Our Patients
Our People
Our Place

NHS
The Dudley Group
NHS Foundation Trust

Council of Governors Meeting Papers

Thursday 19 June 2025 4:00pm – 6:00pm

Seminar Rooms 1 & 2, Undergraduate Centre, 2nd Floor, North Wing, Russells Hall Hospital, Pensnett Road, Dudley, DY1 2HQ

Our Patients
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Performance for May 2025

- 28 day faster diagnosis standard (Target 75%)– 86.7%
- 31 day decision to treat to treatment (Target 96%) – 94.8%
- 62 day referral to treatment (Target 85%) – 71.8%

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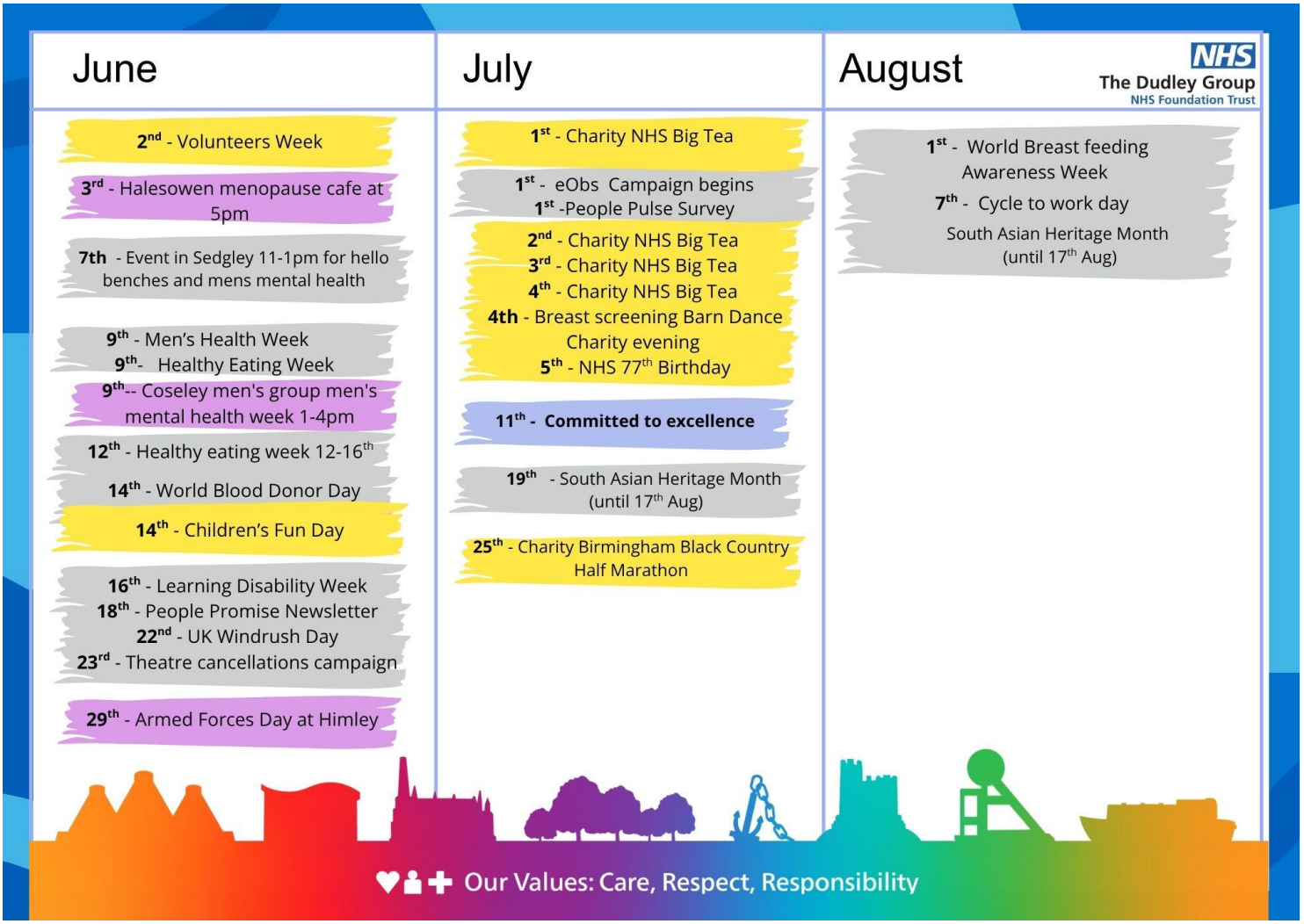
Infection prevention & control for May

- Clostridium difficile – 2 post 48 hours (hospital onset).
- MRSA bacteraemia – 0 cases post 48-hour cases.
- MSSA bacteraemia – 3 post 48-hour cases.
- E coli bacteraemia – 4 post 48-hour cases.
- Klebsiella bacteraemia – 1 post 48-hour cases.
- Pseudomonas bacteraemia – 1 post 48-hour cases.

Dates for your diary – Local events governors can participate in



The Dudley Group
NHS Foundation Trust

COMMUNICATIONS ACTIVITY JUNE

During June we had lots to share and celebrate across the Trust, including celebrating our volunteers, kicking off Pride month and achieving university hospital status!

UNIVERSITY HOSPITAL STATUS!

Big news! Our Trust has been granted university status! 🎓 In partnership with Aston University we're driving innovation, research, and education to shape the future of healthcare in Dudley and beyond. You can read more here

VOLUNTEERS' WEEK

Earlier this month we celebrated our wonderful volunteers as part of Volunteers' Week 2025. Our volunteers are an integral part of our organisation helping us to provide a good experience to our patients and visitors and supporting our staff in a variety of ways on wards and within admin and clerical support.

TRUST CHARITY FUNDS NEW MATERNITY MULTI-PURPOSE ROOM REFURBISHMENT

Families who suffer the heartbreak of losing a baby at birth or a complicated birth can now spend time together in a homely, private space thanks to donations the Dudley Group NHS Charity's Baby Bereavement Appeal.

The maternity department's new multi-purpose room at Russells Hall Hospital is a specialised room to provide a safe space for women and their families. The room is sound proofed for privacy, it features a calming and bright visuals to provide a home away from home feel. The room include comfortable seating, a fridge, cabinets and soft furnishings.

ODP PROGRAMME: PLACEMENT OF THE YEAR AWARD

Our operating department professional development team has been nominated and shortlisted for the Placement of the Year Award for Birmingham City University's ODP programme.
The nomination was made by final year ODP students at Birmingham City University, thanking our team for their support for the students during their course.

WE ALSO SUPPORTED

Diabetes Week
Spring Vaccinations
Menopause Cafe
Men's Health
'Say Hello' benches

BIRMINGHAM PRIDE 2025

AWhilst in previous years we have marched alongside other local NHS trusts at Birmingham Pride, this year we joined together with Dudley Council to represent Dudley Place, as the two leading employers and Anchor Institutions in Dudley.

Although both organisations have taken part in the parade the past, coming together added something new to the experience. It was great to have the opportunity to meet people we may not have done otherwise to get to know them and learn about their own work.

WE NEED YOUR SUPPORT IN THE COMING MONTHS

NHS Birthday and NHS Big Tea

5th July

Celebrations will be taking place across the Trust so please get involved where you can.

Learning Disability Week

June 16th-22nd

Windrush Day

June 22nd

NHS Big Tea

July 1st - 4th

People Pulse Survey

July 1st - 31st

Promoting the NHS App

We are working with regional colleagues to ensure the NHS App is accessed by our local communities

Trust social media channels

Please share our key messages across Facebook, Twitter (X), LinkedIn and TikTok!

Our Patients
Our People
Our Place

Agenda

NHS
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Full Council of Governors meeting

19 June 2025 16:00hr
Seminar Rooms 1 & 2, Undergraduate Centre, 2nd Floor, North Wing, Russells Hall Hospital, Pensnett Road, Dudley, DY1 2HQ

No.	Time	Item	Paper ref.	Purpose	Presenter
1.	16.00	**Welcome** 1.1 Introductions & Welcome 1.2 Apologies	Verbal	For noting	Gary Crowe, Deputy Chair
2.		**Council Meeting** 2.1 Declarations of Interest https://www.dgft.nhs.uk/about-us/publications/register-of-interests/ 2.2 Quoracy 2.3 Announcements	Verbal	For noting	Gary Crowe, Deputy Chair
3.		**Previous Meeting** 20th March 2025 – Full Council 3.1 Minutes 3.2 Matters Arising – Rapid release – Medical Examiner 3.3 Update on actions	Enc 1 Enc 2	For approval/ assurance	Gary Crowe, Deputy Chair
4.	16.05	**Service Spotlight - Dudley PLACE and update for governors**	Presentation		Kat Rose, Chief Integration Officer
5.	16.25	**Chief Executive's update**	Enc 3	For information & discussion	Diane Wake, Chief Executive
6.	16.35	**Chair's update** 6.1 Board of Directors held May 2025 6.2 Non-executive committee chair feedback *by exception in respect of items for assurance, items to escalate and corporate risks*	Enc 4 Verbal	For information / assurance	Gary Crowe, Deputy Chair
7.	16.45	**Integrated Quality and Operational Performance Report**	Enc 5	For noting/ assurance	Jo Wakeman, Deputy Chief Nurse Jack Richards, Deputy Chief Operating Officer
8.	16.55	**The Journey to Single Board**	Verbal	For information	Gary Crowe, Deputy Chair
9.	17.00	**Remuneration & Appointments Committee** Output of Non-executive Director and Chair appraisal for 2024/25	Enc 6	For approval	Gary Crowe, Deputy Chair Catherine Holland, Senior Independent NED
10	17.10	**Trust Strategy & Annual Plan progress report – Q4 2024/25**	Enc 7	For assurance	Adam Thomas, Group Chief

					Strategy & Digital Officer Ian Chadwell, Deputy Director of Strategy
11	17.15	**Annual Plan – 2025/26**	Enc 8	For information	Adam Thomas, Group Chief Strategy & Digital Officer Ian Chadwell, Deputy Director of Strategy
12	17.20	**Quality Account 2024/25** Including Governor comment for Quality Account	Enc 9	For approval	Jo Wakeman, Deputy Chief Nurse
13	17.25	**Complaints Responsiveness Report**	Enc 10	For assurance	Jill Faulkner, Associate Director of Patient Experience
14	17.35	**Board Secretary update**	Enc 11	For approval / assurance	Helen Board, Board Secretary
15	17.45	**Lead Governor update**	Verbal	For information	Alex Giles, Lead Governor
16	17.50	**Experience & Engagement Committee update**	Enc 12	For assurance	Mushtaq Hussain, Committee Chair
17	17.55	**Any Other Business** (to be notified to the Chair)	Verbal	For noting	Gary Crowe, Deputy Chair
18	17.57	**Reflections on the meeting**	Verbal		All
19		**Close of meeting and forward meeting dates 2025:** **Council of Governors Meeting:** 18th September and 18th December **Annual Members Meeting:** 16th October	Verbal		Gary Crowe, Deputy Chair

Quoracy:
To consist of eight governors, of which at least five must be public elected governors and including at least the chair / deputy chair to preside over the meeting.

Items marked*: indicates documents included for the purpose of the record as information items and as such, no discussion time has been allocated within the agenda. Access to report information as guidance.

Enclosure 1

The Dudley Group NHS Foundation Trust

UNCONFIRMED Minutes of the Full Council of Governors meeting
Thursday 20th March 2025, 16:00 hrs
Corbett Outpatient Centre, Vicarage Road, Amblecote, Stourbridge, DY8 4JB

Present:	Status	Representing
Mr Julius Adams	Public Elected Governor	Halesowen
Mr Lewis Callary	Public Elected Governor	Rest of England
Mr Alexander Giles	Public Elected Governor	Stourbridge
Mrs Sandra Harris	Public Elected Governor	Central Dudley
Ms Natalia Hill	Appointed Governor	University of Wolverhampton
Mrs Vicky Homer	Public Elected Governor	South Staffordshire & Wyre Forest
Mr Mushtaq Hussain	Public Elected Governor	Central Dudley
Ms Clare Inglis	Staff Elected Governor	Allied Health Professionals & Health Care Scientists
Mr Yunzheng Jiao	Staff Elected Governor	Allied Health Professionals & Health Care Scientists
Mrs Lyndsay Millington	Staff Elected Governor	Nursing & Midwifery
Cllr Alan Taylor	Appointed Governor	Dudley MBC
Mr Phil Tonks	Public Elected Governor	Brierley Hill
Mrs Mary Turner	Appointed Governor	Dudley CVS
Ms Joanne Williams	Public Elected Governor	Halesowen

In Attendance:

Mrs Helen Board	Board Secretary	DG NHS FT
Ms Becky Cooke	Equalities Business Partner	DG NHS FT
Professor Gary Crowe	Non-executive Director	DG NHS FT
Ms Hannah Dodd	Chair – Women's Network	DG NHS FT
Mrs Joanne Hanley	Non-executive Director	DG NHS FT
Mrs Madhuri Mascarenhas	Governance Administration Lead (minutes)	DG NHS FT
Mrs Martina Morris	Chief Nurse	DG NHS FT
Sir David Nicholson	Trust Chair – **Chair of meeting**	DG NHS FT
Ita O'Donovan	Associate Non-executive Director	DG NHS FT
Ms Raghvinder Ram	Vice Chair – EmbRACE Network	DG NHS FT
Mr Adam Thomas	Chief Information Officer	DG NHS FT
Mr Chris Walker	Interim Director of Finance	DG NHS FT

Apologies:

Mrs Liz Abbiss	Director of Communications	DG NHS FT
Ms Karen Brogan	Interim Chief People Officer	DG NHS FT
Ms Jill Faulkner	Staff Elected Governor	Non-Clinical Staff
Mr Peter Featherstone	Non-executive Director	DG NHS FT
Professor Anthony Hilton	Associate Non-executive Director	DG NHS FT
Dr Julian Hobbs	Medical Director	DG NHS FT
Ms Catherine Holland	Non-executive Director	DG NHS FT
Professor Liz Hughes	Non-executive Director	DG NHS FT
Mrs Karen Kelly	Chief Operating Officer	DG NHS FT
Mr Anand Letha	Staff Elected Governor	Nursing & Midwifery
Dr Mohit Mandiratta	Appointed Governor	Primary Care Representative
Dr Atef Michael	Staff Elected Governor	Medical and Dental
Mrs Anne-Maria Newham	Non-executive Director	DG NHS FT
Mrs Khadeejat Ogunwolu	Staff Elected Governor	Nursing & Midwifery
Ms Yvonne Peers	Public Elected Governor	North Dudley
Mr Andy Proctor	Director of Governance	DG NHS FT
Ms Kat Rose	Director of Strategy & Partnerships	DG NHS FT
Mr Vij Randeniya	Non-executive Director	DG NHS FT
Ms Diane Wake	Chief Executive	DG NHS FT

Mr Lowell Williams	Non-executive Director	DG NHS FT
Mr Jonathan Woolley	Staff Elected Governor	Partner Organisations

Not In Attendance:

Mrs Maria Lodge-Smith	Public Elected Governor	Stourbridge
Mrs Elizabeth Naylor	Public Elected Governor	North Dudley
Ms Angelika Pachowicz	Public Elected Governor	Brierley Hill

COG 25/1.0 16.00	**Welcome**
COG 25/1.1	**Introductions & Welcome** The Chair introduced himself and welcomed everyone to the meeting. He acknowledged the walkaround at Corbett Outpatient Centre that governors participated in prior to the meeting and posed a question about the number of patients seen annually at the site. A Giles responded that approximately 130,000 outpatient appointments took place there each year. The Chair confirmed this and noted that this represented 20% of the Trust's total outpatient activity. The Chair also welcomed Trust staff from the Staff Inclusion Networks, who were in attendance at the meeting to provide governors with an overview of the work being carried out across the staff networks. M Hussain informed the Council that he would need to leave the meeting at 5:00 pm, and the Chair noted his early departure. The Chair thanked Governor Craig Nevin, who had stepped down from his position due to personal reasons. He acknowledged Craig's significant contributions to the Council, noting his expertise in inspection and regulation, as well as his active and engaged participation. With the Council's consent, the Chair would send Craig a message of thanks and good wishes on behalf of the Trust.
COG 25/1.2	**Apologies** Apologies had been received, as noted above.
COG 25/2.0	**Council Meeting**
COG 25/2.1	**Declarations of interest** The Chair asked if anyone present had any declarations or conflicts of interest to note regarding any of the items on the agenda; there were none. He declared he was also the Chair of Sandwell and West Birmingham NHS Trust, The Royal Wolverhampton NHS Trust and Walsall Healthcare NHS Trust. There were no other declarations made.
COG 25/2.2	**Quoracy** The meeting was declared quorate.
COG 25/2.3	**Announcements** There were none.
COG 25/3.0	**Previous meeting**

COG 2/3.1	**Previous Full Council of Governors meetings held on 19th December 2024** (Enclosure 1) The minutes from the previous meeting held on 19th December 2024 were approved as an accurate record of the meeting.
COG 25/3.2	**Matters arising** M Hussain referred to the item on page 10 of the meeting pack regarding the Medical Examiners service and thanked staff for the report. He requested an update on engagement with faith leaders, as highlighted in the report. A Thomas responded that discussions had taken place between the Medical Director's team and faith leaders. Weekend service for early release of bodies had been implemented on several occasions across the Black Country. M Hussain emphasised the importance of using this as an opportunity for wider engagement with faith communities. He also raised concerns regarding the absence of GP involvement and asked how cases where patients died outside the hospital were being managed. A Thomas agreed to follow up with the Medical Director, J Hobbs, for clarification, noting his understanding that the Medical Examiner's Service remained the central point of contact. The Chair reiterated that the Medical Director would be asked to provide an update. He acknowledged the two key areas raised: 1. Ensuring meaningful engagement with faith groups. 2. Clarifying arrangements for deaths in the community and the role of GPs. **Action:** - Medical Director to provide an update at a future Full Council of Governors meeting on: o Ongoing engagement with faith communities regarding the Medical Examiner's Service o Current arrangements for managing deaths in the community, including the involvement of GPs. No further matters were raised.
COG 2/3.3	**Update on actions** **COG24/53.2** – Matters Arising ● Medical Director to share the written update regarding the Medical Examiner service with Governor M Hussain in respect of proposed arrangements for rapid release of bodies at weekends. o The letter was shared with Governor M Hussain on 24 December 2024. This action is now completed. **COG24/55.2** – Achieving Synergy – closer working with Sandwell & West Birmingham Hospitals NHS Trust ● A Proctor to provide Ward to Board visit reports and confirm accessibility of the programme schedule to Governor C Nevin. o All relevant reports were shared with Governor C Nevin on 3 January 2025. This action is now completed. **COG24/56** – Integrated Quality and Operational Performance Report ● Complaints Management to be added to the agenda for March 2025. M Morris to provide a more detailed update on complaint resolution.

	○ Paper will be presented at the Council of Governors meeting in June 2025. ○ At the March meeting, M Morris mentioned that this paper would be submitted to the June Council of Governors meeting to coincide with the annual Quality Account report submission. This action is still open. **COG24/61** – University Hospital Status ● A letter of thanks will be sent to the working group involved in the university hospital status process. ○ Letter sent on 10 January 2025. This action is now completed.
COG 25/4	**Presentation - Staff Inclusion Network Leads** The Chair introduced the session by emphasising the Trust's commitment to employing a diverse workforce and the critical role that supportive staff networks play in reflecting and serving the local community. He welcomed staff network representatives to share updates and priorities. B Cooke, equalities business partner, shared the achievements of the staff networks since their establishment in 2021, and highlighted their contributions towards strategic goals in Equality, Diversity and Inclusion. The key achievements were: • **Disability Network**: Improved disability declaration rates; centralised reasonable adjustment process; improved access to flexible working policies. • **LGBTQ+ Network**: Applied for Rainbow Badge Accreditation; delivered awareness training; participated in Birmingham Pride alongside Dudley Council. • **EmbRACE Network**: Awareness on health inequalities and cancer care; anti-racism and anti-discrimination initiatives; first Ethnicity Pay Gap report published. • **Women's Network**: Supported menopause awareness and period poverty initiatives; free sanitary products provided for a year; addressed sexual harassment via the Sexual Safety Charter; tackled gender pay disparities. R Ram, vice chair of the EmbRACE network, shared updates for the Disability and EmbRACE networks: • **Disability Network**: ○ Continued focus on declaration rates and reasonable adjustments. ○ Supporting staff returning from long-term sickness and signposting to relevant resources. ○ Focus on bullying and harassment from both staff and patients. ○ Key events: Global Accessibility Day (16 May), Disability History Month (November). • **EmbRACE Network**: ○ Welcomed new Chair (Simone Moore) and Co-Vice Chair (Mohammed Khan). ○ Prioritising Race Code renewal and addressing bullying and harassment. ○ Data analysis to identify trends. ○ Key events: South Asian Heritage Month (June-July) and Black History Month (October). H Dodd, **c**hair of the Women's Network, shared updates for the LGBTQ+ and Women's Network: ● **LGBTQ+ Network**: ○ Celebrated LGBTQ+ History Month in February. ○ Planning for Pride (June) and World AIDS Day (1 December). ○ Focused on Phase 2 of the Rainbow Badge Programme. ○ Continued awareness sessions and patient inclusion initiatives. ● **Women's Network**: ○ Celebrated International Women's Day and World Book Day. ○ Hosting menstrual hygiene and period dignity events (May and September). ○ Developing a proposal for sustainable menstrual product access.

	○ Continuing work on menopause, sexual safety work and breastfeeding support (expressing rooms). ○ Contributing to the bullying and harassment policy review. B Cooke noted the importance of collaboration across networks. She shared updates on the new networks launched (Armed Forces and Carers). She informed the council that the networks were looking to launch a Men's Group that would focus on men's mental health and was seeking volunteers. She mentioned that the staff networks published a bi-monthly newsletter that contained information on upcoming events and updates. The April edition could be accessed shortly on the Trust website. N Hill asked about collaborations with external charities regarding period poverty. H Dodd responded that they were exploring multiple sustainable options. A Giles asked about preparedness for anticipated government welfare changes. B Cooke explained more about the Trust's support model, including network communications and the Employee Assistance Programme and signposting for support. M Hussain asked whether work pressures impacted network activity. B Cooked and R Ram highlighted that most network roles were voluntary and in addition to day jobs. The events were supported; however, attendance was varied. H Dodd acknowledged the voluntary nature of leadership roles and clinical workload pressures but affirmed strong support and commitment. The Chair thanked the network leaders for their voluntary contributions and reiterated that the Trust supported their efforts not because of policy mandates but because they aligned with the core values of the Trust. No further comments or questions were raised.
COG 25/5	**Chief Executive's update** (Enclosure 2) A Thomas presented the Chief Executive's update on behalf of D Wake. He acknowledged the recent government announcements affecting NHS England and Integrated Care Boards. Although the announcements did not directly impact the Trust, the broader NHS system, colleagues, and partners would be affected. Currently, no formal guidance had been received, and the updates were based on assumptions or media reports. These developments may influence upcoming planning guidance. He provided an update on the ongoing work at Dudley Place in collaboration with local partners, which aligned with the principle of "Community where possible, hospital when necessary." In line with the requirements from the Integrated Care Board, the Trust had successfully established a Women's Health Hub. This achievement was recognised as a positive step within the overall programme, demonstrating strong partnership and commitment to women's health services. In February, the Housing and Health Forum for social housing providers was refreshed. Communications had been issued to reinforce commitment to the Warm Homes scheme, which aimed to reduce conditions such as asthma and respiratory illnesses. The initiative had benefited from the support of the Trust's newly appointed Family Support Worker, funded by the George Collier Memorial Fund. The Dudley Communication Information Directory continued to support local citizens in accessing self-care resources and community health outreach. It also served as a tool for community healthcare practitioners, particularly in pharmacies and GP practices, to refer and signpost individuals to appropriate services. Screenshots and a link to the website were included in the meeting papers.

The WorkWell scheme remained a key initiative, providing targeted interventions for individuals facing health-related barriers to employment. The programme supported local residents in gaining, sustaining, and succeeding in employment, which contributed to improved long-term well-being and social mobility.

The following points were highlighted for the operational performance of the Trust:
Referral to Treatment (RTT) Pathways:

- Performance in January showed continued improvement across RTT pathways for elective procedures. There were zero breaches of the 65-week target. Efforts to reduce the number of patients waiting over 52 weeks remained effective, with the Trust reporting a position in December that was 570 pathways ahead of plan. The current national guidance sets a target of less than 1% of the waiting list exceeding 52 weeks, and the Trust was currently ahead of trajectory to meet this standard.

Ambulance Handover Delays:

- Ambulance handover performance remained a significant challenge, particularly during the winter period. Over 600 handovers exceeded one hour. A Thomas acknowledged this was a continued area of concern and a key operational pressure. Plans were being developed to meet the revised national target of completing handovers within 45 minutes. These would include strategic actions focused on attendance and admission avoidance, improved discharge processes, and optimised front-door pathways aligned with the “community first” approach. A detailed discussion took place in the Quality and Productivity Workstream to address these priorities and ensure adequate support was in place at the hospital’s point of entry.

NHS England Visit:

- The national urgent care team from NHS England visited last week and provided positive feedback. While no major issues were identified, the visit helped prioritise improvement areas, including optimising Same Day Emergency Care (SDEC) to focus on appropriate patients and reviewing the Acute Medical Unit (AMU) size to reflect local population needs better.

The Black Country Provider Collaborative continued to provide updates on system-wide performance and financial planning as the financial year-end approached. The reports received reflected ongoing activity and emerging priorities across the system.

Work was underway to transform and strengthen corporate services across the Black Country provider organisations. This aligned with forthcoming national planning guidance, which required corporate services costs to be reduced to April 2022 levels. A redesign of existing functions was being explored to meet this requirement, focusing on collaboration and shared service models to build resilience and enhance efficiency.

Progress was noted on the South Elective Hub for Dudley, part of the Black Country Elective Hubs initiative. The Hub was being developed at Sandwell Health Campus in collaboration with Sandwell and West Birmingham Hospitals NHS Trust and The Dudley Group NHS Foundation Trust, now under the leadership of D Wake, the Chief Executive of both organisations. A short-form business case for the South and North Hubs was being refined due to the changes in this year’s planning priorities. The aim was to increase elective care capacity and reduce waiting lists, with lower complexity procedures considered for the Sandwell site, while Midland Met and Dudley sites would continue to manage more complex cases for their respective populations.

The Collaborative Executive received an update on the development of a tender to appoint a partner for a feasibility study on a Black Country-wide aseptic pharmacy service. The service, which prepared bespoke sterile therapies, was fragile and costly to maintain. Efforts were ongoing to consolidate and optimise aseptic services across the four acute trusts to improve efficiency and sustainability.

	There was a renewed focus on cancer planning guidance with targets to improve the 62-day cancer standard to 75% and the 28-day Faster Diagnosis Standard to 80% by March 2026. Significant work was underway to achieve these goals within the next year. The next fundraising event, the Glitter Ball, was scheduled for 25 September at Copthorne, Brierley Hill, supporting the cancer appeal. The hospital charity had raised over £170,000 for the dementia appeal. Additionally, a £10,000 Tesco Bags of Help grant had funded the refurbishment of a calm sensory environment for paediatric patients in cubicle 4 of the paediatric emergency department, enhancing care for young patients. The Healthcare Heroes programme recognised and celebrated the outstanding contributions of staff within the organisation. Further details were available in the meeting paper. M Hussain asked whether the recent government announcement on NHS changes felt liberating. A Thomas responded that while there was sympathy for those affected, the changes presented significant opportunities. He noted the anticipation for further guidance from Sir Jim Mackey, Chief Executive of NHS England, and his team. He highlighted the chance to take greater local control over commissioning and service delivery in Dudley and the wider Black Country and emphasised the importance of balancing appropriate oversight with localised services to meet the needs of the community. He concluded that with collaborative efforts, these changes could indeed be liberating. M Hussain further inquired about the involvement of private housing or landlords in the work programme update referenced on page 25 of the meeting papers, specifically regarding attendance from four social housing providers. A Thomas responded that while private landlords' participation was unclear, the Dudley Place update was presented to the Health and Wellbeing Board, which included local authority representatives responsible for social housing. He noted that the voluntary sector housing division was involved in those discussions and acted as the key link to private landlords. He emphasised that this was part of a place-based partnership involving multiple sectors, with the NHS contributing from a local health authority perspective. M Hussain expressed his gratitude to the Same Day Emergency Care (SDEC) team and shared a positive personal account of a family member who received excellent care from reception staff and clinical teams. He requested that his thanks be passed on to the team. A Thomas echoed the appreciation and commended the SDEC team for their outstanding work. He confirmed the feedback would be shared. He highlighted the importance of sustaining and developing the service, particularly in light of winter pressures, and was pleased to hear of such a positive patient experience. A Giles conveyed the governors' congratulations to Lisa Birch for receiving the Chief Nursing Officer Award and recognised her commitment to outstanding patient care. M Morris informed the council that Lisa Birch had been invited to participate in a radio talk show in April. No further comments or questions were raised.
COG 25/6.0	**Chair's Update**
COG 25/6.1	**Chair's Update - Board of Directors Meeting - March 2025** (Enclosure 3) The Chair noted that the March 2025 Public Board of Directors meeting summary reflected many points previously discussed by A Thomas. A recent Board of Directors meeting focused on patient experience during the winter period. It was noted that while winter pressures were often assessed quantitatively, the qualitative experience of patients was equally vital. Despite the calculated risk of

	upgrading the hospital's resuscitation unit mid-winter, which temporarily impacted Accident & Emergency flow, patient experience remained stable, with no rise in complaints. This outcome was attributed to the staff's commitment to maintaining service quality under challenging conditions. The Same Day Emergency Care (SDEC) team received commendation for their exceptional performance during this period. Developments in the relationship with Sandwell and West Birmingham Hospitals NHS Trust were discussed. The lead governor was actively engaged, and the Board reported positive progress. Opportunities existed to expand elective services at the Sandwell campus to help reduce waiting lists and to adopt effective community service models successfully implemented in Sandwell. D Wake, now Chief Executive of both trusts, was identifying staff to work across organisations. Proposals on the joint running and shared services of the two trusts would be forthcoming. Discussion on recent NHS executive changes highlighted that such shifts typically coincide with government transitions. The current government was positioning its senior NHS team ahead of the upcoming spending review and NHS 10-year plan, and aimed to secure leadership which aligned with its objectives. While the announcement sequence – announcement before detailed plans – had caused some confusion, it also presented opportunities for local bodies like Dudley to innovate and exert greater control. The NHS faced a significant funding gap estimated between £6 and £7 billion. The incoming leadership team, led by Sir Jim Mackey, aimed to address this deficit. Locally, efforts were underway to develop balanced plans within available resources, which would necessitate cost improvement programs and workforce reductions, including decreased reliance on temporary staff. Further details would be communicated. A visit to the Midland Metropolitan University Hospital (MMUH) for the council of governors was being arranged. The Chair encouraged the governors to visit the site as it offered insight into ongoing organisational collaborations. It was noted that emergency patient flows had shifted, with more patients who previously attended City and Sandwell hospitals now coming to Dudley. Agreements were in place to transfer appropriate resources from Sandwell to Dudley to support this change, representing a positive step forward in regional collaboration. No comments or questions were raised. The report was noted for assurance.
COG 25/6.2	**Non-executive committee chair feedback by exception** (Verbal) The Chair invited non-executive directors to provide updates on the sub-committees they are members of. J Hanley reported that audit activities were progressing well, with the draft annual audit report completed and meeting expectations, which was a positive outcome. However, she noted that improvements were needed to strengthen the risk control environment. She acknowledged that the Trust was facing challenges similar to those experienced by other organisations in the region. G Crowe highlighted that the committees had focused on maintaining quality and safety standards throughout operational and financial pressure periods. He assured that patient care standards had been upheld during ongoing improvement efforts. He acknowledged continuing financial planning and workforce restructuring challenges, emphasising that the approach prioritised service delivery and patient outcomes despite the difficult decisions. Further clarity was expected through the upcoming planning process. H Board highlighted that some governors had been attending the Board of Directors meetings and encouraged those who had not yet done so to consider attending. She emphasised the value of these meetings in providing robust and insightful debate, which

	would enhance their understanding of the challenges and solutions being considered. This experience would enable governors to effectively fulfil their role in holding the Board to account. The Chair spoke positively about the Trust's performance over the past year, noting that most of the main goals were met. The Trust was on track to meet its financial targets and had delivered well on most patient care standards. The one area with slower progress was reducing staff numbers, which had been handled carefully to ensure that patient care remained a top priority. No further comments or questions were raised.
COG 25/7	**Integrated Quality and Operational Performance Report** (Enclosure 4) M Morris presented the Integrated Quality and Operational Performance report and highlighted that the Trust had faced a challenging winter period, which inevitably impacted quality and performance. Despite this, assurance was given that robust systems and processes remained in place to mitigate patient harm. Where harm did occur, investigations were undertaken, and learning was actioned. The report reflected areas of positive progress. For instance, an identified issue around dementia assessments was found to be due to incorrect data being pulled from the IT system, and it was confirmed that the Trust had, in fact, been compliant throughout. A comprehensive approach was being taken towards dementia and frailty care. The Eat, Drink, Dress, Move (EDDM) initiative, led by a physiotherapist, was noted as a promising improvement project. This aligned with the Trust's wider frailty programme. Two major projects were outlined: 1. Prevention of unnecessary hospital admissions through enhanced community care. 2. Mitigation of patient deterioration during acute hospital stays. On performance, it was noted that elective care continued to progress positively. However, ambulance handover delays remained a key area of concern. Feedback from external stakeholders was received and would be incorporated into a revised improvement plan. The Trust was committed to resolving this persistent challenge. The following three key clinical interface issues were noted from the winter period: ● **Pressure ulcers –** An increase had been observed, primarily in community settings. A new team member was leading this work and developing a targeted intervention plan. ● **Timeliness of clinical observations** – Delays were often technical, resulting from data being recorded on paper and entered into the system later, causing apparent breaches. Further analysis was underway. ● **Infection Prevention and Control (IPC)** – Some indicators exceeded new national thresholds. The Trust was actively participating in a system-wide IPC group to share learning and implement improvements. It was noted that challenges were not isolated to hospital settings but also involved community prevention measures. M Morris concluded by echoing earlier sentiments that, despite significant winter pressures and workforce strain, the organisation maintained a high quality and safety standard overall. The Trust remained vigilant in areas requiring improvement and actively addressed them. A Giles assured governors by echoing M Morris's earlier points regarding the challenges discussed in the Quality Report. He confirmed attendance at the recent Quality Committee meeting, noting that there was a robust and thorough discussion on the three key challenge areas previously highlighted by M Morris. He assured the council of

	governors that the committee members were fully engaged and committed to addressing these issues effectively. Y Jiao inquired about the mention of corporate teams supporting clinical areas and requested further clarification. M Morris explained that staff sickness posed challenges during the winter period, and additional areas had to be opened to accommodate patients in acute settings. To reduce reliance on bank staff, clinicians from corporate teams – typically in non-patient-facing roles – were redeployed to support clinical areas. She emphasised that this support maintained clinical credibility and visibility, noting that she also participated directly, including out-of-hours walkabouts and regular clinical shifts. She highlighted the "active floor programme" launched in April 2024 to increase senior leadership visibility and hands-on support in clinical areas. The Chair noted that the redeployment of clinical staff currently working in non-clinical roles was being incorporated into the Trust's planning process. He noted that, due to ongoing pressures, some staff from corporate services were now undertaking clinical shifts regularly. This arrangement was expected to continue and become a regular part of future workforce planning. He added that this approach helped ease staffing pressures and strengthened the connection between staff and frontline care. A Thomas appreciated M Morris and her team's visible presence on the wards and acknowledged their dedication and frequent ward visits. He praised their efforts and contribution to frontline support. No further comments or questions were raised. The report was noted for assurance.
COG 25/8	**Remuneration & Appointments Committee** (Enclosure 5) G Crowe presented the update from the Remuneration and Appointments Committee which met on 11 March to discuss the appraisal approach for the Chair and Non-executive Directors (NEDs). The recommendation was to use the same appraisal format, which was successfully used last year for NEDs, with no changes proposed. For the Chair's appraisal, Catherine Holland (Senior Independent Director) would lead a combined appraisal process on behalf of the four acute trusts, given Sir David Nicholson's shared chair role. A single submission would be sent to NHS England. The process would include 360-degree feedback from executives, NEDs, and governors. Governors were encouraged to complete their feedback thoroughly. The outcome of the Chair's appraisal would be reviewed by the Remuneration and Appointments Committee in June and then endorsed at the next Full Council of Governors meeting before submission to NHS England. G Crowe would lead NED appraisals and set objectives for the upcoming year. This would involve 360-degree feedback from a selected group of executives, NEDs, and governors based on their involvement with the relevant Board subcommittees. A review of upcoming NED term completions and the skills matrix would also be undertaken. An emerging consideration was the potential for joint working with Sandwell and West Birmingham Hospitals NHS Trust, where discussions may begin with Lesley Writtle (Deputy Chair, Sandwell and West Birmingham Hospitals NHS Trust) about aligning skills and forming collaborative groups across both trusts.

	The Chair encouraged governors to take the opportunity to provide feedback on the performance of either himself or any Non-executive Directors when invited. He emphasised the value of constructive feedback for the appraiser and the individual being appraised. He noted that meaningful feedback was essential for personal and professional development, as continuous improvement relied on honest reflection and input. The Council of Governors resolved the following: - **Endorsed** – the Chairs and non-executive appraisal plan for the period 24/25. No comments were raised. The report was noted for approval.
COG 25/9	**Trust Strategy Quarterly Report Q3 2024 - 25** (Enclosure 6) A Thomas presented the Trust Strategy Q3 report (period ending December 2024), noting that while the data originated in January, much progress had occurred. Through enhanced processes, the Trust had continued to deliver on commitments, including strong mortality performance and improvements in outpatient 'Did Not Attend' rates. The vacancy rates remained low, with strong staff retention. Although planned reductions in bank staffing were not fully achieved, substantive staffing plans were delivered. A comprehensive workforce plan was being developed for the next year, balancing service growth needs with reductions in workforce costs. The Trust's financial performance was slightly off target in January. Recovery plans were in place to meet end-of-year financial goals. Updates would be presented to the Finance and Productivity Committee. It was noted that the Trust was measured using two productivity metrics. The primary method used in the report was cost per weighted activity unit, which compared the cost of activity against other trusts nationally. The Trust had shown improvement in this area, moving up from the fourth quartile towards the national average. A second, newer metric measured year-on-year productivity change by comparing current performance to the same period in the previous year. Under this measure, the Trust was among the top-performing organisations nationally, indicating strong positive momentum and impact. The number of patients waiting over 65 weeks was nearly eliminated. The Trust was on track to bring the number of patients waiting over 52 weeks below 1%, with continued improvements in achieving 18-week targets. Progress on carbon reduction was limited due to constraints involving external partners (e.g., the Trust PFI partners). A refresh of the Green Plan was underway, with an increased focus on measurable environmental impact, including monitoring air quality via newly installed pollution sensors. A Thomas concluded by noting that the Q4 report and planning updates for the upcoming financial year would be presented at the next council meeting. No comments were raised. The report was noted for assurance.
COG 25/10	**Update on Trust Strategy and Annual Plan for 2025/26** (Enclosure 7) A Thomas presented a brief update on the Trust Strategy and Annual Plan for 2025/26, given as enclosure 7.

	He noted that the feedback from the council of governors at the December workshop had been incorporated into the Trust's revised strategy, which was now nearing final Board approval. The Board had reviewed the latest drafts, outlining long-term priorities and specific actions planned for the coming year, which were aligned with NHS England's financial, activity, and workforce planning requirements. The Trust continued to navigate a complex planning environment, pending the national 10-year plan and government spending review. A significant regional planning meeting, chaired by Sir David Nicholson, was scheduled for the following day, 21 March 2025, with all the Black Country acute providers to present and review plans for 2025/26. The Trust's cost improvement target for the next financial year was £45 million, equivalent to over 7% of the total income. Currently, approximately £13 million of this has been identified through a new governance structure supporting transformation, with oversight from executive and senior leaders and regular reporting to the Board. Governors were assured that their previous input had been thoughtfully considered and integrated into the Trust's strategic planning. The Chair noted that the Trust's operational and financial plans would become clearer over the next 5 to 6 weeks, as several key funding and planning details remained uncertain. Further updates would be provided through Board sub-committees and at the next Full Council of Governors meeting. G Crowe reported that, as a member of the executive team involved in the working groups and mobilisation of workstreams, he wished to formally acknowledge the efforts of those involved. He noted that, despite the challenges, the teams were doing a great job in organising themselves and progressing with their tasks. The Chair added that the Trust remained one of the best-managed within the Black Country, reinforcing confidence in its planning and delivery efforts. No further comments were raised. The report was noted for information.
COG 25/11	**Consultation on the quality and safety delivery plan – overarching priorities** (Enclosure 8) M Morris presented a brief overview of the quality and safety delivery plan, given as enclosure eight. Governors were reminded that the Trust produced annual Quality Accounts, on which the council was consulted and which would be brought back to the Full Council of Governors for review. The Trust was moving towards a streamlined approach by aligning all efforts under one overarching strategy, supported by the quality and safety delivery plan, rather than having multiple stand-alone strategies. This aimed to reduce confusion among staff and improve clarity on priorities. The current paper outlined the proposed quality and safety priorities for the next three years. These priorities were shaped by national policy, internal focus areas, and identified performance challenges. The priorities were developed through consultation with staff across the Trust and also discussed at the recent Council of Governors' Experience and Engagement Committee meeting. Governors were invited to provide feedback on the proposed priorities, either during the meeting or via email. M Morris noted that while not all initiatives could be included in the delivery plan, this did not imply a lack of focus elsewhere.

