The Dudley Group
NHS Foundation Trust

Quality Account 2021-22

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Foreword

What is a Quality Report?

All providers of NHS services in England have a statutory duty to produce an annual report to the public about the quality of services they deliver. This is called the Quality Report and includes the requirements of the NHS (Quality Accounts) Regulations 2010 as amended by the NHS (Quality Accounts) Amendments Regulations 2011 and the NHS (Quality Accounts) Amendments Regulations 2012. The Quality Accounts (and hence this report) aims to increase public accountability and drive quality improvement within NHS organisations. They do this by getting organisations to review their performance over the previous year, identify areas for improvement, and publish that information, along with a commitment to you about how those improvements will be made and monitored over the next year.

Quality consists of three areas which are essential to the delivery of high-quality services:

• How safe the care is (patient safety)

• How well the care provided works (clinical effectiveness)

• How patients experience the care they receive (patient experience)

Some of the information contained within this Quality Report is mandatory. This report contains all of NHS England and NHS Improvement's detailed requirements for quality reports.

Scope and structure of the Quality Report

This report summarises how well the Dudley Group NHS Foundation Trust ('the Trust') did against the quality priorities and goals we set ourselves for 2021/22. It also sets out the Quality Priorities we have agreed for 2022/23 and how we intend to achieve them.

This report is divided into four parts, the first of which is a statement from the Chief Executive.

Part 2 sets out the quality priorities and goals for 2022/23 and explains how we decided on them, how we intend to meet them, and how we will track our progress.

Part 3 includes statements of assurance relating to the quality of services and describes how we review them, including information and data quality. It includes a description of audits we have undertaken and our research work.

Part 4 includes performance against national priorities.

The annexes also include a glossary of terms used.

The annexes at the end of the report include the comments of our external stakeholders.

Any text shown in blue boxes is a compulsory requirement to be included in the Quality Report as mandated within NHS Improvement's Annual Quality Accounts Regulations.

Part 1: Introduction - Chief executive's statement

The Dudley Group NHS Foundation Trust aims to always provide safe and effective care. This means that patient safety and quality are at the heart of everything we do. Our people are central to delivering the care standards that we expect every patient to receive.

2021/22 has remained incredibly challenging as we have continued to adapt our services during the global COVID-19 pandemic. I am incredibly proud of what we have collectively achieved to look after patients in hospital with COVID-19, how we have adapted our out-patient and other services in order that they could continue as we reintroduced patients, staff, and visitors back into the hospital.

This report will describe the quality of care provided by the Trust during 2021/22, highlighting both areas for improvement and areas of good practice.

We monitor safety, clinical effectiveness, and patient experience through a variety of other methods:

- Quality Indicators - monthly audits of key nursing/midwifery and allied health professional interventions and their documentation. Each area has an electronic Quality Dashboard that all staff and patients can view so that the performance in terms of the quality of care is clear to everyone.
- Ongoing patient surveys that give a 'feel' for our patients' experiences in real time allowing us to quickly identify any problems and correct them
- A variety of senior clinical staff attend the monthly three key sub-committees of the Board to report and present on performance and quality issues within their area of responsibility: Quality and Safety Committee, Finance and Performance Committee and Workforce and Staff Well-being Committee.
- The Trust works with its local commissioners, scrutinising the Trust's quality of care at joint monthly review meetings and the executives from both organisations meet quarterly.
- External assessments of the Trust services

Despite the challenges we have faced, our staff continued to pull together to do the right thing for our patients. I would like to take this opportunity to thank our people, once again, as without their hard work and commitment we would not have achieved the successes we have.

We are now delivering services in the new NHS where COVID-19 will continue to be with us, and we may see further peaks, and where we must continue to deliver our planned and other non-COVID services to our local population.

The biggest challenges have been the continued, unprecedented increase in the number of emergency patients attending the hospital. We are working collaboratively with our system partners to identify further innovative ways to meet these increasing demands to ensure patients receive timely treatment and care.

Our priority is always to provide high quality, safe care for all patients, and to learn from our mistakes if we fall short of these standards. We are committed to driving improvement and a culture of excellence throughout the organisation.

Our Trust Priorities for 2022/23 have been developed to ensure that we recover as quickly and safely as we can from the pandemic and embed quality improvement into our daily practice whilst adapting to the 'new normal' for the NHS.

We remain hugely concerned about the national growth in waiting lists for diagnosis and treatment, and for the people who may not have come forward for vital tests or treatment due to the pandemic. We will continue to do everything possible to maximise the number of patients that we can safely treat, and to ensure that patients on our waiting lists are regularly risk assessed and seen according to clinical priority.

We will keep patients informed about any delays to treatment and ensure that they can contact us if their condition changes

We have included as much information as possible in our report and are confident in the accuracy of the data we have published. There are a few areas where the data is not available, including where reporting was suspended or changed at a national level because of the pandemic.

To the best of my knowledge, the information in this document is accurate

Part 2: Priorities for improvement

Quality improvement priorities
How we decided on our quality priorities

Each year, utilising internal intelligence, in consultation with internal and external key stakeholders, and service user groups the Trust commit to our quality priorities which are our focus for the upcoming financial year. Agreed key performance indicators related to the quality priorities are monitored on a continuous basis through the Trusts Quality and Safety Group/Committee to provide oversight and assurance of the clinical care provided

Looking back

The table below provides a summary of the 2021/22 quality priorities. To note, progress against the achievement of the quality priorities has been negatively impacted on because of the COVID-19 pandemic and the unprecedented capacity and workload experienced.

Quality Priority	How did we do?
Patient Experience	
1. Improve the way we communicate and engage with patients. a) Staff treating and examining patients will introduce themselves (target of 95%). b) Patient will have been informed about what is going to happen to them each day, i.e., tests, investigations (target of 95%) c) Hold a quarterly forum/focus group with each prioritising key planned actions, undertaking those actions and measuring the outcomes and success. d) Hold at least quarterly People Panel, each prioritising key planned actions, undertaking those actions and measuring the outcomes and success. e) Engage with Expert Volunteers ensuring we raise	a) Through monthly patient audit we achieved 98.17% (numerator 2747/denominator 2798) compliance against patients reporting that staff members introduced themselves. b) Through monthly audit we achieved 90.5% (numerator 1398/denominator 1545) compliance against patients reporting that they knew what was going to happen to them each day. c) At the July 2021 Patient Experience Group (PEG) meeting the chief nurse instructed all staff to hold a Listening into Action (LIA) event. Most departments and teams booked an LIA event and several teams had already hosted these events (Cancer Services, Home Oxygen Team). Several events were postponed due to lack of patient attendance or due to the cancellation of non-essential meetings due the pandemic. d) In July 2021, the attendees were able to share their overall views on their experience of our hospital and discuss their thoughts on how we can improve our services. The main themes were around communication and delays in the Emergency Department. The feedback was shared with matron leads for action planning and learning. Our new Patient Experience Strategy for 2021-2023 has been developed to embrace the aims and objectives set out in the Trust's Quality Priorities and the vision to deliver 'excellent health care, improved health for all'. The aim of the strategy is to ensure that all patients, relatives, carers, and visitors have a positive experience in our care, ensuring their emotional and physical needs and expectations are met. We want to listen to our patients, families, and carers to understand what is important to them, to value their ideas and learn from and act on the feedback we receive. We will monitor our progress against delivering the objectives in this strategy through a set of key performance indicators that will measure the impact of the processes in place for improving patient experience and engagement. e) In partnership with the Governance team, a policy has been produced which provides a framework that details the recruitment, support, and governance arrangements in place to ensure Patient Voice Volunteers and Patient Safety Partners are inducted and supported to be effective in their roles. This includes patients, carers, families, and other members of the public who use their experiences of services to inform and influence the delivery, planning, quality, and safety of services we provide.

the patient voice so that services are delivered compassionately (providing assurance of involvement, recommendations and actions taken forward)	
2. <u>Ensure all complaints are responded to in accordance with the Trust complaints and concerns policy.</u> a) Improve the percentage of complaints responded to within the internal timeframe of 30 working days. b) Actions will be completed and learning/changes in practice identified and shared across the organisation.	a) The current overall response rate for 2021-22 (Quarters 1 to Quarters 3) is 35.9%. There was initial improvement during Quarter 1 2021-22, but this has declined since for Quarters 2 and 3 2021-22. Quarter 2 and Quarter 3 2021-22 continued to have challenges from the COVID-19 pandemic with staff absences within services and staff being required to work clinically to support colleagues resulting in decreased administration time. The restrictions placed on visiting has also impacted the ability to hold local complaints resolution meetings. Quarters 2 and 3 2021-22 also received the highest number of new complaints (September 100 new complaints and November 104 new complaints) and the increasing number of complaints received has also added a further challenge to services to investigate and respond in a timely manner. The Complaints Department continue work with individual staff, teams and divisions discussing at governance team and divisional meetings in respect of timescales and matters due to breach the 30-working day timescale. In addition, the Complaints Department meet each week to discuss any matters due to breach, send out reminders to staff for the responses and the complaints manager sends out a weekly tracker to the Divisional Chief Nurses informing of any matters that require response and escalating those that require their assistance to obtain those responses. b) In respect of learning, services continue to share complaints anonymously not only with those immediately involved but also on a wider basis during mandatory training sessions, ward, and departmental meetings, so that staff can reflect, learn, and make improvements to practice if appropriate.

Developments that occurred in Patient Experience in 2021/2022:

- To ensure there is improvement and achievement against this priority we have delivered and supported several initiatives with a focus on how we improve the way we communicate and engage with patients.

- We have carried out several patient panels throughout the year. The theme of the April 2021 panel was communication and included the question ‘do staff treating and examining you introduce themselves?’ Action and learning plans from the panels are shared in the patient experience monthly reports, quarterly reports, governance, and Patient Experience Group meetings.

