The Dudley Group
NHS Foundation Trust

BOARD MEETINGS
PUBLIC INFORMATION SHEET

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

1. Introduction

This sheet provides some information about how Board meetings work.

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

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

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

Helen Attwood
Directorate Manager to:
Sir David Nicholson, Chairman
The Dudley Group NHS Foundation Trust
And, Sandwell & West Birmingham Hospitals NHS Trust
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2. Board Members' interests

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

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

3. Opportunity for questions

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

4. Debate

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

5. Minutes

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

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

6. Key Contacts

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To: Integrated care board:

- chairs
- chief executives

NHS trust and NHS foundation trust

- chairs
- chief executives

NHS England
Wellington House
133-155 Waterloo Road
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26 June 2025

cc: NHS England regional directors

Dear colleague,

Publication of the NHS Oversight Framework 2025/26

We have today published the NHS Oversight Framework 2025/26.

It has been developed with the engagement and contributions from the NHS leadership and staff, representative bodies and think tanks, including through two public consultations. You said that NHS England's approach to oversight and performance improvement needs to be consistent and our interactions coherent. I want to thank you and your teams for your contributions and engagement.

The new framework describes a consistent and transparent approach to assessing integrated care boards (ICBs) and NHS trusts and foundation trusts, ensuring public accountability for performance and providing a foundation for how NHS England works with systems and providers to support improvement.

This 1-year framework sets out how NHS England will assess providers and ICBs, alongside a range of agreed metrics, promoting improvement while helping us identify quickly where organisations need support.

The framework will be reviewed in 2026/27 to incorporate work to implement the ICB operating model and to take account of the ambitions and priorities in the 10 Year Health Plan.

Publication reference: PRN02028

The framework is supported by a focused set of national priorities, including those set out in the planning guidance for 2025/26, aiming to strengthen local autonomy. These are presented alongside wider contextual metrics that reflect medium-term goals in areas such as inequalities and outcomes. The contextual metrics do not constitute part of the score but will inform how NHS England responds to segmentation.

The NHS priorities and operational planning guidance 2025/26 made it clear that achieving a financial reset this year is a priority. The NHS must live within the budget it is allocated, reduce waste and increase productivity to deliver growth against demand. It set the expectation that every ICB and provider must deliver a balanced net system financial position in collaboration with its system partners. NHS England will identify organisations that are not performing and take quick action. Our approach to assessment will mean that unless providers are delivering a surplus or breakeven position, their segmentation will be limited to no better than 3.

Our improvement approach will be based on the results of our assessment and tailored to the support providers in each delivery segment need. Discussions about performance will be led by colleagues at NHS England who are experienced in addressing delivery challenges, with a focus on offering informed evidence and practical guidance that is grounded in a deep understanding of the operational challenges faced.

Our assessment will be the starting point for how we work with organisations throughout the year and will help us determine how we can support them to improve. We will do this by considering an organisation's segment score, as set out in this framework, and leadership capability.

The framework outlines the circumstances in which providers can obtain increased freedoms. It also describes how we will determine whether a provider's performance falls below an acceptable standard and/or has governance concerns that may lead NHS England to use our regulatory powers to step in and secure improvement. NHS England's approach to the use of enforcement powers is set out in the NHS enforcement guidance.

We will not be segmenting ICBs in 2025/6, as this will be a year of significant change for ICBs as they transform in line with the Model ICB Blueprint to focus on strategic commissioning and implement plans to meet the running cost reductions. Support for ICBs this year will focus on the safe implementation of their plans. ICBs that are currently in the Recovery Support Programme will continue in this programme and will be assessed against their current improvement trajectory to agree a transition plan. This will be the equivalent to segment 5.

We will report ICB performance against the full suite of oversight metrics, but not issue a comparative rating. ICBs will still be assessed through a statutory annual assessment, which reviews how well each ICB is performing its statutory duties. Where there are performance or

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governance concerns, NHS England will step in and we may use our regulatory powers to secure improvement. We will introduce the segmentation approach for ICBs in 2026/27.

Thank you again for your continued work and engagement.

Yours sincerely,

Glen Burley
Financial Reset and Accountability Director

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Classification: Official

NHS England

NHS Oversight Framework 2025/26

Publication reference: PRN02028

Summary

The new NHS Oversight Framework 2025/26 describes a consistent and transparent approach to assessing integrated care boards (ICBs) and NHS trusts and foundation trusts, ensuring public accountability for performance and providing a foundation for how NHS England works with systems and providers to support improvement. It has been developed with the engagement and contributions from the NHS leadership and staff, representative bodies and think tanks, including through two public consultations. They said that NHS England's approach to oversight and performance improvement needs to be consistent and our interactions coherent.

This 1-year framework sets out how NHS England will assess providers and ICBs, alongside a range of agreed metrics, promoting improvement while helping us identify quickly where organisations need support.

The framework will be reviewed in 2026/27 to incorporate work to implement the ICB operating model and to take account of the ambitions and priorities in the 10 Year Health Plan.

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Performance assessment

Roles and responsibilities

We recognise that streamlining the NHS operating model will be an important step in laying the foundations for the delivery of the 10 Year Health Plan. We need a less duplicative, leaner and simpler way of working, where every part of the NHS is clear on its purpose, what it is accountable for and to whom. The clarified roles and responsibilities for ICBs, providers and NHS England are set out below.

Integrated care boards (ICBs):

- provide system leadership for population health, setting evidence-based and long-term population health strategy and working as healthcare payers to deliver this, maximising the value that can be created from the available resources
  - this includes holding their partners in the integrated care system (ICS) to account using the system levers that bind them together, such as joint system plans, partnership agreements, joint committees and collaboratives
- through effective strategic commissioning, invest in, purchase and evaluate the range of services and pathways required to ensure access to high quality care, to improve outcomes and to reduce inequalities within their footprint
  - this includes monitoring provider performance against their contractual obligations for the services purchased as part of the ICB's population health strategy
- strategically align funding and resources with long-term population health outcomes and manage clinical and financial risks

Providers (NHS trusts and foundation trusts):

- deliver high quality (safe, effective and positive patient experience) and efficient care
- comply with the requirements of the NHS provider licence

NHS England:

- oversee overall delivery, performance and improvement of both ICBs and providers (a statutory responsibility
- conduct an ICB performance assessment each financial year
- determine how to support and drive improvement in each organisation, including where necessary the use of enforcement powers

Overview

NHS England will use the performance assessment process to measure delivery against an agreed set of metrics. This will determine the segment score for each provider and identify where improvement is required. NHS England's improvement response will be based on the segmentation score alongside consideration of the organisation's leadership and governance (provider capability) to ensure that it is tailored and nuanced, balancing performance improvement and management. We plan to finalise our approach to the assessment of provider capability and issue guidance during Q2. It is our intention to align our approach with that of the Care Quality Commission (CQC).

Drawing on the 4 purposes of an ICS (improving population health and healthcare; tackling inequalities in outcomes, experience and access; enhancing productivity and value for money; and supporting social and economic development), the performance assessment process measures each provider's delivery on key metrics across 6 domains, as set out in Table 1. Each domain has a range of appropriate metrics for each type of organisation (acute, mental health, community and ambulance trusts).

For this transitional year, a focused set of metrics, which reflect the 2025/26 NHS priorities and operational planning guidance, will contribute to the segment score for an organisation. While not scored and rated as part of our segmentation approach, we have identified a longer list of contextual metrics that sit largely in the areas of population health, primary prevention and health inequalities. The performance data on contextual metrics will be available for boards to consider, aligned with the Insightful Board approach (as described in the insightful provider board guidance) and we will consider this in our oversight response. Annex A identifies those metrics that will be scored and those that are contextual.

Table 1: Scoring and non-scoring domains of the framework

Domains and sub-domains
Access to services • elective care • cancer care • urgent and emergency care • mental health care
Effectiveness and experience of care
Patient safety

People and workforce
Finance and productivity
Improving health and reducing inequality (non-scoring) • improving population health • primary prevention • inequalities

Where providers are part of a provider collaborative or group model, they will be measured as a trust and not as a wider group. The effectiveness with which providers are collaborating and supporting system working will form part of the provider capability assessment.

Integrated care boards

For ICBs, a set of metrics and system considerations have been selected to reflect the NHS priorities and operational planning guidance, system performance and longer-term strategic priorities. However, ICBs will not be segmented this year, given the significant changes they are undertaking during this year. This means these metrics will not be scored to inform segmentation, but they will be reported as contextual information to be used in strategic planning and improvement conversations. Although ICBs will not be segmented, their leadership capability will be assessed through our annual assessment of ICBs, which reviews how well each ICB is performing its statutory duties.

Primary care providers

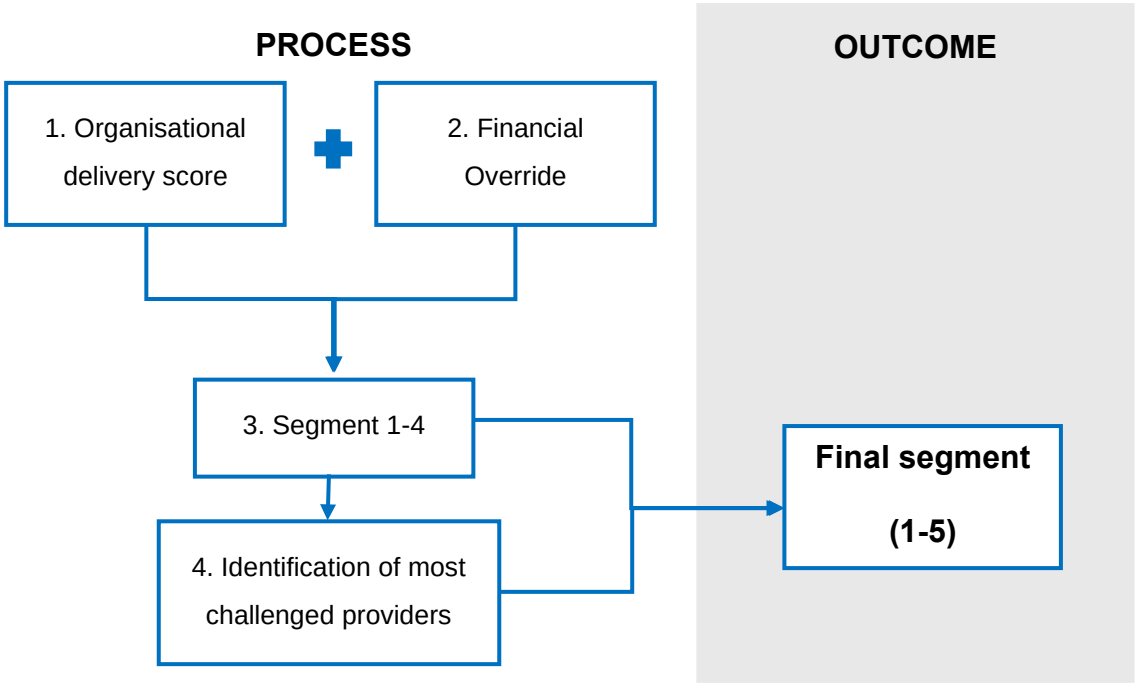
Primary care providers, primary care networks and other non-trust providers or partnerships, such as provider collaboratives, will not be allocated their own segments. However, we will continue to keep under review our arrangements for accountability of primary care providers as we move towards the planned shift to neighbourhood health.

Independent providers

For independent providers of NHS services, ICBs will be expected to continue to ensure quality and performance through contractual levers and escalate concerns to NHS England regions. We will continue to oversee and assure certain independent providers under the Independent Providers Risk Assessment Framework (IPRAF) and NHS-controlled providers under either the IPRAF or this framework.

Segmentation approach

Figure 1: Process for determining a segment



Step 1 – Organisational delivery score

Each provider will receive an **individual organisational delivery score** derived from its performance against the metrics listed in Annex A.

Each metric has an individual set of scoring rules and, based on these, a provider will receive a score between 1 and 4 for each metric.

To calculate the overall organisational delivery score, the individual metric scores are averaged according to the number of metrics the organisation will be measured against. The scores are then benchmarked against those for the rest of the country and divided into 4. These quartiles are numbered 1 to 4 with the highest performance scoring quartile numbered 1 and these numbers become each organisation's overall organisational delivery score.

Further detail on the scoring approach is given in the separate methodology manual. The specific scoring regime for each metric will be detailed in a separate technical document that we will publish when we release initial segments in July.

Step 2 – Financial override

As part of the scoring methodology an override relating to organisational, not system-wide, financial performance will be applied. The override means all organisations in deficit or in receipt of deficit support will be limited to an organisational delivery score of no greater than 3.

Step 3 – Segmentation

Based on the process described above, we will place every provider into a segment. This indicates its level of delivery from 1 (high performing) to 4 (low performing) and informs its support or intervention needs. Entry into segment 5 will be reserved for the most challenged organisations that require the most support to improve. See Table 2 for descriptions of the 5 segments.

Step 4 – Allocation to segment 5

To establish which providers will be allocated to segment 5, we will review the outputs of both segmentation and capability assessments. Those providers rated low for both performance and capability will be considered for entry into the Provider Improvement Programme (PIP), which replaces the Recovery Support Programme (RSP), and is the support for the most challenged providers. All providers in the PIP will be placed in segment 5. Providers already in the RSP will be placed in segment 5 when the initial segments for 2025/26 are published in July 2025. For providers currently undergoing a diagnostic as part of the planning process, the outcome of the diagnostic will inform their potential entry into the PIP and segment 5.

In exceptional circumstances, where NHS England has identified concerns about a provider's capability such as failures of governance, it may be necessary, regardless of the provider's existing segment, to review whether it should be placed in segment 5 and the PIP. This is to ensure it is allocated the appropriate support and intervention. This review will be agreed with the appropriate NHS England committee.

Finalisation of segments

Once NHS England has approved the final segmentation decision, this will be officially communicated to each organisation and published on NHS England's website.

Segmentation data will be reviewed at least quarterly as part of a review meeting and segments may be updated at any time based on emerging information.

Table 2: Segment descriptions

Segment	Description
1	The organisation is consistently high-performing across all domains, delivering against plans.
2	The organisation has good performance across most domains. Specific issues exist.
3	The organisation and/or wider system are off-track in a range of domains or are in financial deficit.
4	The organisation is significantly off-track in a range of domains.
5	The organisation is one of the most challenged providers in the country, with low performance across a range of domains and low capability to improve. or The organisation is a challenged provider where NHS England has identified significant concerns.

Publication of data

To support transparency, NHS England will publish a dashboard to give the public access to the data that underpins segmentation.

Each provider's domain scores, organisational delivery score and final segmentation will be shown alongside the individual metric scores used to calculate them. Although contextual metric results for providers and ICBs, including measures of progress against reducing health inequalities, will not contribute to these scores, they will also be shown on this dashboard. An overall score will also be displayed for each provider indicating its position relative to organisations of the same type. Data related to segmentation will be updated quarterly.

In addition, once our approach to provider capability is finalised, we anticipate that the dashboard will include the provider capability ratings.

Segmentation response

Segmentation combined with consideration of NHS England's assessment of provider capability will inform our oversight response.

Each NHS England region will co-ordinate the response to segmentation with NHS England national teams and wider system partners. We will use the segmentation scores alongside wider information to direct our oversight activities at those organisations that have lowest performance and lack the capability to improve without support.

We will base our **oversight of performance improvement activities** on essential principles that will be focused on the delivery of joint system plans. The frequency of review meetings with ICBs will depend on the confidence the region has in the ICB's capability to deliver the required improvements. The system's providers will be included in these meetings where required, for example where the ICB cannot drive the required improvement of a provider using the contractual levers it has with the provider. Further meetings to monitor in-year delivery and co-ordinate support will be scheduled as required.

We will align our **improvement support offer** to organisational delivery scores. For some priority areas for 2025/26 (reflected in the finance, urgent and emergency care, elective and mental health sub-domains), those providers with a relevant sub-domain score of 4 will receive the most intensive improvement support and this will be provided onsite. The offer for those with a sub-domain score of 3 will be predominantly offsite support. A universal improvement offer will be available to all organisations.

Where required, NHS England regional teams will undertake **performance management activities** (tiering) for providers with low performance in the priority areas of finance, urgent and emergency care, elective and mental health. In addition, a proportion will receive more intense scrutiny, and they may be supported by national programmes. Those organisations in segment 4 with an associated low provider capability may enter into the programme of support for our most challenged providers, the Provider Improvement Programme (PIP).

Example: Contract management of a provider

A provider is placed in segment 2 and has good performance across all domains including elective care. As a result, the relevant NHS England region does not plan to take any performance improvement actions.

The ICB reviews the provider's performance against its contract for elective care services. It finds that the provider is meeting its 18-week referral to treatment target but not fully meeting its contractual requirements to treat patients with complex needs. This means that patients with complex needs are waiting significantly longer than those who do not.

The identified concern is more appropriate for the ICB to manage under its statutory responsibilities for arranging services than for intervention under NHS England oversight functions.

NHS England has no concerns about the ICB's leadership capability, so the ICB agrees with the region that it will manage the provider's underperformance using its contractual levers. After speaking to the provider, the ICB issues a Contract Performance Notice under General Condition 9 of the NHS Standard Contract, the condition that sets out the contract management process. The ICB and provider then hold a contract management meeting and following this they agree a remedial action plan.

The ICB will escalate to the region if it does not see improvement or wider concerns develop through performance management. The region will monitor the ICB's progress in the management of the provider and will keep our view of ICB leadership capability under review as part of our wider oversight of the ICB.

Table 3: Segment support needs

Segment	How NHS England supports	How NHS England drives improvement	How NHS England intervenes
1	No specific support or intervention needs are identified. All organisations will have access to NHS IMPACT, the universal NHS improvement approach.	The organisation is expected to take a leadership role in developing and sharing best practice and improvement initiatives in areas that it excels in.	NHS England's use of its enforcement powers is not expected for organisations in this segment as they do not have intervention or support needs, but, if necessary, we will take enforcement action.
2	The organisation can diagnose and clearly explain its support needs, which are predominantly met locally. Our support on specific issues is provided where appropriate.	The organisation works with us to support the development of best practice in areas it shows high performance in and is expected to lead on its own improvement. Minimal, targeted support is aimed at improving specific areas where issues have been identified.	Due to the relatively high-performing nature of the organisation and its level of maturity, NHS England's use of its enforcement powers will be uncommon, but we may use these where specific issues call for this approach.
3	NHS England agrees the support needs of the organisation	The organisation receives increased scrutiny targeted at	NHS England may apply interventions and/or require the organisation to take

	involving the provider's relevant ICB in the decision. To do this we take account of segmentation and capability. Support is delivered through local support offers, defined national support programmes and bespoke regional interventions.	delivering improvement in challenged performance areas.	action in specific areas of low performance. This may involve use of our enforcement powers, particularly where performance concerns persist.
4	NHS England will consider the organisation's challenges and support needs, taking account of segmentation and capability to inform the appropriate support or intervention. As with segment 3, support needs are prioritised through local support offers, defined national support programmes and bespoke regional interventions.	The organisation receives intense scrutiny targeted at delivering improvement in the most challenged performance areas. Recovery KPIs and trajectories are agreed and proactively monitored.	NHS England may apply interventions and/or require the organisation to take broad actions or address specific concerns related to known issues. This may involve use of our enforcement action, particularly to secure improvement or where improvement is insufficient.
5	The organisation will be subject to NHS England's most intensive support – the Provider Improvement Programme (PIP) – to ensure it meets improvement goals.	The organisation is subject to the highest level of NHS England scrutiny and performance management to meet agreed transition criteria to leave the PIP or meet its agreed improvement plan. These demonstrate it can sustain levels of improvement.	Alongside support for the most challenged organisations, it is likely that enforcement action will be agreed through the relevant executive governance group if deemed necessary. Transition out of segment 5 requires the transition criteria to be met.

Emerging information and capability assessments

As part of NHS England's assessment process, we will gather insights across the assessment domains. We will collect this mix of quantitative data and qualitative information annually, in-year or by exception.

Qualitative information may be derived from:

- ICBs and providers as part of routine interactions, for example around emerging financial risks or clinical quality risks in line with the National Quality Board guidance on risk response and escalation
- reports from other regulators such as the CQC, including ICS assessments and internal and external audit reports
- the police and coroner reports
- third-party information, for example whistleblowing, 360-degree feedback, peer reviews, complaints or formal publications/assessments

NHS England will work with regulators, including the CQC, Health and Care Professions Council, General Medical Council and Nursing and Midwifery Council, through the national and regional Joint Strategic Oversight Group. This group provides a space for regulators to share intelligence and develop aligned approaches to support organisations.

We will assess the information we gather as part of the separate provider capability assessment process; we will publish our approach for this in Q2 of 2025.

Critical to the assessment approach is the early identification of emerging issues and concerns, so they can be addressed before they have a material impact or performance deteriorates further. If necessary, this could include the use of NHS England's enforcement powers in response to emerging information outside of the segmentation process. Issues and concerns may be identified outside the quarterly review of segmentation and may not relate directly to segmentation data. Organisations should not wait for the next cycle of the assessment process to acknowledge performance, finance or quality concerns. ICBs and providers should promptly escalate all issues that are significantly affecting performance, finance or quality to their NHS England regional team.

Oversight of delegated commissioning

NHS England remains accountable for those services it has delegated responsibility for the commissioning of to ICBs. These include certain specialised services and all primary care services (primary medical care, dentistry, pharmacy and ophthalmic services) and the

handling of associated complaints. NHS England will hold ICBs to account for the performance of these services in their system through delegation agreements.

Oversight of delegated functions will form part of NHS England's wider oversight of ICBs. In particular, NHS England will use the ICB annual assessment to judge whether delegated commissioning activities and associated complaints handling are being carried out appropriately. This may involve the in-year monitoring of additional data in relation to delegated services.

Incentives and consequences

NHS England is committed to supporting providers and ICBs to drive improvement and deliver high quality care for all. We want to see high-performing systems across the country and to embed earned autonomy and incentives into the operating framework. There has already been progress: fewer national priorities in the planning guidance increases local flexibility in decision-making.

NHS England will work closely with those providers that are high performing, as reflected by their segment and their leadership capability, to draw on their expertise in shaping and driving national policy and to test new models of care.

NHS England will also introduce greater performance incentives in 2025/26 and these will be reviewed for 2026/27 as we implement the 10 Year Health Plan. For example, to incentivise revenue performance, the 2025/26 capital planning guidance proposes that high-performing providers and ICBs that demonstrate effective governance, strong financial management and operational resilience will receive some freedoms and flexibility, including a partial release of revenue surpluses for capital expenditure. As set out in the Elective Reform Plan, we also intend to introduce capital incentives for improvements in elective performance.

Furthermore, to hold senior leaders to account for their performance in delivering high quality care and managing finances, in line with the NHS very senior managers pay framework, very senior managers of organisations in segment 5 (noting the ICBs in the RSP will be treated as such) will not be eligible for the annual pay award, unless exempt.

Enforcement

NHS England's oversight of ICBs and providers may involve the use of our regulatory powers to take enforcement action, in line with the NHS enforcement guidance, against a provider if it has breached its licence or we suspect it has.

NHS England has a range of statutory powers to address serious issues at providers. While the NHS Oversight Framework is the operational tool through which NHS England will identify providers that require support or intervention, where our assessment and monitoring

highlight serious concern with performance, quality or other areas and, after further enquiries or investigation, we are satisfied that the relevant statutory thresholds are met, we may use our enforcement powers to address the concern, according to the level of concern and in accordance with the NHS enforcement guidance. We do not expect to use of our enforcement powers for organisations in segment 1 as they do not have intervention or support needs. However, if necessary (for example, if a serious leadership or governance concern emerges), we can still take enforcement action for organisations in this segment and their segment may be reviewed.

Where providers fail to comply with their obligations under their provider licence (or are reasonably suspected of failing), NHS England may use powers including:

- Provider undertakings – can be used where NHS England has reasonable grounds to suspect that a provider has failed to meet the conditions of its NHS provider licence. We may agree to accept legally binding undertakings to secure progress where providers are capable of resolving performance issues themselves.
- Provider discretionary requirements – can be imposed to require the remedy of a breach of an NHS provider licence where NHS England is satisfied that a breach has occurred. We may consider imposing discretionary requirements based on a range of considerations to ensure that progress is made, including where we do not have confidence the provider is taking sufficient action to resolve performance issues.

NHS England has powers in relation to NHS trusts that we may use in appropriate cases to effect executive leadership change, and the power to remove chairs and non-executive directors. For NHS foundation trusts, NHS England can also impose additional licence conditions relating to governance, breach of which may then lead to leadership change.

NHS England may consider using our powers of direction or additional licence conditions in more serious cases of governance failure.

More information can be found in the NHS enforcement guidance, including how NHS England chooses which powers to use and when, the factors we consider when enacting them and how we ensure consistency in approach.

Annex A: Delivery metrics

The assessment process measures each provider's delivery across 6 domains, as set out in Table 1 of the framework. Each domain has a range of appropriate metrics for each type of organisation (ICB, acute, mental health, community and ambulance trusts); these are set out in the tables below. For this transitional year, the scoring metrics **(in bold)** reflect the 2025/26 NHS priorities and operational planning guidance. The other contextual metrics will not influence the segmentation score.

Table A1: Access domain metrics

These metrics relate to the national objectives set out in the 2025/26 NHS priorities and operational planning guidance and other commitments relating to the NHS Constitution. All metrics are scored (denoted in bold) other than 2 mental healthcare and 2 primary care contextual metrics which do not form part of the segment score.

Elective care

Metric	Organisations to which the metric relates
Annual change in the size of the waiting list	Integrated care boards (contextual)
Percentage of patients waiting less than 18 weeks (absolute performance and performance compared to plan)	Acute trusts
Percentage of patients waiting over 52 weels	Acute trusts
Percentage of patients waiting over 52-weeks for community services	Community trusts

Cancer

Percentage of urgent referrals to receive a definitive diagnosis within 4 weeks	Acute trusts
Percentage of patients treated for cancer within 62 days of referral	Acute trusts
Percentage of all cancers diagnosed at stage 1 or 2	Integrated care boards (contextual)

Urgent and emergency care

Percentage of emergency department attendances admitted, transferred or discharged within 4 hours	Acute trusts

Percentage of emergency department attendances spending over 12 hours in the department	Acute trusts
Average Category 2 ambulance response time	Ambulance trusts

Mental health care

Annual change in number of children and young people accessing NHS-funded MH services	Mental health trusts
Community mental health access rate	Mental health trusts
Percentage of people with suspected autism waiting more than 13 weeks for contact	Mental health trusts

Primary care

Growth in number of urgent dental appointments provided versus target	Integrated care boards (Contextual)
Percentage of patients to describe booking a general practice appointment as easy	Integrated care boards (Contextual)

Table A2: Effectiveness and experience of care domain metrics

These metrics relate to the role of NHS bodies to continuously improve the quality of care patients receive. Most metrics are scored (bold), but some are non-scoring contextual metrics and therefore do not contribute to the overall domain and segment score.

Metric	Organisations to which the metric relates
Summary Hospital Level Mortality Indicator	Acute trusts
Acute bed days per 100,000 people	Integrated care boards (contextual)
Change in the number of inpatients who are autistic or have a learning disability	Integrated care boards (contextual)
Average number of days from discharge ready date and actual discharge date	Integrated care boards (contextual) and acute trusts
Percentage of continuing healthcare referrals completed in 28 days	Integrated care boards (contextual)
Readmission rate band	Acute, community and mental health trusts
Percentage of mental health bed days that are out of area	Integrated care boards (contextual)
CQC inpatient survey satisfaction rate	Acute trusts
National maternity survey score	Acute trusts

Percentage of inpatients with >60 day length of stay	Mental health trusts
Urgent community response 2-hour performance	Mental health trusts
Community mental health survey satisfaction rate	Mental health trusts
Percentage of ambulance patients conveyed to emergency departments	Ambulance trusts
NHS staff survey – advocacy score	Ambulance trusts

Primary care

Percentage of patients who receive all 8 diabetes care processes	Integrated care boards (contextual)
Percentage of patients with GP recorded CVD who have their cholesterol levels managed to NICE guidance	Integrated care boards (contextual)
Percentage of hypertension patients treated to target	Integrated care boards (contextual)
Percentage of patients with a preferred general practice professional reporting they were able to get an appointment with that professional	Integrated care boards (contextual)

Table A3: Patient safety domain metrics

These metrics relate to how organisations ensure that patients are kept safe, a core element of high-quality care. Most are scored (bold), but some are non-scoring contextual metrics.

Metric	Organisations to which the metric relates
NHS Staff Survey - raising concerns sub-score	All organisations (contextual only for ICBs)
CQC safe inspection score (if awarded within the preceding 2 years)	All trusts
Rates of Healthcare Associated Infection (MRSA, C-Difficile and E-Coli)	Acute trusts
Number of neonatal deaths and stillbirths per 1,000 total births	Integrated care boards (contextual)
Rate of restrictive interventions use	Mental health trusts
Percentage of patients in crisis to receive face-to-face contact within 24 hours	Mental health trusts
Percentage of inpatients acquiring a new pressure ulcer	Acute trusts (contextual)

Primary care

Percentage of children (aged 0–9) prescribed antibiotics in the last 12 months	Integrated care boards (contextual)

Table A4: People and workforce domain metrics

These metrics relate to how NHS organisations ensure the wellbeing of those who provide and support care. These are a mix of scored (bold) and contextual metrics.

Metric	Organisations to which the metric relates
Sickness absence rate	All trusts (contextual only for ICBs)
NHS staff survey engagement theme score	All trusts (contextual only for ICBs)
NHS staff survey education and training theme score	Integrated care boards (contextual)
National Education and Training Survey overall satisfaction score	All trusts (contextual)

Primary care

GP leaver rate	Integrated care boards (contextual)

Table A5: Finance and productivity domain metrics

These metrics will be used to judge individual organisational financial delivery. They all contribute to trust segmentation but are contextual for ICBs.

Finance

Metric	Organisations to which the metric relates
Planned surplus/deficit	All organisations (contextual only for ICBs)
Variance year-to-date to financial plan	All organisations (contextual only for ICBs)

Productivity

Implied productivity level	Integrated care boards (contextual only) and acute trusts
Relative difference in costs	Mental health, community and ambulance trusts

Table A6: Improving health and reducing inequality domain metrics

These metrics relate to longer-term priorities aimed at improving population health and reducing inequalities. They are all non-scoring contextual metrics and therefore do not contribute to the overall domain and segment score.