	H Board raised a query on the Trust's approach to patient experience, noting that governors were strongly interested in this area. She asked whether patient experience was addressed through a separate strategy or incorporated within the broader organisational strategy. M Morris clarified that while patient experience was currently part of the broader Trust strategy, a dedicated delivery plan existed for patient experience. This supported the Trust's strategic priority to improve patient experience survey outcomes. Efforts were ongoing to integrate multiple strategies, as currently, around 10 to 12 were presented annually to the Quality Committee. M Morris noted this integrated approach had proven effective in other trusts and aimed to maintain a clearer focus and alignment. A Thomas supported this approach and explained that while a strategy outlined the "why" and "what," delivery plans specified the "how." Patient experience, and other focus areas such as quality and safety, digital transformation, and sustainability, were driven through clear delivery plans. These plans aimed to translate strategic intent into operational reality, ensuring staff could see how their work contributed to the Trust's overall goals. No further comments or questions were raised. The report was noted for assurance.
COG 25/12	**Board Secretary Update** (Enclosure 9) H Board presented the Board Secretary's update, given as enclosure 10. She informed the council about the upcoming governor elections, which would be held for vacancies in two public constituencies (North Dudley and Tipton and Rowley Regis) and one staff constituency (Medical and Dental). Formal thanks were placed on record for Yvonne Peers, who served as interim Lead Governor during the transition period. An update was provided on the Lead Governor appointment process. In the December full Council meeting, the governors were informed that Alex Giles' term as a lead governor had ended as it was co-terminus with his term as governor. At the start of the year, expressions of interest were invited for the Lead Governor role. One nomination was received from A Giles. The Council of Governors were asked to endorse the reappointment of A Giles as Lead Governor. The endorsement was supported by the Full Council of Governors. The Chair noted and appreciated A Giles' continued contribution to the role. The Council of Governors resolved to: - **Endorse** the reappointment of Alex Giles as lead governor. There were no questions or comments raised.
COG 25/13	**Lead Governor update** (Verbal) A Giles expressed his gratitude to Yvonne Peers for her support as interim Lead Governor. He thanked the governor colleagues who attended the joint governor training with Black Country Healthcare NHS FT on 28 January. The session was well-received and highlighted the value of collaborative work. He commended the in-house training on risk management and compliance held in February, highlighting the excellent work of Amanda Last and her team in ensuring that the Trust remained compliant with its processes. Governors were encouraged to

	participate in Patient-Led Assessments of the Care Environment (PLACE) audits and Ward to Board visits to gain firsthand insight into the Trust's daily operations. He informed the council that the next training session, focusing on finance, was scheduled for 1 April. Governors were encouraged to attend to receive updates on the Trust's financial status and prepare for the forthcoming challenging period. A membership promotion event was planned for 9 April at Halesowen College, where the Trust would have a stand. Governors willing to support, even for part of the day, were asked to contact the Foundation Trust Office. He thanked fellow governors for their support and expressed his commitment to leading the council for the upcoming term. There were no questions or comments raised.
COG 25/14	**Experience & Engagement Committee Update** (Enclosure 10) N Hill presented an update from the Experience and Engagement committee, given as enclosure 11. Public membership figures remained steady at just over 13,000. Governors were reminded of their ongoing responsibility to actively support efforts to maintain membership levels above the minimum threshold. Membership forms were provided for distribution. Governors were encouraged to take the forms home at the end of the meeting and promote membership within their constituencies. The Quality Committee provided positive assurance at the last Experience and Engagement Committee meeting. Governors were briefed on the new approach to the Quality and Safety Delivery Plan, as outlined by M Morris earlier in the meeting. The committee members discussed and approved the Trust's intention to introduce a new mentoring/buddy system to support both new and existing governors. The Chair reminded attendees that membership forms were available at the back of the room and encouraged everyone to take some upon departure. No comments were raised. The update was noted for assurance.
COG 25/15	**Any other Business** (Verbal) None
COG 25/16	**Reflections on the meeting** (Verbal) The Chair noted that the chosen venue was effective for the meeting. V Homer formally extended a vote of thanks on behalf of the governors to Lyndsay Millington for organising the walkaround. The visit was informative and insightful, although it was cut short due to time constraints. A suggestion was made to revisit the site in the future. V Homer raised a concern regarding the Dermatology department. She commended the department for delivering an excellent service, but noted that the unit treated many patients from outside the Dudley borough, particularly Worcestershire. This increased demand and placed pressure on an already limited service capacity, potentially impacting provision for Dudley patients. She inquired about future plans to expand the department to ensure it remained able to meet local needs effectively.

	L Millington provided an overview of the current capacity challenges within the Dermatology department. She noted that while there were 10 consultants, only 7 consultation rooms were available, necessitating the use of additional rooms on a shared basis. To maintain accessibility for patients across the Dudley borough, additional clinics were held at Guest Hospital and Russells Hall Hospital. It was explained that due to limited dermatology services in neighbouring boroughs, patients from areas such as Worcester and South Birmingham were increasingly choosing to attend services in Dudley, where waiting times were shorter. This had added pressure to the already constrained capacity at Corbett Hospital. A Thomas acknowledged the ongoing challenges related to increasing demand for dermatology services. He noted that, while the high referral volume could be seen as a compliment to the quality of the service, it had created pressure on clinic capacity. The Medicine Division, led by Rory McMahon and his team, had been regularly updating the Executive Team on dermatology activity. A technological solution, “Consultant Connect,” had been implemented to manage referrals more effectively. This enabled GPs to triage cases better and refer only those requiring specialist input, thereby alleviating pressure on the clinics. A Thomas acknowledged that while this initiative has had a positive impact, further work was needed to address the gap between clinic demand and available capacity. He suggested exploring alternative locations and community-based options for delivering dermatology services. The Merry Hill facility was noted as a potential site for service expansion, offering greater geographical coverage across the borough. He confirmed he would take these considerations forward to ensure services remained accessible and effective for the Dudley population. J Hanley proposed that the Trust could explore the opportunity to generate income by offering dermatology services to other NHS Trusts that cannot meet patient demand. In response, A Thomas highlighted that, due to evolving planning guidance and challenges with waiting lists and NHS income, the Trust’s primary opportunity lay in repatriating work currently being delivered by the private sector. He emphasised the importance of collaborating with neighbouring Integrated Care Boards (ICBs) to assess service provision and identify opportunities to meet unmet patient needs within Dudley and the wider region. The Chair concluded that exploring new income-generating opportunities was a strategic priority. While expansion at the current site may be limited, alternative locations such as Merry Hill and town centres should be considered for future service growth. He proposed that dermatology be placed on the agenda for a future Governors' meeting for further review. **Action:** - An update on the dermatology service to be included as an agenda item for a future Council of Governors meeting to explore potential income opportunities and options for service expansion at alternative locations such as Merry Hill and town centres.
COG 25/17	**Close of meeting and forward Council of Governor meeting dates: 2025** The next meeting dates were as follows for 2025: 19 June, 18 September and 18 December Annual Members Meeting: 16 October

	The meeting closed at 17:40 hrs.

Sir David Nicholson, Chair of the meeting

Signed……..…….. Dated …….

Outstanding	Item to be addressed
To be updated	Item to be updated
Complete	Item complete

Council of Governors meeting held 26th September 2024

Item No	Subject	Action	Responsible	Due Date	Comments
COG 24/56	Integrated Quality and Operational Performance Report	Complaints Management to be added to the agenda for March 2025. M Morris to provide a more detailed update on complaint resolution.	Martina Morris	**Completed**	June Meeting Agenda item 13
COG 25/3.2	Matters Arising	Medical Director to provide an update at a future Full Council of Governors meeting on: ● Ongoing engagement with faith communities regarding the Medical Examiner's Service ● Current arrangements for managing deaths in the community, including the involvement of GPs.	Medical Director's Office	**Completed**	June Meeting Agenda Item 3.2
COG 25/16	Reflections on the Meeting	An update on the dermatology service to be included as an agenda item for a future Council of Governors meeting to explore potential income opportunities and options for service expansion at alternative locations such as Merry Hill and town centres.	Medicine Division – Rory McMahon	**To be updated**	

Enclosure 2

The Dudley Group NHS Foundation Trust

Paper for submission to the Full Council of Governors on 19 June 2025

Report Title:	Update on Medical Examiner Out of Hours Service
Sponsoring Executive:	Dr Julian Hobbs, Medical Director
Report Authors:	Dr Julian Hobbs, Medical Director Rebecca Edwards, Directorate Manager

1. Summary of key issues using Assure, Advise and Alert

Assure

The Trust, as the host organisation for the Dudley Medical Examiner Service, notes the challenges to the rapid release of Medical Certificate of Cause of Death (MCCDs) at the weekend following the statutory implementation of the ME Service from September 2024.

Advise

An interim Out of Hours Service is currently being provided as a cost pressure to the Trust. As of 11 June 2025, there have been 2 calls to the Out of Hours Service, however no bodies have been released due to one case being a community death and one case requiring a coronial review. There have been no bodies released or Medical Cause of Death Certificates issued out of hours on faith grounds in 2025.

Alert

A Pan Black Country provision remains the preferred option, however the disparate IT solutions across Trusts and differing operating models are considerable barriers. This option will not resolve the scrutiny of community deaths due to GP practice availability out of hours. This would require a change in contract for GP practices who operate as individual entities.

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

3. Report journey
Full Council of Governors Meeting – 19 June 2025

4. Recommendation(s)
The Council of Governors are asked to:
a) Note the financial and service impact of a weekend ME provision.

5. Impact		
Board Assurance Framework Risk 1.1	X	Deliver high quality, safe person centred care and treatment
Board Assurance Framework Risk 1.2	X	Achieve outstanding CQC rating.
Board Assurance Framework Risk 2.0	X	Effectively manage workforce demand and capacity

Board Assurance Framework Risk 3.0	X	Ensure Dudley is a brilliant place to work
Board Assurance Framework Risk 4.0	X	Remain financially sustainable in 2023/24 and beyond
Board Assurance Framework Risk 5.0	X	Achieve carbon reduction ambitions in line with NHS England Net Zero targets
Board Assurance Framework Risk 6.0	X	Build innovative partnerships in Dudley and beyond
Is Quality Impact Assessment required if so, add date:		
Is Equality Impact Assessment required if so, add date:		

REPORT FOR ASSURANCE

Medical Examiner Out of Hours Service

1 EXECUTIVE SUMMARY

1.1 This paper is to provide an update to the Governors following the previous discussions regarding an out of hours Medical Examiner service via this forum.

1.2 Following discussion amongst the Black Country Medical Examiners, a Black Country provision is proposed. However this would not resolve the scrutiny of community deaths due to GP practice availability out of hours. The disparate IT systems across the Black Country pose a challenge to the implementation of the service as full access to the patient record is required to ensure appropriate scrutiny to be undertaken.

1.3 An interim weekend model is operating for acute deaths. Since launch in March 2025, 2 calls have been received, however no bodies have been released or Medical Cause of Death Certificates issued.

2 BACKGROUND INFORMATION

2.1 The implementation of the statutory Medical Examiner Service has led to significant improvements in the death certification process. It has also presented challenges; one such challenge is the provision of rapid review and release of bodies for burial or cremation for those who request this service.

2.2 Historically, prior to the legal requirement for an independent review and implementation of safeguards ensuring accuracy and eligibility for the issue of a Medical Certificate of Cause of Death (MCCD), acute hospitals have been able to provide this service. The provision of Out of Hours issue of MCCDs in community medicine has always been a rare occurrence. There is no Coroner's Service at the weekend with whom to discuss cases that may potentially require Coronial input.

2.3 For this reason, the ongoing discussion to establish a Black Country wide service only intends to address the delivery of an Out of Hours Medical Examiner Service for patients who die in an acute hospital outside of the normal working week. It is important that the level of review Out of Hours does not differ from that provided during the normal week. It is accepted that practices and procedures may vary between hospitals within the group, but these variations will be subtle.

2.4 The Dudley Group NHS Foundation Trust, as host organisation for the Dudley Medical Examiner Service, has been operating an interim weekend service from 01 March 2025 covered by a Medical Examiner and Medical Examiners Officer. During this period 2 calls have been received; one related to a community death and one required Coroner's input, so neither body was released or death certificate issued. From August 2025 the service will look to cover Bank Holidays with the exception of Christmas Day.

3 RISKS & MITIGATIONS

3.1 The Medical Director is maintaining an ongoing dialogue with elected members in the Borough.

3.2 An interim service is in operation as a cost pressure to the Trust.

4 RECOMMENDATIONS

4.1 The delivery of an Out of Hours Medical Examiner Service across the Black Country remains the preferred option. An interim local service will continue to operate during ongoing discussions to establish this preferred model.

Enclosure 3

The Dudley Group NHS Foundation Trust

Paper for submission to the Full Council of Governors on 19 June 2025

Report title:	Public Chief Executive Report
Sponsoring executive:	Diane Wake, Chief Executive
Report author:	Alison Fisher, Executive Officer

1. Summary of key issues using Assure, Advise and Alert

Assure

- Research & Innovation

Advise

- Leadership update at The Dudley Group NHS Foundation Trust and Sandwell and West Birmingham NHS Trust
- Operational Performance
- Black Country Provider Collaborative
- Getting it Right First time
- Charity Update
- Healthcare Heroes
- Patient Feedback
- Awards
- Visits and Events

Alert

- Regulation 28 Prevention of Future Deaths notice (PFD), issued in April 2025.

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

3. Report journey
Board of Directors – 8 May 2025
Full Council of Governors Meeting - 19 June 2025

4. Recommendation(s)
The Council of Governors is asked to:
a) Note and discuss the contents of the report

5. Impact		
Board Assurance Framework Risk 1.1	X	Deliver high quality, safe person centred care and treatment
Board Assurance Framework Risk 1.2	X	Achieve outstanding CQC rating.
Board Assurance Framework Risk 3.0	X	Ensure Dudley is a brilliant place to work
Board Assurance Framework Risk 4.0	X	Remain financially sustainable in 2023/24 and beyond
Board Assurance Framework Risk 6.0	X	Build innovative partnerships in Dudley and beyond
Board Assurance Framework Risk 7.0	X	Achieve operational performance requirements
Board Assurance Framework Risk 8.0	X	Establish, invest and sustain the infrastructures, applications and end-user devices for digital innovation

Research and Innovation

As a department we have continued to enhance our portfolio of achievements and celebrations.

Publications

Publications in high impact journals continue to grow and are recorded by our medical library. Examples include:

A recent major paper was accepted and published in the British Medical Journal by Matthew Popplewell, Consultant vascular surgeon, Assistant Professor of Vascular surgery, University of Birmingham (BASIL Prospective Cohort Study).
Palliative Care Congress 2025 – a total of 10 abstracts accepted.
European Association for Palliative Care Congress in Helsinki, oral presentation accepted (May 2025).

Research Studies

Many new studies providing the opportunity for patients to access new treatments and interventions, to include:
OPTIMA – Principal Investigator, Dr. Vipin Kuriakose, Consultant clinical Oncologist. Second highest recruiter in West Midlands for this study (personalised treatment of early breast cancer).
NAZA study – Principal Investigator, Dr. Shani De Silva, Gastroenterology Consultant. Star recruiter award (Crohns disease and Ulcerative Colitis).
The NHS Cancer vaccine Launch pad (CVLP), Principal Investigator Mr. Akinfemi Akingboye, Consultant laparoscopic colorectal and General Surgeon.

Innovations

Forty one innovations registered, 25 completed and implemented within services to include: digital, education and patient pathway projects e.g. virtual ward.

Successful Grant Applications

One hundred thousand pound UK bid from IBUS (Intestinal Ultrasound for the monitoring of bowel inflammation in primary cholangitis associated inflammatory bowel disease), this is a multicentred study with Dudley Group NHS FT as a study centre. Principal Investigator, Dr. Shani De Silva.
Three hundred and twenty thousand pound Capital Investment Funding bid success for refurbishment of our research laboratory, to enhance research capability at Russells Hall site, with a focus on vascular, colorectal and cardiology specialities which are research active and are continuing to grow at pace.

Special Recognition

Dr Sunil Nadar, Consultant cardiologist, appointed as West Midlands Regional Research Delivery Network Cardiovascular Speciality Lead.

Leadership update at The Dudley Group NHS Foundation Trust and Sandwell and West Birmingham NHS Trust

I am pleased to announce four appointments to my executive team structure. These group roles will work across both Dudley and Sandwell and West Birmingham to enhance our capabilities, streamline operations, and ultimately improve the quality of care we provide to our patients.

To lead this transformation, we have appointed key leaders who will play pivotal roles in moving our organisations forward.

Rachel Barlow will be Group Chief Development Officer, looking at regenerative opportunities with wider partners and focussing on how we use our estate in order to maximise productivity and create environments to support high quality care.

James Fleet will be Group Chief People Officer, with a focus on our most important asset – you. His focus will be on wellbeing, optimising our workforce and developing a positive workplace culture.

Adam Thomas will be Group Chief Strategy and Digital Officer, spearheading our strategic planning and digital transformation efforts, looking at how we can optimise technology to enhance patient care and operational efficiency.

These roles will all start on 1 April.

Laura Broster will join the organisations on 1 June as Group Director of Communications, managing our internal and external communications, to ensure that staff have the information they need to deliver high quality care and that our patients and local communities feel informed, engaged and connected with our organisations.

I have also appointed Deputy Chief Executives in each organisation, Karen Kelly who is Chief Operating Officer at Dudley Group and Mel Roberts, who is Chief Nursing Officer at Sandwell. These are for an initial 12-month period.

Operational Performance

18-week performance continues to improve and is now at 59.9% for March 25 against the end of year target of 64.2%.

Recovery & Restoration / Operational Performance

March has shown continued improvement in the RTT performance. Unfortunately, 2 65-week breaches were reported at the end of the month. One patient breached as we were unable to provide complex endometriosis surgery, due to sickness of the only surgeon able to undertake this complex procedure. Patient 2 was a gastroenterology patient, whose procedure was deferred in order to treat a more clinically urgent patient. Mutual aid options were explored for both patients 52-week performance has shown some deterioration in month against trajectory. Given the high activity level delivered in March, further work is underway to understand and rectify the cause of this adverse variation.

Ambulance Handover

This month's activity saw 10,120 attendances. This has increased when compared to the previous month of February with 8,402. Twenty one out of the 31 days saw more than 300 patients; 3,215 patients arrived by ambulance; this shows an increase from the 3,189 ambulances that attended last month. Five hundred and twenty nine of these offloads took <1hr (16%). This is the same as our performance when compared with last month's performance of 16%.
Over the month, the average length of stay (LOS) in ED was 210 mins for non-admitted patients and 450 mins for those waiting for a bed following a decision to admit. This represents an Improvement when compared to last month where the LOS was 217 mins and 469 mins, respectively.

Cancer performance

<u>28-day Faster Diagnosis Standard (FDS)</u>

Performing well at 87.1% and remains above national target of 77%.. Increased focus on individual tumour site pathways.

<u>31 day combined</u>

31 day combined achieving 93.6% against national target of 96%. Surgical and diagnostic capacity and BCPS reporting delays impact performance. 31 day trajectory to achieve 96% submitted to ICB. Renal and skin are tumour sites most challenged.

<u>62 day combined</u>

Achieved 70.5% and remains above NHSE target of 70% by end of March 2025. (This target does not supersede the 85% constitutional standard but set to support tiering measures for cancer performance).

Late Tertiary referrals closely monitored. Primarily urology, colorectal and lung. Actions in place to reduce. Cancer performance is reviewed at Regional Performance Tier Calls with NHSE.

Black Country Provider Collaborative – April 2025

The following are the key messages from the **7th April 2025** Black Country Provider Collaborative (BCPC) Executive meeting.

A. IMPROVEMENT

- **Clinical & Operational Productivity** – The Collaborative Executive were provided a brief update on the following key items:
  - **Clinical Improvement programme** – The BCPC CMO presented a summary report highlighting the key progress reported at the recent monthly Clinical Network meetings. Key highlights include:
    - **Breast Service developments** – work is progressing at a pace to draft a business case in support of the Breast DIEP reconstruction service, with work on track to share in late May / early June. A further workshop will be progressed to explore deeper the concept of the Breast Unit consolidation in late May / early June to ensure input, buy-in and ownership of the preferred solutions.
    - **Colorectal** – the Clinical Leads will be discussing and agreeing a way forward with colleagues on the current 'double-FIT' testing (and its implications) in addition to refocusing on assessment against NBOCA data.
    - **Gynaecology** – work continues to on the development of a single Endometriosis Centre for the Black Country, to comply with future national requirements. Focus will also turn to the development of Gynae-Oncology arrangements for the Black Country, with a meeting scheduled for mid-April to progress this.
    - **Ophthalmology** – ahead of the forthcoming national GiRFT visit, the Ophthalmology team at DGFT delivered in excess of 20 Cataract cases in a day for the first time, a significant step up from an average of 3 per session 6 months ago. Furthermore, the Clinical Network has reached an agreement on the expansion of the Wolverhampton Glaucoma Referral Refinement Scheme (GERS) across the Black Country, with commissioning teams finalising the updated specification and to confirm the rollout model shortly.
    - **Orthopaedics** – following the recent interview processes, one of the two Clinical Leads being recruited for has been appointed. Dr. William Hart from RWT was the successful candidate for the North patch and has accepted the appointment on a 1PA per week arrangement for the 25/26 financial year.
    - **Pharmacy** – work continues at a pace to establish the Pharmacy Aseptic proposal, with two stakeholder engagement workshops being delivered in early May, and a draft output report due for circulation to all partners in early June prior to discussion at the next available BCPC Executive.
    - **Elective Care** – work continues with ICB and primary care colleagues on the development of specialty specific service specifications, which will support the management of NHS resources within the Black Country NHS, whilst retaining high standards of care delivery for the Black Country population.
  - **CNO update** – The BCPC CNO provided a brief update on key activities including "Workforce Alignment", and the Neonatal Partnership Board and its key workstreams. Of particular note was the proposed future arrangement of the "Local Maternity & Neonatal System" (LMNS) transitioning to the BCPC, with further dialogue required to understand, responsibility, accountability and liability issues aligned to governance arrangements.

- **'Delivery Partner'** – Work continues with the procurement team and the preferred Delivery partner and will be concluded shortly. Final elements of the work will ensure that any "diagnostic phase" will be reduced with a greater emphasis on supporting delivery of productivity and efficiency opportunities. The host organisation for this has been identified as SWBT, and it is anticipated that the work will commence imminently.

B. TRANSFORMATION

- **Corporate Service Transformation (CST) –** The BCPC SRO and Programme Lead provided a brief update on progress against the 8 recommendations agreed at the recent JPC.

  A more concise update is provided from the summary notes of the Programme Board, which was scheduled (and held) on Monday 14th April 2025.

C. STRATEGIC & ENABLING PRIORITIES

- **Communications - Public Involvement Exercise** – The BCPC System Lead for Communications provided an update on Public Involvement activities being undertaken to support the range of Clinical Service Transformation work agreed by JPC in February 2025.

  Learning from the previous 'North Hub' experiences it was essential that early engagement and public involvement activities commenced to inform the development and establishment of subsequent Business Cases as part of any service transformation / change processes.

  Work is rapidly being progressed in parallel to ensure that a briefing is provided for a Joint Health & Overview Scrutiny Committee, alongside a briefing for staff and stakeholders, combined with preparation for a wider public involvement exercise, the outputs of which can be appropriately used in all appropriate business cases.

- **Medical Bank Rate Harmonisation –** The task group led by the BCPC CMO continues to work on analysing the current Medical Bank rates being paid across the four partner Trusts, with a view to recommending a standard rate for all. Initial assessment is that there is a significant opportunity for efficiency through harmonisation and it is anticipated that this work will navigate some remaining steps arriving at a conclusion shortly.
- **BCPC Governance –** Draft terms of reference were received for two new proposed forums. The BCPC Managing Director will review with authors and consider their alignment in due course.

Key Messages on the Corporate Services Transformation Programme Board – April 2025

The following are the key messages from the **14th April 2025** Corporate Services Transformation Programme Board.

KEY MESSAGES

- **Terms of Reference:** the draft Terms of Reference for this new programme board were approved subject to the amendments to include CEO delegated representation within the formal membership and to explicitly document the seven corporate services that are in scope of this programme for 2025/26.
- **Progress against JPC actions:** the board received progress updates against a series of actions that were identified following the approval of eight recommendations presented to Joint Provider Committee in February 2025.
- **Robotic Process Automation:** the programme is supporting participation in an exciting free national NHSE Robotic Process Automation (RPA) pilot. RPA enables the automation of workflows to follow a predefined process. It enables the ability to automate high volume, rule-based, repeatable tasks. Three RPA opportunities specific to Human Resources workflows are explored. A digital Project Manager has been assigned and is working with HR colleagues across the system to progress the pilot, with support from the NHSE Head of Digitisation and Automation.
- **Delivery Partner Opportunity Analysis:** an update was received regarding the recently commissioned rapid analysis work which is progressing with two external consultancies. The

aim of this activity is to obtain an independent assessment of the scale of opportunity to deliver improvement, resilience, and efficiency through a single, system-level transformation approach for the seven in-scope corporate service areas. The analysis specification also seeks insight, based on consultancy experience and industry best practice, as to optimum service models, a consideration of potential digital investment and automation opportunities, and recommended delivery roadmap. Final reports are due later this month and following review, a summary paper will progress to JPC schedule in May 2025 outlining recommended next steps.

- **Legal Framework:** the programme board received an update regarding the work that has been commissioned from an external Legal partner to develop a 'Legal Framework' (which would be consistent with the Collaboration Agreement) for the establishment of a managed shared service. Consideration of recent national guidance relating to "wholly owned subsidiaries" (WoS) is also being considered and work continues to develop the framework.
- **Case for Change:** in response to early programme engagement activity and in readiness to progress to formal Business Case, the board received a draft Case for Change for review and comment. This consolidates several early governance reports and materials developed during the early programme preparation phase. Its purpose is to summarise the challenges identified across the system which need to be address and provides the rationale for why change is needed. The draft was received with initial amendments noted and further feedback to be provided by **Thursday 17th April** to support final updates to support its progress to final approval.

Regulation 28 Prevention of Future Deaths notice

In April 2025, the Trust was issued a regulation 28 Prevention of Future Deaths notice (PFD), relating to a patient who was discharged in April 2024 with no evidence of communication from the Trust to a care agency, which resulted in the patient not receiving their package of care post discharge. The patient sadly passed away. This incident was reviewed as part of the safeguarding adult review. Immediate actions were considered at the time, and the Trust continues to work on improving our discharge processes. The Divisions are currently working collaboratively to respond to this notice and ensure we learn from this tragic incident. The response to the coroner is required by 10th June 2025.

Getting it Right first Time

The Trust continues to drive the GIRFT Further Faster Programme, as well as Specialty GIRFT Meetings since July 2023, with key priorities delivering on Outpatients Pre-Appointments / Reducing and managing DNAs / Remote Appointments / Outpatient throughput / Patient Initiative Follow Ups across 17 core outpatient services. Improving Pathways through: - Diagnostics / Surgical Pathways / Theatres.

From October 2024 DGFT is now a part of the GIRFT Further Faster 20 initiatives, announced by the Secretary of State in September 2024, to target support for systems to improve and streamline pathways for patients and spread good practice in areas with high levels of economic inactivity. This is an opportunity for resource and focus to be placed in areas where we can have substantial impact to reduce the waiting list and continue to build on work we have already commenced. It is an opportunity to further improve care across our communities and link together Primary and Secondary care. It is also in line with the government's economic policy focus.

We have more work to do to ensure that the GIRFT Further Faster 20 programme embeds further within the Trust, and we are creating a Trust GIRFT subgroup to provide clinical guidance, challenge and direction to all specialties.

See **appendix** 1 for further details

Charity Update

Staff Wellbeing Rooms

The programme of works for our first phase of the staff wellbeing rooms is progressing well. The first three rooms; B1, C1 and C5 are almost complete. Next we have B5 and later in the year it will be ED. We have also agreed a supplier for wall art and furniture for all the rooms and have developed a brochure of themes for the rooms to support staff engagement.

We are now looking at the second phase of the project and will be reviewing the costings for them in the upcoming weeks.

Refurbished Paediatrics ED Cubicle
Colleagues from across the Trust gathered for the launch of the newly refurbished Cubicle 4 in the Children's Emergency Department at Russells Hall Hospital. A £10,000 grant to the Dudley Group NHS Charity from the Tesco Bags of Help scheme has funded the refurbishment of Cubicle 4 transforming it into a calming sensory space to help calm and distract our younger patients.

We are now appealing to businesses and the public to help sponsor the other seven cubicles we have on the ward, https://www.justgiving.com/campaign/ChildrensED

Cuddle Bed C4 Georgina Ward
Following a year of fundraising along with generous donations to the Dudley Group NHS Charity Georgina Ward charitable fund, the department has been able to purchase a £15,000 'cuddle bed'. The cuddle bed is electronic and expands by the touch of a button to double width and will help the C4 ward in delivering palliative care.

The ability to be able to get into the same bed as your loved one and have a cuddle or offer comfort at the most tender of times is proving to be incredibly beneficial. The bed is fully certified for two people, giving patients and carers peace of mind that not only is it helping to provide care, but it is also doing it safely.

Thank you to Montcalm International who allowed the ward to trial the bed for two weeks to ensure the equipment meets the needs of patients. We are very pleased that the bed has arrived in the Trust, we hope that this will make a difference to patients and their families.

Marathon 2025 – Meet our #TeamDudley runner
On Sunday, 27th April 2025, 50,000 runners took part of one of the biggest marathons staged anywhere in the world, the TCS London Marathon.

Our amazing runner, Adam has been fundraising for our charity, and we have been profiling his journey and supporting him with his fundraising efforts **#TeamDudley.**

Adam turns 40 this year and he can't think of a better way to celebrate than taking part in the pinnacle of all running events. His wife is a midwife in the Trust's maternity department, and he is proud of the hard work and dedication of all NHS workers, and he appreciates how fortunate we are to have such a brilliant healthcare system. Adam decided to raise funds for the Dudley Group NHS Charity to support the baby loss and bereavement team, he said "they provide such an important service at such an incredibly difficult time for families so to be able to help raise funds for resources for them would be fantastic opportunity". To support and donate please visit - https://2025tcslondonmarathon.enthuse.com/pf/adam-cotterill

Charity Consultants Cricket T20 Match
Bring your camping chairs, picnic blankets and your cheering voices to support an all derby T20 charity cricket match. It will be a competitive afternoon of cricket of consultants vs consultants from the Dudley Group NHS Foundation Trust and Sandwell and West Birmingham NHS Trust.

The match will take place at Pedmore Cricket Club on Sunday 11th May at 2pm, the club house will be open to purchase drinks and food from the BBQ.

All funds raised for the event will be split between the Dudley Group NHS Charity and Your City & Metropolitan Hospitals Charity.

Both charities' will there on the day selling programmes, raffle tickets, merchandise to raise additional funds.

It will be a great day to support your colleagues and raise vital funds for two local charities. To spectate please click on the below link, costs are £2 for adults and free for children under 16, https://register.enthuse.com/ps/event/PlayersDudleyGroupNHSCharityCricketMatch

Dragon Boat Race

On Sunday 18th May 2025, 60 members of staff from the Dudley Group NHS Foundation Trust will be competing against each other, and 20 other boats, at the Wolverhampton Rotary Dragon Boat Race on the lake at Himley Hall.

Our three amazing teams consist of staff from Trust HQ, Surgery, Women's and Children's and Anaesthetics departments. They all are raising funds for the Dudley Group NHS Charity, and we are profiling their journey and supporting them through their fundraising efforts!

To support team Trust HQ Team Will it float – visit https://dudleygroupnhscharity.enthuse.com/pf/will-it-float

To support the Anaesthetics team Row-crew-ronium - visit www.justgiving.com/page/andrea-baker-1724340598555?utm_medium=FR&utm_source=CL

To support the surgery, women's and children's team Black Pearl – visit https://dudleygroupnhscharity.enthuse.com/pf/black-pearl-ee49f

Committed to Excellence
Committed to Excellence is back and our charity is once again looking for businesses who would be interested in sponsoring and presenting key awards with one of our platinum, gold, silver, or bronze sponsorship packages.

Winners are announced during the Oscars-style black-tie awards dinner at the Copthorne Hotel in Dudley on Friday 11th of July 2025 which sponsors have the opportunity to attend. If you have any contacts please get in touch with nithee.patel@nhs.net

Healthcare Heroes (Liz/Hannah)

Rebecca George

Rebecca was nominated by a patient who wanted to thank her for everything she has done to help them.

The nomination said "I can wholeheartedly say that I would not have achieved the goals I have without Rebecca's unwavering support and care. After being wheelchair-bound for over ten years due to an incurable neurological condition, I am now able to take steps with minimal support."

Lauren Ward-Davies

Lauren was nominated specially by a patient's relative who wanted to recognise what she did for their family during a really difficult and emotional time when their loved one was dying.

The nomination mentioned Lauren's patient focused approach, professionalism, her kindness and that she went above and beyond when providing palliative care to their loved one.

The family said that Lauren's support and actions made all the difference, helped to alleviate any fears they had and that she made them feel like they mattered.

Sally Mole

Sally's journey over the past 14 months has been incredible as she has been undergoing treatment for Lung Cancer! While battling cancer she has been instrumental in major IT projects which have made a real difference to patients here at the Trust and has also completed a Leadership and Management course at Dudley College.

Sally was described by a colleague as Superwoman and we would have to agree!

Perinatal Team

Congratulations to the Perinatal Team which is made up of staff from both Maternity and the Neonatal Unit.

The team were nominated for the way they continue to work through challenges they face and how they all strive to continuously improve, which has resulted in better outcomes for babies.

Patient Feedback

Pulmonary Rehabilitation Team - The staff/nurses make you feel welcome and give the patients reassurance of their exercise abilities.

Day Surgery Unit, Russells Hall - Treated very well by all staff, they were very attentive and friendly, and I was kept up to date throughout the day.

Neonatal - I just think the team in Neonatal are more than fabulous and I can't say anything or complain at all... amazing team.

Own Bed Instead – Staff were very kind and supportive to my father, he explained everything in a way that he could understand.

Daycase Unit, Corbett - Staff were always very warming and polite. Nothing was ever too much to ask. Acted professionally and allowed patients privacy if needed.

C4 Oncology – Caring, professional treatment and treated with a smile and made to feel relaxed and confident with care.

General Community - My mother received excellent service. All staff were efficient, friendly and professional.

CAPD - The nurses were so welcoming and couldn't do enough to make me feel comfortable. Appointment was on time. Really impressed.

Ward C3 - Very caring staff, exceptionally clean wards and easy to speak to clinicians regarding my mother's treatment.

Awards

HSJ Digital Awards 2025
We are proud to announce that we have been shortlisted for two national HSJ Digital awards.

Our first shortlisting for Digital Organisation of the Year recognises that we are leading NHS digital transformation and achieving significant advancements in digital maturity. Engagement with stakeholders and patients was a cornerstone of our delivery. All delivery is co-owned by a product owner from the organisation and on average we deliver 29 digital initiatives a year due to this collaborative approach.

Over the last two years, our organisation has experienced a measurable increase in digital maturity, with sustained progress across all domains. This transformation has been underpinned by key initiatives such as the Sunrise EPR upgrade and the introduction of EPAC.

The adoption of theatres scheduling via a bespoke in house developed solution has addressed long-standing inefficiencies in scheduling, significantly reducing delays and improving theatre utilisation rates. Similarly, the eERS system has optimised resource allocation, enabling faster and more accurate referrals. Migrating to the cloud has enhanced system resilience and reduced downtime, ensuring uninterrupted service delivery and alignment to the national Cloud agenda.

We have seen significant reductions in operational inefficiencies, improved clinical outcomes through real-time decision support, and increased capacity for service delivery.

Our second shortlisting for Empowering Patients Through Digital Clinics recognises the work that been undertaken through the innovative Surgery Hero platform with Dr Anna Pierson. The Digital

Clinics Project was developed, using remote health coaching, to tackle longstanding challenges in elective surgery, including inconsistent patient preparedness, extended length of stay (LOS), and resource inefficiencies.

Key outcomes demonstrate the project's success:

- Reduced Length of Stay (LOS): Patients engaging with the platform saw a 0.59-day reduction in LOS compared to non-participants, freeing up 273 bed days and avoiding £925,470 in costs.
- Increased Surgical Capacity: This additional capacity enabled 99 extra surgeries, generating £111,969 in income.
- Improved Health Outcomes: Patient activation measure increased by 18%, physical health increased by 19%, sleep increased by 15% and diet increased by 10% reflecting improved confidence and preparedness for surgery

We are really proud of all of the colleagues and teams who have contributed to this success and who continue to support our digital innovation journey.

In addition, chief information officer, Ravi and members of her team have received a wonderful commendation from Will Goodwin, NHS England's regional director of digital transformation following a recent presentation to the Midlands Digital Leads Collaboration Forum.

Commending the hard work of Ravi and her team, Will said:

The presentation, focusing on the work undertaken regarding Digital Maturity Assessments, was incredibly insightful and very well-received by the digital leads from across the Midlands region. It clearly demonstrated the significant progress made by the Trust and showcased the thoughtful approach and strong leadership Ravi has provided in this crucial area. The work is a real credit to her and the entire digital team, offering valuable learning for colleagues across the region.

On a related note, I also wanted to personally acknowledge how consistently supportive and collaborative Ravi has been in her engagement with myself and my team. Her willingness to share expertise and contribute positively to wider regional initiatives is genuinely appreciated and will make a tangible difference to our collective efforts.

Finally, I was delighted to see the recent announcement of the HSJ Award nominations. Please accept my sincere congratulations, and extend them to the team, for securing two nominations for the Digital Team. This is fantastic recognition of their hard work, innovation, and the positive impact they are having. It is thoroughly deserved.

I greatly value the contribution of Ravi and her team to the wider Midlands digital community.

Visits and Events

Date	Activity
1 March 2025	Black Country Provider Collaborative Executive
7 March 2025	Black Country Financial Recovery System Oversight Group
10 March 2025	NHSE/Black Country ICB Operational Plan Review
13 March 2025	NHSE National Planning Event
14 March 2025	Dudley MPs Briefing
17 March 2025	Black Country Integrated Care System Cancer Board
17 March 2025	Black Country Provider Collaborative Senior Responsible Officers
18 March 2025	Black Country ICB Planning Assurance – Follow up
21 March 2025	Black Country Provider Collaborative Joint Board Workshop
21 March 2025	Black Country Integrated Care System Leadership Event
24 March 2025	HSJ Interview
25 March 2025	Midlands Endoscopy Network Board
26 March 2025	NHSE Midlands Regional Director monthly update
26 March 2025	Black Country Regional Performance Tiering Call

26 March 2025	Black Country Elective and Diagnostic Strategic Board
27 March 2025	Finance and Productivity Committee
27 March 2025	Black Country Integrated Care Board meeting
3 April 2025	Black Country Provider Collaborative Senior Responsible Officers
4 April 2025	Monthly Non-Executive Directors briefing
7 April 2025	Black Country Provider Collaborative Executive
9 April 2025	Board of Director Development Workshop
9 April 2025	Council of Governors Achieving Synergy briefing
14 April 2025	Corporate Services Transformation Programme Board
15 April 2025	NHSE/ICB Oversight and Assurance
17 April 2025	Black Country Provider Collaborative Senior Responsible Officers
23 April 2025	NHSE Midlands Regional Director monthly update
23 April 2025	Consultant Gastroenterology Interview Panel
24 April 2025	Finance and Productivity Committee
28 April 2025	Black Country Integrated Care System Cancer Board
28 April 2025	Freedom to Speak Up Guardian Steering Group
29 April 2025	NHSE Leadership Event
30 April 2025	Connect, Collaborate and Eat Cake Leadership event
30 April 2025	Black Country Elective and Diagnostic Strategic Board

Appendix 1

DGFT - GIRFT Further Faster 20 Programme

The trust continues to drive the GIRFT Further Faster Programme, as well as Specialty GIRFT Meetings since July 2023, with key priorities delivering on Outpatients Pre-Appointments / Reducing and managing DNAs / Remote Appointments / Outpatient throughput / Patient Initiative Follow Ups across 17 core outpatient services. Improving Pathways through: - Diagnostics / Surgical Pathways / Theatres.

From October 2024 DGFT is now a part of the GIRFT Further Faster 20 initiatives, announced by the Secretary of State in September 2024, to target support for systems to improve and streamline pathways for patients and spread good practice in areas with high levels of economic inactivity.

Surgical Pathways - March 25

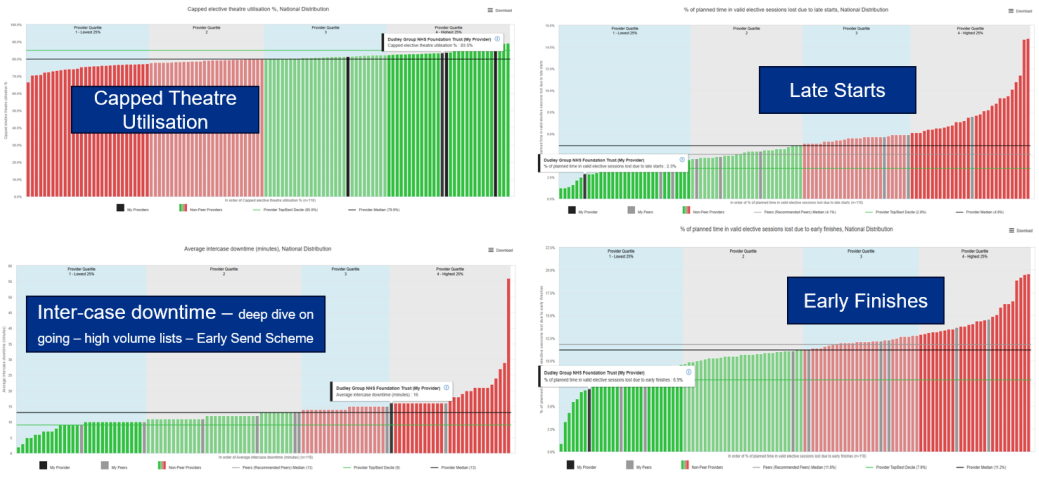
March RTT position 59.9% vs 25/26 target of 64.2% by end of March 2026. March has shown continued improvement in the RTT performance. 52-week performance has shown some deterioration in month, but further work is underway to understand and rectify the cause of this adverse variation.

