

We know that public health is inseparable from the health of our planet. Without a sustainable environment, we cannot sustain a healthy population. That is why we are committed to embedding sustainability across our organisation and working with local and national partners to deliver positive, lasting change.

Through the South Black Country Group – a collaboration between Sandwell and West Birmingham NHS Trust and Dudley Group NHS Foundation Trust – we are further strengthening our commitment to sustainability. The Joint Infrastructure Committee, with a remit covering digital, data, estates, facilities, and sustainability, is aligned to the Government's 10-year plan and will ensure that our infrastructure supports clinical excellence, improved outcomes, and a sustainable future for the communities we serve.

This Green Plan is not just about reducing carbon – it is about building resilience, protecting public health, and securing a better future for generations to come.

Rachel Barlow
Group Chief Development Officer
The Dudley Group NHS Foundation Trust and Sandwell & West Birmingham NHS Trust

EXECUTIVE SUMMARY

Sandwell and West Birmingham (SWBT) NHS Trust and The Dudley Group NHS Foundation Trust (DGFT) recognise climate change as a critical public health issue driven by human activity and commits to mitigating its impact through partnership and collective action.

The refresh of the Green Plan aims to refocus engagement and action on areas within the Trust's control. Focusing on embedding lower carbon care principles through the whole patient pathway.

This plan outlines the Trust's updated strategies and ambitions across several critical areas to achieve its net zero and sustainability goals, driven by strong commitment from its people, strategic estate management, sustainable transport initiatives, responsible medicine practices, and a circular economy approach to procurement and food. Significant strides have been made, particularly through new partnerships and collaborations. However, systemic, transformational changes are still required across the healthcare system to achieve net carbon zero and sustainable ways of working. The Trust is dedicated to addressing climate change as a core public health responsibility through strategic planning, strong partnerships, and continuous effort towards a more sustainable future.

INTRODUCTION

Our key overarching aims across the Trusts are:

- To deliver high-quality care without exhausting resources or causing environmental damage to preserve resources for future generations,
- To develop ambitious net carbon zero plans, including decarbonising our estates,
- To embed sustainability into the heart of our organisation and lead on driving working practice towards using resources, like energy and water, more efficiently to reduce wastage, and
- To engage and inspire our colleagues and patients to take actions that will collectively make a big impact.

ABOUT US

The Dudley Group NHS Foundation Trust is the main provider of hospital and community services to the population of Dudley, parts of the Sandwell borough and smaller but growing communities in South Staffordshire and Wyre Forest.

The Dudley Group provides a wide range of medical, surgical and rehabilitation services to a population of over 450,000 people from three main sites; Russells Hall Hospital, Guest Outpatient Centre in Dudley and Corbett Outpatient Centre in Stourbridge, and in people's homes from the Trust's community sites.

Since October 2024, the Trust also offers primary care services and hosts two General Practices, High Oak in Pensnett and Chapel Street, in Lye. This was part of the transition of staff and services from Dudley Integrated Health and Care Partnership. With the addition of primary care services, the Trust now employs over 6,000 substantive staff and provides a bigger range of integrated services.

WHY DO WE NEED A GREEN PLAN?

The climate emergency is a health emergency. From poor air quality to rising heat-related morbidities and extreme weather events, climate change is already impacting the health and wellbeing of our communities, especially the most vulnerable.

The NHS is the first health system in the world to embed net zero into legislation. Under the Health and Care Act 2022, NHS England, Integrated Care Boards (ICBs) and Trusts now have a legal responsibility to contribute to statutory emissions targets. In line with this, all NHS organisations must have a Board-approved Green Plan, regularly reviewed and informed by staff, patients, and wider communities.

At the same time, the UK's Climate Change Act sets out our national carbon reduction commitments. The NHS accounts for around 4-5% of the UK's total carbon footprint, making us both part of the problem and key to the solution.

We are legally obliged to address climate change, with a reduction in carbon emissions set out in the UK's Climate Change Act (CCA). This Plan responds to these and other requirements placed on the Trust to manage and reduce our environmental impact.

We published our first Green Plan in 2020; this refresh continues that journey, building on good practice and further embedding sustainability within the Trust. We have developed our Green Plan to be inclusive and representative whilst responding to a rapidly changing world. Sustainable healthcare will help our budgets stretch further; it contributes towards the green ambitions of the region and aligns with prevention to further reduce pressure on health services.

We are committed to delivering high quality, low carbon health care. Our vision is to provide lower carbon and sustainable care to improve patient outcomes and reduce emissions throughout the whole patient pathway. By 2032, we aim to achieve a 47% reduction in

carbon emissions, aligning with NHSE targets and ensuring we play our part in tackling the climate crisis, as it to, is a health emergency.

OUR PROGRESS SO FAR

Momentum with our Green Plan has really grown over the last two years, with more staff becoming engaged and joining the Green Team to develop their own sustainable projects. We've had some great examples, such as Greener Pharmacy, which won a Committed to Excellence Award in 2024 for their medicine return project.

The 2023/24 carbon report showed that our emissions have reduced by 7% since the baseline year (2019/20). For us to meet the net zero target, we need to reduce emissions by a further 5.4% each year, or 2,148 tCO_2e[1]. We're working with the PFI[2] partners within the Energy and Estates Sub-Group to progress action and meet net-zero. LED lighting and ventilation setbacks are just some of the projects that are building momentum as we head into 2025/26.

Green Plan Working Group have delivered many Green Week campaigns, engaging with hundreds of staff, organised feedback sessions and toured the hospital to raise awareness and gather feedback from those on the shopfloor for their sustainable improvement ideas.

The Trust has partnered with travel providers to deliver travel offers for staff and patients, resulting in a modal shift and reducing the cost of travel.

Key achievements:

- Increased Green Team members to over 100 members
- Delivered many training sessions, awareness events and green weeks
- The Trust-wide Committed to Excellence now has a dedicated Sustainability Award
- Established a Greener Pharmacy Team to deliver projects such as the medicine returns, saving £81,267.97 and 50 tCO_2e in 24-25.
- Food waste is now being sent to anaerobic digestion, generating energy for the national grid.
- Secure funding from NEEF for Solar Panels and LED lighting replacement within the retained estate
- Delivered over 600 free travel tickets to staff and patients
- Green Team members are working to reduce plastic waste whilst reducing unnecessary blood testing, improving recycling and overall sustainability knowledge.
- Digital Patient Letters: reducing emissions and cost from both paper and transport.
- Remove the use of Desflurane

1 tCO_2e, tonnes of Carbon Dioxide equivalent
2 PFI – Private Finance Initiative; **Private Finance Initiative partners - The Dudley Group NHS Foundation Trust**

Series of photos from events and training across the Trust. From bulb planting to team projects, green week events and cycling maintenance.

STAKEHOLDERS

Delivery of the Green Plan cannot be achieved in isolation. We will therefore continue to work closely with our system partners and proactively engage with a broad range of stakeholders. This includes seeking collaborative opportunities with local authorities, universities, transport providers, third-sector organisations, and industry partners to support the delivery of Green Plan actions. In particular, our PFI partners, Mitie and Summit, who are responsible for the lifecycle works of our sites, therefore collaboration is required to ensure lifecycle and other projects align with the estate's net-zero targets. We will also explore alternative funding streams to invest in our estate, accelerate innovation, and strengthen progress towards net zero.

BLACK COUNTRY ICS

- Black Country ICB
- The Royal Wolverhampton NHS Trust
- Sandwell & West Birmingham Hospitals NHS Trust
- The Dudley Group NHS Foundation Trust
- Walsall Healthcare NHS Trust
- Black Country Healthcare NHS Foundation Trust
- West Midlands Ambulance Service
- Primary Care Services

WIDER NHS

- Birmingham and Solihull ICS
- Greener Midlands Teams
- NHS England
- Midlands Clinical Product Evaluation Group
- Midlands Nursing and Midwifery Clinical Transformation Group
- National workstream groups such as estates, waste, biodivesrity etc.

EXTERNAL

- West Midlands Combined Authority
  - Travel
  - Air Quality Monitoring
  - Climate Adaptation
- Travel Providers and Operators
- Local Authorities
- Property Services
  - PFI
  - NHS Property Services
  - CHP
- Local University and Colleges
- Suppilers

AREAS OF FOCUS

Our People, Workforce & Leadership

Encourage and inspire staff, local population and wider stakeholders to implement good environmental practices.

Estates & Facilities

Transition to low carbon technologies, ensuring our estates are as energy and utility efficient as possible.

Travel & Transport

Encourage active and sustainable modes of travel and transition to low emission vehicles.

Medicines

Enable care pathways that improve patient outcomes whilst reducing resource use and carbon emissions.

Food & Nutrition

Deliver high-quality, healthy and sustainable food and minimise waste.

Net Zero Clinical Transformation

Enable patient and clinician led service redesign and embed prevention into the development of our care models. Encourage patients and staff to make lifestyle choices that will improve their health.

Digital Transformation

Prioritise sustainability in the procurement, design and management of digital services.

Climate Change Adaptation

Plan, mitigate and build future resilience so that there is limited impact on the delivery of our patient care and to our staff.

Supply Chain & Procurement

Transition to whole lifecycle environmental, social and costings based decision making. Use evidenced based practice to challenge overuse of products and look at care pathways that deliver outcomes that also save resources..

OUR PEOPLE, WORKFORCE & LEADERSHIP

Real change happens when people understand why sustainability matters, see their role in how to deliver it, and are supported to act. Without engagement and training, our Green Plan risks having a limited impact, and we will not meet our net-zero targets.

Success depends not just on infrastructure, but on people. Training empowers everyday action, while leadership drives change and secures investment. Without this, we risk missing national targets and being left with outdated systems, higher costs, and greater health impacts.

WE HAVE

9 in 10 staff support the NHS net zero ambition, while 6 in 10 say they are more likely to stay in an organisation taking decisive climate action (YouGov, 2023).

The Trust has embedded sustainability within the Preceptorship Programme and is looking to host sessions within other development courses to raise awareness and increase the number of projects.

WE WILL

- By 2027/28 increased awareness of sustainability amongst staff.
- Increase workforce carbon literacy via E-learning for health or other courses and education opportunities.
- Embed sustainable quality improvement into every QI project.

KEY PERFORMANCE INDICATORS

- Increase how well-informed staff are on the green plan from 38% feel informed to 60% by 2028.
- Number of staff completed the online training module.

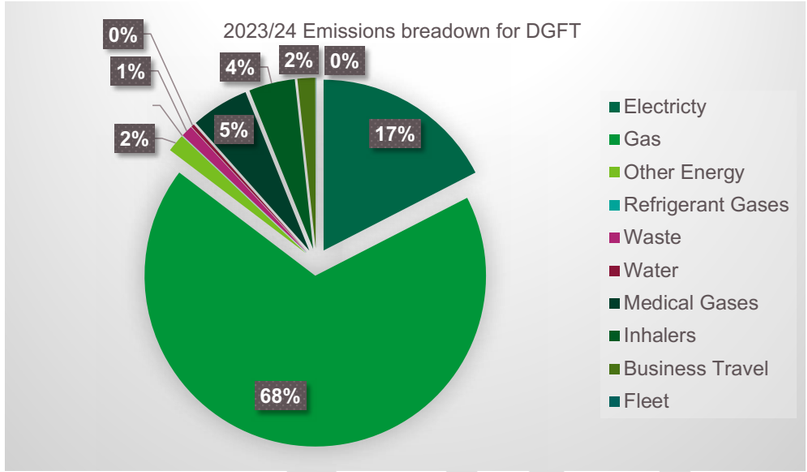
RISKS

- Resource and dedicated time for colleagues to deliver sustainability actions.
- Time and availability of colleagues for training.