Improving population health

Metric	Organisations to which the metric relates
Average number of years people live in healthy life	Integrated care boards
Percentage of patients receiving talking therapies who achieve reliable recovery	Mental health trusts

Primary prevention

Cervical, breast and bowel cancer screening rates	Integrated care boards
Percentage of pregnant women who quit smoking	Integrated care boards
Percentage of inpatients referred to in-house tobacco treatment services who make a supported attempt to quit stop smoking	Integrated care boards
Percentage of patients supported by obesity programmes	Integrated care boards
MMR vaccine uptake rate	Integrated care boards
Percentage of people waiting over 6 weeks for a diagnostic procedure or test	Acute trusts

Inequalities

Deprivation and ethnicity gap in pre-term births	Integrated care boards
Deprivation gap in early cancer diagnosis gap	Integrated care boards
Deprivation gap in myocardial infarction and stroke admissions	Integrated care boards
Percentage of annual health checks completed for patients with a learning disability or who are autistic	Integrated care boards
Under 18s elective waiting list growth	Acute trusts
Percentage of older inpatients (over 65) with >90 day length of stay	Mental health trusts

Table A7: System performance for ICBs

These metrics relate to tests applied at a whole system level for ICBs. They are contextual metrics and not applied in 2025/26.

National priority	Test
Urgent and emergency care	Has the system been in the lowest quartile for 4 hour UEC performance for each of the last three months?
Elective care	Has the system been in the lowest quartile for 18-week performance for each month of the last quarter?

Cancer care	Has the system been in the lowest quartile for 62-day performance for each month of the last quarter?
Primary care	Is the system in the lowest quartile for overall primary care patient satisfaction?
Mental health	Is the system in the lowest quartile for proportion of healthchecks for severe mental illness completed in the last year?
Finance	Is the system projecting an annual deficit of over 2.5% or a deficit below 2.5% that is over 1% off plan?

To:
- ICB and NHS trust chairs and Executive teams

cc.
- NHS England regional directors

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

3 July 2025

Dear colleagues

Fit for the Future: 10 Year Health Plan for England

Today sees the publication of Fit for the Future, our 10 Year Health Plan for England: an important milestone in the broader reset of the NHS, which describes the ambitions of the staff, patients, partners and citizens that have contributed to its development over the last year.

Throughout our leadership discussions over the last few months, the importance of returning to being more ambitious for our staff and patients has been a consistent theme: Fit for the Future provides the platform for us as a leadership community to inspire our teams to be bold and impatient for change.

It's a pivotal moment. We've talked a lot about the three big shifts over the last 12 months: today's publication sets out a route map on how we can use these to fundamentally change the way we deliver care over the next decade.

That change will only happen if we get the foundations right. So, our continued leadership focus on resetting how we work over the months ahead is crucial to creating the conditions and headspace we need to deliver change. In the short term, prioritising financial discipline, delivery of our commitments and a relentless focus on preparing for winter this year will put us in good shape to push on with the ambitions set out in the 10 Year Health Plan.

For our part, moving us quickly to medium term planning, aligning how the centre and regions work to support you better, and simplifying rules and accountability, remain absolute priorities for the months ahead.

We will work closely with you over the summer to align all of these priorities and agree our collective delivery approach for Fit for the Future – focusing on those elements of the plan that will have the most immediate impact on our staff and patients, while looking ahead at the more medium and long-term changes we need to make.

Alongside the plan, your team will receive a communications pack to support you in cascading its key messages. It would be great if you and your senior team could spend time looking at the plan, so we can talk through next steps in more detail in the coming weeks.

In the meantime, we are all aware of the very real challenges we face getting the NHS back to a place where our staff and public want and need it to be. Today's publication of Fit for the Future gives us all an opportunity to galvanise energy and optimism about the future, and the need for your leadership in this has never been more important.

Yours sincerely

Dr Penny Dash
Chair, NHS England

Sir James Mackey
Chief Executive, NHS England

To:
- Trust CEOs and chairs

cc.
- ICB CEOs
- Regional directors

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

23 June 2025

Dear colleague

Maternity and neonatal care

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

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

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

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

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

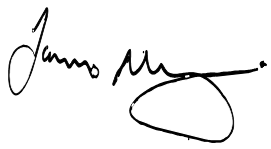
In the meantime, we ask every local NHS Board with responsibilities relating to maternity and neonatal care to:

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

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

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

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



Sir Jim Mackey
Chief Executive

Duncan Burton
Chief Nursing Officer for England

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The Dudley Group NHS Foundation Trust

Paper for submission to Public Board of Directors 10th July 2025

Report title:	Perinatal Quality Surveillance Report.
Sponsoring executive:	Martina Morris, Chief Nurse and Board Level Maternity Safety Champion
Report author:	Claire Macdiarmid, Director of Midwifery and Maternity Safety Champion

1. Summary of key issues

Assure

- Perinatal Mortality data remains in a stable position; all rates remain below the national rates.
- Maternity and Neonatal services undertook a 15 steps event on the 20th May that was well attended by families that had used our services. Formal feedback will follow once collated by the Maternity and Neonatal Voices Partnership (MNVP) but overall, the visit was very positive, welcomed by the families in attendance and lots of lovely feedback for the teams.

Advise

- Midlands Maternity Heatmap score has increased to 32 for June 2025. This increase is reflective of the vacancy currently within the Midwifery and Maternity support worker workforce. Rectification plans are in place for this.
- There were 2 new cases referred to the Maternity and Newborn Safety Investigations (MNSI) during April and May 2025, by the Trust. 1 case has been rejected due to lack of family engagement. There has been 1 new incident response commenced during April and May 2025. There was 1 incident response concluded during April and May 2025.
- APPENDIX 3 demonstrates the current Midwifery workforce position, presented to the Quality Committee and Board Bi-annually to comply with requirements of the Maternity Incentive Scheme year 7. Main highlights show, that the Maternity unit has funded establishment in line with Birthrate plus requirements. There is however a vacancy in the Midwifery workforce of 12.68 WTE and Midwifery Support Workers of 9.6 WTE. All posts have been recruited in to; the majority of these people will commence employment September/October 2025. Most of this RM vacancy is within the Community Midwifery department, with mitigations in place. Despite the vacancy challenges:
    - The Midwife to birth ratio for April is 1:29, this is within acceptable levels.
    - Maternity specific multidisciplinary training compliance remains above 90%.
    - There have been 0 instances where the shift leader has not been supernumerary, or when a woman has not been provided with 1:1 care in labour. This is a requirement of the Maternity Incentive Scheme year 7.

Alert

- Safeguarding level 3 children training compliance within the midwifery and obstetric teams has reduced to 66% in May, from 80% in April for Midwives, and 79% to 58% in

obstetrics. Rectification plans are in place between the Matron and Maternity Practice Development team team to address this position.

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

3. Report journey
LMNS Perinatal Quality Surveillance meeting. Maternity Governance Group. Quality Committee.

4. Recommendation(s)
a) The Board is asked to accept this report as assurance against the national requirements for Boards to have oversight of maternity services with a dataset of information as set out by the Perinatal quality surveillance model, and the three-year delivery plan.

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

REPORT FOR ASSURANCE

The Dudley Group
NHS Foundation Trust

Perinatal Clinical Quality Surveillance

Report to Trust Board – 10th July 2025

1 EXECUTIVE SUMMARY

1.1 This report outlines locally and nationally agreed measures to monitor maternity and neonatal safety as outlined in the NHS England/Improvement (NHSEI) document "Implementing a revised perinatal quality surveillance model" (December 2020). The purpose of the report is to inform the Quality Committee, Trust Board and Local Maternity and Neonatal System (LMNS) board of present or emerging safety concerns or activity to ensure safety with a two-way reflection of ward to board insight across the multidisciplinary multi professional maternity and neonatal service teams. The information within the report will reflect actions in line with Ockenden and 3-year delivery plan and progress made in response to any identified concerns at provider level.

1.2 In line with the perinatal surveillance model, the Trust is required to report the information outlined in the data measures proforma monthly to the trust board. Data contained within this report is for **APRIL and MAY 2025.** Please note that the PQSM is due to be revised during 2025 to the Perinatal Quality Oversight Model (PQOM). Further guidance is awaited from NHSE/NHSR on this change.

2. BACKGROUND INFORMATION

2.1 Perinatal surveillance dashboard

Safeguarding level 3 children training compliance within the midwifery and obstetric teams has reduced to 66% in May, from 80% in April for Midwives, and 79% to 58% in obstetrics. This is due to a large proportion of the staff undertaking their training at the same time. Rectification plans are in place between the matron and Practice Development team to address this position.

There has been a further increase in midwifery vacancies, with all being recruited into and due to start September/October 2025. Mitigations are in place to maintain safe staffing levels.

		Jan	Feb	March	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	March	April	May
PMRT	Perinatal Mortality Review Tool cases opened in month	1	0	4	1	1	2	0	2	0	1	3	2	1	0	1	1	2
	PMRT reviewed in month	2	1	2	2	2	2	2	0	2	1	4	2	2	4	2	2	2
HSIB/ MNSI	Number of cases referred to and accepted by MNSI (with 72 hr review)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1*	0
	Reports received from MNSI	0	0	0	1	2	0	1(SWBH)	0	1(RWT)	0	0	0	0	0	0	0	0
	MNSI investigations ongoing	4	4	4	3	1	1	1(RWT)	1(RWT)	0	0	0	0	0	0	0	1	1
	MNSI open action plans	0	0	0	1	1												
	New MNSI															1		
PSIRF	The number of incidents logged as moderate or above:	1	0	1	0	0	2	0	1	1	1	0	0	0	1	1	1	0
	PSII Reported	0	1	0	0	0	4	0	1	0	1	0	0	0	1	1	0	1
	PSII Completed	0	0	0	2	0	1	0	0	0	0	1	3	1	0	0	0	0
	PSII Ongoing	2	3	3	1	1	4	4	5	5	6	5	2	1	2	3	3	4
	Oustanding Investigation Actions - overdue	7	3	3	5													
	Oustanding Investigation Actions - open			6	7													
	Maternity Incidents Improvement Plan - overdue actions					12	12	10	13	18	19	13	17	13	12	15	14	13
	Maternity Incidents Improvement Plan - open actions					13	15	18	28	24	23	17	31	24	21	18	17	14
Clinical Outcome	Stillbirth rate (National crude rate 3.54 per 1000 births)	2.44	2.43	3.4	2.9	2.62	2.62	2.63	2.39	1.92	1.92	2.68	2.92	3.17	3.19	2.46	2.73	2.99
	Neonatal Death Rate 1.65 (> 22+0 - up to 28 days post delivery)	2.44	2.19	2.19	2.19	1.67	1.67	1.68	1.2	1.2	0.72	0.73	0.73	0.49	0.49	0.49	0.24	0.25
	Neonatal death rate only including babies born over 24/40			1.21	1.21	0.96	0.95	0.96	0.72	0.72	0.24	0.24	0.24	0.24	0.24	0.24	0.24	0.25
	Total Perinatal Mortality Rate (MBRRACE figure 5.19 per 1000 births)	4.88	4.62	5.59	5.08	4.29	4.29	4.3	3.52	3.13	2.64	3.68	3.65	3.65	3.69	2.95	2.98	3.24
	Avoidable term admission to NNU (reported quarterly)		3			4			3			5			2			
Appraisals	All Maternity staff (90%) (Apraisal window April-July)						93% (16.7.24)	94.30%	94.30%									30% 2/6/25
Midwifery Tra	Fetal Monitoring Training (90%)*	99%	97%	98%	96%	96%	99%	98%	98%	99%	99%	100%	98%	99.00%	97%	98%	99%	98%
	Obstetric Emergency Simulation Training (PROMPT) (90%)*	99%	97%	96%	96%	98%	99%	99%	97%	99%	100%	100%	98%	98.00%	99%	99%	99%	100%
	Safeguarding (level 3) Adult (90%) (Database not accurate)	84%	83%	77%	70%	83%	78%	85%	90%	90%	91%	87%	91%	92.00%	84%	91%	86%	84%
	Safeguarding (level 3) Children (90%)	78%	79%	82%	79%	83%	80%	90%	94%	95%	88%	86%	89%	80.00%	78%	83%	80%	66%
	Neonatal Resusitation (90-95%)*	93%	92%	90%	86%	90%	87%	88%	90%	90%	90%	92%	94%	96.00%	94%	95%	92%	82%
	Adult Resusitation (90 - 95%)*	94%	93%	91%	86%	84%	88%	90%	91%	92%	91%	92%	93%	92.00%	92%	92%	89%	88%
Obstetrics Tr	Fetal Monitoring Training (90%)*	97%	100%	100%	95%	95%	98%	98%	97%	97%	97%	100%	100%	100.00%	98%	100%	100%	97%
	Obstetric Emergency Simulation Training (PROMPT) (90%)*	92%	97%	97%	95%	100%	100%	98%	97%	97%	98%	98%	100%	98.00%	97%	98%	100%	98%
	Safeguarding (level 3) Adult (90%)	81%	73%	73%	80%	80%	93%	93%	94%	100%	100%	80%	100%	100.00%	100%	100%	100%	94%
	Safeguarding (level 3) Children (90%)	68%	68%	71%	72%	80%	80%	80%	86%	66%	73%	82%	89%	85.00%	66%	70%	79%	58%
	Neonatal Resusitation (90-95%)*	86%	85%	80%	90%	92%	87%	90%	92%	90%	97%	90%	96%	90.00%	90%	97%	92%	76%
	Adult Resusitation (90 - 95%)*	86%	85%	91%	88%	90%	91%	90%	91%	90%	97%	95%	95%	90.00%	90%	92%	89%	87%
	[illegible]																	
Safe staffing	Obstetric consultant cover on delivery suite	91	91	91	91	91	91	91	91	91	91	91	91	91	91	91	91	91
	Vacancies midwifery (WTE)	0	0	0	0	0	0	0	0	0	0	0	4	9	9	12	13	14
	Obstetric Consultant vacancies (WTE)	0	0	0	0	0	0	0	0	0	0	0	0.4	0.4	0.4	0.4	0.4	0.4
	Total Red flag data: Total number of red flags (As per acuity tool)	5	1	0	14	14	12	8	2	6	4	3	3	7	2	7	7	14
	Shift Leader supernumuary at start of shift : % of time	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	1:1 care in labour achieved	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	Birth Before Arrival (BBA)	2	1	1	3	2	2	(1unbooke	1	2	1	3	2	2	0	1	3	2
Service user feedback	MVP (Quarterly)	.	.	6.3.24	.	.	~~6.6.24~~	.	.	16.09.24	.	.	17.12.24	.	.	18.03.25	.	.
	MNVP Extraordinary meetings* Bereavement / Neonatal / EDI	.	.	21.3.24	25.4.24	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil	20/05/25 15 steps
Engagement	Response Rate (%)	7%	11%	25%	33%	17%	20%	19%	12%	26%	11%	9%	12%	14%	13%	15%	21%	17%
	Recommendation Response Rate (Good/ Very Good %)	17%	86%	81%	82%	77%	89%	88%	84%	83%	76%	76%	84%	85%	90%	75%	88%	79%
	PALS	3	9	5	3	4	9	5	7	8	1	6	1	5	9	6	7	
	Complaints	5	5	3	6	4	6	4	1	7	5	5	7	4	5	4	4	
	Compliments	71	65	70	72	67	67	59	65	65	62	72	80	58	77	64	70	68
Safety Champ	Maternity Safety champions walk- about	None	Cancelled	None	none	13.5.24		24.7.24		25.9.24		04.11.2024		21.01.25	06.02.25	26.03.25		28/5/25
	Maternity and Neonatal Safety Champion Meeting	None	28/2/24	None	24.4.24		26.6.24		28.8.24		30.10.24		18.12.24			31.03.25		
	Perinatal Assurance meeting (previously Maternity Quad / MIS)	None	None	None	25.4.24	Kornferry	None	01.07.24	28.08.24			04.11.24		06.01.25			25/04/25	5/5/2025 Rearranged
External	MNSI/NHSR/CQC or other organisation with a concern or request for action made directly with the trust	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Legal	New Legal cases (Maternity only- Including Coroners cases and ENS claims)	0	0	0	3	0	2	0	0	1	1	0	0	2	0	1	1	0
	Ongoing Claims Cases													17	17	17	18	18
	Ongoing Early Notification Scheme Cases													4	4	4	5	5

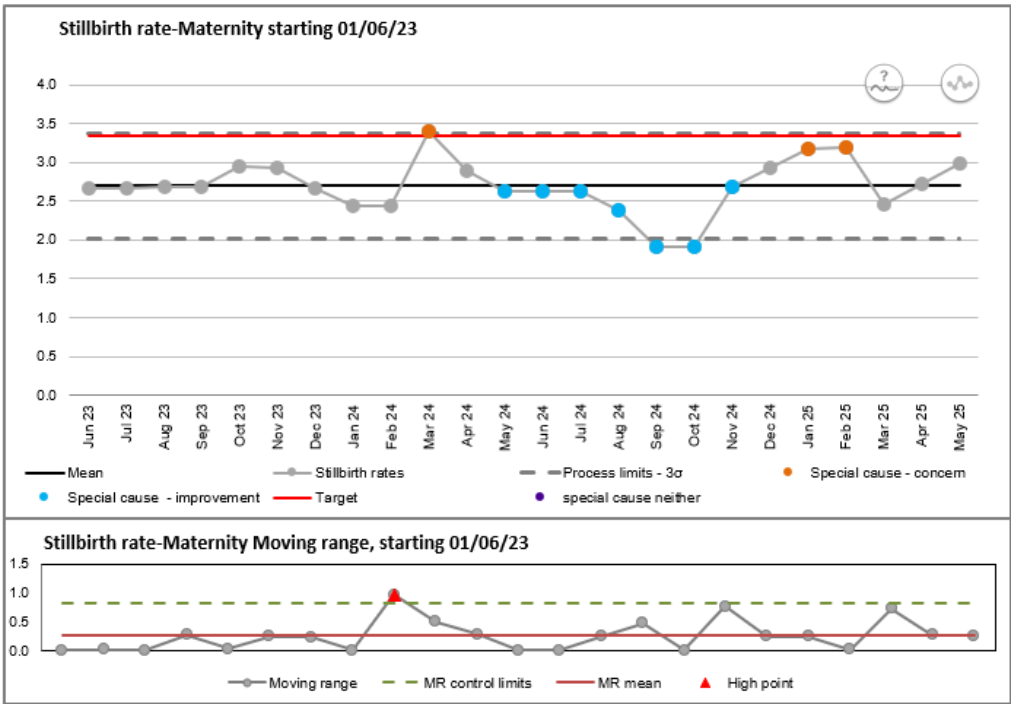
Red flags incidents have notably increased in May 2025 (14). This is mainly due to a significant increase in activity (356 total births), paired with an increased midwifery and Midwifery Support Worker (MSW) vacancy and a decrease in the number of staff taking on additional shifts as bank. To note, 10 extra elective caesarean section lists were undertaken throughout April and May (24 additional theatre slots). Acuity was noted to have had an increase in red shift (11%) compared to the previous 6-month average of 4.8% of shifts being rated as red. The maternity team will continue to monitor staffing levels to ensure safety is not compromised and escalate any concerns via the Maternity safety champions.

2.2 Midlands Perinatal Heatmap

Appendix 1 demonstrates updated position on the Midlands regional heatmap for June 2025. The Trust's score has increased to 32. This increase is reflective of the vacancies currently within the midwifery and MSW workforce. Rectification plans are in place. One further point was added due to lack of progress with perinatal pelvic health services; however, work has moved at pace in recent weeks between the ICB PPH (perinatal pelvic health service) have been working together to rectify this position.

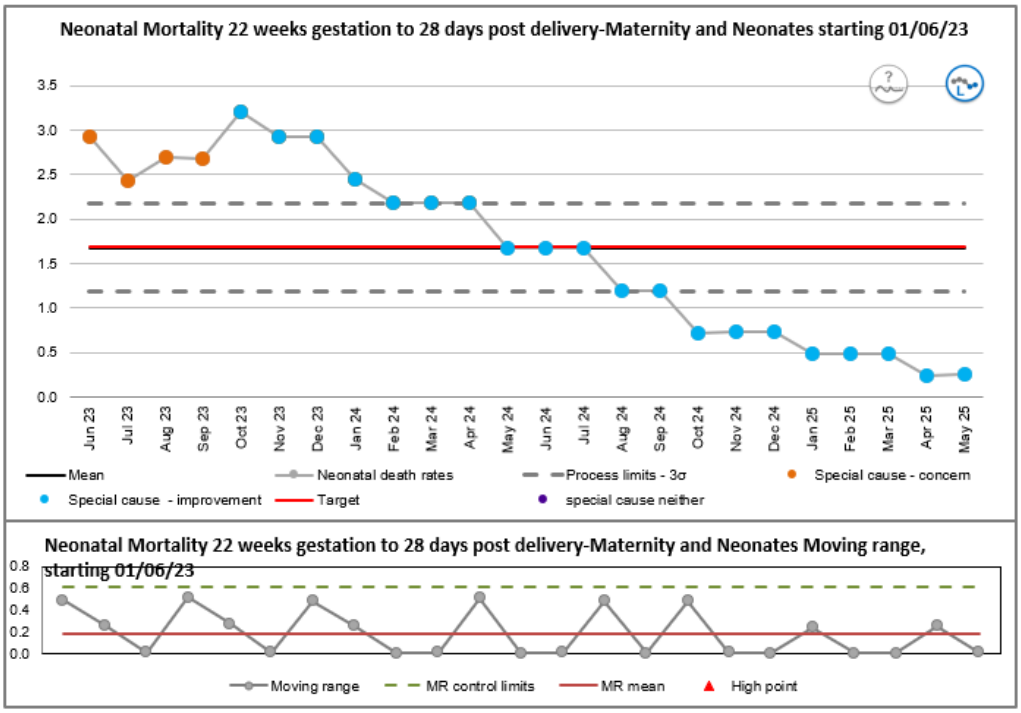
2.3 Perinatal Mortality data

Stillbirth rates



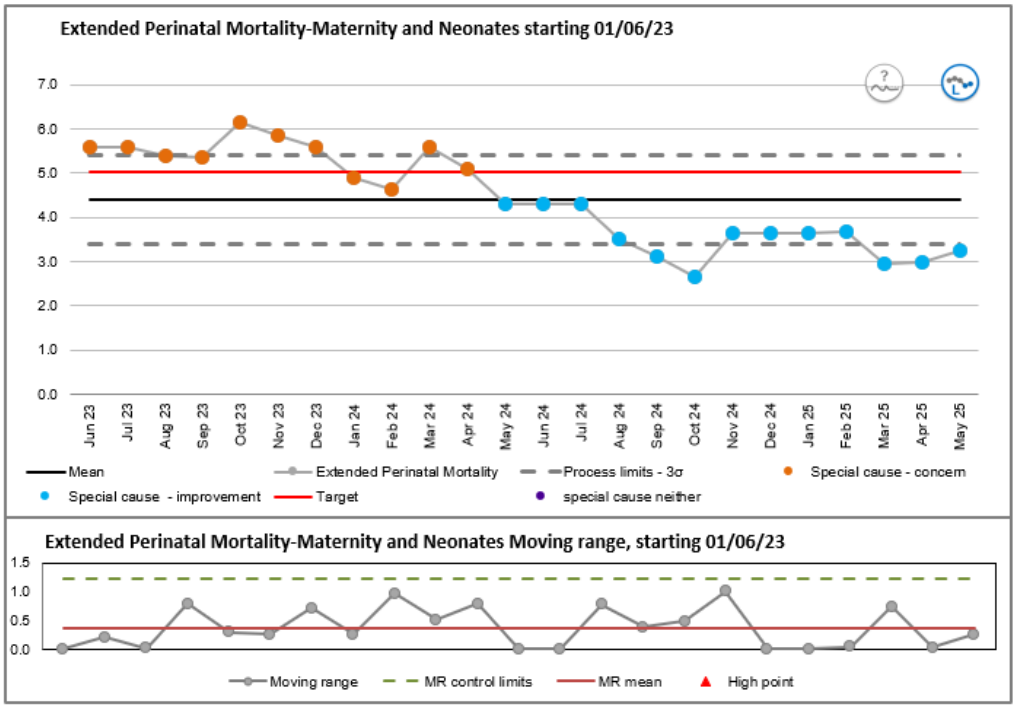
The Stillbirth rate has increased slightly to 2.99 for May 2025 but remains below the national rates.

Neonatal mortality rates



Neonatal death rates (from 22 weeks gestation) have decreased further to 0.25 for April and May 2025, below the national rates.

Extended Perinatal Mortality rates



Extended rates have increased slightly to 3.24 which reflects the slight increase in stillbirth rate. This remains below the national rate.

2.4 Serious incidents and Maternity and Newborn Safety Investigations

There were 2 new cases referred to the Maternity and Newborn Safety Investigations (MNSI) during April and May 2025, by the Trust. 1 case has been rejected due to MNSI being unable to successfully contact the family. There are no concerns raised by the family or identified by the department.

There has been 1 new incident response commenced during April and May 2025.

There was 1 incident response concluded during April and May 2025.

INC160756 – A woman undergoing an emergency caesarean section suffered a major haemorrhage and cardiac arrest. Whilst the team were commended for their management of the emergency, wider learning was identified.

Areas identified for improvement were as follows:

- Urgent communication sent out across the Trust, as many staff/ departments are felt to not be aware of the changes to requesting blood, from the National amber alert.
- Ensure that requests are reviewed and actioned appropriately in the blood bank and communicated where necessary. A maternity criterion for cross match is to be agreed.
- Consider potential patient safety issues due to the distance from blood bank to obstetric theatres. To explore the possibility of a blood fridge within the Maternity Unit.
- Ensure appropriate escalation of IT system issues regarding printing errors in blood bank.

2.5 Coroner Regulation 28 made directly to the Trust

There were 0 Coroner regulation 28 made directly to the Trust in respect of perinatal or maternal deaths in April or May 2025.

2.6 Claims score card (CLIP report)

APPENDIX 2 shows the most recent analysis of the claims scorecard, Incident themes and complaints. The team utilise this intelligence to form the basis of their QI work, as well as themes for Multidisciplinary training.

Learning from Q4 has highlighted:

- Improvement required in VTE calculation (QI project ongoing Chief nurse fellowship)
- Communication training with case studies in the Fetal Monitoring Training Day
- Holistic overview of clinical condition in conjunction with CTG interpretation to be included in mandatory annual Fetal Monitoring Study Day
- ‘WHEEP’ introduced to support fresh eyes for CTG monitoring
- Review of medical staffing escalation process
- Review of results monitoring and follow up process

2.7 Maternity Safety Champions

Bimonthly Maternity Safety Champion (MSC) meetings occur alternating with the MSC walkaround. The meeting planned for 5th June has had to be rescheduled to the 16th July 2025.

The last Maternity Safety Champion walkaround occurred 28th May 2025. No concerns were raised during this walkaround requiring escalation. The next walkaround is planned for 30th July 2025.

MSC Speak up session for the Perinatal team is due to be held on the 17th June 2025 – email correspondence and posters have been circulated to raise awareness. An event on TEAMS is planned to ensure community midwifery will be available to attend.

Freedom to speak up

There has been a concern raised to the FTSU lead during June relating to community midwifery. This mainly related to the gaps in Midwifery staffing, leading to larger caseloads than normal per community midwife, and issues around safeguarding compliance. The leadership team is working with the community midwifery team to mitigate some of their concerns and share actions already taken to rectify this position. Actions being taken are:

- Action plan in development with a collated position of response to the staffing shortages to be shared with the CMW team.
- Staff encouraged to add additional hours worked to their roster to ensure a log is kept and workload is able to be tracked.
- Datixs to be completed when staff can not maintain their safeguarding responsibilities or do not have the time to attend important milestones in the case. Escalation to the deputy matron.
- Senior maternity team undertaking audits of clinics to ensure clinic time is optimally used.
- Collaboration with safeguarding to enhance the relationship between community midwifery and the safeguarding team.
- Maternity safety champions to host a TEAMs speak up session for community midwifery.
- Audit of safeguarding to be undertaken, and good news stories to be shared with the team.
  Comparison of safeguarding processes against an exemplar unit to be undertaken.

Progress will be discussed at Maternity safety champions and shared with the committee.

Perinatal Assurance Group

Last meeting took place on 25th April 2025 (re arranged from 14th April). No concerns were raised within this meeting requiring escalation.

2.9 Saving Babies Lives

Update on gap analysis against SBLV3.2

Saving Babies Lives Care Bundle Version 3.2 was released on 24th April 2025.

The NHSE audit tool was released 4th June 2025 and now reflects the changes made to the publication. The majority of the changes are to the technical definitions and/ or minimum evidence requirements which will reduce the data workload. The SBL Team will work to update the tool and submit for the quarterly compliance meeting with the Black Country LMNS in August.

2.10 Service user feedback

2.10.1 MNVP 15 steps

Maternity and Neonatal services undertook a 15 steps event on the 20th May that was well attended by families that had used our services. Formal feedback will follow once collated by the MNVP but overall, the visit was very positive, welcomed by the families in attendance and lots of really lovely feedback for the teams.

Summary of areas to highlight include:

Neonates:

- Good signage to get to the unit
- Kitchen and family areas well equipped and welcomed by the families
- Inclusive to dads/partners
- Well maintained

Areas to be highlighted for action:

- No bell from maternity to neonates to gain access if staff aren't around
- Some negative signage around 'stop' on doors
- Felt clinical

The families commented that they could see and feel a notable improvement in the unit, and this was commented on several times throughout the visit. All feedback has been welcomed by the Neonatal leadership team and work is already underway to rectify and issues.

Maternity

- Security guard was very polite, and the post was welcomed by the families
- The area was clean, calm and welcoming
- Staff were friendly and approachable
- 'Team of the shift' signage was very welcomed

Areas to be highlighted for action:

- Posters were mostly in English and didn't have QR codes to be able to read in other languages
- The day room had some clinical activity occurring with a neonatal baby which confuses its purpose

- The families were unsure what the Maternity safety champions was, despite the posters within the unit and what was the purpose
- Some notice boards were empty and could have been utilised better

Overall, a very positive 15 steps with work to do in all areas to make this a better experience for all. Huge well done to the Perinatal team.

2.10.2 Service user feedback- Friends and Family results April and May 2025 as per Perinatal Safety Data tool.

Feedback from the Friends and family feedback for May included the following comments:

What was good about your visit?

Amazing staff so lovely and kind always happy to help always supportive, we have been for daily CTGs, and all the staff have always listened to my worries and have always reassured me and explained things to me.

Being a surrogate, the whole team have been amazing, making the parents an important part of the process, very good care and info throughout.