THEATRES

The Trust's capped theatre utilisation remains in the highest quartile at 84%. While late starts and early finishes continue to be monitored to improve utilisation, both figures are in the highest quartile. Inter-case downtime remains a focus for improvement with on going deep dives.

Model Health Data - Theatre Metrics as of 23.2.25 – Continue to monitor / drive actions through Specialty Productivity Mtgs / Theatre User Group

NHS England



Theatre Key Actions - ongoing:-

- GIRFT representatives will attend the Trust in the first week of June to offer scrutiny, guidance and advice prior to the Trust's onboarding of Cohort 10.
- Theatre booking system now fully operational. E-consenting/paperless consent has begun in theatres.
- Guests from SWBH attended theatres and list planning to share experiences and learning between the two trusts. Further meetings and site visits are likely following the experience.
- The next Paediatric Super Saturday is planned for 12th April with three specialties taking part so far. The team also won February's Healthcare Heroes award for their work in organising and running the weekends so effectively.
- Gynaecology, Breast, General Surgery, Colorectal, Plastics, Ophthalmology, T&O, Urology, Pain, ENT/Max Fax & Vascular – Extra Weekend Lists.
- ENT, Vascular, General Surgery/Colorectal, Urology undertakes additional Weekday Evening Sessions.

Super Saturdays – Press Release 18.12.24
Transforming young lives: Dudley hospital dedicates surgery days to local children

The Dudley Group NHS Foundation Trust recently hosted three 'Super Saturday' days at its Russells Hall Hospital, with surgeries, morning until night, dedicated solely to children. By focusing on paediatric patients, the days allowed children to undergo various elective surgeries, relieving pressures on wait times and addressing the health inequalities for children awaiting surgery.

Diane Wake, chief executive of the Dudley Group NHS Foundation Trust, said: "We are thrilled to see the success of our Super Saturday events over the last few months. "This initiative allowed our staff – including our paediatrics, anaesthetics, theatre staff, day-case staff, play team, operations team and many more – to dedicate their day to delivering the right care to children needing surgery.

Karen Anderson, head of children's services, said: "We know that surgery can be a daunting experience, and even more so for our paediatric patients, so these days are of utmost importance to our community and staff".

Helping to prepare children for their surgery, the team shared an informative video, produced collaboratively with the RGUC Digital Media team, for all upcoming paediatric patients detailing what to expect on the day. Over the three days 79 children underwent surgical procedures ranging from tonsillectomies to squint surgeries.

Chloe Littler, mum of 7-year-old Ronnie, said: "The Super Saturday idea is brilliant and seeing so many children on the ward was amazing. Our son arrived early in the morning and the staff did a great job in calming his anxieties. Thanks to everyone at Russells Hall Hospital for a great job."

Russells Hall Hospital achieves milestone in cataract surgery - The Dudley Group NHS Foundation Trust

The Dudley Group NHS Foundation Trust has achieved a record milestone in its high volume, low-complexity cataract surgery service at Russells Hall Hospital. Performing an astounding 21 cataract operations in a single day, this initiative is a key part of the Trust's efforts to reduce NHS waiting times and improve patient access to high-quality ophthalmic care in Dudley and the wider Black Country region.

NHSE
The following was supplied but did not feature in the published release (Crack teams get patients off waiting lists at twice the speed - GOV.UK):

***The Dudley Group** have run Super Clinics and high flow theatre lists for General Surgery & Ophthalmology – the Super Clinics enable patients to have diagnosis and treatment earlier and using high flow theatre lists have improved the usage of theatres by over 85%.*

Our amazing General Surgery Surgical Team have been undertaking weekend High Intensity Theatres for primarily hernia and laparoscopic cholecystectomy cases to support the reduction in waiting lists. Since June 2024 there have been an astonishing 226 surgeries of which 206 (91%) had same day discharges.

Improving Pathways – Diagnostics - Community Diagnostic Centre (CDC) - Corbett CDC Hub & Spoke Model

- Positive impact on DM01 performance and reduced wait for cancer patients.
- Echocardiography longstanding waiting list reduced and sustained.
- Endoscopy and Respiratory commencing some activity end of March 25.
- Dermoscopy expanded to support rapid access, urgent and routine referrals.
- System mutual aid provided to SWBH since November 2023.
- CYP Asthma pathway commences April 25.

Delivering Outpatients

Pre-Appointment – on going
A&G & RAS – 7-9k referrals triaged monthly across a combination of 56 Specialty areas. **Cinapsis Eye eRS System** from Community Optometrists – Oct 23 – Mar 25 – Total referrals 2637. **CDC Dermoscopy** – Jan – Feb 25 – Total referrals 4115. **Neurology Consultant Connect** – Oct 24 to date – 1431 referrals triaged.

Reducing & Managing Missed Appointments (DNA's) – on going
February 25 Missed Appts (DNAs) Performance – 6% - CSS 7.5% - MIC 4.7% - SWC 6.7%.

Remote Appointments – on going
March 25 - 80.18% F2F vs 19.82% Virtual.

PIFU - on going
March 25 PIFU Performance – 3.4% - CSS 15.8% - MIC 2.5% - SWC 2.5%.

GIRFT BC ICB System Visit 28 April 25 – Updates and Next Steps:-
The GIRFT visit received overall positive feedback from Professor Briggs and the NHSE Midlands Team.

- Professor Briggs highlighted the urgent need to standardise clinic templates across the System.
- All specialities to conduct a review of variations in key metrics within the System with strategies for resolving the variation through shared learning and work on achieving top decile within Model Hospital.

Outpatients Transformation
PIFU & Missed Appointments
Remains areas of continued focus across all providers within the BC ICB System.

Surgical Flow / Early Health Screening – APOM Handbook updated March 25
Working towards May 2025 GIRFT visit the group completed questionnaires and reviewed variances that may exist between providers related to Post Op Care.

Key Specialty ENT Initiatives
ENT is a key national challenged specialty highlighted for attention in the new planning period in the "Reforming Elective Care" Report. Current Projects:- Shared Surgical Pathways for Tonsils, Adenoids and Grommets. Community ENT frameworks for Hearing Loss, Ear Wax and Tinnitus; meeting between BC ICB representatives, BC Elective Hub and GIRFT ENT representatives to take place in May 2025.
RR/1.5.25

Enclosure 4

The Dudley Group NHS Foundation Trust

Paper for submission to the Full Council of Governors on 19 June 2025

Report title:	Chair's update Board of Directors meetings (public session) held May 2025
Sponsoring executive/ presenter:	Sir David Nicholson, Chair
Report author:	Helen Board, Board Secretary

1. Summary of key issues

Summary report from the Board of Directors meeting held in May 2025 that had been held at the Russells Hall Hospital, Dudley, highlighting items of assurance, concern, action or decision. Governors are invited to discuss matters further to establish any triangulation and assurance relating to:

- The Trusts financial position for the current year and recovery planning in respect of future years
- The Trusts performance in relation to the Constitutional performance standards
- Decisions and approvals made

All governors and members receive a direct invitation and are actively encouraged to attend the bi-monthly Board of Directors (public session) meetings. All governors receive the full meeting pack of documents which are also published on the Trust website Board meetings - The Dudley Group NHS Foundation Trust (dgft.nhs.uk). The May 2025 meeting was not attended by any Trust governors.

2. Alignment to our Vision

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

3. Report journey

Full Council of Governors Meeting - 19 June 2025

4. Recommendation(s)

The Council of Governors is asked to:

a) Note and discuss the matters included in this report

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

CHAIRS LOG UPWARD ASSURANCE REPORT FROM BOARD OF DIRECTORS

Date Board last met: May 2025

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE

- The Board was advised that the Trust had received a Regulation 28 – Prevention of Future Deaths (PFD) Notice and noted that it was being overseen by the Quality Committee who would monitor delivery of any actions arising.
- An alert was noted around some infection, prevention and control (IPC) indicators with the Trust continuing its focus on improvement and taking learning from other organisations.
- Issues related to ambulance handover delays was noted and that there had been a helpful visit by NHSE. Work was ongoing to improve the triage position within ED majors.
- Complaints response times would remain a focus with an improvement plan to be presented to the Quality Committee.
- The Board received the Winter Plan 2024/2025 Debrief report that had largely under delivered.
- The Performance Against Workforce Forecast report set out the final position which was 7.6% over plan. A reduction had been seen in month 12 of substantive staff but over deployment of Bank staff. Lessons learnt had been put into practice for the 2025/26 plan. Month one for the current year showed performance was just under plan

MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY

- The Board noted the ED Majors Triage Improvement Plan and requested a report that set out how the flow issue would be resolved.

POSITIVE ASSURANCES TO PROVIDE

- Patient Story – the Board welcomed the Director of Midwifery, the Trust Bereavement Midwife and a mother and baby who presented her Patient Story that shared the mother's story and experience of the Rainbow Service.
- The Board noted the Month 12 March 2025, Trust financial position. The Trust had achieved the financial plan for 2024/25 financial year. March performance was in line with forecast noting that Bank usage was higher than expected with leave and unfunded surge beds open. There had been continued non pay overspend, offset by additional income of which some was non-recurrent.

DECISIONS MADE

- The Board reviewed and approved the month 12 financial report.
- The Board approved the Emergency Preparedness, Resilience and Response (EPRR) Strategy.
- The Board approved the Annual Plan for 2025/2026.
- The Board approved the updates made to the Board Assurance Framework made since the last meeting and noting the committee assurance level ratings that were all given as positive.
- The Board approved the delegation of authority to the Audit Committee for the Trust Annual Report and Accounts

• The Cost Improvement Programme had delivered to plan and the excellent achievement was noted • The committee chairs quadrant upward reports from Finance & Productivity, Quality, Workforce and Integration Committees were received noting assurances as given on the range of subjects considered. • The Board received a combined Chief Nurse and Medical Director Report that focused on review of quality and safety during the challenging winter period. • The Board received the Perinatal Quality Report noting that the Mortality data remained below national rates and noted work being undertaken related to demographic of families losing babies and that 50% of these were from areas of deprivation. One new case had been referred for newborn safety investigation. • The Board received a staff Wellbeing update noting positive impact in a number of areas. • The Freedom to Speak Up Guardian Report illustrated the growth in champions across the Trust and summarised key theme of matters raised by staff. • A summary of the Safer Staffing review completed during January-February 2025, was presented noting overall positive staffing levels in clinical areas and risks were mitigated. • Integrated Quality and Operational Performance Report noted Trust performance against national standards and local recovery plans performing well overall. Expectation to deliver all within required timeframes. Noting that Cancer service performance targets were achieved. Elective recovery was seeing progress with those waiting seeing a reduction.	
Chair's comments on the effectiveness of the meeting Meeting held face to face at the Russells Hall Hospital noting three apologies received from board members. The meeting was attended by a foundatio member and no Trust governors.	

Paper for submission to the Full Council of Governors on 19 June 2025

Report title:	Integrated Quality and Operational Performance Report.
Sponsoring executive:	Martina Morris, Chief Nurse and Director of Infection Prevention and Control Julian Hobbs, Medical Director Karen Kelly, Chief Operating Officer
Report author:	Leigh Dillon, Associate Deputy Chief Nurse - Quality

1. Summary of key issues

This report summarises the Trust's Quality and Performance data for the month of March 2025 (January/ February 2025 for Cancer and VTE).

Assure

Quality:

Falls: The overall number of recurrent and inpatient falls have declined further since February. March saw 88 falls, 4 of which were a recurrent fall. There were 0 moderate harm incidents reported.

Stroke: February and March data is currently unvalidated and are provisional. All areas compliant in Jan 2025 - Ward stay 92%, target 85%. Swallow screen performance 98%, target 70%. Thrombolysis 57%, target 50%. High Risk TIA compliant at 91%. Russells Hall Hospital was 2nd out of 9 peer trusts continuing to maintain a SSNAP score of 77 in Q2 which is a SSNAP level B.

Performance:

Emergency Performance: In March ED 4-hour performance was at 80.49% vs the national target of 78%.

Cancer Performance: The 28 day Faster Diagnostic Standard (FDS) achieved 87.1% (February 25 validated) against the constitutional standard of 77%. 31-day combined decision to treat performance achieved 93.6% in February against the national target of 96%. Performance against the 62 Day combined target achieved 70.5% in February which remains above the national target of 70%.

DM01 Performance: March's DM01 performance achieved 86.5%.

Black Country Pathology Service (BCPS): Urgent 10-day Histology: 60% in March against national target 70%. Urgent requesting remained static at 55%.

Elective Restoration & Recovery
18-week performance continues to improve and is now at 59.9% against the end of year target of 64.2%.

Advise

Quality:

Safer staffing: Staffing compliance and care hours per patient per day (CHPPD) remained consistent with February data. There was continued increase in bank costs for registered and clinical support workers due to additional beds remaining open. Bank usage in some areas has

also remained high due to increase in vacancy rates and annual leave. Additional beds on super surge are now closed but additional beds on AMU remain open. Additional TES areas continue to be utilised based on capacity needs, including recent ED corridor utilisation to ensure patients could be off loaded from the ambulances timely due to high demand. Risk assessments continue to be completed prior to the TES areas used.

Safer staffing establishment review – January-February 2025:

- Overall, the safer staffing establishments within the assessed areas are in a positive position to maintain the provision and delivery of safe, effective, high-quality care.
- No serious concerns pertaining to quality and safety have been identified by the Divisional Chief Nurses based on the current establishments. However, based on professional judgement and triangulation of quality metrics and acuity, some clinical areas feel additional staffing or change of skill mix may enhance care and experience in these areas. The Nurse Sensitive Indicators reviewed as part of the review, indicate that ongoing improvement work is required for example, with regards to patient observations, medicine management, pressure ulcers and falls amongst others.
- Inconsistent approach in how the 22% headroom/relief is applied and how this is utilised where in place has been noted, negatively contributing to the bank usage. A discussion was held with the Chief People Officer (interim), Chief Nurse (CN) and Divisional CNs, and agreement reached to standardise the approach across the Trust by recruiting into the 15% headroom/relief and using the rest for contingency cover which should see a positive impact on bank use.
- It is evident from the quantitative data that there is a disconnect between the recommended staffing establishments and the current funded staffing establishments, due to quantitative data collection issues, which we continue to work on. Professional judgement has been a key guiding factor with decision making and the knowledge of seasonal variation within the patient cohorts, the impact of flow and capacity challenges during the data collection month and the additional measures undertaken to support patient flow and patient experience.
- Following Divisional reviews, a number of recommendations were put forward to increase staffing establishments. As part of the review conducted between the Divisions and Chief Nurse, the majority have not been supported as the review did not highlight any immediate quality and safety concerns requiring changes in establishments. However, establishment changes in two clinical areas are recommended, which include Paediatrics Emergency Department (convert vacant band 6 posts into a Band 7 post to enable 24/7 senior nurse cover) and Paediatrics ward (increase establishment with a clinical Band 7 post). Both recommendations have been supported by the Executive team and will be enacted within the allocated financial envelope. They will strengthen leadership and quality oversight in these areas. Please refer to the Board reading room for more details.

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

Sepsis: 63% ED patients and 60% inpatients received antibiotics for sepsis within 1 hour of time zero. Matters impacting on compliance include, Delays of documentation of vital signs at the point of care, Delays in commencing screening tool at time zero, Delay in senior clinical review will impact time available to administer antibiotics, increase in additional patients to standard ward format is impacting on timeliness of treatment of inpatients with suspected sepsis. Divisions will report sepsis/ deteriorating patient improvement plans at the next Deteriorating Patient Group meeting in May 2025.

Mental Health (Adults and CYP): There has been 0 patients detained to DGFT on a section 2 or 3 and 1 patient detained on a section 5(2) during March 2025. There have been 3 patients who have been liable to be detained on a section 2 who have been admitted to acute wards. All three patients, once they completed their physical health treatment, were transferred to mental health

hospitals where the section was applied. ED had 4 patients liable to be detained on a section 2 and 1 patient on a section 3. Again, these sections did not become live until they were admitted to mental health hospitals. In terms of informal activity, we were not able to report on this for March 25 as there is a new process in place to report on all MH activity.

43 children with mental health concerns attended the Trust. This is a similar figure to the previous month. Of which, 27 CYP were reviewed within ED and discharged. The remaining 16 were admitted to C2. In terms of the age range of CYP contact for mental health purposes, the 14-15 and 16–17-year-old population are the main age groups with mental health concerns. With the monitoring of the out of area attendances, Sandwell patients are continuing to have a greater representation within the Trust. This may be due to RHH being closer to patients' homes than MMUH.

Chief Nurse Dashboard (inpatient areas): 8 ward areas now reported as RAG red for vacancy WTE data – 50% increase in areas reporting this since January 2025. Rising sickness, which continues to be attributed to seasonal illness, was 9.49% overall in January 2025, now 15.9%. A task and finish group to review patient observations completed on time is in progress to focus on improving performance.

Performance:

ED Triage: February's Overall Triage position is 76.1% vs 95% national target.
Arrivals via ambulances and front triages were high, limiting the front triage performance, along with high acuity of patients.

Ambulance Handover: This month's activity saw 10,120 attendances. This has increased when compared to the previous month of February with 8,402. 21 out of the 31 days saw >300 patients. 3,215 patients arrived by ambulance; this shows an increase from the 3,189 ambulances that attended last month. 529 of these offloads took <1hr (16%). This is the same as our performance when compared with last month's performance of 20%.

Cancer (Data to December):
Since October 2023 National Cancer Constitutional standards now monitor against 28 day Faster Diagnostic Standard (FDS), 31-day combined decision to treat, and 62 days combined referral to treatment. NHSE have revised the new March 2025 targets for the 28-day FDS and 62-day to change to 77% and 70% respectively.

31 day combined & 62 combined actions
- Prostate: increased first OPA and biopsy capacity required for April. Extra capacity planned.
- Gynae: remains challenged. ICB aware and the team are working on extra capacity.
- Extra capacity requirements across all pathways continues to be monitored.

DM01: Dexa, Endoscopy, Cardiology and Ultrasound are performing well at 95% or above. Sleep Studies, Cardiac MRI and Cardiac CT remain challenged.
Sleep studies backlog has significantly impacted the overall DM01 position. March performance is 41.63%. There is a recovery plan to improve this position by end of June 2025. Increased staffing and additional equipment will provide extra capacity. Respiratory to commence in CDC over coming weeks. Suitable space for services to operate is in progress.
Elective Restoration & Recovery: 52-week performance has seen some deterioration in March. The latest position is 388 behind plan. Investigation underway to understand the sudden drop off in performance.

Alert

Quality:

Infection Prevention and Control: The trust has reported 3 Hospital-Onset Healthcare Associated (HOHA) cases of Clostridium difficile (CDI) and 3 Community-Onset Healthcare

Associated (COHA) cases in March 2025, this shows a total of 97 cases against a threshold of 73 for 2024/25. CDI continues to increase nationally, and the Trust attends the ICB Task and Finish CDI group. The Infection Prevention and Control Team (IPCT) completed a CDI thematic review for Q3, Q4 is underway and at present, there is no new identified learning. When comparing CDI cases and DGFT admissions, they have similar peak patterns, there is a noticeable increase in both CDI cases and admissions over the past three financial years. In terms of other infections, 4 HOHA and 3 COHA cases of E coli blood stream infection (BSI) were reported, a total of 79 against a threshold of 75 for 2024/25. 3 HOHA and 3 COHA cases of *Klebsiella spp.* BSI were reported, a total of 32 against a threshold of 19 for 2024/25. 1 HOHA and 1 COHA MSSA bacteremia cases were reported, with a total of 52 for 2024/25.

The Trust has reviewed its Cleaning and Disinfection of Environment policy, in line with National Standards of Healthcare Cleanliness (NSoHC, January 2025) and strengthened various aspects to ensure that cleaning and disinfection are provided as per the requirement. All areas have been reviewed and mapped against the FR1–6 ratings detailed in the NSoHC 2025 with different work areas in larger departments being separated out according to the clinical activity taking place within each area, rather than just the name if that area. During this review, 30 areas have had their functional risk rating reduced and 8 areas have had their functional risk rating increased. A Quality Impact Assessment has been completed as part of this review to assess and mitigate any risks associated with these changes. There remains robust oversight of cleanliness across the organisation, with prompt escalation when concerns are identified. Over the last couple of months, we have seen an increase in norovirus across the Trust and a decision was made to introduce chlore clean in all areas to reduce the risk of infection spread.

The IPC BAF is enclosed in the reading room for information and outlines the Trust's compliance. The BAF has recently been updated by NHS England and the Trust will adopt the latest version going forward.

Vital Signs Compliance: The compliance for observations (vital signs) on time demonstrates an increase in compliance from 51.11% to 52.05% of all vital signs recorded in March. Vital signs are often continued in patients reaching their end of life unnecessarily, these patients may be scoring highly on NEWS2 requiring increased monitoring that can be uncomfortable. There remains a significant number of patients (5848) that staff have taken over 15 minutes to document the vital signs from the point of undertaking them. A Task and Finish improvement group has been established with 4 wards areas across medicine and surgery to better understand the problems and solutions, to enable an improvement plan, with first meeting planned for May 2025.

Performance

- Nil to report

to note that detailed reports are in the further reading pack associated with this meeting

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

3. Report journey
Trust Management Group Quality Committee Public Trust Board – 8 May 2025 Full Council of Governors Meeting - 19 June 2025

4. Recommendation(s)
The Council of Governors is asked to:
a) Note and discuss contents of this report and gain assurance on oversight of quality, safety and operational performance.

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

Paper for submission to the Full Council of Governors on 19 June 2025

Report title:	Remuneration and Appointments Committee report to full Council - Chair appraisal 2024/2025 - Non-executive Director appraisal 2024/25
Sponsoring executive/ presenters:	Sir David Nicholson, Chair Catherine Holland, Senior Independent Non-executive Director
Report author:	Helen Board, Board Secretary

1. Summary of key issues using Assure, Advise and Alert

Chair appraisal 2024/2025

NHS trusts are responsible for ensuring that the chair receives regular appraisals of their performance, at least annually. The formal annual appraisal process is set out in national guidance issued February 2024.

The appraisal process for the full year 2024/2025 concluded in June 2025 and aligns with the Trust's appraisal window. As shared chair across four trusts, Sir David Nicholson, the appraisal process was combined and run as a single process, with one submission prepared to be sent to NHS England.

Appraisal process

- 360 degree feedback sought using survey based on NHS England framework to reveal perceived strength and development needs. Survey was sent to board members, Council of Governors and external stakeholders e.g. Integrated Care Board.
- Senior Independent non-executive directors from each of the four trusts reviewed feedback and nominated Catherine Holland to complete the chair's appraisal, set objectives and determine any development needs.

Reporting

- Chairs appraisal outcome (appendix 1) was considered at a meeting of the Remuneration and Appointments Committee on 10th June where it was agreed to submit to the Full Council of Governors for endorsement prior to submission to NHS England by 31st July 2025.

Fit and Proper Persons

To note that the chair was required to complete the self-assessment against the Fit and Proper Persons test, and it had been reported to NHS England using the Annual FPPT Reporting Template. To note that the shared chair maintains an up-to-date record of interests as required.

Non-executive Director appraisal 2024/25

NHS trusts are responsible for ensuring that the non-executive directors (NEDs) receive regular appraisals of their performance, at least annually. Trusts can determine the approach to appraisal that is most relevant to their local circumstances.

The appraisal process for the full year 2024/2025 concluded in June 2025 and aligned with the Trust's appraisal window:

- Considered 360 degree feedback sought using a survey based on NHS England framework to reveal perceived strength and development needs from 10 – 12 raters

- Deputy chairman completed non-executive director appraisals, reviewed performance against objectives set for 2024/2025, set objectives for 2025/2026 and determined any development needs.
- The chairman completed the deputy chair's appraisal.
- Considered the terms of office and remuneration of the non-executive directors

Reporting

- Summary of all non-executive director appraisals (appendix 2) and recommendations for terms of office were considered at the June meeting of the Remuneration and Appointments Committee where it was agreed to submit to the Full Council of Governors for endorsement on 19th June 2025.

Fit and Proper Persons – non-executive directors

The appraiser has confirmed they continue to be a 'fit and proper persons' as outlined in Regulation 5 and in line with the updated NHS England Fit and Proper Person Test Framework, a submission with this assertion was made to NHS England in June 2025. There are no pending proceedings or other matters which may affect their suitability for appointment.

To note that non-executive directors maintain an up-to-date record of interests as required.

Non-executive succession planning

The Trust has for a long time adopted a recruitment approach that supports a staggered end of term for non-executive directors and in line with best practice as set out in the NHS England Code of Governance, rigour is applied to any term of office that exceeds six years. In recent years the Trust has actively appointed associate non-executive directors to act as a pipeline and support succession planning to ensure the skill mix and experience is maintained.

Mapping the Journey to a Single Board

As part of the ongoing project to work more closely with Sandwell & West Birmingham Hospitals NHS Trust, a review is underway to map the journey to establishing a number of joint committees in the next few months and to operate a joint board of directors from 1st April 2026.

At the time of writing, finalisation of the process and timeline to achieve the required composition of voting and non-voting non-executive directors to support the skills, experience and diversity criteria is being developed and will, in due course, be submitted to the Committee and onwards to the full Council for endorsement. The Lead Governor from The Dudley Group will continue to be involved.

Non-executive remuneration

The remuneration for non-executive directors is between £13,190 and £13,585 p.a. This is consistent with the guidance issued by NHSE in 2019 "A remuneration structure for NHS provider chairs and non-executive directors" and was applied extant to the recently appointed candidates.

The committee was advised that a review of non-executive remuneration and terms and conditions is underway in respect of non-executive at each of the acute trusts that make up the Black Country Provider Collaborative.

To note that The Dudley Group has previously awarded supplementary payments to the deputy chair, senior independent non-executive director and for those that chair committees of Board and will be factored into remuneration discussions. This will run concurrently as we develop plans to achieve group working with Sandwell that will include shared non-executive arrangements with associated remuneration uplift reflecting the wider roles.

Current recommendations for renewals

The following non-executive directors will or have reached reach their end of term with recommendations given below. The Council is asked to endorse in principal the following as part of current discussions related to the establishment of a joint board:

Gary Crowe, end of term July 2025 – seek to renew
Anthony Hilton, end of term July 2025 – seek to renew
Ita O'Donovan, end of term June 2025 – not renew

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

3. Report journey
Remuneration & Appointments Committee 10th June 2025 Full Council of Governors 19th June 2025

4. Recommendations
The Council of Governors is asked to:
a) **Endorse** the Chairs appraisal for 2024/25 ahead of its submission to NHS England
b) **Endorse** the non-executive directors appraisal outcomes for 2024/25
c) **Endorse** the recommendations in principal for the renewal and non-renewal as given above

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

Appendix 1

Appendix 1: NHS chair appraisal reporting template

This template should be used to formally record a summary of the key outcomes from the appraisal discussion between chairs and appraisal facilitators.

Name of organisation:	**The Dudley Group**
Name of chair:	Sir David Nicholson
Name and role of appraisal facilitator:	Catherine Holland (on behalf of all four Trusts) Senior Independent Director (Dudley) 7th May 2025
Appraisal period:	2024/2025

Part 1: Multisource stakeholder assessment outcomes (for completion by appraisal facilitator)

a. Summary of significant emergent themes from stakeholder assessments:
360 mostly consistent with self-apprasial, and view of SIDs from each organisation. Indentified an issue about engagement with NEDs, post the appointment of Deputies and taking on Chair role across multiply Trusts. Noted that some may find direct approach difficult at times, but noted other feedback that style is amended according to audience.
b. Highlighted areas of strength:
Breadth of experience and knowledge. Good reputation and contacts in the system. Ability to read the broader environment, and guide formation of an effective strategy.

c. Identified opportunities to increase impact and effectiveness:
Give thought to how to approapriately engage with NEDs. Need to consider more how to build relationships with voluntary/third sector. Need to continue to consider the developing deputy role and links to NEDs

Part 2: Self-reflection (for completion by chair)

Summary of self-reflection on multisource stakeholder assessment outcomes:
Overall, a successdul year, with signifiicant steps taken towards more efficient and effective governance, through bringing Boards together. Challenges in establishing financial sustainability remain, partcularly in Wolverhampton currently. Midland Met development well done, but now need to drive on to the next level. In Dudley, more work needed in developing Community services.

Part 3: Personal development and support (for completion by chair and appraisal facilitator)

Personal development and/or support needs identified:			
Description	Proposed intervention	Indicative timescale	Anticipated benefit/ measure of success
None Identified			

Part 4: Principal objectives (for completion by chair and appraisal facilitator)

3 principal objectives identified for next 12 months:		
Objective	Anticipated benefit/ measure of success	Anticipated constraints/ barriers to achievement
1.By the end of my term, to have led the four Trusts to be ready for two Board Chairs and two Boards with merged Committees.	Structures established, appointment process underway.	Resistance to the plan from some areas (though the majority are keen) Desire for some to make changes before we are

	Greater efficiency through reduced expenditure and time on governance Greater effectiveness though shared learning, and deploying best practice across the region. Greater resillience through reducing organisational barriers.	ready, compromising effective governance Risk of losing key people, or the wrong people at the wrong time. Needs proactive conversations with those affected.
2. By the end of my term, to have established all four Trusts on a sustainable clinical and financial basis	Financial and clincal sustainability. Increased confidence in delivery	Moving ‘goal posts’ (funding decisions) and mixed national messages. Local resistance to necessary changes Polictial will for change in services does not match directive to reduce spend.
3. Develop and maintain strong partnerships at all levels a) Local Councils – good already, except Dudley b) ICB – good already/regular contact with Chair c) Voluntary/Indpendent Sector (needs more work) d) Regional and national – good already e) Primary Care collaboration.	Improved services though greater collaboration Improved reputation and confidence	

Part 5: Suitability for appointment (for completion by chair and appraisal facilitator)

The appraisee has been assessed in the last 12 months under the NHS England FPPT Framework and it is confirmed that they continue to be a 'fit and proper person' as outlined in regulation 5 and there are no pending proceedings or other matters which may affect their suitability for appointment. Regulation 5: Fit and proper persons: directors - Care Quality Commission (cqc.org.uk)
YES

Part 6: Overall Assessment Rating and Confirmation

Assessment ratings:

1) **Satisfactory** (they are meeting their formal expectations)
2) **Cause for concern** (they are not meeting their formal expectations and will be formally logged and addressed)

Confirmation of overall assessment rating and confirmation (please circle and sign below)		
1) Satisfactory	~~2) Cause for concern~~	
Confirmed by	Signature	Date
Chair		7/5/25
Senior Independent Director, Deputy Chair or Regional Director		7/5/25

Part 7: Confirmation

Confirmation of key outcomes of appraisal discussion:		
Confirmed by	Signature	Date
Sir David Nicholson, Chair		7/5/25
Catherine Holland, Senior Independent Non-executive Director and Appraisal facilitator		7/5/25

Part 8: Submission

a. Copy submitted to england.chairsappraisal@nhs.net who will forward to your regional director for review

Name	Date

b. Endorsement by NHS England Chief Operating Officer (NHS England will action)

Name	Date

Appendix 2

The Dudley Group NHS Foundation Trust

Non-executive team - Appraisal summary 2024/25

Organisation	The Dudley Group NHS Foundation Trust
Chair	Sir David Nicholson
Deputy Chair	Gary Crowe

Name of NED	Overall score (Satisfactory or cause for concern)	Learning & development needs identified	Any issues that might affect suitability for appointment	Does the NED demonstrate your Trusts values and behaviours?
Gary Crowe	Satisfactory	Continue to pursue opportunities to be involved with a regular interaction with call with MPs and other important stakeholders. Continue to contribute strategically at the JPC, on the CST programme and on developing the group roles and joint governance structure across Dudley and SWB to draw on his skills and experience.	none	Yes
Peter Featherstone	Satisfactory	Influence how the new Group committees form and operate as a member of the joint group Infrastructure & Digital Committee. As part of the F&P committee be responsible to ensure the productivity challenges are embraced and delivered as part of the significant uplift in performance requested in the 2025/6 planning/central objectives. Support the work of the Trust and Board to culturally tackle and improve EDI outcomes and embed Continuous Improvement as a mindset and practice.	none	Yes
Joanne Hanley	Satisfactory	As part of the emerging joint working with Sandwell as a 'group' contribute as Audit Committee chair to the development of effective integrated governance and assurance frameworks and practice. Support the work of the Trust and Board to culturally tackle and improve EDI outcomes and embed Continuous Improvement as a mindset and practice.	none	Yes

Anthony Hilton	Satisfactory	Continue to draw on his relationships and understanding of both Dudley and Sandwell trusts as the 'group' structure forms and new governance established in the board. As part of the recruitment plan for a new Medical Director Anthony is well placed to support the process as the relationship and expertise on research, education and innovation will be an important selection criteria.	none	Yes
Catherine Holland	Satisfactory	As part of the emerging joint working with Sandwell as a 'group' contribute to ensure strong governance and Board reporting which currently exists remains in place.	none	Yes
Elizabeth Hughes	Satisfactory	Liz's term of office expires this Autumn which means the development requirement is more focused on ensuring the committee practice and business is well placed for a successful hand over. This includes exploring the opportunities to share best practice and learnings from the Sandwell Trust as our two Trusts increasingly work together.	none	Yes
Ita O'Donovan	Satisfactory	Continue to take opportunities to support ward to board type assurance activities, develop relationships and rapport with our governors, and both support and challenge the implementation of the new strategy. The organisation will have difficult choices to make on allocating resources and the NED role is to ensure as a unitary group we make the best use of funding.	none	Yes
Mohit Mandiratta	Satisfactory	As part of the Integration committee be responsible to ensure the progress with 'community first' initiatives and adoption of improvement practice which has commenced in areas like the management of the frailty pathway and out-patient services.	none	Yes
Anne-Maria Newham	Satisfactory	Continue o attend 'ward to board' activities and interactions with Governors to develop an effective relationship with those who represent our communities	none	Yes

		and rely on the NEDs for assurance on performance. As a member of the Joint Infrastructure and Digital Committee, a priority will be both ensuring a strong understanding and representation of the Dudley position and priorities in this area and working well with new colleagues showing an appreciation of the Sandwell business/requirements. The Board has a growing focus on productivity and please grow your personal understanding of the data/insight as well as ensuring appropriate scrutiny and challenge in this domain.		
Vij Randeniya	Satisfactory	Continue to lead the Integration committee towards more community-based services, service improvement activities (via DIP) and place-based collaborations for patient benefits. The Board and Trust has more to do to embed the culture envisioned in the Dudley People Plan and EDI strategy which Vij can continue to advocate for and support.	none	Yes
Lowell Williams	Satisfactory	Continue to support the work of the Trust and Board to culturally tackle and improve EDI outcomes and embed Continuous Improvement as a mindset and practice.	none	Yes

Enclosure 7

The Dudley Group NHS Foundation Trust

Paper for submission to the Full Council of Governors on 19 June 2025

Report title:	Strategy & Annual Plan progress report – Q4 2024/25
Sponsoring executive:	Adam Thomas Group Chief Strategy and Digital Officer
Report author:	Ian Chadwell, Deputy Director of Strategy

1. Summary of key issues using Assure, Advise and Alert

Assure

Mortality performance continues to be good.

Continued reduction in DNA rate for outpatients and theatre utilisation above England average. Vacancy rate remains below the target of 7% with low turnover for nursing, midwifery and AHP staff.

Achievement of the financial plan.

Advise

Sixty five week waiters have been virtually eliminated this quarter with challenges remaining in some specialties.

Alert

The number of complaints and response times have not been reduced as originally planned.

Planned reduction in bank usage has not been delivered, in part due to the continued use of surge areas and waiting list initiatives to deliver elective targets.

This summary report is supported by additional information available in the reading pack. This is the last time this report will be submitted in this format. Following the completion of the annual plan for 2025/26 a new format will track progress against the in-year objectives and the assurance metrics that show whether the strategy is being delivered. First report will cover the period April – June 2025.

2. Alignment to our Vision

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

3. Report journey

Executive Directors – 15th April 2025
Relevant sections to all four committees – 24th, 29th, 30th April 2025
Public Trust Board – 8th May 2025
Full Council of Governors Meeting - 19 June 2025

4. Recommendation
The Council of Governors is asked to:
a) To note the strategy progress report for Q4 2024/25

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

STRATEGY PROGRESS REPORT – Q4 2024/25

Report to Board of Directors on 8th May 2025

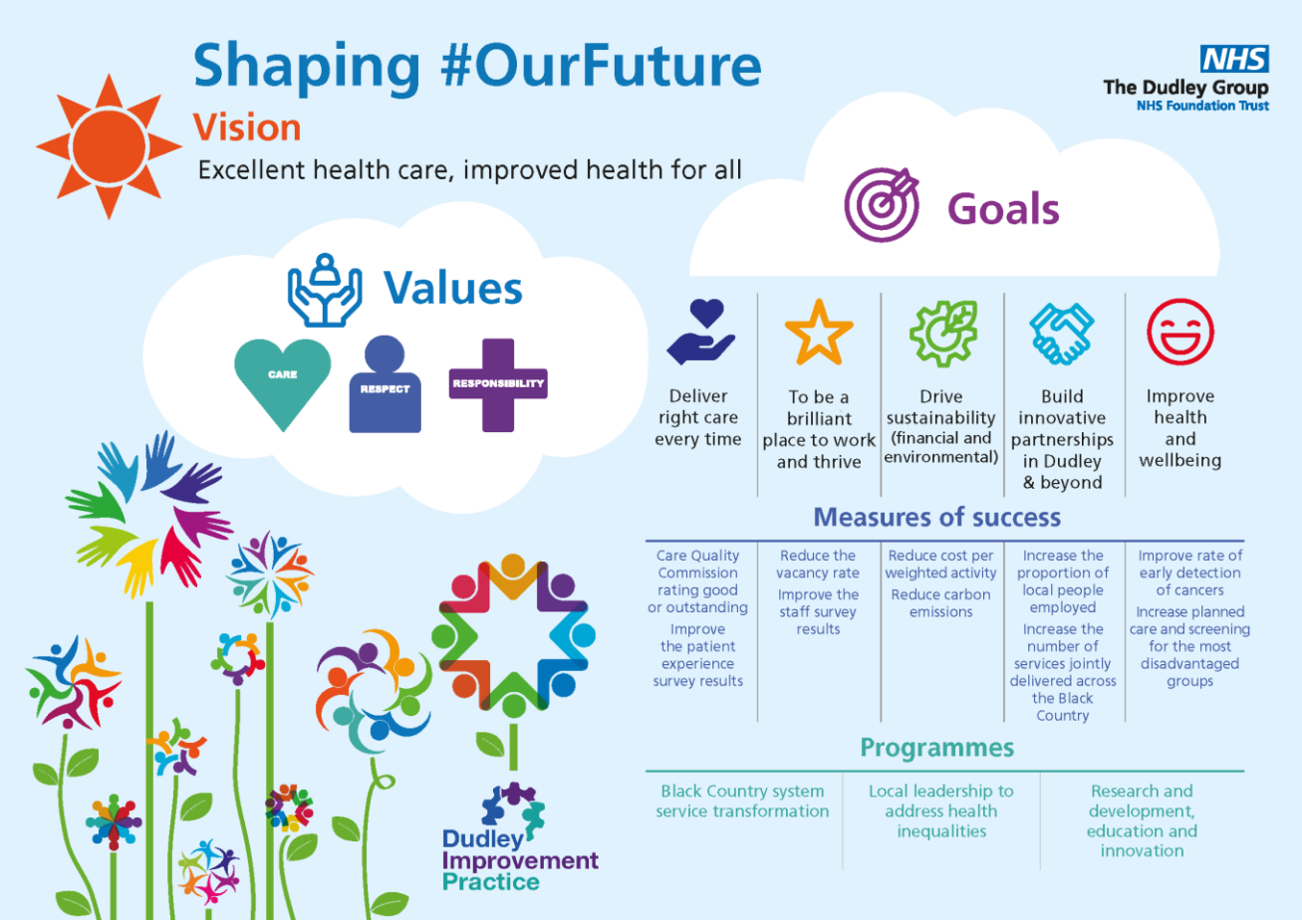
EXECUTIVE SUMMARY

This report summarises progress against the goals and measures of success in the Trust's strategic plan 'Shaping #OurFuture' and the annual plan 2024/25. Detailed progress updates were made to Executive Directors and the relevant Board sub-committees during April.

The committees received the reports as being a comprehensive reflection.

BACKGROUND INFORMATION

The Strategic Plan 'Shaping #OurFuture' was approved by Board of Directors in September 2021. Quarterly reporting on progress against the five goals and the three transformation programmes in the strategic plan has been in place since the last quarter of 2021/22.



Current status, progress in the past quarter and actions planned for the next quarter for each workstream contributing to the delivery of the goals has been compiled. This has been presented to Executive Directors and then at the respective board committees according to the following schedule of delegation for assurance.