- The ‘Hello My Name’ is campaign is presented to new employees at Trust induction.

- In partnership with the Professional Development Team Evolve training, we have now implemented customer care training, and this is delivered to newly qualified nurses and other staff within the Trust.

- To improve the response rate, an informatics dashboard is currently being created to share performance data with teams easily via the Trust’s intranet and this will allow patient experience data and complaints data to be viewed. It is anticipated that the sharing of this data much more

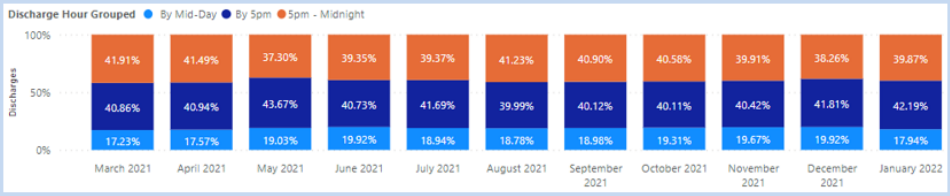
readily will improve staff complaint responsiveness as it will also link directly to the Datix complaint record.

- A training package centred around communication is being developed by Medicine & Integrated Care division.

- There has been a reduction in the number of complaints around lost property following a partnership with Emergency Department (ED) and patient experience where boxes and seals have been procured so that property can be placed in these boxes in ED and then remain undisturbed until the patient is transferred out of emergency theatres post operatively.

- It is recognised that the Datix (complaints reporting database) learning, and action section is not readily completed by divisions for action assurance, and this has been addressed at divisional governance meetings and a short guide on how to complete this section has been prepared and shared with divisional leads to share and discuss with their staff.

Patient experience activity is presented through divisional updates at the quarterly Patient Experience Group meeting and the monthly patient experience report to the Quality and Safety Committee for assurance of recommendations having been completed and improvements made.

Quality Priority	How did we do?
	Discharge Management
3. **30% of discharges to have left their bedded area by 12 noon, 80% by 5pm (for patients without an identified right to reside)**	Despite seeing some overall improvements in discharges before midday, we did not achieve either of our targets related to this priority.  The Trust continues to participate in the system wide efforts to reduce unnecessary admissions and promote earlier discharges.

Developments that occurred in discharge management in 2021/2022:

- **Preadmission -** The Trust works in partnership with primary care through the clinical hub to triage referrals that could be managed by community services and through General Practice. This is showing some benefits especially for patients residing in care homes as the number of calls from these services to the clinical hub have increased over recent months. In addition, conveyances through ambulances are being targeted to ensure that earlier intervention and care at home to prevent an attendance; this is supported through clinical triage by a paramedic, which forms part of a trial supported by WMAS, the Trust and the CCG.

- **Post admission and discharge -** A dedicated team exists to oversee the facilitation of patients back to their home. This team works in partnership with Local Authority colleagues and a system wide call takes place twice daily to review those patients that could receive support from community and domiciliary care. A new initiative, supported by NHSE to encourage use of hotel accommodation for medically optimised patients is also underway in the Trust and we have seen some use of this, in its early days.

For those patients awaiting a decision for discharge, these are being supported with patient trackers who monitor the journey of patients by ward, escalating key milestones for decision making. Patient awaiting

transfer can utilise the Discharge Lounge which is now operational, and patients can receive their medication post discharge through the medicine's delivery service, which is being co-ordinated by our Pharmacy team.

Data is a key driver for ensuring patients that have had an excessive length of stay and this is being facilitated through the recently introduced Sunrise Dashboards. Patients with a longer length of stay benefit from a senior medical review co-ordinated by the Deputy Chief Medical Officer.

Looking forward

Priority 1 for 2022/23: Delivering a great patient experience

1. Using patient feedback to drive improvements (inpatient survey results)

Improve inpatient survey scores related to the following questions:

a. Involving patients and their carers in care and treatment decisions (Q23) (target = 72%, current baseline = 68%)
b. Leaving hospital - communication around discharge (Q34) (target = 71%, current baseline = 66%)
c. Information around conditions and treatment is shared with patients (Q24) (target = 89%, current baseline = 86%)

2. Ensure all complaints are responded to in accordance with the Trust complaints and concerns policy*

d. Improve complaint closure within 30 days to 50% by April 2023
e. Reduce outstanding backlog by 70% by April 2023

*Trust Governors have chosen this priority to champion throughout 2022/23

Why we chose this (Rationale)

When compared to our peers, the Trust had been in the lowest 20% response rate for questions relating to communication. Including specific questions for improvement in our quality priorities allows focused attention to drive improvement.

The rationale for including this priority is to improve the response time for complaints. The key performance indicator is 90% response rate for complaints investigations to be completed and a response sent to the complainant within 30 working days of receipt. It was identified that by completing complaint investigations and responding to complainants within the period of 30 working days, that the complainant would feel that their complaint had been taken seriously.

The NHS Complaints Regulations 2009 section 3 (2) sets out arrangements for dealing with complaints ensuring that they are dealt with efficiently, properly investigated and complainants are treated with respect and courtesy. Complainants often raise a complaint as a last resort, or last attempt at being listened to, they may approach the service as they have grave concerns regarding how their or their loved ones' care was given, and this may be following a bereavement. It is recognised that a complainant may feel very upset, be grieving and already in distressed and vulnerable position at the time of approaching the Complaints Department. It is not best practice or a good patient experience in keeping complainants waiting for a response to their complaint as it reinforces their feelings that they are not being listened to or taken seriously.

The Trust's aim is to 'deliver a great patient experience' and within the Patient Experience Strategy 2021-23, one of the core objectives is to 'enhance our listening and responding to what people say' and this includes promoting lessons learnt and sharing of good practice.

In respect of sharing learning, the NHS Standards acknowledge an effective complaint handling system promotes a culture that is open and accountable when things do not go as they should. It creates an environment where staff feel supported and empowered to learn when things do not go as expected, rather

than feeling blamed. It is important that learning is used to improve services and that staff promote a just and learning culture.

How we will monitor and share progress

The response rate is measured monthly and recorded via the integrated performance report as well as within the service's monthly, quarterly, and annual report which are reported internally and externally.

The response rate for complaints is shared at divisional and team governance meetings monthly.

Responsible Person/Team

Patient Experience/Divisional Teams

Priority 2 for 2022/23: Treating patients in the right place, at the right time

3. Capacity and patient flow Same Day Emergency Care (SDEC) pathways

    a. Providing SDEC services (Surgery, Medicine, and Paediatrics) for 12 hours a day, 7 days per week
    b. Assessment in 30 minutes from arrival in SDEC, for those patients identified on the 'frailty pathway'
    c. Increased referral pathways to SDEC, resulting in a decrease in admissions across all relevant specialities
    d. Improve the quality of referrals direct to SDEC from West Midlands Ambulance Service and primary care

4. Discharge management*

    e. Every inpatient ward will identify 1 to 2 patients everyday (7 days per week) as part of 'Home for Lunch' initiative.
    f. Improved use of the discharge lounge, both seated and bedded areas, for all definite discharges
    g. All discharge communication with patient, carers and families and 3rd parties are initiated on admission

    *Trust Governors have chosen this priority to champion throughout 2022/23

Why we chose this (Rationale)

- It is important that patients are assessed, diagnosed, and treated in a timely and effective way and are not in hospital longer than is necessary where there is a greater risk of developing complications.
- At present, 18 per cent of patients are being discharged before midday.
- Ensure effective discharge planning starts at the point of admission to ensure patients get the best possible care in the right place.
- Ensure patients feel involved in their discharge planning to ease any anxiety or distress which may be caused by admission to hospital.

How we will monitor and share progress

We measure and record this priority with the time of discharge recorded on the electronic patient administration system, which links with the Trust's discharge database.

Responsible Person/Team
Operations team/Divisional teams

Priority 3 for 2022/23: Reducing avoidable harm
5. Pressure Ulcers a) Clear outstanding incident backlog for category 3 and 4 pressure ulcers up until March 2022 b) All grade 3 and 4 pressure ulcers will be investigated and closed within 45 working days c) Develop systems to promote timely investigation and validation of pressure ulcers recorded via the datix system d) Identify and report pressure ulcers earlier in patient pathway anticipating an increase in reported category 1 and 2's correlating to reduction of reported category 3 and 4's.
Why we chose this (Rationale)
Due to the increased numbers of reported pressure related damage incidents, in particular category 3, it was deemed that our systems and processes needed review and updating to identify learning and support a positive reporting culture.
How we will monitor and share progress
Quality and Safety Group
Responsible Person
Tissue Viability Lead/Divisional Chief Nurse for Surgery, Women' and Children's division

Part 3: Statements of assurance from the Board of Directors

Review of services

During 2021/22, Dudley Group NHSFT provided 59 hospital and community NHS services. A detailed list is available in the Trust's 'Statement of Purpose' available on our website CQC Registration - Aims and Objectives (dgft.nhs.uk) .The Trust has reviewed data available on the quality of care in all of these services through its performance management framework and its assurance and governance processes. The income generated by the services reviewed in 2021/22 represents 98.5 per cent of the total income received for the provision of NHS services in the financial year.

Participation in national clinical audits, national confidential enquiries, and local clinical audit

During 2021/22, 56 national clinical audits and 5 national confidential enquiries covered relevant health services that the Trust provides. During that period, the Trust participated in 100 per cent of the national clinical audits and 100 per cent of the national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that the Trust participated in, and for which data collection was completed during 2021/22 are listed below. **Tables 1 and 2** show the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

The reports of 56 completed national clinical audits were reviewed in 2021/22. Below are some examples from across the Trust of actions taken to improve the quality and safety of our services because of local clinical audit.