Everything was thoroughly explained, staff were welcoming and friendly. Made to feel comfortable and looked after, lots of aftercare information provided for both mom and baby. We couldn't have wished for a better experience.

Kate with the scanning team was very comforting when looking at baby. She was chatty and fun. Ms Banerjee was lovely and listened to my thoughts on what birth I would like, wonderful.

What could have made it better?

More fans, very hot day.

Cooler waiting room, very hot for heavily pregnant ladies.

Decaf drinks (tea, coffee).

The waiting times was appalling appointment was 2PM time of writing this was 15:40PM and still not seen doctor

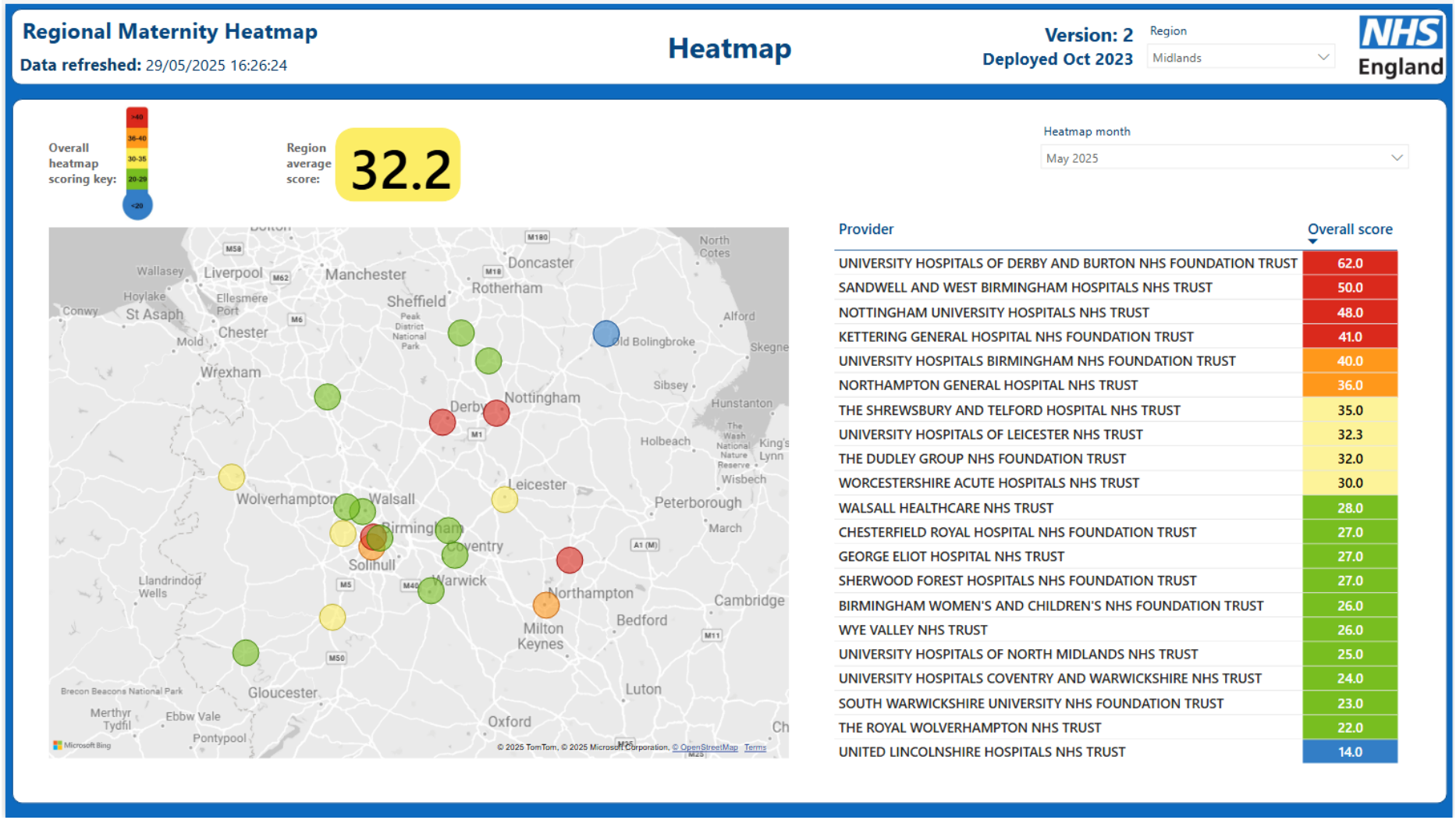
3. RECOMMENDATION(S)

3.1 The Public Board of Directors is invited to accept the paper as assurance against all national standard requirements including SBLV3 and Perinatal quality surveillance model (Ockenden 2022) currently fulfilling requirements of the Maternity incentive scheme (MIS) year 7.

Name of Author: Claire Macdiarmid
Title of Author Director of Midwifery

Date: 29th June 2025

APPENDIX 1


Regional Maternity Heatmap
Data refreshed: 29/05/2025 16:26:24
Heatmap
Version: 2
Deployed Oct 2023
Region
Midlands
NHS England
Overall heatmap scoring key:
>40
36-40
30-35
20-29
<20
Region average score:
32.2
Heatmap month
May 2025
Provider
Overall score
UNIVERSITY HOSPITALS OF DERBY AND BURTON NHS FOUNDATION TRUST 62.0
SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST 50.0
NOTTINGHAM UNIVERSITY HOSPITALS NHS TRUST 48.0
KETTERING GENERAL HOSPITAL NHS FOUNDATION TRUST 41.0
UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST 40.0
NORTHAMPTON GENERAL HOSPITAL NHS TRUST 36.0
THE SHREWSBURY AND TELFORD HOSPITAL NHS TRUST 35.0
UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST 32.3
THE DUDLEY GROUP NHS FOUNDATION TRUST 32.0
WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST 30.0
WALSALL HEALTHCARE NHS TRUST 28.0
CHESTERFIELD ROYAL HOSPITAL NHS FOUNDATION TRUST 27.0
GEORGE ELIOT HOSPITAL NHS TRUST 27.0
SHERWOOD FOREST HOSPITALS NHS FOUNDATION TRUST 27.0
BIRMINGHAM WOMEN'S AND CHILDREN'S NHS FOUNDATION TRUST 26.0
WYE VALLEY NHS TRUST 26.0
UNIVERSITY HOSPITALS OF NORTH MIDLANDS NHS TRUST 25.0
UNIVERSITY HOSPITALS COVENTRY AND WARWICKSHIRE NHS TRUST 24.0
SOUTH WARWICKSHIRE UNIVERSITY NHS FOUNDATION TRUST 23.0
THE ROYAL WOLVERHAMPTON NHS TRUST 22.0
UNITED LINCOLNSHIRE HOSPITALS NHS TRUST 14.0
Liverpool
Manchester
Doncaster
Rotherham
Sheffield
Chester
Wrexham
Derby
Nottingham
Leicester
Wolverhampton
Walsall
Birmingham
Coventry
Solihull
Warwick
Northampton
Milton Keynes
Bedford
Cambridge
Peterborough
Luton
Oxford
Gloucester
Pontypool
Ebbw Vale
Llandrindod Wells
Brecon Beacons National Park
Holbeach
Hunstanton
Skegness
Alford
Old Bolingbroke
Sibsey
Wisbech
March
King's Lynn
North Cotes
Conwy
St Asaph
Mold
Hoylake
Wallasey
Ellesmere Port
Peak District National Park
Microsoft Bing
© 2025 TomTom, © 2025 Microsoft Corporation, © OpenStreetMap Terms

Regional Maternity Heatmap

Data refreshed: 29/05/2025 16:26:24

Scoring

Region: Midlands

NHS England

Heatmap month: May 2025

Provider	Overall score	CQC Mat overall rating	Stake holder concerns	CQC S29a	CQC s31	Ext. ind. review	Coroner reg 28	Mat Oversight	MIS	CNST repay ment	Eth. DQ	CQC Mat Survey	SBL	Midw ives vac.	MSW vac.	Obs vac.	Unfilled roles	Snr L'ship not in post	Safety champs	Birthrate + (last 3 yrs)	Neonatal death rate	Perinatal death rate	Stillbirth rate
BIRMINGHAM WOMEN'S AND CHILDREN'S NHS FOUNDATION TRUST	26.0	1.0	1	0	0	0	0	0	0	0	0	4	3	0	1	3	0	0	0	0	5	5	3
CHESTERFIELD ROYAL HOSPITAL NHS FOUNDATION TRUST	27.0	3.0	1	0	0	0	0	0	0	0	0	0	3	2	1	3	0	5	0	0	3	3	3
GEORGE ELIOT HOSPITAL NHS TRUST	27.0	1.0	1	0	0	0	0	0	0	0	0	3	3	1	3	3	1	0	0	0	5	3	3
KETTERING GENERAL HOSPITAL NHS FOUNDATION TRUST	41.0	3.0	2	0	0	0	0	5	3	0	0	3	3	3	5	0	1	0	0	0	5	5	3
NORTHAMPTON GENERAL HOSPITAL NHS TRUST	36.0	3.0	1	0	0	0	0	0	2	0	0	3	3	2	2	2	1	5	3	0	3	3	3
NOTTINGHAM UNIVERSITY HOSPITALS NHS TRUST	48.0	3.0	6	0	0	5	0	5	0	0	0	3	5	1	4	4	0	5	0	0	1	3	3
SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST	50.0	3.0	4	5	0	0	0	3	2	0	0	3	3	3	5	4	0	0	0	0	5	5	5
SHERWOOD FOREST HOSPITALS NHS FOUNDATION TRUST	27.0	1.0	2	0	0	0	0	0	0	0	0	3	3	1	5	3	0	0	0	0	3	3	3
SOUTH WARWICKSHIRE UNIVERSITY NHS FOUNDATION TRUST	23.0	1.0	2	0	0	0	0	0	0	0	0	2	3	0	4	0	0	0	0	0	5	3	3
THE DUDLEY GROUP NHS FOUNDATION TRUST	32.0	1.0	3	0	0	0	0	0	0	0	0	4	3	0	2	1	0	5	0	0	5	5	3
THE ROYAL WOLVERHAMPTON NHS TRUST	22.0	1.0	3	0	0	0	0	0	0	0	0	3	3	0	0	3	1	0	0	1	1	3	3
THE SHREWSBURY AND TELFORD HOSPITAL NHS TRUST	35.0	2.0	2	0	0	0	0	5	0	0	0	3	3	0	0	3	1	5	0	0	5	3	3
UNITED LINCOLNSHIRE HOSPITALS NHS TRUST	14.0	1.0	0	0	0	0	0	0	0	0	0	1	3	0	2	0	0	0	0	0	1	3	3
UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST	40.0	4.0	6	0	0	0	0	5	0	0	0	5	5	3	1	0	0	0	0	0	5	3	3
UNIVERSITY HOSPITALS COVENTRY AND WARWICKSHIRE NHS TRUST	24.0	1.0	1	0	0	0	0	0	0	0	0	3	3	2	3	4	0	0	0	0	1	3	3
UNIVERSITY HOSPITALS OF DERBY AND BURTON NHS FOUNDATION TRUST	62.0	5.0	5	10	10	0	4	5	3	0	0	3	3	1	0	0	1	5	0	0	1	3	3
UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST	32.3	2.3	2	0	0	0	0	3	0	0	0	3	3	1	0	5	0	0	0	0	5	5	3
UNIVERSITY HOSPITALS OF NORTH MIDLANDS NHS TRUST	25.0	1.0	1	0	0	0	0	0	0	0	0	3	3	1	2	1	0	0	0	0	5	5	3
WALSALL HEALTHCARE NHS TRUST	28.0	3.0	3	0	0	0	0	0	0	0	0	3	3	1	4	1	1	0	0	0	3	3	3
WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST	30.0	1.0	2	0	0	0	0	2	0	0	0	3	3	1	5	0	0	0	0	0	5	5	3
WYE VALLEY NHS TRUST	26.0	1.0	0	0	0	0	0	2	0	0	0	3	3	0	2	0	1	5	0	0	3	3	3

APPENDIX 2

Claims Scorecard Incident date 01/04/2014 to 31/03/2024

Top injuries by volume: Stillborn (6) Adtnl/unnecessary operation (5) Brain damage (5) Unnecessary pain (5) Not specified (5)	**Top injuries by value:** Brain damage (5) Hypoxia (2) Cerebral palsy (1) Not specified (5) Amputation - upper (1)
Top causes by volume: Fail/ delay in treatment (17) Inappropriate treatment (5) Failure/ delay in diagnosis (4) Fail to recognise complication (4) Failure to monitor 1st stage (2)	**Top causes by value:** Fail to monitor 2nd stage labour (2) Fail/ delay treatment (17) Failure/ delay in diagnosis (4) Failure to recog. Complication of (4) Inappropriate treatment (5)

Complaints Quarter 4 2024-25

13 complaints in total
3 Patient care
6 Clinical care/ treatment
1 Values and Behaviours
1 Appointments/ delay/ cancellation
2 Communication
2 VTE related incidents

Incidents Quarter 4 2024-25

1 MNSI (cooling)
2 PSII incidents (delayed care/ treatment)
4 PMRT cases (2 x IUD/ stillbirth, 2 x IUTs below 27 weeks (1x stillbirth, 1 x NND))
28 unexpected term admissions to NNU
20 massive obstetric haemorrhage >1500mls
11 clinical care
13 maternal readmissions
9 third degree tears
5 workload/ staffing

Maternity Incentive Scheme – SA9

Quarterly review of Trust's claim scorecard alongside incident and complaint data and discussed by the maternity, neonatal and Trust Board level Safety Champions at Trust level (Board or directorate) quality meeting.

Themes Quarter 4 2024-25

Escalation and handover
Review and action of investigation results
Incorrect VTE assessment
Communication

Learning/ Actions Quarter 4 2024-25

Communication training with case studies in the Fetal Monitoring Training day
Holistic overview of clinical condition in conjunction with CTG interpretation to be included in mandatory annual Fetal Monitoring Study Day
'WHEEP' introduced to support fresh eyes for CTG monitoring
Review of medical staffing escalation process
VTE improvement project
Review of results monitoring and follow up process

APPENDIX 3

The Dudley Group NHS Foundation Trust

Paper for submission to the Public Board of Directors 10th July 2025

Report title:	**Bi-Annual Midwifery Workforce paper.**
Sponsoring executive:	Martina Morris - Chief Nurse and Board Level Maternity Safety Champion
Report author:	Claire Macdiarmid - Director of Midwifery and Maternity Safety Champion

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

This report outlines the current position with Maternity department staffing. This is in line with the recommendations published in the Ockenden report (2020 and 2022). The report covers the period 1st November 2024 to 30th April 2025.

There have been 0 instances where the shift leader has not been supernumerary, or when a woman has not been provided with 1:1 care in labour. This is a requirement of the Maternity incentive scheme year 7.

Incident of 'red' acuity calculated via the Birthrate plus acuity tool remains low with a mean average of 4.8%. Green shifts remain high with an average of 75%. Shift fill rates are contained within the report with a decline in fill rates for community midwifery, lined to current vacancy.

The Maternity unit has funded establishment in line with Birthrate plus requirements. There is however a vacancy in the Midwifery workforce of 12.68 WTE and Midwifery support workers of 9.6 WTE. All posts have been recruited to; the majority of these people will commence employment September/October 2025. Most of this RM vacancy sits within the Community Midwifery department.

The Midwife to birth ratio for April is 1:29, this is within acceptable levels.

Maternity specific multidisciplinary training compliance remains above 90%. Some elements of other Trust mandatory training are currently below 90% however there are rectification plans in place. MIS requirements state that we must be at 90% compliance or above by the end of the reporting period.

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

3. Report journey:
Quality Committee. Maternity Safety Champions LMNS Perinatal Quality Surveillance.

4. Recommendation(s)
The Trust Board is asked to:
a) Accept assurance within this biannual report of current position with Midwifery workforce as per MIS year 7 requirements, and any required mitigation.

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

The Dudley Group
NHS Foundation Trust

Midwifery Workforce

Supporting compliance with MIS year 7 Safety action 5

Report to Public Board of Directors 10th July 2025

1 EXECUTIVE SUMMARY

This report outlines the current position with Midwifery and Midwifery support worker workforce. This is in line with the recommendations published in the Ockenden report (2020 and 2022).

This report demonstrates Dudley Group are funded to the required Birthrate plus recommended establishment, and currently have a vacancy of 12.68 WTE, which has actively been recruited into. New starters will commence over the next 6 months.

2. BACKGROUND INFORMATION

The aim of this report is to provide assurance to the Quality Committee and Trust Board that there is an effective system of midwifery workforce planning, and monitoring of safe staffing levels. This is a requirement of the Maternity Incentive Scheme Year 7- safety action 5. The report provides an accurate account of the current workforce status.

Table 1

Number of births at Dudley Group by month November 2024- May 2025

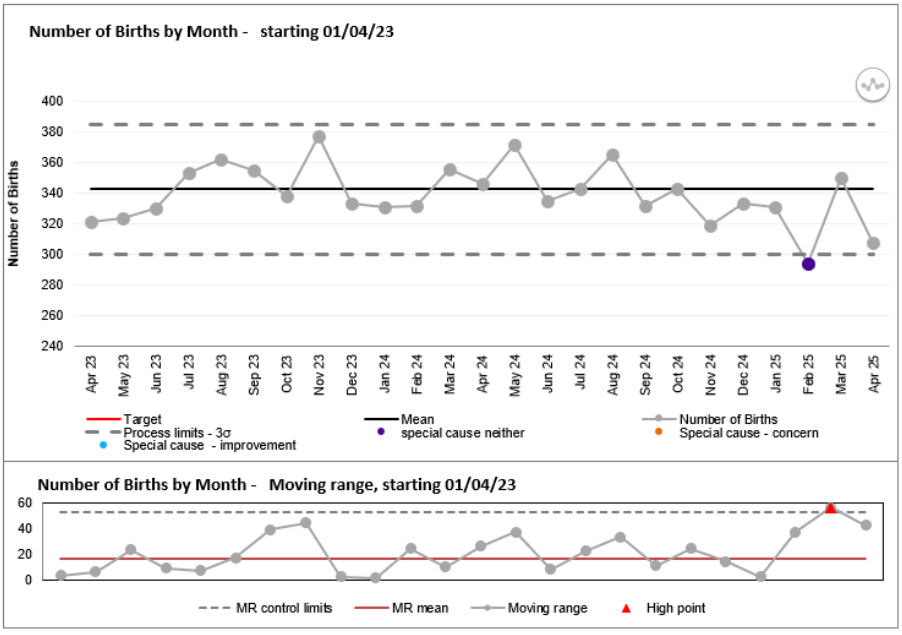


Table 1.1

CCG		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
NHS DUDLEY CCG	**2024/25**	237	267	243	251	248	248	263	224	246	253	210	259	2949
	2023/24	245	209	238	255	254	257	250	276	237	237	245	256	2959
NHS SANDWELL AND WEST BIRMINGHAM CCG	**2024/25**	85	87	73	71	94	69	61	76	66	62	64	76	884
	2023/24	60	94	77	75	80	78	74	77	80	71	59	82	907
NHS WOLVERHAMPTON CCG	**2024/25**	2	2	3	1	4	2	2	2	4	1	4	3	30
	2023/24	5	3	5	4	3	1	3	8	5	1	5	3	46
OTHER	**2024/25**	22	16	16	20	19	13	17	17	17	15	16	12	200
	2023/24	11	18	10	19	25	19	11	16	11	22	23	15	200
TOTAL	**2024/25**	346	372	335	343	365	332	343	319	333	331	294	350	4063
	2023/24	321	324	330	353	362	355	338	377	333	331	332	356	4112

Table 1 highlights the number of births at the Trust by month. There were 4063 babies born at the Trust during the 2024/25 financial year. This number remains similar to previous years as shown below:

Table 1.3

Year	Number of births	% of non-Dudley Births
2019/20	4144	29%
2020/21	4055	30%
2021/22	4156	29%
2022/23	4158	29%
2023/24	4112	28%
2024/25	4063	27%

Birthrate plus acuity tool

Table 2 provides the staffing position on the high-risk Delivery suite over the last 6 months using scoring from the Birthrate acuity tool, which is completed in real time by the shift leader on the Delivery suite and the Maternity ward, every 4 hours. Compliance with completion of the tool over the period 1/11/4 to 30/4/25 is demonstrated below:

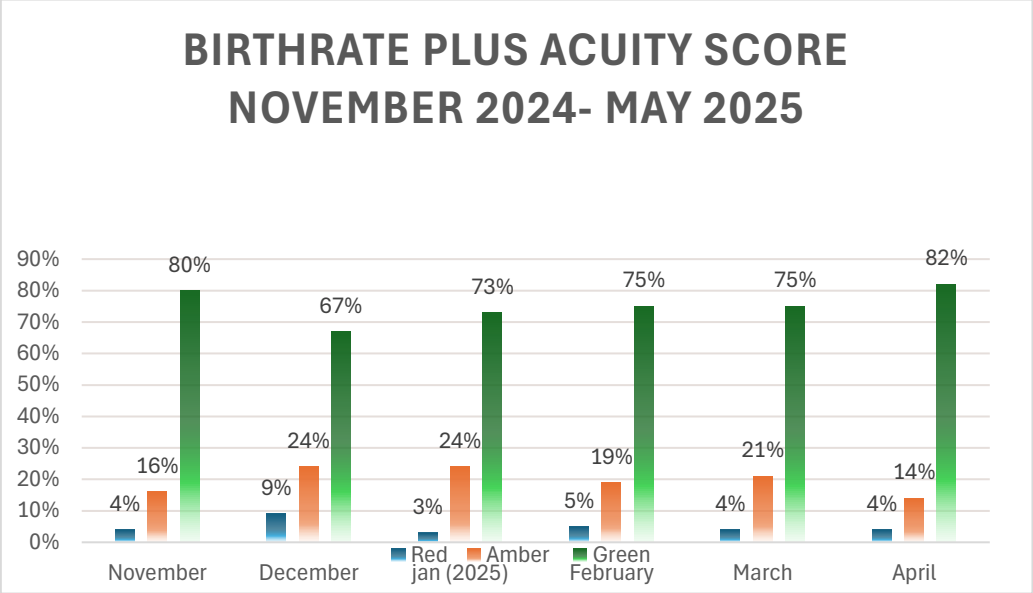
Compliance in completing the Birthrate plus acuity tool.

	November	December	January	February	March	April
Compliance %	79.44%	73.66%	74.73%	80.36%	69.89%	73.33%

The green bar demonstrates the number of times the Maternity unit has had the correct number of staff for the number of patients and the complexity of their health needs. The amber bar evidences the percentage of shifts that are short staffed by up to 2 midwives, with the red bar evidencing the percentage of shifts that were over 2 midwives short.

The table demonstrates that red shifts equate to between 3 and 9% of entries with a **mean average of 4.8%** and green shifts vary between 67% and 82% with a mean **average of 75%.**

Table 2



Red Flags

A midwifery red flag event is a warning sign that there may be concerns with midwifery staffing. If a midwifery red flag event occurs, the midwife in charge of the service should be notified. The midwife in charge should determine whether midwifery staffing is the cause, and the action that is required. The classification of a midwifery red flag is as follows:

- Delayed or cancelled time-critical activity.
- Missed or delayed care (for example, delay of 60 minutes or more in washing and suturing (due to lack of midwifery staffing).
- Missed medication during an admission to hospital or midwifery-led unit (for example, diabetes medication).
- Delay of more than 30 minutes in providing pain relief.
- Delay of 30 minutes or more between presentation and triage.
- Full clinical examination not carried out when presenting in labour.
- Delay of 2 hours or more between admission for induction and beginning of process.
- Delayed recognition of and action on abnormal vital signs (for example, sepsis or urine output).
- Any occasion when 1 midwife is not able to provide continuous one-to-one care and support to a woman during established labour.
- Other midwifery red flags may be agreed locally.

Table 3: Red flags

Safe midwifery staffing for maternity settings

Month (2024/25)	Total number of red flags	1:1 care in labour not met	Coordinator not supernumerary
November	3 (Missed or delayed care)	0	0
December	7 (Missed or delayed care)	0	0
January 2025	7 (6 x Missed or delayed care, 1 x delayed pain relief)	0	0
February	2 (Missed or delayed care)	0	0

March	7 (2 x delayed time critical activity, 5 x missed or delayed care)	0	0
April	7 (missed or delayed care)	0	0

*Missed or delayed care relates to delays in undertaking artificial rupture of membranes, during the induction of labour process. No incidents occurred as a result of the delay and no harm was caused).

There have been 0 occasions between 1st November 2024 and 30th April 2025 where 1:1 care in labour has not been achieved.

There have been 0 occasions between 1st November 2024 and 30th April 2025 where the band 7 shift leader has not been worked in a supernumerary capacity. This data is gathered via the Datix system and via on call manager handover information. Birthrate plus acuity is also scrutinised for any gaps in this provision.

Midwifery Recruitment

Table 4

	Funded Establishment	**In Post May 2024**	**Birthrate plus recommended staffing figures**	**Shortfall in funded establishment**
Total Midwives Band 5-8	172.98 WTE	160.30 WTE	172.98	0
Qualified band 3 MSW	5.99	5.99	5.99	0
Total	178.97	166.29	178.97	-

Current vacancy Midwifery workforce: 12.68WTE RM

Current vacancy in Maternity support workers: 9.6 WTE (3.6 WTE recruited to and awaiting start date)

Birthrate plus staffing inclusive of 22% uplift which is recruited into fully.

Recruitment has taken place to fill all vacancy for registered midwives. There has been delays in the recruitment processes due to trust process, however Midwifery support worker vacancy will be recruited to as soon as is possible to do so. The reason midwifery haven't not seen a vacancy of this size recently, is due to the previous over recruitment that mitigated the gap between the budgeted establishment and the birthrate plus recommended figures.

Midwife to birth ratio for April 2025 is 1: 29

This calculation takes into consideration the number of births for the month vs number of available midwives available to undertake direct clinical care (as per BR Plus calculations). Note this does not take into consideration the impact of deprivation, ethnicity or additional care needs. The figure should be between 1:26 and 1:34.

Please note a revised Birthrate plus calculation for the workforce at Dudley Group is due for publication later this month and will be reported to the relevant groups and committees for consideration.

Table 5: Fill rates for maternity inpatients

Fill rates for maternity inpatients.	November 2024	December 2025	January 2025	February 2025	March 2025	April 2025
Day	94%	92%	94%	90%	90%	92%
Night	96%	96%	98%	97%	94%	96%

Table 6: Fill rates for Community Midwifery:

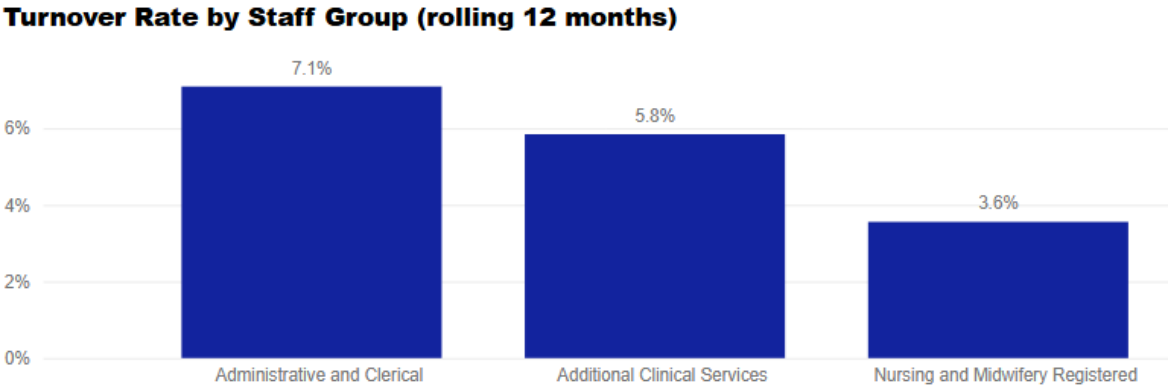
	May 24	June 24	July 24	August 24	Sept 24	Oct 24
Fill rates for community Midwifery	96%	97%	90%	85%	97%	89%

	November 2024	December 2024	January 2025	February 2025	March 2025	April 2025
Fill rates for community Midwifery	91%	87%	87%	79%	89%	81%

Table 5 and 6 evidence a fully green position relating to fill rates of Midwifery shifts in inpatient areas. Community midwifery has declined, and this is predominantly due to a Midwifery vacancy. The vacancy has been out to advert multiple times and a rectification plan is in place to ensure band 5 midwives are fast tracked out to their community posts.

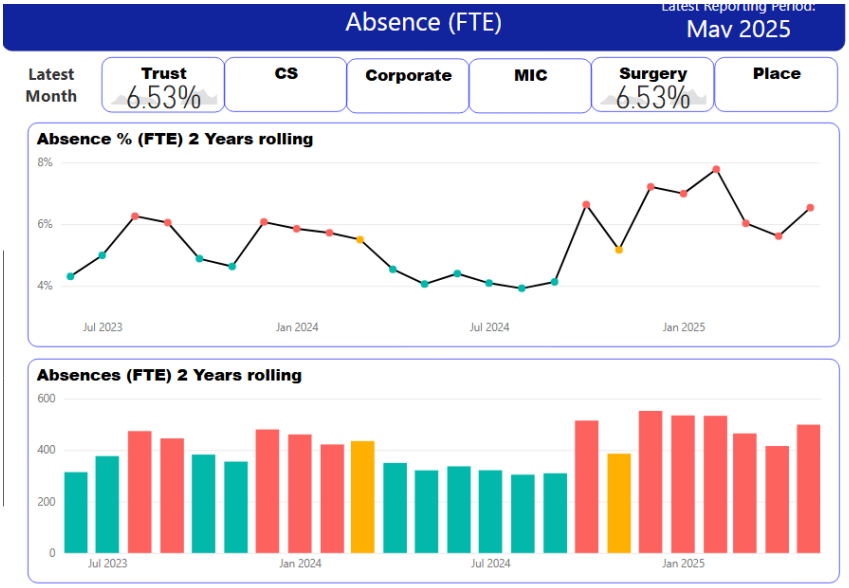
Turnover by staff group

Table 7- Maternity unit.