Goal	Committee
Deliver right care every time	Quality
Be a brilliant place to work and thrive	People
Drive sustainability	Finance & Productivity
Build innovative partnerships in Dudley and beyond	Integration Committee
Improve health & wellbeing	Integration Committee

The committees have received the detailed reports in April as being a comprehensive reflection with no changes requested. Appendix 1 contains the summary of status against each measure of success.

Progress to highlight from quarter 4 2024/25

- Continued good performance against the constitutional targets for elective care;
- Continued good performance for mortality;
- Vacancy rate remains below the target of 7% with low turnover for nursing, midwifery and AHP staff;
- 'ICan' programme to support local employment achieved more than target;
- Ahead of trajectory for reducing 52-week waiters;
- Achievement of the financial plan.

- Number of complaints and response times have not reduced as originally planned.
- Planned reduction in bank usage has not been delivered, in part due to the continued use of surge areas and waiting list initiatives to deliver elective targets.

A copy of the full quarterly report that went to the Committees is included in the reading pack if further information is required.

This is the last time this report will be submitted in this format. Following the completion of the annual plan for 2025/26 a new format will track progress against the in-year objectives and the assurance metrics that show whether the strategy is being delivered. First report will cover the period April – June 2025.

RISKS AND MITIGATIONS

Risks and mitigations associated with delivery of the strategic plan are recorded within the Board Assurance Framework which is reported to public Board.

RECOMMENDATIONS

To note the strategy progress report for Q4 2024/25.

Ian Chadwell
Deputy Director of Strategy
30th April 2025

APPENDICES:

Appendix 1 – Summary progress against strategy and objectives in the annual plan 2024/25

Appendix 2 – Strategic Planning Framework 2024/25 as agreed by Board of Directors

Appendix 1

Summary progress against strategy and objectives in the annual plan 2024/25

Goal, success measure and objective from annual plan	RAG rating	
	This quarter	Last quarter
Deliver right care every time		
Measures of success		
CQC good or outstanding		
Improve the patient experience results		
Achieve NHS constitution targets		
Objectives from the annual plan		
Reduce complaints by 15% compared to 23/24		
90% of complaints to be responded to in 30 days		
Increase responses to patient experience survey by 20%		
Reduction in incidents resulting in significant harm		
Standardised hospital mortality index (SHMI) better than England average		
Re-admission within 28 days better than England average		
Eliminate 65 week waits by September 2024 and reduce 52 week waits		
Improve productivity (reduce DNA rate to better than England average, increase PIFU to 5%, theatre utilisation 85%)		
Be a brilliant place to work and thrive		
Measures of success		
Improve the staff survey results to better than England average		
Reduce the vacancy rate to 7% or below		
Objectives from the annual plan		
Improve retention rates for nursing, midwifery and AHP groups		
Bullying and harassment – staff survey results better than England average		
Raising concerns – staff survey results better than England average		
Recommend trust as a place to work – staff survey results better than England average		
Drive sustainability		
Measures of success		
Reduce cost per weighted activity to better than England average		
Reduce carbon emissions (year-on-year decrease to achieve net zero by 2040)		
Objectives from the annual plan		
Deliver financial plan (deficit of £32.565m)		
Deliver recurrent cost improvement programme of £31.896m		
Reduction in use of bank by 25%		
Build innovative partnerships in Dudley and beyond		
Measures of success		
Increase proportion of local people employed to 70% by Mar-25		
Increase the number of services delivered jointly across the Black Country		
Objectives from the annual plan		
A total of 35 people into work via ICan (through jobs and skills hubs or paid work experience		
Improve discharge processes		
Improve health and wellbeing		
Measures of success		
Improve rate of early detection of cancers (75% of cancers diagnosed at stages I,II by 2028)		
Increase planned care and screening from disadvantaged groups		
Objectives from the annual plan		
Achieve acceptable coverage for breast screening (70%) and work towards achievable level (80%)		

Appendix 2

Strategic Planning Framework 2024/25

	DRIVE SUSTAINABILITY	RIGHT CARE EVERY TIME		INNOVATIVE PARTNERSHIPS	HEALTH & WELLBEING	BRILLIANT PLACE TO WORK
	Finance	**Experience**	**Quality**	**Access**	**Inequalities**	**Workforce**
Success Measures	Achieve financial sustainability	Improve our patient experience results	CQC rated good or outstanding	Achieve NHS Constitution targets (Referral to treatment, diagnostics, cancer, emergency access)	Improve rate of early detection of cancers	Staff survey results above England average
	Reduce cost per weighted activity to better than average			Increase the number of services delivered jointly across the Black Country	Increase planned care and screening from disadvantaged groups	Reduce vacancy rates
	Reduce Carbon Emissions				Increase proportion of local people employed	
In year objectives	Deliver financial plan (deficit of £32.565m)	Reduce complaints by 15% compared to 2023/24	Reduction in incidents resulting in significant harm (moderate, severe, death)	Eliminate 65 week waits by Sept 24 and reduce 52 week waits	Achieve acceptable coverage for breast screening (70%) and work towards achievable coverage (80%)	Improve retention rates for Nursing, Midwifery and AHP groups in particular retain 80% of our internationally recruited workforce
	Deliver recurrent cost improvement programme of £31.896m	90% of complaints to be responded to in 30 days	Standardised Hospital Mortality Index (SHMI) (quarterly) better than England average	Improve productivity (reduce DNA rate to better than England average, increase PIFU to 5%, theatre utilisation at 85%)	A total of 35 people into work via ICan (through jobs and skills hubs or paid work experience)	Bullying and harassment - experience of bullying from managers - staff survey results better than England average experience of bullying from colleagues: staff survey results better than England average
	Reduction in use of bank by 25%	Increase responses to patient experience survey by 20%	Re-admission within 28 days better than England average	Improve discharge processes (30 discharges per day from MOFD list, 90% of patients to be discharged within 24 hours once known to system partners, reduce number of incomplete discharges on the complex list – no more than 5% failed per day, 30% of In-patient's discharges are home for lunch for each RHH ward		Raising concerns - I feel safe to speak up staff survey results better than England average
						Recommend trust as a place to work staff survey results better than England average
Multi-year commitments	Delivery of Digital 3 year Plan					
	Work collaboratively to increase elective capacity Delivery of Financial Recovery Plan Productivity (outpatient transformation, theatre utilisation, discharge)					
	Delivery of People Plan and associated journeys (Recruitment and Retention, EDI, Wellbeing, OD and leadership)					
	Delivery and Implementation of Community Diagnostic Centre					
	Implement Delivery plan for maternity and neonatal services					
	Transformation and integration of community services					
	Implement Targeted Lung Health Check Programme					
	Working towards university hospital status (DGFT, SWBH and Aston University)					
Task and finish	Consolidate payroll function across provider collaborative	Redevelopment of resuscitation area in ED	Embedding of Patient Safety Incident Response Framework (PSIRF)	Transfer services from DIHC into DGFT	ICan (pre-employment programme)	Establishment and embedding of the Brilliant Place to Work group to deliver actions associated with the Culture and Learning journey
	Corporate improvement programme	Discharge, Nutrition, hydration and pain quality improvement programmes established	Provision of more services in the Family Hubs to provide better services to families	Establish structures to support DGFT becoming Lead Provider for Dudley Health and Care Partnership by March 2026	Develop policies and procedures around patient equality	An improvement project to be included in each staff appraisal as part of embedding the Dudley Improvement Practice
		Development and implementation of dementia and delirium and autism and learning disability strategies			Contribute to design of Health Innovation Dudley and the range of courses offered	Establishment and embedding of the recruitment and retention group to deliver actions associated with the journey
		Shared across Joint Provider Committee (Black Country)		Shared across Dudley Health & Care Partnership		

Enclosure 8

The Dudley Group NHS Foundation Trust

Paper for submission to the Full Council of Governors on 19 June 2025

Report title:	Annual Plan 2025/26 – final submission and narrative plan document
Sponsoring executive:	Adam Thomas Group Chief Strategy and Digital Officer
Report author:	Ian Chadwell, Deputy Director of Strategy

1. Summary of key issues using Assure, Advise and Alert

Assure

The annual plan was approved at an extraordinary private board meeting on 26th March following extensive discussions at Board. The narrative document describes the six objectives identified and how the plan fits into the longer-term strategy refresh.

Alongside the plan, the Board also agreed an assurance statement requested by Black Country ICB and NHS England. The Board of Directors meeting (public session) received and approved the final annual plan 2025/26.

Advise

The plan commits the trust to delivering all the success measures in the priorities and operational planning guidance for 2025/26.

The annual plan requires the trust to achieve cost improvement of £39m with planned total expenses of £611.5m. Schemes are in development for £30m with a further £8.9m currently unidentified. The plan commits the trust to delivering 1% more cost weighted activity than the outturn for 2024/25 at reduced cost, with an implied productivity growth of 3.3%. The plan includes additional funding from NHS England and the ICB in order for the trust to submit a balanced financial plan.

NHS England sought assurance from the trust that all cost improvement plans had been developed by 16th May. Weekly assurance meetings were in place. Project initiation documents are being developed, starting with the schemes that are fully developed or in planned development.

The plan commits the Trust to reducing the overall workforce size by 335 wte (5%) made up of a reduction of 135 wte (2%) substantive staff and large reductions in bank (196 wte equivalent to 32%). Agency use in the trust is already very low but the plan does commit us to deliver a further reduction of 4 wte.

Alert

A high proportion of schemes remain as ‘opportunities’ with detailed delivery plans still in development. There is a further unidentified CIP of £8.9m. The plan does not include system-wide transformation of services and plans to progress this are required to be developed.

2. Alignment to our Vision	
Deliver right care every time	**x**
Be a brilliant place to work and thrive	**x**
Drive sustainability (financial and environmental)	**x**
Build innovative partnerships in Dudley and beyond	**x**
Improve health and wellbeing	**x**

3. Report journey
Executive Directors – 18th March 2025 Extraordinary Board of Directors – 26th March 2025 Finance & productivity Committee – 27th March 2025 Public Board of Directors – 8th May 2025 Full Council of Governors Meeting – 19 June 2025

4. Recommendation(s)
The Council of Governors is asked to:
a) Note the content of the annual plan;
b) Note the content of the board assurance statement which was forwarded to the ICB.

5. Impact		
Board Assurance Framework Risk 1.1	X	Deliver high quality, safe person centred care and treatment
Board Assurance Framework Risk 1.2	X	Achieve outstanding CQC rating.
Board Assurance Framework Risk 2.0	X	Effectively manage workforce demand and capacity
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Board Assurance Framework Risk 7.0	X	Achieve operational performance requirements
Board Assurance Framework Risk 8.0	X	Establish, invest and sustain the infrastructures, applications and end-user devices for digital innovation
Is Quality Impact Assessment required if so, add date:		
Is Equality Impact Assessment required if so, add date:		

REPORTS FOR ASSURANCE

Annual Plan 2025/26 – final submission

Report to Public Board of Directors on 8th May 2025

1 EXECUTIVE SUMMARY

The annual plan has been developed over a series of weeks in the context of strategy development, most recently at the Board training and development day on 13th February. The narrative document describes the six objectives identified and how the plan fits into the longer term strategy refresh.

Private trust board met on 26th March to approve the plan and agree the assurance statement requested by Black Country ICB. The plan commits the trust to delivering all the success measures in the priorities and operational planning guidance for 2025/26.

The annual plan requires the trust to achieve cost improvement of £39m with planned total expenses of £611.5m. Schemes are in development for £30m with a further £8.9m currently unidentified. The plan commits the trust to delivering 1% more cost weighted activity than the outturn for 2024/25 at reduced cost, with an implied productivity growth of 3.3%. The plan includes additional funding from NHS England and the ICB in order for the trust to submit a balanced financial plan.

NHS England is seeking assurance from the trust that all cost improvement plans have been developed by 16th May. Weekly assurance meetings are in place. Project initiation documents are being developed, starting with the schemes that are fully developed or in planned development.

A high proportion of schemes remain as 'opportunities' with detailed delivery plans still in development. There is a further unidentified CIP of £8.9m. The plan does not include system-wide transformation of services and plans to progress this are required to be developed.

2 BACKGROUND INFORMATION

Following publication of the planning support tool and planning guidance in January, work has continued to develop the annual plan.

A headline submission was made to the ICB on 14th February which in turn populated the system headline submission on 27th February. A planning assurance meeting was held with the ICB on 5th March to clarify the content of the plan. The level of unidentified CIP presented the greatest risk.

A full submission was made to the ICB on 14th March following verbal update and discussion with directors on 11th March. A final submission was made to the

ICB/NHS England on 26th March following agreement of distribution of finances between different organisations in the system.

This submission was discussed at the extraordinary private board of directors on 26th March. Following receipt of feedback from NHS England on the system's plan, a further system submission is required by 30th April. The Trust has been requested to change the expected delivery date for elimination of 52+ week waiters (moved from delivery at the end of quarter 1 to delivery at the end of quarter 2). This paper provides visibility of the plan to a wider audience.

Activity and performance trajectories

Activity and performance trajectories for the full submission include activity plans as well as the performance trajectories included in the headline submission.

Success measures	Period	Target	Trust value	Comment
Reduce the time people wait for elective care				
Improve the percentage of patients waiting no longer than 18 weeks for treatment	Mar-26	65%		Current performance 58.2% (Dec-24). Trajectory under development
Improve the percentage of patients waiting no longer than 18 weeks for a first appointment by at least 5 percentage points year on year	Mar-26	67.7%		Baseline is 62.7% in November making our target 67.7% by Mar-26. Trajectory under development
Reduce the proportion of people waiting over 52 weeks for treatment to less than 1% of the total waiting list	Mar-26	1% of total list		Trajectory shows elimination of 52+ week waits by Jun-25
Improve performance against the headline 62-day cancer standard	Mar-26	75%	75%	Trajectory increases from current 71% to 75% by end of the planning period
Improve performance against the 28-day cancer Faster Diagnosis Standard	Mar-26	80%	82%	Achieves compliance
Improve A&E waiting times and ambulance response times				
Improve A&E waiting times	Mar-26	78%	78%	Trajectory show compliance as currently achieving at least this
A&E 12 hours (type 1 only)	2025/26	better than 2024/25		Current proposed trajectory shows absolute number of 12 hour breaches as less than 24/25 forecast outturn
Live within the budget allocated, reducing waste and improving productivity				
Deliver a net balanced financial position	2025/26			Current financial plan shows a deficit but is line with NHSE deficit funding
Reduction in agency expenditure	2025/26	30% reduction on 24/25		Plan delivers the required reduction
Close the activity / WTE gap against pre-COVID levels	2025/26	Not specified		More information about this expected in technical guidance. Model Hospital does publish metrics on clinical activity per WTE

Workforce

Workforce trajectory shows a 5% reduction overall made up of 2% reduction in substantive, 32% reduction in bank and 40% reduction in agency. The plan includes known additions to staff such as through the Community Diagnostic Centre, ICan programme and additional deanery doctors.

Delivery plans include:

- Reduction in bank rates from 31st March 2025
- Reduction of waiting list initiatives being addressed in the quality and productivity workstreams
- Taskforce to reduce sickness absence
- Exit plans for all instances where agency being used
- Payment of shifts at the right band
- Stretch target to be achieved through ongoing grip & control

Financial plan

The expectation is that the trust achieves a balanced financial plan during the year with total expenses of £611.5m. In order for this to be achieved, the trust will receive additional funding from NHS England (the trust's share of the £95m deficit funding across the Black Country system). The trust needs to deliver cost improvement savings of £39m. The table below summarises the current status of these schemes. Schemes for £30m are under development with a further £8.9m unidentified.

Scheme	Status	Outpatients £m	UEC / Non-elective £m	Electives £m	Temporary Staffing £m	Corporate & Commerical £m	Divisional Savings/ Other Acute £m	Total £m	Category
CIP Values identified by Quality and Productivity Groups									
Reduction in WLIs and other costs through improved productivity	Agreed at Group	2.9						2.9	**Opportunity**
Reduction in WLIs and other costs through improved productivity	Agreed at Group			1.3				1.3	**Opportunity**
Reduction in Agenda for Change Bank Rates	Previously Agreed				2.2			2.2	**Fully developed in delivery**
Improved Sickness Rates	Final Agreement Required				0.5			0.5	**Opportunity**
Right Shift Right Band	Final Agreement Required				0.1			0.1	**Opportunity**
Agency Reduction	Final Agreement Required				0.35			0.35	**Plans in progress**
PFI	Agreed at Group					0.65		0.65	**Plans in progress**
Contract Mgt within divisions	Agreed at Group					0.2		0.2	**Opportunity**
Corporate Contract Management	Agreed at Group					0.2		0.2	**Opportunity**

Payroll Shared Service	Agreed at Group					0.05		0.05	**Fully developed in delivery**
Other Identified CIPs aligned to Groups									
Procurement							0.9	0.9	**Fully developed in delivery**
CNST	Confirmation required						0.5	0.5	**Fully developed in delivery**
High Cost Drugs	Confirmation required						0.5	0.5	**Fully developed in delivery**
Stretch Agreed at Directors		1.1	7.0		2.2	0.8	8.6	19.7	**Opportunity**
Total identified		4.0	7.0	1.3	5.4	1.9	10.0	30.0	
Unidentified Gap							8.9	8.9	**Unidentified**
Grand Total		**4.0**	**7.0**	**1.3**	**5.4**	**1.9**	**19.4**	**39.0**	

3 RISKS AND MITIGATIONS

The following risks have been identified:

- The current level of CIP is high. Urgent work is underway in the quality and productivity workstreams focused on realising the cost opportunity as highlighted in the productivity and efficiency packs. All workstreams are now active;
- NHS operational pressures will impact the ability of service leads and clinical leads to engage in the transformation required to deliver the plan. This will be mitigated by releasing clinical time to support the transformation.

4. RECOMMENDATION(S)

Board of Directors is asked to:

- Approve the content of the annual plan;
- Note the content of the board assurance statement which was forwarded to the ICB.

Ian Chadwell
Deputy Director of Strategy
24th April 2025

APPENDICES:

Appendix 1 – Annual plan 2025/26 narrative (technical appendices with trajectories)
Appendix 2 – Board Assurance Framework

Appendix 1

The Dudley Group
NHS Foundation Trust

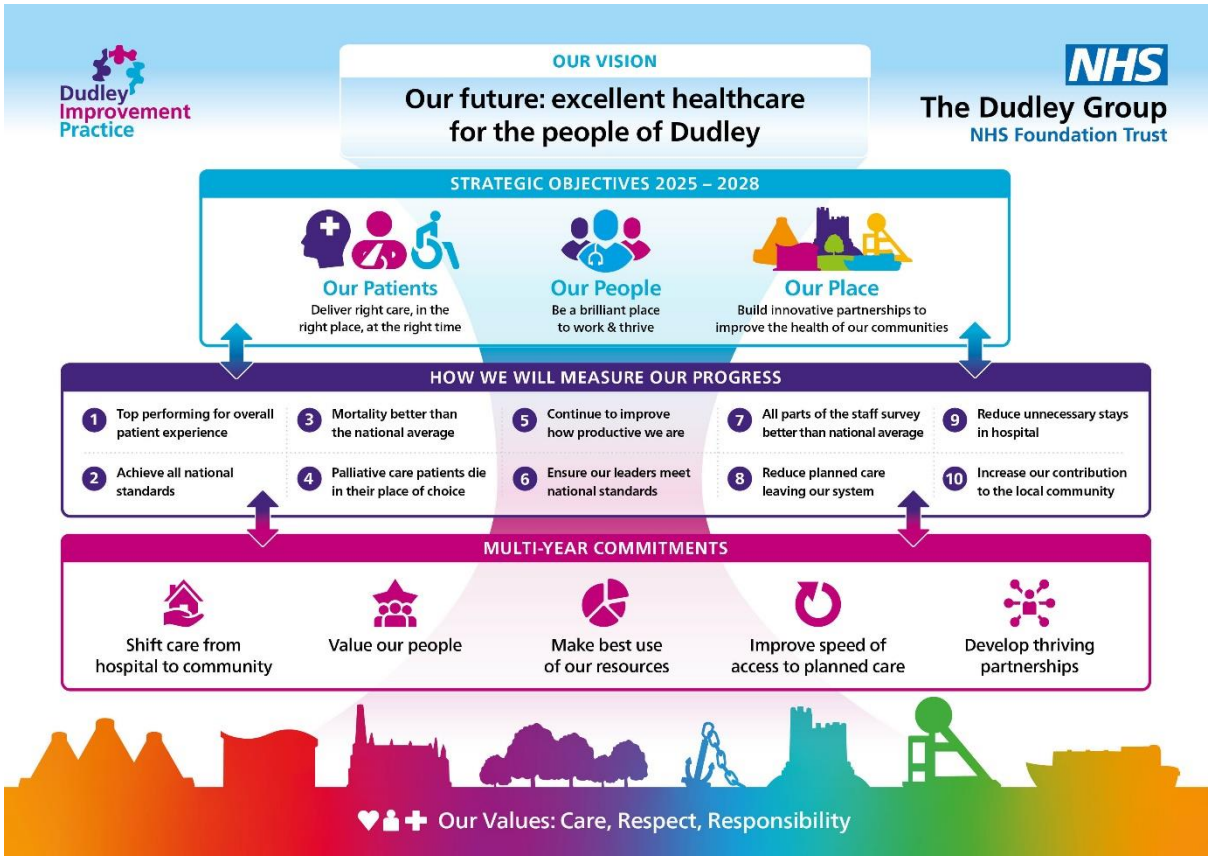
Annual Plan
2025/26


Dudley Improvement Practice
ANNUAL PLAN 2025 – 2026
This is how we will deliver our plan
NHS
The Dudley Group
NHS Foundation Trust
MULTI-YEAR COMMITMENTS
Shift care from hospital to community
Value our people
Make best use of our resources
Improve speed of access to planned care
Develop thriving partnerships
IN-YEAR OBJECTIVES
Implement care navigation centre
Implement a new model of care for urgent and emergency care
Develop an anti-bullying, anti-discrimination culture
Establish an elective hub south of the Black Country
Transform outpatient services
Transform corporate services
TASK AND FINISH PROJECTS
Implement community portal and develop a case for electronic patient records
Maximise potential of same day emergency care by reviewing operating hours
Develop a new model for frailty
Increase membership for all staff networks
Use national manager development framework to develop and deliver internal career progression framework
Implement productivity/financial recovery programme
Improve theatre productivity
Implement the Community Diagnostic Centre
Automation of administration tasks
Optimisation of NHS App
Review of medical workforce
Standardisation of bank rates
Transform clinical services
Our Values: Care, Respect, Responsibility

Context - Strategic objectives and assurance metrics

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

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



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

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

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

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

- **NHS England operational planning guidance 2025/26**. This sets out targets to be achieved by all types of services and organisations in the NHS to improve quality and access. We have prioritised the metrics that will have the biggest impact for patients. In all instances, we have set ourselves at least the national or regional target (set by the Integrated Care System), or higher.

- **Care Quality Commission**. The standards set out by NHS England align with and inform the Care Quality Commission quality standards. Our annual objectives address key areas to improve our overall CQC rating.

- **NHS Staff Survey and People Plan.** Our people annual objectives, like our overall people plan, directly aligns to the national people plan.

- As with our strategy, we have considered other national strategies and guidance such as the **NHS Long Term Plan** and the **Joint Forward Plan** and **Integrated Care Strategy** in our Black Country Integrated Care System.

- The findings of the **Darzi review** and the emerging themes likely to feature in the government's 10-year health plan expected to be published in the spring. This is likely to signal the move to make providers accountable care organisations.

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

Multi-year commitments

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

Our in-year objectives for 2025/26

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

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

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

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

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

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

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

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

Task & Finish Projects

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

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

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

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

The role of Black Country Provider Collaborative

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

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

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

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

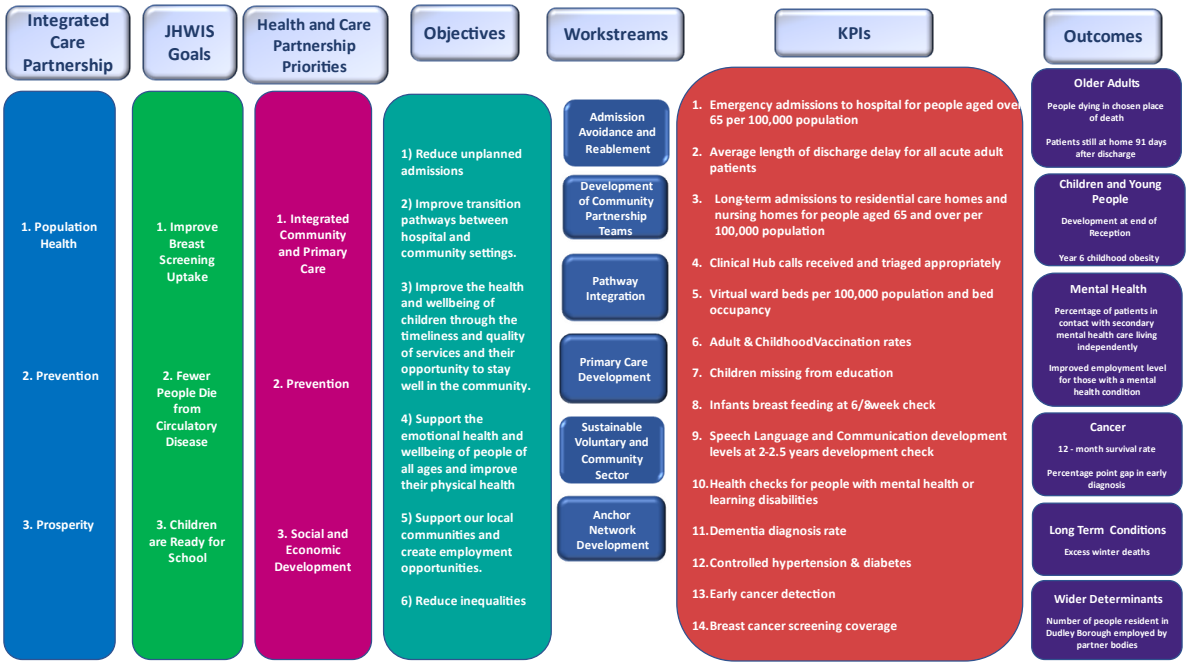
These developments are dependent on the creation of the elective hub which will release the necessary capacity in Russells Hall Hospital.

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

The role of Dudley Health & Care Partnership

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

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



Risks and Mitigations

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

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

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

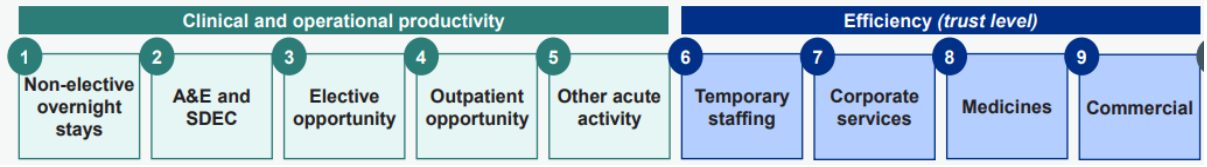
Governance

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

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

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

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



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

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

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

Appendix 1 – activity and planning trajectories agreed with ICB / NHSE
Appendix 2 – workforce trajectory agreed with ICB / NHSE
Appendix 3 – financial plan agreed with ICB / NHSE

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

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

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

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

Outpatients - ERF definition	Apr 2025-Mar 2026	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Outpatient procedures - ERF definition	79,180	6,259	6,259	6,572	7,198	6,259	6,885	7,198	6,259	6,572	6,572	6,259	6,885
Outpatient first attendances without a procedure - ERF definition	204,581	16,172	16,172	16,981	18,598	16,172	17,790	18,598	16,172	16,981	16,981	16,172	17,790
Outpatient follow up attendances without procedure - ERF definition	317,038	25,062	25,062	26,315	28,822	25,062	27,569	28,822	25,062	26,315	26,315	25,062	27,569

Time to first attendance		Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Patients waiting less than 18 weeks		18,695	18,695	18,695	18,695	18,695	18,695	18,695	18,695	18,695	18,695	18,695	18,695
Total patients waiting for first attendance		29,971	29,757	29,543	29,329	29,115	28,901	28,686	28,472	28,258	28,044	27,830	27,606

Incomplete RTT pathways		Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
RTT waiting list - total		44,339	44,064	43,789	43,514	43,239	42,964	42,689	42,414	42,138	41,863	41,588	41,313
RTT waiting list - 52+ weeks		691	600	415	277	139	-	-	-	-	-	-	-

RTT waiting list - less than 18 weeks		26,570	26,576	26,581	26,583	26,583	26,581	26,576	26,570	26,561	26,551	26,538	26,523

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

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

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

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

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

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

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

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

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

Appendix 2 – workforce trajectory agreed with ICB / NHSE

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

Appendix 3 – financial plan agreed with ICB / NHSE

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

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

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

Appendix 2

Section B: Provider Assurance

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

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

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

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

Enclosure 9

The Dudley Group NHS Foundation Trust

Paper for submission to the Council of Governors meeting 19th June 2025

Report title:	Quality Account 2024/25
Sponsoring executive:	Martina Morris - Chief Nurse and Director of Infection, Prevention and Control (DIPC)
Report author:	Jo Wakeman – Deputy Chief Nurse Jennifer Bree – Corporate Lead Nurse/Improvement

1. Summary of key issues

The annual Quality Account has been developed in line with national requirements and presented at the Executive meeting on 13th May and Quality Committee on 27th May 2025.

The document has also been shared for consultation with the following stakeholders:

- Trust Governors
- Integrated Care Board
- Health and Adult Social Care Scrutiny Group, who due to a recent change in vice chair and chair of the group, have been unable to provide a statement in response.
- Healthwatch, who made the decision not to provide a response to Quality Account this year due recent local cuts to services which have resulted in reduced capacity of the team.

The commentary received from each stakeholder has been included in the final version which will be published on 30th June 2025.

The annual quality priorities will now form part of a three-year Quality and Safety Delivery Plan. This will aid forward thinking, proactive management but also demonstrate sustainability in delivering quality safe care to our patients. This delivery plan will offer overarching priorities, and we will build on these priorities over a three-year period with renewed objectives each year. Reporting on progress will be ensured via the Quality Committee.

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

3. Report journey

Executive meeting - 13 May
Quality Committee - 7 May
Full Council of Governors – 19 June 2025
Trust Board - 26 June

4. Recommendation(s)

The Council of Governors is asked to:

a) Note the Quality Account 2024/25

b) Approve the governor's comments on the Quality Account 2024/25

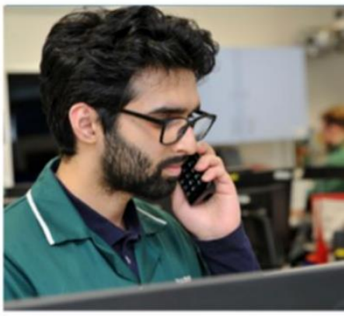
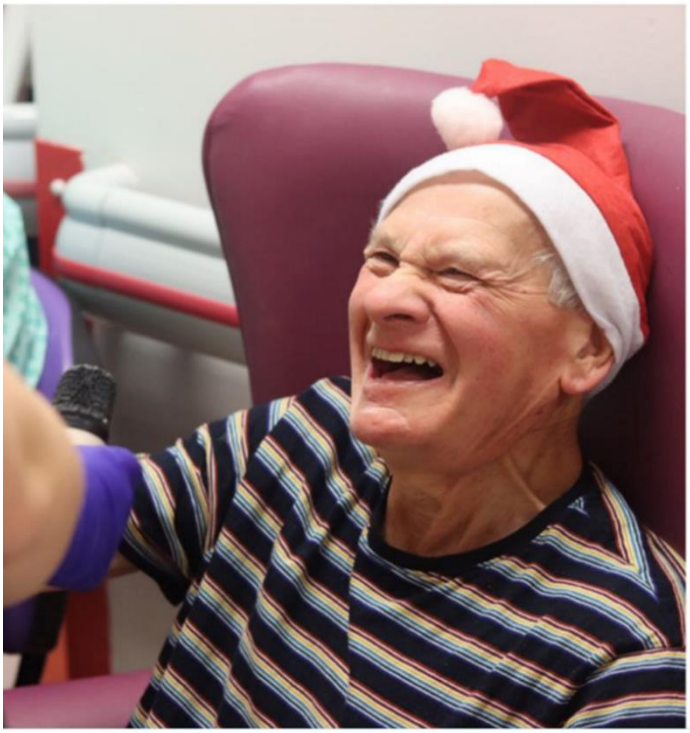
5. Impact		
Board Assurance Framework Risk 1.1	X	Deliver high quality, safe person-centred care and treatment
Board Assurance Framework Risk 1.2	X	Achieve outstanding CQC rating.

Our Patients
Our People
Our Place

NHS
The Dudley Group
NHS Foundation Trust

Quality Account
2024/2025




Our Values: Care, Respect, Responsibility

Our Patients
Our People
Our Place

NHS
The Dudley Group
NHS Foundation Trust

The Dudley Group NHS Foundation Trust Quality Account 2024/25

Contents

Foreward

All providers of NHS services in England have a statutory duty, under the Health Act 2009 and subsequent Health and Social Care Act 2012, to produce an annual report to the public about the quality of services they deliver. This is called the 'Quality Account' and includes the requirements of the NHS (Quality Accounts) Regulations 2010 as amended by the NHS (Quality Accounts) Amendment Regulations 2011 and the NHS (Quality Accounts) Amendment Regulations 2012.

The Quality Account aims to increase public accountability and drive quality improvement within NHS organisations. They do this by ensuring organisations review their performance over the previous year, identify areas for improvement and publish that information, along with a commitment to the public 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 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 2025/26. It also sets out the Quality Priorities we have agreed for 2025/26 and how we intend to achieve them.

This report is divided into the following four parts:

- Part 1 is a statement from the chief executive.
- Part 2 provides an end year position on 2024/25 quality priorities, sets out the quality priorities and goals for 2025/26 and explains how we have agreed them, how we intend to deliver 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 for 2024/25.
- The annexes at the end of the report include the comments of our external stakeholders alongside a glossary of terms used.

Part 1 – Introduction

1.1 Chief Executive Statement

Welcome to The Dudley Group NHS Foundation Trust's Quality Account for 2024/25.

I am delighted to introduce this year's Quality Account, which highlights the key areas of quality we monitor across our services. This report showcases examples of best practice, as well as areas where we are committed to making further improvements to ensure the highest standards of care for our patients.

2024/25 has been another significant year for The Dudley Group.

We have continued to champion our vision of 'Excellent health care, improved health for all', driving forward innovation and service improvements across the Trust.

Some of our key achievements this year include:

- **Launching 'Call for Concern'** – a vital safety service that allows inpatients, their families, carers, or advocates to seek urgent help if they feel a patient's deteriorating condition is not being fully recognised.
- **Breaking ground on our Emergency Department redevelopment** – a major transformation of our resuscitation area into a state-of-the-art facility.
- **Becoming one of the first Trusts in the UK to receive training status** from the International Bowel Ultrasound Group, reinforcing our commitment to clinical excellence.

Looking ahead, our ambitions remain high.

We are actively working towards fully achieving university hospital status in partnership with Aston University. This milestone will enable us to expand research opportunities, secure additional grant funding, and enhance our training facilities. As part of this journey, we will also refresh our identity to reflect this exciting new chapter.

One of the most transformative changes this year has been the integration of colleagues from Dudley Integrated Health and Care NHS Trust into our organisation. This move strengthens collaboration between primary and secondary care services, including the milestone acquisition of our first two GP practices. By bringing services closer together, we are improving continuity of care and ensuring patients receive the right support at the right time.

Of course, this year has not been without challenges. Demand for acute services continues to rise, and we remain focused on reducing waiting times for our patients. Our Emergency Department continues to see high numbers of patients, while across the Trust we are making significant progress in improving access to planned care. We are proud to have met all national targets to reduce long-waiting patients, whilst also supporting our partners across the Black Country.

Working in partnership with the Black Country Provider Collaborative, we have taken important steps to address inequalities in access and the quality of care across key clinical pathways. This work will continue to evolve to ensure all patients receive the highest standard of care, regardless of where they live.

Despite the pressures facing the NHS, our commitment to continuous improvement remains steadfast. It is particularly encouraging to see progress across several of our priorities for 2024/25, including:

- Enhancing shared learning across our organisation.
- Reducing theatre delays to improve efficiency.
- Using AI technology to support early decision-making.
- Improving patient survey results and overall patient experience.

As we look to the future, we are implementing a three-year quality and safety delivery plan, ensuring a long-term, sustainable approach to delivering safe, high-quality care. This proactive plan will support us in continuing to drive forward improvements for our patients, staff, and wider communities.

To ensure we deliver on quality in our areas, we monitor safety, clinical effectiveness, and patient experience through a variety of methods including:

- 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 provide 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 Committee, Finance and Performance Committee and People Committee.
- The Trust works with The Black Country Integrated Care Board to scrutinise the Trust’s quality of care at joint monthly review meetings, and the executives from both organisations meet bi-monthly.
- External assessments of the Trust’s services by regulators and peer review systems.

We are immensely proud of everything we have accomplished this year, and I want to take this opportunity to extend my heartfelt thanks to colleagues across every department at The Dudley Group.

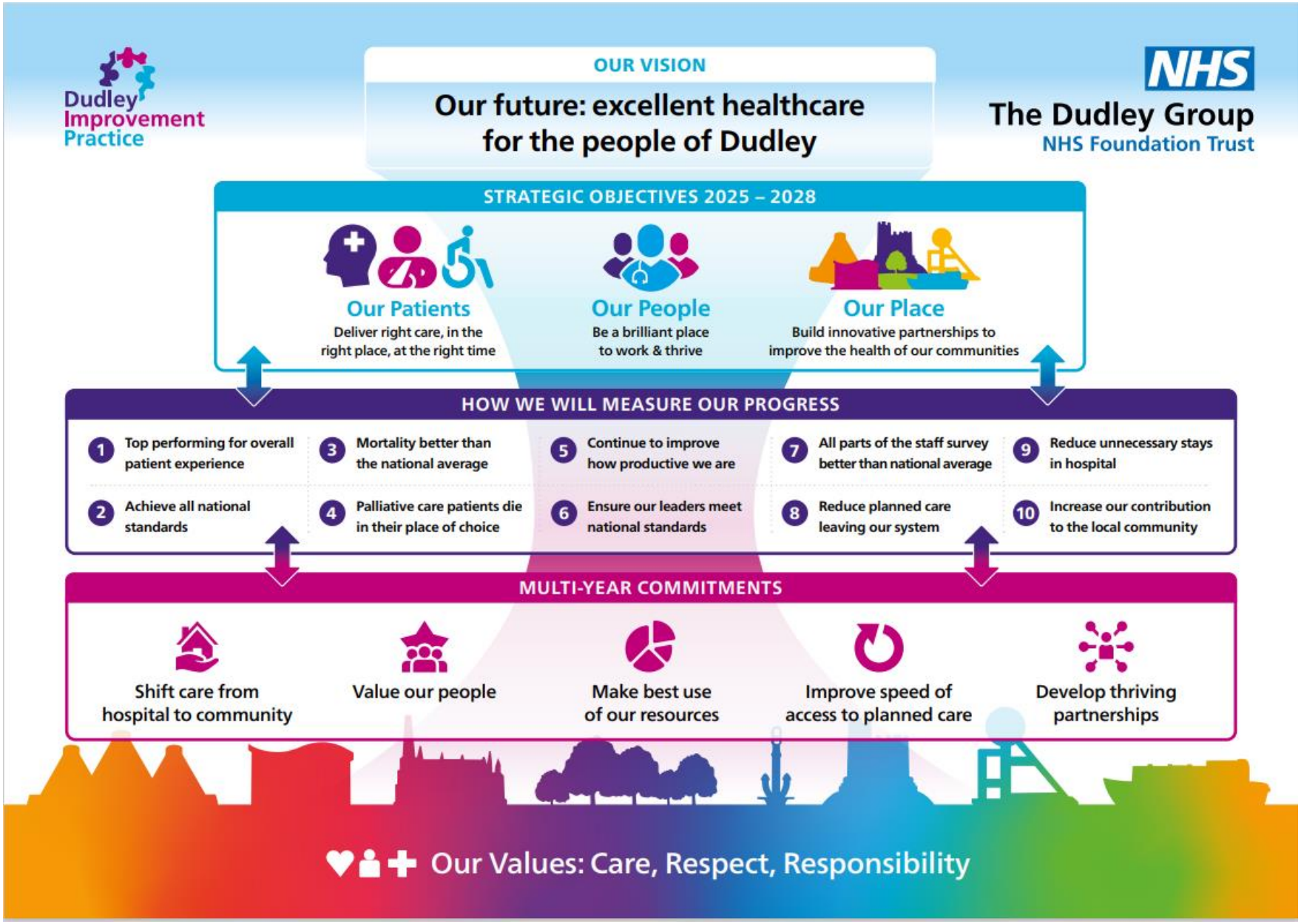
The dedication and resilience of our staff are the driving forces behind our priorities, ensuring that we continue to deliver outstanding care for our patients while fostering a supportive and inspiring workplace. Their hard work and achievements over the past year are truly commendable.

While challenges remain, our commitment to providing high-quality, safe care remains unwavering. We will continue to learn, improve, and uphold the highest standards, nurturing a culture of excellence across the organisation.

Throughout this report we have included as much information as possible and are confident in the accuracy of the data we have published.

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

1.1 Our vision and values



PART 2: PRIORITIES FOR IMPROVEMENT

2.1 QUALITY IMPROVEMENT PRIORITIES

Utilising internal intelligence, in consultation with internal and external key stakeholders and service user groups, the Trust commits 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 Trust's Quality Committee who provide oversight and receive assurance of the clinical care provided.