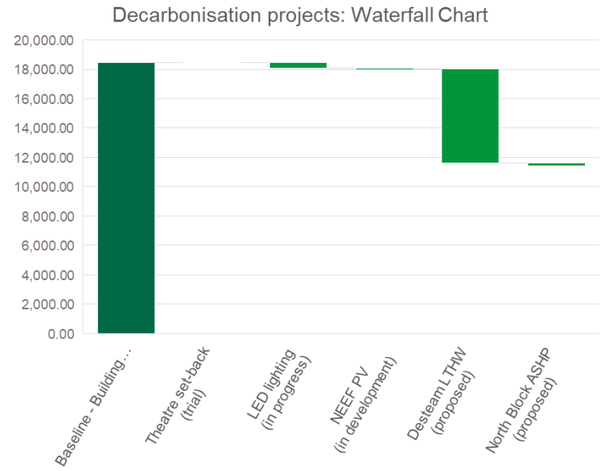
ESTATES & FACILITIES

There are significant opportunities across the NHS estate to reduce emissions and lower costs, while improving energy resilience and patient care. We aim to transition to low-carbon technologies, ensuring our estates are as energy and utilities efficient as possible.

Estates and Facilities is an important part of the Green Plan and the delivery of our carbon reductions. Across the two Trusts, 88% of our NHS Carbon Footprint is from our building energy; electricity, gas, and oil. Action in this area is critical in achieving our net-zero ambition. We will measure and report significant carbon emissions on an annual basis.



The waterfall chart below shows the estates projects under development, in progress and proposed, these would deliver a 7,126 tCO2e or 39% carbon saving for building energy, leaving a further 8% to meet the 47% reduction target by 2032.



WE WILL

- By the end of 2026/27 develop a heat decarbonisation plan, which includes identifying and prioritising the phasing out of all existing fossil-fuel primary heating systems by 2032 and seeking to remove all oil primary heating systems by the end of 2027.
- Remove the 3 oil-fired boilers from North Block by 2027.
- Improve the ground maintenance programme to increase biodiversity onsite.
- Ensure all infrastructure projects deliver a biodiversity net gain.
- Replace lost trees and improve remaining natural spaces.
- Improving waste segregation and compliance by aiming for a 20-20-60 waste split – 20% incineration (yellow bag) waste, 20% infectious (orange bag) and 60% offensive waste.
- Increase the proportion of recycled waste streams against non-clinical waste streams: Achieve 50% of non-clinical waste to be recycled by 2028.
- Achieve at least a 65% recycled rate of non-clinical waste by 2035 (DEFRA target).
- Deliver a 30% reduction in carbon emission from clinical waste segregation; a 50% reduction in the carbon emission produced from wider waste management by 2025/26 and 80% by 2032.
    - Increasing the provision of bins throughout the Trust and communal areas. This will ensure that waste is appropriately segregated which will increase compliance whilst increasing recycling rates.
    - Ensure staff are trained and understand the waste process
    - Ensure that good quality goods are appropriately reused and redistributed within the Trust, and where this isn't possible, will look to offer unwanted goods within the system.

KEY PERFORMANCE INDICATORS

- % of sites with a heat decarbonisation plan.
- Emissions from fossil-fuel-led heating sources.
- % area of lawn with reduced lawn mowing.
- Number of trees and plants planted.
- All new infrastructure projects must achieve and evidence at least a 10% net gain in biodiversity, verified through a recognised biodiversity metric (e.g. Natural England's Biodiversity Metric).
- Tonnes of clinical waste.
- Quantity generated (kg per patient) for each of HTI, AT and OW streams.
- % diverted waste against general waste (tonnes).

RISKS

- Limited funding to deliver net-zero projects. Public Sector Decarbonisation Scheme (PSDS) funding is no longer available for acute Trusts from 2025.
- Lack of internal resources to deliver and fund the relevant energy efficiency schemes and Heat Decarbonisation Plan.
- Limitations of estate improvements and decarbonisation due to the PFI arrangement.
- Funding to provide adequate receptacles to meet waste and recycling targets.

TRAVEL & TRANSPORT

The NHS fleet is the second largest in the country, consisting of over 20,000 vehicles. It directly contributes to harmful air pollution.

WE HAVE

We have worked closely with travel providers to offer better discounts and saving for staff but also to support modal shift. We run an annual staff travel survey that shows roughly 70% of staff travel by car alone to work, and using other data sources, we have identified that 76% live within 5 miles of RHH and 52% live within 3 miles. Showing that our workforce is very localised, active and sustainable travel modes would benefit staff by saving money and improving health and wellbeing. 34% of permits have matching postcodes; this indicates the car-sharing platform should be better utilised.

WE WILL

- Deliver the targets set out in the Travel Plan for RHH.
- Continue to support staff with travel offers.
- Increase the number of staff on the cycle to work scheme.
- Increase the response rate for the staff travel survey, currently at 12% aim for 20% by 2028.
- Increase the offers for patient travel.
- By 2026, all vehicles offered through NHS vehicle salary sacrifice scheme will be electric.

- Monitor Air Quality Levels at RHH, establish baseline for 25/26.
- Review the updated Travel Plan following the release of the Travel and Transport guidance due in 25/26. Develop a Travel Plan for each site.

KEY PERFORMANCE INDICATORS

- Site Specific Sustainable Travel Plan with SMART targets
- Number of staff receiving travel offers
- Monitor the modal shift in travel survey data.
- Number of staff on cycle solutions
- % of Trust staff responding to annual travel survey.
- Number of travel offers and support available for patients.
- Number of patients who have participated in travel offers and total journeys taken.

RISKS

- Resource to deliver site-specific sustainable travel plans by December 2026
- Lack of staff engagement and Trust wide communications to deliver travel offers effectively
- Current cost of sustainable travel modes in comparison to free car parking
- Investment to improve sites for sustainable and active travel modes

MEDICINES

Medicines account for around 25% of NHS emissions, with anaesthetic gases and inhalers being 'point of use' emissions focus areas. Optimising medicine use and reducing waste will reduce emissions and improve patient care.

WE HAVE

We have a well-established sustainability group within the Pharmacy Department. Delivering the Medicine returns project, which won our first Sustainability Award at the annual Committed to Excellence event, has saved 8.1 tCO2e and £63,308.79 by returning 2,300 drugs.

Promoted ICS engagement 'lunch and learn' sessions with guest speakers to engage colleagues on the importance of assessing inhaler technique and prescribing, where clinically appropriate, Dry Power Inhalers (DPI) which have a much lower carbon impact than Meter Dose Inhalers (MDIs).

Established a Greener Theatres Group with an action plan to drive the move to greener ways of working.

No desflurane has been purchased since 2016; desflurane is a very high carbon anaesthetic gas with a potent global warming potential. Sevoflurane is the primary anaesthetic gas used across the Trust. Sevoflurane is one of the lowest carbon inhalational anaesthetic agents. We have also worked closely with Mitie to decommission the Nitrous Oxide Manifold, which is estimated to save 414 tCO2e annually.

WE WILL

- Reduce the number of medicines and inhalers that are automatically ordered on admission.
- Continue to move from IV-administered medicine to oral medicine when clinically appropriate.
- Continue to deliver the pharmacy returns scheme

KEY PERFORMANCE INDICATORS

- Inhalers ordered within the emergency department and SDEC.
- Paracetamol – IV and Oral
- Antibiotics – IV and Oral
- Number of drugs returned to the pharmacy
- Monitor tonnes of pharmaceutical waste produced

RISKS

- Demonstrating the impact of improving inhaler prescribing
- Lack of funding to support the upfront costs for sustainable medicine projects, resulting in delays or project termination

FOOD & NUTRITION

When food is produced, processed, distributed, served and then wasted, it creates an unnecessary carbon impact. Procuring local, seasonal and healthy food and reducing waste will significantly reduce the environmental impact of the food we procure. It will also improve the health of our population.

WE WILL

- Continue to monitor food waste via digital ordering.
- Establish baseline data for food waste.
- Ensure all areas that generate food waste have an adequate waste stream and collection schedule for the volume of food waste generated by March 2026.
- Ensure that menu reviews consider opportunities to make menus healthier and lower carbon by supporting the provision of seasonal menus high in fruits and vegetables and low in heavily processed foods.

KEY PERFORMANCE INDICATORS

- Food waste sent for anaerobic digestion
- % of ward-level food waste from digital ordering platforms

RISKS

- Data accuracy for monitoring food waste and source
- Operations of food services, ensuring suppliers can offer seasonal and lower-carbon foods

NET ZERO CLINICAL TRANSFORMATION

Delivering health care with increasing environmental, social and financial pressures is challenging but essential. For our health care system to become more efficient and futureproof, we need to embed holistic sustainable practices and take a more proactive (rather than reactive) approach.

WE HAVE

In February 2025, the Midlands Team launched a transformation challenge for Nursing and Midwifery, in the Black Country and Dudley, the focus is on "Bathroom First" to support reducing single-use items like pulp bowls whilst improving care and patient experience. We have also embedded these actions with the Trust's Quality Priorities.

WE WILL

- Reduce use of single use products:
- Reduce the unnecessary use of non-sterile gloves used
- Reduce the use of pulp products (used for patient hygiene)
- Embed sustainability into the quality agenda so it's not an additional piece of work but a "green" thread running through everything we do
- Plan to transition to reusable items where safe to do so in line with the Department of Health and Social Care (DHSC) Design for life Circular economy work.
- Measure the impact of Virtual Wards and Remote Outpatient Appointments on travel emissions.

KEY PERFORMANCE INDICATORS

- Projects include carbon consideration in their outputs.
- 3-year delivery plan against the Quality Priority 11, focused on Bathroom First, Gloves Off and Couch Roll.
- Reduction in waste, spend and carbon footprint
- Percentage of outpatient follow-up appointments conducted remotely
- Number of virtual wards and patients cared for at home

RISKS

- Lack of time and resources for staff to develop and drive sustainability projects
- Progression of digital and virtual wards could lead to an increase in travel emissions with staff travelling to patients (Grey Fleet)
- Drive to return to normal post-COVID when virtual appointments peaked, since then percentage of virtual appointments has dropped

DIGITAL TRANSFORMATION

Digital sustainability is a critical element in transforming health and social care. Recognising the environmental and cost impacts of digital technology, the Trust's Digital Strategy supports the Trust's commitment to delivering a green agenda that aligns with both local and national sustainability objectives, including the Greener by Design and the Fit for the Future ten-year health plan, which is a blueprint for transforming healthcare in England. The plan is deeply intertwined with digital sustainability, ensuring that technological innovation supports long-term health outcomes, environmental responsibility, and operational resilience.

Strong digital foundations are essential for transforming care by improving access, quality, productivity and reducing emissions. Although digital services can sometimes increase carbon output, our transition to new digital ways of working has the potential to reduce travel and other carbon emissions associated with delivering and managing healthcare.

WE HAVE

The Trust has transitioned to digital patient letters, with 66% of letters being sent via text. Resulting in patients being able to reschedule or cancel appointments, adding appointments to their diaries, and supporting the Trust to reduce Did Not Attend.

Work has begun to improve the efficiency of processes by transitioning regularly used paper forms and referrals to digital to save on not only paper, printing and lost work, but also improving staff time and communication pathways.

WE WILL

- Continue to support remote working for colleagues to reduce the impact of commuting
- Continue to transition to digital systems to minimise resource consumption from paper to postage.
- Work with an IT disposal company to improve end of end-of-life process for equipment i.e. donate devices to local charities and recycle and reuse component parts by 2028.
- Investigate the feasibility of automatic shutdown of devices and the energy savings associated.
- Integrate circular economy principles into our informatics, focusing on repair and reuse to minimise waste.

