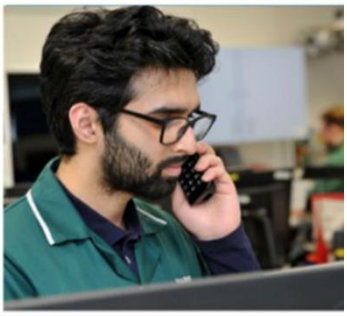
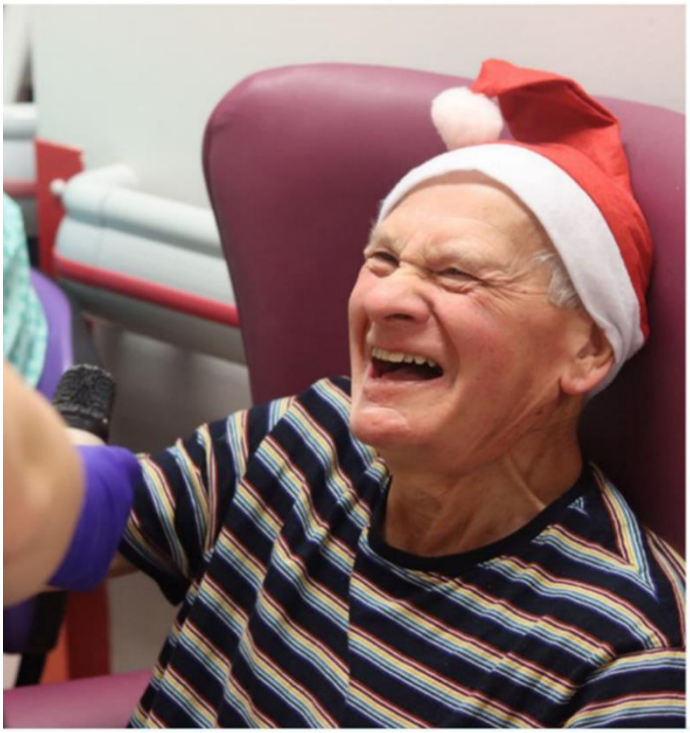
Our Patients
Our People
Our Place

NHS
The Dudley Group
NHS Foundation Trust

Quality Account
2024/2025




Our Values: Care, Respect, Responsibility

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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.

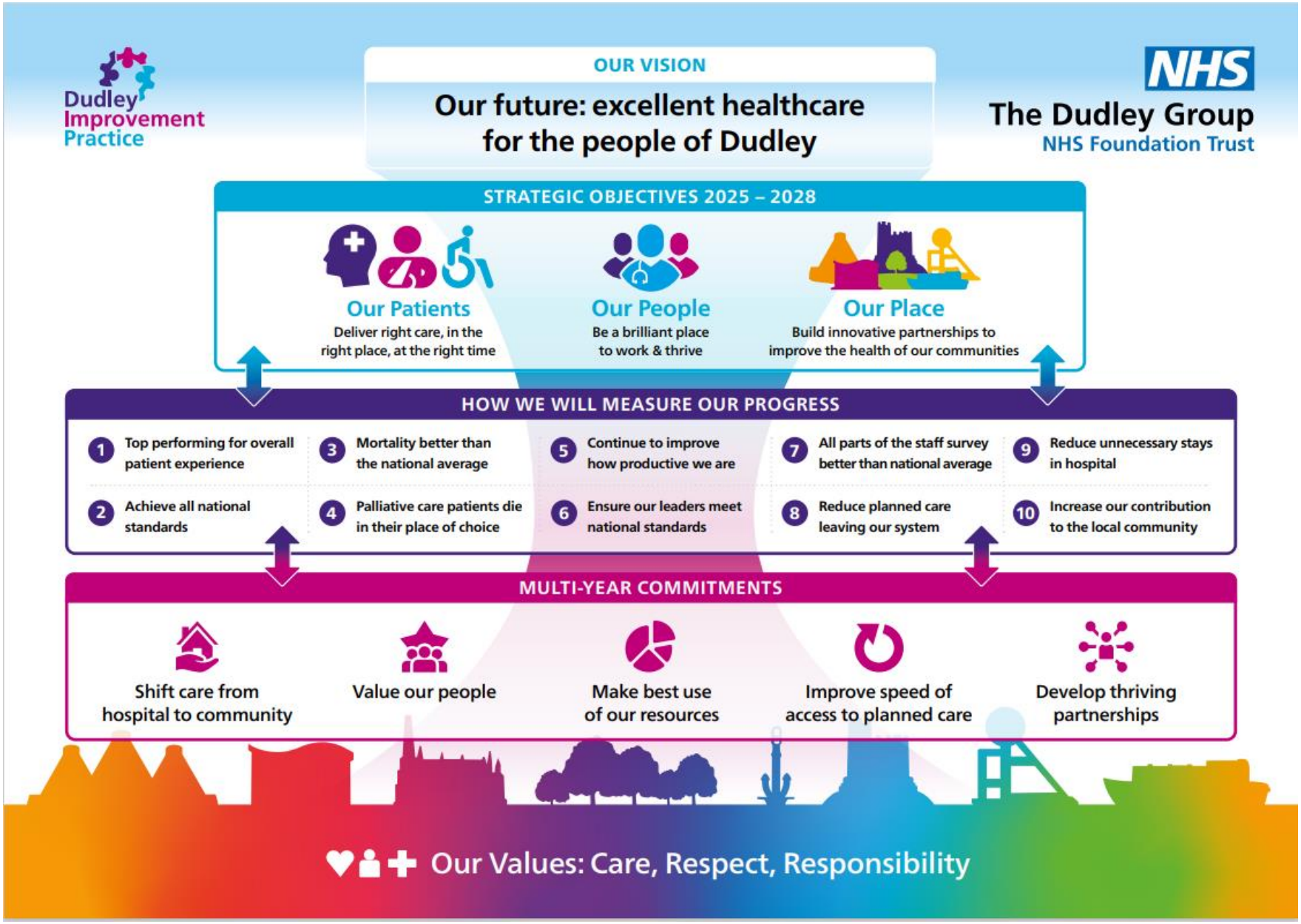
The dedication and resilience of our staff are the driving forces behind our priorities, ensuring that we continue to deliver outstanding care for our patients while fostering a supportive and inspiring workplace. Their hard work and achievements over the past year are truly commendable.