Looking Back

The table below provides a summary of the 2024/25 quality priorities as at the end of the year. This year has continued to be challenging with demand for acute services and continuing to reduce treatment time waits for our patients.

Overall there have been some improvement against the 2024/2025 demonstrated across all of the priorities. At year end the Trust achieved 14 green indicating achievement against target and 7 ambers against targets set indicating improvements have been made but target has not been achieved.

Patient Safety - Management of diabetes across all service within DGHFT as achieved 3 of the 3 targets. A diabetes dashboard is in development to create OP clinic capacity and capture data for NICE diabetes audit submission.

Clinical Effectiveness - Improve outcomes for our patients admitted with a fractured neck of femur. 4 out of 5 targets have been achieved. The SHIMI reduced from 133 TO 113 but did not achieve a goal of 100.

Improve outcomes for our patients admitted with cerebral vascular accident. All goals achieved.

Patient experience - To improve our patient Survey results in four key areas as identified as main themes from 2022 results received by the Trust October 2023. 79% of our patients said their pain was well controlled. 91% of our patients said we had met their dietary needs. Involving our patients in the discharge planning requires further work as 26-34% of our patients were aware of their discharge date.

Dementia and Delirium – against the targets one out of three targets have been achieved the appointment of an Admiral Nurse. Recording of chemical restraints within datix remains challenging. Our readmission rates for patients discharged with dementia remains in line follow a national pattern, linked to effective discharge planning and complexities of patients diagnosed with dementia

Learning Disabilities – two out of the four targets have been achieved. Steering group has been set up and 'bags of calm are in use. We have achieved 74% against a target of 90% for tier 1 Oliver McGowen training and 37% of clinical areas have a LD champion in place.

QUALITY PRIORITIES - 2024 / 2025 update

PRIORITY	WHERE ARE WE AT NOW HOW AND WHERE DO WE WHAT TO BE	WHO IS RESPONSIBLE Progress made Q3
1 Patient Safety **Management of diabetes across all service within DGHFT**	**Where are we now?** A monthly cross-divisional Insulin Safety Group has been established to support insulin safety across the Trust, review incidents and provide a Monthly and bi-annual thematic review. Noted high number of incidents but there is no single repository that shows categories of harm at a glance. Availability of hybrid closed loop systems for managing blood glucose levels insufficient to meet demand as recommended by NICE 2023. **Where do we want to be?** Achieved ➢ Development of a power BI report that categorises harm with data collected from Datix. ➢ Shared learning across the organisation with a focus in areas of high numbers of incidents. Working towards ➢ Development of a dashboard that captures those patients that a digital solution to the management of their diabetes.	**Consultant and Service Lead for Diabetes & Endocrinology** Regular engagement of Insulin Safety Group identifies and addresses areas of concern with regular feedback to the Insulin Safety Group members about progress. Referral and management arrangements and pathway are under the final review. We aim, as a first step, to switch within the next 2 years for all patients managed by insulin pump and those who are pregnant or planning pregnancy and have suboptimal diabetes control to closed loop insulin delivery (assuming the patient is willing to be moved to HCL). Relevant staff education is in progress. Harm data is regularly collected, discussed and actions addressed in Insulin Safety Group meetings. Extra sessions aiming to improve knowledge and confidence in management of diabetes on AMU and ED were delivered by Dr Solomon to different staff grades from nurses / PAs to junior doctors and consultants with very positive feedback. New NADIA harms joint project with IT and DOT nurses on reporting and preventing severe hypoglycaemia is in progress. A Power Bi report has been in use since July 2024 and is utilised for National Diabetes Inpatient Safety Audit (NDISA). Data is provided from this program for our Diabetes Business Meeting and Insulin Safety Group. A diabetes dashboard is in development to create OP clinic capacity and capture data for NICE diabetes audit submission.

	Where are we now? The starting position of SHMI for Fractured Neck of Femur was 133. This placed the Trust within the top 10 trusts for poor mortality of this condition. **Where do we want to be?** Achieved ➢ Improvement Group set up to include members of MDT ➢ The group will use the KPI's set out by the National Hip Fracture Database to identify areas where improvement could be made as well as data provided by Informatics. ➢ Early priority areas are to ensure that admission to a specialised ward/unit within an appropriate time is critical as per national standards. ➢ Reducing theatre delays. Working towards ➢ The aim is that the trust will be back within the expected range of 100 within 12 months and maintaining this.	**Consultant and Service Lead for Trauma & Orthopaedics** SHMI 113 at time of report. The Fractured Neck of Femur Improvement Group was established in January 2024 it includes members from Theatre, Anaesthetics, Orthogeriatric, Care of the Elderly, Therapies, Informatics and Clinical Coding. There is an improvement action plan in place that uses the KPIs set out by the National Hip Fracture Database to identify areas where there may be improvement made. The group meets fortnightly to monitor progress and discuss the work streams that have been allocated. A dedicated bed on B2 has been agreed which will allow for patients to be moved to the appropriate ward for optimal care. Currently a Power BI report is being created that will allow the group to fully monitor the individual KPIs and act appropriately if there is an issue identified. 100% of the eligible patients reviewed had been mobilised within 24 hours of surgery – the national average is 81%. By improving the time to surgery and transfer to an appropriate ward not only will patient care be improved but also flow in ED. Additional theatre capacity has been allocated. The group is exploring long day theatre sessions to further increase capacity. The trust is now seeing the average time of 34 hours to surgery following attendance, this is

		under the expected 36 hours. Of those reviewed 66% of the eligible patients were operated on within 36 hours. **Consultant and Service Lead for Stroke**
	Where are we now? The starting position for Stroke SHMI was 135 and there was evidence of reduced SSNAP compliance for recent periods. We have identified lack of access to specialist Stroke beds and delays in CT head acquisition. The latest data shows that we have now achieved SSNAP level C with prioritisation of a thrombolysis bed at all times and rapid vetting of CT head requests has been facilitated. There is still an issue with swallowing assessments being done on time, which is being reviewed by the senior AHP team. **Where do we want to be?** Achieved ➢ The key ambition is to reach a SSNAP score of 70 (Level B) by Q3. ➢ Review and implement New Stroke guidelines published April 23. Will require us to provide additional therapy input for all stroke patients. ➢ AI technology will automatically report CT head within minutes of image acquisition to enable early decision for thrombolysis. It will also enable rapid image transfer between secondary and tertiary sites, improving access to mechanical thrombectomy, as well as thrombolysis, for stroke.	SHMI 103 at time of report. This is now the national average for this condition. Data shows that we achieved a SSNAP level B. Improvement to performance has been driven by implementing a B7 bed manager who liaises directly with the site team to enable stroke patients to be admitted to the unit within 4 hrs, prioritisation of a thrombolysis bed and the implementation of Rapid AI in May 2024 has enabled CT head reports to be available quicker which has enabled timelier treatment planning. Swallow assessments have shown improvement since the last update and has achieved the performance target of 100% in May 24. AHP senior team are currently completing a workforce strategy plan to attract potential therapy students to the trust due to challenges with recruiting into vacant therapy posts. The AHP senior team have also implemented dual roles between physio, occupational and Speech and language therapists to work towards stroke patients receiving the additional therapy input as per the new Stroke guidelines. Rapid AI was implemented in DGFT in May 24 and the % of patients who have received thrombolysis of all strokes has improved from 5% (Mar 24) to 18% vs 20% target (May 24). However, the Stroke team are working closely with Radiology colleagues and the Black Country ICB to enable the clinical

	Where are we now? The results of the 2021 Adult Inpatient survey were published on the CQC website on 12 September 2023. Responses were received from 454 patients at The Dudley Group NHS Foundation Trust (38%). This compares with an average response rate of 40%. The Overall Patient Experience Score (OPES) ranged from the lowest score in England of 7.4 to the highest trust score in England of 9.1. The Trust score for 2022 is 7.8 in comparison to 8.0 in 2021 and is performing 'about the same' when compared to all other trusts. The Trust is in the bottom 5 of trusts with the lowest score in comparison to other trusts within the region. A small number of questions within each section are performing 'somewhat worse than expected/worse than expected' in comparison to the average of Trusts surveyed and these include pain management and hydration & nutrition. **Where do we want to be?** The patient survey results highlight four key themes as detailed below with communication running through each of the themes. The Chief nurse has agreed RSO to support each work stream. To improve our patient experience results in the following areas. Achieved ➢ Pain ➢ Nutrition and hydration Working towards	teams at DGFT to receive training for CT perfusions via Rapid AI, which will improve access to mechanical Thrombectomy. **Deputy Chief Nurse** 113 audits have been carried out in Q4 by our patient experience team/Dudley Healthwatch and our volunteers to access impact of work streams. In Q4, 79% of patients stated 'yes definitely' that staff did all they could to help control their pain in the medicine division, a small improvement from the previous quarter (78%). 74% stated 'yes definitely' in the surgery division, a decline from the previous quarter (84%). 91% of our patients stated they had enough to drink in the surgery division, an improvement from the previous quarter (89%). 88% stated 'yes, always' in the medicine division, a small decrease since Q3 (89%). Where the question was applicable, 26% of our patients stated that we had met their dietary needs in the surgery division (compared to 24% in Q3) and 43% in the medicine division (compared t0 26% in Q3). 59% of our patient's stated the food was very good /good in the surgery division (compared to 67% in Q3) and 67% in the medicine division (compared to 65% in Q3). 54% of our patients stated that someone had spoken to them regarding their discharge in the surgery division, an improvement from the previous quarter (51%) and 40% in

	➢ Discharge Data to be captured each month through our volunteers and audits within AMaT. This will allow for triangulation of data with our RSO ensuring the voice of our patients is reflected in future developments. The RSOs will report through patient experience on progress. ➢ The aim is to improve our overall scores through providing a better patient experience. **Where we are now?** The Dementia and Delirium Team (Formerly Older People's Mental Health Team) are the first point of call for patients with complex vulnerabilities, such as Dementia, Delirium, Korsakoff's and behaviours that challenge and require restrictive interventions, to offer support and advice. Our Dementia data against find, refer and treat has been inconsistent and below agreed compliance. Chemical restraint needs further education improving accuracy of data within Datix. To understand the high readmission rates for those patients with delirium **Where we want to be:** Achieved ➢ Appoint two Admiral Nurses to support the Delerium agenda. Working towards ➢ Monitor Datix for high numbers of chemical restraint being used to provide focused training and education. ➢ To review high readmission rates and understand the reason for readmission and provide learning for any readmissions for failed discharges.	the medicine division, compared to 39% in Q3. 26% of our patients stated they had been informed of their discharge date in the surgery division (in comparison to 47% in Q3) and 34% in the medicine division, a small improvement from the previous quarter (33%). Progress against actions is monitored through updates at the Patient Experience Group meeting for assurance of recommendations having been completed and improvements made. **Deputy Chief Nurse** One Admiral Nurse has started in post 2.9.24. Funding was reduced from two Admiral Nurse posts to one post. The Admiral Nurse service is in process of a soft roll out across RHH. As the Admiral Nurse service develops, the aim is for an audit to take place of the impact of this service and prevention of readmissions of patients with a diagnosis of dementia who have been under the care of the Admiral Nurse service. The service is anticipated to have a positive impact within this area. Current readmission rates of patients with a diagnosis of dementia reflect national patterns and are linked to effective discharge planning and understanding the complex needs of patients diagnosed with dementia. The Admiral Nurse service is anticipated to have an impact on this area with the patients that they are actively involved in. An audit is planned to take place during quarter 4 to review readmissions for patients that have used the Admiral Nurse service. This will support the service to become

	• Aim to reduce readmissions. • Evidence of training and education provided to areas with high usage of chemical restraint. • Reduction of Datix incidents in Q4 once Admiral nurses embedded. **Where are we now:** The NHS learning disability standards benchmarking exercise has identified gaps in the current Trust wide provision offered to people with a learning disability.	embedded before measuring service impact. A band 4 Associate Nurse has been recruited to the Dementia and Delirium Team. A start date is pending as awaiting confirmation of the recruit passing their qualification from the external examination board. Once confirmed (indicated within next few weeks) the recruit can start pending their PIN. In terms of raising the delirium profile, this is being addressed within the increased 30 min to 1 hour training session for Dementia Awareness. World Delirium Awareness Day took place 12.03.25 and the Dementia and Delirium team, Admiral Nurse, MCA lead and MH lead will be supporting with communication and interaction with the wards to further raise this. Delirium questions have also been included within the Core Service Review team so a deep dive across wards of their understanding and awareness of delirium can be gauged. The raising of this area continues which will impact length of stay and use of chemical restraint. Further work has taken place regarding a data cleanse of FAIR data. Data is now being reported accurately by Information Governance and compliance levels are being achieved for the Find element as part of the dementia agenda. Due to the ratio of referrals being actioned from Assess, Investigate and Refer from the number of referrals Trust wide in relation to the small team to complete this work, compliance is not being met within these areas. The Nursing Associate once in post should support addressing this. Reporting of chemical restraint remains poor across the Trust. There

	Where we want to be: Achieved ➢ Embedded learning disability steering group with divisional representation. ➢ Scope and establish mobile resources 'bag of calms' that can be made available for those patients that require them. Working towards ➢ Compliance of 90% for Oliver McGowan training. ➢ Develop champions in every area to support learning disability agenda The Learning Disability Standards action plan will be monitored through Internal Safeguarding Board (ISB) and report into Patient Experience Group. Sensory calm bags are being used throughout the Trust	are now set questions around the use of restraint within Datix. Incidents of Datix under Violence and Aggression category are monitored by the Lead for Mental Health and where chemical restraint has been used but not reported, feedback will be given to the staff and request to reflect this in the Datix. A previous request for security staff to have Datix login details and to report incidents of restraint where clinical staff are not involved e.g. public areas outside of clinical areas where security are first responders is yet to see reporting of such incidents. Meetings are taking place with Mitie and Security to review a process for security to feedback on Datix incidents that they are involved with to ensure the correct terminology is documented. The security Restraint Assessment Records are being used to identify missing Datix reports. These are raised with the staff involved in that incident. This is to raise compliance levels of recording restrictive interventions involving physical and chemical restraint. A Restrictive Intervention roadshow took place on 3.12.24 to raise the profile of restrictive interventions within the Trust including chemical restraint. A PSB on restrictive interventions and chemical restraint have been released. Daily education on restrictive interventions takes place via the work completed by the Dementia and Delirium team and the MCA lead regarding DoLS applications and support in this area. ➢ Oliver McGowan training currently at 74% (Tier 1)

		➢ 37% of patient facing areas have champions in place, more training is planned for June. ➢ The first meeting of the LD Steering Group has taken place.

2.1.2 Looking Forward

2024/2025 has seen unprecedented demand for emergency services coupled with delayed transfers of care creating a bottle neck within acute services. Despite the challenges facing the Trust, the Trust is committed to driving forward improvements that enhance our patient care and their experience whilst in our care at The Dudley Group NHS Foundation Trust.

The annual priorities will now form part of a three-year Quality and Safety Delivery Plan. This will aid forward thinking, proactive management but also demonstrate sustainability in delivering quality safe care to our patients. This delivery plan will offer overarching priorities, and we will build on these priorities over a three-year period with renewed objectives each year. Below identifies the key objectives for 25/26 only. Refer to the Quality and Safety Delivery Plan for the full overview of the three-year ambition.

Priority 1: Improving partnership working
Why we have chosen this (rationale)
There is evidence that shows that when working in partnership the NHS can: • **Better outcomes for people:** through the pooling of diverse perspectives and expertise, resulting in more comprehensive and effective solutions to complex challenges • **More efficient services:** Shared resources, including financial, material, and intellectual assets, enable greater efficiency and productivity, minimizing redundancy and maximizing impact.

- **Stronger communities:** Partnership working builds trust and connection between people, which makes communities stronger.
- **Improved communication:** through transparent and consistent messaging, fostering mutual understanding and mitigating potential conflicts.

To bring together all health and care partners across Dudley to make more effective use of the combined resources available to develop a 'blueprint' for services which are integrated across prevention, primary, community, social and secondary care and improves outcomes and reduces inequalities through services transformation.

1. Meaningful involvement from across a range of different groups and organisations is key to developing a deep and shared understanding of local health issues and inequalities and an impactful response to these.
2. Increased number of integrated care pathways that have been co-produced with partners.
3. Integration of voluntary sector organisations, commissioned to deliver services.

Our Trust Strategy 2025 – 2028 builds on the previous strategy goal to Build innovative partnerships in Dudley and beyond.

Where do we want to be?

Better management of shared workload between primary, secondary and community services –address inappropriate transfer of work through fully operational, end to end pathways with best use of digital and physical assets and the right person acting at the right time to improve patient outcomes. Collaborative pathway design using quality improvement methodology including patient input.
Strengthen community voices – have an established system to bring the patient voice into our health and care decision making, ensuring that there is always opportunity for involvement in ongoing delivery of services, planning of service change and actively taking feedback and insights.

Produce an integrated Trust framework for patient and public involvement in the development and improvement of services focusing on quality and safety workstreams/projects.

Quality and safety delivery plan priority areas will have an identified and active patient safety partner and/or patient voice volunteer.

Responsible person/team

Partnership Programme Director
Dudley Health and Care Partnership
Patient Safety Specialist

Priority 2. Staff Development

Why have we have chosen this (rationale)?

To create an environment which allows everyone to be their best self and provide opportunity for personal growth and to recruit and retain the best talent.

Where do we want to be?

To be a brilliant place to work and thrive.

- Use the national leadership and management framework to develop and deliver internal career progression, reviewing our programmes being delivered to ensure these are all aligned. (Annual Plan)
- Establish a Trust education and training group that has a robust framework, work plan and agreed success measures
- Ensure career pathways provide clear routes to development and progression (Culture and leadership Journey)

Responsible person/team

Head of Education for Nurses, Midwives and AHPs/Head of Learning and Organisational Development

Priority 3: Safe management of the deteriorating patient

Why have we chosen this (rationale)?

Impacts on mortality and provides assurance of quality of care. Completing a set of vital signs and documenting them at the point of care in a timely manner is paramount to the early identification, escalation and response to deteriorating patients. Utilising the national early warning scores (NEWS2, NPEWS, MEOWS & NEWTT2) to determine the frequency of vital signs for everyone as determined by the risk. Completing this on time will reduce the predictable and preventable medical emergency calls across the organisation, ensuring our patients are escalated appropriately and on the correct pathway.

Current compliance for vital signs being completed on time across the organisation is 52%. We will also prioritise our escalation and response to patients identified as deteriorating and continue to improve our sepsis screening and administration of IV antibiotics to those requiring the sepsis six.

Where do we want to be?

- Provide assurance against latest national guidelines.
- Participate in NPEWS Emergency Department pilot
- Integrate NPEWS into triage and Emergency Department escalation processes by Quarter 3.
- Martha's Rule (MR) DGFT pilot site: introduce the patient wellness score to adult and maternity. Improve accessibility for those who need adjustments to MR processes.
- Develop and implement new national MEWS scoring system into sunrise by Q3.
- Develop and implement NEWTT2 scoring system into sunrise by Q4.
- Further develop NPEWS sepsis screening processes in line with national steer.
- Develop eObs Task & Finish Group with four ward areas across medicine and surgery
    - Improve eobs by Q1 55-60%/ Q2 60-65%/ Q3 65-70%/ Q4 70-75%
    - Update policies
    - Digital problem and opportunity mapping
- Continued integration of 'Prevention, Identification, Escalation, Response' (PIER) framework working with ICB partners with the deteriorating patient programme, a three-

year quality improvement project focusing on community hospital avoidance using the PIER approach. PIER stands for**:** **prevention**: planning ahead of any episode of deterioration to stop what is preventable, considering indicators of risk and patient choice, **identification**: tools and methods to identify when deterioration is occurring in a standardised way, **escalation**: timely escalation of care when deterioration has been identified using standardised communication tools, **response**: timely, appropriate and effective response to escalation of the deteriorating patient/person.

- Continue AQUA pathways work aiming for improvement in composite care scores in particular for the AKI pathway, led by one of our Consultants
    - Further develop the information on AKI pathways on the Urology HUB page
    - Develop alert within EPR for acknowledgement of AKI

Responsible person/team

Clinical Director Patient Safety and Deteriorating Patient Lead

Priority 4: Development and implementation of National Safety Standards of Invasive Procedures (NatSSIPs)

Why have we chosen this (rationale)?

Invasive procedures carry clinical risk which can be mitigated by following national safety standards.

Where do we want to be?

To have ratified policies; updated Sunrise template; local audit of practice of NatSSIPs 8 Sequential Steps; incidents pertaining to invasive procedures.

- To have ratified policies; updated Sunrise template; local audit of practice of NatSSIPs 8 Sequential Steps; incidents pertaining to invasive procedures.
- Site marking, consent, retained items, implants, NatSSIPs policies ratified.
- Retained item process to be developed (Sunrise).
- Implant management: uploading data to Medical Devices Outcome Registry.
- Registry of harmonised LocSSIPs in the appropriate areas.

Responsible person/team

Clinical Director Patient Safety

Priority 5: Safe Medicines Management

Why have we chosen this (rationale)

The Health Services Safety Investigations Body (Dec 2024)

Medication not given: administration of time critical medication in the Emergency Department reported concerns around time critical medication administration. Each of the treatment delays are known to negatively impact patient outcomes, underlying disease control

and lead to longer admissions. The report focussed on the critical failures associated with delayed identification, prescribing and administration of Parkinsons medicines.

People with Parkinson's on levodopa-based medication can be taking medication up to every two hours. Even a 30-minute delay in taking medication can lead to profound health implications for a person with Parkinson's.

Missed or delayed doses of Parkinson's medication can lead to anxiety, an increase in symptoms and psychological harm. This also leads to increased morbidity, mortality, length of stay and increasing the cost of care for hospitals.

Where do we want to be?

- Develop a clinically led Time Critical Medicines Stakeholder Group that reports to the Drugs and Therapeutics Group.
- Development of a power BI report and dashboard that categorises the prescribing and administration of defined time critical medicines data collected from Sunrise EPMA.
- Development of a time critical medicines identification and alerting process within the Emergency Department.
- Shared learning across the organisation on time critical medicines with a focus on Parkinson's Disease prescribing and administration.
- 50% improvement on the baseline on administering Parkinsons treatments on time within the Emergency Department.

Responsible person/team

Associate Director of Medicines Optimisation & Chief Pharmacist
Controlled Drug Accountable Officer; Lead Pharmacy Technician - Medicines Safety & Governance

Priority 6: Care closer to home through refined patient discharge processes

Why have we chosen this (rationale)?

Where do we want to be?

We will shift care closer to home, so that only those that need to be in hospital are seen there, providing the best experience of care.
The Trust will create community first pathways that ensure patients receive early interventions in community settings without the need for hospital visits.

- Creation of an effective Clinical Navigation Centre. A recognised clinical triage practice for the appropriate pathway, community first with direct access to virtual ward, step up facilities.
- Roll out of "Estimated Discharge Date (EDD)" and "Criteria Led Discharge (CLD)" across all inpatient areas
- Creation of a multi-agency, Transfer of Care Hub with the support of NHS England to support improved discharge processes and pathways.
- Training for all inpatient wards on 'No Criteria to Reside'.
- Incorporate NHS best practice i.e. SAFER patient flow bundles
- Reduction in the length of stay of our frailty ward.

Responsible person/team

Director of Strategy and Partnerships

Priority 7: Improving patient outcomes

Why have we chosen this (rationale)?

Clinical Accreditation was championed by the Chief Nursing Officer for England in 2019. Clinical accreditation involves developing a set of standards against which quality of care can be measured. It brings together key measures of nursing and clinical care to enable a comprehensive assessment of the quality-of-care delivery at ward, unit or team level. When used effectively, clinical accreditation can drive continuous improvement in patient outcomes, increase patient satisfaction and staff morale, encouraging ownership and influencing excellence in patient care delivery.

The Eat Drink Dress Move (EDDM) initiative is a nationally recognised enabling approach to care that helps patients to actively participate in their recovery. The Trust has adopted the principles with the physiotherapist and therapy clinical team for frailty and is being led as part the Chief Nurse Fellowship programme. The work is being piloted by the therapy team on three wards with input from the MDT. Early evidence is demonstrating a significant change to the levels of activity of patients on the target ward.

PIVOT: Promoting increased physical activity in hospitalised older adults with trained volunteers. This will focus on the impact of targeted activity delivered by hospital volunteers on patient outcomes including length of stay, care needs on discharge and re-admission rates. The research programme is supported by the National Institute for Health and Care Research (NIHR) and the site initiation visit on 8 January 2025 proved successful with training for the team of physiotherapists, assistant therapy practitioners and therapy assistants commencing soon. Trust volunteers will deliver two half hour sessions of daily activity following adequate training and continual support from registered staff. The process of recruitment is now underway with 14 volunteers identified. The project once initiated will involve data collection over a six month period in relation to patients' balance, mobility and strength.
The team is also considering other elements that may need to be incorporated as part of the EDDM philosophy such as impact on falls rates and outcomes and patient experience.
The Trust manual handling team have been working alongside the EDDM team to promote single handed care on the wards by introducing Transfer Pros which has received positive feedback from both the clinical support workers and nursing colleagues.

Nutritional and Hydration: Access to and provision of high-quality nutrition and hydration should be seen as a priority for all healthcare organisations. This includes the fundamentals of a healthy balanced diet as well as availability of food and drink to meet individual dietary needs and preferences for all patients, visitors and staff. The Trust has responded to patient feedback that indicates there is room for improvement in terms of the food and drink we serve, how it is presented, and the support given to patients to eat and drink independently. One priority for the

Nutrition and Hydration Improvement Group is to work with ward areas to establish mealtime champions who will be trained and supported to lead an enhanced mealtime experience for the ward area. The launch of the initiative took place on 4 March 2025 and has been well received by the clinical support workforce. A suite of metrics is also under development that will measure the impact of any changes implemented from a quality perspective.

Where do we want to be?

- **Clinical Accreditation**
  - Roll out the clinical accreditation process across all inpatient wards ensuring all wards are assessed in this financial year.
  - At least 80% of inpatient wards will have received a clinical accreditation visit by end of Q4, 2025/26, with a level of accreditation that has been validated by the Clinical Accreditation Board.
- **EDDM**
  - Roll out project to ward C3 and FMNU with MDT involvement
- **PIVOT**
  - Complete a feasibility research study, funded for one year, initially trialling on B6; C3; Forget Me Not Unit for patients with dementia.
  - Recruit and train 20 volunteers for 30 patients.
- **Nutrition and Hydration**
  - Mealtime champions on each ward with positive patient and staff experiences

Responsible person/team

Associate Deputy Chief Nurse/Quality Lead/ AHP

Priority 8: Safer staffing – in patient wards, assessments wards, emergency departments and children and young people wards and community

Why have we chosen this (rationale)

This is nationally driven to ensure we have the right workforce to meet the needs of our patients, in line with skill mix and competence.

By using the NHS England (NHSE) Safer Staffing Nursing Tool licenced by Shelford Group, these support the chief nurse to determine optimal nurse staffing levels helping NHS hospital staff measure patient acuity and/or dependency to inform evidence-based decision making on staffing and workforce. The tools can also support the Trust to deliver evidence-based workforce plans to support existing services or to develop new services.

Where do we want to be?

Determine optimal nursing staffing with departments.

- To ensure the safer staffing is undertaken as based on the licence agreement and the time scale of the data is completed based on a Black Country system wide approach as approved by the Chief Nurse.
- To implement the new Community Nurse Safer Staffing Tool and continue to undertake the acute safer staffing tool.

- Await directive from National NHSE for the new Community Nursing Safer Staffing Tool, then implement the tool.
- Continue to undertake the acute safer staffing tool
- Assess inpatient acuity over a given 30-day period, every six months, in January and June, logging data into a central data base for analysis.
- **By Q4 2025/26:**
    - 80% of band 6, 7 and 8a staff will have a defined programme of learning aligned to a standard Trust competency set.
    - All new graduates take up a place on a preceptorship programme within four weeks of commencing employment and have completed initial competencies within 12 weeks.
    - Training needs analysis forms part of service and workforce planning and allocation of CPD funding to meet patient need.
    - TNA/NA-RN conversion programme is delivered in line with the agreed plan and allocated financial envelope.
    - 80% of final year students choose The Dudley Group as their organisation of choice.
    - 80% of international recruits retained.

Responsible person/team

Associate Deputy Chief Nurse – Workforce

Priority 9: Comprehensive and reliable handover- 7ds

Why have we chosen this (rationale)

Standard 4 of Seven Day Service Standards highlights that ‘handovers must be led by a competent senior decision maker and take place at a designated time and place, with multi-professional participation from the relevant in-coming and out-going shifts. Handover processes, including communication and documentation, must be reflected in hospital policy and standardised across seven days of the week’. In our last deep dive, the standard was rated as Amber.

Where do we want to be?

We would like to meet the recommended standard with shift handovers kept to a minimum (recommended twice daily) and take place in or adjacent to the ward or unit with clinical data recorded electronically, according to national standards for structure and content and include the NHS number. This should be consistent across the Trust and supported by the MDT.

- Roll out an improvement plan to embed the standard across all inpatient areas.

Responsible person/team

Operational Medical Director/Chiefs of Service

Priority 10: A culture of positive learning with clear measurement and improvement as reflected with the AQUA tool and the use of learning from excellence
Why have we chosen this (rationale)
The Trust has recently relaunched Greatix to encourage staff to highlight examples of excellence and there is an opportunity to increase the level of reporting from the platform. The new tool has improved reporting functions to extract trends and improved data to drive improvement. The Trust has access to the AQuA tool to drive improvements in this area and adopt a learning from excellence approach as highlighted in the Darzi report moving away from a deficit model of improvement.
Where do we want to be?
Key indicators of success would be: • Improved staff and patient survey results including support to those involved in incidents • Outcomes improved in mortality and morbidity. • Increased use of GREATIX and workstreams from this.
Responsible person/team
Medical Consultant and Deteriorating Patient Lead

Priority 11: Reducing the carbon footprint of clinical care in line with the Greener NHS sustainability agenda and the DGFT Green Plan
Why have we chosen this (rationale)
In 2020, the NHS became the world's first health service to commit to reaching carbon net zero by 2045, in response to the profound and growing threat to health posed by climate change (Greener NHS, 2020). Nursing and midwifery are the largest workforce, so it is in our gift to support the Greener NHS aspiration of Net Zero by 2045. It is also required as part of the well-led CQC domain and is laid out in the NHS Constitution (2023). Environmental stewardship will help reduce health inequalities, reduce air pollution and reduce hospital admissions.
Where do we want to be?
• Increase the nursing, midwifery and AHP knowledge of the impact of care on our Trust's carbon emissions, and their roles and responsibilities in reducing that impact. • Reduce unnecessary use of single use items – Relaunch the 'Gloves Off' campaign. • Reduce financial spend on gloves and capture the carbon emissions savings. • Agree a programme of works implementing a reduction in other high volume single use products.
Responsible person/team
Sustainability Lead/ Associate Deputy Chief Nurse/ Infection prevention Lead

Priority 12: Patient Safety Systems
Why have we chosen this (rationale)
Maximising learning opportunities, approaches, and their contribution to quality & patient safety improvement.
Where do we want to be?
All local Patient Safety Incident Response Plan (PSIRP) priority areas have detailed supporting plans of improvement which incorporate impact and outcome measures. Safety II (good care events) is incorporated into governance reports at all levels. • The key focus will be to continue strengthening our PSIRP, to ensure that improvement objectives are clear, outcomes and impact can be measured and are monitored. This includes working with newly transitioned services (PLACE division) to embed PSIRF. • The Learn from Patient Safety Events (LFPSE) reporting will continue to be developed to enable direct reporting of incident responses as STEIS is decommissioned.
Responsible person/team
Patient Safety Specialist

How will we monitor and share progress of our Quality Priorities?
Monitoring of the Quality Priorities will be through a quarterly report to the Quality Committee who will monitor the Trust's progress whilst supporting to resolve any barriers to ensure we achieve our priorities.

The Dudley Group's Russells Hall Hospital site.

Part 3: Statements of Assurance

3.1 Review of services

During 2024/25, The Dudley Group NHSFT provided 58 hospital and community NHS relevant health 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 Dudley Group NHS Foundation Trust has reviewed all the data available on the quality of care in all its services through its permanence management framework and its assurance and governance processes.

The income generated by the relevant health services reviewed in 2024/25 represents 99.6% of the total income generated from the provision of relevant health services in The Dudley Group NHS Foundation Trust.

3.1.1 Services transferred from Dudley Integrated Health & Care NHS Trust

Following extensive discussions and careful planning with system colleagues, from 1 October 2024, the Trust has taken on responsibility for a number of services that were previously managed by Dudley Integrated Health & Care NHS Trust.

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

During 2024/25, 105 national clinical audits and 15 national confidential enquiries covered relevant health services that the Trust provides.

During that period, the Trust participated in 79 (20 missing) (75%) per cent of the national clinical audits and 100 per cent of the national confidential enquiries of which we were eligible to participate in.

There was one national audit the Trust did not participate in as this was co-ordinated at Integrated Care Board level during 24/25.

- Fracture Liaison Service Database (FLS-DB)

Tables 1 and 2 below show details of this participation in relation to:

- The national clinical audits and national confidential enquires that The Dudley Group of Hospitals NHS Foundation Trust participated in, and for which data collection was completed during 2024/25. To include the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of the audit or enquiry.

Table 1

Number	Title					
1.	BAUS Data & Audit Programme - BAUS I-DUNC	N/A	Yes	Yes	100%	April 1 to May 21 2024
2.	BAUS Data & Audit Programme - BAUS Penile Fracture (SNAP) Audit	N/A	Yes	Yes	No cases identified as yet	
3.	BAUS Data & Audit Programme - Environmental Lessons Learned and Applied to the bladder cancer care	N/A	No	No	The Trust plans to follow GIRFT guidance on sustainability, which covers much broader care for urology	

Number	Title					
	pathway audit (ELLA)				patients and not just those diagnosed with bladder cancer.	
4.	Breast and Cosmetic Implant Registry	N/A	Yes	No		
5.	British Hernia Society Registry	N/A	No	No	Not Applicable to Trust	
6.	Case Mix Programme (CMP)	N/A	Yes	Yes	100%	April 2024 to March 2025
7.	Cleft Registry and audit network database	N/A	No	No	Not applicable to Trust – procedure not carried out	
8.	Emergency Medicine QIPs	Mental Health	Yes	Yes	200	October 2022 to October 2024
9.	Emergency Medicine QIPs	Care of Older People	Yes	Yes	197	May 2023 to October 2024
10.	Emergency Medicine QIP	Time Critical Medications	Yes	Yes	113	November 2023 to October 2024
11.	Epilepsy 12 - National Audit of Seizures and Epilepsies for Children and Young People	Epilepsy12	Yes	No	Issues with SWBH impacts on Dudley not submitted.	Data submitted up to January 2025
12.	Falls and Fragility Fracture Audit Programme (FFFAP)	Fracture Liaison Service Database (FLS-DB)	No	No	No service currently. This is being coordinated at an ICB level during 2024.	N/A
13.	Falls and Fragility Fracture Audit	National Audit of Inpatient Falls	Yes	Yes	7/10	April 2024 to March 2025

Number	Title					
	Programme (FFFAP)					
14.	Falls and Fragility Fracture Audit Programme (FFFAP)	National Hip Fracture Database	Yes	Yes	574	April 2024 to March 2025
15.	LeDeR - learning from lives and deaths of people with a learning disability and autistic people	Mortality Surveillance	Yes	Yes	18 deaths	April 2024 to March 2025
16.	Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRACE)	Maternal mortality surveillance (MMS)	Yes	Yes	100%	April 2024 to Marh 2025
17.		Maternal morbidity confidential enquiry - serious maternal morbidity (SMM)	Yes	Yes	100%	April 2024 to March 2025
18.		Maternal mortality confidential enquiries (MMCE)	Yes	Yes	No maternal deaths	April 2024 to March 2025
19.		Perinatal mortality and serious morbidity confidential enquiry (PMSM)	Yes	Yes	100%	April 2024 to March 2025
20.		Perinatal Mortality (PMRT)	Yes	Yes	15 (100%)	April 2024 to March 2025
21.	Mental Health Clinical Outcome Review Programme1	N/A	No	No	Not relevant to the Trust – Mental Health	
22.	National Audit of Cardiac Rehabilitation	N/A	Yes	Yes	Unable to ascertain numbers	April 2024 to March 2025

Number	Title					
23.	National Audit of Cardiovascular disease Prevent in Primary Care	N/A	No	No	Not relevant to the Trust – GP Audit	
24.	National Audit of Dementia	N/A	Yes	No	Data not submitted – New lead wasn't aware of audit	
25.	National Adult Diabetes Audit (NDA)	National Diabetes Core Audit	No	No	Not relevant to the Trust – GP Audit	
26.	National Adult Diabetes Audit (NDA)	Diabetes Prevention Programme (DPP) Audit	N/A	N/A	Not relevant to the Trust – GP Audit	
27.	National Adult Diabetes Audit (NDA)	Transition (adolescents and Young Adults) and young type 2 adults	Yes	Yes	100%	Data taken from historical diabetes data sets
28.	National Adult Diabetes Audit (NDA)	National Diabetes Foot Care Audit	Yes	Yes	No cases in Trust	April 2024 to March 2025
29.	National Adult Diabetes Audit (NDA)	Gestational Diabetes Audit	Yes	Yes	100% - info taken from already submitted data	April 2024 to March 2025
30.	National Adult Diabetes Audit (NDA)	National Diabetes in Pregnancy Audit	Yes	Yes	40 (100%)	1st January 2024 to 31st December 2024
31.	National Adult Diabetes Audit (NDA)	National Diabetes Inpatient Safety Audit (NDISA)	Yes	Yes	15 (100%)	April 2024 to March 2025
32.	National Respiratory Audit Programme (NRAP)	Adult Asthma Secondary Care	Yes	Yes	125	April 2024 to March 2025

Number	Title					
33.	National Respiratory Audit Programme (NRAP)	Chronic Obstructive Pulmonary Disease Secondary Care	Yes	Yes	567	April 2024 to March 2025
34.	National Respiratory Audit Programme (NRAP)	Paediatric Asthma Secondary Care	Yes	Yes	98	April 2024 to March 2025
35.	National Respiratory Audit Programme (NRAP)	Pulmonary Rehabilitation	Yes	Yes	12	April 2024 to March 2025
36.	National Audit of Care at the End of Life (NACEL)	N/A	Yes	Yes	80	April 2024
37.	National Bariatric Surgery Registry	N/A	No	No	Not applicable to Trust – procedure not carried out	
38.	National Cardiac Arrest Audit (NCAA)	N/A	Yes	Yes	92 cases	Jan to Dec 2024
39.	National Cardiac Audit Programme (NCAP	National Adult Cardiac surgery audit	No	No	Not applicable to Trust – procedure not carried out	
40.	National Cardiac Audit Programme (NCAP	National Congenital Heart Disease Audit	No	No	Not applicable to Trust – procedure not carried out	
41.	National Cardiac Audit Programme (NCAP)	Myocardial Ischaemia National Audit Project (MINAP)	Yes	Yes	302 (100%)	April 2024 to March 2025

Number	Title					
42.	National Cardiac Audit Programme (NCAP)	National Audit of Cardiac Rehabilitation	Yes	Yes	Unable to determine numbers	April 2024 to March 2025
43.	National Cardiac Audit Programme (NCAP)	National Audit of Cardiac Rhythm Management (CRM)	Yes	Yes	446 (100%)	April 2024 to March 2025
44.	National Cardiac Audit Programme (NCAP)	UK Transcatheter Aortic Valve Transplantation Registry	No	No	Not applicable to Trust – procedure not carried out	
45.	National Cardiac Audit Programme (NCAP)	Left Atrial Appendage Occlusion Registry	No	No	Not applicable to Trust – procedure not carried out	
46.	National Cardiac Audit Programme (NCAP)	Patent Foramen Ovale Closure Registry	No	No	Not applicable to Trust – procedure not carried out	
47.	National Cardiac Audit Programme (NCAP)	Transcatheter Mitral and Tricuspid Valve Registry	No	No	Not applicable to Trust – procedure not carried out	
48.	National Cardiac Audit Programme (NCAP)	National Audit of Percutaneous Coronary Intervention (NAPCI)	No	No	Not applicable to Trust – procedure not carried out	
49.	National Cardiac Audit Programme (NCAP)	National Heart Failure Audit	Yes	Yes	498 (100%)	April 2024 to March 2025
50.	National Child Mortality	N/A	Yes	Yes	19 (100%)	April 2024 to March 2025

Number	Title					
	Database (NCMD)					
51.	National Clinical Audit of Psychosis (NCAP)	N/A	No	No	Not applicable to Trust – Mental Health Trusts only	
52.	National Comparative Audit of Blood Transfusion	2024 Bedside Transfusion Audit	Yes	Yes	40 (100%)	March - April 2024
53.	National Comparative Audit of Blood Transfusion:	Audit of Blood Transfusion against NICE Quality Standard 138	Yes	Yes	50 (100%)	2024
54.	National Early Inflammatory Arthritis Audit	N/A	Yes	Yes	17 (100%)	April 24 to March 25
55.	National Emergency Laparotomy Audit (NELA)	N/A	Yes	Yes	134 (100%)	April 24 to March 25
56.	National Emergency Laparotomy Audit (NoLap)	N/A	Yes	Yes	0	April 24 to March 25
57.	National Joint Registry	Primary replacement and revision of replacement for hip knee shoulder elbow ankle	Yes	Yes	956 (100%)	April 2024 to March 2025
58.	National Maternity and Perinatal Audit (NMPA)	N/A	Yes	Yes	100%	data from Maternity National data Set
59.	National Neonatal Audit	N/A	Yes	Yes	100% cases	Cases automatically gathered

Number	Title					
	Programme (NNAP)					from the Badger system
60.	National Obesity Audit	N/A	No	No	Not applicable to Trust	
61.	National Ophthalmology Database	Age Related Macular Degeneration Audit	Yes	No	The Trust does not have the platform to upload the data	
62.	National Ophthalmology Database Audit (NOD)	Adult Cataract Surgery Audit	Yes	Yes	810 (100%)	April 2024 to March 2025
63.	National Paediatric Diabetes Audit	N/A	Yes	Yes	221	April 2024 to March 2025
64.	National Pulmonary Hypertension Audit	N/A	No	No	Not Applicable	Specialist Unit
65.	National Cancer Audit Collaborating Centre	Metastatic Cancer	Yes	Yes	100% - taken from Somerset Cancer Registry data	Jan to Dec 2024
66.	National Cancer Audit Collaborating Centre	Primary breast Cancer	Yes	Yes	100% - taken from Somerset Cancer Registry data	Jan to Dec 2024
67.	National Cancer Audit Collaborating Centre	National Bowel Cancer Audit	Yes	Yes	100% - taken from Somerset Cancer Registry data	Jan to Dec 2024
68.	National Cancer Audit Collaborating Centre	National Kidney Cancer Audit	Yes	Yes	100% - taken from Somerset Cancer Registry data	Jan to Dec 2024
69.	National Cancer Audit	Non Hodgkins Lymphoma Audit	Yes	Yes	100% - taken from	Jan to Dec 2024

Number	Title					
	Collaborating Centre				Somerset Cancer Registry data	
70.	National Cancer Audit Collaborating Centre	National Oesophagogastric Cancer Audit	Yes	Yes	100% - taken from Somerset Cancer Registry data	Jan to Dec 2024
71.	National Cancer Audit Collaborating Centre	National Ovarian Cancer Audit	Yes	Yes	100% - taken from Somerset Cancer Registry data	Jan to Dec 2024
72.	National Cancer Audit Collaborating Centre	National Pancreatic Cancer Audit	Yes	Yes	100% - taken from Somerset Cancer Registry data	Jan to Dec 2024
73.	National Lung Cancer Audit	N/A	Yes	Yes	100%	Jan to Dec 2024
74.	National Prostate Cancer Audit (NPCA)	N/A	Yes	Yes	925 (100%)	Jan to Dec 2024
75.	National Vascular Registry	N/A	Yes	Yes	267	April 2024 to March 2025
76.	Out of Hospital Cardiac Arrest Outcomes	N/A	No	No	Not applicable	Ambulance Service audit
77.	Paediatric Intensive Care Audit Network	N/A	No	No	Not Applicable	No Paediatric ICU
78.	Perioperative Quality Improvement Programme	N/A	Yes	Yes	We have reached our quota so no patients added for 2024	
79.	Prescribing Observatory for Mental Health	N/A	No	No	Not applicable	Mental Health Trust
80.	Quality Outcomes in Oral and	Oncology and reconstruction	No	No	Not applicable	Procedure not carried out

Number	Title					
	Maxillofacial Surgery					
81.	Quality Outcomes in Oral and Maxillofacial Surgery	Trauma	No	No	Not applicable	Procedure not carried out in Trust
82.	Quality Outcomes in Oral and Maxillofacial Surgery	Orthognathic Surgery	No	No	Not applicable	Procedure not carried out in Trust
83.	Quality Outcomes in Oral and Maxillofacial Surgery	Non Melanoma Skin Cancers	No	No	Not applicable	Procedure not carried out in Trust
84.	Quality Outcomes in Oral and Maxillofacial Surgery	Oral and Dentoalveolar Surgery	No	No	Not applicable	Procedure not carried out in Trust
85.	Renal Audits	National Acute Kidney Injury Audit	Yes	Yes	100% Data submitted directly to Renal Registry	April 2024 to March 2025
86.	Renal Audits	UK Renal Registry Chronic Kidney Disease Audit	Yes	Yes	100% Data submitted directly to Renal Registry	April 2024 to March 2025
87.	Sentinel Stroke National Audit Programme (SSNAP)	N/A	Yes	Yes	574 (90%+)	April 2024 to March 2025
88.	National Major Trauma Audit (NMTA)	N/A	Yes	Yes	267	Apr 2024 to Dec 2024
89.	UK Cystic Fibrosis Registry Cystic Fibrosis Trust	N/A	No	No	Not applicable	Condition not managed in the Trust

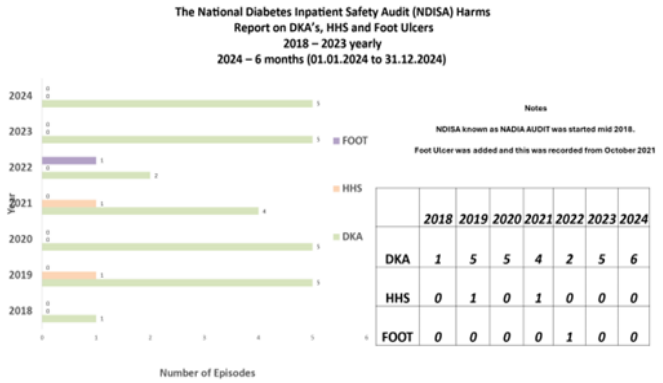
Table 2 – NCEPOD Studies for April 2024 – March 2025.