KEY PERFORMANCE INDICATORS

- Measure waste produced from IT services, estimate a benchmark either in tonnes or the number of items
- Paper consumption reduction

RISKS

- Digital improvements can lead to an increase in IT equipment turnover and overall wastage
- Digitalisation and shift to AI tools can increase our footprint from data storage and cloud hosting

CLIMATE CHANGE ADAPTATION

Climate change poses a fundamental threat to places, species and people's livelihoods. Due to climate change, heatwaves, storms and floods are affecting the way that care is delivered across the NHS. Scientific evidence strongly indicates that these events will only become more frequent over the next 30 years.

We will plan, mitigate and build future resilience with a changing climate to reduce the risk posed to the delivery of care.

WE WILL

- Align the current climate adaptation plan with the NHS Climate Adaptation Framework
- Work with local partners to integrate within broader emergency planning, alerts and climate resilient practices
- Track overheating within buildings
- Climate resilience is included in the Trust resilience planning and adaptation strategies

KEY PERFORMANCE INDICATORS

- Overheating occurrences triggering a risk assessment:
- Number of occasions, as outlined in the trust's "heatwave" plan, that in each occupied ward or clinical area where the **daily maximum temperature exceeded 26˚C**.

RISKS

- Investment to improve and adapt the estate
- Impact of heat events on services, estate infrastructure has limited cooling capability impact the safe delivery of care.
- Current levels of preparation for a changing climate are inadequate across the UK (**CCC.org.uk, 2025**)

SUPPLY CHAIN & PROCUREMENT

The NHS is a vast consumer of goods and natural resources. Procurement of medical devices, equipment and medicines are major contributors of carbon emissions – they make up 62% of the NHS, Public Health and Social Care total carbon footprint (2020 data).

WE WILL

- Ensure 10% social value is monitored
- Engage with suppliers to increase the number of products that meet circular economy principles; i.e. reusable, remanufactured.
- Review the Trust's Adverse Weather Plan and Action Cards with climate change in mind.
- Reduce the risk of surface level flooding, review the risk level at RHH, and increase the number of trees planted.
- Work with supply chains to ensure their climate adaptation and ours align should major incidents like floods or heatwaves don't impact services
- Measure scope 3 emissions from our procurement spend

KEY PERFORMANCE INDICATORS

- The five social value theme outputs are tracked and reported quarterly and via the integration committee as well as finance and performance committee.
- Number of product lines moved to reusables.
- Carbon and waste reduction.
- Collaborative climate adaptation plan written with NHS supply chain

RISKS

- Resilience in the supply chain to mitigate impact on service delivery within a changing climate
- Availability of data for accurate carbon reporting
- Resource to monitoring contracts and delivery of the 10% for social value

GOVERNANCE & ACCOUNTABILITY

The Green Plan Working Group will be established and will meet on a quarterly basis, reporting to the Joint Infrastructure Committee.

The Joint Infrastructure Committee will be led by the net zero board lead that oversees DGFT and SWBT progress on the Green Plan.

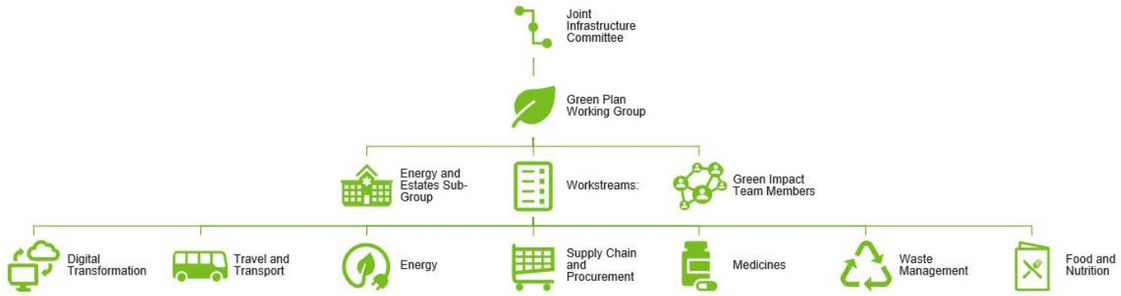
The Energy and Estates relevant sub-groups will meet on a bi-monthly basis to progress the pressing need to address estate emissions and to develop a heat decarbonisation plan. Elements of the carbon footprint will be monitored on an annual basis, full carbon accounting take place by NHSE to avoid double counting emissions.

The Sustainability Lead for DGFT and the Head of Sustainability for SWBT will provide regular reports to various boards and committees, alongside reporting key achievements in the Trust's Annual Reports. Joint, overarching KPIs will be set across both Trusts, and these will be monitored regularly.

DEVELOPING THIS PLAN

The Green Plan Working Group members and workstream leads have had sight of the green plan refresh and the guidance from NHSE.

We conducted a staff survey in July 2024, which helped us understand the current level of understanding within the Trust and what staff's ideas and focuses were for greener activity.



LEGISLATION

Health and Care Act 2022 (legislation.gov.uk)

Environment Act 2021 (legislation.gov.uk

RELEVANT DOCUMENTS

Green Plan Guidance

Greener NHS Guide (2021)

NHS Standard Contract 2025/26 Service Conditions: SC18

NHS Clinical Waste Strategy

Net Zero Travel and Transport Strategy

Carbon reduction plan and net zero commitment requirements for the procurement of NHS goods, services and works

NHS Net Zero Building Standard

A greener NHS

CQC – Well Led: Environmental sustainability

TRUST DOCUMENTS

Green-Plan-DGFT-2020-2025.pdf

Climate Change Adaptation Plan

Waste Management Policy to be reviewed in December 2024 Waste Management Policy.pdf

OUR STAFF PUBLICATIONS

- Nash, C (2021) Time to act: what nurses can do to reduce the environmental burden of PPE. *Nursing Times*, 117 (8), pp 18-20.
- Nash, C. (2023) It's not easy being green. Available at: Nursing Times [online] August 2023 / Vol 119 Issue 8
- Nash, C. and Nelson, J. (2024) Reusable tourniquets – their impact on patients, planet, and public purse. *Nursing Times* [online]120 (8) pp2-6.

GREEN PLAN 2025 - 2028

M8510 Designed by Medical Illustration Design Team at Sandwell and West Birmingham NHS Trust. swbh.miprint@nhs.net

Our Patients
Our People
Our Place

NHS
The Dudley Group
NHS Foundation Trust

Quarterly strategy and annual plan progress report Apr – Jun 2025

Our Patients
Our People
Our Place

NHS
The Dudley Group
NHS Foundation Trust

Progress against annual plan 2025/26

Dudley Improvement Practice

ANNUAL PLAN 2025 – 2026

This is how we will deliver our plan

NHS
The Dudley Group
NHS Foundation Trust

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

In Year Objective : Implement care navigation centre

Quarter: Apr – Jun 2025	Executive sponsor: Kat Rose

Objective status

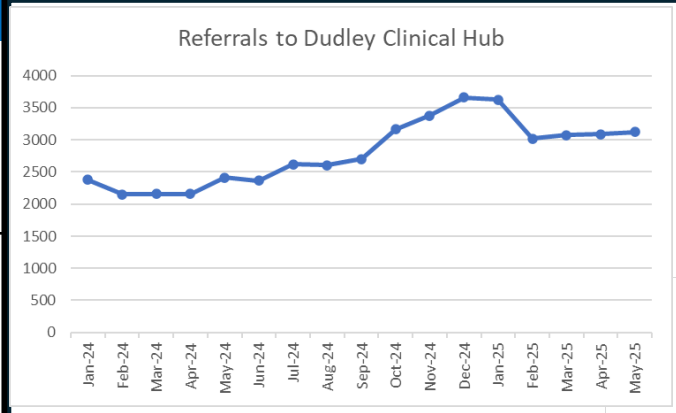
		Status
Summary	Decision to allocate a portion of funding held in reserves to support expansion of Dudley Clinical Hub into a Care Navigation Centre. Business case developed quantifying the benefits which are estimated to be over 11,000 fewer patients attending ED by offering alternative pathways. Outputs from Community First Value Stream Analysis in April supporting the implementation	

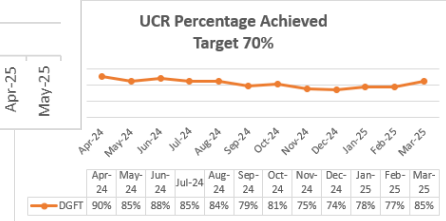
How achieved?	Status	Progress this quarter	Priorities for the next quarter
Staffing capacity and skill mix to meet increased demand		Decision to proceed at risk with recruitment Recruitment successful with 3.33 wte being re-advertised Business case developed and apprved	Develop communications to ensure all relevant parties are aware of what the new Centre can provide Complete recruitment and staff training Launch Care Navigation Centre from 1st September
Development of alternative pathways to admission		Data analysis conducted to quantify impact Pathways to Emergency Surgical Hub, agreed Post of surgical tracker included within the business case Pathway to heart failure and acute medicine virtual ward step up agreed Referral forms and data sets developed to ensure data collection Pilot for OOH (6.30-8am) CAD referral review and stacking by Wolverhampton for all of the Black country started 16th June	Development of pathway for DVT, Urology. Pathway for Frailty to be developed Training for all Triage staff in new pathways Care home engagement event planned for Sept 25. Working with Communications to develop a comms plan for the project.
Making centre available to patients and carers working with Sandwell		Discussions with Sandwell to develop a single point of access across the south of the Black County	Work with Sandwell on opportunities for workforce and a shift of resource Engagement with care homes, primary care and WMAS to increase utilisation of the CNC.

Risks and mitigations

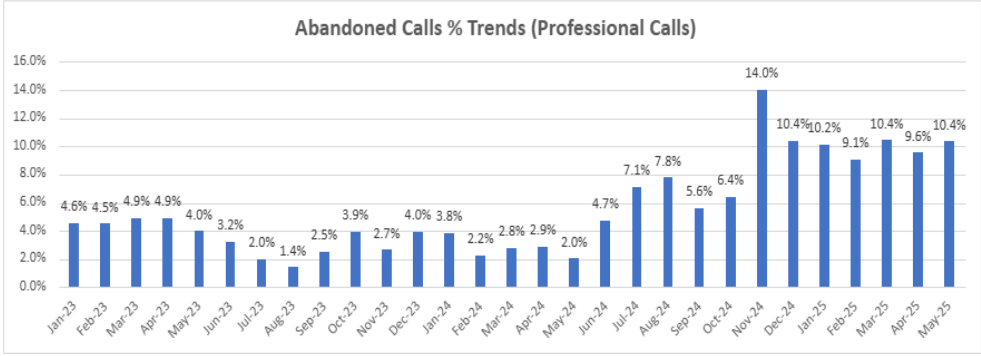
Risk: delays in development of standard operating procedures/criteria preventing staff training and launch
Mitigation: work with clinical leads and use experience from Sandwell as required
Risk: lack of utilisation of the CNC by WMAS, Primary care and care homes resulting in unnecessary attendances to ED
Mitigation: Work with communications to develop communications plan to support project, engagement events with primary care and care homes.