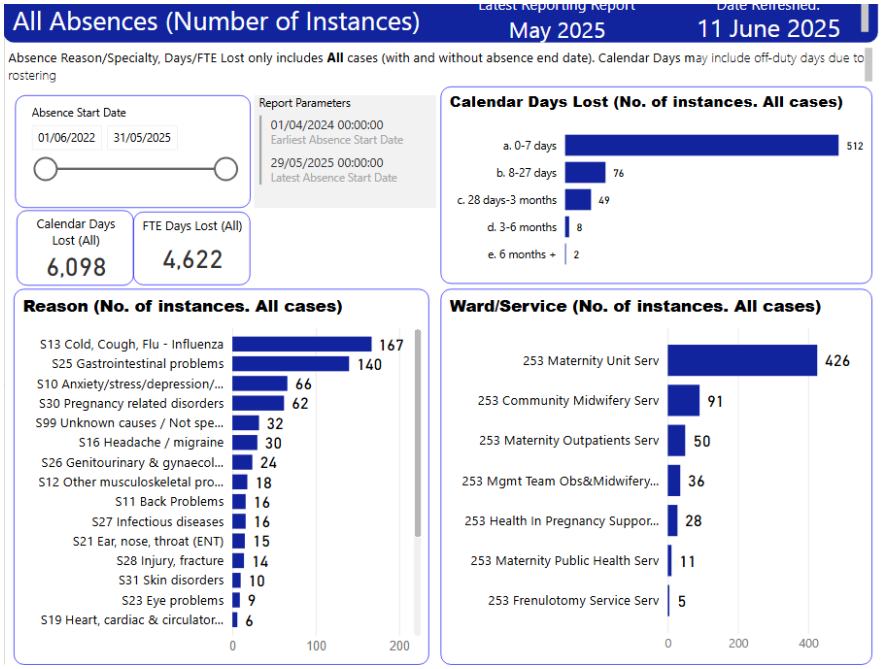


Unavailability

Table 8 Absence FTE- May 2025



Absence target:
Green <=5%. Amber >5% and <5.5%. Red >5.5%



*Midwives only

Line managers have been working with HR to support staff following sickness absence to return to work in a supportive way in an effort to reduce the elevated sickness absence figure.

Maternity specific training

Table 9

	MIDWIVES COMPLIANCE %	OBSTETRIC COMPLIANCE %
PROMPT	**100%** **MSW 100%** **Anaes 94%**	**98%**
CTG/FM	**98%**	**97%**
Saving Babies Lives	**99%**	**100%**

	Midwifery compliance %	Obstetric compliance %
Adult Resuscitation	88%	87%
Neonatal Resuscitation	82%	76%

*Reminders are sent out electronically to all staff to remind them of the importance of booking in a timely manner, so they do not reduce compliance by going out of date. This will

be monitored closely to ensure compliance is not affected and staff who do not book onto sessions will be reported to Line Managers/Management.

These sessions are facilitated on Delivery Suite by the Resus Team/SPMW PD and the NLS (Newborn Life Support) Instructors.

*MSW Neonatal resus. training is adapted from the full NLS to be relevant and appropriate to their job role.

Table 9 demonstrates current position with maternity specific mandatory training, which forms the core competency framework V2, as part of compliance with the Maternity incentive scheme year 7. The service is currently compliant. A robust plan maintains in place to ensure compliance remains above 90%. The scheme requires 90% attendance of relevant staff groups by the end of the 12-month period in the topics:

1. Fetal monitoring training

2. Multi-professional maternity Emergencies training /PROMPT

3. Neonatal Life Support Training

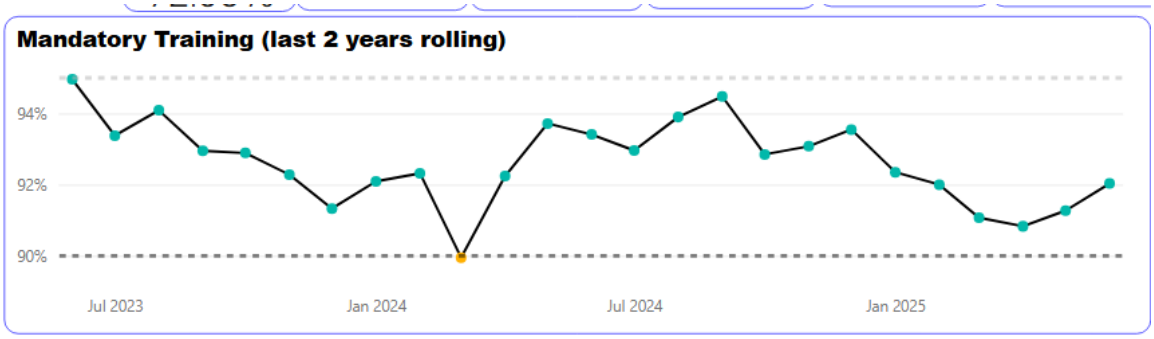
*PROMPT is PRactical Obstetric Multi-Professional Training

Trust specific mandatory training- Midwifery

Table 10

Specialty Table

Group4Description	January 2025	February 2025	March 2025	April 2025	May 2025	June 2025
253 Maternity Public Health Spec	89.47%	89.47%	87.30%	88.59%	91.22%	95.61%
253 Maternity Unit Spec	91.53%	91.64%	90.75%	90.58%	90.75%	90.95%
253 Midwifery Mgmt Spec	94.44%	96.96%	96.20%	95.73%	95.13%	95.39%
253 Midwifery Outpatients Community Spec	94.28%	92.10%	91.16%	90.58%	91.56%	93.34%
Total	**92.35%**	**92.00%**	**91.07%**	**90.83%**	**91.27%**	**92.03%**



Mandatory training rates have remained above 90% across all topics.

*Maternity public health is a much smaller group of staff therefore small changes have a big impact on the rates.

3.0 RISKS AND MITIGATIONS

The requirements for evidence for Ockenden, Maternity incentive scheme year 7, and the perinatal quality surveillance model for assurance are very specific, and significant in its amount. The Committee is required to receive and minute detailed information particularly in relation to Maternity workforce current position and plans to mitigate risks.

The current risks are as follows:

- The Midlands Regional Maternity heat map has demonstrated a concern around the Midwifery leadership structure that we have committed to resolve. This has resulted in the title change and reviewed job description of the substantive Head of Midwifery to become the Director of Midwifery, and a process to create a new Head of Midwifery role. This process is due to conclude in July 2025.
- The Maternity service currently has a vacancy within the Midwifery and Midwifery support worker workforce, which has been recruited to, and new starters are due to commence over the coming months, with the majority joining in September/October 2025. Funded midwifery workforce aligns with the calculations recommended by birthrate plus in 2022.

4. RECOMMENDATION(S)

The Public Board of Directors are asked to accept this paper as assurance that Maternity Workforce is being thoroughly reviewed twice per year as per requirements of the Maternity incentive scheme year 7, Safety action 5, and safety is being demonstrated through the data contained within this paper.

Name of Author: Claire Macdiarmid

Title of Author Director of Midwifery

Date 29th June 2025

Audit Committee Chairs Report

Committee Chair: Joanne Hanley (19/05) and Peter Featherstone (23/06)

19th May 2025	
RSM Local Counter Fraud Specialist Annual Report 2024/25	Reasonable Assurance
Implementation of Internal Audit Recommendations	Partial Assurance
Annual Compliance of Declaration of Gifts, Hospitality and Interests	Substantial Assurance
Board Assurance Framework	Substantial Assurance
Data Breaches Thematic Review	Reasonable Assurance
Losses and Special Payments	Reasonable Assurance

23rd June 2025	
Audit Findings for the Dudley Group Trust Accounts 2024/25	Substantial Assurance
Dudley Group NHS Foundation Trust Auditor's Annual Report 2024-25	Reasonable Assurance
Dudley Group NHS Trust Annual Accounts 2024/25	Substantial Assurance
Internal Audit Progress Paper 2025/26	Reasonable Assurance
RSM Progress Report 2025/26	Reasonable Assurance
Caldicott and Information Governance Group Upward Report	Reasonable Assurance

Meeting Held on 19th May 2025

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE

- Greater focus required on timely addressing of control weaknesses identified through Internal Audit activity. To support this, a framework for audit action delivery has been established by the committee with high priority actions to be delivered within one month, medium actions within three months and low actions within six months.

MAJOR ACTIONS AGREED

- Clinical Effectiveness Audit plan to be retabled at a future AC along with the current year look back and post approval of both at Quality Committee with a supplementary supporting opinion/statement from Quality Committee.

POSITIVE ASSURANCES TO PROVIDE

- The data breach thematic review provided reasonable assurance with no systemic issues identified.
- Substantial Assurance gained through the annual declaration of gifts, hospitality and interests compliance report with significant advancement in the framework during the period.
- The Committee noted that the draft annual report is advancing well.
- Received the finalised Internal Audit Annual Report & Opinion and the Charitable Funds Annual Report both providing reasonable assurance.

DECISIONS MADE

- The Trust's Annual Governance Statement was approved with some minor changes.
- Approval of the Committee Effectiveness Review with good debate and challenge around the focus of the Committee and positive view on the Committee operating provided both Internal Audit and External Audit.
- Extensions to two audit actions in the people arena approved.

Meeting Held on 23rd June 2025

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE	MAJOR ACTIONS AGREED
• The Auditor's Annual Report acknowledges a strong performance in 2024/25, but highlights that a substantial portion of the 2024/25 savings target remains in early-stage planning or still at the 'opportunity' stage. It also flags that the MTFP, while updated, still projects an underlying deficit at the end of 2028/29.	•
POSITIVE ASSURANCES TO PROVIDE	**DECISIONS MADE**
• The Auditor had issued an ***'unqualified opinion'*** on the Trust's financial statements, which is a significant assurance for the Board and wider stakeholders. • The Auditor's Annual Report provided improved assurance of value for money arrangements, finding no significant weaknesses and with one supporting improvement recommendation. • The Auditors and the Interim Director of Finance provided assurance that the Trust Annual Accounts were consistent with the Annual Report, Governance Statement, and the Audit Findings Report. • Whilst the overall risk rating relating to the Cyber Assessment Framework was 'High' this is not an unusual assessment for an NHS Trust. Furthermore, the Auditor's confidence level in the veracity of the DSPT self-assessment is 'high' – which is a positive situation to be in ahead of the 30 June deadline for toolkit submission. • The Committee was 'reasonably assured' by the development of the 'Data Security & Protection Toolkit, noting that 43 of the 47 required outcomes were already meeting the expected standard, and that internal audit had not flagged any significant risks.	• Subject to two minor amendments agreed at the meeting, the Committee agreed with the management's representation as set out in the Letter of Representation • The Dudley Group NHS Charity Audit Plan for 20245/25 was agreed, together with the timeline for the report and the Audit fees. • The Trust Annual Accounts 2024/25 were discussed and found to be compliant, accurate, and supported by appropriate judgements and disclosures, and were subsequently approved • Subject to final proof reading, the Committee, acting under delegated authority from the Board of Directors, approved the Trust Annual Report 2024/25

Finance and Productivity Committee Chairs Report

The Dudley Group NHS Foundation Trust

Committee Chair: Joanne Hanley (29/05) and Lowell Williams (26/06)

29th May 2025	
Corporate Risk Register	Substantial Assurance
EPRR Annual Report	Reasonable Assurance
Digital Trust Steering Group Update	Reasonable Assurance
Cyber Security Report	Reasonable Assurance
Trust Annual Plan and CIP Plan 2025/26	Reasonable Assurance
PFI Contract Performance	Reasonable Assurance

26th June 2025	
Divisional Deep Dive – Community With Core Clinical Services	Substantial Assurance
Integrated Performance Report – Month 2 2025/26	Reasonable Assurance
Black Country Pathology Service	Minimal Assurance
Post Business Case Implementation Reviews – Surgical Robots	Substantial Assurance
CIP Performance Report	Partial Assurance
Corporate/Back Office Cost Reductions	Substantial Assurance

Meeting held on 29th May 2025

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE

- Greater clarity required around the Infrastructure Committee scope to ensure clear delineation across the Committees and avoid duplication
- Limited progress with CIP productivity schemes delivery which are key to the Trust being able to deliver on its financial performance for the year

MAJOR ACTIONS AGREED

- No formal actions were commissioned.

POSITIVE ASSURANCES TO PROVIDE

- BAF risk refresh is well underway with the refresh of risk 4 fully completed, risk 7 is in progress and risks 5 and 8 have transitioned to the Infrastructure Committee.
- A good level of assurance on cyber prevention activity undertaken by the Trust whilst recognising the high threat environment.
- Operational performance continues in line with previous levels with the challenging areas of performance discussed at board level persisting.
- A good start to the year with Month 1 Financial Performance on track.
- Assurance provided around implementation of the final elements of Paediatrics business case which are having the intended impact.

DECISIONS MADE

- The score for BAF risk 4 remained at 20.
- The score for BAF risk 7 remained at 20. This BAF would be refreshed for the new 2025/26 financial year.

Meeting held on 26th June 2025

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE	MAJOR ACTIONS AGREED
• Ambulance handover delays remained a significant concern. • The committee expressed concern around the problematic performance of Black Country Pathology Service (BCPS) with reduced turnaround times and weak pathology performance impacting negatively on patient care particularly in skin and urology. In addition, BCPS faces financial challenges. • The Trust was currently reporting a £13m unidentified Cost Improvement Programme (CIP) target with most significant risks related to non-elective schemes at £7.3m. • Bank and agency usage remains above target whilst the workforce plan assumes a reduction.	• No formal actions were commissioned.
POSITIVE ASSURANCES TO PROVIDE	**DECISIONS MADE**
• Strong overall performance was seen against national targets which is becoming embedded into day-to-day operations. • Community with Core Clinical Services presented a positive deep dive showing impressive grip and control across finance, workforce and quality and productivity workstreams. The division has strong performance outcomes, and a range of important and impactful community projects planned. • Additional information provided for the post implementation review of the surgical robot gave assurance of improved patient care and outcomes and enhanced cost effectiveness. • Good progress was made in identifying corporate back-office reductions, noting the need for continued collaboration with Sandwell and West Birmingham. • The month 2 workforce position is positive at 32WTE under plan.	• The committee agreed BAF risk 5, noting that further actions are required to close off gaps in key controls.

The Dudley Group NHS Foundation Trust

Paper for submission to the Board of Directors on 10 July 2025

Report Title:	Quality Committee Chair's Report.
Sponsoring Executive:	Professor Liz Hughes, Non-Executive Director
Report Authors:	Helen Turbutt, Assistant Directorate Manager Martina Morris, Chief Nurse and Director of IPC

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

This paper outlines the key points of assurance and escalation from the Quality Committee meetings held on 27 May and 24 June 2025. The report details work commissioned as a result of discussions held and any decisions made.

Please note:

- A letter from the Chief Executive and Chief Nursing Officer at NHSE is included as Appendix 1 for Board oversight.
- A summary Perinatal Quality Report (Appendix 2) and Maternity Workforce Report (Appendix 3) is included as Appendices for Board oversight and assurance.

Assure

- Maternity Services Perfect Week in February 2025 resulted in 34 Procedural Documents ratified within 1 month.
- Substantial assurance gained from the associated improvement interventions from the Complaints, Litigation, Incident, PALS (CLIP) report and Mortuary Report, including Fuller review and Prevention of Future Deaths.
- Positive assurance from the Quality Account draft report.
- 7 Day Services Deep Dive demonstrated improvements made over the last 7 years.
- Research activity continues to increase across the organisation and work is ongoing to meet requirements for University Hospital application.
- Vascular Team shortlisted for best clinical research for the Journal of Wound Care Award; positive for research profile within organisation.
- Positive assurance from the Chief Nurse and Medical Director report focusing on staff wellbeing, resilience and psychological safety.
- Perinatal mortality data remains stable, with all rates below national rates.
- Maternity and Neonatal Services 15 Steps Event took place on 20 May which was well attended; very positive verbal feedback with formal feedback awaited from MNVP.
- Maternity Annual Insight visit from Black Country LMNS and regional NHSE teams on 23 April; supportive to offer advice and guidance with very positive feedback, final report awaited.
- Annual balanced reports celebrating successes, challenges and focus for 2025/26.

Advise

- The assurance level for BAF Risk 1.1 remains as positive with further assurance regarding discharge improvement sought. The Quality Committee's previous recommendation to the Board was to decrease the overarching risk score to 9, meeting the target level.
- Agreed that Discharge Improvement Group report to address challenges will be submitted to Quality Committee. Reporting upwards to the Board; Quality Committee Terms of Reference have been updated to reflect this.
- Gloves Off campaign ongoing across the Trust to improve education and hand hygiene.

- Challenges with timely patient observations, with improvement work in place and focus via the new Quality and Safety Delivery Plan. Improvements are staring to take place. Let's Get Ob 'Sessed' campaign starting in July to raise profile of importance of Vital Signs compliance and back-to-basic training.
- Complaints responsiveness improvement plan in place, with wider data reporting to Quality Committee and Board.
- Digital bed management system to be launched in July, working with partners to enable safe and appropriate discharge.
- HITWAFE (Home in Time when Arrangements Finalised and Enabled) to replace Home for Lunch.
- National CQC Children and Young People's Survey 2024 results received, with improvement plan developed.
- Increase in pressure ulcer incidents in April, linked to long stays on ambulances and/or trollies. There is a longer-term piece of work for pressure ulcers and falls from a PSIRF perspective. However, overall reduction observed in May.
- Increase in midwifery vacancies noted (registered midwives=14 WTE and Midwifery Support Workers=9.6 WTE as at June). Reasons include some internationally recruited staff relocating, retirements, reductions of hours post maternity leave, some Band 5 midwives moving outside of the system following their preceptorship. All midwifery vacancies have been recruited to, the majority starting during September/October. 3.8 WTE of MSWs have been recruited with further recruitment planned. The Community Midwifery team have been specifically challenged, with mitigations and additional support being provided.

Alert

- Increase in number of avoidable VTEs; improvement work ongoing through implementation of electronic system to perform initial assessment and monitoring via Risk & Assurance Group.
- 202 overdue Procedural Documents across Medicine and Integrated Care and Corporate Divisions; oversight and accountability via Risk and Assurance Group.
- Further cases of VRE and E-coli in sputum (no evidence of cross infection) on Critical Care; HPV machines sourced to eradicate VRE. Weekly improvement meetings established to address ongoing concerns, which have had a positive impact.
- Safeguarding Children Level 3 training poor compliance, with recovery actions in place resulting in improvement during May.
- Trust-wide TES data to be publicised. Reporting in place, as well as SOP and risk assessments, to enable better oversight. New Risk added to Corporate Risk Register (Amber) in relation to TES.
- Sepsis improvement work is ongoing via Deteriorating Patient Team and group, monitoring of SHMI and establishing dashboard for real time data.
- Letter received from Chief Executive and Chief Nursing Officer at NHSE to advise of an independent investigation to conduct urgent reviews of Maternity and Neonatal Services of up to 10 Trusts with specific issues. Identified actions within letter already being undertaken by DGFT, for which the Trust will formally respond to ensure good governance via the Committee and Board.

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

3. Report journey
Trust Board - 10/07/2025.

4. Recommendation(s)
The Public Trust Board is asked to:
a) Note the assurances provided by the Committee, the matters for escalation and the decisions made by the Committee.

5. Impact		
Board Assurance Framework Risk 1.1	X	Deliver high quality, safe person centred care and treatment
Board Assurance Framework Risk 1.2	X	Achieve outstanding CQC rating.
Is Quality Impact Assessment required if so, add date: N/A		
Is Equality Impact Assessment required if so, add date: N/A		

Quality Committee Chair's Report

Committee Chair: Professor Liz Hughes

27 May 2025	
Integrated Quality Report	Reasonable Assurance
Discharge Improvement Work	Reasonable Assurance
Procedural Document Report	Reasonable Assurance
Complaints, Litigation, Incident, PALS (CLIP)	Substantial Assurance
Performance Against Workforce Forecast	Reasonable Assurance
Research & Innovation Report	Substantial Assurance
Mortuary Report (including Fuller review)	Substantial Assurance
Learning Disability Delivery Plan	Substantial Assurance
Quality Account Draft	Substantial Assurance
7 Day Service Deep Dive Review Report	Reasonable Assurance

24 June 2025	
Integrated Quality Report	Reasonable Assurance
Discharge Improvement Work	Partial Assurance
Complaints Responsiveness Report, including Improvement Plan	Reasonable Assurance
Chief Nurse & Medical Director Report	Substantial Assurance
Quality Impact Assessment Report	Reasonable Assurance
Corporate Risk Register	Substantial Assurance
Perinatal Quality Surveillance Report	Substantial Assurance
Performance Against Workforce Forecast	Reasonable Assurance
Maternity Deep Dive	Substantial Assurance
Internal Safeguarding Highlight Report	Substantial Assurance
Children & Young Persons Patient Experience Survey	Reasonable Assurance

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE	MAJOR ACTIONS AGREED/WORK UNDERWAY
• Increase in pressure ulcer incidents in April, linked to long stays on ambulances and/or trollies; 1 deemed moderate harm due to missed opportunities. Despite the increase, only 11 additional cases compared to previous month as a result of ongoing improvement work. There is a longer-term piece of work for pressure ulcers and falls from a PSIRF perspective. Partial reduction in May. • Increase in number of avoidable VTEs; improvement work ongoing through implementation of electronic system to perform initial assessment. A report to review the quality of VTE assessments will be presented to Risk & Assurance Group to feed into Quality Committee. • Concern raised in relation to 202 overdue Procedural Documents across Medicine and Integrated Care and Corporate Divisions; oversight and accountability via Risk and Assurance Group. • Further cases of VRE and E-coli in sputum on Critical Care; HPV machines sourced to eradicate VRE. Weekly meetings established to address ongoing concerns. • Cost implication noted once University Status received. • Trust-wide TES data to be publicised; operational colleagues providing data to regional NHSE team to ensure accurate. Reporting in place, as well as SOP and risk assessments, to enable better oversight. • Sepsis improvement work ongoing via Deteriorating Patient Team monitoring of SHMI and establishing dashboard for real time data. • Poor training compliance remains for Safeguarding Children Level 3. • New Risk added to Corporate Risk Register (Amber) in relation to TES. • Letter received from Chief Executive and Chief Nursing Officer at NHSE (Appendix 1) to advise an independent investigation to conduct urgent reviews of Maternity and Neonatal Services of up to 10 Trusts with specific issues. Identified actions within letter already	• Agreed that Discharge Improvement Group report to address challenge will be submitted to Quality Committee and report upwards to Board; Quality Committee Terms of Reference updated to reflect this. • Gloves Off campaign across the Trust to improve education and hand hygiene. • Challenges with patient observations recorded on time continue to be addressed with focussed improvement work. Let's Get Ob 'Sessed' campaign starting in July to raise profile of importance of Vital Signs compliance and back-to-basic training. • Complaints responsiveness improvement plan in place and recommendations on actions ongoing. • Digital bed management system to be launched in July to help identify Red to Green ahead of Winter, working with partners to enable safe and appropriate discharge. • HITWAFE (Home in Time when Arrangements Finalised and Enabled) to replace Home for Lunch.

being undertaken by DGFT, for which the Trust will formally respond to ensure good governance. • Increase in midwifery vacancies noted (registered midwives =14 WTE and Midwifery Support Workers=9.6 WTE as at June). Reasons include some internationally recruited staff relocating, retirements, reductions of hours post maternity leave, some band 5 midwives moving outside of the system following their preceptorship. All midwifery vacancies have been recruited to, the majority starting during September/October. 3.8 WTE of MSWs have been recruited with further recruitment planned. The Community Midwifery team have been specifically challenged, with mitigations and additional support being provided.	
POSITIVE ASSURANCES TO PROVIDE • Maternity Services Perfect Week in February 2025 for Procedural Documents resulted in 34 documents ratified within 1 month. • Substantial assurance gained from the associated improvement interventions from the Complaints, Litigation, Incident, PALS (CLIP) report and Mortuary Report, including Fuller review and Prevention of Future Deaths. • Positive assurance from the Quality Account draft report. • Reasonable assurance from the 7 Day Service Deep Dive with significant improvements made over the last 7 years. • Research activity continues to increase across the organisation and work ongoing to meet requirements for University Hospital application. • Vascular Team shortlisted for best clinical research for the Journal of Wound Care Award; positive for research profile within organisation. • No evidence of the current workforce reduction plan compromising quality and safety. Of note, Bank and Agency use have reducing trajectories with risk will not achieve plan; significant work ongoing with medical and nursing teams to mitigate risk. • Reasonable assurance received for the QIA report and CIP.	**DECISIONS MADE** • The assurance level for BAF Risk 1.1 remains as positive with further assurance regarding discharge improvement sought. Previous recommendation to Board to reduce risk score to 9, meeting the target level. • BAF refreshed as part of Trust Strategy work with completion of the following actions linked directly gaps in key controls; - Implemented and embedded the clinical accreditation programme - Reviewed and strengthened the nursing and midwifery audits - Developed and delivered an improvement plan to address patient observations not being completed and recorded on time. - Undertaken a thematic review of incidents and have discussed it at the Incident Decision and Learning Group, including agreement on the next steps • The Committee reviewed, discussed, and approved the following documents: - Terms of Reference: Quality Committee - Quality and Safety Delivery Plan, 2025-2028 - Terms of Reference: Discharge Improvement Group (for review in 6 months)

• Vital Signs compliance increased in line with Quality and Safety Delivery Plan. • Positive assurance from the Chief Nurse and Medical Director report focusing on staff wellbeing, resilience and psychological safety, with work ongoing in conjunction with Human Resources team. • Perinatal mortality data remains stable, all rates below national rates. • Maternity and Neonatal Services 15 Steps Event on 20 May well attended; very positive feedback with formal feedback awaited from MNVP. • Maternity Annual Insight visit from Black Country LMNC and regional NHSE teams on 23 April; supportive to offer advice and guidance with very positive feedback, final report awaited. • Perinatal Quality Surveillance Report detailed in Appendix 2. Of note, the Ockenden self-assessment and Maternity Workforce Report is appended to the Perinatal Quality Surveillance Report for information. • National CQC Children and Young People's Survey 2024; Children's Services shared results with feedback incorporated into improvement plan. • Good levels of assurance on work underway in matters relevant to their portfolio for Quality & Safety, Risk & Assurance, Infection Prevention & Control, Chief Nurse Senior Leaders, Safeguarding, Health, Safety & Fire, Patient Experience, and Discharge Improvement Work. • Annual Reports meeting on 09 June noted balanced reports celebrating successes, challenges and focus for 2025/26.	

People Committee Chairs Report

The Dudley Group NHS Foundation Trust

Committee Chair: **Catherine Holland**

27th May 2025	
• The MIC divisional deep dive covered staff survey results, sickness absence, actions underway on mandatory training. The Committee took positive assurance on the actions being taken.	**Reasonable Assurance**
• An update on the Band 2/3 management of change confirmed that the back pay payment date was planned as September 2025 due to the national pay award being given in August. There was positive assurance on the work being undertaken	**Reasonable Assurance**
• Wellbeing deep dive provided positive assurance of achievement against the Wellbeing journey	**Reasonable Assurance**

24th June 2025	
• Positive assurance given across mandatory training, vacancies, retention and turnover. The in-month sickness absence figure had reduced to under the Trust target of 5% for the first time in twelve months.	**Reasonable Assurance**
• Performance against workforce forecast - Month 2 saw a positive position, with reasonable assurance on the key actions.	**Reasonable Assurance**
• Three deep dives were received, Bank Usage, Employee Relations and CCCS Divisional Deep Dive - all provided the Committee with reasonable assurance on key issues and key actions.	**Reasonable Assurance**

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE

May

- Workforce KPI's - the downward trend in sickness absence was noted, but it remains above target. There was positive assurance on actions being taken to address sickness absence.

June

- Workforce KPI's - the downward trend in sickness absence had continued. In-month sickness absence decreased to 4.59%, below the Trust target of 5%. Rolling 12-month absence also slightly improved, but still above target at 5.33%, though trending downward. Continued monitoring and taskforce interventions are in place.
- Statutory Training Subjects: Three subjects remained red-rated (<80% (Safeguarding Children Level 3, Resus Paediatric and Resus Adult). However, these were all now amber rated and showing marked improvement.
- Workforce plans overall were performing well with the Trust Position 32 WTE under plan, but sustained reductions will be required to stay on track for March 2026.

MAJOR WORKS COMMISSIONED/ACTIONS AGREED

May

- N/A.

June

- N/A

POSITIVE ASSURANCES TO PROVIDE

May

- The Committee reviewed and were happy with the refreshed BAF and agreement was reached on the risk appetite of Seek and the proposed risk scores for the refreshed BAF 2.
- Turnover, Retention and mandatory training are all within the Trust targets and remain stable.
- The corporate risk register would be reviewed by the team once the BAF 2 had been finalised to ensure alignment.
- Band 2/3 – the back pay payment date was planned as September 2025 due to the national pay award being given in August.
- The MIC divisional deep dive covered staff survey results, sickness absence, actions underway on mandatory training. The Committee took positive assurance on the actions being taken.
- The Committee was very pleased to hear about the achievements for Wellbeing and the progress against the Wellbeing Journey.

June

- Sickness absence level has reduced below the 5% target for the first time in twelve months.
- The Committee received deep dives on Bank Usage which provided reasonable assurance on the management of temporary staffing.
- The Employee Relations deep dive provided a focus on the plans to reduce the number of formal processes, this was a good report that provided with reasonable assurance of the management of employee relations matters.
- CCCS Deep Dive covered statutory and mandatory training compliance, staff survey results, workforce reductions, bank and agency reductions and sickness absence. The Committee took reasonable assurance from the actions being taken.

DECISIONS MADE

May

- Agreed to retain BAF Committee assurance levels as 'Positive' for the refreshed BAF 2.

June

- N/A.

Integration Committee Chairs Report

The Dudley Group NHS Foundation Trust

Committee Chair: **Vij Randeniya**

28th May 2025	
Dudley Health and Care Partnership (DHCP) Update	**Substantial Assurance**
Quarterly Community First Update	**Reasonable Assurance**
University Hospital Trust Application Update	**Substantial Assurance**
Re-location of Outpatient Services Update	**Reasonable Assurance**

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE

28th May 2025

- Following the committee meeting there were no matters of concern or key risks to escalate.

MAJOR WORKS COMMISSIONED/ ACTIONS AGREED

28th May 2025

- Within the Dudley Health and Care Partnerships (DHCP) Update it was noted following feedback from Board Members a reduction in the number of KPIs and a focus on three priorities and objectives has been proposed, asking the committee to provide feedback on this proposal. The chair asked the committee to provide feedback on the revised priorities and objectives outside of the committee.