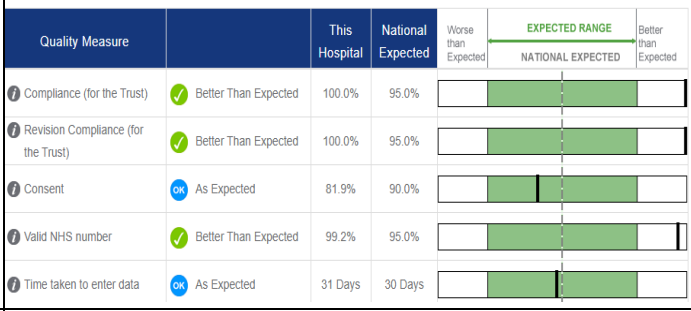
Please note, as these have been the active studies that data has been returned for in this financial year. Some studies may roll over into next year.

Name of Study	Number of cases included	No. and % of cases / questionnaires submitted against number required	No. of case notes submitted	Organisation questionnaire submitted?
Blood Sodium study	4	2/4	4	
Acute Limb Ischaemia	9	6/9	9	
Rehabilitation following critical illness	6	5/6	6	Yes
Juvenile Idiopathic Arthritis	2	1/2	2	Yes
Emergency Surgery in Children and Young People	7	2	7	Yes

National Clinical Audit Reports Reviewed by the Provider

The reports of 40 national clinical audits were reviewed by the provider in 2024/25 and The Dudley Group NHS Foundation Trust has identified actions that have been / need to be undertaken to ensure compliance to national recommendations and improve the quality of healthcare provided.

Specialty	Brief description of audit/outcome/improvements	Actions taken/to be taken
Diabetes	Nadia Harms: The Trust recorded 5-6 hospital-acquired DKA episodes /year, which is estimated to be ~ 10-fold less than national average NADIA: 1in 25 patients {4%} with type 1 diabetes develop DKA, while being admitted) For the last 2 years there have been no foot ulcer incidents. (NADIA: an average of 1% patients with diabetes develop food ulcer during their hospital admission)	Positive assurance 

Specialty	Brief description of audit/outcome/improvements	Actions taken/to be taken
	In the last 9 months, there has been more than 2-fold reduction in the incidence of Severe hypoglycaemia (recorded glucose < 2.2 mmol/l) for patients with diabetes **admitted** to Russell Hall Hospital HHS: No episodes of hospital acquired HHS were recorded in eth last 3 years. Overall, 2 episodes are reported since 2018	
T&O	National Joint Registry The Trust performs better than expected at a rate of 100% with the exception of consenting patients which is 81.9% compared to the 90% national average.	Positive assurance 
Respiratory	National Lung Cancer Audit Ensure services are implementing targeted lung cancer screening for people aged 55 to 74 who are at high risk of lung cancer.	Positive Assurance This service has already been implemented within the community
Urology	National Prostate Cancer Audit - Decisions regarding treatment should consider life expectancy and co-morbidity, balancing the treatment benefits and risks, to ensure equitable care.	Positive Assurance This is common practice for all clinicians already.
Breast Surgery	National Audit of Metastatic Breast Cancer - Ensure the care for people newly diagnosed with MBC is discussed within a breast multidisciplinary team (MDT) meeting.	Positive Assurance This is standard practice for patients diagnosed with MBC
All cancer Specialties	All Cancers - Improve data completeness of key items in national cancer registration	Positive Assurance – there were no issues identified with data completeness across any of the tumour sites.

Specialty	Brief description of audit/outcome/improvements	Actions taken/to be taken
	datasets to allow risk-adjustment of performance indicators	
T&O	#NOF Database	Positive Assurance - The Trust has a task and finish group in place looking at improving the results of the key standards in the national audit to reduce patient morbidity and mortality. This work has improved compliance to the national standards
Stroke	SSNAP	Positive Assurance - The stroke team now complete a validation of the notes on a monthly basis to ensure coding is correct and they also ensure that the correct classification is been entered on to the SSNAP database. This has led to an improvement in the audit compliance over the last 12 months.
Paediatrics	Epilepsy 12	Negative Assurance – The Trust relies on patient identification from City Hospital .City Hospital have stopped registering patients onto the programme due to staffing issues. This means that we have been unable to submit data for the last quarter of 2024 / 2025.
Respiratory	NRAP - All people with COPD and asthma should have access to tobacco dependence support.	Positive Assurance – Smoking status is ascertained on all patients admitted to the hospital and all smokers are offered referral to the smoking cessation service.
Falls	National Audit of Inpatient Falls - Trusts and health boards should ensure that there are robust governance processes in place to understand when post-fall checks fail to correctly identify a fall-related injury.	Positive Assurance – The Trust has a robust policy in place to ensure that patients have medical checks following a fall. Where a fall has led to significant harm then the PSIRF process kicks in and the incident is investigated using a swarm. In addition to this there are regular thematic reviews.
Urology	NCEPOD Report – Twist and Shout – testicular Torsion	The Urology pathway was reviewed following an incident and in line with the NCEPOD pathway and the Trust pathway was strengthened to ensure that it met the requirements of NCEPOD and reduced the risk of the incident recurring.

3.3 Local Clinical Audit

The reports of 142 local clinical audits were reviewed by the provider in 2024/25 and The Dudley Group NHS Foundation Trust intends to take the following actions to improve the quality of

healthcare provided. Below are some examples from across the Trust of actions taken to improve the quality and safety of our services as an outcome of local clinical audit.

SPECIALTY	AUDIT TITLE	ACTION PLANNED	IMPROVEMENT
Pharmacy / Neurology	Compliance with NPSA Valproate Alert	To ensure that all patients have their annual review and that these are documented electronically.	A register of all patients on valproate has been set up and those that have annual reviews are recorded on paper. Pharmacy is in the process of ensuring that these ARAFs are uploaded onto sunrise and that all patients have a completed ARAF.
ED	Paracetamol Dosing in patients with low body weight – following publication of a national report	Results indicated that there was a general lack of understanding of the correct dose of paracetamol for patients with a low body weight.	The team produced a Patient Safety Bulletin to be shared across the Trust.
Cardiology	Audit of DC cardioversion for AF	The results showed that the patients would benefit from a change to the AF pathways so that they can get a timely cardioversion	The revised pathway has been completed
Maternity	Documentation in emergency C Sections	The audit identified that key timings were being missed during these procedures, and it was identified that Theatres needed new whiteboards to ensure that these were documented	New whiteboards are now in place
Paediatrics	Audit of intubations	During the process of the audit, it was identified that the staff undertaking intubations should be using the BAPN checklist.	This has been introduced into the service.

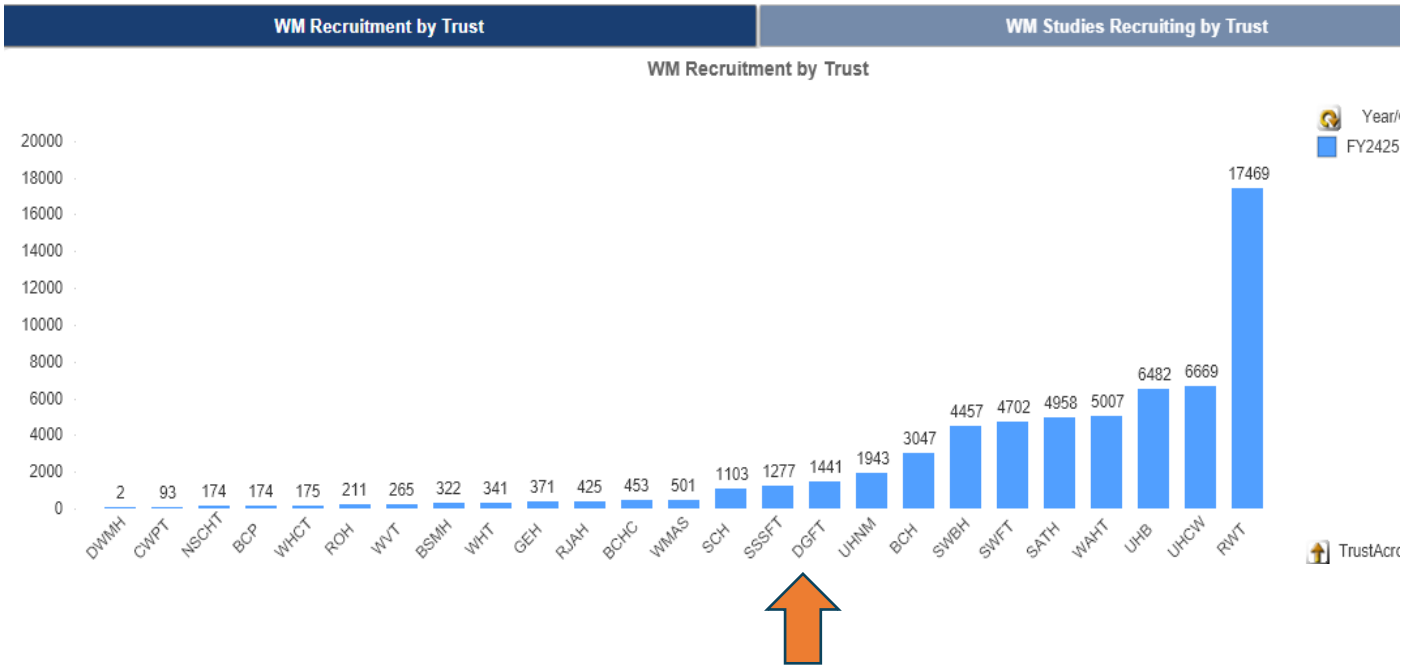
3.4 Research and Innovation (R&I)

During 2024/25, we have seen a significant increase this year (since covid-19 pandemic) in the number of participants that participated in research studies within The Dudley Group NHS Foundation Trust, with an end of year total of 1451 participants. Of these 1451 participants, 1441 participants were recruited into studies adopted onto the National Institute for Health and Care Research (NIHR) Portfolio and 10 participants were recruited into a local home-grown vascular study.

During this period, we have had a total of 97 studies open. Of these 97 studies, 28 non-commercial and 5 commercial studies opened this year 2024-2025.

These 97 studies consisted of 11 commercial studies and 86 non-commercial studies, with a further 22 studies currently in set-up (10 x commercial studies and 12 non-commercial).

Table 1: Number of participants recruited to NIHR Portfolio studies only, within Trusts across the West Midlands, 2024-25



The balance of the research portfolio spans several specialties, including anaesthetics and critical care, cancer, cardiology, chemical pathology, dermatology, diabetes, education gastroenterology, general surgery, geriatrics, haematology, immunology, mental health, neurology, orthopaedics paediatrics, renal, rheumatology, respiratory, reproductive health, stroke, vascular, and urgent public health all continuing to participate or express an interest in research. Ear, Nose & Throat have recently opened their first audiology study.

Interest in research across non-medical/Allied Health Professions (AHP) staff groups has increased with several staff being supported to progress innovation or research ideas. Currently we have three studies that have AHP involvement (respiratory, physiotherapy and vascular specialities). Promotion of research within our Allied Health Professional Teams and Community Teams, to increase their involvement continues to take place, with the Research and Innovation Department representatives attending regular key meetings.

3.4.1 Innovation

Clear evidence for a research innovation culture is demonstrable across the organisation. The monitoring and reporting of all innovation projects is reported monthly to our Research Education and Innovation Group. We continue to work closely with the Health Innovation Network West Midlands and MidTech to develop ideas further.

There are currently 41 innovation ideas logged, with 6 of these actively progressing forward and 25 completed/incorporated within the service or across the Trust. These include digital, education and patient pathway projects.

We have seen an increase of innovation funding bid applications, with four submitted this year, and three being successful (one is pending outcome and one unsuccessful). The increase has been due to the merger with Dudley Integrated Healthcare with the Trust in October 2024. We are working closely with our Dudley PLACE colleagues on a number of these projects, particularly in cardiovascular disease.

3.4.2 University Hospital Standards

The Trust has been successful in applying to change the Trust name to incorporate the word ‘University’. We are continuing to work towards the criteria for University Hospitals Association application, which will be a joint bid with Sandwell and West Birmingham Hospitals NHS Trust, and our primary academic collaborator, Aston University. A five-year trajectory has been developed to monitor achievements against the criteria for University Hospital Status (UHS).

Across the Trust Research, Innovation and Education have shown many examples of excellence and we are ‘showcasing’ some of these areas through staff videos that will formulate part of the application process for UHS. The videos are now complete and will be promoted across the Trust and available for patients and public.

Aston Research Centre for Health and Ageing (ARCHA) collaboration, includes patient and public involvement promoting PhD and research proposal opportunities. Annual conferences attendances by our Research Leads.

3.4.3 Training and Infrastructure

The Trust was a partner in the Black Country Research Celebration event held in November 2024 which was highly successful with a wide range of speakers, oral and poster presentations and good attendance, including staff from all other Black Country Trusts, ICB and local universities. We plan to hold an event in 2025.

The Trust continues to support student nurses and AHP placements on a regular basis, mainly from Wolverhampton and Birmingham universities. We received extremely positive feedback from the students regarding their placement within the research and development team.

The department continues to promote research related training sessions on Good Clinical Practice and Principal Investigator Essentials Masterclasses.
We have two new in-house training courses, hosted by the Trust: 1) EVOLVE Leadership Training incorporating Research in Healthcare Evidence based practice sessions and 2) Enhancing Trauma and Orthopaedic Care MSc modules.

We also support staff Research Champions and have regular attendance at the meetings and training sessions. We hold monthly lunchtime drop-in meetings to support any research and innovation ideas, on an ongoing basis.

3.4.4 Celebrating Success

The Dudley Group NHS Foundation Trust has successfully supported a bid to establish one of the UK's new National Institute for Health and Care Research (NIHR) Commercial Research Delivery Centres (CRDCs). This will expand access to innovative clinical trials and deliver life-changing treatments to some of the UK's most underserved communities. This transformative £7 million investment will establish the Central and Northwest Midlands (C&NWM) Commercial Research Delivery, hosted by Birmingham Women's and Children's NHS Foundation Trust (BWC), working closely with regional partners Midlands Partnership University NHS Foundation Trust and the Black Country Provider Collaborative. The new CRDC will make it easier for individuals to take part in research trials for cutting-edge healthcare treatments, partnering with drug companies to deliver treatment trails in a safe and responsible way. The new centre will also work closely with local businesses, patient groups and charities to help it reach a broad range of communities, including those that haven't taken part in research before.

The Cancer Research team have enrolled their first three participants into our first NHS Cancer Vaccine Launchpad (NHS CVLP). The study is looking at establishing a UK platform for tumour samples to perform DNA sequencing for the development of personalised cancer vaccines.

We are the second highest recruiter in the West Midlands for the OPTIMA study. This study is seeking to advance the development of personalised treatment of early breast cancer by the prospective evaluation of multi-parameter analysis as a means of identifying those patients who are likely to benefit from chemotherapy whilst sparing those who are unlikely to do so from an unnecessary and unpleasant treatment, and to establish the cost-effectiveness of this approach. We have recruited 52 participants to this study, against a recruitment target of 21.

3.4.5 Public engagement

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.

We have a patient representative who attends our Research, Education and Innovation Group, attends Trust Listening into Action patient events, and is a member of our Research Protocol Review Panel for any 'home grown' studies.

3.4.6 Publications

Trust publications for the calendar year 2024-2025 logged and available on the Library Services Open Repository, including conference posters, stands at 135. Full list of publications can be accessed here: DGFT publications 2024

3.5 Commissioning for quality and innovation (CQUIN) payment framework

A proportion of The Dudley Group NHS Foundation Trust income (1.25%) was conditional on achieving quality improvement and innovation goals agreed between the Black Country and West Birmingham Integrated Care System (ICB) and NHS England Prescribed Specialised Services for the provision of relevant health services thought the Commissioning for Quality and Innovation Payment framework.

There are eight incentivised CQUINs, with 12 CQUINs to be undertaken for reporting and quality monitoring. Full payments were included within contractual sums, no clawbacks are anticipated for underperformance, as we continue to provide demonstrable evidence of engagement.

3.6 Care Quality Commission (CQC) registration and reviews

The Trust is required to register with the Care Quality Commission (CQC), registration has been in place since 2010, and the current status is registered without conditions.

In October 2024, the Trust's registration was updated to include the primary care services that transitioned to the Trust from the former Dudley Integrated Health and Care NHS Trust. These services are yet to be inspected and rated by the CQC.

The Trust's statement of purpose has been updated accordingly to include the additional regulated activities. The Guest Hospital was also registered as a separate location, consistent with Corbett Hospital, rather than a satellite site to Russells Hall Hospital, to ensure standardisation during external scrutiny.

The Trust's overall CQC rating has remained as 'Requires Improvement' during 2024/25. There have been no new CQC inspections throughout the year and our current CQC ratings remain unchanged. The Care Quality Commission has not taken enforcement action against the Trust during 2024/25.

Whilst not classed as an inspection, the Trust received a CQC monitoring visit in July 2024, focussing on Mental Health Act compliance. All recommendations from this visit have been taken forward and associated actions completed.

Russells Hall Hospital and Corbett Hospital were last comprehensively inspected in January/February 2019 and the report was published in July 2019, the result of which was an overall rating of 'Requires Improvement'. The full report of the January 2019 inspection is available at www.cqc.org.uk/provider/RNA

The current ratings for core services across the Trust can be found below

Russells Hall Hospital Current Ratings March 2025

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires Improvement (Nov 2023)	Good (Nov 2023)	Good (Nov 2023)	Requires Improvement (Nov 2023)	Good (Nov 2023)	Requires Improvement (Nov 2023)
Medical care (including older people's care)	Good (April 2018)	Good (April 2018)	Good (April 2018)	Good (April 2018)	Good (April 2018)	Good (April 2018)
Surgery	Requires Improvement (May 2019)	Good (May 2019)	Outstanding (May 2019)	Good (May 2019)	Good (May 2019)	Good (May 2019)
Critical care	Good (May 2019)	Good (May 2019)	Good (May 2019)	Requires Improvement (May 2019)	Good (May 2019)	Good (May 2019)
Maternity	Good (April 2023)	Good (April 2023)	Good (April 2023)	Good (April 2023)	Good (April 2023)	Good (April 2023)
Services for children and young people	Requires Improvement (Nov 2023)	Good (Nov 2023)	Good (Nov 2023)	Good (Nov 2023)	Good (Nov 2023)	Good (Nov 2023)
End of Life care	Good (May 2019)	Good (May 2019)	Good (May 2019)	Good (May 2019)	Good (May 2019)	Good (May 2019)
Outpatients	Requires Improvement (May 2019)	N/A	Good (May 2019)	Good (May 2019)	Requires Improvement (May 2019)	Requires Improvement (May 2019)
Diagnostic imaging	Inadequate (January 2019)	N/A	Requires Improvement (May 2019)	Requires Improvement (May 2019)	Inadequate (May 2019)	Inadequate (May 2019)

Overall	Requires Improvement (April 2023)	Good (May 2019)	Good (May 2019)	Requires improvement (May 2019)	Good (November 2023)	Requires improvement (May 2019)

Corbett Outpatients Centre Current Ratings March 2025

	Safe	Effective	Caring	Responsive	Well-led	Overall
Surgery	Requires Improvement (May 2019)	Good (May 2019)	Good (May 2019)	Good (May 2019)	Good (May 2019)	Good (May 2019)
Outpatients	Requires Improvement (May 2019)	N/A	Good (May 2019)	Good (May 2019)	Requires Improvement (May 2019)	Requires Improvement (May 2019)
Diagnostic Imaging	Inadequate (May 2019)	N/A	Good (May 2019)	Good (May 2019)	Inadequate (May 2019)	Inadequate (May 2019)

Overall	Inadequate (May 2019)	Good (May 2019)	Good (May 2019)	Good (May 2019)	Inadequate (May 2019)	Inadequate (May 2019)

Community Health Services Current Ratings March 2025

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community health services for adults	Good (April 2018)	Good (April 2018)	Good (April 2018)	Requires Improvement (April 2018)	Good (April 2018)	Good (April 2018)
Community end of life care	Good (May 2019)	Good (May 2019)	Outstanding (May 2019)	Good (May 2019)	Good (May 2019)	Good (May 2019)

Overall	Good (May 2019)	Good (May 2019)	Outstanding (May 2019)	Requires Improvement (April 2018)	Good (May 2019)	Good (May 2019)

3.6.1 Improvement plans

Following all inspections, action plans have been created to support improvements. Plans are reviewed regularly and presented to the CQC for assurance.

3.7 Quality of Data

3.7.1 Hospital Episode Statistics

The Dudley Group NHS Foundation Trust submitted records during 2024/25 to the Secondary Uses Service (SUS) for inclusion in the Hospital Episode Statistics (HES) which are included in the 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%	99.6%
Outpatient Care	99.9%	99.8%
Accident and Emergency Care	99.7%	98.9%

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%	99.8%
Outpatient Care	99.9%	99.5%
Accident and Emergency Care	100%	99.5%

Latest available figures from NHS England CDS DQ Dashboard:
Provider View (for APC and OPA) and ECDS Current View for April 2024 to November 2024

3.7.2 Information Governance

All organisations that have access to NHS patient information must provide assurances to NHS England that they have the appropriate measures in place to ensure that information is kept safe and secure. To do this, they must complete the NHS England's Data Security & Protection Toolkit (DSPT).

The Dudley Group NHS Foundation Trust is practising good data security by currently reviewing and providing evidence for its return on the DSPT which has now been changed to adopt the

National Cyber Security Centre's Assessment Framework (CAF) as its basis for cyber security and information governance assurance.

The toolkit is measured against five objectives with an overall 47 outcomes for the organisation to measure against. Evidence items vary from policies and procedures to examples of good practice and technical security controls which are in place.

The date for the submission of the 2024-25 toolkit is 30 June 2025 and, therefore, the results were 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).

3.7.3 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 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 2024/2025**
Primary diagnosis	>= 90.0%	>= 95.0%	92.0%
Secondary diagnosis	>= 80.0%	>= 90.0%	95.05%
Primary procedure	>= 90.0%	>= 95.0%	96.12%
Secondary procedure	>= 80.0%	>= 90.0%	92.47%

Standards were exceeded in each category.

Outcomes / Recommendations	Actions
The coding guidance issued for various non-indexable conditions enhanced consistency in coding across the Clinical Coding Department. It was noted that coders consistently checked histology reports to ensure accurate coding of diagnosis following excisions and biopsies. The clinical documents on the patient record did not always clearly state key diagnoses, but coders did a good job of extracting information from the sources available. Additionally, it was noted that coders diligently obtained comorbidities from the patient's Shared Care Record to obtain additional comorbidities from GP records that were not always to be found within the clinical record. Dialogue will continue with clinical teams.	Continue to work with clinicians to remind of the importance of accurate and up-to-date recording of diagnoses and comorbidities to ensure the coders can code an accurate reflection of the patient episode. Emphasise to clinicians the need for clear diagnostic statements, in particular a clear indication of the primary diagnosis for the episode to aid the accurate coding of the patient encounter. Provide feedback and training to the clinical coding department to address errors identified during the audit and the use of EPR systems Continue to liaise with departments to ensure the clinical coding receives full documentation, including operation notes (Addresses C7).

3.8 Learning from deaths

During 2024/5, 1686 of The Dudley Group NHS Foundation Trust patients died. This comprised of the following number of deaths which occurred in each quarter of that reporting period (see chart below).

By 31 March 2025, 224 case records reviews and 34 investigations have been carried out in relation to the 1686 deaths.

In 34 cases a death was subjected to both a case record review and an investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out is shown below.

3.8.1 Harm

Four deaths representing 0.2% of the 1686 patient deaths during the reporting period are judged to be more likely than **not** to have been due to problems in the care provided to the patient. In relation to each quarter, this consisted of:

- 0 representing 0% for the first quarter.
- 0 representing 0% for the second quarter.
- 1 representing 0.5% for the third quarter.
- 0 representing 0% for the fourth quarter.

1682 deaths representing 99.8% of the 1686 patient deaths during 2024/5 are judged to be more likely **not** to have been due to problems in the care provided to the patient.

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).

Dudley Group NHS FT	**Reporting Period 2024/5**				
	Q1	**Q2**	**Q3**	**Q4**	**Comments**
Number of patients who died	370	322	417	577	
Number of deaths subjected to a case note review	31	35	20	54	
Number of deaths subjected to an investigation	15	6	11	18	
Number of deaths subject to a case note review and investigation	15	6	11	18	
Number and representing percentage of quarterly total judged more than likely **NOT** to be due to problems in care	31 (100%)	35 (100%)	19 (95%)	18 (100%)	
Number and representing percentage of quarterly total judged more than **likely** to be due to problems in care	0 (0%)	0 (0%)	1 (5%)	0 (0%)	
Estimate of the number of deaths thought to be more likely than not due to problems in the care provided	0	0	1	0	

3.8.2 Learning

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.
- The Trust and community teams are continuing to implement 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.
- There is continued awareness of patients remaining for over four hours within ED which does not allow for best holistic care.
- Continued inappropriate admissions to hospital 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 a very short period, but many are due to challenges in flow.

- A gap in updating the Gold Standard Framework (GSF) for patients when they begin to deteriorate. Overall end of life care is good within the Trust.
- A lack of completion of mental capacity assessments on patients known to have dementia/learning disabilities.
- An increase in the number of falls coming to Structured Judgement Review.

A description of the actions and lessons learnt the Trust has taken during the period.

- Ongoing implementation of the GSF.
- The medical examiner system is now reviewing all deaths within the Dudley Borough.
- Cases with learning are highlighted to the specialty and discussed at the Joint Mortality Meetings within the ICS.
- Implementation of improvement groups for fractured neck of femur and EmLap.
- Positive assurance related to quality of care includes, SJRs output, falling HSMR with no weekend effect and no regulation 28 notices in five years.
- The Trust is being supported by the Advancing Quality Alliance (AQuA) to look at several deteriorating patient pathways. The condition groups undertaking this work are Community Acquired Pneumonia, Acute Kidney Injury, Sepsis and Decompensated 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.
- Implementation of RESPECT document both within the Trust and the community setting.
- Validation of case notes for Acute Cerebrovascular Disease, Pneumonia and Fracture Neck of Femur.

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

- Sepsis mortality continues to be stable albeit an outlier.
- Medical Examiner scrutiny is used as the primary review of death to allow a more robust approach to structured judgement reviews and alerts.
- Fracture Neck of Femur Improvement Group continue to action improvements in patient care, aligned with the National Hip Fracture database including the building of a Power BI that reflects the KPIs.
- Continuing reduction in the SHMI for Fracture Neck of Femur and Acute Cerebrovascular Disease. Both conditions are now within the acceptable range for the Trust.
- EmLap Improvement Group have implemented a trust wide policy for EmLap patients, there are work streams working on improving the time to scan and movement to the appropriate ward.

3.9 Seven Day Hospital Services (7DS)

The ‘7 Day Service’ (7DS) programmes aim is to provide a standard of consultant-led care to patients presenting urgently or as an emergency to ensure outcomes are optimised and there is equity of access nationwide. Until 2020, the Trust was required to complete a Board Assurance Framework return to NHS England.

The Trust now reports via an internal board report and a deep dive into compliance was submitted to the Quality Committee in March 2024. This provided assurance that services are in place to meet the required 10 standards. Compliance with '7-day service' standards has been a fundamental element of job planning consistency checks in 2024/25.

Priority Standards

Standard	Assurance
Standard 2: All emergency admissions must be seen and have a thorough clinical assessment by a suitable consultant as soon as possible but at the latest within 14 hours from the time of admission to hospital.	The Trust has a strong assurance in relation to the 14 hours review standard due to the continual review model in Acute Medicine. In addition, acute physicians work within the Emergency Department daily. This was evidenced in job plans from the last planning round and confirmed during consistency panels. Seven day consultant cover was documented in the majority of consultant plans.
Standard 5: Hospital inpatients must have scheduled seven-day access to diagnostic services, typically ultrasound, computerised tomography (CT), magnetic resonance imaging (MRI), echocardiography, endoscopy, and microbiology. Consultant-directed diagnostic tests and completed reporting will be available seven days a week.	There is emergency and urgent access to CT, MRI and Ultrasound based on the critical (1 hr) and urgent (12 hr) turnaround time. Whilst overall compliance has been achieved for Standard 5, further work is required for compliance against all modalities specifically CT and MRI as significant challenges remain. Due to staffing and skill mix MRI scans are not available overnight with an SLA in place with UHB for transfer of patients requiring emergency neurological imaging. A seven day consultant on-call service is provided by endoscopy procedures and is evident in gastroenterology consultant job plans. Consultant Microbiology workforce provides 24/7; 365 service via a duty microbiologist rota which is available via switchboard and directly accesses a consultant at any time. This service also delivers the Health and Social Care Act requirement to have 24/7; 365 infection control advice as the IPC nursing team currently work only within the core working week; all other advice provided out of hours and weekends is provided by the Microbiology Consultant workforce.
Standard 6: Hospital inpatients must have timely 24 hour access, seven days a week, to key consultant-directed interventions that meet the relevant specialty guidelines, either on-site or through formally agreed networked arrangements with clear written protocols. These interventions would typically be:	The Trust has a critical care unit supported by critical care outreach 24/7. There is emergency and urgent access to interventional radiology and CT for thrombolysis. A consultant on-call model is in operation for urgent endoscopy requests seven days per week.

Standard	Assurance
• critical care • interventional radiology • interventional endoscopy • Emergency general surgery • emergency renal replacement therapy • urgent radiotherapy • stroke thrombolysis and thrombectomy • percutaneous coronary intervention • cardiac pacing (either temporary via internal wire or permanent).	A consultant on-call model is in operation for general and vascular services. Dudley consultants work on a shared rota with Royal Wolverhampton to provide coronary interventions.
Standard 8: All patients with high dependency needs should be seen and reviewed by a consultant TWICE DAILY (including all acutely ill patients directly transferred and others who deteriorate). Once a clear pathway has been established, patients should be reviewed by a consultant at least ONCE EVERY 24 HOURS, seven days a week, unless it has been determined that this would not affect the patient's care pathway.	Over 90% of consultants had a signed off job plan in 2023/24 with speciality level consistency panels held during Summer 2024. A key criterion for the panel was seven day service compliance. Respiratory and endocrinology had previously been highlighted as partially compliant. Endocrinology was again partially compliant, with reliance on the current consultant body undertaking additional sessions to provide the required cover. A business case has been approved for additional resource, but recruitment remains a challenge. Respiratory are partially compliant and were able to demonstrate job planned ward rounds at weekends.

A Trust wide audit will be included in the 2025/26 audit plan to reassess all standards. This will complement existing work underway to improve the quality of handover in the Trust.

3.10 Raising Concerns

The Trust is committed to giving every member of staff the opportunity to speak up. A concern can be about anything that gets in the way of people doing their job. The Freedom to Speak Up (FTSU) Guardians are impartial and provide support and a safe environment to listen to the work force.

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

- Diane Wake - CEO and executive lead for Freedom to Speak up.

- Catherine Holland – non-executive lead for Freedom to Speak up.
- April Burrows – Lead Freedom to Speak up Guardian.
- Mwamba Bennett – Freedom to Speak Up Guardian
- Philippa Brazier – Freedom to Speak up Guardian.

The team operates an open-door policy and information and contact details for the service can be found on the Trust intranet and on posters displayed around the Trust sites.

3.10.1 Governance arrangements

The FTSU steering group, which meets quarterly, includes representation from human resource staff side and communications. The group reports into the Workforce Committee and to Trust Board as required.

In line with the National Guardian's Office (NGO) 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.

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.

The Black Country Integrated Care System Guardians have monthly meetings to provide peer support and develop joint working where appropriate.

3.10.2 Champions

To maximise the accessibility of the FTSU service, we have a network of 35 champions across the Trust in various roles including administrative, AHP, nursing and medical. 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.

Proactive efforts have been undertaken to ensure there are champions based in as many key areas as possible: this includes champions across all sites. Ongoing recruitment continues, with training days planned over the year.

A core group of experienced champions remain in place throughout the acute and community sites including imaging, pharmacy and Brierley Hill Health and Social Care Centre.

It is widely acknowledged that some staff groups may experience barriers to speaking up/raising concerns and the FTSU team are committed to working towards removing these barriers. The champion network includes representation from EmbRACE, LGBTQ+ disability and women's staff networks.

3.10.3 Next steps being taken by the Trust.

1. All three FTSU training modules have now been released by the National Guardian's Office. They are not mandated at present but are recommended for the following staff groups:

- Speak up – for all staff.
- Listen up – for all managers.
- Follow up – for senior leaders.

Online training sessions to be introduced from April 2025 for the Speak up – for all staff.
Managers training session to be introduced from July 2025 for the Listen Up.
Senior Leaders continue to complete the online module with a face-to-face session from National Guardian's Office (NGO) in June 2025 at the ICB collaborative training event.

2. The NGO 'Freedom to Speak up – a reflection and planning tool' has been completed by senior leaders. A collaborative training event is planned for the summer 2025 for all executive and non- executive leaders across the ICB.
3. The Freedom to Speak up policy and strategy is being updated in 2025. Which is in line with the NGO recommendations.

3.10.4 Recent activities

Drop-in sessions planned across all locations, including the following weekly session: Thursday afternoon in the information hub and Friday afternoons in C4 POD on the second-floor main corridor.

By monthly visits to Corbet Hospital and Dudley Guest will continue through 2025.

3.11 Junior Doctor Rota Gaps and The Plan for Improvement

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 and strengthened by the 2024 publication 'Improving the working lives of doctors in training'.

The Trust has taken several actions to minimise gaps. These include:

- A medical training initiative (MTI) training programme has been established. These doctors help to cover any ongoing Deanery and Trust vacancies at registrar and Senior House Officer 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 medical teams with appropriate supervision. This has been particularly successful in the Acute Medical Unit and has been extended to other areas in the Trust.
- 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. The Trust is working to roll our Medirota to all medical teams in 25/26.

- Funding of rota co-ordinators in specific departments to co-ordinate rotas and provide a single point of contact for doctors.

Theatre staff and Ophthalmology staff.

Part 4: National Core Set of Quality Indicators

4.1 Preventing People from Dying Prematurely

4.1.1 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

SHMI	2020 –2021	2021 –2022	2022 – 2023	2024 - 2025
Trust	1.12 (Band 1)	1.13 (Band 1)	1.04 (Band 2)	1.01 (Band 2)
National Average	1.01	1.02	1.00	1.00
Best	0.75	0.67	0.67	0.71
Worst	1.21	1.27	1.22	1.3
Palliative Coding % - Trust	19.5%	20.9%	51.1%	52.97%
England Average	36.8%	37.8%	42.0%	-

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:

- Ongoing implementation of the Gold Standards Framework (GSF).
- The Medical Examiner system is fully implemented and reviews 100% of deaths within Dudley and the wider community.
- Collaboration between mortality and governance to identify themes that identified via the PSIRF process.
- Improvement Groups have been implemented for Fracture Neck of Femur and EmLap. Using KPI's identified in the national audits areas where improvements can be made the groups have built actions and work streams. To date there have been improvements made in both areas including the implementation of the trust wide SOP for EmLap

Pathway and the decrease in the SHMI for Fractured Neck of Femur to a level that is within the acceptable range for the trust.

- 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 supported by the Advancing Quality Alliance (AQuA) to look at several deteriorating patient pathways. The condition groups currently been undertaken AKI, sepsis, community acquired pneumonia and decompensated liver disease. Significant improvements have been noted in DLD. The Trust also has developed an electronic Deteriorating Patient Pathway to highlight patients at risk of deterioration, which has been embedded across the whole Trust resulting fewer medical emergency team (MET) calls and cardiac arrests.

4.2 Helping People to Recover from Episodes of Ill Health or Following Injury

4.2.1 Patient reported outcome measures

This data is no longer reported in the official publication of all Quality Accounts national audits.

4.2.2 Readmissions to Hospital within 30 Days of Discharge

	2023/24		2024/25		
	0 – 15 years	16 & over	0 – 16 years	16 & over	Total
Discharges*	**4301**	**122745**	**4749**	**137274**	**142023**
Readmissions within 30 days (number)	**267**	**13515**	**349**	**16384**	**16733**
Percentage %	**6.2%**	**11.0%**	**7.3%**	**11.9%**	**12%**

- **National Readmission data is not available until end of Q1 25/26 therefore this is a reflection of internal monitoring and is unlikely to match and subsequent nationally published data on readmissions**

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

4.3 Ensuring People Have a Positive Experience of Care

4.3.1 Responsiveness to the Personal Needs of Patients

Following the merger of NHS Digital and NHS England on 1st February 2023, the future presentation of the NHS Outcomes Framework indicators are being reviewed. As part of this review, the annual publication which was due to be released in March 2023 has been delayed. This is indicator is currently not available on NHS England Digital 4.2 Responsiveness to inpatients' personal needs - NHS England Digital

4.3.2 National Patient Experience Surveys

The Trust participates in the national annual patient experience survey programme and undertakes all national surveys as referenced by the Care Quality Commission (CQC) each year.