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 DGFT 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 DGFT**	**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** SHMI 103 at time of report. This is now the national average for this condition.
	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.	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.
	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.	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 teams at DGFT to receive training for CT perfusions via Rapid AI, which will

	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 ➢ Discharge Data to be captured each month through our volunteers and audits within AMaT. This will allow for triangulation of data with our RSO	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 the medicine division, compared to 39% in Q3. 26% of our patients stated they had been informed of their discharge date

	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. • Aim to reduce readmissions.	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 embedded before measuring service impact. A band 4 Associate Nurse has been recruited to the Dementia and Delirium

	• 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. **Where we want to be?**	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 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

	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 	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 2025/26 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 Parkinson's 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 Parkinson's 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 NHS Foundation Trust 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 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	N/A	No	No	The Trust plans to follow GIRFT guidance on sustainability,	

Number	Title					
	and Applied to the bladder cancer care pathway audit (ELLA)				which covers much broader care for urology 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	N/A

Number	Title					
					level during 2024.	
13.	Falls and Fragility Fracture Audit Programme (FFFAP)	National Audit of Inpatient Falls	Yes	Yes	7/10	April 2024 to March 2025
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	

Number	Title					
22.	National Audit of Cardiac Rehabilitation	N/A	Yes	Yes	Unable to ascertain numbers	April 2024 to March 2025
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	Adult Asthma Secondary Care	Yes	Yes	125	April 2024 to March 2025

Number	Title					
	Programme (NRAP)					
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	

Number	Title					
41.	National Cardiac Audit Programme (NCAP)	Myocardial Ischaemia National Audit Project (MINAP)	Yes	Yes	302 (100%)	April 2024 to March 2025
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	National Heart Failure Audit	Yes	Yes	498 (100%)	April 2024 to March 2025

Number	Title					
	Programme (NCAP)					
50.	National Child Mortality Database (NCMD)	N/A	Yes	Yes	19 (100%)	April 2024 to March 2025
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

Number	Title					
59.	National Neonatal Audit Programme (NNAP)	N/A	Yes	Yes	100% cases	Cases automatically gathered 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

Number	Title					
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 Collaborating Centre	Non Hodgkins Lymphoma Audit	Yes	Yes	100% - taken from Somerset Cancer Registry data	Jan to Dec 2024
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	

Number	Title					
					added for 2024	
79.	Prescribing Observatory for Mental Health	N/A	No	No	Not applicable	Mental Health Trust
80.	Quality Outcomes in Oral and Maxillofacial Surgery	Oncology and reconstruction	No	No	Not applicable	Procedure not carried out
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

Number	Title					
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.