Key Performance Indicator





Balancing metrics



In Year Objective : Implement a new model of care for urgent and emergency care

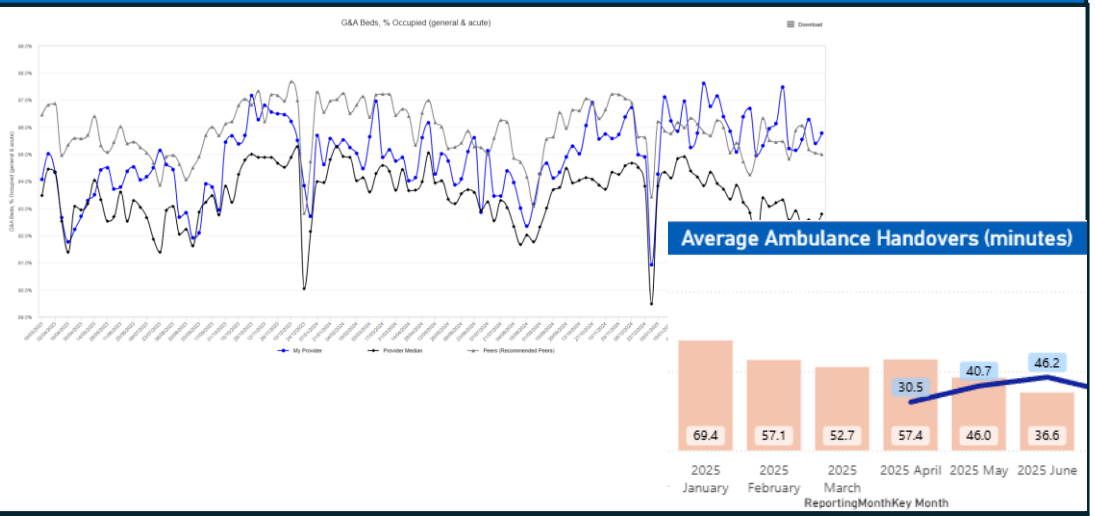
Quarter: Apr – Jun 2025	Executive sponsor: Karen Kelly

Objective status

Summary	Status
Bed occupancy remains high preventing patients being admitted to a bed when required. The trust remains an outlier for ambulance handovers. The UTC is currently filtering an insufficient number of patients which is resulting in unnecessary admissions. Discharge improvements are being made through the Care Transfer Hub and the development of an electronic bed management system.	

How achieved?	Status	Progress this quarter	Priorities for the next quarter
Optimising flow between UTC and ED		Review of recommendations from recent NHSE visits Initiated discussions with Malling Health and commissioner Researched other models for streaming patients presenting at UTC	Complete visits to other sites Agree a new model for Dudley with commissioners and Malling Health Prepare plan or business case as required
Development of alternatives to hospital admission		Preparation of plans for different models discussed in Quality and productivity workstream for non-elective care including proposals to expand virtual wards Rapid Enablement Assessment Care Coordination Therapy and Treatment (REACCT) model in place in ED to prevent admission Discussions with external company to provide support	Agree what external support to be brought in to support redesign of pathways Consolidate all recent visit recommendations concerning UEC Assess impact of REACCT
Discharge improvement		Soft launch of Care Transfer Hub by bringing together resources from different organisations forming a single coordination model for discharge and admission avoidance from June Electronic bed management system developed	Commence roll-out of electronic bed management system from July

Key Performance Indicator



Balancing metrics

Risks and mitigations

Risk: investment needed to increase capacity in virtual wards
Mitigation: utilise funds held in reserve for shifting care from hospital to community
Risk: changes in staff behaviour required to ensure bed management system shows 'real-time' bed state
Mitigation: roll-out of system to include appropriate standard operating procedure with training

In Year Objective : Develop an anti-bullying, anti-discrimination culture

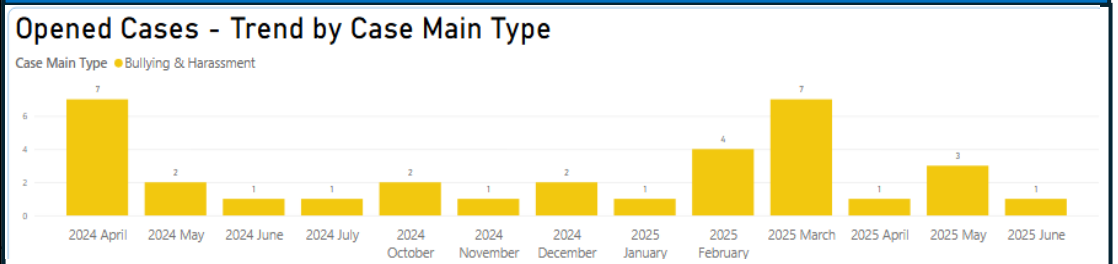
Quarter: Apr – Jun 2025 | *Executive sponsor: James Fleet*

Objective status

Summary	To embed a culture of anti-bullying and anti-discrimination culture across the Trust to ensure Dudley is a brilliant place to work and thrive	Status

How achieved?	Status	Progress this quarter	Priorities for the next quarter
A clear policy framework and expectations		The new Anti-Bullying and Anti-Discrimination Policy is now launched and associated briefing videos and comms have been disseminated Policy focus during Make it Happen	• Continued communication plan across the year • Commence planning for Anti Bullying Week later this year
Tools and skills to adopt and sustain		Several toolkits have been developed and launched. Manager training has been developed and will launch in June A bespoke hub page is now live on the "hub" under the HR pages	• Roll out managers training
Bespoke support for challenged teams		Diagnostic work has commenced in identified teams with high levels of reported concerns.	• Tailored interventions are being co-designed with team leaders and HR Business Partners.

Key Performance Indicator



Comparing April to June 2024 over the same period in 2025 – there has been a small increase in reported cases (10 cases in 2024 to 12 in 2025.

Looking at closed cases between April 2024 to June 2024 against the same period in 2025. In 2024 86% of closed cases were closed after informal action. In 2025 70% of cases were closed formally. This suggests that it is potentially too early to see the benefits of informal resolution under the new policy as many of the cases closed during Q1 would be historical.

Risks and mitigations

Risk: Low engagement with the new Anti-Bullying and Anti-Discrimination Policy and toolkits.

Mitigation: Ongoing communication campaigns to raise awareness including engagement with staff networks, Embedding policy discussions into team meetings and appraisals. Monitoring usage metrics of the bespoke hub and toolkits.

Risk: Managers may lack confidence or time to deliver training effectively.
Mitigation: Provide flexible, bite-sized training modules, Offer live Q&A sessions and peer support forums. Track completion rates and follow up with support where needed.

Risk: Delayed impact of informal resolution processes due to legacy cases.

•**Mitigation:** Track and analyse outcomes of new cases separately, Provide refresher training on informal resolution techniques. Use case studies to demonstrate successful informal resolutions.

Balancing metrics

•Staff survey results on perceptions of fairness and inclusion will be monitored quarterly.

•Monitoring of staff turnover and sickness absence in teams receiving bespoke support.

•Feedback from training sessions and toolkit usage will be gathered to assess impact.

•Pulse surveys to track confidence in informal resolution processes.

In Year Objective : Establish an elective hub south of the Black Country

Quarter: Apr – Jun 2025	Executive sponsor: Karen Kelly

Objective status

		Status
Summary	Black Country system successful in bid for capital for elective hub from the Constitutional Standards Programme (£9.75m) at start of May. Business case is under development with target to submit through committees in July followed by regional and national approval. Project group with representatives from both Sandwell and Dudley has been meeting regularly to ensure deliverables. Current plan is for phase 1 (mutual aid) to start in September with refurbished day case theatres becoming operational at the end of quarter 3.	

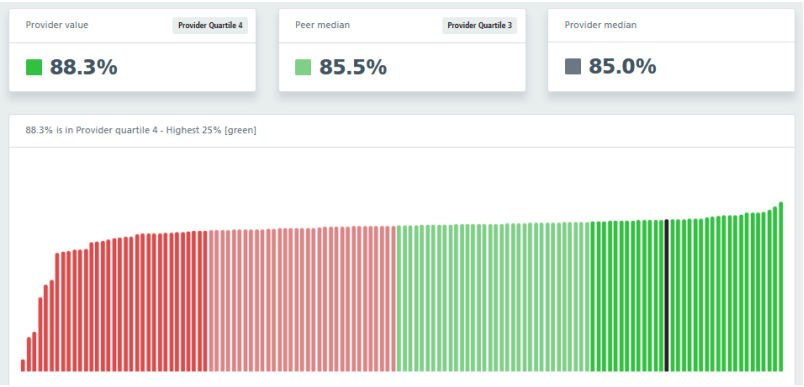
How achieved?	Status	Progress this quarter	Priorities for the next quarter
Development of business case		Business case (short form) developed and amended to reflect change to NHS payment system in 2025/26 Patient and public communications launched in mid-June Agreement of which services will utilise the Hub (orthopaedics, general surgery, gynaecology)	Complete business case with approval at Finance & Productivity Committees in both trusts in July followed by board sign-off Report the outcome of public consultation
Refurbishment, equipment purchasing and staff		Sandwell leading on refurbishment of 4 operating theatres and 2 wards Finalising equipment purchase Review of staffing models in both organisations	Commission refurbishment on confirmation of approval of business case (16 week lead-in time) Agree future workforce model
Agreement of pathways and operational procedures		Informal site visit from regional GIRFT team for surgical hub accreditation for Russells Hall Hospital day surgery unit	Submission of formal application by 17th September with visit from national GIRFT team expected 1st October

Risks and mitigations

Risk: business case is not financially viable
Mitigation: focus on shifting services to the elective Hub rather than providing overall additional capacity
Risk:
Mitigation:

Key Performance Indicator

Achieving top quartile performance for the basket of procedures recommended by British Association of Day Surgery (3 months to end of March 2025)



Balancing metrics

Include something about theatre cancellations?

In Year Objective : Transform outpatient services

Quarter: Apr – Jun 2025	Executive sponsor: Karen Kelly

Objective status		Status
Summary	Active participation in the Further Faster 20 programme with progress against outpatient metrics such as missed appointments and Patient-initiated follow-up (PIFU), as well as pre-appointment advice & guidance & remote appointments. Clinic template review by GIRFT has potential to identify capacity that ought to be deliverable from existing resources. OPD Digital Programme commenced in April 2025 with early signs from ambient AI showing positive results.	

How achieved?	Status	Progress this quarter	Priorities for the next quarter
Participation on Further Faster 20 to improve outpatient processes		Clinic templates across 17 focus specialties reviewed and submitted to GIRFT as part of benchmarking exercise. Missed appointment rates reducing with ongoing monitoring via outpatient group. Progress against patient-initiated follow-up with some areas to pilot PIFU by default.	Feedback from GIRFT regarding benchmarking exercise and estimation of the amount of additional activity that can be delivered. Use of clinic templates and job plans to quantify the amount of activity that can be delivered. Strengthen primary and secondary care interface forum to support use of advice and guidance.
Develop a plan for re-locating outpatient services		Acute therapy appointments now being offered from a variety of community locations instead of Russells Hall. Plans developed for use of additional space at Merry Hill Centre to deliver outpatients (4 rooms). Discussions with directorates to identify more services to re-locate.	Agreement over which services delivered from Merry Hill and start service delivery Workshop with services to discuss future use of Brierley Hill with the building owner
Deployment of digital solutions to improve efficiency and productivity		OPD Digital Programme commenced in April 2025 with clinic documentation digitisation and pilot of use of ambient AI Roll out of Video Consultation software delayed due to information governance concerns	Implementation of PIFU across agreed service areas. Approval of AI business case to continue implementation Pilot of e-outcomes form. Decision to be made on video consultation

Risks and mitigations

Risk: Recent increase in GP referrals observed which puts future achievement of RTT at risk.
Mitigation: Work with ICB / Primary care to understand changing referral patterns.
Risk: Uptake of patient-initiated follow-up not increasing as planned.
Mitigation: Share good practice through GIRFT forums and leverage clinical leaders to bring about change in practice.