Speciality	Brief description of audit/Improvements
Medicine and Integrated Care	**Society for Acute Medicine Benchmarking Audit (SAMBA)** All criteria were met in 100% of the patients All patients admitted to an AMU should have an early warning score (EWS) measured upon arrival. Target: 90% Achieved 93% All patients should be seen by a competent clinical decision maker within 4 hours* of arrival on AMU, who will perform a full assessment and instigate an appropriate management plan Target 74% Achieved:90% Clinical Quality Indicator 3: All patients should be reviewed by the admitting consultant physician Target: 80% Achieved:93%
Surgery, Women's and Children's	**Children and Young People Asthma Audit** Steroids administered within one hour of arrival - 50% Inhaler technique checked - 45% Personalised Asthma Action Plan (PAAP) issued/reviewed - 41% The following have been implemented and the re-audit is due this year - Asthma admission pack and discharge bundle
Medicine and Integrated Care	**National Comparative Audit of Blood Transfusion: Audit of the Medical Use of Red Cells** This is a national audit of a sample of patients who have been transfused with red blood cells while under the care of a physician. The audit will allow comparison of practice against standards derived from guidelines issued by the British Society of Haematology, NICE and others looking at how physicians use red blood cells. This audit combines elements of previous audits. Standard 1: A pre-transfusion haemoglobin (Hb) is taken in 100% of cases within 3 days of transfusion (and preferably the same day) Result: 100% National Result: 96% Standard 2a: No patient (without acute coronary syndrome or cardio-respiratory disease) is transfused with a pre-transfusion Hb > 70g/L without adequate clinical reason Result:53% National Result: 29.7%

	Standard 2b: No patient with Acute Coronary Syndrome or Cardiorespiratory Disease is transfused with a pre-transfusion Hb > 80g/L without adequate clinical reason Result: 50% National Results 39% Standard 3: A post-transfusion Hb is taken in 100% of cases within 3 days following transfusion (and preferably the same day) to assess the effectiveness of the red cell transfusion Result: 97% National Results 90% Standard 4: Patients receiving multiple units are clinically reassessed and have their haemoglobin levels checked after each unit of red blood cells they receive, unless they are bleeding or are on a chronic transfusion programme. Result: 23% had their Hb checked between units National Results 21% Result: 15% were clinically assessed between units National Results: 23%
Surgery, Women's and Children's	**TARN – Trauma Audit Research Network** The Trust quality of data submitted is 98.4% compared to the national mean score of 93.5%. 53% of the patients are submitted within the 40-day discharge criteria. CT within 60 minutes of admission is 55.6% compared to the national average of 47.7%. Patients with a rehab prescription is 41% compared to the national of 29.5%.

Local clinical audit

The reports of 76 completed local clinical audits were reviewed in 2021/22. Below are some examples (one from each division and one from Trust wide) from across the Trust of actions taken to improve the quality and safety of our services because of local clinical audit.

Speciality	Brief description of audit/Improvements
Medicine and Integrated Care	**NORSE Referral Audit.** Referrals to the spinal surgery service at QEHB: The audit was carried in April 2021 and then a re-audit completed in August. The compliance was improved by contacting IT who are responsible for imparting training on NORSE to junior doctors joining the trust. The training material can be found on the NORSE landing page. The induction slides have been modified and available. Radiology have reduced the reporting times and the audit was presented to other areas such as AMU Stroke and ED medicine Meetings. A video for training also developed for the NORSE referral process.
Surgery, Women's and Children's	**Audit of Necrotising Fasciitis patients treated in the Plastic Surgery department over the last four years.** This audit was for necrotising fasciitis patients treated in the Plastic Surgery department over the last four years The patient demographics and the Types of Necrotising Fasciitis compare well with the studies done by other authors. Our treatment of these patients has been in line with accepted standards internationally. Most patients were operated early and had appropriate antibiotics. The mortality rate was 26%, which is on par with other studies, which had a mortality rate ranging from 17 -40%. Most patients, who underwent debridement and reconstruction, had multiple specialty input
Clinical Support Services	**A retrospective 'Snap-shot' audit of compliance with prescribing on the endoscopy recovery chart**

	There have been improvements in all 3 standards with near perfect compliance to standards 1 and 3. A major factor for this has been due to the implementation of the electronic prescribing system (sunrise) which went online Trust wide in August 2020 and the embedding of prescribing practice following the LFE QI project. This was further assisted in the production of a GI order set which facilitated prescribing practice thereby reducing any barriers prescribers may have previously had prior to this being available. The pre-formatted nature of this order set has made for safer prescribing as it minimises the error of misinterpretation when prescribed electronically as opposed to handwritten prescription. The utilisation of sunrise for prescribing has made allergy documentation clear and provides a prompt for safe prescribing should a medication be accidentally prescribed for whom a patient has an allergy for. It has also made it clear to review and assess whether a patient has had a medication administered to them with the option to input why it was not administered to provide a clear audit trail for that patient, aiding safer prescribing. The recommendation from the LFE QI project involved assessing whether prescribing practice has improved and been maintained within the GI endoscopy unit. This re-audit has shown assurance that prescribing practice has improved and is likely to be embedded into endoscopists working in GI unit as they have become familiar with prescribing electronically.
Trust wide	**Case file audit to assess the quality of safeguarding documentation to include the use of 'making safeguarding personal' across a variety of settings to include ED and ward settings.** Overall, there were areas of both excellent and poor practice. There are no obvious patterns to indicate that any departments were better or worse than others. Encouragingly, 66% of the documentation reviewed was assessed to have been of a good or of outstanding quality. It is also positive to note that there was documented evidence that a multi-disciplinary approach was taken in 70% of the cases.

Table 1

Title of National Audit	Participation	submitted
Case Mix Programme	YES	YES
Child Health Clinical Outcome Review Programme	YES	YES
Chronic Kidney Disease registry	N/A	N/A
Elective Surgery (National PROMs Programme)	YES	YES
RECM - Severe sepsis and septic shock (care in Emergency Departments)	YES	YES
RCEM- Pain in Children (care in Emergency Departments)	YES	YES
Fracture Liaison Service Database	YES	YES
National Audit of Inpatient Falls	YES	YES
National Hip Fracture Database	YES	YES
Inflammatory Bowel Disease Audit	YES	YES
Learning Disabilities Mortality Review Programme	YES	YES
Maternal and Newborn Infant Clinical Outcome Review Programme (MBRRACE-UK)	YES	YES
National Diabetes Core Audit	YES	YES
National Pregnancy in Diabetes Audit	YES	YES
National Diabetes Footcare Audit	YES	YES
National Inpatient Diabetes Audit	YES	YES
National Diabetes In-patient Audit – Harms	YES	YES
NACOPD -Paediatric Asthma Secondary Care	YES	YES
NACOPD -Adult Asthma Secondary Care	YES	YES
NACOPD -Chronic Obstructive Pulmonary Disease Secondary Care	YES	YES
NACOPD -Pulmonary Rehabilitation-Organisational and Clinical Audit	YES	YES

National Audit of Breast Cancer in Older Patients	YES	YES
National Audit of Cardiac Rehabilitation	YES	YES
National Audit of Care at the End of Life	YES	YES
National Audit of Dementia	YES	YES
National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy 12)	YES	YES
National Cardiac Arrest Audit	YES	YES
National Audit of Cardiac Rhythm Management	YES	YES
Myocardial Ischaemia National Audit Project (MINAP)	YES	YES
National Heart Failure Audit	YES	YES
National Child Mortality Database	N/A	N/A
2021 Audit of Patient Blood Management & NICE Guidelines	YES	YES
2021 Audit of the perioperative management of anaemia in children undergoing elective surgery	N/A	N/A
National Early Inflammatory Arthritis Audit	YES	YES
National Emergency Laparotomy Audit	YES	YES
National Oesophago-gastric Cancer audit	YES	YES
National Bowel Cancer Audit	YES	YES
National Joint Registry	YES	YES
National Lung Cancer Audit	YES	YES
National Maternity and Perinatal Audit	YES	YES
National Neonatal Audit Programme	YES	YES
National Paediatric Diabetes Audit	YES	YES
National Perinatal Mortality Review Tool	N/A	
National Prostate Cancer Audit	YES	YES
National Vascular Registry	YES	YES
Out-of-Hospital Cardiac Arrest Outcomes Registry	YES	YES
National Outpatient Management of Pulmonary Embolism	YES	YES
National Smoking Cessation 2021 Audit	YES	YES
Sentinel Stroke National Audit Programme (SSNAP)	YES	YES
Serious Hazards of Transfusion (SHOT)	YES	YES
Society for Acute Medicine Benchmarking Audit (SAMBA)	YES	YES
Transurethral Resection and Single instillation mitomycin C Evaluation in bladder Cancer Treatment	YES	YES
Trauma Audit & Research Network (TARN)	YES	YES
Cytoreductive Radical Nephrectomy Audit	N/A	N/A
Management of the Lower Ureter in Nephroureterectomy Audit (BAUS Lower NU Audit)	YES	YES

Table 2

National Confidential Enquiries				
Name of Study	**No. of Cases included**	**No. and % of clinical questionnaires submitted**	**No. of case notes submitted**	**No. of organisation questionnaires submitted**
Epilepsy Study Organisational Questionnaire	N/A	N/A	N/A	1
Transition from child to adult health services: Organisational questionnaire	N/A	N/A	N/A	1
Alcohol Related Liver Disease	N/A	N/A	N/A	1
Dysphagia in people with Parkinson's Disease: Clinician questionnaire	N/A	2/2 (100%)	N/A	1
Out of Hospital Cardiac Arrest: Clinical Questionnaire	N/A	2/9 (23%)	N/A	1

Research and development (R&D)

The number of patients receiving health services provided or sub-contracted by the Trust in 2021/22 that were recruited during that period to participate in research approved by a research ethics committee was 1389.