National Inpatient Survey
The CQC National Adult Inpatient Survey 2024 will not be publishing its results until August 2025. To note the following scores and actions relate to the latest published National Adult Inpatient Survey 2023.

The Inpatient Survey is part of a national survey programme and collects feedback on the experiences of inpatients using NHS services across the country. The feedback from the Inpatient Survey provides invaluable feedback which we use to drive improvement and to improve patient experience. Patients were eligible to participate in the survey if they were aged 16 years or over, had spent at least one night in hospital. The survey is split into 11 categories: admission to hospital, the hospital and ward, doctors, nurses, care and treatment, operations and procedures, leaving hospital, feedback on the quality of your care, kindness and compassion, respect and dignity, and overall experience.

The results from the National Adult Inpatient Survey 2023 (published August 2024) shows that the Trust is performing 'about the same' when compared to all other trusts. The Trust top five results for the Trust were for:

- ✓ **Support from health or social care services:** Patients getting enough support to recover/manage condition after leaving hospital
- ✓ **Sleeping:** Patients being prevented from sleeping at night due to hospital lighting
- ✓ **Cleanliness:** Cleanliness of hospital room or ward

- ✓ **Leaving hospital:** Staff discussing with patients whether patients may need further health/social care services after leaving
- ✓ **Privacy:** Patients being given enough privacy when being examined or treated

The table below details questions from the national Inpatient Survey 2023 where there was a decline in score in comparison to the previous year's survey and the national average.

Question/Quality Priority	Trust Score 2023	Trust Score 2022	National Average	Expected Range
The Hospital and Ward				
If you brought medication with you to hospital, were you able to take it when you needed to?	7.0	7.3	8.0	**Worse than expected**
Your Care and Treatment				
Did the hospital staff take into account your existing individual needs?	6.9	N/A	7.6	**Worse than expected**
Leaving Hospital				
Were you given enough notice about when you were going to leave hospital?	6.0	6.1	6.8	**Worse than expected**
Before you left hospital, were you given any information about what you should or should not do after leaving hospital?	7.0	7.1	7.8	**Worse than expected**
Thinking about any medicine you were to take at home, were you given any of the following?	3.8	4.0	4.3	**Somewhat worse than expected**

The key themes included patients feeling involved, informed and listened to. Patients being able to take their own medication has been a recurring theme from previous surveys over the past five years.

Preparation for discharge, communication around what should/should not be done after leaving hospital and being given advice and support on medicines to take home. Communication relating to discharge has been a recurring theme from previous surveys and is a quality focus for the Trust for 2024/2025. We recognise that involving patients in planning their discharge earlier in the patient's pathway facilitates the patient to be involved in decision making and an improvement in discharge planning centred around our patients' needs.

A Discharge Improvement Group (DIG) has been established and is a standing item on the Patient Experience Group (PEG) agenda. Progress is monitored through updates against the workstreams at PEG for assurance of recommendations having been completed and improvements made.

National Cancer Patient Experience Survey (CPES) 2023 (Published July 2024)

Historically, the survey demonstrates an improved picture. Questions in the ‘Hospital Care’ and ‘Your Treatment’ have seen the biggest improvement since the 2022 survey around communication and controlling pain.

There has been an improvement in scores in the ‘Your Treatment’ section and the most improved scores were for patients being provided with understandable information on hormone therapy and immunotherapy.

There are 12 questions that are below the expected range of what Trusts of the same size and demographics are expected to perform. These scores are in the lower limit of the expected range and are negative outliers.

The main themes for improvement and where scores fell below or within the lower expected range were around information on diagnostic tests, involvement in care planning and decisions about care and treatment, information about leaving hospital and having a member of staff to talk to whilst being treated as an outpatient or day case.

Scores for teams working together, administration and patient’s average rating of care and support from the patients GP during treatment fell below the expected range. Scores were below the average and within the lower expected range for waiting times for diagnostic tests and length of waiting time at clinic and day unit for cancer treatment, a recurring theme from the 2022 survey. Although the score for waiting times at clinic has seen an improvement from the previous year.

To improve the National Cancer Patient Experience Survey results the cancer triumvirate are working with the clinical teams and divisions to improve pathways/waiting times and implement the best practice timed pathways for each tumour group.

Urology, Colorectal, Gynae and Skin have implemented triage processes to streamline patients into the most suitable pathway. Colorectal and Skin have implemented a Straight to Test service for patients to reduce waiting times. At the end of 24/25 we achieved the 80% FDS target by March 2026 set by NHSE and are close to achieving the 75% target for 62 days.

The Living with and Beyond Cancer team are manning the patient information centre once a week to provide cancer support to the Trust’s patients/visitors. Cancer Services continue to provide cancer waiting times training to all Trust staff.

National Maternity Survey 2024 (Published November 2024)

The survey demonstrates a much-improved picture in comparison to the 2023 survey. The Trust is performing ‘about the same’ as other trusts nationally in 2024. There has been a decrease in the number of questions that are performing ‘somewhat worse, worse, or much worse’ than the expected range in 2024 in comparison to the 2023 survey.

Areas where the Trusts ‘somewhat worse/worse’ than expected’ in 2024 are around women being offered a choice, and information on where to have their baby, being asked about their mental health during antenatal check-ups and after having their baby, staff introducing themselves.

There are two questions that are performing ‘better than expected’ in 2024 in comparison to no questions in 2023: for women being asked if their decisions about how they wanted to feed their baby was respected by midwives and if they were given enough advise.

Best and worst performance relative to the trust average

The top five results for the Trust that are highest compared with the average of all Trusts were for postnatal care (feeding your baby and care in the ward after birth) as follows:

1. Did you feel that midwives gave you enough support and advice to feed your baby?
2. Do you think your healthcare professionals did everything they could to help manage your pain in hospital after the birth?
3. Thinking about the care you received in hospital after the birth of your baby, were you given the information or explanations you needed?
4. On the day you left hospital, was your discharge delayed for any reason?
5. Were your decisions about how you wanted to feed your baby respected by midwives?

The bottom five scores for the trust that are lowest when compared with the average of all trusts where patient experience could be improved is around postnatal care (care at home after birth) and antenatal care (the start of your care during pregnancy):

1. Thinking about your stay in hospital, if your partner or someone else close to you was involved in your care, were they able to stay with you as much as you wanted?
2. Were you offered a choice about where to have your baby?
3. Were you given information about any changes you might experience to your mental health after having your baby?
4. Did you get enough information from either a midwife or doctor to help you decide where to have your baby?
5. Were you told who you could contact if you needed advice about any changes you might experience to your mental health after the birth

To improve the survey results a coproduced action plan has been developed alongside the Maternity and Neonatal Voices partnership. Areas of comment included increased visiting times, more access to hydration and nutrition as well as delays in waiting for care and discharge.

The Maternity team has worked on developing 24/7 birth-partner visiting, the first organisation across the Black Country to adopt this pattern of visiting. A hydration station has been purchased from charitable funds to ensure women on the ante and post-natal ward always have access to food and drink day or night. Improvement workstreams across delivery suite and the ward are underway to enhance waiting times for procedures as well as for discharge home. All pathways are under constant review and being fed back to the Maternity and Neonatal Voices Partnership quarterly meetings.

Urgent and Emergency Care (UEC) 2024 (Published November 2024)

The Overall Patient Experience Score (OPES) ranged from the lowest score in England of 6.0 to the highest trust score in England of 8.5. The Trust score for 2024 is 7.0 a decline since 2022 (7.7). This score is performing ‘about the same’ when compared to all other trusts but is below the national average score of 7.3.

The Trust is performing ‘about the same’ as other trusts nationally. There are two questions that are performing ‘better than expected’ in 2024 in comparison to no questions in 2022 (Q7. were you told why you had to wait with the ambulance crew and Q41. if you contacted any health or social care services after leaving A&E, was the care and support available when you needed it).

One question is ‘somewhat better than expected’ (Q38. From the information you were given by hospital staff, did you feel able to care for your condition at home).

Two questions are performing ‘somewhat worse than expected’ in 2024 in comparison to no questions in the 2022 survey (Q13. were you informed how long you would have to wait to be examined or treated and Q30. do you think the hospital staff helped you to control your pain). 24 out of 29 questions are performing ‘about the same’ as other trusts nationally).

Patients who attended A&E were positive around being given information about medications and being able to care for their condition at home.

Top five scores (compared to national average)

1. Were you told why you had to wait with the ambulance crew?
2. Thinking about any new medication you were to take at home, were you given any of the following?
3. From the information you were given by hospital staff, did you feel able to care for your condition at home?
4. To what extent did you understand the information you were given on how to care for your condition at home?
5. If you needed help to take medication for any pre-existing medical conditions, did staff help you?

Improvements focus on waiting, care and compassion, privacy and helping to control pain:

Bottom five scores (compared to national average)

1. While you were waiting, were you able to get help with your condition or symptoms from a member of staff?
2. Were you informed how long you would have to wait to be examined or treated?
3. Do you think the hospital staff helped you to control your pain?
4. If you had any anxieties or fears about your condition or treatment, did a doctor or nurse discuss them with you?
5. Were you given enough privacy when discussing your condition with the receptionist?

To improve patient feedback scores in the Emergency Department (ED), several targeted actions are being implemented based on insights from the 2024 Urgent and Emergency Care Survey. Efforts include enhancing privacy for patients discussing symptoms by introducing written slips at reception and clearer signage, as well as managing queuing with floor markers. Communication regarding wait times is being improved through additional digital boards, verbal updates from reception staff, and regular audible announcements.

To address difficulties in accessing help, call button response times are being monitored, and leadership details are displayed in cubicles. Reducing patient time in the department remains a priority, with increased collaboration with external partners, improved patient tracking, and dedicated therapy teams to prevent delays. Additionally, efforts to enhance communication about test results and further care include ensuring discharge documentation is properly shared and developing informational leaflets. Finally, to maintain dignity and respect, hot meals are now available for all patients, and volunteers provide additional support. These initiatives are monitored through ongoing review meetings and assurance metrics to ensure lasting improvements in patient experience.

Progress against actions is monitored through divisional updates at the PEG meeting for assurance of recommendations having been completed and improvements made.

4.3.3 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 survey 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	2022/23	2023/24	2024/25
% Very Good/Good	83%	83%	83%
National Benchmarking	90%	91%	91%
% Very Poor/Poor	6%	6%	6%
National Benchmarking	6%	4%	5%

*No data for March 2025

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

The percentage of very good/good scores have improved from the previous year. We had increased the number of mechanisms for patients to leave feedback and the Trust have implemented the Patient Experience Champions role within each ward and service to drive the FFT.

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.
- Patients' responses and feedback are shared with teams for earning and service improvement, comments and 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 patients' maternity antenatal and postnatal notes and ensure that the FFT is accessible to all, as SMS text messaging was not available within the service. Posters and paper surveys are to be updated in the Antenatal Department as these are currently out of date.
- We have implemented the Patient Experience Champions role within the Trust and each ward and service have identified a Patient Experience Champion for their area. The

champions will promote patient experience within their areas to help drive Trust-wide improvements, share good practice, and provide the best patient experience and care.
- We have hosted a number of patient panels and supported several departments and teams to deliver 'Listening into Action' events throughout the year to capture people's views and experiences on what we did well and what we could improve to help us shape future service.

4.3.4 Staff Recommendation to Family and Friends

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

	2024/25			
	Q1	**Q2**	**Q3**	**Q4**
Dudley Group NHS FT	**53.6%**	**52.4%**	**56.8%**	**51%**
National average for Acute and Combined acute/community Trust	Data not available	Data not available	**61.54%**	Data not available
Highest Acute and Combined acute/community Trust	Data not available	Data not available	**89.59%**	Data not available
Lowest Acute and Combined acute/community Trust	Data not available	Data not available	**39.72%**	Data not available

Data source

Quarter 1, 2 and 4 – National Quarterly People Pulse.
Score is a % score based on positive answer (Strongly Agree and Agree) to If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation.
Response rate for People Pulse varies across each quarter. Average <10% response rate.
Quarter 3 – National Staff Survey – Delivered across two months in Q3. Response rate higher than People Pulse. For Q3 2024/25, response rate 49%.

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

- Continuing workforce pressures have resulted in staff unable to deliver the care they aspire to
- 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 remain low (<20%). Data in these months are lower than for the national staff survey. Performance in the national Staff Survey has remained static.

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

- Increasing response rates to People Pulse to ensure data is comparable across each quarter

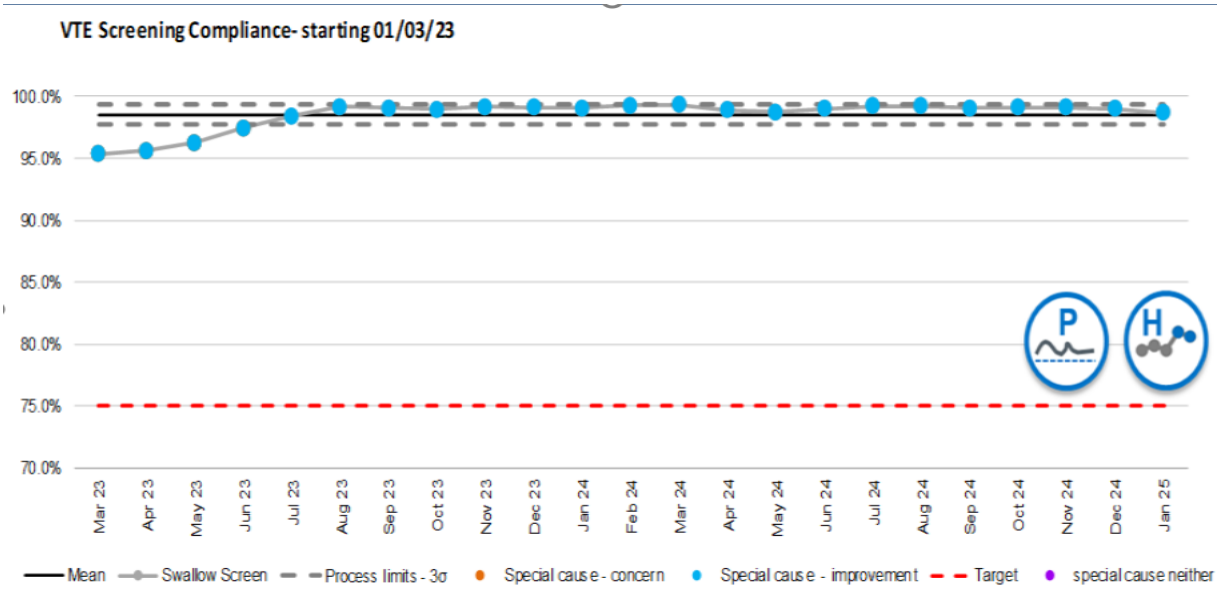
- Using quarterly pulse data to capture areas where staff identify improvements can be made in this area
- Continuing to increase the Staff Survey response rate with a 4% improvement this year
- Focusing on workforce recruitment and retention activity through the Trust People Plan and Recruitment and Retention Journey. This includes a focus on flexible working, development support and ongoing recruitment which will improve staff experience in the long term.
- Developing local action plans and additional engagement and support 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.
- Promoting compliments and showcasing examples of positive patient experience to ensure recognition of staff contribution to delivery of care

4.3.5 Chaplaincy

The Chaplaincy Service at Dudley NHS Trust provides holistic, multifaith, and person-centred spiritual care for patients, families, and staff. Between April 2024 and March 2025, the service received 84 referrals, with 19% linked to end-of-life care. The team conducted 19 funeral services, including 13 baby bereavement funerals, and supported 6 urgent baby bereavement cases. Their integration into palliative care and ED trauma support (TRiM) has strengthened resilience for staff and patients. Chaplaincy services also expanded staff well-being initiatives, offering one-to-one pastoral care, text-based support, and reflective sessions. Faith-based engagement included memorials, cultural celebrations, and prayer services. Looking ahead, the team will enhance training for student chaplains, expand digital accessibility, and strengthen end-of-life pastoral support. The Chaplaincy team remains committed to delivering compassionate, inclusive care that aligns with NHS Dudley Trust's strategic priorities.

4.4 Venous Thromboembolism

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.
The Trust provides updates via the Integrated Performance Report to Trust Board on a regular basis. Compliance with the first assessment has been above the 95% target since May 2023 as shown below. Work continues to improve the second assessment requirement.



The Dudley Group NHS Foundation Trust has the following actions in place to sustain the improved position:

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

4.5 Infection Control – Clostridiodes Difficile (C.DIFF)

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

	2021/22	2022/23		2023/24	2024/25
Trust apportioned cases (Lapses in care)	18	3	**Trust Apportioned case (HOHA)**	37	48
Trust bed days	242,400	242,400		242,000	242,000
Rate per 100,000 bed days	43.9281982040303	26.3075971956101		48.9282584092785	

National average	25.1971091564799	27.55607775882		29.4754188907972	
Best performing trust	0	0		0	
Worst performing trust	138.379575174704	133.644082989716		131.2401362	

Data source: CDI annual data table 2024/2025

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

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

- The Trust has seen an increase in *Clostridiodes difficile* cases over the last 12 months in line with the both the local and national pictures.

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

- The process for reviewing CDI cases in line with the national framework is now embedded.
- During 2023/2024 the trust moved away lapse/no lapse in care and reviewed cases for learning outcomes and common themes which are shared across the trust and discussed at The Infection Prevention and Control Group.
- The Infection Prevention and Control Team carry out CDI Round wards weekly with an antimicrobial pharmacist to review all CDI cases.
- 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.

4.6 Patient Safety Incidents

Dudley Group NHS FT	Latest reporting period Apr 2022 – Mar 2023	Latest reporting period Apr 2023 – Mar 2024	Latest reporting period Apr 2024 – Mar 2025

Total number of reported incidents *	**19382**	**19564**	**19762**
Incident reporting rate (per 1000 bed days)	**73.36**	**72.46**	**66.66**
Total number of patient safety events	**9768**	**10554**	**13485**
Total number of good care events	**888**	**1143**	**1125**
National average (acute non-specialist)	No data available	No data available	No data available
Highest reporting rate (acute non-specialist)	No data available	No data available	No data available
Lowest reporting rate (acute non-specialist)	No data available	No data available	No data available

**including present on admission pressure ulcers and sa*

Dudley Group NHS FT	**Latest reporting period Apr 2022 – Mar 2023**	**Latest reporting period Apr 2023 – Mar 2024**	**Latest reporting period Apr 2024 – Mar 2025**
Incidents causing Moderate, Severe harm or Death	**122**	**106**	**126**
% of incidents causing Moderate, Severe harm or Death	**0.63**	**0.54**	**0.63**
Incidents causing Severe harm or Death only	**26**	**19**	**28**
% of incidents causing Severe harm or Death only	**0.13**	**0.09**	**0.14**
National average (acute non-specialist)	No data available	No data available	No data available
Highest reporting rate	No data available	No data available	No data available
Lowest reporting rate	No data available	No data available	No data available

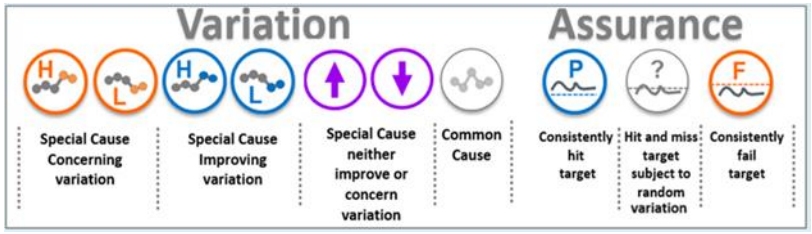
During the reporting period 2024/25, the number of patient safety incidents (events) reported has increased compared to previous reporting periods; this is a positive finding. Following the implementation of the Learning from Patient Safety Events (LFPSE) system in September 2023, monthly reporting numbers declined. This fall in reporting was not unique to Dudley Group; this was seen nationally and in the main was a consequence of the additional information mandated in reporting forms. The Trust has worked hard with reporters and the system supplier to develop reporting templates alongside training sessions and supportive approaches to restore and build upon our reporting numbers. Over the latter part of 24/25, monthly reporting has exceeded pre-LFPSE levels.

The proportion of incidents reported to have resulted in significant harm or death has remained low; all incidents reported to have resulted in significant harm are subject to robust review and consideration for the enactment of Duty of Candour.

4.7 Our performance against the thresholds set out in the Risk Assessment and Single Oversight Frameworks

Constitutional Performance

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



Trust data from DM01 Diagnostic Waiting Times submissions to NHSD
*2023/24 Trust performance shows year to date i.e., April 2022 to December 2022
**2023/24 National performance taken from NHSE website of “Trust” provider DM01 submissions

Glossary of terms:

A&E	Accident and Emergency (also known as ED)	HQIP	Healthcare Quality Improvement Partnership
AAA	Abdominal Aortic Aneurysm	ICB	Integrated Care Board
AKI	Acute Kidney Disease	ICNARC	Intensive Care National Audit & Research Centre
Bed Days	Unit used to calculate the availability and use of beds over time	ICP	Integrated Community Provider
C. diff	Clostridiodes difficile	IPC	Infection Prevention and Control
CMP	Case Mix Programme	KPI	Key Performance Indicator
CPR	Cardiopulmonary Resuscitation	MDT	Multidisciplinary Team
CQC	Care Quality Commission	MRSA	Methicillin-resistant Staphylococcus aureus
CQUIN	Commissioning for Quality and Innovation payment framework	NCEPOD	National Confidential Enquiry into Patient Outcome and Death
CT	Computed Tomography	NEWS	National Early Warning System
DATIX	Company name of incident management system	NHSI	NHS Improvement
DCH	Dudley Clinical HUB – A single point of access for adult community services	NICE	National Institute for Health and Care Excellence
DNACPR	Do Not Attempt Cardiopulmonary Resuscitation	NIHR	National Institute for Health Research
DVT	Deep Vein Thrombosis	PROMs	Patient Reported Outcome Measures
EAU	Emergency Assessment Unit	SDEC	Same Day Emergency Care
ED	Emergency Department (also known as A&E)	SIT Tool	Shortened Investigation Tool
EmLap	High Risk Emergency Laparotomy Pathway	SHMI	Summary Hospital-level Mortality Indicator
FFT	Friends and Family Test	SMS	Short Message Service is a text messaging service
FY1/FY2	Foundation Year Doctors	SOP	Standard Operating Procedure
GI	Gastrointestinal	STEIS	Strategic Executive Information System is the national database for serious incidents
GMC	General Medical Council	SUNRISE	Trust electronic patient record system
GP	General Practitioner	SUS	Secondary Uses Service
HCAI	Healthcare Associated Infections	TTO	To take out medications once discharged as an inpatient
HED	Healthcare Evaluation Data	VTE	Venous Thromboembolism
HES	Hospital Episode Statistics	WBR	Ward Board Rounds
HFL	Home for Lunch Initiative		

Annex

Comment from the Trust's Council of Governors – 2024/25

Each year, the Trust publishes a Quality Account, which provides an overview of the quality of services offered. This report is available to the public and it serves as a key tool for local NHS services to report on their quality performance and show improvements in the care provided to local communities and stakeholders.

The Council of Governors is invited to review the draft Quality Account and provide feedback. For the 2024/2025 report, a copy of the draft was circulated to all governors for review and comment. Governors were supported in gathering responses and preparing a consolidated comment, which is included below:

The Council of Governors has reviewed the 2024/25 Quality Account in detail and is reassured that patient care remains a top priority, with the Trust continuing to focus on delivering quality services despite the financial constraints. The Council will continue to closely monitor how this balance is maintained moving forward.

Throughout the year, the Council has regularly reviewed the Trust's performance data, comparing it against quality indicators and constitutional performance standards. The Council encourages the Trust to continue prioritising improvements in the discharge process by providing timely and clear communication to patients about the process.

The Council also noted that the Quality Priorities for 2024/2025 came from the Adult Inpatient Survey 2022, which highlighted recurring concerns around pain management, nutrition and hydration, and discharge and communication. Although the 2023 survey showed some improvement in these areas, discharge-related scores remain the lowest-performing in national surveys and real-time patient feedback.

The Council commends the Trust for achieving a Level B rating in the Sentinel Stroke National Audit Programme (SSNAP). This reflects service improvement initiatives such as the appointment of a Band 7 bed manager, who works closely with the site team to ensure timely admission of stroke patients to the dedicated unit.

The Council of Governors had supported Priority 5 and Priority 6 for 2024/2025. They were pleased to note the appointment of an Admiral Nurse to support dementia-related targets under Priority 5 and noted encouraging progress with Priority 6, including a 74% completion rate of Tier 1 Oliver McGowan training and the presence of learning disability champions in 37% of clinical areas.

It was reassuring to the Council to see the progress and achievement made by the Trust in reducing the outstanding backlog of complaints not closed within 30 days.

The Council wishes to acknowledge the Trust's ongoing dedication to continuous improvement, which is demonstrated by its proactive approach to enhancing service quality and fostering a culture of innovation. A notable example is the work undertaken by the diabetes team to strengthen staff confidence in managing patients with diabetes. Targeted training sessions on insulin safety and diabetes management were delivered to clinical staff in the Acute Medical Unit and Emergency Department. In addition, the team is developing a diabetes dashboard to support outpatient clinic capacity and streamline data collection for submission to the National Institute for Health and Care Excellence (NICE) audits.

The Trust is also conducting a PIVOT study, which is a new research initiative by the Therapy Department in collaboration with the University of Southampton. This study aims to assess the use of trained volunteers

to help promote increased physical activity among older patients in the hospital. Previous research has shown that low activity levels in this group are linked to poorer health outcomes and reduced independence. Volunteers, trained by the therapy team, will support patients with walking and chair-based exercises depending on their mobility levels. Ten volunteers have been trained, and the programme is scheduled to begin in April 2025.

The Council of Governors were proud of the Trust's implementation of Martha's Rule (also known as "Call for Concern") during this year. This initiative, aimed at empowering patients and families to escalate care concerns, was widely promoted by the organisation and reinforces the Trust's commitment to patient safety and engagement.

The Council has also discussed the Trust's plans to explore the use of artificial intelligence (AI) and is interested in seeing how it could help improve patient experience while maintaining quality standards.

Finally, the Council commends the Trust's work to create a safe and inclusive environment for staff where all staff feel empowered to raise concerns and are confident they will be heard.

The Council was also briefed on the new Quality and Safety Delivery Plan. It was noted that the shift to a joint three-year plan represented a significant change, and while patient experience is not separately listed as a priority, it is understood to be embedded throughout all priority areas.

For 2025/2026, the Council is keen to support the following three Quality Priorities:

- Priority 1 – Improving partnership working
- Priority 6 – Care closer to home through refined patient discharge processes
- Priority 7 – Improving patient outcomes

Comment from the Black County Integrated Care Board – 2024/25

The Black Country Integrated Care Board (ICB) welcome the opportunity to review and comment on the Dudley Group NHS Foundation Trust Quality Account for 2024/2025. This was a transparent, honest and a comprehensive account of the previous year. We would like to take the opportunity to thank the Trust and the staff for their dedication, commitment, and hard work throughout the previous year.

The ICB commends the improvements made by the Trust against the 2024/2025 priorities, with launching 'Call before Convey', re-developing the Emergency Department, improving waiting times for cancer, the see and treat waiting times within the Emergency Department service, Improvements across the Maternity and Neonatal services and the Integration of Dudley Integrated Health and Care Trust. The integration of Dudley Integrated Health and Care Trust provides an opportunity to strengthen collaboration between primary, community and secondary care, improving and innovating high quality care closer to home through seamless integrated neighborhood models of care and reducing demand for acute emergency care services.

We note that the quality priorities for 2024/2025 were partially achieved and acknowledge the ongoing commitment to improving data quality through improved data dashboards within the clinical areas, embedding quality improvement initiatives to improve the discharge processes to improve waiting times and the ongoing improvements to meet the priorities of reducing avoidable harm across the Trust.

You have set clear, comprehensive priorities for the next three years, aligned to the values of the Trust's vision and values. We strongly support your priorities in relation to improving partnership working, improving staff development, and improving the discharge processes, whilst improving waiting times and reducing the number of delayed discharges. We look forward to supporting you with the safe management of the deterioration patient program, ensuring the population of Dudley receives the right care, at the right time, in the right place, delivered by the right person.

The section 'Clinical Audit' provides evidence of the Trust's effectiveness performance. It is positive to see the increased participation in the number of clinical audits undertaken during 2024/25. It is also encouraging to see that the Trust continues to be a strong advocate for research, development, learning, improvement, and innovation, becoming one of the first Trusts in the United Kingdom to receive training status from the International Bowel Ultrasound Group. It is evident from the Trust's quality account that the Dudley Group NHS Foundation Trust are doing great work to progress research, improvement, and innovation across the various departments within the Trust, whilst working with Aston University to work towards gaining University Hospital status.

Throughout this Quality Account, the Trust demonstrates their commitment and aspirations to improve safety and quality of care of services delivered, and the ICB would welcome a continued focus on reducing avoidable harm, including pressure injuries and falls within and across the Trust. Opportunities for strengthened partnerships through revised arrangements in the out of hospital portfolio will support to assure alternative arrangements to treat patients in the right place at the right time, ensuring seamless transfer of care pathways. The continued focus on those patients

with a learning disability and/or mental health condition alongside the opportunity to support people with learning disability and/or mental health condition in collaboration with the Mental Health LDA Lead Provider are welcomed.

Heading into 2025/2026, we thank you for your continued engagement at the provider Quality Meeting and the System Integrated Assurance Groups, continuing our collaborative partnership for the Trust to continuously improve the quality, safety and experience of services available for the population of Dudley place.

Sally Roberts
Chief Nursing Officer/Deputy Chief Executive Officer
Black Country Integrated Care Board

Comment from Healthwatch Dudley

Healthwatch Dudley – Quality Account Statement 2024/25

Due to recent local cuts to services which have resulted in reduced capacity for our team, we have made the decision not to provide a response to the Quality Accounts this year. That said, we are as always, keen to work with you and collaborate on more targeted opportunities that help capture the voice of patients / those accessing services and their carers and families.

Jason Griffiths

Chief Officer

Date: April 2025

Comment from the Health and Adult Social Care Scrutiny Group

Health and Adult Social Care Scrutiny Group – Quality Account Statement 2024/25

The trust has completed its legal obligation to share the 2024/25 annual Quality Account with the Health and Adult Social Care Scrutiny Group. However, due to change in vice chair and chair of the group, they have been unable to provide a statement in response.

Dr. David Pitches

Head of Healthcare Public Health

Date: June 2025

Statement of Directors' Responsibilities in Respect of the Quality Report 2024/2025

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 2024/2025* 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 2024 to March 2025
- Papers relating to quality reported to the board over the period April 2024 to March 2025
- Feedback from Integrated Care Board June 2025
- Feedback from governors June 2025
- Feedback from Healthwatch May 2025
- Feedback from Overview and Scrutiny Committee Dudley Metropolitan Borough Council Health and Adult Social Care Scrutiny Committee May 2025
- The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009,
- The latest national inpatient survey March 2025
- The latest national staff survey, dated March 2025
- 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: Sir David Nicholson
Chair
Date: June 2025

Signed: Diane Wake
Chief Executive
Date: June 2025

Enclosure 10

The Dudley Group NHS Foundation Trust

Paper for submission to the Full Council of Governors on 19 June 2025

Report title:	**Complaints Responsiveness Report**
Sponsoring executive:	Martina Morris, chief nurse
Report author:	Jill Faulkner, associate director of patient experience Lara Fullwood, complaints and PALS manager

1. Summary of key issues

Complaint responsiveness continues to be an issue along with increased number of complaints being received.

Despite actions being taken to improve the responsiveness, the response rate does not attain the Trust's KPI of 90% response rate within 30 working days.

Further review of complaints statistics have been reviewed to identify an improvement plan/recommendations on actions that can be taken during 2025/2026 to improve the responsiveness rate.

The Quality Committee has oversight of the improvement plan. Please see this plan in Appendix 1.

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

3. Report journey

Full Council of Governors Quarterly Meeting

4. Recommendation(s)

The Council of Governors is asked to:

a. To note the comparison between 2023-24 and 2024-25 complaints data.

b. To note the challenges faced and improvement actions made to date.

c. To note the improvement plan/recommendations in light of the above data, challenges faced, and improvement actions already in place.

5. Impact

Board Assurance Framework Risk 1.1	X	Deliver high quality, safe person-centred care, and treatment
Board Assurance Framework Risk 1.2	X	Achieve outstanding CQC rating.

Board Assurance Framework Risk 3.0	X	Ensure Dudley is a brilliant place to work
Is Quality Impact Assessment required if so, add date:		
Is Equality Impact Assessment required if so, add date:		

Complaints Responsiveness Report

1. Introduction

The response rate for complaint handling has been a persistent challenge. The key performance indicator (KPI) for the response rate within the locally set timeframe of 30 working days is 90%. The current average response rate for the last financial year (2024/25) was 47%. Despite this increasing in the last few years (2021/22- 31.9%, 2022/23- 35.9%, and 2023/24- 42.8%), the increase has been slow and steady with the Trust still unable to attain 90% response rate. This continues to remain a concern for the Trust.

This report sets out the comparisons within 2023/24 and 2024/25 figures, in order to identify where the challenges may lie, provides benchmarking data for local trusts for 2023/24 (2024/25 benchmarking data is not currently available), identifies the improvement actions that have been taken and puts forward an improvement plan to be undertaken over the next financial year to improve the response rate.

2. Comparison between 2023/24 and 2024/25

Table 1 below details the comparison key figures between 2023/24 and 2024/25. There have been ten negative increases/decreases with complaints figures and eight positive increases/decreases. One has remained the same (the complaint activity vs. patient contact activity) and one is not possible to compare as reporting in such way only changed in 2024/25 (data not available) (average response rate of first response only complaints within six months).

Please note the below key:

- Negative increase/decrease on last year's figures
- Same increase/decrease on last year's figures
- Positive increase/decrease on last year's figures

Table 1

Activity and performance data	2023/34	2024/25	Increase/ decrease on previous year	Notes
Number of complaints received *(not including reopened complaints)*	956	1053	Increase	When comparing previous year's figures, it is predicted (due to a growing trend in the number of new complaints received) there will be an increase year on year with complaints
Average number of complaints per month at the end of the year (as of 31 March)	79	87	Increase	With the increase in the number of complaints each month, the average has increased. This makes managing the backlog and closing complaints more challenging.
Complaint activity vs. patient contact activity	0.07%	0.07%	Same	Despite the increase in the number of complaints and the increase in patient activity during 2024-25, the % remains the same as the year before.

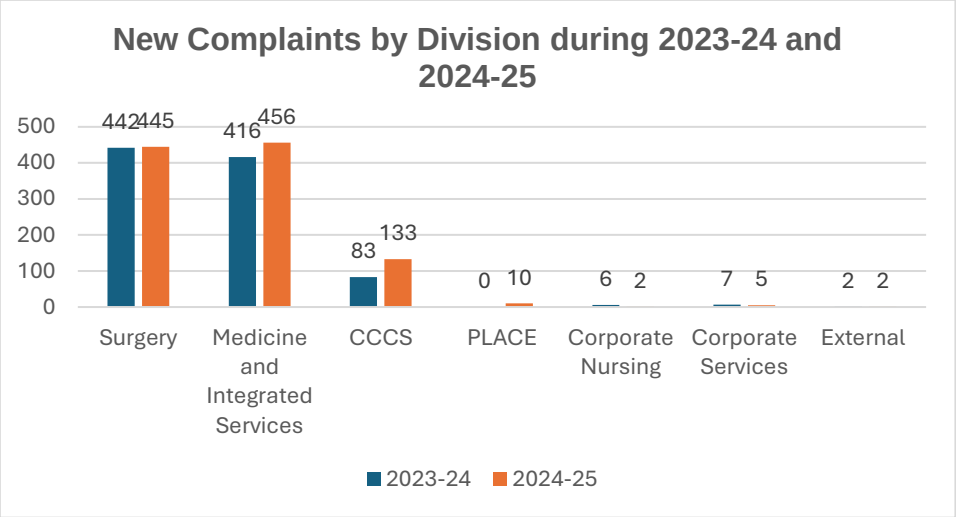
% increase/decrease on number of new complaints received the year before	-7.8%	10.1%	Increase	As mentioned above, the historical trend for complaints is a year-on-year increase and 2023-24 unusually had a decrease in the number of complaints received. In terms of benchmarking, other local trusts also reported a decrease for 2023-24.
Number of all complaints closed	1059	1118	Increase	With the increase in the number of complaints received, it is important for the Trust to close the same amount or more complaints than received in order to prevent breached complaints and have a manageable workload.
Average response rate for all closed complaints (including reopened and early resolution complaints where applicable) within 30 working days	42.8%	47%	Increase	This has improved for the last few years but continues to be a slow and steady improvement. The KPI of 90% is not being reached.
Average response rate for all closed complaints (including reopened and early resolution complaints) within six months	94.4%	98.6%	Increase	NHS Complaints Regulations 2009 allow organisations six months to respond to a complaint. Our local timeframe is 30 working days. There has been an improvement since 2023-24 for closures within six months and this indicates complaints are being responded to in a timelier manner and work continues on the backlog. Please note that those not replied to within six months during 2024-25 were Parliamentary Health Service Ombudsman (PHSO) cases which have entered the second stage of the complaints process.
Average response rate for all closed complaints (excluding reopened and early resolution complaints) within six months	Data not available	99.6%	-	It is not possible to comment on whether there has been an improvement as data is not available for 2023-24. However, it is positive that the Trust has been able to respond to most first response complaints within six months, in line with legislation.
Number of all complaints open at the end of year (as of 31 March)	145	153	Increase	This has increased from 2023-24 but is anticipated given the increase of the number of new complaints. This is a 5.5% increase on 2023-24. Even though this is an increase of 5.5%, there was a 10.1% increase in the number of new complaints received for 2024-25 and to have an increase of 5.5% at the end of the year shows the complaints team are continuing to work on lowering the number of complaints open.
Number of first response only complaints open at the end of the year (as of 31 March)	111	134	Increase	This is an increase of 20.7%. In March 2025, the Trust received a high number of new complaints (101), above the average of 87 and as such these complaints were still under investigation as of 31 March 2025 and this can be seen in the number of first response complaints open that have not yet breached.

Number of first response only complaints breached at the end of the year (as of 31 March)	26	35	Increase	This is a 34.6% increase on last year's figure with a nine-complaint difference.
% of first response only complaints breached at the end of the year (as of 31 March)	23.4%	26.1%	Increase	This is a 2.7% increase.
Average % of first response only complaints breached at the end of the year (as of 31 March)	31.3%	29.6%	Decrease	The above figures compared the data/position as of 31 March 2024 and 31 March 2025. This figure takes the yearly average which is a more accurate/representative figure to consider given the fluctuating nature of the number of complaints received month on month and how this can impact the number of complaints open and breached.
Number of reopened complaints	133	135	Increase	This has only slightly increased and indicates the Trust is able to resolve the concerns raised by the vast majority of its complainants.
Number of early resolution complaints	98	225	Increase	This has increased from the year before showing the Trust is attempting to resolve more complaints through this process.
Average response rate for early resolution complaints	88%	74%	Decrease	Sadly, with the increased number of concerns being dealt with via the early resolution process, there has been a decrease in the response rate. This continues to be above the Trust average (47%) but is below the 90% response rate KPI.
Number of total PALS received (including signposting contacts)	5142	5361	Increase	There have been more PALS total concerns received (4.2%)
Number of PALS concerns and comments received	4144	3875	Decrease	The number of concerns about the Trust has decreased, with the number of signposting contacts increasing (concerns about another organisation, hence the increase in the total PALS activity above).
Complaints formally investigated by the PHSO	5	2	Decrease	It is reassuring the Trust has received only two PHSO cases for 2024-25. This indicates the Trust is providing good responses at local resolution stage as they are not progressing to the PHSO stage.
Complaints investigated by the LGO	0	0	Same	As above.