POSITIVE ASSURANCES TO PROVIDE

28th May 2025

- Positive assurance was received following the update on Dudley Health and Care Partnerships (DHCP), noting the appointment of the new chair Andy Gray from Dudley Council Voluntary Services, and Kat Rose confirmed as a permanent Chair of DHCP Executive Group. Noting the establishment of Finance Partnership, Health and Housing Group and Care Home Community Partnership Team. An update was received on the coproducing of a Pain Management Clinic. It was confirmed a further 1-year grant has been confirmed to deliver the Family Hubs in Dudley.
- Reasonable assurance was received following the update on Community First, noting the work planned for the next quarter which included the development of the Dudley Care Navigation Centre (CNC) and the update of Merry Hill Centre with will now include paediatric and provide additional services.
- Following the update on Re-location of Outpatient Services, reasonable assurance was received, noting the ongoing work the project team are doing to progress this.
- Positive assurance was received on the update on University Hospital Trust Application Update, noting we are allowed to use the word 'University; within the Trust title, aiming for a delivery date of October 2025. Currently are in the process of looking at a University Hospital Association Application.

DECISIONS MADE

28th May 2025

- Following an update on Community First, the chair noted it would be useful to know what the timeframe for all this work and how far along on the project we currently are; being able to understand the quantum of the work, with the ask at the next scheduled update at the committee to include this information.
- The Integration Committee was stood down on the 25th of June due to high number of apologies.

The Dudley Group NHS Foundation Trust

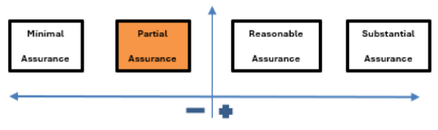
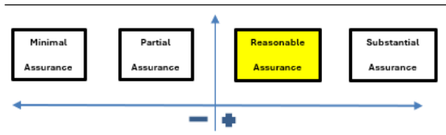
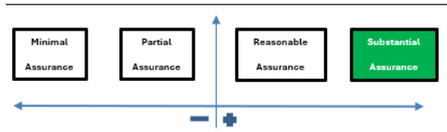
Charity Committee Chairs Report

Committee Chair: **Anne-Maria Newham**

26th June 2025	
Finance Update	**Substantial Assurance**
Fundraising Update	**Substantial Assurance**

Meeting held on 26th June 2025

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE	MAJOR ACTIONS AGREED
• Mrs Patel reported that the fundraising team has not met its targets for the year, citing a decrease in corporate donations and unsuccessful grant applications as key reasons.	• The committee asked for a more detailed proposal to be written up for the request for adding contactless donation points across the Trust.
POSITIVE ASSURANCES TO PROVIDE	**DECISIONS MADE**
• Mrs Patel reported on the progress of the staff wellbeing rooms project, with several rooms completed and awaiting furniture. Positive feedback had been received from departments and there were plans for a launch event to showcase the new spaces. • The maternity department's new multi-purpose room at Russells Hall Hospital had been opened, this was thanks to donations to the Baby Bereavement Appeal. • A £10,000 unrestricted grant had been received from ShareGift a share donation charity. The donation came about from a connection of the head of fundraising, who had heard about all the great work the Dudley Group NHS Charity has been doing. • The charity submitted an expression of interest for just under a £100k to NHS Charities Together Innovation Challenge Round Two EOI, this focused on support for children and young people who are waiting for support from Child and Adolescent Mental Health Services (CAMHS). • A joint bid had been submitted alongside Sandwell and West Birmingham to NHS Charities Together and NHS England for the Fit to Care project. This was a comprehensive, three-tiered wellbeing framework designed to proactively support staff health, reduce sickness absence, and build organisational resilience. It focuses on early intervention, accessible support pathways, and streamlined occupational health access, tailored to local needs across both Trusts. • A Lond Marathon runner from the Trust had raised £4,080 for the Baby Bereavement Appeal.	• The committee approved the recommendation of Smith Cooper as the auditor for the Charity Accounts on a five year term.

	Management cannot clearly articulate the matter or issue; something has arisen at Committee for which there is little or no awareness and no action being taken to address the matter; there are a significant number of risks associated where it is not clear what is being done to control, manage or mitigate them; and the level of risk is increasing.
	There is partial clarity on the matter to be addressed; some progress has been made but there remain a number of outstanding actions or progress against any plans so will not be delivered within agreed timescales; independent or external assurance shows areas of concern; there are increasing risks that are only partially controlled, mitigated or managed.
	There is evidence of a good understanding of the matter or issue to be addressed; there are plans in place and these are being delivered against agreed timescales; those that are not yet delivered are well understood and it is clear what actions are being taken to control, manage or mitigate any risks; where required there is evidence of independent or external assurance.
	There is evidence of a clear understanding of the matter or issue to be addressed; there is evidence of independent or external assurance; there are plans in place and these are being actively delivered and there is triangulation from other sources (e.g. patient or staff feedback)

Emergency Preparedness, Resilience and Response (EPRR) Annual Report 2024/25

Contents

Executive Summary 2

1.0 Purpose of this Report 4

2.0 EPRR Governance and Assurance 4

2.1 Reporting Lines for EPRR 4

2.2 The Corporate Resilience Team 4

2.3 EPRR Governance Reporting 4

2.4 External Group Participation 5

2.5 EPRR Board Reports 5

3 Progress against 2024/25 Strategic Objectives 7

4 Risk Management 8

5 Maintaining Plans 8

6 Business and Service Continuity Plans 8

7 Exercising and Training 8

7.1 EPRR Training 8

8 EPRR Exercises 9

9 EPRR Incidents 10

9.1 Lessons Learnt 11

10 Warning and Informing 11

11 Chemical, biological, radiological, nuclear (CBRN) and hazardous materials (HAZMAT) 11

12 COVID-19 Public Enquiry 12

13 Incident Response Mailbox (Single Point of Contact SPOC) 12

14 Core Standards 2024/25 12

15 Conclusion 14

Executive Summary

The Dudley Group NHS Foundation Trust (DGFT) has a responsibility to ensure that it is properly prepared to respond to *and* recover from an emergency as defined by the Health and Social Care Act 2012 (S46) and the Civil Contingencies Act 2004 as supported by NHS Emergency Preparedness, Resilience, Response and Recovery Guidance.

Health and Social Care Act 2012 Section 46

Indicates the requirements for the Trust as a category 1 responder to ensure that we are prepared for and able to respond to and recovery from emergencies:

"The Board (NHS England) must take such steps as it considers appropriate for securing that each relevant service provider is properly prepared for dealing with a relevant emergency, this must include monitoring compliance of the service provider with any requirements imposed on it by its service arrangements for the purpose of securing that it is properly prepared for dealing with a relevant emergency."

Civil Contingencies Act 2004

Under this Act the Trust is defined as a Category 1 responder and as such has six core duties that must be fulfilled during its planning process

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

Business Continuity

The Trust is also required to be aligned to ISO 22301 in respect to Business Continuity; this is a requirement under the NHS England Core Standards process.

Summary of the EPRR Activity 2024/25

The EPRR team, in line with national core standards have reviewed the EPRR strategy and associated documents. The team have developed and delivered the following training:

- CBRN ED incident Response Training
- Loggist Training
- Supported Site Team and the Communications team training days to deliver EPRR specific training
- On Call Training

The team have developed and delivered the following exercises

- Business Continuity specific
- High Consequence Infectious Disease
- RAAC specific exercise
- CBRN
- Communications

- Maternity and Neonatal baby abduction exercises
- Cyber Security exercise
- External exercises

1.0 Purpose of this Report

The purpose of this report is to provide the Trust Board with a summary of principle activity and performance relating to the establishment and continued development of emergency preparedness, resilience and response principles, specifically:

- Review and maintenance of emergency plans
- Business Continuity Management
- Specialised resilience planning
- Training and Exercising
- Response- Live events
- Partnership working
- EPRR Core Standards Process for 2024/25

The aim of this report is to provide the Trust Board with assurance that there is a suitably effective framework in place to ensure DGFT is able to meet its statutory and non-statutory requirements in respect of the Civil Contingencies Act 2004, NHS standard contract for Emergency Preparedness, Resilience and Response, The Health and Care Act, 2022, and NHS England Core Standards for Emergency Preparedness Resilience and Response 2022.

2.0 EPRR Governance and Assurance

2.1 Reporting Lines for EPRR

Emergency Planning, Resilience and Response (EPRR) is overseen by the Chief Operating Officer as the Trust appointed Accountable Emergency Officer (AEO). The AEO has strategic responsibility for ensuring the Trust has robust arrangements in place to respond to a wide range of incidents and emergencies which could impact the Trusts ability to deliver safe, effective and responsive healthcare.

2.2 The Corporate Resilience Team

During 2024/25, the EPRR Team remained under the remit of the wider Corporate Resilience Team. The Corporate Resilience Team ensures the Trust can meet national legislation, guidance and standards pertaining to health and safety, fire safety, emergency planning and business continuity, providing professional input to compliance requirements within the Trust. This includes development and maintenance of policy, plans and business continuity arrangements, organising and delivering training, facilitating exercises to test suitability of planning arrangements to ensure that local services and the Trust are familiar with the required standards and comply with statutory legislation and national guidance.

2.3 EPRR Governance Reporting

The EPRR Assurance Group meets quarterly and has responsibility for monitoring all EPRR related issues and compliance applicable to the Trust. It assures management arrangements are in place, to monitor and review the implementation of EPRR. The AEO is Chairperson to the Group with the Deputy Chief Operating Officer acting as deputy Chairperson. The Group triangulates data, receives assurance, challenges and identifies gaps and risks. It is ultimately accountable to the Trust Board and the Chief Executive of the organisation and reports directly to the Finance and Performance Committee, a designated committee of the board, and through that committee up to Trust Board.

The EPRR Assurance Group met on 4 of 4 occasions throughout 2024/25. Quoracy was achieved at 2 of 4 of these meetings. In line with internal governance arrangements, the Terms of Reference were subject to an annual update and approved on 19th July 2024.

2.4 External Group Participation

2.4.1 Local Health Resilience Partnerships

The Trust AEO or Deputy attends Local Health Resilience Partnership (LHRP) meetings. These are chaired by the ICB and held quarterly.

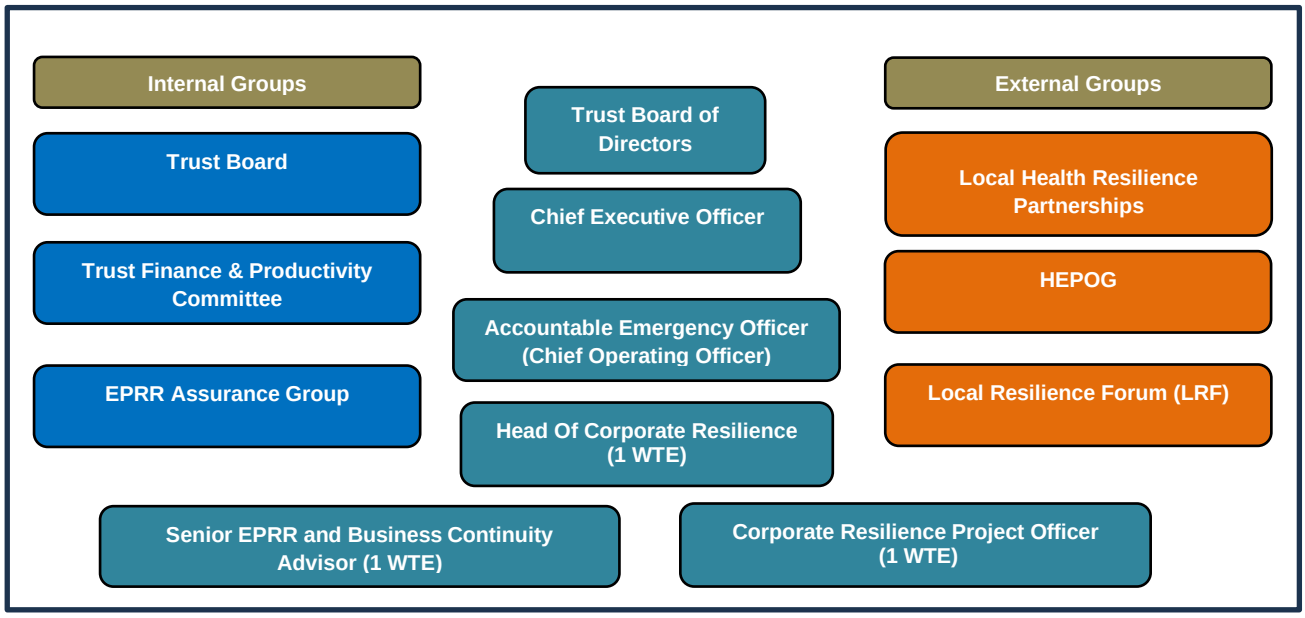
2.4.2 Health Emergency Planning Organisation Group (HEPOG)

The West Midlands and Warwickshire (WM&W) HEPOG provides a forum for organisations within the Birmingham, Solihull, Coventry, Warwickshire and the Black Country Integrated Care Systems to facilitate health sector preparedness at a system level and deliver the strategic aims of the WM&W Local Health Resilience Partnership (LHRP). The Head of Corporate Resilience attends these meetings.

2.4.3 Multi-agency Local Resilience Forum (LRF)

The Local Resilience Forum (LRF) consists of agencies etc. such as Police, Fire, Ambulance, UKHSA, and Local Authority and, on behalf of NHS trusts, the ICB. The LRF has a number of sub-groups including Infectious Diseases, Training and Exercising, Business Continuity, CBRN and more. The Senior EPRR and Business Continuity manager attends these meetings.

The diagram below represents the internal and external Emergency Planning, Resilience and Response (EPRR) governance structure:



2.5 EPRR Board Reports

The Chief Executive Officer ensures that the Accountable Emergency Officer discharges their responsibilities to provide EPRR reports to the Board. The following reports were submitted to the Finance and Productivity Committee and Trust Board last year.

Report Title	Purpose	Submission Date
EPRR Core Standards Outcome 2024/25	Assurance	F&P November 2023
EPRR Strategy 2024/256 Ver 8.0	Approval	F&P November 2023 Trust Board March 2024
EPRR Annual Report	Assurance	F&P May 2024 Trust Board June 2024 *

Following review of our EPRR core standards submission in 2024, the Trust received comments from the ICB and NHSE specifically in terms of the robustness of governance arrangements. The Trust needs to be assured that the Board has full oversight of EPRR arrangements to gather assurance. The Core Standards Outcome report was not presented at the Trust Board and the Annual Report, although highlighted within the upward report from F&P committee, was not presented in totality. A robust workplan has been developed in 2025 to ensure upward reporting to committee and Trust Board reflects core standards requirements.

3 Progress against 2024/25 Strategic Objectives

A number of objectives were set for 2024/25 of which the following table provides a summary, evidence of progress and actions outstanding for completion:

Objective	Outcomes	Action outstanding
Achieve full business continuity coverage	• This was completed, all BC plans for critical areas were reviewed and plans re-issued. • Business Continuity Exercises also tested to measure resilience within the Trust. • Awareness sessions and exercising carried out with community services.	• No actions outstanding
Plan and deliver a cyber-attack exercise for the Trust	• Cyber security tabletop exercise was carried out with support and in co-ordination with Trust IT.	• No actions outstanding
Deliver a variety of tabletop / live / Emergo-type exercises	• Increase in the number of exercises carried out.	• No actions outstanding
Updates to key policies and SOPs	• All policies and SOPs are routinely updated in a timely manner as per EPRR core standards and inline with current guidance	• As part of the core standards confirm and challenge process with NHSE, observations were made with regards to Trust plans, these observations have been added to the EPRR workplan as actions for completion throughout 2025/26.
Increase awareness across the Trust for EPRR and Business Continuity	• Business Continuity Awareness sessions and exercising carried out with services. • EPRR Team are developing an e-learning Business Continuity package	• No actions outstanding

4 Risk Management

This section details how the Trust is complying with the duty to undertake risk assessments for the purpose of informing contingency planning activities.

EPRR risks are recorded on the Trust risk register. Risks are reviewed by the Trust Risk Assurance Group and Trust Board. The EPRR Assurance Group managed oversight of the risk below during 2024/25.

Risk Lead	Risk Mitigator	Risk Title	Opened (date risk identified)	Risk level (current)	Risk level (Target)
Karen Kelly	Adam Woodhall	COR2012 Industrial Action: If staff decide to strike this would reduce the workforce and would have an impact on services and patient safety and the Trust's ability to provide care.	13/10/2022	Major	Moderate

Community Risk Register

DGFT contributes to the development and maintenance of the West Midlands Local Resilience Forum Risks. This collective information is referred to as the Community Risk Register (CRR) PDF.

The information sets out what West Midlands responders and other partners are doing about the risks. It also outlines what the consequences of these risks are likely to be along with advice on what actions can be taken by the public to prepare for and respond to these risks

5 Maintaining Plans

During 2024/25 all EPRR policies and Standard Operating Procedures that required update were completed.

- CBRN - Following updated national guidance and recommendation from the annual CBRN audit carried out via WMAS
- Mass Countermeasures – Following updated national guidance
- Adverse Weather - Following updated national guidance
- Major Incident/Critical Incident – Following lessons learnt and recommendations from incidents at the trust were used to strengthen the current plans

6 Business and Service Continuity Plans

During 2024/25, the EPRR team completed the annual update with business continuity leads of the Business Continuity arrangements for the Trust. Of a 111 identified services within the Trust, 109 had a current in date Business Continuity Plan, meaning the Trust assessed itself as 98% compliant during 2024/25.

7 Exercising and Training

7.1 EPRR Training

Over the past 12 months, EPRR related training has been delivered throughout the Trust. The table below details the type of training and number of personnel trained:

Type	Number
On Call Manager/Executive (All managers/ execs on on-call rota)	100%
Loggist	46*n*
ED - Chemical, Biological, Radiological and Nuclear	73%
NB: Figures correct of 03/2025	

8 EPRR Exercises

Guidance set out by NHSE stipulates that exercises must be carried out and provides a time frame for the type and frequency of exercises. See table 1 below: Under our commitments under the Civil Contingencies Act 2004, live exercise undertaken every 3 years, annually for tabletop and a 6-monthly communications test, we have met the below:

Exercise Type	Exercise Name	Exercise date	Minimum Frequency
Live exercise	Blue Rinse	07/10/2024 14/10/2024	3-Yearly
	Baby Abduction	07/08/2024	
Table-top Exercise	Aero	24/04/2024	12 monthly
	Cable Cable 2	09/04/2024 18/09/2024	
	Drax	17/06/2024	
	Abacus	10/07/2024	
	Bella	05/09/2024	
	Cyber security	26/09/2024	
Communication Test	Hermes	07/08/2024	6 monthly

The EPRR team carried out business continuity exercises, various tabletop exercise including RAAC and Baby abduction exercises. The aim of each exercise; to test and strengthen the trusts planning and resilience arrangements. A summary of learning from exercises conducted throughout the year is provided below:

- **Exercise Aero:** Aim to exercise the response to a RAAC failure at Russell's Hall Hospital. New RAAC specific action cards were developed prior to the exercise. It gave the trust an opportunity to test. lessons learnt and recommendations were taken into consideration and action cards along with actions were completed and amended to ensure maximum resilience.

- **Exercise Cable:** Aim to exercise the response to a Business Continuity Incidents in community specifically Dudley Clinical Hub. Raised awareness of business continuity and the effect on community services

- **Exercise Bella:** Aim to exercise the response and Business Continuity plan within the Brest Screening Service. Lesson learnt included how to link in with suppliers of 3rd party business continuity plans

9 EPRR Incidents

The EPRR team has supported in the response to incidents that have affected the Trust. Where necessary, following these incidents the team has produced a Post Incident Report which has feeds continued improvement of Trust plans and processes:

Incident	Incident Type	Date
Road Traffic Collision (off site)	Other	30/04/2024
Road Traffic Incident (overturned lorry)	Other	08/05/2024
Radiology / PACS IT Issues	Business Continuity	06/06/2024
Power Outage	Business Continuity	04/07/2024
Sewage Leak	Business Continuity	30/07/2024
National Riots / Disruption	Other	05/08/2024
Suspect package	Other	17/08/2024
Car Park Incident	Other	22/08/2024
Water Leak	Business Continuity	04/10/2024
Internal Capacity Incident	Other	10/10/2024
Internal Capacity Incident	Other	18/10/2024
Internal Capacity Incident	Other	25/10/2024
Internal Capacity Incident	Other	20/11/2024
Sunrise Printing Issues	Business Continuity	24/11/2024
Internal Capacity Incident	Other	26/11/2024
Sewage Leak	Business Continuity	29/11/2024
Internal Capacity Incident	Other	12/12/2024
CRIS system failure	Business Continuity	03/01/2025
Capacity Incident	Other	21/01/2025
Sunrise issues	Business Continuity	21/01/2025

Sunrise issues	Business Continuity	21/02/2025
Mitie Radio System Failure	Business Continuity	25/02/2025
Sunrise issues	Business Continuity	05/03/2025
Sunrise issues (Discharge Team)	Business Continuity	07/03/2025
Sunrise issues	Business Continuity	09/03/2025
Nerve centre issues	Business Continuity	12/03/2025
Sewage Leak	Business Continuity	12/03/2025
Sewage Leak	Business Continuity	14/03/2025
WMAS total radio outage	Business Continuity	24/03/2025

9.1 Lessons Learnt

Key learning learnt following a 'suspect' package incident, resulted in ACT Awareness training being circulated to a number of teams including community phlebotomy services based within the Merry Hill Centre.

Sunrise Business Continuity incidents have made ward areas more business continuity aware with teams actively reviewing the suitability of their local arrangements. During the current financial year, audits are being undertaken to determine availability of paper documentation to enable continuity of care in the event of electronic patient records failure. Access and login details for the Business Continuity PCs are being checked to ensure teams have correct details available at ward and department level.

10 Warning and Informing

As a category one responder under the Civil Contingencies Act 2004 the Trust has a "duty, in partnership with others to warn and inform the public of emergencies". The Trust Communications Team continues to work in partnership with NHS England and the ICB to inform and warn the public when circumstances warrant it. The Communications Team issue messages either directly or in collaboration with the ICB and UK Health Security Agency (previously Public Health England) and are part of a local network of NHS Communications Teams. In the event of a major incident NHS England would ensure communications are coordinated and will link into the Trust communications department.

11 Chemical, biological, radiological, nuclear (CBRN) and hazardous materials (HAZMAT)

In line with the resilience framework, West Midlands Ambulance Service audited the Trusts CBRN capability on 23 July 2024. Following the audit, feedback provided confirmed that the 'Trust has a well developed CBRN plan which is integrated into

the generic Major Incident preparedness'. The EPRR team continue to work alongside the Emergency Department to provide CBRN training on a monthly basis.

12 COVID-19 Public Enquiry

The Trust and the Corporate Resilience team will participate as required in the Covid-19 Public Inquiry, which continues.

13 Incident Response Mailbox (Single Point of Contact SPOC)

The incident response mailbox acts as a single point of contact for the Trust to receive any national, regional and external partner information.

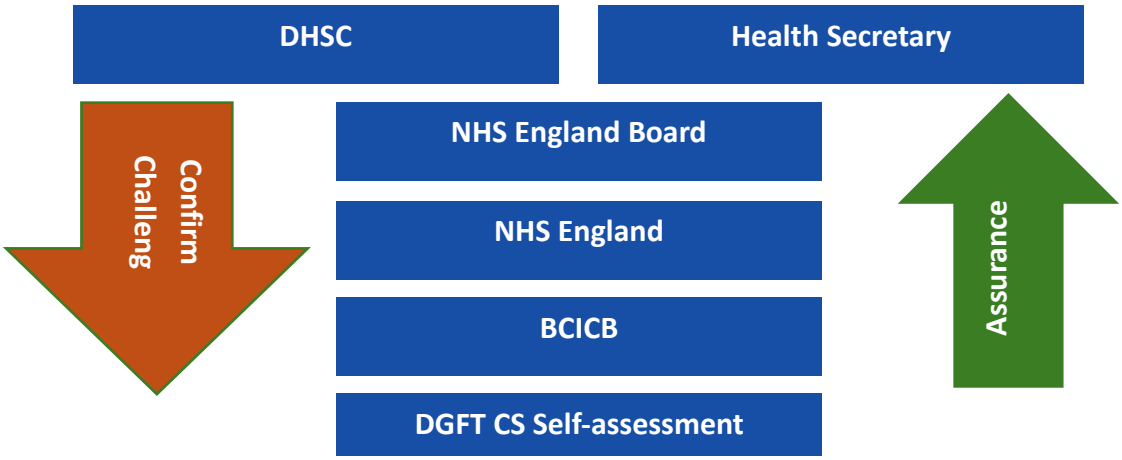
During 2024/25 the EPRR team facilitated the distribution of information via SPOC. The Incident Room dealt with aspects of compliance and other elements of risk. The informatics team have also assisted in this process to ensure compliance and automation of sitreps.

14 Core Standards 2024/25

The Trust is required to submit its annual self-assessment against the national EPRR core standards to the Black Country Integrated Care Board (BCICB). The self-assessment is reviewed and subject to a 'confirm and challenge' meeting which takes place in the autumn between the Trust AEO, BCICB and NHSE to determine assurance compliance. The annual assessment process is led nationally and regionally by NHS England (NHSE Midlands) and locally by Integrated Care Boards (ICBs).

Following the process, overall assurance is reported to the Department of Health and Social Care and the Secretary of State for Health and Social Care by NHSE Board.

Image: Annual Assurance Process



The assessment sets out sixty-two core standards divided into ten domains to provide an overall compliance rating:

1. Governance
2. Duty to risk assess
3. Duty to maintain plans
4. Command and control
5. Training and exercising

6. Response
7. Warning and informing
8. Cooperation
9. Business Continuity
10. Chemical Biological Radiological Nuclear (CBRN) and Hazardous Material (HAZMAT).

During 2024/25, the Trust submitted evidence to support the annual deep dive. This assessed our cyber security resilience and IT incident related response plans. This does not contribute to the Trust's overall compliance rating. In terms of evidence supplied, the ICB did not raise any observations or recommendations.

The Trust provided NHS/E evidence of compliance in the form of Core standard completion. Following the Trust confirm and challenge with NHSE and the ICB in November 2024, the final assessment evaluated the Trust as 'Partially Compliant' at 84%; an increase in compliance from 77% in 2023. This assessment consists of 52 'Fully Compliant' standards and 10 'Partially Compliant' standards.

The 10 Partially Compliant standards identified by NHSE during the confirm and challenge process are listed in the table below.

Domain No:	Domain	Number of Standards applicable to an Acute Trust	Number fully compliant	Number partially compliant
01	Governance	6	6	0
02	Duty to Risk Assess	2	2	0
03	Duty To Maintain Plans	11	7	4
04	Command and Control	2	2	0
05	Training and Exercise	4	4	0
06	Response	7	7	0
07	Warn and inform	4	4	0
08	Cooperation	4	3	1
09	Business Continuity	10	6	4
10	CBRNE	12	11	1
	Total	**62**	**52**	**10**
11	Deep Dive – Cyber Security	10	N/A	N/A

Rationale for the assessment outcome indicated gaps in our plans where greater clarity and detail regarding processes was required. These are summarised in the table below:

	Partial Compliance	Rationale
CS12	Infectious disease	HCID pathway provision for the trust to be included in plan (System wide)
CS13	New and emerging pandemics	Document to have annual review and must align to national guidance.

CS14	Mass countermeasures	Plan to include distribution of countermeasures
CS15	Mass casualty	Required reporting and burns management to be included in plan, trust currently have bed capacity as %, NHSE suggest this to be shown as a number and where beds will come from within organisation footprint.
CS43	Information sharing	EPRR related information release or localised process for sign-off of the release of information.
CS50	Business continuity management system – monitoring and evaluation	KPI's to be established in the BC policy document for monitoring and these should be regularly reported to management.
CS51	Business continuity audit	BC policy to include a review of its operation based on the reports of audits and the measured KPI. (How and what we do)
CS52	Business continuity management system – continuous improvement process	As above
CS53	Assurance of commissioned providers and supplier's business continuity	EPRR Team to undertake review of fit for purpose of 3rd. party business continuity plans, rather than just requesting a copy of the plan
CS56	Hazardous Materials (HAZMAT) and Chemical, Biological, Radiological and Nuclear (CBRN) risk assessment	Risk assessment to be reviewed and updated.

Consequently, the EPRR Team have developed a robust action plan, incorporated into the annual workplan to ensure gaps are mitigated through the annual documentation review and general maintenance of plans.

15 Conclusion

The EPRR team has worked incredibly hard over the previous 12-months, engaging Trust staff and key stakeholders to provide assurance that there is a suitably effective EPRR framework in place to ensure DGFT is able to meet its statutory and non-statutory requirements. The framework employs a Plan/ Do/ Check/ Act methodology, which essentially promotes a continuous cycle of improvement. As such, lessons learnt throughout the year from operational aspects of EPRR and the national Core Standards process is fed back into a robust work plan to promote continued learning and greater assurance moving forward. The EPRR workplan is regularly reviewed, maintained and monitored via the EPRR Assurance Group.

The Dudley Group NHS Foundation Trust

Paper for submission to the Public Board of Directors 10th July 2025

Report title:	**Annual Learning from Complaints Report 2024/25**
Sponsoring executive:	Martina Morris, Chief Nurse
Report author:	Jill Faulkner, associate director of patient experience Lara Fullwood, complaints and PALS manager

1. Summary of key issues

Summary of key statistics:

PALS:

The Trust received 3875 informal concerns and comments and 1486 signposting contacts (in total 5361 cases/activity) to the Patient Advice and Liaison Service (PALS) in 2024/2025. This is an increase from the previous year (2023/24) figures of 5142 in total (4144 informal concerns and comments and 998 signposting contacts). This equates to an increase of 219 total cases/activity (4.2%)

The main theme for PALS concerns was regarding appointments (delays and cancellations).

Complaints:

- 1053 new complaints received.
- 1118 complaints closed.
- 100% of complaints (1053) were acknowledged within three working days of receipt.
- 47% of complaints received a response within 30 working days.
- 51.5% of complaints closed (576) were upheld/partially upheld. A decrease from 2023/24 (54%) of 2.5%.
- 12% of complaints closed (135) were reopened- a decrease from 2023/24 which was 14%.
- There were 225 complaints under the early resolution process with 162 of the 225 complaints (74%) responded to within 30 working days (please note data is incomplete for March early resolution complaints as ten of these remain under investigation at time of reporting).
- Medicine and Integrated Care Division received the most complaints at 465 for 2024/25.
- The main theme for complaints overall was poor communication with patients and relatives.
- Patient activity compared to complaint activity remains at 0.07%. Indicating that despite the rise in the number of complaints, this is relative to the increase in patient activity.
- At the end of March 2025, there were 153 (all complaints activity) open with 134 of those requiring a first response. Of those 134 complaints, 35 of those had breached the local time frame (26.1%). This is an increase on the position at the

end of March 2024. However, the average breached complaints for 2024/25 is slightly lower than 2023/24 at 29.6% compared to 31.3%.