The balance of the portfolio across specialties covers Anaesthetics & Critical Care, Cancer, Cardiology, Chemical Pathology, Dermatology, Diabetes, Gastroenterology, Haematology, Paediatrics, Trauma & Orthopaedics, Rheumatology, Stroke, Vascular, General Surgery and Palliative Care all continuing to participate or express an interest in research.

We have continued to prioritise Urgent Public Health Studies, and despite some staff shortages due to covid, plus other sickness absences and staff vacancies we have re-opened almost all other non-urgent public health studies.

Due to the pandemic and guidelines for external visitors coming to the Trust, the Trust had to suspend students from our collaborating Universities coming to the Trust, for majority of 2021-22 to carry out their research projects. This will be re-started 2022/23.

Research into practice

The Urgent Public Health studies which are ongoing are listed below with number of recruits into each with a brief description of the study purpose. These provide a clear example of how research can be integrated into clinical practice, contribute to improving outcomes and become business as usual.

The NIHR COVID-19 studies the Trust have participated in:

URGENT PUBLIC HEALTH RESEARCH:

ISARIC/WHO Clinical Characterisation Protocol for Severe Emerging Infections in the UK (CCP-UK): The primary objectives include describing the clinical features, response to treatment, pathogen and host factors that relate to disease severity and immune response. The study will gain important information about respiratory infections so we can try to find better ways to manage and treat them in the future. **Total number of patients recruited 2168 (recruitment has now closed).**	**SIREN: The impact of detectable anti SARS-CoV-2 antibody on the incidence of COVID-19 in healthcare workers:** to establish whether staff working in healthcare organisations who have evidence of prior COVID-19, detected by antibody assays (positive antibody tests), are protected from future episodes of infection compared to those who do not have evidence of prior infection (negative antibody tests). This study is also exploring both short and long-term effectiveness of a vaccine against infection and immunological response to a vaccine. Participants complete short questionnaires and have COVID PCR tests fortnightly, and antibody tests every four weeks. Follow-up will continue for one year (minimum) with an optional extension to 24-month follow-up from recruitment. 332 members of staff are currently in follow-up. **425 participants recruited (closed to recruitment 31.03.21)**
COVIP - COVID-19 in very old intensive care patients: COVID-19 in very old intensive care patients. The COVIP study group proposes to investigate the relationship between age, co-morbidities, pre-treatment, frailty, and outcomes in a group of elderly patients receiving critical care for COVID-19. It will explicitly investigate how the frailty and nursing situation was before the acute illness, which comorbidities existed and how the therapy was carried out in the intensive care unit. **25 patients recruited (closed to recruitment Sept 2021).**	
Randomised Evaluation of COVID-19 therapy (RECOVERY): This is a randomised trial for patients hospitalised with COVID-19. All eligible patients are randomly allocated between several treatment arms, each to be given in addition to the usual standard of care in the participating hospital. The RECOVERY trial has so far recruited over 39,000 patients and is currently investigating baricitinib, di-methyl fumarate, and high vs low dose corticosteroids. **244 patients recruited to date**	**RECOVERY - Respiratory Support**. This trial will look at three different approaches to providing ventilatory support to patients suspected or confirmed COVID-19, all of which are currently in use in clinical practice at present. **Total patients recruited to date is 12.**
Randomised, embedded, multifactorial platform trial for community-acquired pneumonia (REMAP-CAP): This study was devised before the pandemic to explore interventions in an intensive care unit setting to improve outcomes of patients with community acquired pneumonia from any cause – most are bacterial in adults. As the pandemic took off, the trial was essentially re-purposed as a COVID study using the same structure which is similar to RECOVERY which allows for multiple interventions to examined both sequentially and simultaneously.**184 patients recruited to date.**	**CCP Cancer UK - Clinical Characterisation Protocol for Severe Emerging Infections in the UK (CCP-UK) – a prospective companion study for patients with Cancer and COVID-19:** Patients with cancer are considered a high-risk group given the significant concerns regarding the potential risks of acquiring SARS-CoV-2. CCP-Cancer UK is a companion study to the Clinical Characterisation Protocol for Severe Emerging Infections (CCP-UK) study. This is the largest study in the world of the effects of COVID-19 on patients with cancer. **86 patients recruited.**
Genetics of susceptibility and mortality in critical care (GenOMICC): *Genetics of susceptibility and mortality in critical care (**GenOMICC**).* Will identify the specific genes that cause some people to be susceptible to specific infections and consequences of severe injury. **57 patients recruited to date.**	**UKOSS: Pandemic Influenza in Pregnancy:** This study is a national study of women hospitalised with confirmed COVID-19 in pregnancy. The information will be analysed to inform ongoing guidance for women and maternity staff as we respond to the pandemic. Specifically, the study will describe

	incidence, management and outcomes of COVID-19 in pregnancy and identify factors associated with better outcomes for women and their babies. **41 patients recruited to date.**

Non-COVID research

Majority of non-covid studies have now re-opened with just five studies still 'on hold' due to study sponsors decision. Recruitment into these studies remains slow, affected both by new ways of working where fewer patients attend the hospital for appointments, and many patients still fear attending hospital. We have recruited 42 patients into non-COVID studies since 1st April 2021 with surgery and critical care specialties dominating, with some recruitment in cardiology, musculoskeletal and diabetes also. We will continue to focus on improving this, whilst also continuing with Urgent Public Health studies.

Training and infrastructure

We continue to support Student Nurse placements on a regular basis. Since the beginning of November 2021, R&D have also been host to a rotation of Physiotherapy AHP students from Wolverhampton and Birmingham Universities. We have a 2-week training programme for students, to develop their knowledge and understanding of clinical research. We have received extremely positive feedback from the students regarding their placement within R&D.

The department has continued to promote training sessions on Good Clinical Practice via e-learning and have face-to-face sessions for Principal Investigator Masterclasses, as required.

Public engagement

The R&D department has not been able to provide any events to engage the public due to the pandemic restrictions. We had planned a Listening into Action (LIA) event October 2021; however, this was postponed due to the lack of patient attendance in the pandemic.
We participate in the NIHR National Patient Research Experience Survey (PRES), throughout the year, obtaining patients views on their experience of taking part in research. The results of the surveys are published annually on the NIHR website.

Publications

Trust publications for the calendar year 2021, including conference posters, were 224.

Commissioning for Quality and Innovation (CQUIN) payment framework

The Trust's income in 2021/22 was not conditional on achieving quality improvement and innovation goals through the Commissioning for Quality and Innovation payment framework because there were no CQUINs due to the contract's suspension because of the COVID-19 pandemic.

Care Quality Commission (CQC) registration and reviews

The Dudley Group NHS Foundation Trust is required to register with the Care Quality Commission (CQC) and its current registration status is registered without conditions. The Care Quality Commission has not taken enforcement action against the Trust during 2021/22.

The Trust was last inspected in January/February 2019 and the report published in July 2019, the result of which was an overall rating of 'Requires Improvement'. In arriving at this overall assessment, the CQC assessed 56 elements within nine areas. Of the 56 elements, 32 were rated as 'Good' which meant that for surgery, critical care, end of life care (hospital) and end of life care (community services) the Trust was in fact rated as 'Good'. In addition, surgery at Russells Hall Hospital and end of life care community services were both given an 'Outstanding' rating for 'Caring'. Two of the core services, diagnostic imaging, and urgent and emergency planning, had two and one element respectively rated as 'Inadequate' resulting in an overall rating for diagnostic imaging of 'Inadequate'.

The CQC undertook an unannounced focus inspection of the Emergency Department in February 2021 as part of their 'Resilience 5 Plus' process. The previous rating of an overall 'Requires Improvement' remained as this was not a full inspection. What was reviewed fully was the safe domain which was found to have met the requirements of previous enforcement action and was rated as 'Requires Improvement' rather than 'Inadequate' from the previous inspection.

The Trust has not participated in any special reviews or investigations by the Care Quality Commission during 2021/22.

The full report of the January 2019/February 2019 inspection is available at www.cqc.org.uk/provider/RNA

Quality of data

The Trust submitted records during 2021/22 to the Secondary Uses Service (SUS) for inclusion in the Hospital Episode Statistics (HES) latest published data.

The percentage of records in the published data which included the patient's valid NHS number

	The Dudley Group	National average
Admitted Patient Care	99.9%	86.5%
Outpatient Care	99.9%	86.5%
Accident and Emergency Care	99.7%	86.5%

The percentage of records in the published data which included the patient's valid General Medical Practice Code

	The Dudley Group	National average
Admitted Patient Care	100%	90.2%
Outpatient Care	100%	90.2%
Accident and Emergency Care	100%	90.2%

All above figures are April – October 2021. Latest available from NHS Digital Data Quality Maturity Indictor DQMI monthly report.

The Trust submitted the Data Protection and Security Toolkit as 'Standards Met' for 2020-2021. The date for the submission of the 2021-22 toolkit is June 2022 and therefore the results are not available at the time this report was written.

The Trust was not subject to the Payment by Results clinical coding audit during the reporting period.

The Trust will be taking the following action to improve data quality:

- The Trust continually monitors data quality externally via Secondary Uses Service (SUS) reporting, NHSI Data Quality Maturity Indicator (DQMI), and University Hospitals Birmingham Hospital Evaluation Data tool (HED).

Clinical coding error rate

Accurate clinical coding underpins the planning and monitoring of healthcare provision, supports effective commissioning and is key to clinical audit and research. Clinical coding also supports many measures of quality and efficiency, and its accuracy will be important as the NHS seeks significant improvement in both areas. In effect accurate information is essential to identify and deliver efficiency improvements within the NHS.

Constructive auditing of Clinical Coding data is essential to ensure that the information created is accurate, consistent, and complete. Audits can be used to identify clinical coding issues as well as to evaluate the information processes involved in the quality of information approved.

The table shows the overall percentage of correct coding in the trust.