Key Performance Indicator

DNA rate in April at 6.0% better than England average.
Patient-initiated follow-up (PIFU) rate = 3.4% in May with expectation of increase to 3.9% in June.
Remote Consultation Rate = 14.1% which is in the lowest quartile nationally – the Model Hospital data includes non-Oasis activity. May 25 Oasis PAS performance – 80.9% F2F vs 19.1% Virtual - over 12 week period (17.3.25 – 2.6.25) CSS 80% F2F vs 20% Virtual - MIC 76% F2F vs 24% Virtual - SWC 86% F2F vs 14% Virtual.
Pre-Appointment – A&G & RAS – 7-9k referrals triaged monthly across a combination of 56 Specialty areas – A&G 50% accepted & 50% rejected – RAS 80% accepted & 20% rejected. Cinapsis Eye eRS System from Community Optometrists – Oct 23 – May 25 – Total referrals 3449 – 71% accepted & 18% rejected A&G. CDC Dermoscopy – Jan 24 to Apr 25 – Total referrals 4888 – 31% (1525) rejected with A&G. Neurology Consultant Connect - April 25 to date:- 2k referrals triaged – 31% (651 referrals) rejected with A&G.

Balancing metrics

Trust DNA target – 5% March 2026.
Trust PIFU target – 6% March 2026.

In Year Objective : Transform corporate services

Quarter: Apr – Jun 2025	Executive sponsor: Chris Walker

Objective status		Status
Summary	Plan to achieve corporate growth reduction has been submitted to NHSE with further plans being developed working across the group with Sandwell and the whole of the Black Country	

How achieved?	Status	Progress this quarter	Priorities for the next quarter
Improvements in payroll		Shared management across Dudley and Sandwell since 1st April	Post implementation monitoring of service changes
Develop plans to reduce back office costs		Meetings with executive directors in April & May Bottom up plan established which meets expectations Plan submitted to NHSE on 30th May All corporate cost improvement identified (procurement, PFI etc.)	Monitor implementation and continued collaboration for all joint corporate service areas Individual Directors to progress with shared service restructure plans with Sandwell as appropriate
Contribution to development of wider plan for corporate services		Provider Collaborative has commissioned development of legal framework for the agreed strategic vehicle of a Managed Shared Service (MSS) Development of case for change in readiness for business case	Continued development of legal framework Identify early adopters for transition to system wide MSS – collaborative bank, recruitment, R&D

Risks and mitigations

Risk: failure to transform corporate services and deliver the cash releasing efficiencies expected
Mitigation: develop and implement plans at individual organisation, group and system-wide level
Risk:
Mitigation:

Key Performance Indicator

Target reduction from national team was £3.97m
Allowing for proposed exceptions the trust has submitted a compliant growth reduction plan

Balancing metrics

Annual plan dashboard

	RAG	Current status against plan	Comments
Elective activity		Day case +3% against plan (+339 cases) Ordinary elective +1% against plan (+18 cases)	Indicative activity plan agreed with commissioners. Continue to monitor activity and any over-performance closely as financial impact of any over-performance on elective activity will need to be balanced from other commissioner funds
A&E and Non-elective activity		Non-elective admissions +4% against plan (+670 cases) A&E attendances (type 1) +7.9% over plan (+2211 attendances)	
Performance		Total RTT waiting list at the end of June 46,789 patients which is 2,899 above plan Percentage waiting less than 18 weeks 62.7% against plan of 60.7% Percentage waiting less than 18 weeks to first appointment 65.9% against plan of 63.3% 52+ week waiters 455 which is 40 above plan Overall diagnostic activity (all modalities) to end of May 0.5% lower than plan (161 tests). Below plan for MRI and ultrasound	Concern that recent increase in referral rate is making the percentage within 18 weeks higher whilst the overall list size is growing
Workforce		Overall, Trust Position: The Trust is 32 WTE under plan, indicating a positive variance. Corporate Services: Performing well with 29 WTE under plan, including 31 WTE under plan for substantive workforce. CCCS Division: Showing 15 WTE under plan, with 18 WTE under plan for substantive staff. Sickness Absence: Continued improvement with five consecutive months of reduction, now at 4.58% for May. Bank Controls: Established steering groups in place, driving Improved reporting and additional control, including reduced AFC bank rates and ongoing medical bank rate negotiations.	Bank Usage: Minimally above plan in most divisions (Medicine, CCCS, Corporate), though controls are improving. Agency Usage: Low overall but above plan in Medicine and SWC divisions. Monitoring and challenge of agency reduction plans continues. SWC Division: Reporting 20 WTE above plan, with 19 WTE above plan for substantive staff and 5 WTE above plan for agency—worsening since M1. Medicine Division: Although under plan overall, bank and agency usage are above plan, risking delivery of M3 targets. Key Risk Across Divisions: Persistent bank and agency usage above plan in several areas, with a reducing trajectory that may jeopardize M3 delivery.
Finance		At the end of month 3, deficit was £4.459m which was £73k better than the financial plan	

Our Patients
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OUR VISION

Our future: excellent healthcare for the people of Dudley

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STRATEGIC OBJECTIVES 2025 – 2028

Our Patients
Deliver right care, in the right place, at the right time

Our People
Be a brilliant place to work & thrive

Our Place
Build innovative partnerships to improve the health of our communities

HOW WE WILL MEASURE OUR PROGRESS

1. Top performing for overall patient experience
2. Achieve all national standards
3. Mortality better than the national average
4. Palliative care patients die in their place of choice
5. Continue to improve how productive we are
6. Ensure our leaders meet national standards
7. All parts of the staff survey better than national average
8. Reduce planned care leaving our system
9. Reduce unnecessary stays in hospital
10. Increase our contribution to the local community

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

Our Values: Care, Respect, Responsibility

	Assurance metric theme	Measure	Indicators	Frequency	Latest Period	Value	*Compared with other trusts*
1	**Overall Patient Experience Score**	**Children and young people's survey**	Overall Experience - Parents and carers' reports (0-15 years)	Every 4 Years	2024	8.3 / 10	*About the same*
			Overall Experience - Parents and carers' reports (8-15 years)	Every 4 Years	2024	8.4 / 10	*About the same*
		Maternity survey	Labour and Birth	Annual	2024	Not available	
			Staff Caring for you	Annual	2024	8.4 /10	*About the same*
			Care in Hospital after the birth	Annual	2024	7 / 10	*About the same*
		Urgent and emergency care survey - type 1	Experience Overall	Every 2 Years	2024	7 / 10	*About the same*
		Adult inpatient survey	Experience Overall	Annual	2023	8.1 / 10	*About the same*
2	**Constitutional Standards**	**Emergency access standard**	Emergency access 4-hour wait	Monthly	Jun-25	79.8%	
		Referral to Treatment (RTT-18 weeks)	RTT Incomplete Pathways - % waiting within 18 Weeks	Monthly	Jun-25	63.2%	
		Diagnostics Waits (6 weeks)	Diagnostic Tests - % waiting less than 6 weeks (DM01)	Monthly	May-25	84.1%	
		Cancer Waiting Times	28 Day Combined	Monthly	May-25	77.7%	*Target = 75%*
			31 Day Combined	Monthly	May-25	93.70%	*Target = 96%*
			62 Day Combined	Monthly	May-25	74.30%	*Target = 85%*
		Financial Balance	Performance against financial plan	Monthly	Jun-25	£73k better than plan	
3	**Mortality**	**Summary Hospital Mortality Indicator (SHMI)**	Indicator value for expected number of deaths - 12 month rolling value	Monthly	Feb24-Jan25	0.992	*As expected*
4	**People die in their preferred place**		Percentage of all of deaths that occurred in the location the patient had identified as their preferred place of death.	Annual	2024/25	23%	*Not yet available*
5	**Productivity**	**Implied productivity metric**	New Implied Productivity Growth (year-to-date compared to 2019/20)	Monthly	Feb-25	-5.7% Quartile 3	*-10.8% (provider median)*
			New Implied Productivity Growth (year-to-date compared to last year)	Monthly	Feb-25	6.0% top quartile	*2.5% (provider median)*
6	**Leaders meeting national competency framework**	**Metrics to be developed**	Metrics to be developed	Monthly		Estimated implementation date is October 2025 as part of national roll-out	

	Assurance metric theme	Measure	Indicators	Frequency	Latest Period	Value	*Compared with other trusts*
7	Staff Survey	People Promise	We are compassionate and inclusive	Annual	2024	7.18 Quartile 2	*5.92 (benchmark median)*
			We are recognised and rewarded	Annual	2024	5.81 Quartile 2	*6.74 (benchmark median)*
			We each have a voice that counts	Annual	2024	6.56 Quartile 2	*6.24 (benchmark median)*
			We are safe and healthy	Annual	2024	5.95 Quartile 3	*6.84 (benchmark median)*
			We are always learning	Annual	2024	5.64 Quartile 2	*7.21 (benchmark median)*
			We work flexibly	Annual	2024	6.17 Quartile 3	*6.09 (benchmark median)*
			We are a team	Annual	2024	6.70 Quartile 2	*6.67 (benchmark median)*
		Themes	Staff engagement	Annual	2024	6.71 Quartile 2	*5.64 (benchmark median)*
			Morale	Annual	2024	5.75 Quartile 3	*5.93 (benchmark median)*
		The National Quarterly Pulse Survey	Employee Engagement Score	Quarterly	Q1 2025/26	6.4 Quartile 3	*6.4 (national average)*
8	Reduce planned care leaving our system	Pecentage of elective activity performed at trust for Dudley PCNs	Simple cataracts	Quarterly	2024/25	15.6%	*Percentage in independent sector in Dudley 61.4% compared to 64.2% median*
			Primary Hip and Knee replacement	Quarterly	2024/25	36.1%	*Percentage in independent sector in Dudley 28.0% compared to 32% Black Country (GIRFT data)*
9	Reduce unnecessary bed days	Internal Monitoring	Number of Hours between Medically Optimised for Discharge(MOFD) to Physical Discharge	Monthly	Jun-25	2,555	National monitoring not yet available
10	Increase our contribution to the local community		Proportion of staff living locally	Quarterly	Jul-25	68%	*not available*
			Proportion of procurement spend in local economy (Birmingham and the Black Country)	Quarterly	2024/25	7%	*not available*
			Air quality monitoring at Russells Hall Hospital	Quarterly		Awaiting report from West Midlands Combined Authority	*not available*

Assurance metric	Explanatory information
Overall patient experience score	Taken from national CQC surveys which are conducted annually or every other year. In instances where surveys are not carried out annually, an internal survey using a similar methodology to the national survey will be used to track progress
People die in their preferred place	This metric comes from an annual audit of data relating to end of life care using both primary and secondary care records. Comparative results from other places are not yet available but a dashboard is being developed by Black Country ICB
Implied productivity metric	The methodology for calculating the implied productivity metric has changed recently to make it more sensitive to changes in case mix and the range of services covered. The calculation is done by NHSE using monthly financial returns submitted by the trust and activity data covering services such as A&E, outpatients and admissions. The first metric shows the difference between now and 2019/20 (prior to COVID) and the second metric compares now with the previous year. This metric compares performance over time and indicates whether we are getting more or less productive. A positive value indicates productivity better than the base period, converse for a negative value
Planned care leaving our system	Metric defined as the percentage of elective activity for the population covered by the 6 Dudley PCNs taking place at the trust for simple cataracts and primary hip and knee replacements. Designed to replicate metrics being used by the GIRFT High Volume Low Complexity programme for elective recovery. Reporting of this metric was made possible by The Black Country ICB. The aim is that these percentages increase as the trust becomes the provider of choice as waiting times reduce
Reduce unnecessary beddays	This has been interpreted as difference between discharge ready date and actual discharge date. For the time being this metric has been calculated locally but it will form part of the metric set for the NHS Oversight Framework 25/26 and will be published nationally. It is intended to use this which will provide a comparative position
Increase our contribution to the local community	This is made up of three elements: - Proportion of staff living locally. This is the same metric that was used to monitor the previous strategy and remains unchanged - Proportion of procurement spend in the local economy (defined as Birmingham and the Black Country). This will be updated quarterly. Benchmarking comparisons are not yet available - Air quality. An air quality monitor has been installed outside Russells Hall Hospital and has been continuously monitoring air quality since October 2024. Quarterly reports will be produced by the Combined Authority and the output from these included in future quarterly reports. Further details will be included in the reports on progress against the Green Plan