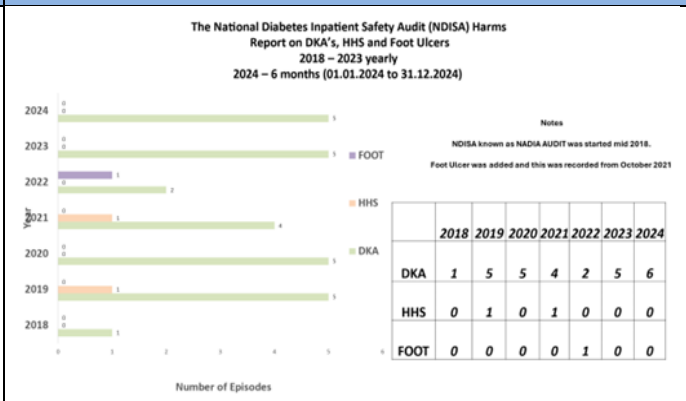
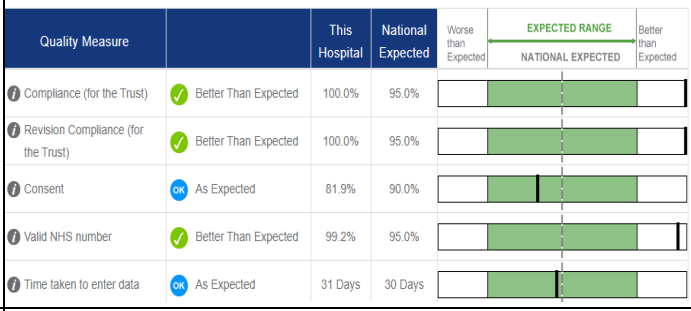
Please note, as these have been the active studies that data has been returned for in this financial year. Some studies may roll over into next year.

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	Positive assurance

Specialty	Brief description of audit/outcome/improvements	Actions taken/to be taken
	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) 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 the 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	Positive Assurance

Specialty	Brief description of audit/outcome/improvements	Actions taken/to be taken
	for people newly diagnosed with MBC is discussed within a breast multidisciplinary team (MDT) meeting.	This is standard practice for patients diagnosed with MBC
All cancer Specialties	All Cancers - Improve data completeness of key items in national cancer registration datasets to allow risk-adjustment of performance indicators	Positive Assurance – there were no issues identified with data completeness across any of the tumour sites.
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

Specialty	Brief description of audit/outcome/improvements	Actions taken/to be taken
		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.

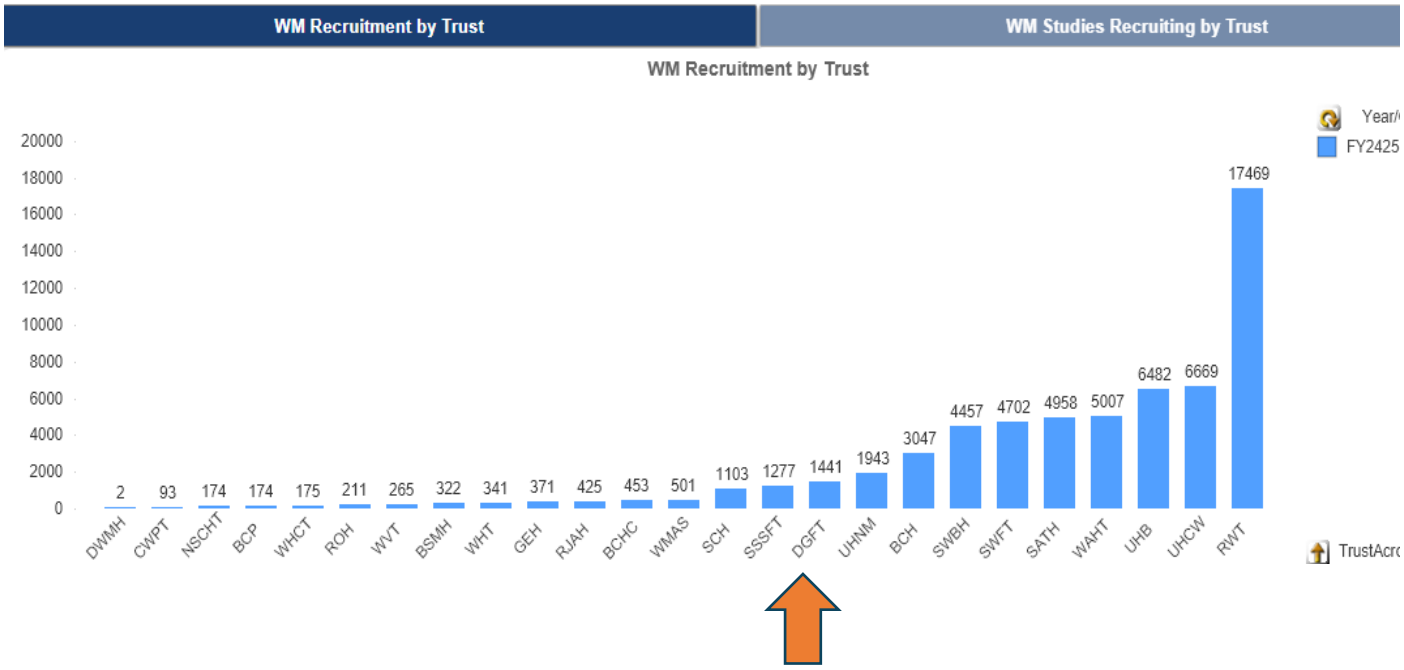
3.4 Research and Innovation (R&I)