	Level of attainment mandatory	Level of attainment advisory	Trust Percentage correct
Primary diagnosis	>= 90.0%	>= 95.0%	90.0%
Secondary diagnosis	>= 80.0%	>= 90.0%	95.6%
Primary procedure	>= 90.0%	>= 95.0%	94.1%
Secondary procedure	>= 80.0%	>= 90.0%	95.0%

Of the 2736 diagnoses and procedures recorded, the coding inaccuracy rate is 4.9 per cent.
The accuracy of the coded clinical data has increased significantly in every area since the 2017/18 audit was undertaken specifically in the primary procedure area, which is critical for the accuracy of procedure driven HRGs in the surgical specialties.

The depth of coding (number of recorded diagnosis codes) in this sample is 5.6 which is above the national average of 5.3.

Recommendation	Action taken
Increase the level of clinician validation of the coded clinical data. Pilot and refine the process to allow all stakeholders to benefit. Work with the clinicians on the expected record keeping standards in electronic format to ensure capture of primary diagnosis and comorbidities. Review the specific errors identified in the audit and discuss with the coding team at team meetings to reduce the incidence of error. Continue to audit each coder as per audit plan but also use the analytics tools to target areas of weakness for the whole team Review the admission method data table in OASIS and ensure that the information passed to 3M Medicode, the primary encoding tool, meets the national standards in the NHS Data Dictionary.	The Coding team in the last 12 months have increased Validation and now the Validation process of coded data regularly involves: All patients deaths, Palliative care patients, Strokes, Pneumonia, Cardiac Cath lab procedures, Angiographies, Charlson index codes, HRG U codes. Any discrepancies in coded data identified within trust departments are audited and validated when necessary. The Coding team are looking to further increase validation in the next 12 months. The Coding team also has a presence on the Mortality Surveillance Group and Data Quality meetings. Coding awareness sessions take place with various specialities and Junior Doctors throughout the year. This is to stress the importance of accurate documentation on the Electronic Patient Record system (Sunrise) within the clinical teams and to ensure accurate Primary Diagnostics and Procedures and that all relevant Co-morbidities are recorded. • Regular Team meetings are held to discuss coding errors from audits and to discuss Coders queries. • Communication has been enhanced with the introduction of Microsoft Teams where Coding issues are shared amongst the Team. • Although the trust no longer has a Nationally Qualified Clinical Coding Auditor the first steps towards training a new Coding auditor for the trust, have been taken. • The Coding Team play a vital role in validating accurate admission information on the trusts PAS system OASIS

Learning from deaths

Dudley Group NHS FT	Q1	Q2	Q3	Q4	Comments
Number of patients who died	394	450	512	499	
Number of deaths subjected to a case review or investigation	11	21	11	14	In addition, 123 Healthcare acquired COVID deaths were subject to review
Estimate of the number of deaths thought to be more likely than not due to problems in the care provided		2	1		3 cases were deemed probably avoidable (More than 50:50)

These numbers have been estimated using a) The Trust's mortality review process which includes a medical examiner scrutiny and a Level 1 peer review of all deaths by the department concerned using a standard questionnaire. This may lead to a Level 2 review performed by a mortality panel using a structured case note review data collection as recommended by the National Mortality Case Record Review Programme, b) Coroner Rule 28 cases when making recommendations about future care and c) root cause analysis reports following investigations if a death is reported as a serious incident if that is clinically appropriate (e.g., death potentially avoidable).

There are outstanding Serious Judgement Reviews for 2021/22 however it should be noted that all deaths receive a review by Medical Examiner and any concerns are escalated through the Trust governance process as appropriate. The panels in 2021/22 have predominantly focused on COVID deaths and

Learning Disability Deaths. There is a plan in place to complete outstanding inpatient reviews in Q1 of 2022/23.

A summary of what the provider has learnt from case record reviews and investigations conducted in relation to the deaths identified above.

Strengthening of Advanced Care Plan or DNA CPR to establish ceilings of care and appropriate care settings. A gap in updating GSF for patients when patients begin to deteriorate. Overall end of life care is good within the trust. Delays in implementation of best supportive care may occur when decisions are awaited from tertiary centres. Such delays may prevent a transfer home or to a hospice at an appropriate time. EMLAP and NELA data are above the national average but with opportunities to further improve performance with multi-departmental working. Learning disability reviews - care was appropriate although there are some questions raised over appropriateness of wording on MCCD and DNA CPR. LD team are currently auditing DNA CPR for presentation at MSG.	Lack of understanding of DNACPR and the perception that this is the ceasing/withdrawal of all treatment rather than allowing “natural” death to occur. There is continued awareness of patients remaining for over 4 hours within ED which does not allow for best holistic care There remain a few inappropriate admissions to hospital from care homes often at end of life Place of death – some patients do die within the Emergency Department – this may sometimes be because it would have been inappropriate to move them due to End of Life and expected to die within very short period but may be due to capacity challenges. Readmissions within 7 days are rarely due to the previous discharge and are unavoidable deaths. The Trust and community teams are implementing the RESPECT document which may help to minimise unnecessary admissions at end of life. Similarly, the Palliative Care teams are working to highlight such issues and to improve discharge planning for such patients.

A description of the actions which the provider has taken in the reporting period, and proposes take following the reporting period, in consequence of what the provider has learnt during the reporting period.

Developed a pathway for the deteriorating patient that is currently being digitalised Ongoing implementation of the Gold Standards Framework (GSF). The Medical Examiner system is in place with over 95% of deaths receiving a Medical Examiner review. Increased usage of the priorities of care documentation across the Trust. Cases with learning are highlighted to the specialty and discussed at the Joint Mortality Meetings within the ICS.	The Trust is being supported by the Advancing Quality Alliance (AQuA) to look at several deteriorating patient pathways. The first condition groups to undertake this work were AKI, sepsis and alcohol related liver disease. Work stream plans have been generated and are in the process of being fully implemented in association with the specific teams and audit department. Pathways for pneumonia work has been a focus with The British Thoracic Society bundle being implemented. New mortality module launched via AMAT (audit management tool) Implementation of RESPECT document

An assessment of the impact of the actions described above which were taken by the provider during the reporting period.

Mortality SHMI has decreased to 1.12 Further reduction in sepsis mortality Reduction in investigation requests from the coroner.	Decreased number of serious incidents. A positive external assessment of COVID related care.

Seven-day hospital services (7DS)

The 7-day service standards were first introduced in 2013 by NHS Improvement, four of which were identified as clinical priorities in 2016 based on their potential to positively affect patient outcomes. The 7DS programme aim is to provide a standard of consultant led care to all patients presenting urgently or as an emergency such that their outcomes are optimised and there is equity of access nationwide but also outcomes are not dependent on the time of day or day of the week patients present. It should be noted that national reporting has been suspended due to COVID-19 pressures.

By March 2020 NHS England expected all Trusts in the country to be 90% compliant with the 4 clinical standards. The Trust reported in June 2020 that these standards had been achieved.

Priority Standard 2 (time to first Consultant review) and Standard 8 (ongoing daily review)
The Trust had achieved 92% for standard 2 and for standard 8 94% for once daily review and 87% for twice daily reviews. Assurance of continued compliance of these standards now forms part of the annual job planning cycle for all departments overseen by the Medical Job Planning Consistency Committee.

Priority Standard 5 (access to diagnostics) and 6 (Access to Consultant led interventions)
Significant progress has been made since the launch of the 7DS standards and following previous audit work performance against standard 5 is reported and monitored in real time. For the week ending 31/01/2022 90.9% of all radiology requests were completed within 24 hours. Further work is ongoing to improve compliance across all modalities specifically CT and MRI scans.

Raising concerns

The Freedom to Speak up (FTSU) service aims to provide all staff (including non-substantive) with a safe route to raise concerns in the workplace. Concerns can be raised confidentially with the FTSU team who will listen and offer support and signposting as well as escalating appropriately as/when necessary. The service is represented as follows:

Diane Wake - CEO and Executive Lead for Freedom to Speak up.
Julian Atkins – Non-executive Lead for Freedom to Speak up.
Rebekah Plant – Lead Freedom to Speak up Guardian.
Philippa Brazier – Freedom to Speak up Guardian.
Lesley Bucknall – Freedom to Speak up champion and administrative support.

Information and contact details for the service can be found on the Trust intranet and on posters displayed around the Trust sites.

Governance arrangements

The FTSU steering group, which meets quarterly, includes representation from Human Resources, Staff side and Communications. The group reports into the Workforce Committee and to Trust Board as required.

The Lead Guardian participates in twice monthly informal meetings with other FTSU Guardians in our region: best practice and new initiatives are shared in this way.

In line with the National Guardian office (NGO)'s guidance the Trust submits anonymised data, about the numbers and types of concerns received, to their online portal on a quarterly basis. These submissions are analysed using the model hospital system and can be compared to local and national Trusts.

Freedom to Speak Up Strategy

The 2021 FTSU strategy set the following priorities for achievement:

- Staff irrespective of role, from any area and any background feel safe to raise valid concerns about their workplace and their experience.
- Managers and Senior Leaders approach the resolution of concerns in a structured manner which supports and reinforces the values and benefits of a speaking up culture
- All levels of the organisation are aware of the FTSU service and view it as a credible independent and objective support service.

To achieve the priorities the service strives to continuously improve – an ongoing action plan is in place which is based on an independent NHSI review of our FTSU arrangements in late 2020. Actions from a review by our internal auditors (2020) have also been implemented.

Champions

To maximise the accessibility of the FTSU service we have a network of 23 champions across the Trust in various roles including administrative, medical, nursing and AHP. Their role is a combined FTSU and patient safety role and the team are there primarily to listen and signpost: champions do not usually handle concerns themselves.