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Productivity dashboard

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Metric	DGFT performance	Time period	Data source	Number of patients	Comment
Cost per weighted activity unit (WAU)					
Cost per weighted activity unit (WAU)	£3,688	2023/24	Model Hosp		Metrics for 23/24 published
Medical staff cost per WAU	£825	2023/24	Model Hosp		Metrics for 23/24 published
Nursing staff cost per WAU	£1,019	2023/24	Model Hosp		Metrics for 23/24 published
(New) Implied productivity					
New implied productivity growth (year to date compared to last year)	6.0%	Feb-25	Model Hosp		A new metric which refines the methodology taking better account of casemix changes Latest data shows trust in the highest quartile
New implied productivity growth (year to date compared to 2019/20)	-5.7%	Feb-25	Model Hosp		A new metric Latest data shows trust in the 3rd quartile nationally. Majority of providers showing a negative variance and all other providers in the system show a variation more negative than DGFT
Theatres					
Theatre utilisation (capped elective)	86.2%	15/06/2025	Model Hosp		Consistently been above national and peer averages over recent months
Ophthalmology average number of cases per 4 hour list	3.6	15/06/2025	Model Hosp		Performance is highly variable
Minimal access rate for patients (less than 50 years) receiving hysterectomy for benign condition (12mths to qtr end)	44.9%	Q4 2024/25	Model Hosp	66	Slight improvement from previous quarter but remains below the benchmark of 77.7%
Length of stay					
Length of stay for primary hip replacement (12 mths to quarter end)	2.2	Q4 2024/25	Model Hosp	319	Below benchmark of 2.7 days
Length of stay for primary knee replacement (12 mths to quarter end)	2.2	Q4 2024/25	Model Hosp	409	Better than the benchmark (2.7)
Length of stay for fractured neck of femur (12 mths to quarter end)	16.7	Q4 2024/25	Model Hosp	498	After a period of continuous improvement, this metric is now below the national (17.7) and peer median (18.6)
Day case rates					
BADS All: Day case and outpatient % of total procedures (3mths to month end)	88.3%	Mar-25	Model Hosp	6072	Performance in top quartile nationally
Day case rate for adult tonsillectomy (12 mths to quarter end)	95.2%	Q4 2024/25	Model Hosp	59	Improved performance has been sustained in last quarter and exceeds the benchmark of 90%
Day case rate for TURBT (12 mths to quarter end)	17.2%	Q3 2024/25	Model Hosp	28	Performance remains well below the benchmark of 44%
Day case rate for elective cholecystectomy (12 mths to quarter end)	75.8%	Q4 2024/25	Model Hosp	401	Better than national average and the benchmark of 71.4%
Outpatient transformation					
PIFU utilisation rate	3.4%	May-25	Model Hosp	1877	Slightly below the national average 3.7%. Trend still demonstrates improvement
Remote consultation rate	14.1%	May-25	Model Hosp	7775	This metric puts us in the lowest quartile nationally
DNA rate	6.0%	Apr-25	Model Hosp	3640	Better than national (6.5%) and peer (6.7%) averages

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Quarterly strategy and annual plan progress report Apr – Jun 2025

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Progress against annual plan 2025/26

Dudley Improvement Practice

ANNUAL PLAN 2025 – 2026

This is how we will deliver our plan

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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

In Year Objective : Implement care navigation centre

Quarter: Apr – Jun 2025	Executive sponsor: Kat Rose

Objective status

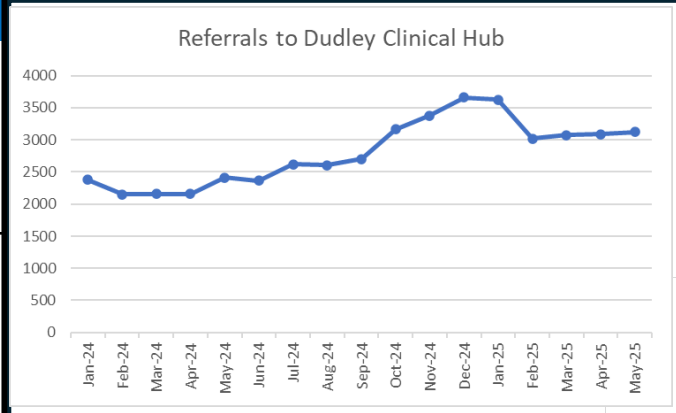
		Status
Summary	Decision to allocate a portion of funding held in reserves to support expansion of Dudley Clinical Hub into a Care Navigation Centre. Business case developed quantifying the benefits which are estimated to be over 11,000 fewer patients attending ED by offering alternative pathways. Outputs from Community First Value Stream Analysis in April supporting the implementation	

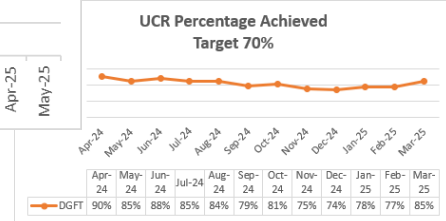
How achieved?	Status	Progress this quarter	Priorities for the next quarter
Staffing capacity and skill mix to meet increased demand		Decision to proceed at risk with recruitment Recruitment successful with 3.33 wte being re-advertised Business case developed and apprved	Develop communications to ensure all relevant parties are aware of what the new Centre can provide Complete recruitment and staff training Launch Care Navigation Centre from 1st September
Development of alternative pathways to admission		Data analysis conducted to quantify impact Pathways to Emergency Surgical Hub, agreed Post of surgical tracker included within the business case Pathway to heart failure and acute medicine virtual ward step up agreed Referral forms and data sets developed to ensure data collection Pilot for OOH (6.30-8am) CAD referral review and stacking by Wolverhampton for all of the Black country started 16th June	Development of pathway for DVT, Urology. Pathway for Frailty to be developed Training for all Triage staff in new pathways Care home engagement event planned for Sept 25. Working with Communications to develop a comms plan for the project.
Making centre available to patients and carers working with Sandwell		Discussions with Sandwell to develop a single point of access across the south of the Black County	Work with Sandwell on opportunities for workforce and a shift of resource Engagement with care homes, primary care and WMAS to increase utilisation of the CNC.

Risks and mitigations

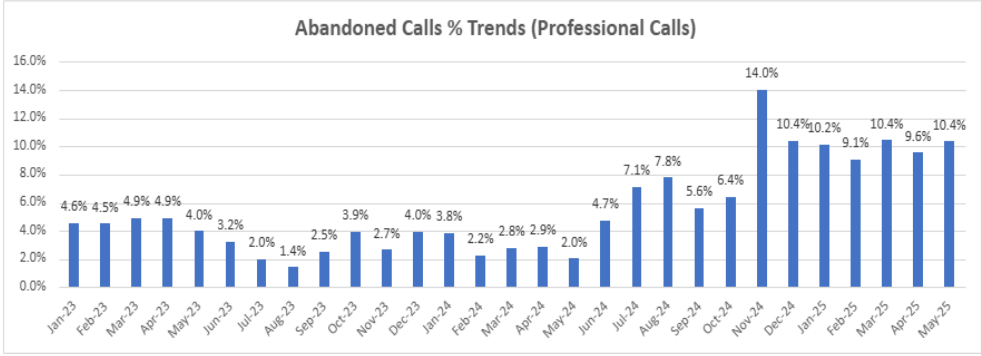
Risk: delays in development of standard operating procedures/criteria preventing staff training and launch
Mitigation: work with clinical leads and use experience from Sandwell as required
Risk: lack of utilisation of the CNC by WMAS, Primary care and care homes resulting in unnecessary attendances to ED
Mitigation: Work with communications to develop communications plan to support project, engagement events with primary care and care homes.

Key Performance Indicator





Balancing metrics



In Year Objective : Implement a new model of care for urgent and emergency care

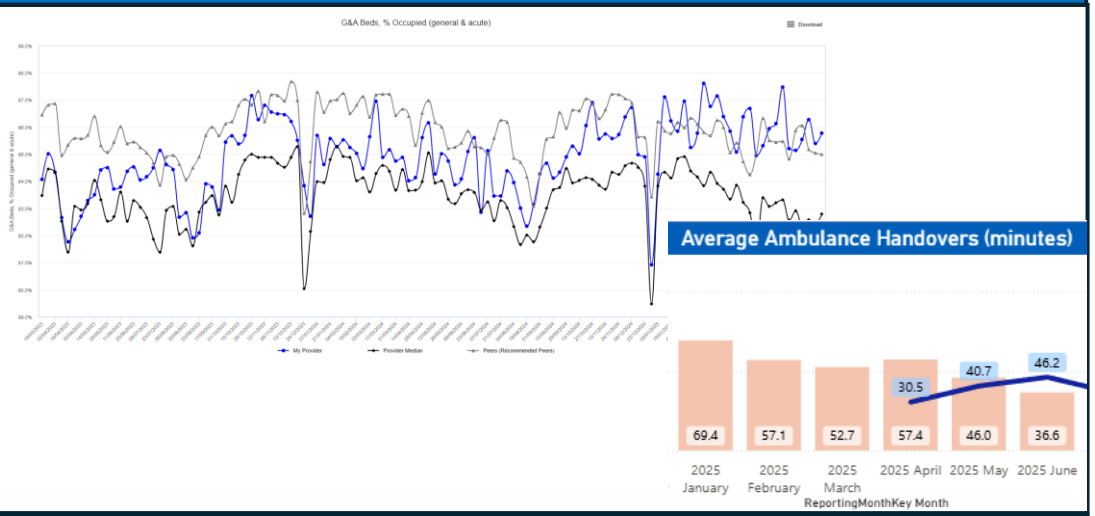
Quarter: Apr – Jun 2025	Executive sponsor: Karen Kelly

Objective status

Summary	Status
Bed occupancy remains high preventing patients being admitted to a bed when required. The trust remains an outlier for ambulance handovers. The UTC is currently filtering an insufficient number of patients which is resulting in unnecessary admissions. Discharge improvements are being made through the Care Transfer Hub and the development of an electronic bed management system.	

How achieved?	Status	Progress this quarter	Priorities for the next quarter
Optimising flow between UTC and ED		Review of recommendations from recent NHSE visits Initiated discussions with Malling Health and commissioner Researched other models for streaming patients presenting at UTC	Complete visits to other sites Agree a new model for Dudley with commissioners and Malling Health Prepare plan or business case as required
Development of alternatives to hospital admission		Preparation of plans for different models discussed in Quality and productivity workstream for non-elective care including proposals to expand virtual wards Rapid Enablement Assessment Care Coordination Therapy and Treatment (REACCT) model in place in ED to prevent admission Discussions with external company to provide support	Agree what external support to be brought in to support redesign of pathways Consolidate all recent visit recommendations concerning UEC Assess impact of REACCT
Discharge improvement		Soft launch of Care Transfer Hub by bringing together resources from different organisations forming a single coordination model for discharge and admission avoidance from June Electronic bed management system developed	Commence roll-out of electronic bed management system from July

Key Performance Indicator



Balancing metrics

Risks and mitigations

Risk: investment needed to increase capacity in virtual wards
Mitigation: utilise funds held in reserve for shifting care from hospital to community
Risk: changes in staff behaviour required to ensure bed management system shows 'real-time' bed state
Mitigation: roll-out of system to include appropriate standard operating procedure with training

In Year Objective : Develop an anti-bullying, anti-discrimination culture

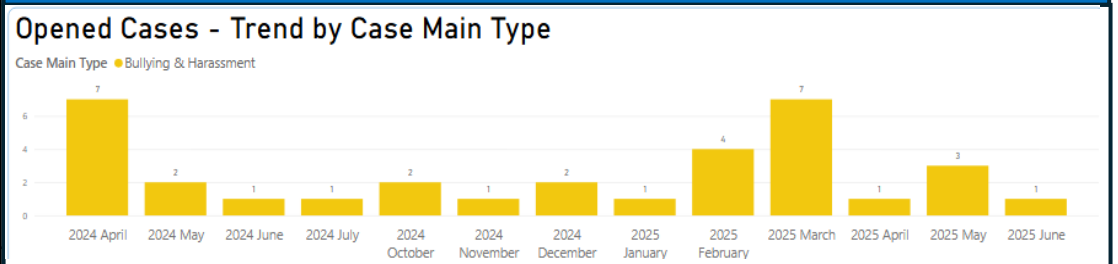
Quarter: Apr – Jun 2025 | *Executive sponsor: James Fleet*

Objective status

Summary	To embed a culture of anti-bullying and anti-discrimination culture across the Trust to ensure Dudley is a brilliant place to work and thrive	Status

How achieved?	Status	Progress this quarter	Priorities for the next quarter
A clear policy framework and expectations		The new Anti-Bullying and Anti-Discrimination Policy is now launched and associated briefing videos and comms have been disseminated Policy focus during Make it Happen	• Continued communication plan across the year • Commence planning for Anti Bullying Week later this year
Tools and skills to adopt and sustain		Several toolkits have been developed and launched. Manager training has been developed and will launch in June A bespoke hub page is now live on the "hub" under the HR pages	• Roll out managers training
Bespoke support for challenged teams		Diagnostic work has commenced in identified teams with high levels of reported concerns.	• Tailored interventions are being co-designed with team leaders and HR Business Partners.