- The Parliamentary Health Service Ombudsman (PHSO) formally investigated two new cases. Six formal investigation cases were carried over from previous years, with five of those now closed. There is one PHSO under investigation from 2023/24 as at the end of 2024/25.
- No complaints were formally investigated by the Local Government Ombudsman (LGO) during the year and there are no LGO cases under investigation.

Achievements:

- The team closed 1118 complaints.
- All new complaints were acknowledged within three working days.
- 47% of complaints received a response within 30 working days. An improvement from 2024/25.
- There has been an increase of complaints under the early resolution process (225 complaints when compared to 98 complaints for 2023/24. 74% of these were responded to within 30 working days).
- 12% of complaints closed (135) were reopened- a decrease on 2023/24.
- There is a slight decrease in the average number of breached complaints/backlog at 29.6% for 2024/25.
- Patient activity compared to complaint activity remains at 0.07%.
- The PHSO formally investigated only two new cases, and these have now been closed. Both of these cases were partially upheld.
- No complaints were formally investigated by the LGO during the year and there are no LGO cases under investigation.

Challenges:

- There was an increase in the number of new complaints received by 10.1% from 2023/24.
- The complaints backlog continues to be challenging with the number of new complaints received versus dealing with complaints over 30 working days as the workload is unpredictable. At the end of March 2025, there are more complaints outstanding (153 for all complaint activity and 134 for first response complaints) and more breached/in backlog (35) when compared to the end of March 2024, there were 145 complaints open with 111 of those being first response and backlog being 23.4%.
- The average number of complaints received each month has increased from 2023/24 (79) to 87 for 2024/25.

Actions taken to overcome challenges:

- The complaints team continue to use the escalation process to assist with complaints open over 30 working days.
- An online form is available via the Trust's website to improve communication methods with the complaints and PALS teams.
- The complaints team continue to offer an informal approach (PALS route) to address concerns where applicable.

- The complaints team are putting in place an ‘After Action Review’ to understand how the Trust can better learn from complaints from the complainant (starting April 2025).

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

3. Report journey
The Trust Board Extraordinary meeting Public Board of Directors

4. Recommendation(s)
The Patient Experience Group is asked to:
a) To note complaints and PALS activity in 2024/25
b) To approve the content of the ‘Annual Learning from Complaints Report 2024/25’
c) To note how learning from complaints is implemented and the challenges faced, and actions taken.

5. Impact		
Board Assurance Framework Risk 1.1	X	Deliver high quality, safe person-centred care, and treatment
Board Assurance Framework Risk 1.2	X	Achieve outstanding CQC rating.
Board Assurance Framework Risk 3.0	X	Ensure Dudley is a brilliant place to work

COMPLAINTS

ANNUAL REPORT 2024-25

1. Introduction

This annual report summarises the complaints and Patient Advice Liaison Service (PALS) activity and performance at The Dudley Group NHS Foundation Trust (The Trust) for the year 1 April 2024 to 31 March 2025. The report is written in line with the 'Local Authority Social Services and National Health Service Complaints (England) Regulations 2009' whereby the Trust must prepare an 'annual learning from complaints' report each year.

The report includes details of the number of complaints and PALS received during the year, our performance in responding to complaints, PHSO and LGO investigations, and the actions taken by the Trust in response to the feedback and concerns raised.

Our arrangements for receiving and investigating complaints is just one element of a wide range of feedback methods used to ensure that we listen to and learn from the experiences of the patients, their families and carers who use our services.

The Trusts strategic vision is to deliver 'excellent healthcare, improved health for all.' The Trust has a strong focus on improving patient experience.

Patient complaints and PALS concerns are reported to the Patient Experience Group, and thereafter to the Quality Committee (a delegated committee) of the Trust Board, on a quarterly basis. The patient experience report integrates complaints data and PALS activity along with national surveys, Friends, and Family Test (FFT), NHS Choices and compliments.

Since April 2019, the Trust holds 'Learning by Experience' events which are attended by staff across the Trust. Members of the public attend to talk about their experience of their care, promoting, and encouraging staff members to learn.

In April 2023, The NHS Complaints Standards 2023 were created and implemented to provide a consistent approach to complaints handling for trusts. These Standards have highlighted the importance of good complaints handling in a healthcare setting and learning from these to improve patient care and safety going forward.

The Standards set out the need to involve complainants from the outset, focusing on early resolution, and for trusts to embed learning to improve services. The Trust has implemented these Standards within the existing complaints process and, where applicable, the early resolution process is working well.

Key points to note for 2024/25:

- 1053 complaints received.
- 1118 complaints closed.
- 100% of complaints (1053) were acknowledged within three working days of receipt.
- 47% of complaints received a response within 30 working days.
- 51.5% of complaints closed (576) were upheld/partially upheld. A decrease from 202324 (54%) of 2.5%.

- 12% of complaints closed (135) were reopened- a decrease on 2023/24 which was 14%.
- There were 225 complaints under the early resolution process with 162 of the 225 complaints (74%%) responded to within 30 working days (please note data is incomplete for March early resolution complaints as ten of these remain under investigation at time of reporting).
- Patient activity compared to complaint activity remains at 0.07%. Indicating that despite the rise in the number of complaints, this is relative to the increase in patient activity.
- The PHSO formally investigated two new cases, and these have now been closed. Six formal investigation cases were carried over from previous years, with five of those now closed. There is one PHSO under investigation from 2023/24 as at the end of 2024/25.
- No complaints were formally investigated by the LGO during the year.

2. Definitions

Throughout this report the term '*complaints*' is used to describe formal complaints requiring a response from the Chief Executive (or the delegated executive director in their absence). All formal complaints are managed through the Trust's complaints process and are reported to NHS Digital by KO41 (formally the Health and Social Care Information Centre) on an annual basis.

The term *'early resolution complaints'* are managed in accordance with the Complaints Standards. These are used to describe complaints that involve one service and/or one complaint theme (such as waiting times, values, and behaviours of staff, etc) that may be capable of being resolved by early contact from the service involved. Early resolution complaints aim to be resolved promptly with early contact by the service within three working days with a written response to follow.

The term *'reopened complaint'* refers to a complaint that has already been investigated and a response has been shared with the complainant as part of the first stage of the complaints process (local resolution). The complainant has returned to the Trust either dissatisfied with the response or they are seeking further clarification, asking further questions or they wish to meet with Trust staff to understand the investigation outcome (these meetings are known as local resolution meetings). Where possible the Trust will try to resolve any concerns raised as a complaint in order to achieve local resolution for the complainant. Where local resolution is not possible and several responses may have been shared with the complainant, the Trust will direct the complainant to the PHSO as part of the second stage of the complaints process.

The term '*concerns*' is used to describe informal contact with PALS which requires a faster resolution to issues that may be resolved in real time. These are usually concerns, queries, or requests for information which do not require a detailed and formal investigation, but which may require guidance, signposting, or information.

Staff are encouraged to try and resolve complaints at ward and/or local departmental level. Where required the clinical teams will be involved in resolving the concerns as quickly as possible. Where this is not possible, they can direct the

patient/families/carers to the PALS and complaints team. A dedicated email address and telephone number is available for both PALS and the complaints teams and there is also an online enquiry form that complainants can use in the first instance.

3. Complaints

The Trust investigates complaints in a manner appropriate to the issues raised and where necessary we may seek and obtain consent for an independent review. We aim to resolve all complaints as quickly as possible and keep the complainant informed as far as reasonably practicable as to the progress of the investigation and the rationale for any delays.

Each complaint is triaged by the Associate Director of Patient Experience supported by the complaints and PALS manager. This ensures a consistent approach, and an independent view of the issues raised.

All complaints are expected to be acknowledged within three working days from receipt. A timescale is identified in line with the Trust policy of 30 working days or where necessary negotiated with the complainant as part of the process at the start of the investigation. This is intended to ensure a realistic timescale is given in the context of the anticipated investigation.

Learning from patient/family feedback and using it to drive service improvement is fundamental to our Trust to ensure service improvement and support the continued journey working towards improving a person's experience of care.

At the start of April 2025, the complaints team are introducing and piloting the use of 'After Action Reviews' to learn from complaints. It is anticipated this will bring the voice of the patient or the family, in the form of answers to four questions post the complaints process and investigation. These four questions being:

1. What did you expect to happen?
2. What actually happened?
3. What was the difference?
4. What could be done better in future?

The theory is that our patients and their families offer a unique insight into the way we are working and caring for them and they may make valuable contributions to our learning and create systemic change. By engaging them in this way, we demonstrate our commitment to involving them in their care and our desire to improve. The feedback from this will be shared with the services/Divisions involved for additional learning from complaints.

4. Activity & Performance

This section provides an overview and detailed breakdown of key performance and activity data for 2024/25. It includes the number of complaints received, the number of complaints closed, response times and a breakdown of the subjects raised in complaints.

4.1 Complaints as a proportion of our activity

Table 1 details the number of complaints received in each quarter in comparison to patient activity.

Table 1

ACTIVITY	TOTAL year ending 23/24	Total Q1 ending 30/6/24	Total Q2 ending 30/9/24	Total Q3 ending 31/12/24	Total Q4 ending 31/03/25	TOTAL year ending 24/25
Total patient activity	**1,281,120**	322,475	327,614	345,364	333,488*	**1,328,941***
% Complaints against activity	**0.07%**	0.07%	0.07%	0.07%	0.08%*	**0.07%**

**at the time of reporting not all data had been submitted to Community Services Data Set (CSDS) for the National deadlines so it is anticipated the patient activity data for Quarter 4 (Q4) 2024/25 may be slightly higher.*

This demonstrates that despite an increase in patient activity of 47,821 the complaint activity remains the same as 2023/24 at 0.07% indicating the increase of the number of complaints is relative to the increase in patient activity.

Table 2: Activity and Performance Data

Activity and performance data	2020/21	2021/22	2022/23	2023/34	2024/25
Number of complaints received *(not including reopened complaints)*	711	935	1038	956	1053
% increase/decrease on number of new complaints received the year before	4.8%	31.5%	11%	-7.8%	10.1%
Number of all complaints closed	811	975	1132	1059	1118
Average response rate for all closed complaints (including reopened and early resolution complaints where applicable)	34.3%	31.9%	35.9%	42.8%	47%
Number of reopened complaints	96	124	118	133	135
Number of early resolution complaints	-	-	-	98	225

Average response rate for early resolution complaints	-	-	-	88%	74%
Number of total PALS received (including signposting contacts)	3929	4329	4110	5142	5361
Number of PALS concerns and comments received	3362	3715	3547	4144	3875
Complaints formally investigated by the PHSO	4	3	4	5	2
Complaints investigated by the LGO	0	1	0	0	0

There was an increase in complaints activity during 2024/2025 (1053) from 2023/24 (956) by 10.1%.

To understand if the increase in complaint activity is reflected nationally, we would usually compare such data with neighbouring trusts, but this is not available on NHS Digital at the time of writing this report. When this data becomes available, we will benchmark our activity and report any variance to the Trust's Quality Committee.

The Trust received 3875 informal concerns and comments and 1486 signposting contacts (in total 5361 cases/activity) to PALS in 2024/25, which is an increase from the previous year (2024/24) figures of 5142 in total (4144 informal concerns and comments and 998 signposting contacts). This is an increase of 219 total cases/activity (4.2%) but a decrease in the number of formal concerns and comments dealt with (4144 for 2023/24 compared with 3875 for 2024/25).

The increase in the total number of complaints and PALS concerns/activity received is reflective of the frustrations we hear from patients and their families with delays to procedures and appointments. Concerns continue to be raised regarding nursing care and the discharge process. The rise in signposting contacts for PALS is reflective of patients wanting to raise complaints about other organisations such as GP practices. The PALS team signpost patients to the correct organisation. Therefore, we can also see frustrations from patients regarding other NHS services.

The NHS Complaints Standards 2023 encouraged 'early resolution' where possible. The table below shows the number of complaints through the early resolution process and the response rate of these responded to within 30 working days.

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

Table 3: Early resolution complaints per month and response rate

Month	Received	Responded within 30 working days	% response rate within 30 working days
Apr-24	10	9	90%
May-24	9	8	89%
Jun-24	6	3	50%
Jul-24	12	10	83%
Aug-24	19	17	89%
Sep-24	31	19	61%
Oct-24	34	21	62%
Nov-24	19	18	95%
Dec-24	21	15	71%
Jan-25	17	13	76%
Feb-25	24	16	66%
Mar-25	23	13 (10 still under investigation as of 8 April 2025)	56%
Total	**225**	**162**	**74% (average)**

Complaints and concerns are reviewed monthly to identify themes and trends across the Trust. These are shared with the divisions each month at their divisional governance meetings. Improvement actions and learning is put into practice and reported to the Patient Experience Group, the Quality Committee, and the Board of Directors. Learning is shared through 'Learning from Experience' events held during the financial year.

4.2 Complaints and Concerns Received

Table 4 shows the number of concerns and complaints received during 2024/25. This demonstrates a steady increase quarter on quarter during 2024/25 and an increase per quarter when compared to 2023/24. The number of PALS concerns have decreased in 2024/25 when comparing to the previous year's quarters, although they do continue to be variable at around 900 to 1050 concerns each month over the two years data.

Table 4

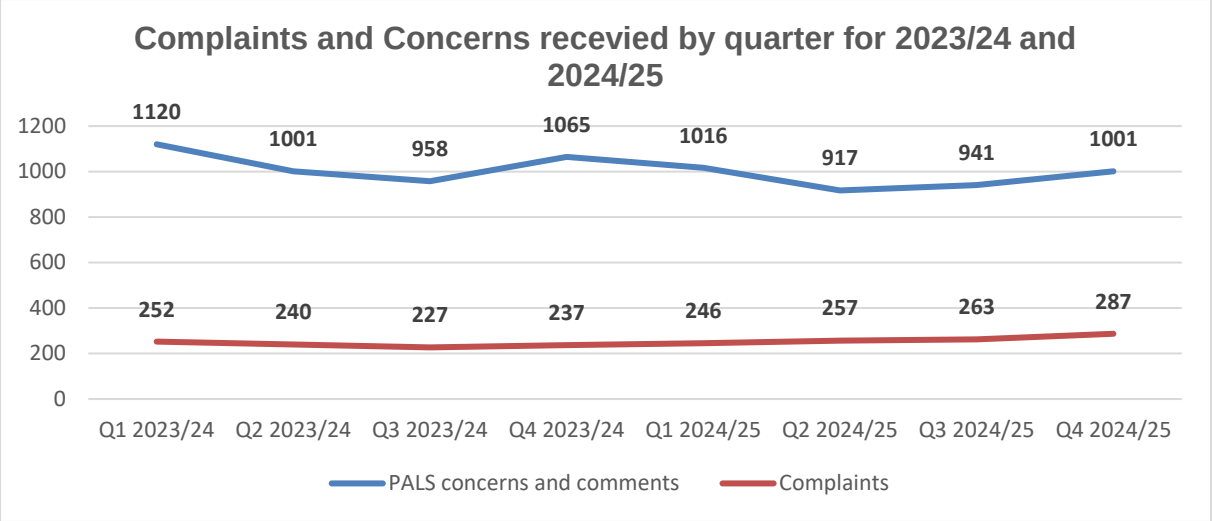
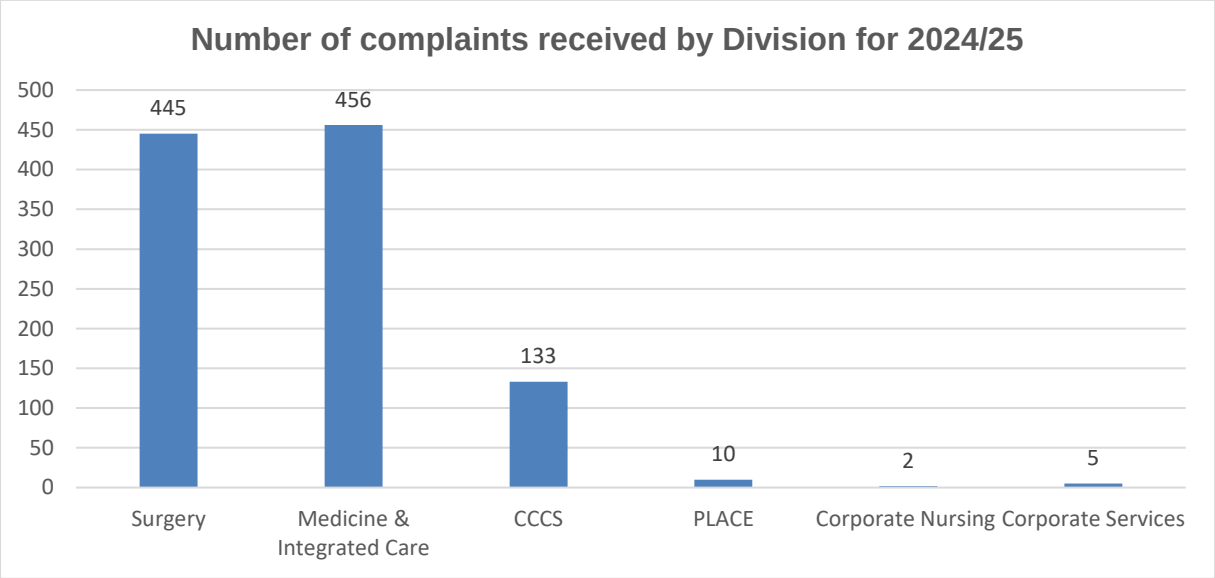


Table 5 details the number of complaints received in each division during 2024/25. The Medicine and Integrated Care Division received the most complaints (456) followed by the Surgery Division (445).

Table 5



4.3 Complaints received by method

Complaints are received by various methods including face to face, email, telephone, and letter. Staff are available to meet at any time during office hours, between 9.00am and 5.00pm, Monday to Friday. In addition, during 2024/25, the Trust developed an online enquiry form accessible 24/7 via the Trust's website.

4.4 Complaints by subject by quarter

Table 6 shows the top themes of complaints received by quarter during the year. The themes of complaints we receive remain similar from year to year, reflecting the

importance that patients place on communication, values and behaviour, effective treatment, timely appointments, discharge, and transfers.

Table 6

Q1, 2024/25	Q2, 2024/25	Q3, 2024/25	Q4, 2024/25
Communications	Patient Care including Nutrition and Hydration	Clinical Treatment - General Medicine	Communications
Patient Care including Nutrition and Hydration	Communications	Patient Care including Nutrition and Hydration	Patient Care including Nutrition and Hydration
Values and Behaviours (Staff)	Values and Behaviours (Staff)	Communications	Clinical Treatment - General Medicine
Appointments including delays and cancellations	Admissions, discharges, and transfers (excluding delayed discharge due to absence of package of care)	Values and Behaviours (Staff)	Values and Behaviours (Staff)
Clinical Treatment - Surgical Group	Clinical Treatment - General Medicine	Clinical Treatment - Surgical Group	Clinical Treatment - Surgical Group

Table 7 below shows the main themes for the four main divisions (highest to lowest)

Table 7

Surgery, Women & Children's Division	***Number of concerns 2023/24***	***Number of concerns 2024/25***
Clinical Treatment - Surgical Group	217	213↓
Communications	241	190↓
Patient Care including Nutrition and Hydration	184	170↓
Values and Behaviours (Staff)	114	125↑
Appointments including delays and cancellations	108	95↓
Medicine and Integrated Care Division		
Clinical Treatment - General Medicine	103	265↑
Patient Care including Nutrition and Hydration	270	230↓
Communications	232	199↓
Admissions, discharges, and transfers (excluding delayed discharge due to absence of package of care)	112	143↑
Values and Behaviours (Staff)	132	121↓
Community with Core Clinical Services (CCCS)		

Admissions, discharges, and transfers (excluding delayed discharge due to absence of package of care)	80	94↑
Patient Care including Nutrition and Hydration	105	88↓
Clinical Treatment- radiology	17	81↑
Communications	92	76↓
Appointments including delays and cancellations	26	54↑
PLACE		
Values and Behaviours (Staff)	N/A	6
Patient Care including Nutrition and Hydration	N/A	4
Communications	N/A	2

Table 8 shows the themes for complaints received during 2024/25.

Table 8

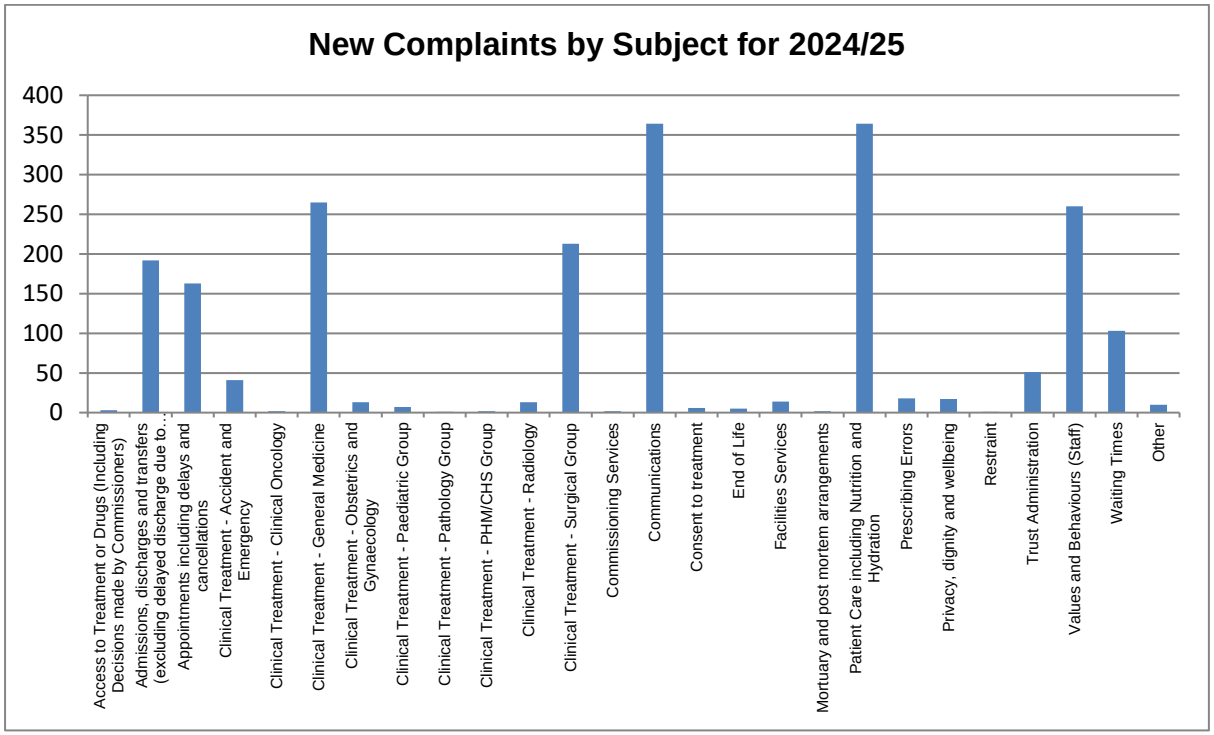
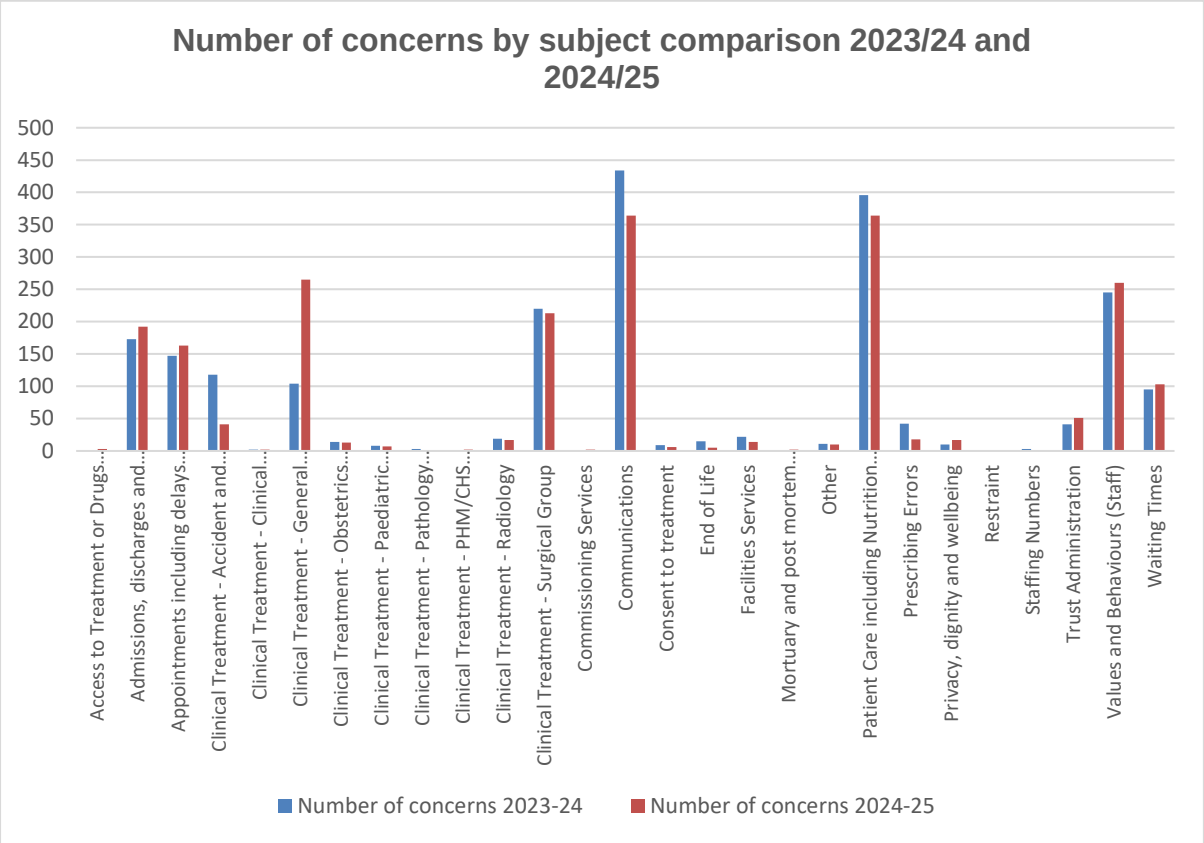


Table 9 shows the number of concerns received by subject compared to the previous financial year.

Table 9



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

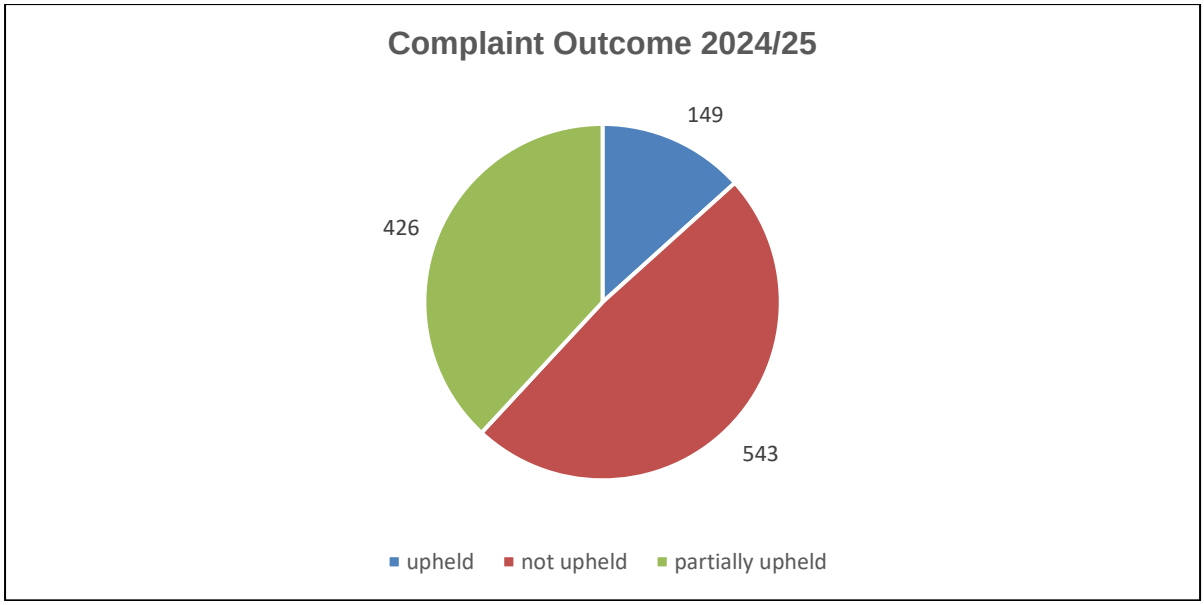
4.5 Complaint outcomes

Upheld	Complaints in which the main or majority of concerns were found to be correct on investigation and an apology given.
Partially Upheld	Complaints in which, on investigation, the main concerns were not found to be upheld, however some of the concerns or issues raised by the complainant were found to be correct and an apology is given.
Not Upheld	Complaints in which the main or majority of concerns were not found to be upheld on investigation. If a complaint is not upheld, we still recognise the validity of the concern to that complainant and we acknowledge that we have failed to meet the complainant's expectations.

The total number of upheld/partially upheld complaints for 2024/25 was 576 out of a total 1118 closed complaints (51.5%). This is a decrease of 2.5% on the previous year (2023/24) whereby 54% of all formal complaints were upheld or partially upheld.

It is of note that upheld complaints are a subjective viewpoint by the investigator and the threshold for partially upheld/upheld complaints may vary from trust to trust and thus cannot be used as a benchmark.

Table 10



4.6 Response times

For 2024/25 there were 1118 complaints closed with appropriate apologies offered in the letter of response from the Chief Executive or within a local resolution meeting. Divisions are required to take action and demonstrate learning from complaints. Complaints are discussed and progressed through the divisional governance arrangements.

Performance in responding to complaints within the agreed timeframe is variable but is slowly and steadily improving. All complainants are contacted to advise of any delay to their complaint and a new timeframe is given and agreed.

The Trust has worked at decreasing the backlog of complaints along with responding within 30 working days and the response rate has improved since 2023/24 from 42.8% to 47% for 2024/25. Timescales are discussed at governance meetings and regular correspondence with staff when complaints are due to breach 30 working days. An escalation process is in place to encourage prompt responses.