The Trust adheres to the National Guardian Office 'Guidance for developing a champion network' (2021) and champions undertake training on induction which is refreshed annually thereafter. Champion group meetings are held (mixture of face to face and virtually for our community staff) on a quarterly basis in addition to 1:1 'catch ups' with the Guardians.

Recent activities

For 'Speak up' month 2021 (October) the Exec and non-executive team supported FTSU with a series of 'walk rounds' around the Trust sites to talk staff about the service.

The Executive and Non-executive Leads for FTSU were profiled on Twitter along with the Guardians and Champions and the hospital was lit up, in green, in honour of Freedom to Speak up.

Junior doctor rota gaps and the plan for improvement to reduce these gaps

In 2016 contractual rules were introduced to ensure rotas are designed and managed in a way that allows doctors to meet their training needs, avoid fatigue and overwork and maintain work-life balance, while allowing employers to deliver the service. These were reviewed and updated in 2019. Rota gaps, long-term staff vacancies and intensifying workload continue to be major issues across the NHS.

The Trust has taken and intends to take several actions to minimise these gaps. These include

- A medical training initiative (MTI) - a two-year training programme has been established. These doctors help to cover any ongoing Deanery and Trust vacancies at registrar and SHO level. They also help backfill any shifts unfilled by the increasing number of LTFT (less than full time) trainees we are assigned by the Deanery.
- Increased physician associate roles in several areas to support SHO level activity. This has been particularly successful in the Acute Medical Unit and is being extended to other areas in the Trust.
- The use of head-hunting agencies for particularly hard to fill, senior level vacancies within specialist areas.
- Increasing our internal bank coverage so that, for example, when junior staff leave due to their rotation elsewhere to undertake research, we are arranging for those staff to remain on our internal staff bank.
- More effective rostering using the Medirota system for junior doctors has been implemented across all divisions within the Trust. The General Internal On call rota is fully implemented and solely used and managed via Medirota. Work to fully embed the individual specialty rotas, especially in Medicine and ED continues.

Part 4: National core set of quality indicators

All trusts are required to include comparative information and data on a core set of nationally used indicators where available. The tables include the two most recent sets of nationally published comparative data as well as, where available, more up-to-date Trust figures. It should be appreciated that some of the 'Highest' and 'Lowest' performing trusts may not be directly comparable to an acute general hospital, for example, specialist eye or orthopaedic hospitals have very specific patient groups and so generally do not include emergency patients or those with multiple long-term conditions.

Preventing people from dying prematurely

Mortality

The summary hospital level mortality indicator (SHMI) is a mortality measure that takes account of several factors, including patient's comorbidities. It includes patients who have died whilst having treatment in hospital or within 30 days of being discharged from hospital. The SHMI score is measured against the NHS average which is 1.00. A score below 1.00 denotes a lower-than-average mortality rate and therefore indicates good, safe care.

Summary hospital-level mortality indicator

	November 2019 – October 2020	November 2020 – October 2021
SHMI		
Trust	1.20	1.12 (Band 1)
National Average	1.00	1.01
Lowest	6.9	7.5
Highest	1.2	1.21
Trust	17.5%	19.5%
National Average	35.7%	36.8%
Lowest	6.0%	9.1%
National	79.2%	80.2%

Data source: HED Benchmarking Tool

The Dudley Group NHS Foundation Trust considers that this data is as described for the following reasons:

Data is taken from Secondary Users Service (SUS) Hospital Episode Statistics (HES) data which is audited on an annual basis by external auditors.

The Dudley Group NHS Foundation Trust has taken the following actions to improve these percentages, and so the quality of its services, by:

- Developed a pathway for the deteriorating patient that is currently being digitalised
- Ongoing implementation of the Gold Standards Framework (GSF).
- The Medical Examiner system is in place with over 95% of deaths receiving a Medical Examiner review.
- Increased usage of the priorities of care documentation across the Trust.
- Cases with learning are highlighted to the specialty and discussed at the Joint Mortality Meetings within the ICS.
- The Trust is being supported by the Advancing Quality Alliance (AQuA) to look at several deteriorating patient pathways. The first condition groups to undertake this work were AKI, sepsis and alcohol related liver disease. Work stream plans have been generated and are in the process of being fully implemented in association with the specific teams and audit department.
- Pathways for pneumonia work has been a focus with The British Thoracic Society bundle being implemented.
- New mortality module launched via AMAT (audit management tool)
- Implementation of RESPECT document

Helping people to recover from episodes of ill health or following injury

Patient reported outcome measures

Primary hip replacement	2020/21	2021/22
Dudley Group NHS FT	No data available	No data available
National Average	No data available	No data available
Highest	No data available	No data available
Lowest	No data available	No data available

Primary knee replacement	2020/21	2021/22
Dudley Group NHS FT	No data available	No data available
National Average	No data available	No data available
Highest	No data available	No data available
Lowest	No data available	No data available

Source: Finalised Patient Reported Outcome Measures (PROMs) in England for Hip and Knee Replacement Procedures (April 2019 to March 2020)

During the Covid-19 pandemic, elective orthopaedic surgery was paused. The distribution of PROMs forms has now recommenced.

Readmissions to hospital within 30 days of discharge

	2020/21			2021/22		
	0 – 15 years	16 & over	Total	0 – 15 years	16 & over	Total
Discharges*	8542	75980	84522	10939	94123	105062
Readmissions within 30 days (number)	187	8083	8270	242	10011	10253
Percentage %	2.2%	10.6%	9.8%	2.2%	10.6%	9.8%

Source: https://digital.nhs.uk/data-and-information/publications/clinical-indicators/compendium-of-population-health-indicators/compendium-hospital-care/current/emergency-readmissions-to-hospital-within-30-days-of-discharge/emergency-readmissions-to-hospital-within-30-days-of-discharge

**PBR rules applied to the number of discharges does not include Day case, Maternity, Virtual ward, Same Day Emergency Care or procedures undertaken at Ramsey Private Hospital*

The Dudley Group NHS Foundation Trust considers that this data is as described for the following reasons:

Data is taken from Secondary Users Service (SUS) Hospital Episode Statistics (HES) data which is audited on an annual basis by external auditors.

The Dudley Group NHS Foundation Trust has taken the following actions to improve these percentages, and so the quality of its services, by:

A work stream is in place to review and improve clinical unwarranted variation across all specialities. This will include reviewing readmission rates and other clinical improvements emerging from various sources such as the national Getting it Right First-Time programme, data available on the Model Hospital Portal and the NHS benchmarking tool service peer reviews and any contract breaches

Ensuring people have a positive experience of care

Responsiveness to the personal needs of patients

Our score is for the five questions in the national patient survey relating to responsiveness and personal care.

	2020/21	2021/22
Dudley Group NHS FT	61.7	71.7
National average	67.7	67.9
Highest	83.9	84.1
Lowest	54.4	54.4

NHS OUTCOMES FRAMEWORK (NHS OF) digital.nhs.uk

The Dudley Group NHS Foundation Trust considers that this data is as described for the following reasons:

This indicator is based on questions from the National Inpatient Survey and patients have scored the Trust highly on the five aspects taken as part of this indicator. The Trust score is higher than the national average indicating a 'good' patient experience.

The Dudley Group NHS Foundation Trust has taken the following actions to improve these percentages, and so the quality of its services, by:

- Making patient experience a quality focus for 2022/23 as one of the Trusts Quality Priorities
- Improvement actions developed in collaboration with the Matron Group

Patient recommendation to family and friends

The Friends and Family Test scores remain a national focus, provides valuable benchmarking information and drive improvement to the patient experience The NHS Friends and Family Test (FFT) is firmly embedded within the Trust with all patients given the opportunity to complete the during or after each episode of care and treatment in all areas of the organisation. Feedback is captured through a variety of methods (SMS, tablet, paper, online). The FFT is presented as the percentage of respondents that rate their experience very good/good and the percentage of respondents that rate their experience poor/very poor.

Dudley Group NHS FT	2020/21	2021/22
Response rate	19%	20%
% Very Good/Good	82%	80%
National Benchmarking	90%	90%
% Very Poor/Poor	5%	7%
National Benchmarking	5%	5%

Unify - community - Patient experience survey reporting
https://www.england.nhs.uk/publication/friends-and-family-test-data)

The Dudley Group NHS Foundation Trust considers that this data is as described for the following reasons:

- Covid-19 pandemic
- An increase in patients being nursed in isolated rooms with restrictions on leaving the ward area

- The suspension of visitors

The Dudley Group NHS Foundation Trust has taken the following actions to improve these percentages, and so the quality of its services, by:

- 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 were required.
- Patient's responses and feedback are shared with teams for learning and service improvement, comments are scores are sent to all members of staff and discussed in the daily huddles and You Said We Have actions are reported to the Patient Experience Team.
- We have distributed posters throughout the hospital displaying the links to the FFT and we have seen an increase in the number of patients completing the survey online.
- We produced FFT stickers with online links/QR codes for the maternity department to put on patient's maternity antenatal and postnatal notes to improve response rates and to ensure that the FFT is accessible to all, as SMS text messaging s not available within the service. Posters and paper surveys are to be updated in the Antenatal Department as these are currently out of date.

Staff recommendation to family and friends

Measure of staff recommendation of the organisation as a place that they would recommend to receive care or recommend family to receive care as gather in the National Staff Survey (Quarter 3); and in the National Quarterly People Pulse (Quarter 1, 2 and 4)

2021/22	Q1	Q2	Q3	Q4
Dudley Group NHS FT				
National average for combined acute/community trust	Not available	57% Work 61.2% Care	55.1% Work 60.4% Care	54.6% Work 62.1% Care
Highest combined acute/community trust	Not available	Not available	77.6% Work 89.5% Care	Not available
Lowest combined acute/community trust	Not available	Not available	38.5% Work 43.6% Care	Not available

Data source

Quarter 1 – **Not available** – changes to Staff FFT to National Quarterly People Pulse from Q2 2021/22. Change is also from 2 recommend questions to Staff Engagement Score which provides an overall metric against 9 staff engagement questions.