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 Health and Care NHS Trust 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 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 Outpatient Centre was also registered as a separate location, consistent with Corbett Outpatient Centre, 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 Outpatient Centre 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 Outpatient 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 Corbett Outpatient Centre and Guest Outpatient Centre 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 for the following 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:

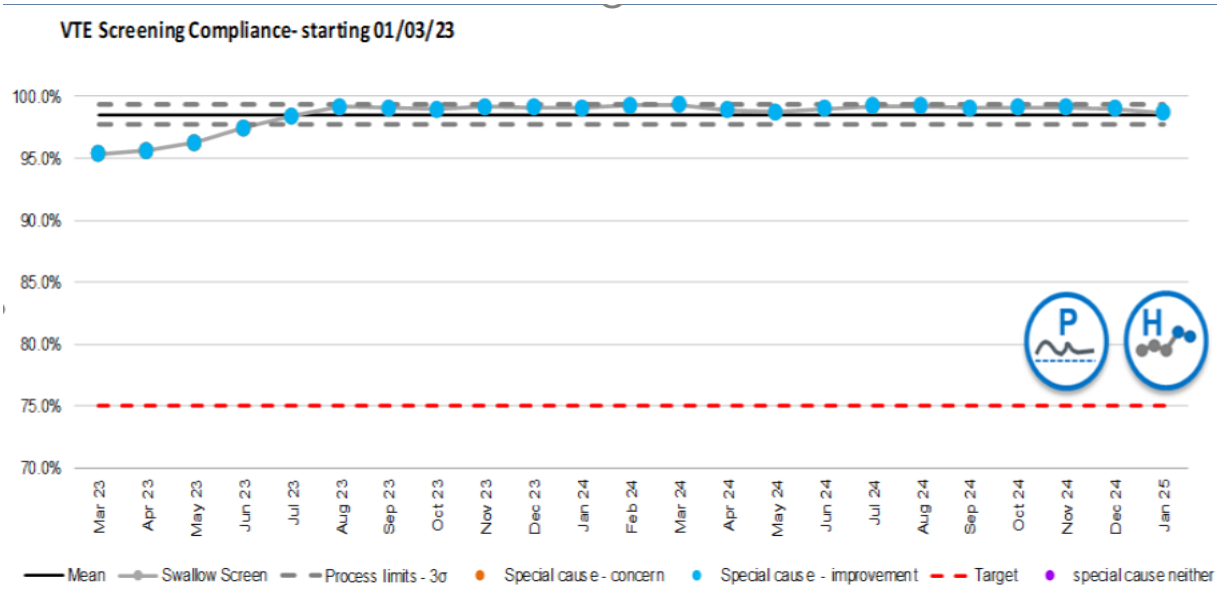
- Increasing response rates to People Pulse to ensure data is comparable across each quarter
- Using quarterly pulse data to capture areas where staff identify improvements can be made in this area
- Continuing to increase the Staff Survey response rate with a 4% improvement this year
- Focusing on workforce 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 the 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 the 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	25.197109156479	27.5560777588 2		29.4754188907 972	
Best performing trust	0	0		0	
Worst performing trust	138.379575174 704	133.644082989 716		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

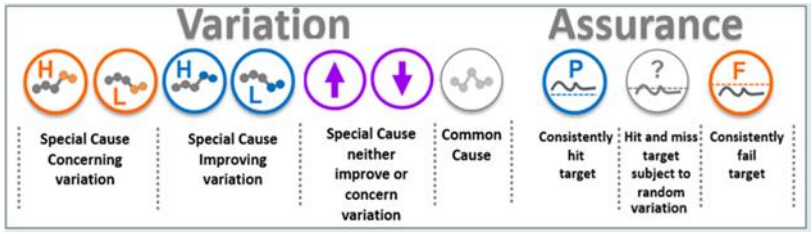
During the reporting period 2024/25, the number of patient safety incidents (events) reported has increased compared to previous reporting periods; this is a positive finding. Following the implementation of the Learning from Patient Safety Events (LFPSE) system in September 2023, monthly reporting numbers 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 2024/25, 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