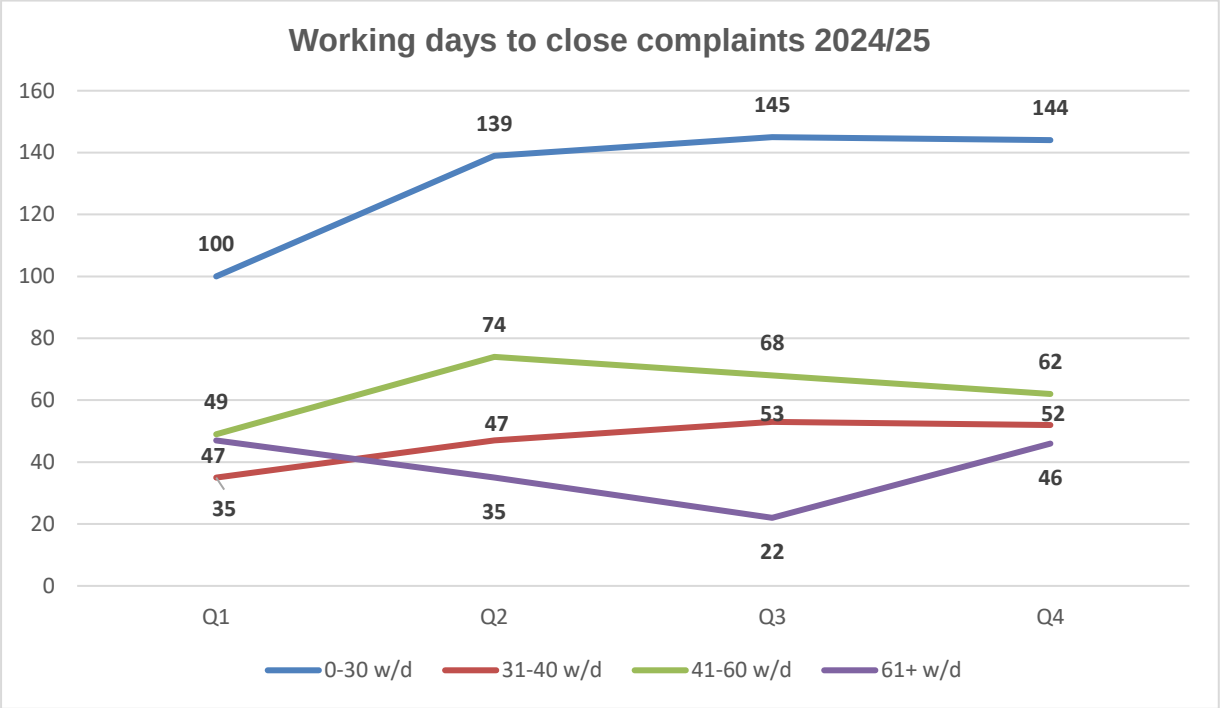
Table 11 details the performance for responding to formal complaints.

Table 11

	0-30 w/d	31-40 w/d	41-60 w/d	61+ w/d
Q1	100	35	49	47

Q2	139	47	74	35
Q3	145	53	68	22
Q4	144	52	62	46

Table 12



These tables indicate the focus remains on closing complaints within 30 working days and this has increased since Q1, 2024/25. Complaints open longer than 31 plus working days remains variable quarter on quarter but indicates steady progress. There are fewer open complaints over 30 working days each quarter.

4.6 Number of breached complaints

The Trust continues to monitor complaints which have exceeded the local timeframe of 30 working days (referred to as breached complaints or 'backlog').

The table below shows the number of complaints received, open at the end of the month and the number of complaints that have breached the local timeframe for financial year 2024-25.

Table 13

Month	New Complaints	Closed Complaints (all)	Outstanding Complaints (exc reopen & exc PHSO)	Overdue Complaints (exc reopened and Exc PHSO)
Apr-24	83	75	129	47
May-24	87	82	139	44
Jun-24	76	74	150	56
Jul-24	92	116	121	38

Aug-24	73	104	105	30
Sep-24	92	75	128	30
Oct-24	103	106	128	26
Nov-24	87	89	134	43
Dec-24	73	93	124	40
Jan-25	97	114	119	38
Feb-25	89	71	139	33
Mar-25	101	119	134	35

At the end of March 2024, there were 145 complaints open which included reopened complaints and PHSO cases (all complaint activity). There were 111 complaints open that were first response complaints (not reopened and not PHSO cases). Of those 111 complaints, 26 complaints were in backlog (23.4%).

At the end of March 2025, there were 153 complaints open which included reopened complaints and PHSO cases (all complaint activity). There were 134 complaints open that were first response complaints (not reopened and not PHSO cases). Of those 134 complaints, 35 complaints were in backlog (26.1%). This is an increase on the figure at the end of March 2023/24 (23.4%). However, comparing the position at the end of the financial year (as of 31 March 2024/2025) as opposed to taking the average over the financial year is not truly reflective given the fluctuating nature in the number of complaints received which impacts the backlog each month.

The average number of breached complaints for 2024/25 is 29.6% compared to the average of 31.3% for 2023/24 which does show a decrease in the backlog and improvement. This continues to remain challenging with the increased number of complaints received.

The graphs below compare the backlog with the data for 2023/24 and 2024/25.

Table 14

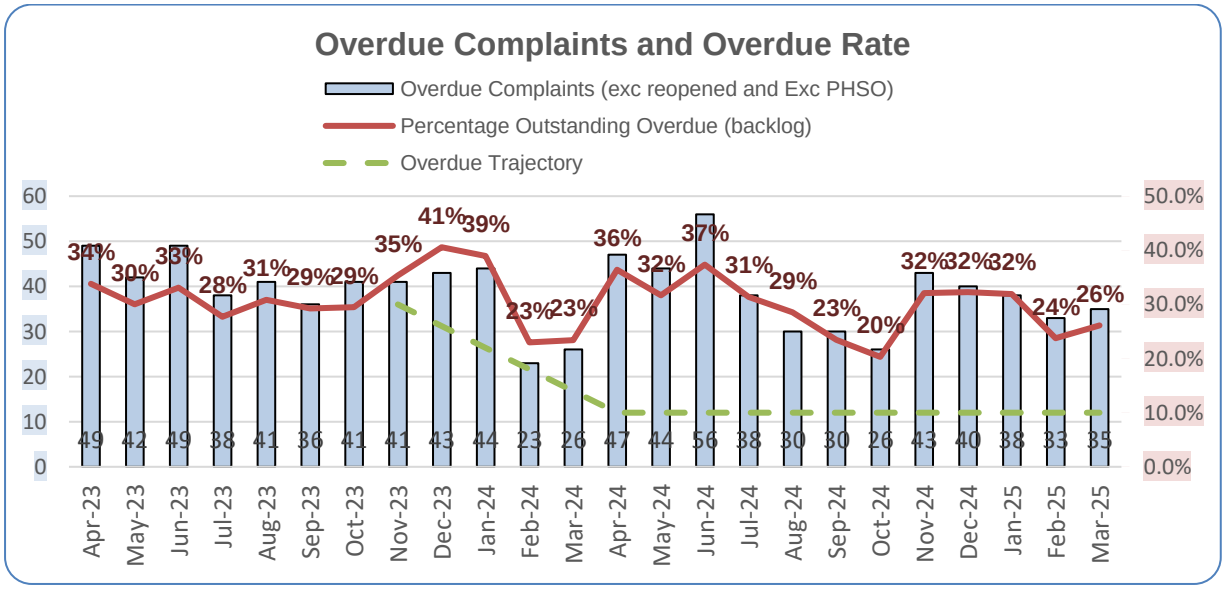
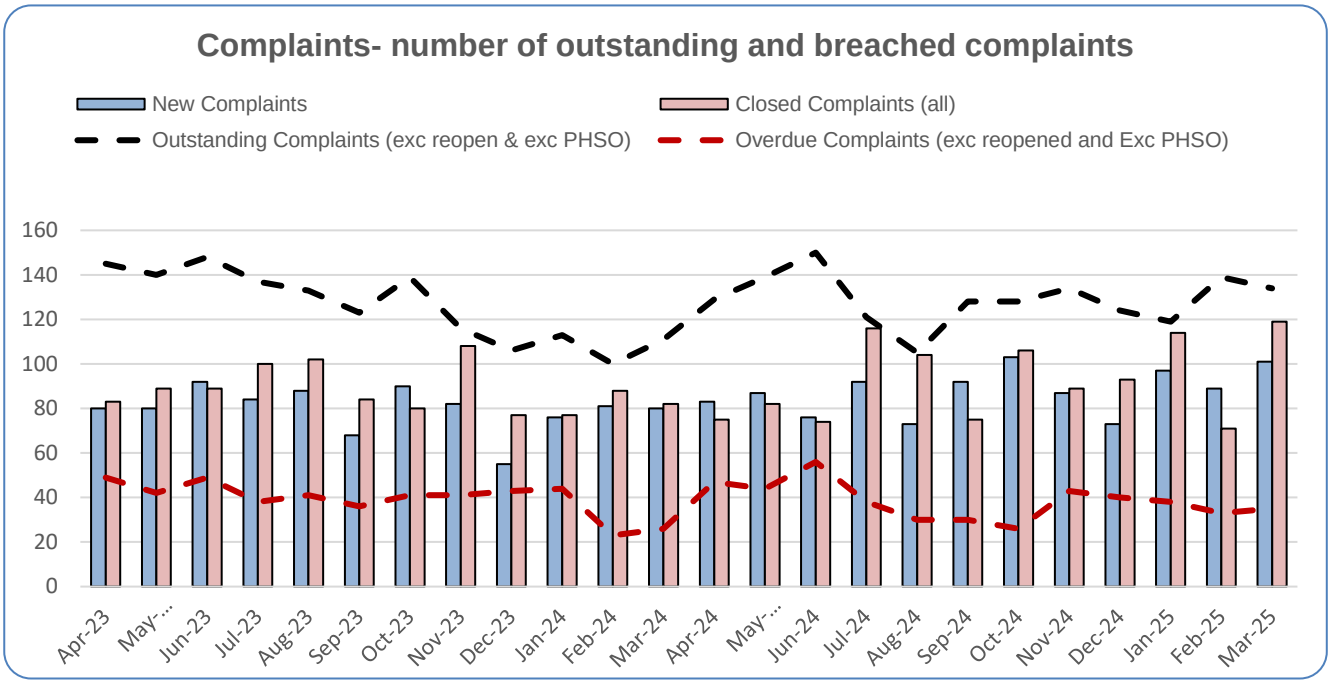


Table 15



These graphs show that during 2023/24 the backlog remained fairly consistent during the first two quarters at around 30%. This then increased in quarter 3 and decreased in quarter 4 to its lowest amount of that year. This then increased during quarter 1, 2024/25, dipping to the lower end of the 20's during the second quarter and increasing in quarter 3 to the 30's and dipping again at the end of quarter 4 to the mid-20's. The backlog has been much more variable during 2024/25, and this is always more challenging when a larger volume of complaints are received each month.

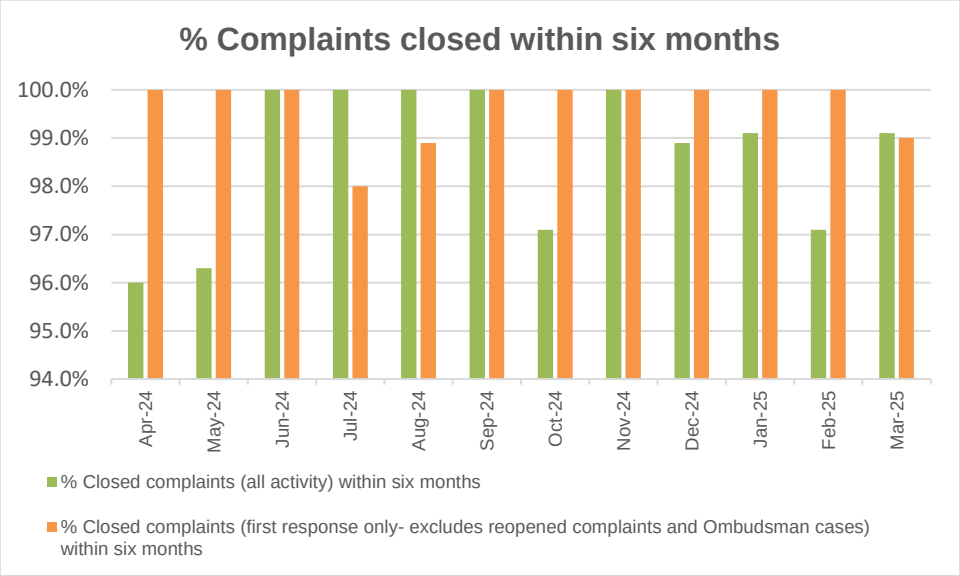
The Trust's local timeframe to respond to complaints is 30 working days, however, the NHS Complaints Regulations 2009 allows trust's six months to respond to a complaint at local resolution stage (stage one).

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

Table 16

Month	Total number of closed complaints (all activity)	Number of complaints closed (all activity) within six months	PHSO cases closed	% Closed complaints (all activity) within six months	Total number of closed complaints (first response only- excludes reopened complaints and PHSO cases)	Number of complaints closed (first response only- excludes reopened complaints and PHSO cases) within six months	% Closed complaints (first response only- excludes reopened complaints and PHSO cases) within six months
Apr-24	75	72	0	96.0%	64	64	100%
May-24	82	79	1	96.3%	72	72	100%
Jun-24	74	74	0	100%	59	59	100%
Jul-24	116	116	0	100%	100	100	98%
Aug-24	104	104	0	100%	91	91	98.9%
Sep-24	75	75	0	100%	67	67	100%
Oct-24	106	103	2	97.1%	97	97	100%
Nov-24	89	89	0	100%	77	77	100%
Dec-24	93	92	1	98.9%	79	79	100%
Jan-25	114	113	1	99.1%	98	98	100%
Feb-25	71	69	2	97.1%	62	62	100%
Mar-25	119	118	0	99.1%	102	102	99%

Table 17



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

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

5. Parliamentary Health Service Ombudsman (PHSO) / Local Government Ombudsman (LGO)

The PHSO and LGO represent the second stage of the complaints process.

5.1 Parliamentary Health Service Ombudsman (PHSO) cases

During the latter end of the 2020/21, the PHSO began to take a different approach to resolution, returning to the Trust to attempt mediation/local resolution at Trust level by offering an apology and/or financial remedy.

The below information summarises the cases for local resolution/mediation brought to the Trust’s attention by the PHSO and the remedy suggested by them without them carrying out a formal investigation:

Local resolution cases

The Trust received no new cases for local resolution during 2024/25 with one case carried over from 2023/24 and closed in 2024/25. The outcome of this is as follows:

- An apology, payment of £1200 and action plan, received in March 2024 with the action plan to be completed by June 2024. The action plan was completed and the PHSO confirmed closure of this case on 8 August 2024 (Datix 10362).

There are no local resolution cases open at the end of 2024/25.

Mediation/Dispute resolution

The Trust received no new cases for mediation/dispute resolution for 2024/25, with one case carried over from 2023/24 (Datix 10122). A mediation meeting with the complainant was held by the PHSO in June 2024 and an action plan devised. This was completed at the start of February 2025. This case was closed in March 2025.

There are no mediation cases open at the end of 2024/25.

Formal PHSO investigation

At the start of 2024/25, there were six formal PHSO cases open. This included one formal investigation case carried over for 2021/22, one carried over from 2022/23 and four carried over from 2023/24.

There were two new PHSO formal complaints received for 2024/25.

During 2024/25, the case carried over from 2021/22, the case from 2022/23 and three cases from 2023/24 and the two new cases from 2024/25 were closed (please see details of the outcomes of these below).

There is one formal investigation case open which has been carried over from 2023/24 and remains under investigation.

Closed formal investigation cases

Of the PHSO case carried over from 2021/22:

- This was closed in October 2024 following the completion of an action plan to the complainant. This case was partially upheld. The PHSO found that there was no delay in diagnosing the patient. They found most of the Trust's actions were in line with relevant guidelines. However, it should have done a neurological assessment during the patient's admission.

The PHSO case received in 2022/23:

- This was closed in May 2024 following completion of an action plan and an apology to the complainant. This case was partially upheld. The PHSO found the Trust did not follow relevant guidelines when making decisions about the patient's pregnancy care. However, they did not consider the Trust missed the opportunity to diagnose the baby's condition before they were born. They do appreciate this failing did cause some of the distress the patient experienced when not knowing if her baby's condition could have been diagnosed during her pregnancy. The Trust had not acknowledged this failing or reflected on the distressing impact it had. In relation to the patient's complaint about the Trust losing the baby's blood sample on three occasions, the PHSO found the Trust did not fully explain to the patient what happened to the samples. However, the Trust did acknowledge what the patient said, and the distress caused, provided an apology, and also explained what steps it has taken to try and stop the same thing happening again. The PHSO found the Trust followed relevant guidelines when trying to resolve the complaint.

Of the PHSO cases received in 2023/24 and closed in 2024/25, the PHSO found and recommended the following:

- Case closed in October 2024 following completion of the PHSO's recommendations of an apology, an action plan and financial remedy of £10,000 to the complainant. The PHSO upheld this complaint. The PHSO found the Trust failed in the treatment of the patient. They found the Trust failed to take any action on the patient's positive faecal immunochemical test (FIT) during the first admission and discharged the patient home. Had the patient remained in hospital, treatment for the gallbladder could have been escalated and, on balance, the patient's death from multi organ failure and sepsis avoided.

- Case closed in December 2024 following completion of the PHSO's recommendations of an action plan and financial remedy of £120 to the complainant. The PHSO partially upheld this complaint. The PHSO identified failings with the Trust's communication with the patient's family about the patient's condition and with the comments some of the staff members made. They believed the impact of these are likely that the patient's spouse suffered from unnecessary discomfort, and the family suffered from added distress, whilst dealing with bereavement. The Trust failed to conduct a malnutrition screening. However, the impact of this was mitigated by the Trust's effective care planning. They also identified a potential issue with the Trust not providing a red allergy band to the patient. However, this had no impact on the patient.

- Case closed in February 2025 following completion of the PHSO's recommendations of an apology, an action plan and financial remedy of £600 to the complainant. This complaint was partially upheld. The PHSO found the Trust did not accurately document the patient had dentures on admission. Had the Trust done so, it is more likely than not the Trust would have monitored and safely stored these, and the denture would not have been lost. The PHSO believed this would have avoided the patient's family being upset by witnessing the patient struggling to eat. The PHSO found the Trust did not always follow the patient's food requirements and preferences. It did not act in line with its own dietician referral guidance. Family were left feeling the Trust did not give the patient the best chance at staying well and having proper nutrition and this exacerbated the family's bereavement.

Of the PHSO cases received in 2024/25 and closed the same year, the PHSO found and recommended the following:

- Closed in January 2025 following completion of the PHSO's recommendations of an apology, an action plan and financial remedy of £320 to the complainant. The PHSO partially upheld this complaint. The PHSO found the Trust failed to properly monitor the patient's cannula and mouth pain and there was poor communication about MET calls and the patient's care plan. The PHSO believed these failings meant the patient experienced pain and discomfort during the hospital admission and the poor communication meant the patient's spouse did not understand what was happening with the patient's care. This caused the family confusion and distress at an already distressing time.

- Closed in February 2025 following completion of the PHSO's recommendations of an apology, an action plan and financial remedy of £750 to the complainant. This complaint was partially upheld. The PHSO found clinicians did not follow the relevant standards in relation to three different areas of the patient's medication management. The PHSO did not find these failings had any impact on the patient's health or contributed to the death. They did identify how they affected the patient's family and led to distress that could have been avoided.

5.2 Local Government Ombudsman (LGO) cases

During 2024/25, there were no LGO cases, and no previous cases carried forward. There are no LGO cases open.

6. Learning from complaints

The Trust has made several changes and improvements in response to formal complaints. Listening to patient/relative/carer feedback and engaging with the experiences of patients through meetings, patient stories and focus groups, supports our staff to improve the standard of care and service provided.

The Trust continues to provide training which includes the Trust induction training for all new employees, the AHP preceptorship programme, and additional managing complaint training. Complaints are viewed as extremely important pieces of valuable information without which we would not be given the opportunity to learn from errors and improve care and safety for others.

Complaints are reviewed on a monthly basis to identify themes and trends across the Trust. These are then shared with the clinical teams and services. Improvement actions and learning is put into practice and reported to the Patient Experience Group, the Quality Committee, and the Trust Board.

The divisions have provided the following examples of learning from complaints in 2024/25. These aim to improve the process and the opportunity to change. It is recognised that the focus must be on the actions taken as a direct result of complaints to improve the care we deliver.

Table 18

Communication **Complaint Description:** Concerns raised regarding lack of communication to parents regarding a patient's discharge.
Learning and action taken: It was recognised that communication needs to be improved. • `Meet the matron` advertised for every Friday • Band seven clinical nurse leadership teams are now fully established. To promote visibility and role modelling for junior staff. Band seven clinical nurses meet families daily. • Discharge is not always planned and is dependent upon progress. However, it has been identified that this is also due to lack of effective communication. The unit have received positive feedback and will continue to monitor this via complaints, PALS process.
Medication delay

Complaint description:
Patient was waiting for their 'to take home' (TTO) medication for six hours, delaying their discharge.

Learning and action taken:
Identified there was a gap in pharmacy process and also in ward-based pharmacy processes. There was a delay in prescribing the TTOs.
The Ward pharmacist junior did not effectively communicate any delays.

- Task and finish group commenced with pharmacy lead for surgery
- Identified gap in pharmacy workforce
- Added to risk register
- To bridge communication gaps between pharmacy and ward
- Ongoing issues – monitored via matron and pharmacy lead daily to improve delays.

Patient Care

Complaint Description:
A family highlighted that the wards did not appear to have a policy for flushing intravenous Paracetamol and that their relative was missing some of his medication each time it was administered.

Learning and action taken:
Pharmacy confirmed this drug requires flushing. If a Posi flush is required, then this is classed as a medical device and does not require prescription. Scoping is now taking place to look at a patient group direction for flushes to ensure best practise is followed going forward.

Lost property

Complaint description:
Loss of a pair of spectacles after a theatre procedure. Property book was completed stating that the glasses were present on admission and the patient states that he walked to theatre with them in situ and removed them in the anaesthetic room.

Learning and action taken:
There was no clear process in place for the patient's valuables.

Immediate action – the day case area and theatres were searched; all trolleys were searched but unfortunately the spectacles were not found.

Long term action – if a patient has to be admitted to an in-patient bed following surgery on day case, the property book has now been up-dated to include a section identifying which ward the patient is being admitted to post-operatively. Any valuables are now collated and stored in a plastic bag for the receiving ward, and this is signed for by them. It is also documented in the property book if the patient goes to theatre wearing their spectacles, to ensure traceability.

In addition, Divisional Chief Nurses (DCNs) have been working with their teams and have developed the below action plan:

- Ensure the Patient Property and Money Policy is visible and accessible to patients and their families, promoting awareness and compliance with best practices for managing patient property. Aiming to do this by publishing the Patient Property and Money Policy on the patient information leaflets and webpage and include guidance on managing property before admission.

- Ensure the Patient Property and Money Policy is up-to-date, consistent, and effectively communicated to staff and patients, fostering better compliance and safeguarding patient property. Aiming to do this by formally reviewing and relaunching the policy. Ensure ward leads, Matrons and DCN team sign off policy

- Communicate the new policy Trust wide and confirm exemptions where necessary.

- Ensure all relevant staff are thoroughly trained on the Patient Property and Money Policy to promote consistent understanding, proper implementation, and compliance across the Trust. Aiming to do this by focusing training efforts on ward leaders, Matrons, and clinical staff who are directly responsible for implementing the Policy.

- Leaders to cascade training to their teams and provide targeted training across the divisions.

- Explore inclusion of policy key points on payslips.

- Policy awareness raised in patient safety huddles.

- To integrate the disclaimer and patient property forms into the current IT system and modify these to allow patients to sign disclaimer electronically (tick box functionality to be reviewed). Explore digital options such as tablets for patients to sign disclaimer and integrate into the digital system.

- Property form management to be consistent and sustainable Patient property forms to be completed and scanned onto digital notes. Regular reviews and audits of this process by conducting monthly sample checks on patient property forms.

- Implement safeguards for protecting patient property out of hours.

- List of ward safes included in policy and the policy to outline actions for wards without safes.

- Ensure the site team receive training in regard to property policy as senior staff on nights support and link in with Site lead to ensure training delivered to team and fed back to extended team.

Use of equipment

Complaint description:
A complaint was received by a relative regarding staff being unable to apply a hoist sling correctly on a Learning Disability patient. The relatives also raised concerns around appropriate nutrition and hydration.

Learning and action taken:
It was identified on this specific ward there was a lack of knowledge regarding hoist application amongst staff.

Manual handling training has been carried out on the unit to include hoist refresher training for all staff.

The ward has identified manual handling champions to ensure there is support for staff if they have any concerns when using a hoist.

Clinical Treatment

Complaint description:
Patient complained they were under a specialist team for many years with no input and did not receive any biologics as they should have done. A treatment they feel has affected their well-being.

Learning and action taken:
A consultant was able to confirm the patient was under the care of the specialist team between 2013 and 2020. During this time, several aspects of care were delivered as evidenced from relevant clinic letters sent to the patient's GP.

The consultant was able to offer assurance that the patient was fully investigated for their symptoms. Unfortunately, the Trust was able to confirm that the patient did not qualify to receive treatment with biologics from a specialist perspective. At that time, other specialist treatment was offered to the patient.

Change and impact:
The specialist team identified that the prescription of drugs is governed by the National Institute of Health and Care Excellence (NICE); NICE criteria differ for each specialty. This is why the patient qualified to receive biologics via one speciality NICE criteria but not via another speciality NICE criteria. The team acknowledge this may have been difficult to understand and apologised if this was not made clearer to the patient you at the time.

Appointments

Complaint description:
Patient raised concerns regarding a wait for a podiatry appointment.

Learning and action taken:
Learning consists of dealing with patient's expectations, not only when they call into the podiatry office but also when the clinicians are treating them, advising on some safe self-care. Explaining to them about PIFU (patient initiated follow up).

The service revised the triage process and referral form and are putting in place an eligibility programme. The team have implemented the OPT-IN process and have implemented a coding system to categorise patients, which may help with the allocation process and the eligibility programme.

7. Conclusion

We are committed to ensuring that we make it easy for patients, relatives, and carers to make a complaint or raise a concern and encourage feedback in various ways. We continue to focus on learning and actions from the complaints and feedback received.

The Dudley Group
NHS Foundation Trust

Paper for submission to the Public Board of Directors 10th July 2025

Report title:	Complex Vulnerabilities
Sponsoring executive:	Martina Morris, Chief Nurse and Director of IPC
Report author:	Joanne Day – Lead for Mental Health and Complex Vulnerabilities

1. Summary of key issues

- During 2024/25 the team have worked hard to ensure that patients with complex vulnerabilities receive the additional support they require throughout their patient journey, ensuring that they feel safe, listened to, and have confidence in the knowledge and skills of our staff.

- The Dementia and Delirium team assists in recognising and identifying early diagnosis for patient with cognitive concerns and working with partner agencies to support safe discharge and ongoing support. With leadership from the Mental health Lead, they maintain oversight of Mental Health Act activity within the Trust. They also support the work of the Mental Capacity Lead in ensuring patients' rights are upheld and the Trust is working within the legal frameworks when restrictive practices are used.

- Introduction of the Admiral Nursing Service with support from Dementia UK to support engagement with internal and external key stakeholders to give direction and priority to improvements in Dementia care.

- The Mental Health and Complex Vulnerabilities Lead is a demanding and challenging role with both operational and strategic responsibilities. The subject matter expertise offered to the Trust has been invaluable in ensuring we recognise and carry out our statutory duties under the Mental Health Act.

- The Learning Disability Team are recognised within Trust and across the system as a leading example of liaison work to ensure learning disabled patients are supported and inequalities in access to health care are addressed.

Achievements:

- Processes in place to ensure Trust is compliant with statutory responsibilities under the Mental Health Act and Mental Capacity Act, including a Mental Health Act Administration service, Responsible Clinician and training provision.
- Work in progress for Mental Health Act compliance providing assurance during a CQC visit.
- Progressive work around management of restrictive interventions, including partnerships with Mitie Security staff and Patient Safety Team
- Collaborative partnership work across the system concerning Right Care Right Person.
- Commencement of an Admiral Nursing Service into the Trust to support improvements in care to patients living with Dementia
- Embedding Reasonable Adjustment flags being added to patients with a Learning Disability as per LeDeR national guidance.

- The funding and provision of the new 'Calm Bags' for patients with Learning Disabilities.
- The Lead Nurse for Mental Health and Complex Vulnerabilities and the Admiral Nurse being nominated for Committed to Excellence Awards.

Challenges and opportunities:

- Strengthen governance around use of chemical restraint, PRN sedation and all restrictive interventions.
- Strengthen process of Mental Health Act detention in line with new processes.
- Uptake of clinical staff completing training provided from the Mental Health Act Administration service.
- Gaps in staff knowledge and culturally held misconceptions at all levels of staff concerning the Mental Capacity Act.
- The challenge to meet compliance targets for Oliver McGowan training within the Trust.
- Improve monitoring and oversight of LeDeR learning actions.
- Delirium – recognition and treatment
- Direction and focus on care of patients with Dementia.
- Review of Trust training provision concerning violence and aggression.

Actions taken to overcome challenges and maximise opportunities:

- The Restrictive Intervention Group meets monthly and is working to engage key stakeholders within the Trust to improve reporting, reviewing and monitoring of chemical restraint and all restrictive interventions impacting on patient care. This is a risk on the safeguarding risk register and is being monitored via the Internal Safeguarding Group.
- Agreed processes concerning the Mental Health Act have been ratified through a policy and standard operating procedure and introduced with the support of the Mental Health Administrator and Mental Health Lead to guide the process.
- Continued training provision of the Mental Capacity Act with targeted support in required areas.
- Continued work with the Oliver McGowan Task and Finish Group to review training challenges and maximize availability.
- Development of a LeDeR action tracker which is overseen by a newly established Learning Disability steering group and progress reported to Internal Safeguarding Group
- Reviewing the means to target training of key staff regarding delirium
- Development of Admiral Nurse service and review of staffing structure of the dementia and delirium team to maximize recruitment and retention.
- A gap analysis of training concerning violence and aggression to inform Trust decision making of new provision.