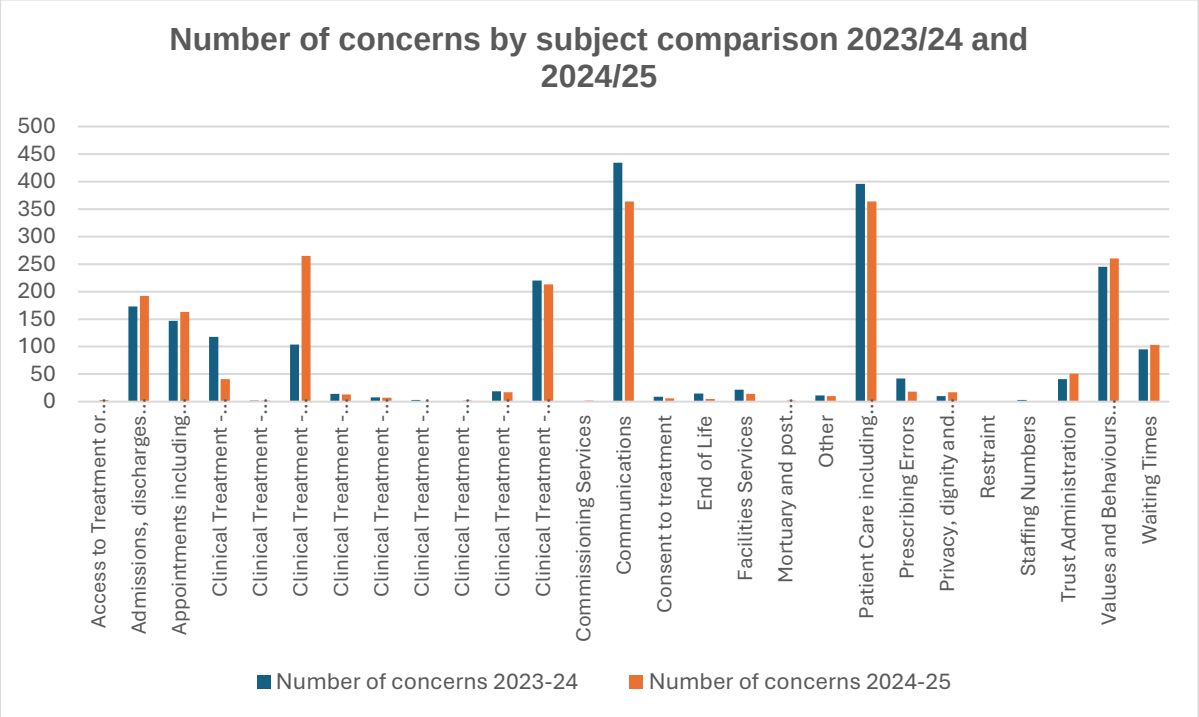
2.1. Early resolution

There were 225 complaints through the early resolution process (compared to 98 for 2023/24). The average response rate of early resolution complaints for 2024/25 is 74% compared to 2023/24 when it was 88% (please note that data for 2024/25 remains incomplete at the time of reporting as there are 10 complaints still under investigation and within the 30-working day time frame). This is a decrease of 14% but with an increase of 127 complaints through this process.

2.2. Comparison of new complaints received per division



2.3. Comparison of complaints by subject



On review of the above graph, with the main themes of complaints (clinical treatment, communications, admissions/discharges, appointments, patient care, values, and behaviours) there has been a slight increase in the number of complaints about admissions/discharges, appointments, values, and behaviours and waiting times. There was a large increase in concerns regarding clinical treatment for general medicine and a decrease in concerns about communications and patient care (including nutrition and hydration). The same main themes occur year on year.

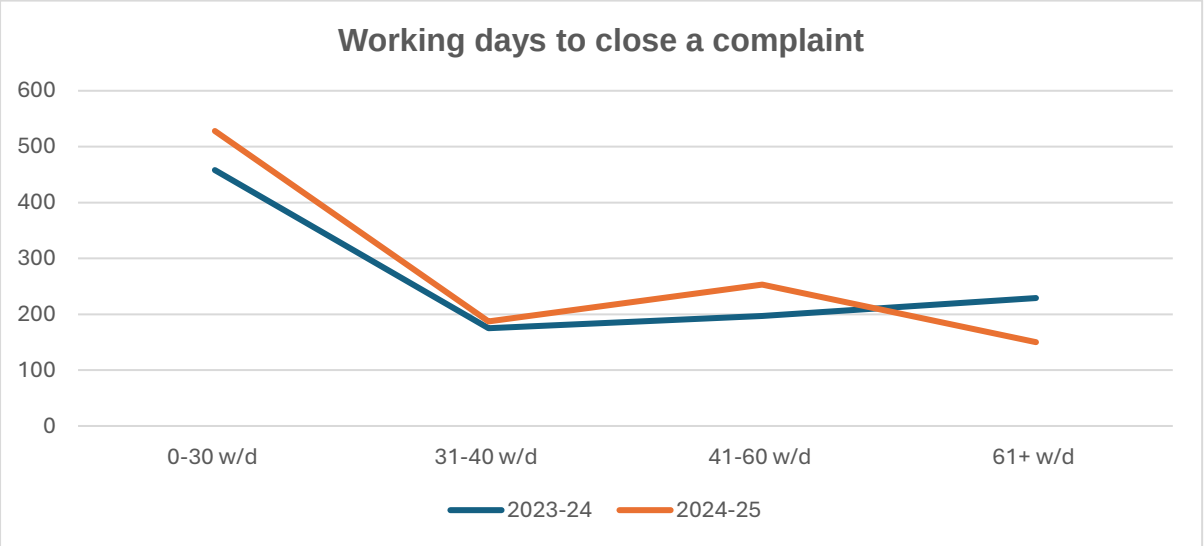
2.4. Comparison of response rate

The Trust has worked at decreasing the backlog of complaints along with responding within 30 working days and the response rate has improved since 2023/24 from 42.8% to 47% for 2024/25.

	0-30 w/d	31-40 w/d	41-60 w/d	61+ w/d
2023-24	458	175	197	229
2024-25	528	187	253	150

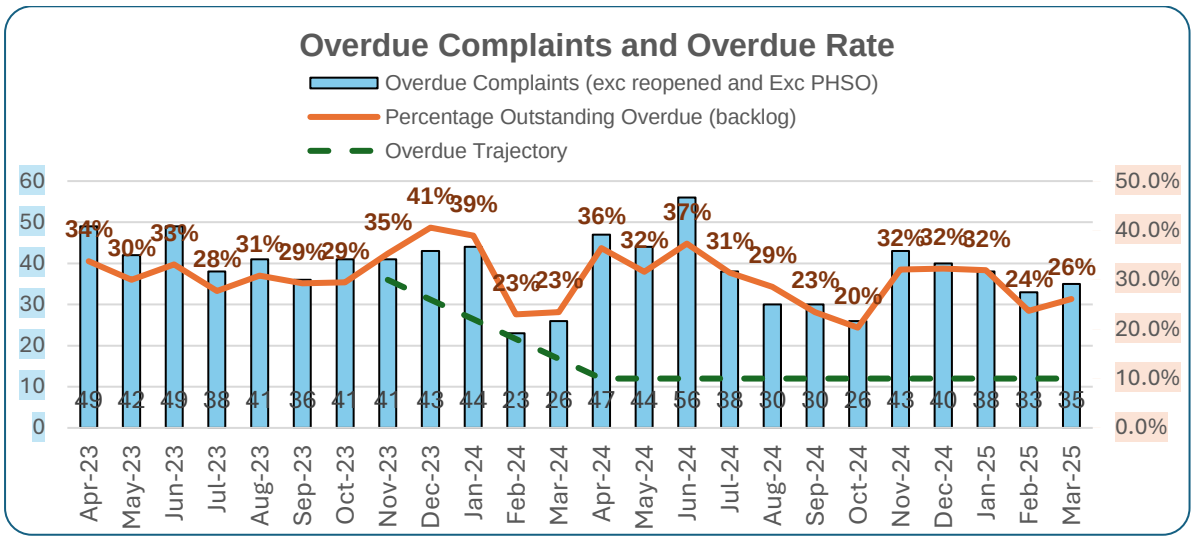
Rate of formal complaints responded to during 2024/25 compared to bed days during 2024/25:

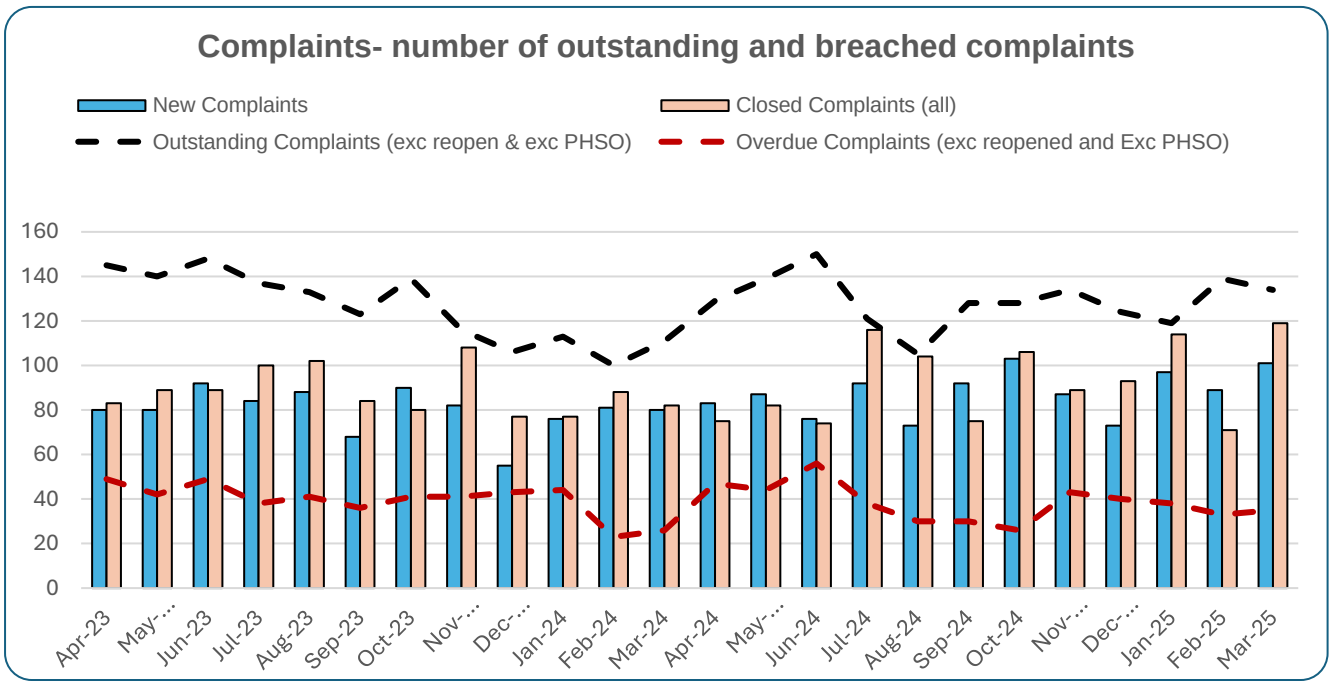
- 528 complaints responded to within 30 working days per 266,421 bed days= 0.19%
- 187 complaints responded to within 31-40 working days per 266,421 bed days= 0.07%
- 258 complaints responded to within 41-60 working days per 266,421 bed days= 0.09%
- 150 complaints responded to over 61 working days per 266,421 bed days= 0.05%



The focus remains on closing complaints within 30 working days with more complaints being closed within 30 working days and up to 60 working days during 2024-25. Less complaints have been closed after 61+ working days showing fewer have been open after 61 working days.

2.5. Comparison of breach complaints





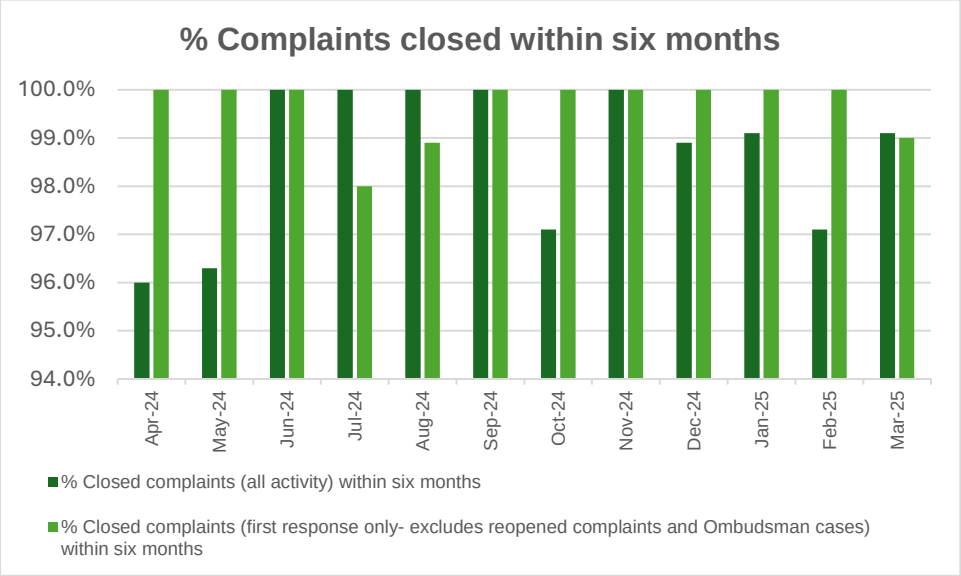
During 2023/34, the backlog remained fairly consistent during the first two quarters at around 30%. This then increased in quarter 3 and decreased in quarter 4 to its lowest amount of that year. This then increased during quarter 1, 2024/25, dipping to the lower end of the 20's during the second quarter and increasing in quarter 3 to the 30's and dipping again at the end of quarter 4 to the mid-20's. The backlog has been

much more variable during 2024/25, and this is always more challenging when a larger volume of complaints are received each month.

The average number of breached complaints for 2024/25 is 29.6% compared to the average of 31.3% for 2023/24, showing an improvement.

The Trust's local timeframe to respond to complaints is 30 working days, however, the NHS Complaints Regulations 2009 allows trusts six months to respond to a complaint at local resolution stage (stage one).

The below graph details the response rate for complaints closed in 2024/25 against a six-month timeframe:



The above table shows the Trust responds to nearly all complaints when first received within the legislative timeframe of six months (99.6%). Four complaints were over 130 working days (six calendar months), and this was due to delays with arranging local resolution meetings/complexity of the complaint.

When reviewing the 'all complaint activity' which includes reopened complaints (where complaints have already had a first response) and PHSO cases (which is the second stage of the complaint process and moved from local resolution stage), the Trust continues to have a high percentage response rate. The months where the Trust falls below 100% for this category is mostly where PHSO cases have been closed. These generally always exceed six months' timescale due to the investigation process by the PHSO. Therefore, where PHSO cases have been closed, it is recognised the Trust will not reach 100% for these months.

2.6. Benchmarking with local trusts

As it is only recently the end of the financial year for 2024-25, it is not possible to benchmark against other trusts for 2024-25. However, we were able to obtain statistics from local trusts for 2023-24 and the information they provided is contained below. It must be noted that each trust has variations on how they handle complaints

and utilise their PALS team (informal concerns). There are also variations on the local response rate.

Trust	No of complaints received 23-24	Response rate against timeframe	No of Ombudsman cases formally investigated 23-24	No of PALS activity
DGFT	958	**42.8%** against 30 working days with a KPI of 90%	5	5142
SWBH	858	**56%** against 30 working days with a KPI of 94%	41	2220
WHT	434	**39.6** against 30 working days **86%** completed to an agreed timeframe with complainant (no set working day timeframe)– average number of days to complete	18	2512
UHB	1869	Response rate within 6 months was 71%. Response rate within **65 working days was 46%** against KPI of 80%	TBC	6411
RWT	460 formal 770 local (early) resolution	**Within 30 w/d report- 52%** 30w/d with breach report (Agreed extension of timeframe) - 98% 99% for 3 months	4	648- only ones where feedback needed

From this, it is clear where trusts have in place a local response timeframe, there are breaches with this timeframe. No trust is 100% compliant against their timeframes. It is noted that RWT and WHT offer a slightly different approach to responsiveness. RWT measure their compliance against complaints that have breached 30 working days but have in place an agreed extension date and this gives them a responsiveness of 98% but it is noted that they are not able to achieve this for complaints measured against their KPI response timeframe of 30 working days (response rate of 52%).

WHT agree with their complainants a response timeframe once their investigating officers have reviewed the complaint and have in place an understanding of how long it may take to investigate. They then set individual timeframes per complaint.

This certainly offers a more personal approach to complaint handling and does improve the response rate. However, it is difficult to monitor, and reporting takes longer whilst each closed complaint is reviewed for response time.

3. Achievements over the last financial year (2024-25)

- The team closed 1118 complaints.

- All new complaints were acknowledged within three working days.
- 47% of complaints received a response within 30 working days. An improvement from 2024/25 which had a response rate of 42.8%.
- All complaints (100%) received a first response within six months.
- There has been an increase of complaints under the early resolution process from 98 in 2023/24 to 225 in 2024/25.
- 51.5% of complaints closed (576) were upheld/partially upheld. A decrease from 202324 (54%) of 2.5%.
- 12% of complaints closed (135) were reopened- a decrease on 2023/24 which was 14%.
- There is a slight decrease in the average number of breached complaints/ backlog at 29.6% for 2024/25.
- Patient activity compared to complaint activity remains at 0.07%. Indicating that despite the rise in the number of new complaints, this is relative to the increase in patient activity.
- The PHSO formally investigated only two new cases, and these have now been closed.
- There is one PHSO under investigation from previous year 2023/24 as at the end of 2024/25.
- No complaints were formally investigated by the Local Government Ombudsman (LGO) during the year and there are no LGO cases under investigation.

4. Challenges over the last financial year (2024-25)

- There was an increase in the number of new complaints received by 10.1% from 2023/24.
- The response rate continues to be below the 90% KPI, at 47% of complaints received a response within 30 working days.
- The complaints backlog continues to be challenging with the number of new complaints received versus dealing with complaints over 30 working days as the workload is unpredictable. At the end of March 2025, there are more complaints outstanding (153 for all complaint activity and 134 for first response complaints) and more breached/in backlog (35) when compared to the end of March 2024, there were 145 complaints open with 111 of those being first response and backlog being 23.4%.
- The average number of complaints received each month has increased from 2023/24 (79) to 87 for 2024/25.
- Delay with staff responding. Escalation process is working well but complaints are continuing to be escalated to Directors and there are occasions when repeat complaints are being escalated to Directors due to lack of response.

5. Improvements in complaints over the last 12-18 months

- ***Training:***

    - Online training modules are now available via the Complaints Department Hub page. A training matrix has been produced for staff to understand what complaints training they need to complete for their level/role.

- Bespoke training to services is offered to help services identify themes and ways to address complaints.
- The Trust's induction checklists have been updated to guide staff towards complaints training suitable for their level/role (complaints training is not mandatory).
- A complaints section has been updated and developed further in the Clinical Governance mandatory training booklet to provide information about the complaints process.
- A complaints training check has been added to the contact section of Datix to add if a staff member has received complaints training. This is in addition to complaints keeping a complaints training register. This allows for quick reference that a staff member is up to date with their training.
- We have reviewed recording telephone conversations received into the PALS team to use these for training purposes (patient stories, learning events) but unfortunately, this will come at a cost to the Trust to put in place new software and not possible.

- ***Escalation and processes:***

  - The complaints team continue to use the escalation process to assist with complaints open over 30 working days.
  - Over the last 18 months, the complaints team have developed various complaints processes to visually aid compliance of this.
  - Guides have been produced to assist staff on how to use Datix, the early resolution process and how to add their learning to Datix. These are available on the complaints team hub page.
  - The complaints team and PALS hub pages are regularly reviewed and where necessary updated to assist staff with guides, processes, and general information.
  - The complaints team will offer (where applicable) early resolution as part of the complaints process to respond to the complaints in a prompt manner to improve the response rate.
  - The complaints team continue to offer an informal approach (PALS route) to address concerns where applicable.

- ***Communication:***

  - An online form is available for patients, families, and carers via the Trust's website to improve communication methods with the complaints and PALS teams.

- ***Learning:***

  - Complaint files are not closed until learning and actions are completed and this is monitored each week with the complaint escalation process being followed where there is poor compliance.

- ***Response rate:***

    - Trialled monitoring response rate of complaints excluding complaints listed for local resolution meetings for three months. This showed little change to the response rate.
    - Where directorates are willing, the complaints team meet with certain teams each week/fortnightly to discuss open complaints (surgery CSL and DM, gynaecology DM, gastroenterology, haematology and oncology DM and children's ward lead nurse). Other team leaders are met as and when required depending on open complaints. This is sadly not taken up by all directorates but capacity within the complaints team may also restrict this.

6. Further recommendations for improvement

To help improve the response rate, the following is recommended:

- Consideration for the KPI for response rate for complaints to be a performance indicator for each division, this will encourage them to take responsibility and accountability for their responses and prompt for speedier responses.
- From May 2025, the complaints team are identifying any staff response that requires more information to ensure a full and thorough investigation/response has been provided. Where a poor response has been given, the complaints and PALS manager will ask the staff member if they would like to attend training about complaint investigation and response writing. If the person decides not to attend training and continues to provide poor responses to complaints, this will be escalated to the associate director of patient experience and the staff member's supervisor/line manager. This is an attempt to target training where needed and prevent reopened complaints due to poor responses.

- Using After Action Review (AAR) surveys post closure of a complaint to further learn from complaints by asking the complainant four questions. With this information, we can then go back to the services and share this feedback through the Patient Experience Group meeting. This started in April 2025 and the complaints team will monitor the uptake and feedback of this each quarter. It is hoped the insight offered by complainants may offer suggestions of further improvements that can be made and in turn reduce the number of complaints received.

- Complaints team are now attending the Surgical Pre-Meet session each week to identify any Surgery Division complaints that have breached and need action by the Division. This hopes to alleviate any breached complaints escalated to the Medical Director each week. This could be suggested for the Medicine and Integrated care Pre-meet session (Medicine and Integrated Care and Surgery Divisions are the two main divisions that receive the most complaints).

- Consideration to be undertaken of how the Trust reports on complaint timeframes. Under NHS Complaints Regulations, trusts are expected to inform complainants of any delays with their complaint investigation and to agree an extension period to respond. We do this by telephoning and/or sending a letter to a complainant on working day 25 to inform them of a delay and provide a further timescale. We do this on all complaints that are likely to breach.

  If we adopted this KPI approach, then our response rate would improve, however the complaint would still have breached the local timeframe of 30 working days and consideration needs to be given as to how this is measured, monitored, and reported. The decision needs to be made as to whether to the standardise the approach using the method with all complaints and not have individual response rates and what those timescales may be. This would make monitoring and reporting easier. It would also need to be decided as to whether it is only one agreed extension period or whether this can continue to be extended during the life of the complaint up to six months.

- Extend the Trust's current KPI to 40 working days response timescale. Based on last year's figures this would have meant the response rate would have been 67.9%.

- If the response timescale were increased to 60 working days taking last year's figures, the response rate would have been 91.9% over the KPI response rate of 90%.

  It must be noted that increasing the response rate does not offer a holistic approach to complaints. Complainants approach the complaints team at a time when they feel their initial concerns may not have been listened to or taken seriously. Extending the response timescale to 40 or 60 working days may result in a complainant feeling their complaint is not being taken seriously. This is feedback we also receive when agreeing an extension timescale. However, at the same time giving a longer timeframe to complainants means that we would not in most cases need to extend the timeframe.

Appendix 1- Improvement Plan

Action Plan	Complaint Responsiveness- Improvement Plan		
Action plan prepared and led by	Jill Faulkner, associate director of patient experience Lara Fullwood, complaints and PALS manager	**Action plan signed off by**	

KEY	**Completed and Assurance Received**	**Action commenced but not yet completed**	**Action Overdue not completed in agreed time scales or at significant risk of note achieving time scales**	**Assurance received**

	Recommendation / Area for Action Identified	Action Agreed	Lead	Date for Completion	Progress / Assurance	Key
1	Poor response writing	Where a poor response has been given, the complaints and PALS manager will ask the staff member if they would like to attend training about complaint investigation and response writing. If the person decides not to attend training and continues to provide poor responses to complaints, this will be escalated to the associate director of patient experience and the staff member's supervisor/line manager.	JF/LF	Review after 6 months (October 2025)	In place since May 2025	
2	Decrease number of complaints received	Using After Action Review (AAR) surveys post closure of a complaint to further learn from complaints and sharing this feedback with divisions and through the Patient Experience Group meeting.	JF/LF	March 2026	In place since April 2025.	
3	Improve responsiveness by divisions	Complaints team attending the Surgical Pre-Meet session each week to identify	LF	April 2025	In place since April 2025.	

		any Surgery Division complaints that have breached and need action by the Division.				
		Complaints team to suggest attending the Pre-meet session to Medicine and Integrated Care Division.	JF	July 2025	To approach triumvirate	
4	Altering KPI/ change of complaints process	Consideration of altering the KPI to be response rate of an agreed timescale with each complainant.	JF		Approval by Directors will be required.	
		Consideration for the KPI for response rate for complaints to be a performance indicator for each division, this will encourage them to take responsibility and accountability for their responses and prompt for speedier responses.	JF		Approval by Directors will be required	
		Consideration of an assigned investigating officer to investigate complaints and be held responsible and accountable to respond within timescales.	JF		Approval by Directors will be required and consultation with divisions on a change of complaint process and escalation processes.	
		Consideration of altering KPI to be 30 working days including those over 30 working days where an extension has been agreed with the complainant.	JF		Approval by Directors will be required.	
		Consider extending the response timescale to 40 working days.	JF		Approval by Directors will be required.	
		Consider extending the response timescale to 60 working days.	JF		Approval by Directors will be required.	

The Dudley Group NHS Foundation Trust

Paper for submission to the Council of Governors 19 June 2025

Report title:	Board Secretary update
Sponsoring executive:	Sir David Nicholson, Chair
Report author/presenter:	Helen Board, Board Secretary

1. Summary of key issues

Council of Governors elections & current vacancies

Public and Staff constituencies
Council of Governor elections overseen by an independent contractor Civica Election Services have concluded on 02 June 2025 and returned successful candidates as follows:.

- Public – Tipton & Rowley Regis **Arinderpal Sikham**
- Staff – Medical & Dental **Dr Rinesh Parmar**

No nominations were received for the following constituency that will remain vacant and be included in the autumn elections.

- Public – North Dudley

Appointed Governors
We are continuing the search for a governor for the constituency of 'Primary Care Representative' and working with primary care and integrated care board partners to identify an individual.

The Council of Governors is advised that the Dudley Metropolitan Borough Council have reappointed Councillor Alan Taylor for a further term.

Terms of Reference

Terms of Reference for the Full Council of Governors (Appendix 1) and the Experience and Engagement Committee (Appendix 2) have been subject to review and are appended for approval by the Full Council of Governors.

University Hospital Status

The Dudley Group NHS Foundation Trust has been granted university status, recognising its hard work to drive innovation, enhance academic collaborations and invest in research partnerships, bringing a variety of benefits to patients, students, and the local community.

The Trust's application has been supported by Aston University. The partnership between The Dudley Group NHS Foundation Trust and Aston University, underpinned by a memorandum of understanding, aims to drive innovation in clinical education, research, and patient care by combining academic expertise and clinical practice and sharing knowledge.

In tandem with being granted university status, the Trust is now working towards being a member of the University Hospital Association, a membership organisation made up of 41 UK university hospitals. It focuses on advancing medical education, research and innovation in healthcare, ensuring that university hospitals contribute effectively to the NHS and medical advancements.
Adhering to a five-year plan, the Trust is undergoing the rigorous process of evidence gathering to meet the Association's criteria for membership. This includes demonstrating that the Trust encourages and nurtures innovation within its workforce, provides opportunities for further training, and collaborates on research studies with facilities such as Aston University.

By meeting these criteria and receiving membership, the Trust will be a part of a unified voice with other university hospitals, connecting with experts, opening new doors to advanced development in care, and shaping the future of healthcare in the UK.

The Dudley Group and Aston University have several joint clinical academic appointments and reciprocal leadership appointments - Professor Anthony Hilton, pro-vice chancellor and executive dean of the College of Health and Life Sciences at Aston University is a non-executive director on the Trust's Board, while the Trust's group chief executive, Diane Wake, sits on the University advisory board.

The partners' research collaborations are developing new medical treatments and technologies which combine the Trust's clinical expertise with the University's academic expertise. This includes projects addressing healthcare challenges particular to Dudley's local communities.

The partnership helps to attract world class clinicians with research expertise to the Trust's hospitals. Healthcare professionals at the Trust, as well as University staff and students, have access to the latest clinical advancements and knowledge, improving patient outcomes. It ensures that the University's medical and healthcare education and training remains evidence-based and responsive to patient needs. The partnership facilitates knowledge exchange, clinical trials, and workforce development.

Consultation regarding the name change is currently underway and will be shared over the coming months.

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

3. Report journey
Council of Governors 19 June 2025

4. Recommendations
The Council of Governors is asked to:
a) **Note** the outcome of election activity for vacancies in the public constituencies of North Dudley (vacant), Tipton & Rowley Regis and staff constituency of Medical & Dental
b) **Approve** the terms of reference for the Full Council of Governors and the Experience and Engagement Committee
c) **Note** the granting of university status

5. Impact		
Board Assurance Framework Risk 1.1	X	Deliver high quality, safe person centred care and treatment
Board Assurance Framework Risk 1.2	X	Achieve outstanding CQC rating.
Board Assurance Framework Risk 2.0	X	Effectively manage workforce demand and capacity
Board Assurance Framework Risk 3.0	X	Ensure Dudley is a brilliant place to work
Board Assurance Framework Risk 4.0	X	Remain financially sustainable in 2023/24 and beyond
Board Assurance Framework Risk 5.0	X	Achieve carbon reduction ambitions in line with NHS England Net Zero targets
Board Assurance Framework Risk 6.0	X	Build innovative partnerships in Dudley and beyond
Board Assurance Framework Risk 7.0	X	Achieve operational performance requirements

Board Assurance Framework Risk 8.0	X	Establish, invest and sustain the infrastructures, applications and end-user devices for digital innovation
Is Quality Impact Assessment required if so, add date:		
Is Equality Impact Assessment required if so, add date:		

The Dudley Group NHS Foundation Trust

COUNCIL OF GOVERNORS
TERMS OF REFERENCE

1. Constitution

1.1 The Trust shall have a Council of Governors, which shall comprise both elected and appointed Governors. The Council of Governors in its workings will be required to adhere to the Terms of Authorisation and Constitution of The Dudley Group NHS Foundation Trust and such other guidance as issued by NHS England for NHS Foundation Trusts. Standing Orders as defined in the Constitution of The Dudley Group NHS Foundation Trust shall apply to the conduct of the working of the Council of Governors.

2. Membership

All Governors
Trust Chair

3. Attendance

3.1 In accordance with the Trust Constitution, the chairman of the Board of Directors or, in their absence, the deputy chairman, shall preside at meetings of the Council. All other members of the Board of Directors shall be entitled to attend and receive papers to be considered by the committee.

3.2 The following members of staff will usually be in attendance at meetings:

- Director with lead responsibility for Governor Development

3.3 Other managers/staff may be invited to attend meetings depending upon issues under discussion. The Council has the power to co-opt for a specified task or period of time or to request attendance of any member of Trust staff as necessary and to commission input from external advisors as agreed by the Chair.

3.4 The board secretary will ensure that an efficient secretariat service is provided to the Council.

3.5 Meetings of the Council of Governors shall normally be a meeting in public. Members of the public may be excluded from the whole or part of a meeting for special reasons, either by resolution of the Council of Governors or at the discretion of the chair of the meeting.

4. Quorum

4.1 As defined in the Trust Constitution a quorum will consist of eight governors of which at least five must be public elected governors and including at least the chair or/ deputy chair to preside over the meeting.

4.2 If the chair or deputy chair is not present the meeting is not quorate. The meeting can proceed but not in public. Another non-executive director present will be nominated to chair by those members present.

5. Frequency of meetings

5.1 Ordinary meetings of the Council shall be held at such times and places as the Board of Directors may determine and there shall be not less than 3 or more than 4 formal meetings in any year except in exceptional circumstances as set out in the Trust Constitution.

5.2 It is expected that members attend at least 75% of the meetings in the year as defined in the Trusts Code of Conduct for Governors.

5.3 In accordance with the Trust Constitution, the chair of the Trust may call a meeting of the Council at any time. If the chair refuses to call a meeting after a requisition for that purpose, signed by at least one third of the whole number of members of the Council, has been presented to him or her, or if, without so refusing, the chair does not call a meeting within seven days after such requisition has been presented to him or her at Trust's Headquarters, such one third or more members of the Council may forthwith call a meeting.

5.4 Where under the terms of 5.3 Governors meet in the absence of action requested of the chair the lead governor shall convene and chair the meeting and request the senior independent director to attend.

6. Statutory Powers and Duties of the Council of Governors

The duties of the Council of Governors, to be undertaken in accordance with the Trust Constitution are:

6.1 To appoint and, if appropriate, remove the chair at a general meeting.

6.2 To appoint and, if appropriate, remove other non-executive directors at a general meeting.

6.3 To decide the remuneration and allowances, and the other terms and conditions of office, of the chair and the other non-executive directors.

6.4 To approve (by a majority of members of the Council) the appointment by the non-executive directors, of the chief executive.

6.5 To appoint and, if appropriate, remove Trust's external auditors at a general meeting.

6.6 To receive the NHS Foundation Trust's annual accounts, any report of the auditors on them, and the Annual Report including the Quality Account at the Annual Members' Meeting.

6.7 To be consulted by the Trust's Board of Directors on forward planning and to have the Council of Governors' views taken into account.

6.8 To receive appropriate assurance from the Board of Directors on any systems, processes or actions that impact on the Trusts ability to meet its responsibilities within the context of the provider licence and other regulatory requirements to inlcude the boards account of its contribution to the wider health and care system

6.9 To approve significant transactions which exceed 25% by value of FT assets, FT income or increase/reduction to capital value.

6.10 To approve any structural change to the organisation worth more then 10% of the organisation's assets, revenue or capital by way of merger, acquisition, separation or dissolution.

6.11 To decide whether the level of Private Patient income would significantly interfere with the Trust's principal purpose of providing NHS services.

6.12 To approve amendments to the Trust's Constitution.

In addition;

6.13 The Council will establish appropriate Committees to assist in the discharge of responsibilities.

6.13.1 Each Committee shall have such Terms of Reference and power and be subject to such conditions (as to reporting back to the Council), as the Council shall decide and shall be in accordance with the Regulatory Framework and any guidance issued by the Independent Regulator. Such Terms of Reference shall have effect as if incorporated into the Standing Orders.

6.13.2 The Council may not delegate any decision-making or executive powers to any of its Committees or Sub-committees.

6.13.3 The Council shall approve the appointments to each of the Committees which it has formally constituted.

6.14 Governors will also undertake duties to support membership engagement and recruitment in line with the Trusts Terms of Authorisation and as set out in the Council of Governors Addendum to Statutory Duties to include the wider public within the Black Country health system.

6.15 To receive appropriate assurance from the Board of Directors on any systems, processes or actions that impact on the Councils ability to meet its responsibilities defined above.

7. Reporting

7.1 The Council of Governors will receive reports from members of the Board of Directors as required to enable the Council to fulfil the duties described above.

7.2 The Council will also receive reports from any Committee established by the Council of Governors to support the business of the Council of Governors. Any recommendations made by these Committees will require ratification by the full Council of Governors.

8. Review

8.1 The Terms of Reference of the Council of Governors shall be reviewed at least annually or as part of any application to amend the Constitution of the Trust.

Appendix 2

The Dudley Group NHS Foundation Trust

COUNCIL OF GOVERNORS
EXPERIENCE AND ENGAGEMENT COMMITTEE
TERMS OF REFERENCE

1. Constitution

The Council of Governors will establish appropriate Committees to assist in the discharge of its responsibilities.

1.1 Each Committee shall have such power and be subject to such conditions (as to reporting back to the Council), as the Council shall decide and shall be in accordance with the Regulatory Framework and any guidance issued by the Independent Regulator. Such Terms of Reference shall have effect as if incorporated into the Standing Orders.

1.2 The Council shall approve the appointments to each of the Committees which it has formally constituted.

2. Membership

2.1 The Committee will comprise a minimum of eight governors.

2.2 The Council of Governors will be the body charged with recommending membership for each committee of the Council. The Council must approve the appointments to each of the committees which it has formally constituted.

2.3 The Chair will be elected by the Governors on the Committee.

2.4 A Vice/deputy Chair will be nominated by members of the Committee.

3. Attendance

3.1 At least one non-executive director linked to the Quality ~~& Safety~~ Committee of Board.

3.2 Director with Lead responsibility for governor development.

3.3 All other members of the Council of Governors and Board of Directors shall be entitled to attend and receive papers to be considered by the Committee.

3.4 Other managers/staff may be invited to attend meetings depending upon issues under discussion. The Committee has the power to co-opt, or to request to attend, any member of Trust staff, as necessary and to commission input from external advisors as agreed by the Chair of the Committee.

3.5 The Board Secretary will ensure that an efficient secretariat service is provided to the Committee.

3.6 Non-executive directors and executive directors will be nominated to attend Council of Governors Committees by the chairman and chief executive respectively. These Board members will be present to advise upon and support the work of the Committee and to provide information about Trust Board considerations, processes and decisions. The presence of Board members will not be for the purpose of justifying decisions of the Trust Board.

4. Quorum

4.1 A quorum will consist of four Governor Members of the Committee.

5. Frequency of meetings

5.1 Committee meetings shall be held at such times and places as the Council of Governors may determine and there shall be not less than two or more than six formal meetings in any year except in exceptional circumstances.

5.2 It is expected that members attend at least half of the meetings in the year.

6. Role and Responsibilities of the Committee

6.1 To discharge any action required of it from the Council of Governors.

6.2 The Council may not delegate any decision-making or executive powers to any committee or sub-committee. Any recommendations received from the Committee will be considered by the Council of Governors and ratified, or not, by those present.

7. Specific duties of the Experience and Engagement Committee will be:

7.1 To support and guide the Council of Governors in representing the interests of Trust members and the public, identifying opportunities for engagement and involvement. Noting that 'the public' is wider than patients and the public local to the Trust or from governors' own electorates: this includes the whole population of the Integrated Care System.

7.2 To oversee and monitor the development and delivery of the Governor and Members Engagement Plan action plan.

7.3 To undertake engagement activity to assess the experience of the Trust's patients, families and their carers and members of the wider community served by the Trust.

7.4 To review governor membership of the Experience and Engagement and Remuneration and Appointments Committee and to make recommendations to the Council of Governors as to the composition of these committees.

7.5 To monitor the Foundation Trust membership level and representation and identify actions required to maintain and support this.

7.6 To ensure that the Council effectively share key points of the Trust strategy with the wider Council members and the members of the wider community served by the Trust.

7.7 To support Council members to both participate in, and provide feedback to, the committee following involvement in Trust led activities including quality audits, attendance at committees of board and other Trust led initiatives that may occur from time to time.

7.8 To review Governor training and development provision on an annual basis.

7.9 To support governor collaboration between organisations to form a rounded view of the interest of the 'public at large'. This is reflective of system wide working arrangements aimed at the delivery of better joined up care.

8. Reporting

8.1 The Committee will receive reports from the Trust as required to enable the members to fulfil the duties described above.

8.2 The Chair of the Committee will regularly submit a report on the work of the Committee to the Council of Governors.

9. Review

9.1 The Terms of Reference of the Council of Governors committees shall be reviewed at least annually or as part of any application to amend the Constitution of the Trust.

Enclosure 12

The Dudley Group NHS Foundation Trust

Paper for submission to the Full Council of Governors on 19 June 2025

Report title:	Update from the Experience & Engagement Committee Meeting held on 13 May 2025
Sponsoring executive:	Helen Board – Board Secretary
Report author:	Mushtaq Hussain – Chair of Experience and Engagement Committee Madhuri Mascarenhas – Governance Administration Lead

1. Summary of key issues

- The Foundation Trust's public membership numbers remain steady at just over 13,000. Governors are encouraged to engage in their own initiatives and Trust-led activities to raise awareness of the governor's role and promote membership with full support, as required, from the Foundation Trust Office.
- Good assurance was received from the Quality Committee and the Quality Priorities update.
- Training and development for governors was continually evolving, with internal sessions provided for both new and existing governors.
- The Council of Governors Effectiveness Survey was approved by the committee and would be circulated to the governors in Quarter 1 of 2025-26, and the feedback/action plan would be reviewed at the Full Council of Governors meeting in September 2025.

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

3. Report journey

Full Council of Governors Meeting - 19 June 2025

4. Recommendation(s)

The Council of Governors is asked to:

a) Note the contents of the report

5. Impact		
Board Assurance Framework Risk 6.0	X	Build innovative partnerships in Dudley and beyond
Is Quality Impact Assessment required if so, add date:		
Is Equality Impact Assessment required if so, add date:		

CHAIRS LOG UPWARD ASSURANCE REPORT FROM THE EXPERIENCE & ENGAGEMENT COMMITTEE MEETING

Date Committee last met: 13 May 2025

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE

- The Trust remains compliant with its terms of license in respect of its public membership and is well-represented by age, constituency, and gender. The public membership figure in the fourth quarter for 2024-25 was 13,286, reflecting a decrease of 32 members compared to the last quarter.
- Limited public membership engagement under age 21. Governors were encouraged to participate in activities that involved youth engagement to help increase the number of Foundation Trust members in the age group below 21.

MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY

- The committee approved the Council of Governors Effectiveness Review Survey, which would be conducted in Quarter 2 of 2025/26.

POSITIVE ASSURANCES TO PROVIDE

- Governor's attendance at the Committees of the Board continued and provided opportunities for governors to draw assurance from the work undertaken and noted the scrutiny and proactive nature of committee business.
- Positive assurances received from the Quality Committee were:
  - Cost Improvement Programme achieved with no adverse patient care impact.
  - High safety and care standards maintained despite winter pressures.
  - Early success in piloting Martha's Rule for second clinical opinions.
- Following positive assurance received from the Quality Priorities update:
  - 14 of 21 targets fully met, 7 partially met. Best performance to date.
  - Stroke care achieved the Sentinel Stroke National Audit Programme (SSNAP) Level B.

DECISIONS MADE

- The terms of reference for the Experience and Engagement Committee were reaffirmed with a minor update.

○ Calm bags were introduced in the Emergency Department for patients with learning disabilities, which was supported by charity funding. • Yvonne Peers updated on the positive assurance received at the Equality, Diversity and Inclusion Steering Group meetings. All networks were collaborating effectively. ICAN programme demonstrated strong employment outcomes, with 50% already in job placements, of which 20% were within the Trust. • Governor training and development continued to be provided internally and externally to new and existing governors and was well received.	

Chair's comments on the effectiveness of the meeting

Meeting held face to face at the Russells Hall Hospital noting three apologies received from board members. The meeting was attended by a foundatio member and no Trust governors.