Quarter 2 – National Quarterly People Pulse (published month 2, Quarter 2)

Quarter 3 – National Staff Survey (published month 3, Quarter 4)

Quarter 4 – National Quarterly People Pulse (published month 2, Quarter 4)

The Dudley Group NHS Foundation Trust considers that this data is as described for the following reason:

- The pandemic has significantly impacted on staff experience due to increased, unexpected demands from staff
- High sickness levels because of COVID 19 isolation requirements
- Additional pressure to recover service delivery
- National results are reflective of a similar trend to Dudley and therefore provides a picture of similar experience across all healthcare workers
- Response rates for the Quarterly Survey are low (<25%) as focus was on the National Survey for 2021/22

The Dudley Group NHS Foundation Trust has taken the following actions to improve these percentages, and so the quality of its services, by:

- Focus for 2021/22 was on the Staff Survey undertaken in Q3 which saw a 13% increase in responses from the previous year to 59% of staff responding
- Staff engagement is a key priority for action and activity to support improvement includes delivery of Managers Essentials to support compassionate line management in teams; investment in support for health and wellbeing of staff; actions to focus on being an inclusive employer
- Delivery of actions within the Dudley People Plan such as focus on flexible working, development support and recruitment will improve staff experience in the long term
- Local action plans and additional engagement and support are in place for areas within the organisation that are outliers (comparatively poorer scores when compared with the organisation's benchmark). This activity includes additional focus on leadership and management development, wellbeing actions and team support.

Venous thromboembolism assessments

Venous thromboembolism (VTE) or blood clots, are a major cause of death in the UK. Some blood clots can be prevented by early assessment of risk for a particular patient.

	2020/21	2021/22
Dudley Group NHS FT	**96.57%**	**93.2%**
National average	**No data available**	**No data available**
Best performing Trust	**No data available**	**No data available**
Worst performing Trust	**No data available**	**No data available**

Data source

EPMA VTE and Bleeding Assessment - Power BI Report Server (wmids.nhs.uk)

The Dudley Group NHS Foundation Trust considers that this data is as described for the following reasons:

Due to the Covid-19 pandemic, the national collection of data related to this metric was paused.

The Dudley Group NHS Foundation Trust has taken the following actions to improve these percentages, and so the quality of its services, by:

- Undertaking a deep dive into the completion of VTE assessments in January 2022. This focused on Surgery, Women and Children as performance was lower than the Medicine division. The audit identified key areas of non-completion of the assessment and paper records were reviewed. A discrepancy between the electronic reporting and paper records was identified and work is now underway to remedy the issue. A re-audit is scheduled once the amendments are made.

- For further assurance outcome and readmission data were reviewed. The Trust is in the lower quartile for readmissions relating to VTE at a rate of 0.111% and outcome data shows continual improvement.

Infection control – clostridium difficile (C.difficile)

This measure shows the rate per 100,000 bed days of cases of C.difficile infection that have occurred within the Trust amongst patients aged two years or over during the reporting period.

	2020/21	2021/22
Trust apportioned cases (Lapses in care)	11	18
Trust bed days	242,400	242,400
Rate per 100,000 bed days	25.66372145	*
National average	46.60237797	*
Best performing trust	2.254715173	*
Worst performing trust	140.5415535	*

*= data not available
Data source
CDI annual data table 2021

Changes to the CDI reporting have been made to align the UK definitions with international descriptions of disease.

These changes will mean that additional patients will be included in the group of patients that the hospital must investigate. The patients who will be included are categorised in the following groups:

1. Hospital Onset Healthcare Associated (**HOHA**): cases that are detected in the hospital 2 or more days after admission.

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

The Dudley Group NHS Foundation Trust considers that this data is as described for the following reasons:

- The Trust continues to perform well against national data. This is especially pleasing in a climate where nationally numbers of cases are increasing.

The Dudley Group NHS Foundation Trust has taken the following actions to improve these percentages, and so the quality of its services, by:

- the process for reviewing CDI cases in line with the new national framework is now embedded.
- All HOHA CDI cases are reviewed both internally and with our external partners where the cases are assigned
- The well-functioning antimicrobial guidelines continue to be updated to reflect national objectives including reductions in carbapenem usage and increased prescribing from within the access list of antibiotics which the Trust is achieving.
- Treatment protocols continue to be updated to ensure they reflect evidence-based practice and follow National guidelines

Patient safety incidents

Dudley Group NHS FT	Latest reporting period Apr 2020 – Mar 2021	Previous reporting period Oct 2019 – Mar 2020
Total reported incidents	31.6 (number 6035)	36.1 (number 4070)
Rate per 1000 bed days		50.7

National average (acute non-specialist)	**No data available**	**No data available**
Highest reporting rate (acute non-specialist)	**118.7 (number 32,917)**	**110.2 (number 11,787)**
Lowest reporting rate (acute non-specialist)	**27.2 (number 3169)**	**15.7 (number 1,271)**

NHS Outcomes Framework Indicators March 2022 release

Dudley Group NHS FT	Latest reporting period Apr 2020 – Mar 2021	Previous reporting period Oct 2019 – Mar 2020
Incidents causing severe harm or death	**17**	**10**
% of incidents causing severe harm or death	**0.09**	**0.1**
National average (acute non-specialist)	**No data available**	**0.3**
Highest reporting rate	**1.08 (number 163)**	**0.5 (number 93)**
Lowest reporting rate	**0.03 (number 4)**	**0.0 (number 1)**

NHS Outcomes Framework Indicators March 2022 release

The Dudley Group NHS Foundation Trust considers that this data is as described for the following reasons:

During the reporting period of April 2020 to March 2021 the number of incidents reported has increased compared with October 2019 and March 2020. The increase in the number of incidents reported shows a positive reporting culture within the Trust whilst the % of these incidents causing severe harm or death has reduced.

The Dudley Group NHS Foundation Trust has taken the following actions to improve these percentages, and so the quality of its services, by:

Work is underway to improve the Trusts Datix Incident reporting system to encourage all staff to continue to report patient safety incidents.

Our performance against the thresholds set out in the Risk Assessment and Single Oversight Frameworks of NHS Improvement

Dudley Group NHS FT	Trust 2020/21	Target 2021/22	National 2021/22	Trust 2021/22
Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate – patients on an incomplete pathway	**77.43%**	**92%**	**63.8% (Dec 21)**	**74.9% (Dec 21)**
A&E: maximum waiting time of 4 hours from arrival to admission, transfer, discharge	**90.02%**	**95%**		**80.53%**
All cancers: 62 day wait for first treatment from urgent GP referral for suspected cancer	**66.27%**	**85%**	**67.49% (Nov)**	**67.97% (Nov)**
All cancers: 62 day wait for first treatment from NHS Cancer Screening Service referral	**69.52%**	**90%**	**72.29% (Nov)**	**94.74% (Nov)**
Maximum 6 week wait for diagnostic procedures	**74.12%**	**99%**	****62.98%**	***81.37%**

Venous Thrombolism (VTE) Risk Assessment	**96.57%**	**95%**	**N/A**	**93.33%**

Trust data from DM01 Diagnostic Waiting Times submissions to NHSD

*2021/22 Trust performance shows year to date i.e., April 2021 to December 2021

**2021/22 National performance taken from NHSE website of “Trust” provider DM01 submissions

Glossary of terms

A&E	Accident and Emergency (also known as ED)	FCE	Full Consultant Episode (measure of a stay in hospital)
AAA	Abdominal Aortic Aneurysm	FFT	Friends and Family Test
AKI	Acute Kidney Disease	FY1/FY2	Foundation Year Doctors
ALARP	As Low As Reasonably Practicable principle	GI	Gastrointestinal
AMU	Acute Medical Unit	GMC	General Medical Council
ANP	Advance Nurse Practitioner	GP	General Practitioner
App	A computing application, especially as downloaded by a user to a mobile device.	HCAI	Healthcare Associated Infections
Bed Days	Unit used to calculate the availability and use of beds over time	HDU	High Dependency Unit
BFI	Baby Friendly Initiative	HED	Healthcare Evaluation Data
CAMHS	Child and Adult Mental Health Service	HES	Hospital Episode Statistics
C. diff	Clostridium difficile (C. difficile)	HQIP	Healthcare Quality Improvement Partnership
CCG	Clinical Commissioning Group	HSCIC	Health and Social Care Information Centre
CMP	Case Mix Programme	ICNARC	Intensive Care National Audit & Research Centre
CNS	Clinical Nurse Specialist	IPC	Infection Prevention and Control
CPR	Cardio Pulmonary Resuscitation	IPCS	Intermittent Pneumatic Compression
CQC	Care Quality Commission	ISO	International Organization for Standardization
CQUIN	Commissioning for Quality and Innovation payment framework	KPI	Key Performance Indicator
CT	Computed Tomography	LocSSIPS	Local Safety Standards for Invasive Procedures
CTG	Cardiotocograph	MBC	Metropolitan Borough Council
CTPA scan	CT pulmonary angiogram is a CT scan that looks for blood clots in the lungs	MCP	Multispecialty Community Provider (now called Integrated Community Provider)
DATIX	Company name of incident management system	MDT	Multidisciplinary Team
DNACPR	Do Not Attempt Cardio Pulmonary Resuscitation	MRI	Magnetic Resonance Imaging
DVD	Optical disc storage format	MRSA	Methicillin-resistant Staphylococcus aureus
DVT	Deep Vein Thrombosis	MUST	Malnutrition Universal Screening Tool
EAU	Emergency Assessment Unit	NatSSIPS	National Safety Standards for Invasive Procedures
ECG	Electrocardiograph	NBM	Nil By Mouth
ED	Emergency Department (also known as A&E)	NCEPOD	National Confidential Enquiry into Patient Outcome and Death
EmLap	High Risk Emergency Laparotomy Pathway	NEWS	National Early Warning System