Key Performance Indicator



Comparing April to June 2024 over the same period in 2025 – there has been a small increase in reported cases (10 cases in 2024 to 12 in 2025.

Looking at closed cases between April 2024 to June 2024 against the same period in 2025. In 2024 86% of closed cases were closed after informal action. In 2025 70% of cases were closed formally. This suggests that it is potentially too early to see the benefits of informal resolution under the new policy as many of the cases closed during Q1 would be historical.

Risks and mitigations

Risk: Low engagement with the new Anti-Bullying and Anti-Discrimination Policy and toolkits.

Mitigation: Ongoing communication campaigns to raise awareness including engagement with staff networks, Embedding policy discussions into team meetings and appraisals. Monitoring usage metrics of the bespoke hub and toolkits.

Risk: Managers may lack confidence or time to deliver training effectively.
Mitigation: Provide flexible, bite-sized training modules, Offer live Q&A sessions and peer support forums. Track completion rates and follow up with support where needed.

Risk: Delayed impact of informal resolution processes due to legacy cases.

•**Mitigation:** Track and analyse outcomes of new cases separately, Provide refresher training on informal resolution techniques. Use case studies to demonstrate successful informal resolutions.

Balancing metrics

•Staff survey results on perceptions of fairness and inclusion will be monitored quarterly.

•Monitoring of staff turnover and sickness absence in teams receiving bespoke support.

•Feedback from training sessions and toolkit usage will be gathered to assess impact.

•Pulse surveys to track confidence in informal resolution processes.

In Year Objective : Establish an elective hub south of the Black Country

Quarter: Apr – Jun 2025	Executive sponsor: Karen Kelly

Objective status

		Status
Summary	Black Country system successful in bid for capital for elective hub from the Constitutional Standards Programme (£9.75m) at start of May. Business case is under development with target to submit through committees in July followed by regional and national approval. Project group with representatives from both Sandwell and Dudley has been meeting regularly to ensure deliverables. Current plan is for phase 1 (mutual aid) to start in September with refurbished day case theatres becoming operational at the end of quarter 3.	

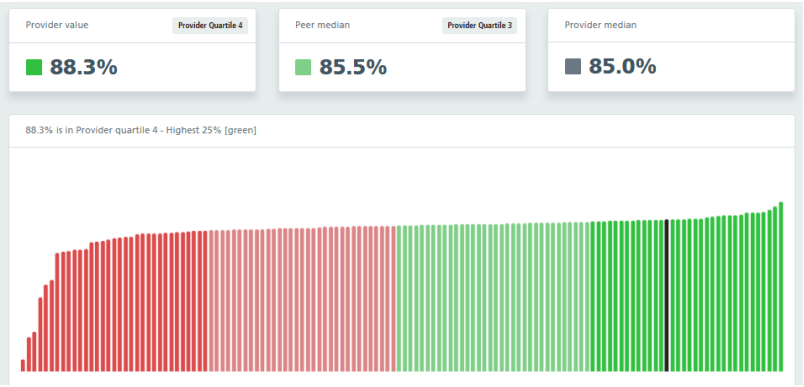
How achieved?	Status	Progress this quarter	Priorities for the next quarter
Development of business case		Business case (short form) developed and amended to reflect change to NHS payment system in 2025/26 Patient and public communications launched in mid-June Agreement of which services will utilise the Hub (orthopaedics, general surgery, gynaecology)	Complete business case with approval at Finance & Productivity Committees in both trusts in July followed by board sign-off Report the outcome of public consultation
Refurbishment, equipment purchasing and staff		Sandwell leading on refurbishment of 4 operating theatres and 2 wards Finalising equipment purchase Review of staffing models in both organisations	Commission refurbishment on confirmation of approval of business case (16 week lead-in time) Agree future workforce model
Agreement of pathways and operational procedures		Informal site visit from regional GIRFT team for surgical hub accreditation for Russells Hall Hospital day surgery unit	Submission of formal application by 17th September with visit from national GIRFT team expected 1st October

Risks and mitigations

Risk: business case is not financially viable
Mitigation: focus on shifting services to the elective Hub rather than providing overall additional capacity
Risk:
Mitigation:

Key Performance Indicator

Achieving top quartile performance for the basket of procedures recommended by British Association of Day Surgery (3 months to end of March 2025)



Balancing metrics

Include something about theatre cancellations?

In Year Objective : Transform outpatient services

Quarter: Apr – Jun 2025	Executive sponsor: Karen Kelly

Objective status		Status
Summary	Active participation in the Further Faster 20 programme with progress against outpatient metrics such as missed appointments and Patient-initiated follow-up (PIFU), as well as pre-appointment advice & guidance & remote appointments. Clinic template review by GIRFT has potential to identify capacity that ought to be deliverable from existing resources. OPD Digital Programme commenced in April 2025 with early signs from ambient AI showing positive results.	

How achieved?	Status	Progress this quarter	Priorities for the next quarter
Participation on Further Faster 20 to improve outpatient processes		Clinic templates across 17 focus specialties reviewed and submitted to GIRFT as part of benchmarking exercise. Missed appointment rates reducing with ongoing monitoring via outpatient group. Progress against patient-initiated follow-up with some areas to pilot PIFU by default.	Feedback from GIRFT regarding benchmarking exercise and estimation of the amount of additional activity that can be delivered. Use of clinic templates and job plans to quantify the amount of activity that can be delivered. Strengthen primary and secondary care interface forum to support use of advice and guidance.
Develop a plan for re-locating outpatient services		Acute therapy appointments now being offered from a variety of community locations instead of Russells Hall. Plans developed for use of additional space at Merry Hill Centre to deliver outpatients (4 rooms). Discussions with directorates to identify more services to re-locate.	Agreement over which services delivered from Merry Hill and start service delivery Workshop with services to discuss future use of Brierley Hill with the building owner
Deployment of digital solutions to improve efficiency and productivity		OPD Digital Programme commenced in April 2025 with clinic documentation digitisation and pilot of use of ambient AI Roll out of Video Consultation software delayed due to information governance concerns	Implementation of PIFU across agreed service areas. Approval of AI business case to continue implementation Pilot of e-outcomes form. Decision to be made on video consultation

Risks and mitigations

Risk: Recent increase in GP referrals observed which puts future achievement of RTT at risk.
Mitigation: Work with ICB / Primary care to understand changing referral patterns.
Risk: Uptake of patient-initiated follow-up not increasing as planned.
Mitigation: Share good practice through GIRFT forums and leverage clinical leaders to bring about change in practice.

Key Performance Indicator

DNA rate in April at 6.0% better than England average.
Patient-initiated follow-up (PIFU) rate = 3.4% in May with expectation of increase to 3.9% in June.
Remote Consultation Rate = 14.1% which is in the lowest quartile nationally – the Model Hospital data includes non-Oasis activity. May 25 Oasis PAS performance – 80.9% F2F vs 19.1% Virtual - over 12 week period (17.3.25 – 2.6.25) CSS 80% F2F vs 20% Virtual - MIC 76% F2F vs 24% Virtual - SWC 86% F2F vs 14% Virtual.
Pre-Appointment – A&G & RAS – 7-9k referrals triaged monthly across a combination of 56 Specialty areas – A&G 50% accepted & 50% rejected – RAS 80% accepted & 20% rejected. Cinapsis Eye eRS System from Community Optometrists – Oct 23 – May 25 – Total referrals 3449 – 71% accepted & 18% rejected A&G. CDC Dermoscopy – Jan 24 to Apr 25 – Total referrals 4888 – 31% (1525) rejected with A&G. Neurology Consultant Connect - April 25 to date:- 2k referrals triaged – 31% (651 referrals) rejected with A&G.

Balancing metrics

Trust DNA target – 5% March 2026.
Trust PIFU target – 6% March 2026.

In Year Objective : Transform corporate services

Quarter: Apr – Jun 2025	Executive sponsor: Chris Walker

Objective status		Status
Summary	Plan to achieve corporate growth reduction has been submitted to NHSE with further plans being developed working across the group with Sandwell and the whole of the Black Country	

How achieved?	Status	Progress this quarter	Priorities for the next quarter
Improvements in payroll		Shared management across Dudley and Sandwell since 1st April	Post implementation monitoring of service changes
Develop plans to reduce back office costs		Meetings with executive directors in April & May Bottom up plan established which meets expectations Plan submitted to NHSE on 30th May All corporate cost improvement identified (procurement, PFI etc.)	Monitor implementation and continued collaboration for all joint corporate service areas Individual Directors to progress with shared service restructure plans with Sandwell as appropriate
Contribution to development of wider plan for corporate services		Provider Collaborative has commissioned development of legal framework for the agreed strategic vehicle of a Managed Shared Service (MSS) Development of case for change in readiness for business case	Continued development of legal framework Identify early adopters for transition to system wide MSS – collaborative bank, recruitment, R&D

Risks and mitigations

Risk: failure to transform corporate services and deliver the cash releasing efficiencies expected
Mitigation: develop and implement plans at individual organisation, group and system-wide level
Risk:
Mitigation:

Key Performance Indicator

Target reduction from national team was £3.97m
Allowing for proposed exceptions the trust has submitted a compliant growth reduction plan