NHSI	NHS Improvement	RCPCH	Royal College of Paediatrics and Child Health
NICE	National Institute for Health and Care Excellence	RECOVERY	Randomised Evaluation of COVID-19 Therapy
NIHR	National Institute for Health Research	SHMI	Summary Hospital-level Mortality Indicator
NMC	Nursing and Midwifery Council	SMS	Short Message Service is a text messaging service
NPSA	National Patient Safety Agency	SOP	Standard Operating Procedure
NRSA	National Research Service Award	STEIS	Strategic Executive Information System is the national database for serious incidents
NVQ	National Vocational Qualification	STEMI	ST-Elevation Myocardial Infarct
PE	Pulmonary Embolus	SUNRISE	Trust electronic patient record system
PFI	Private Finance Initiative	SUS	Secondary Uses Service
PHE	Public Health England	TTO	To take out medications once discharged as an inpatient
PLACE	Patient-led Assessments of the Care Environment	UKOSS	UK Obstetric Surveillance System
PROMs	Patient Reported Outcome Measures	VQ scan	A ventilation–perfusion (VQ) scan is a nuclear medicine scan that uses radioactive material (radiopharmaceutical) to examine airflow (ventilation) and blood flow (perfusion) in the lungs.
RAG	Red/Amber/Green	VTE	Venous Thromboembolism
RCA	Root Cause Analysis investigation	YTD	Year To Date

Annex

Comment from the Trust's Council of Governors

Each year the Trust prepares a Quality Account that reports on the quality of services offered. The report is published annually and is available to the public. Quality Accounts are an important way for local NHS services to report on quality and show improvements in the services they deliver to local communities and stakeholders.

The Council of Governors is invited to review the draft report and prepare a comment. The process adopted in the preparation of the governor comment on the Quality Account 2021/2022 saw a copy of the draft report circulated to all governors for their review and response. Governors were then supported to collate responses and formulate the comment for inclusion as given below:

The Council of Governors has reviewed the 2021/22 Quality Account and acknowledges the Trust's focus on delivering high quality services during another challenging year. Governors fully support the Chief Executives Statement in Section 1 of this report. The Trust has continued to deliver a robust response to the coronavirus pandemic. In line with national focus, the Trust is working hard on the restoration and recovery programme and is actively working with other trusts in the local area to address the backlog of patients awaiting treatment.

The Council of Governors has continued to adapt to new virtual ways of working and participate in a wide range of review activities during the year. The governors are pleased to maintain a close working relationship and regularly attend monthly committee and board meetings and have welcomed the resumption of face-to-face quality and safety review walkrounds. These activities provide governors with an opportunity to triangulate the information they receive and have noted the 'you said, we have' improvement initiatives such as patients provided with LED dashboard in waiting areas so they know what the waiting time is.

The Council of Governors welcomes the continuation of patient experience and discharge management as the Trust's quality priority indicators for 2022/2023. It exemplifies the Trust's desire to be a listening and learning organisation, utilising a wide range of feedback channels including Friends and Family Test responses where it is noted that further work is needed to improve the response rates. The Trust faces continued challenges with patient flow through and out of the hospital and the council has sought assurance that appropriate actions have been implemented to address it. They have noted the establishment of the Home for Lunch initiative and the need to drive performance.

It is reassuring to see that the Trust undertakes a wide range of clinical and non-clinical audits that are valuable to support and improve the quality of services. It is encouraging to see that, through audits, recommendations are made and the actions taken are published. This is necessary to identify how issues raised are being acted upon to meet high standards.

The council recognises the efforts that were made with mandatory vaccination and applauds the role taken by the Trust to host the Black Country and West Birmingham BCWB vaccination programme Employment Bureau: a role that has received national recognition. It is assuring to see that the Trust's rigorous approach to infection prevention and control has resulted in solid performance compared to the national standards.

The council appreciates and applauds the commitment and dedication of staff across all areas and in all disciplines of the Trust. Against the backdrop of COVID-19 and the focus to treat the backlog of patients, they continue day in, day out to embrace all opportunities to treat patients in the right place at the right time. Governors note that the Trust is taking positive steps to support junior doctors to maintain a good work life balance and has adopted a number of initiatives to reduce the reliance on them to fill rota gaps. The council

is pleased that the Trust has enhanced its approach to supporting staff health and wellbeing with a range of health and wellbeing initiatives and has continued its focus on recruitment and retention. The importance of listening to staff to drive improvement is exemplified with the maturity of the Trust's 'Freedom to Speak up' initiative.

The council is proud of the national recognition received by the Trust. Russells Hall Hospital is home to the Black Country vascular hub and has been ranked best performing out of 38 other Abdominal aortic aneurysm (AAA) screening organisations and the audiology service continues to retain its national accreditation. The council is equally proud that the Trust has introduced innovative treatments for treating enlarged prostrate using steam and a new closed loop system for managing type 1 diabetes. Governors also support the Trust's annual Committed to Excellence Awards that celebrates the achievements of individual staff and teams across the Trust.

Comment from the Dudley Clinical Commissioning Group (received 01/06/2022)

As the commissioners of Dudley Group NHS Foundation Trust, the Black Country, and West Birmingham Clinical Commissioning Group (CCG), welcomes the opportunity to provide this statement in response to Dudley Group NHS Foundation Trust 21/22 Quality Accounts.

The information provided within this report presents the progress made by the Trust against the 21/22 Quality Priorities, identifying where the organisation has made progress, where further improvement is required, what actions are required to achieve these goals and outlines the Quality Priorities for 22/23.

The CCG acknowledges that the past two years has been a difficult and an unprecedented time for the entire NHS and social care workforce and sincerely give thanks to Dudley Group NHS Foundation Trust for all the hard work, commitment and dedication given, and continue to do, on ensuring people presenting with health care needs, are supported. Dudley Group NHS Foundation Trust has faced immense challenges, and the CCG are grateful for the tremendous efforts made by the Trust under the unprecedented strains and pressure of the pandemic.

It is reassuring to see how during the COVID-19 Pandemic, the Trust have continued to maintain assurance on quality of care delivered and that the Contract Quality Review Meetings have continued to meet and monitor service delivery. Throughout this period, patient experience, engagement and safety have remained at the heart of the organisation, demonstrating improvement through the patient audits and when safe to do so, holding Listening into Action events.

The CCG recognise the importance of the introduction of the patient voice volunteers and patient safety partners, ensuring the voices of patients are heard and inform, influence the delivery, planning and improvement of services.

The quality priorities for 21/22 reflect areas where improvement is required. The CCG is fully supportive of the Priority ‘Treating patients in the right place, at the right time’. Ensuring patients are assessed, diagnosed, treated and are not in hospital longer than necessary. The CCG will continue to work in partnership with the Trust to embed effective discharge planning starts at the point of admission, patients continue to receive safe, effective and response services at the right time whilst, maintaining choice and control through their personalised plan of care.

The Trust have shown an increase in the number of Grade 3 pressure ulcers developed in their care between 21/22. The Trust has outlined how it will reduce the number of Grade 3 pressure ulcers through implementing a new process. As commissioners, we will continue to work closely with the Trust to regularly review progress, whilst supporting to embed quality improvement initiatives.

The section on clinical audit is comprehensive and clearly articulates the Trust’s performance. It was positive to see the number of clinical audits that have been undertaken during 21/22 and the assurance regarding the actions/improvement taken.

The CCG welcomes the Trust’s commitment to review all deaths as part of the joint mortality group. The Trust has demonstrated that learning from the mortality review process has been of significant benefit and has taken required actions forward to embed the lessons identified.

As the commissioners, we will continue to work collaboratively with Dudley Group NHS Foundation Trust and oversee the organisations progress towards the implementation of their quality Improvement priorities. We are dedicated and committed to engaging with the Trust and to build relationships and foster innovation and improvement moving forward into 22/23.

Katie Welborn

Head of Quality and Safety (Dudley Place).

Statement of directors' responsibilities in respect of the Quality Report 2021/2022

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year.

NHS Improvement has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation trust boards should put in place to support the data quality for the preparation of the quality report.

In preparing the Quality Report, directors are required to take steps to satisfy themselves that:

The content of the Quality Report meets the requirements set out in the *NHS foundation trust annual reporting manual 2018/19* and supporting guidance *Detailed requirements for quality reports 2021/2022* and;

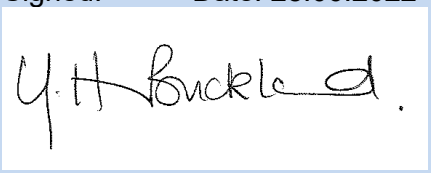
The content of the Quality Report is not inconsistent with internal and external sources of information including:

- board minutes and papers for the period April 2021 to May 2022
- papers relating to quality reported to the board over the period April 2021 to May 2022
- feedback from commissioners Dudley Clinical Commissioning Group May 2022
- feedback from governors May 2022
- feedback from local Healthwatch organisation Healthwatch Dudley May 2022
- feedback from Overview and Scrutiny Committee Dudley Metropolitan Borough Council Health and Adult Social Care Scrutiny Committee May 2022
- the Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, May 2022
- the latest national inpatient survey March 2022
- the latest national staff survey, dated March 2022
- the Head of Internal Audit's annual opinion over the Trust's control environment dated May 2022
- CQC inspection report dated 12th July 2019
- the Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered
- the performance information reported in the Quality Report is reliable and accurate
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice
- the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review
- the Quality Report has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Report.

By order of the board

Signed: Date: 28.06.2022



Dame Yve Buckland
Chairman

Signed: Date: 28.06.2022

Diane Wake
Chief Executive