Balancing metrics

Annual plan dashboard

	RAG	Current status against plan	Comments
Elective activity		Day case +3% against plan (+339 cases) Ordinary elective +1% against plan (+18 cases)	Indicative activity plan agreed with commissioners. Continue to monitor activity and any over-performance closely as financial impact of any over-performance on elective activity will need to be balanced from other commissioner funds
A&E and Non-elective activity		Non-elective admissions +4% against plan (+670 cases) A&E attendances (type 1) +7.9% over plan (+2211 attendances)	
Performance		Total RTT waiting list at the end of June 46,789 patients which is 2,899 above plan Percentage waiting less than 18 weeks 62.7% against plan of 60.7% Percentage waiting less than 18 weeks to first appointment 65.9% against plan of 63.3% 52+ week waiters 455 which is 40 above plan Overall diagnostic activity (all modalities) to end of May 0.5% lower than plan (161 tests). Below plan for MRI and ultrasound	Concern that recent increase in referral rate is making the percentage within 18 weeks higher whilst the overall list size is growing
Workforce		Overall, Trust Position: The Trust is 32 WTE under plan, indicating a positive variance. Corporate Services: Performing well with 29 WTE under plan, including 31 WTE under plan for substantive workforce. CCCS Division: Showing 15 WTE under plan, with 18 WTE under plan for substantive staff. Sickness Absence: Continued improvement with five consecutive months of reduction, now at 4.58% for May. Bank Controls: Established steering groups in place, driving Improved reporting and additional control, including reduced AFC bank rates and ongoing medical bank rate negotiations.	Bank Usage: Minimally above plan in most divisions (Medicine, CCCS, Corporate), though controls are improving. Agency Usage: Low overall but above plan in Medicine and SWC divisions. Monitoring and challenge of agency reduction plans continues. SWC Division: Reporting 20 WTE above plan, with 19 WTE above plan for substantive staff and 5 WTE above plan for agency—worsening since M1. Medicine Division: Although under plan overall, bank and agency usage are above plan, risking delivery of M3 targets. Key Risk Across Divisions: Persistent bank and agency usage above plan in several areas, with a reducing trajectory that may jeopardize M3 delivery.
Finance		At the end of month 3, deficit was £4.459m which was £73k better than the financial plan	

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Progress against Trust strategy 2025 – 2028

Dudley Improvement Practice

OUR VISION

Our future: excellent healthcare for the people of Dudley

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STRATEGIC OBJECTIVES 2025 – 2028

Our Patients
Deliver right care, in the right place, at the right time

Our People
Be a brilliant place to work & thrive

Our Place
Build innovative partnerships to improve the health of our communities

HOW WE WILL MEASURE OUR PROGRESS

1. Top performing for overall patient experience
2. Achieve all national standards
3. Mortality better than the national average
4. Palliative care patients die in their place of choice
5. Continue to improve how productive we are
6. Ensure our leaders meet national standards
7. All parts of the staff survey better than national average
8. Reduce planned care leaving our system
9. Reduce unnecessary stays in hospital
10. Increase our contribution to the local community

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

Our Values: Care, Respect, Responsibility

	Assurance metric theme	Measure	Indicators	Frequency	Latest Period	Value	*Compared with other trusts*
1	**Overall Patient Experience Score**	**Children and young people's survey**	Overall Experience - Parents and carers' reports (0-15 years)	Every 4 Years	2024	8.3 / 10	*About the same*
			Overall Experience - Parents and carers' reports (8-15 years)	Every 4 Years	2024	8.4 / 10	*About the same*
		Maternity survey	Labour and Birth	Annual	2024	Not available	
			Staff Caring for you	Annual	2024	8.4 /10	*About the same*
			Care in Hospital after the birth	Annual	2024	7 / 10	*About the same*
		Urgent and emergency care survey - type 1	Experience Overall	Every 2 Years	2024	7 / 10	*About the same*
		Adult inpatient survey	Experience Overall	Annual	2023	8.1 / 10	*About the same*
2	**Constitutional Standards**	**Emergency access standard**	Emergency access 4-hour wait	Monthly	Jun-25	79.8%	
		Referral to Treatment (RTT-18 weeks)	RTT Incomplete Pathways - % waiting within 18 Weeks	Monthly	Jun-25	63.2%	
		Diagnostics Waits (6 weeks)	Diagnostic Tests - % waiting less than 6 weeks (DM01)	Monthly	May-25	84.1%	
		Cancer Waiting Times	28 Day Combined	Monthly	May-25	77.7%	*Target = 75%*
			31 Day Combined	Monthly	May-25	93.70%	*Target = 96%*
			62 Day Combined	Monthly	May-25	74.30%	*Target = 85%*
		Financial Balance	Performance against financial plan	Monthly	Jun-25	£73k better than plan	
3	**Mortality**	**Summary Hospital Mortality Indicator (SHMI)**	Indicator value for expected number of deaths - 12 month rolling value	Monthly	Feb24-Jan25	0.992	*As expected*
4	**People die in their preferred place**		Percentage of all of deaths that occurred in the location the patient had identified as their preferred place of death.	Annual	2024/25	23%	*Not yet available*
5	**Productivity**	**Implied productivity metric**	New Implied Productivity Growth (year-to-date compared to 2019/20)	Monthly	Feb-25	-5.7% Quartile 3	*-10.8% (provider median)*
			New Implied Productivity Growth (year-to-date compared to last year)	Monthly	Feb-25	6.0% top quartile	*2.5% (provider median)*
6	**Leaders meeting national competency framework**	**Metrics to be developed**	Metrics to be developed	Monthly		Estimated implementation date is October 2025 as part of national roll-out	

	Assurance metric theme	Measure	Indicators	Frequency	Latest Period	Value	*Compared with other trusts*
7	Staff Survey	People Promise	We are compassionate and inclusive	Annual	2024	7.18 Quartile 2	*5.92 (benchmark median)*
			We are recognised and rewarded	Annual	2024	5.81 Quartile 2	*6.74 (benchmark median)*
			We each have a voice that counts	Annual	2024	6.56 Quartile 2	*6.24 (benchmark median)*
			We are safe and healthy	Annual	2024	5.95 Quartile 3	*6.84 (benchmark median)*
			We are always learning	Annual	2024	5.64 Quartile 2	*7.21 (benchmark median)*
			We work flexibly	Annual	2024	6.17 Quartile 3	*6.09 (benchmark median)*
			We are a team	Annual	2024	6.70 Quartile 2	*6.67 (benchmark median)*
		Themes	Staff engagement	Annual	2024	6.71 Quartile 2	*5.64 (benchmark median)*
			Morale	Annual	2024	5.75 Quartile 3	*5.93 (benchmark median)*
		The National Quarterly Pulse Survey	Employee Engagement Score	Quarterly	Q1 2025/26	6.4 Quartile 3	*6.4 (national average)*
8	Reduce planned care leaving our system	Pecentage of elective activity performed at trust for Dudley PCNs	Simple cataracts	Quarterly	2024/25	15.6%	*Percentage in independent sector in Dudley 61.4% compared to 64.2% median*
			Primary Hip and Knee replacement	Quarterly	2024/25	36.1%	*Percentage in independent sector in Dudley 28.0% compared to 32% Black Country (GIRFT data)*
9	Reduce unnecessary bed days	Internal Monitoring	Number of Hours between Medically Optimised for Discharge(MOFD) to Physical Discharge	Monthly	Jun-25	2,555	National monitoring not yet available
10	Increase our contribution to the local community		Proportion of staff living locally	Quarterly	Jul-25	68%	*not available*
			Proportion of procurement spend in local economy (Birmingham and the Black Country)	Quarterly	2024/25	7%	*not available*
			Air quality monitoring at Russells Hall Hospital	Quarterly		Awaiting report from West Midlands Combined Authority	*not available*

Assurance metric	Explanatory information
Overall patient experience score	Taken from national CQC surveys which are conducted annually or every other year. In instances where surveys are not carried out annually, an internal survey using a similar methodology to the national survey will be used to track progress
People die in their preferred place	This metric comes from an annual audit of data relating to end of life care using both primary and secondary care records. Comparative results from other places are not yet available but a dashboard is being developed by Black Country ICB
Implied productivity metric	The methodology for calculating the implied productivity metric has changed recently to make it more sensitive to changes in case mix and the range of services covered. The calculation is done by NHSE using monthly financial returns submitted by the trust and activity data covering services such as A&E, outpatients and admissions. The first metric shows the difference between now and 2019/20 (prior to COVID) and the second metric compares now with the previous year. This metric compares performance over time and indicates whether we are getting more or less productive. A positive value indicates productivity better than the base period, converse for a negative value
Planned care leaving our system	Metric defined as the percentage of elective activity for the population covered by the 6 Dudley PCNs taking place at the trust for simple cataracts and primary hip and knee replacements. Designed to replicate metrics being used by the GIRFT High Volume Low Complexity programme for elective recovery. Reporting of this metric was made possible by The Black Country ICB. The aim is that these percentages increase as the trust becomes the provider of choice as waiting times reduce
Reduce unnecessary beddays	This has been interpreted as difference between discharge ready date and actual discharge date. For the time being this metric has been calculated locally but it will form part of the metric set for the NHS Oversight Framework 25/26 and will be published nationally. It is intended to use this which will provide a comparative position
Increase our contribution to the local community	This is made up of three elements: - Proportion of staff living locally. This is the same metric that was used to monitor the previous strategy and remains unchanged - Proportion of procurement spend in the local economy (defined as Birmingham and the Black Country). This will be updated quarterly. Benchmarking comparisons are not yet available - Air quality. An air quality monitor has been installed outside Russells Hall Hospital and has been continuously monitoring air quality since October 2024. Quarterly reports will be produced by the Combined Authority and the output from these included in future quarterly reports. Further details will be included in the reports on progress against the Green Plan

Our Patients
Our People
Our Place

Productivity dashboard

NHS
The Dudley Group
NHS Foundation Trust

Metric	DGFT performance	Time period	Data source	Number of patients	Comment
Cost per weighted activity unit (WAU)					
Cost per weighted activity unit (WAU)	£3,688	2023/24	Model Hosp		Metrics for 23/24 published
Medical staff cost per WAU	£825	2023/24	Model Hosp		Metrics for 23/24 published
Nursing staff cost per WAU	£1,019	2023/24	Model Hosp		Metrics for 23/24 published
(New) Implied productivity					
New implied productivity growth (year to date compared to last year)	6.0%	Feb-25	Model Hosp		A new metric which refines the methodology taking better account of casemix changes Latest data shows trust in the highest quartile
New implied productivity growth (year to date compared to 2019/20)	-5.7%	Feb-25	Model Hosp		A new metric Latest data shows trust in the 3rd quartile nationally. Majority of providers showing a negative variance and all other providers in the system show a variation more negative than DGFT
Theatres					
Theatre utilisation (capped elective)	86.2%	15/06/2025	Model Hosp		Consistently been above national and peer averages over recent months
Ophthalmology average number of cases per 4 hour list	3.6	15/06/2025	Model Hosp		Performance is highly variable
Minimal access rate for patients (less than 50 years) receiving hysterectomy for benign condition (12mths to qtr end)	44.9%	Q4 2024/25	Model Hosp	66	Slight improvement from previous quarter but remains below the benchmark of 77.7%
Length of stay					
Length of stay for primary hip replacement (12 mths to quarter end)	2.2	Q4 2024/25	Model Hosp	319	Below benchmark of 2.7 days
Length of stay for primary knee replacement (12 mths to quarter end)	2.2	Q4 2024/25	Model Hosp	409	Better than the benchmark (2.7)
Length of stay for fractured neck of femur (12 mths to quarter end)	16.7	Q4 2024/25	Model Hosp	498	After a period of continuous improvement, this metric is now below the national (17.7) and peer median (18.6)
Day case rates					
BADS All: Day case and outpatient % of total procedures (3mths to month end)	88.3%	Mar-25	Model Hosp	6072	Performance in top quartile nationally
Day case rate for adult tonsillectomy (12 mths to quarter end)	95.2%	Q4 2024/25	Model Hosp	59	Improved performance has been sustained in last quarter and exceeds the benchmark of 90%
Day case rate for TURBT (12 mths to quarter end)	17.2%	Q3 2024/25	Model Hosp	28	Performance remains well below the benchmark of 44%
Day case rate for elective cholecystectomy (12 mths to quarter end)	75.8%	Q4 2024/25	Model Hosp	401	Better than national average and the benchmark of 71.4%
Outpatient transformation					
PIFU utilisation rate	3.4%	May-25	Model Hosp	1877	Slightly below the national average 3.7%. Trend still demonstrates improvement
Remote consultation rate	14.1%	May-25	Model Hosp	7775	This metric puts us in the lowest quartile nationally
DNA rate	6.0%	Apr-25	Model Hosp	3640	Better than national (6.5%) and peer (6.7%) averages