2. Alignment to our Vision	
Deliver right care every time	**x**
Be a brilliant place to work and thrive	
Drive sustainability (financial and environmental)	

Build innovative partnerships in Dudley and beyond	**x**
Improve health and wellbeing	

3. Report journey
Internal Safeguarding Board Quality Committee Public Board of Directors

4. Recommendation(s)
The Quality Committee is asked to:
A. Note the information provided regarding trends, themes, achievements, and challenges in the work supporting patients with complex vulnerabilities during 1st April 2024 to 31st March 2025.
B. To gain assurance with respect to compliance with statutory responsibilities and contractual standards.

5. Impact		
Board Assurance Framework Risk 1.1	X	Deliver high quality, safe person-centred care, and treatment
Board Assurance Framework Risk 1.2	X	Achieve outstanding CQC rating.
Board Assurance Framework Risk 6.0	X	Build innovative partnerships in Dudley and beyond
Board Assurance Framework Risk 7.0	X	Achieve operational performance requirements

EXECUTIVE SUMMARY

The Trust Complex Vulnerabilities Annual Report has been developed to provide assurance to the Board that the Trust is compliant with their statutory responsibilities under the legislative frameworks relevant to ensuring safe and accessible care for patients with Learning Disabilities, Dementia, mental capacity issues and mental health conditions.

The report:

- Demonstrates the breadth and depth of the work undertaken by the Complex Vulnerabilities Team to ensure our most vulnerable patients receive high quality care.
- Acknowledges the complexity of needs of this cohort of patients who require the skills and expertise of Complex Vulnerabilities Team to ensure equality, accessibility and patient centred care
- Demonstrates the progress in ensuring compliance with statutory responsibilities and highlights gaps and risks where improvements are required.
- Outlines the future objectives of the team during the year 2025-2026 to support the priorities of the Trust priorities in delivering right care every time and

Complex Vulnerabilities Annual Report 2024-2025

CONTENTS		
1.0	Foreword	
2.0	Introduction	
3.0	National Guidance and Key Legislation	
4.0	The Dudley Group NHS Foundation Trust Complex Vulnerabilities Service	
5.0	Governance	
6.0	Risk Register	
	Mental Health	
8.0	Dementia and Delirium	
9.0	Admiral Nurse Service	
10.0	Mental Capacity Act 2005	
11.0	Learning Disabilities	
12.0	Restrictive Interventions	
13.0	Achievements	
14.0	Conclusion	
15.0	Key Objectives for 2025/2026	

1.0 Forward

The Dudley Group NHS Foundation Trust is committed to ensuring that patients with complex vulnerabilities receive the additional support they require throughout their patient journey, ensuring that they feel safe, listened to, and have confidence in the knowledge and skills of our staff. The Trust supports highly challenging and complex cases, including assessing mental capacity of the patient concerned to make best interest decisions about their care, treatment and safe discharge whilst ensuring least restrictive interventions are maintained throughout. The Team is committed to ensuring that all services are equally accessible to everyone.

The Complex Vulnerabilities Team has a shared vision to support the needs and best interests of the patients, with co-production at its core to support high quality delivery and improvements. The team provide specialist and expert training, advice, support, and supervision to all Trust employees to enable them to fulfil their statutory responsibilities and provide high quality care.

Every adult, whatever their disability, has the right to make their own decisions wherever possible. People should always support a person to make their own decisions if they can - MCA (2005)

2.0 Introduction

This is the third annual report for the Complex Vulnerabilities Team, for Dudley Group NHS Foundation Trust which focuses on the period April 2024 to March 2025. It highlights some of our key achievements, giving us the opportunity to reflect on some of our challenges, looking at our ambitions for the future and ensuring the Trust are in line with key statutory requirements:

- Care Act 2014
- Deprivation of Liberty Safeguards 2009
- The Equality Act (2010)
- The Human Rights Act 1998
- The Mental Capacity Act 2005
- The Mental Health Act 1983

In addition, the Trust, as a registered provider with the Care Quality Commission (CQC), must have regard for the Regulations as established under the Health and Social Care Act (2008). In relation to providing a regulated activity, this includes the assessment or medical treatment for persons detained under the Mental Health Act 1983.

The report provides an overview of the key priorities and activity as well as areas requiring further focus and development to strengthen processes. This is to ensure the Trust is working within legal frameworks to protect against harm and abuse, and ensure vulnerable patients are supported with decision making. This annual report will provide oversight of the key themes and work streams around the Mental Health Act 1983 and the Mental Capacity Act 2005.

3.0 National Guidance and Key Legislation

People with complex vulnerabilities are at greater risk of experiencing deteriorating physical health alongside mental health conditions. Evidence supports that people with a Learning Disability have considerable and often multiple, physical, and mental health conditions and experience high levels of health inequalities. As a Trust we have also identified how the Covid-19 pandemic has had an impact on the mental health of children and young people and are working in partnership with local Mental Health Trusts to bridge the gap between services. Alongside this the Trust has recognised the unprecedented demand on services and the increase in attendance at Emergency Departments for patients with a mental health concern.

3.1 Key Legislation

- Autism Act 2009
- Care Act 2014
- Childrens Act 1989
- Childrens Act 2004
- Deprivation of Liberty Safeguards 2009
- Health and Social Care Act 2008
- Human Rights Act 1998 (Article 5- Right to liberty and security, Article 8 - Respect for private and family life, Article 14- Prohibition of Discrimination)
- Mental Capacity 2005
- Mental Health Act 1983

3.2 National Guidance

- Care quality commission (CQC) (no date) Guide to Assessing Mental Health Care in the Emergency Department.
- Care Quality Commission Monitoring the Mental Health Act 2023/2024
- Care Quality Commission (no date): Care of children in unsuitable hospital settings
- Healthcare for All: The Independent Inquiry into Access to Healthcare for People with Learning Disabilities (2008)
- The NHS Longterm plan (2019)
- NICE (2016) Achieving Better Access to 24/7 Urgent and Mental Health Care
- NICE (NG96): Care and support of people growing older with Learning Disabilities (2018)
- NICE guideline (NG10): Violence and aggression: short-term management in mental health, health and community settings (2015)
- NICE guideline CG103: Delirium: prevention, diagnosis and management in hospital and long-term care (2010)
- NICE guideline NG97: Dementia: Assessment, management and support for people living with dementia and their carers (2018)
- Restraint Reduction Network (2020) Training Standards
- Royal College of Emergency Medicine:

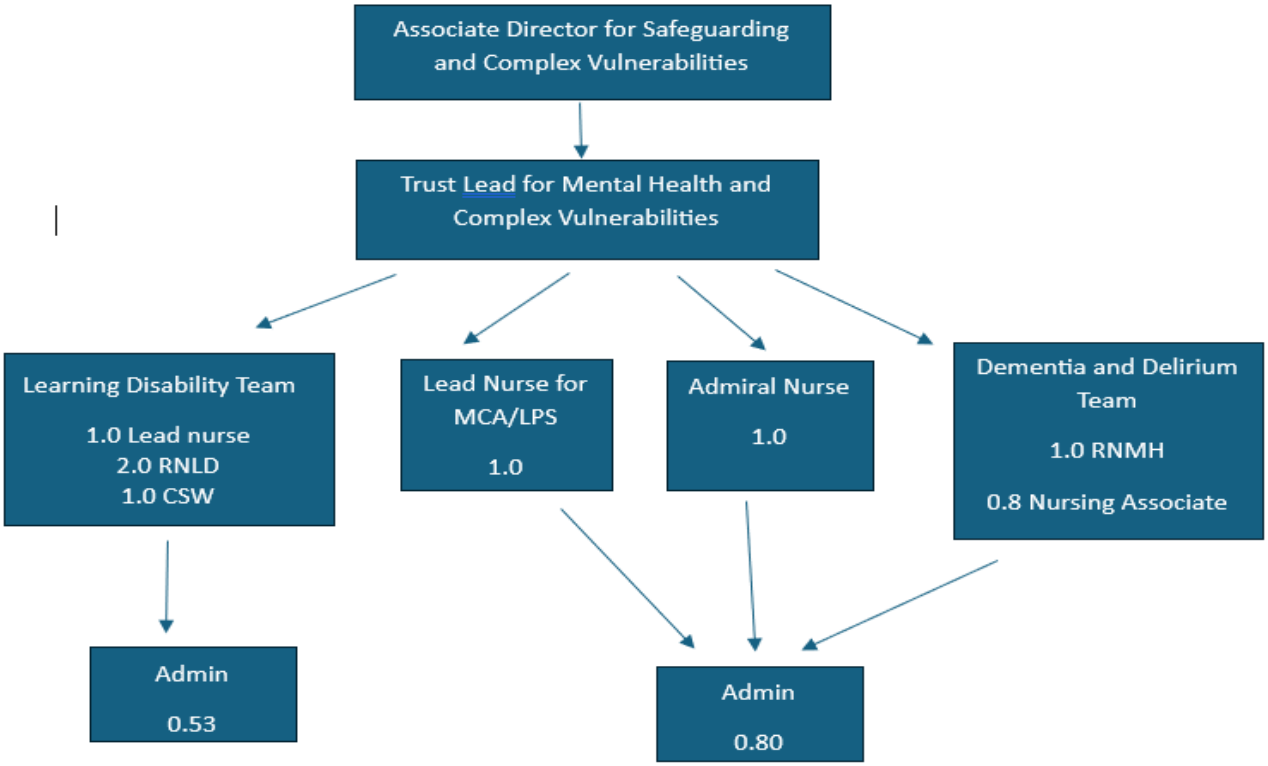
- Care of Older People in the Emergency Department
- Learning Disability Toolkit
- Mental Health in Emergency Departments
- The patient who absconds guideline

- Royal College of Nursing (2011) Meeting the health needs for people with Learning Disabilities
- Royal College of Psychiatrists (2022) PLAN (Psychiatric Liaison Accreditation Network): 7th edition standards
- NHS England: The Learning Disability improvement standards for NHS Trusts

4.0 The Dudley Group NHS Foundation Trust Complex Vulnerabilities Team

The Complex Vulnerabilities Team is an integration of the Dementia and Delirium and Learning Disabilities teams and the new addition of an Admiral Nurse service. It includes the Trust Lead Nurse for the Mental Capacity Act and the Lead for Mental Health. This integrated team recognises the additional vulnerabilities of this group of people and the frequent overlap of mental health, Learning Disabilities and mental capacity issues. The Complex Vulnerabilities Team was developed in 2022/2023 and functions as part of the Trust Safeguarding Team, collaborating closely with the safeguarding nurses. Governance and monitoring are provided by the Trust Internal Safeguarding Board (ISB).

4.1 Team Structure



4.2 Lead for Mental Health and Complex Vulnerabilities

The Lead for Mental Health and Complex Vulnerabilities supports the operational, clinical, and strategic role for mental health within the Trust. Capacity and workload are affected due to support that is required as the subject matter expert for the Trust, along with managing the operational issues within the team.

4.3 Lead Nurse for Mental Capacity/Deprivation of Liberty Safeguards (DoLS)

The Lead Nurse for Mental Capacity and DoLS is responsible for developing and maintaining the policies and procedures on this area, as well as being a subject matter expert. They provide mandatory training to the Trust focusing on this area and provide guidance and expertise for patients with complexities where Trust staff require extra support. They quality assure Deprivation of Liberty Safeguards (DoLS) applications and submission to the Local Authority.

4.4 Dementia and Delirium Team

The team consists of 1.0 WTE Registered Mental Health Nurses (RMN) over a 5-day period. There was a 0.6 WTE Mental Health Nurse who left in June 2024. There have been longstanding recruitment challenges in the team, resulting in the service not being fully staffed since Q4 of 2022. –As a result, the structure of the team was modified, with the introduction of 1.0 WTE Admiral Nurse as of 02.09.24 to

support the team to be fully staffed. The lead for Mental Health has supported with cover but this impacts on the priorities for this role. Due to the Dementia and Delirium Team not having the resources to provide the right support to this client group, this has been placed on the Trust Risk Register until staff resources are resolved.

4.5 Admiral Nurse

The Team expanded in 2024 with the addition of one Admiral Nurse to provide an Admiral Nurse Service. This is a project with Dementia UK to support the family of patients living with dementia (PLWD) during the admission of a patient living with dementia. This service is indicated for when PLWD have particularly complex needs. The service provides support during the admission of the PLWD, the discharge pathway and introducing supportive mechanisms for the family as part of this process.

4.6 Learning Disabilities Team

The provision in Trust of one specialist nurse Band 7 for people with a Learning Disability was implemented in July 2013 and further developed in 2019 with an additional two Band 6 registered learning disability nurses and a part time clerical officer. In 2022 an additional part time post was established with the additional expectation of establishing a pathway to support autistic people in Trust. Due to the Lead Nurse for Learning Disability retiring in May 2024, the post was successfully recruited to from the Learning Disability Team. In part due to the financial position of the Trust and a desire to develop skill mix within the team, the vacant post was filled by a Band 3 Clinical Support Worker. The service has experienced challenges as a Band 6 Learning Disability Nurse began maternity leave December 2024, which due to budgetary restraints could not be backfilled.

The role of the team is to address the identified health care needs of people with a Learning Disability. As the Trust's provision includes working with children, this provides patients and their families with assurance when they attend hospital and when transitioning into adult healthcare services.

5.0 Governance

The Complex Vulnerabilities team is led by the Lead for Mental Health and Complex Vulnerabilities with oversight from the Associate Director for Safeguarding and Complex Vulnerabilities. Due to the increasing workload of the Lead for Mental Health and Complex Vulnerabilities, the Learning Disability team was moved to be managed by the Associate Director for Safeguarding and Complex Vulnerabilities on a temporary basis. This remains under review. The Deputy Chief Nurse holds the services within the Complex Vulnerabilities within their portfolio, and the Chief Nurse provides Board oversight as the Executive Lead. The Trust oversees the governance arrangements through the monthly Internal Safeguarding Board (ISB), which is chaired by the Chief Nurse. The ISB gains assurance on behalf of the Trust Board that it's legal and statutory duties are met in relation to monitoring of the Mental Health Act, Deprivation of Liberty Safeguards, and restrictive interventions. Areas for escalation from the ISB are reported to the Trust Quality Committee.

6.0 Risk Register

Risk Reference	Risk Description	Risk update
N1681	Poor application and implementation of the Mental Health Capacity Act 2005 across the Trust could potentially lead to patients deprived of their liberty and poor quality of care	Risk reduction from 16 to 12
N2382	The Trust requires assurance that PRN sedation is being prescribed, administered and recorded appropriately and safely for the purpose of reducing symptoms of agitation or disturbed behaviour which could potential result in patient harm.	Risk reduction from 15 to 4
N2220	The Trust will be non-compliant with the legal requirement from the Health and Care Act that all health professionals should undergo learning disability and autism awareness training which could potentially impact on the quality of care for people with a learning disability and autistic people.	Risk reduction from 15 to 6
N2144	Resources within the Complex Vulnerabilities Team is insufficient to meet the demands of the service including: Mental Health Strategy, Dementia Strategy and reducing restrictive intervention work. This could lead to a potential risk to miss patients with dementia and offer support required.	Risk reduction from 15 to 4
N2426	The Trust is not fully compliant with processes related to effective implementation of the Mental Health Act which could potentially result in patients' rights not being upheld and detained illegally.	Risk reduction from 9 to 4

7.0 Mental Health

The mental health needs of patients who are treated for emergency or elective treatment of physical health conditions, within the Trust must always be taken into consideration. All staff must ensure patients are treated lawfully when subject to the Mental Health Act 1983. The Mental Health Act 1983 (MHA) sets out the duties and powers that detaining authorities have regarding the assessment and treatment of people with a Mental Health Disorder.

The main purpose of the Mental Health Act is to allow compulsory action to be taken where necessary to ensure that people with mental health problems receive the care and treatment, they need for their own health and safety and for the protection of other people. The MHA Code of Practice 1983 identifies standards that mental health service providers should meet when they perform their responsibilities under the Act.

7.1 Monitoring of the Mental Health Act

The Trust is registered with the Care Quality Commission (CQC) to provide regulated activity. This includes the assessment or medical treatment for persons detained under the Mental Health Act 1983. There needs to be clear governance processes for the administration of all Mental Health Act paperwork. As of July 2024, a service level agreement has been implemented with Walsall Healthcare Trust who provide a Mental Health Act Administration (MHAA) service to the Trust. The MHAA service provides the following elements:

- Ensure the MHA detention papers are complete and have followed due process.
- Provide the secondary scrutiny of all original statutory paperwork.
- Maintain the record of all patients admitted, subject to or who become subject to detention under a section of the MHA.
- Provide all reminders to the required staff regarding statutory reviews.
- Administer any request for a Hospital Managers Hearing and any Mental Health Act Tribunal.
- Maintain a record of patient section rights being read.
- Provide training in relation to the MHA.
- Offer guidance and support to all Trust members in relation to the MHA.
- Contact the Nearest Relative (NR) with patient permission to inform them and their NR rights under the MHA.
- If the patient is already subject to the MHA upon arrival, the MHA Administrator will check the patient has section 17 leave to be at Dudley Group NHS Foundation Trust.

In addition to these elements, the MHAA provide a monthly report to the Executive Team to provide a breakdown of all MHA activity within the Trust as well as daily situational reports. In order to support with transparency of mental health activity, a Power BI database has been created, identifying patients via keywords to ensure that this data is captured to allow reporting within the Trust. Key themes under review include:

- Patients that are detained to the Trust
- Patient that are liable to be detained within the Trust (Emergency Department and inpatient wards).
- Patients that are agreeing to a voluntary admission in the Trust that are awaiting an inpatient bed
- Patients on section 17 leave to the Trust from external mental health hospitals
- Patients that are detained to the Emergency Department Place of Safety under a section 136

The MHAA process is supported by the Mental Health Act Administration policy which has been live since 07.01.25.

A plan is in place to support a live MHAA database through a Power BI tool, with data pulled from the patient record on Sunrise. The MHAA have Trust laptops to access Trust systems and would be able to input into Sunrise to create this tool. This will allow patient data to be held centrally within Sunrise. The process is still in development with the MHAA.

7.2 New Mental Health Act processes within Trust

As a result of the increasing demand for limited mental health services, the impact of this is the need for patients to attend the Emergency Department (ED) in crisis to access emergency support for their mental health needs. Patients in this situation following assessment from Mental Health Liaison Services (MHLS) may require admission to a mental health hospital. This may be required as a voluntary or informal

patient, or via being detained under the Mental Health Act 1983. The Trust acknowledges that patients experiencing mental health crisis require a suitable environment with support provided by staff that are trained in this area. To prevent the delay in accessing this support, the Trust has taken the position to not automatically accept MHA applications to the Trust. Each application is considered against the below criteria, to ensure that the best outcome is identified for the patient:

- A bed is available
- Admission is in the best interests of the patient
- The Trust is the best environment to meet the primary physical needs of the patient
- The Trust can provide appropriate physical treatment to the patient
- The Trust can uphold the safety of the patient and others, avoiding de facto/unlawful detentions where possible
- The appropriate consent/conditions in respect of the patient have been set out in writing in accordance with section 17 of the MHA

As a result of considering these various elements, applications for applying the MHA to the Trust may be declined. In such instances, a patient will become "liable to be detained". This process is monitored by the Trust through the MHAA. The Mental Health Act 1983 Standard Operating Procedure was developed with the overview of the Trust legal team. This document became live 11.02.25, supporting a new process, allowing it to be supported Trust wide.

The pathway is supported by the clinical site team who are informed of patients that have undergone a MHA assessment, where they in turn escalate this through the appropriate channels to the Trust Executive team to consider the application and whether the Trust is the most suitable environment. Should the patient be detained to the Trust, the clinical site team have had training to process the MHA paperwork. The MHAA will scrutinise the MHA paperwork before any the paperwork is legally accepted by the clinical site team to avoid unlawful detentions taking place.

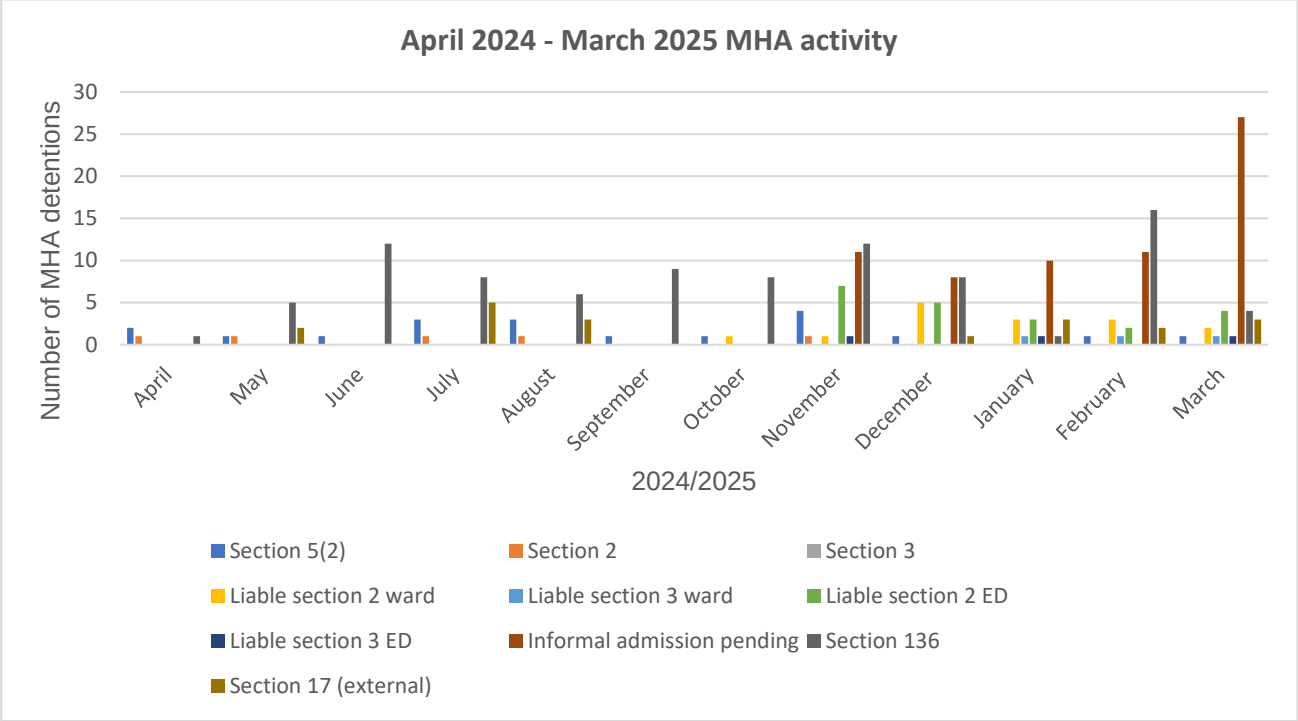
Due to the process being new, problems that arise are fed back into the process to allow it to become more robust and streamlined. Issues identified are raised within the Trust through the monthly MHAA report and via the Mental Health report at the Internal Safeguarding Board. Issues are also being raised with the local Approved Mental Health Professional (AMHP) hub for where processes have not been followed. Concerns can also be reported through Datix and are also raised with the Executive Team as they arise to ensure full transparency. The Trust Quality KPI report which is shared with the Trust Board has a section about mental health and MHA activity in ED and inpatient wards as well as children and young person's activity.

7.3 Provision of a Responsible Clinician

A Trust that is registered with the CQC to accept MHA detentions to the Trust, must have arrangements in place for the care of the patient to be directed by a Responsible Clinician (RC). A contract was agreed 08.07.24 and the arrangement is implemented when a patient is detained to the Trust. During the last 12 months, there have been 2 patients detained to the Trust, August and November respectively, where RC provision was required.

BCHFT have requested a review of the current contract pending their challenge to the Trust regarding not accepting all applications of the MHA to the Trust. This is currently under the review of the contracts and Trust legal team.

The chart below details the number of patients subject to the Mental Health Act over the past 12 months.



The data collation has improved over the financial year, and the type of MHA activity has varied. This is due to the Trust previously not holding patients as being liable to be detained prior to August 2024. Reporting on patients awaiting admission to a mental health hospital on a voluntary basis, whether they were in ED, or an acute ward was also not recorded until December 2024.

7.4 Training

The Trust provides mandatory Mental Health Law training. This is an overview of various legislations that impact on patient care, including the Mental Health Act 1983, but also includes information about the Mental Capacity Act 2005 and the Human Rights Act. The basic training is provided at Trust Induction and is aimed at all staff. Trust compliance is currently 83.2% as of March 2025. An impact on compliance rates is the addition of Dudley Integrated Health and Care NHS Trust (DIHC) to the Trust. Staff from DIHC are required to complete this training, starting from nil compliance.

Following a contract with WHT for the MHAA service, additional training has been introduced, specifically about the MHA. Mental Health Act Awareness training is available to all clinical staff but is aimed at inpatient staff. Section 5(2) training is aimed at medical staff. Both training sessions are available via MS Teams. MHA Awareness is available twice per month and the section 5(2) training is available each weekday. As the MHAA is a service provided across Royal Wolverhampton Hospitals NHS Trust, WHT and the Trust, the training is provided across all sites via MS Teams to improve efficiency of the MHAA time. The section 5(2) training has become a mandated part of medical staff Trust induction, where the MHAA provide this monthly.

The Trust recognises that attendance of staff at the MHA awareness and section 5(2) training is not mandatory and is relatively new, being in place during the previous 8 months. Unfortunately, staff

uptake is not at a place that the Trust would consider is beneficial to staff learning. As a result, this is currently on the Trust safeguarding risk register N2426.

A small training package has been developed to deliver training about providing enhanced observations to core staff in ED and Critical Care. This was delivered by the Lead for Mental Health and Complex Vulnerabilities over 6 sessions. This was in relation to the ongoing demand in ED to provide this intervention and the increasing demand in critical care, where patients have increasingly complex needs and risks. The training focused on:

- The recognition of enhanced observations as a therapeutic intervention
- Reasons for using enhanced observations
- Recognising the anxiety of staff and the patient in this process
- How to support patients
- The recognition of non-verbal communication
- The benefits of kindness
- How to document the process
- Reviewing legal frameworks to support the intervention
- The importance of staff sharing information
- Skills staff can bring
- Managing the environment

7.5 Inspections and Reviews

The CQC carried out a planned MHA monitoring visit on 8 July 2024. Their remit was to review:

- The list of doctors or other clinicians the Trust employ who are approved under section 12 of the MHA
- Any policies, processes or procedures relating to the use of the MHA
- Any Memorandum of Understanding with another provider relating to the use of the MHA
- The number of patients the trust has admitted in the previous 12 months for whom the Trust is the detaining authority
- The records, electronic and/or paper, relating to the last 10 patients the Trust admitted for whom the Trust was the detaining authority.

The Trust prior to the planned inspection was already in the process of conversations with BCHFT to support with an RC contract as well as conversations with WHT to provide an MHAA. The CQC welcomed this development, and the inspection noted good practice:

<u>Purpose and Effectiveness</u>

- The Trust was close to finalising an agreement for the provision of Responsible Clinician services with the Black Country Healthcare NHS Foundation Trust.
- The Lead for Mental Health and Complex Vulnerabilities had issued 2 Patient Safety Bulletins for staff at Russells Hall Hospital, giving key information about the use of the MHA in a general acute hospital setting.
- There were clear policies and guidelines on the use of the Mental Capacity Act (MCA) 2005, setting out how to assess mental capacity and make decisions in a patient's best interests if they lacked capacity to make a specific decision.
- The Trust provided swift, detailed and full responses to the CQC requests for information.

Efficiency and Equity

- A memorandum of understanding was in place with the Black Country Healthcare NHS Foundation Trust to provide psychiatric liaison services.
- The Trust had arranged for Walsall Healthcare NHS Trust to provide Mental Health Act administration services, including scrutiny of detention paperwork and medical recommendations.
- Professionals from Russells Hall Emergency Department, Dudley Metropolitan Borough Council and the Black Country Healthcare NHS Foundation Trust had worked together to develop a brief, straightforward standard operating procedure on the management of patients arriving in the Emergency Department under section 136.

The CQC raised the following concerns formally following their visit:

- The Trust could not provide assurance that treatment for mental disorder prescribed and administered to patients who were detained directly by Russells Hall Hospital was given by or under the direction of the approved clinician in charge of the treatment as required by section 63 MHA.
- The action taken to review the treatment for all current patients detained directly by the Trust at Russells Hall Hospital to ensure that treatment for mental disorder is only given under the direction of an Approved Clinician as required by section 63 MHA.

Following the visit, the Trust was able to provide the following assurance:

- A review of in-patients with a MH condition at the time of the CQC MHA monitoring visit was conducted to ensure that treatment was undertaken with oversight of an appropriate clinician. There were 2 in-patients, one was on section 17 leave from Black Country Healthcare NHS Foundation Trust (BCHFT) and the other had a Responsible Clinician based in the community. All other patients cared for since the CQC MHA monitoring visit had either been on section 5(2) and not been subsequently detained following an MHA assessment or were on section 17 leave from BCHFT.
- Strengthened incident reporting for MH incidents is now in place.
- Key MH data shared via the daily sitrep from the MHAA service, integrated quality report and joint Chief Nurse and Medical Director report.
- Relevant policies and guidance have been updated to reflect the new processes.
- MH training for key operational staff, including at level 4 for the Board, has commenced and will continue throughout September and October 2024.
- A retrospective review of all patients potentially detained between July 2020 and July 2024 has been concluded. The total number of patients who required this review reduced to 20, from the original cohort of 50. This is because some of the originally identified patients were subsequently found to have an RC, were on section 17 leave or were not detained to the Trust. The review has confirmed that none of the patients are deemed to have been detained outside of the legal remit.
- The MHA Administration service has commenced and is providing statutory duties as described in the Mental Health Act.
- The RC contract has been dually signed by the Trust and BCHFT, subject to a satisfactory MHA checklist being submitted to BCHFT to demonstrate MHA compliance.

- As part of the RC and MHA administration service provision, support will be provided to ensure that staff administering medicines for mental disorder, for patients detained under the MHA, understand the treatment authorisation requirements of the MHA. Key training will be arranged for appropriate staff to ensure good understanding.

7.6 Trust Mental Health Strategy

The Mental Health Strategy that was implemented 2022-2026 continues to be an active strategy, of which the Trust are now in year 3 of. The 3-year strategy sets out plans to ensure that patients with mental health conditions attending the Trust receive the additional support they require throughout their patient journey, ensuring that they feel safe, listened to, and have confidence in the knowledge and skills of our staff. The aim of the Mental Health Strategy is to improve the experience, quality, and effectiveness of care received by adults with a mental health condition and that our staff can identify the mental health needs of all patients and ensure the correct support pathways are provided. Due to the wide portfolio of the Lead for Mental Health and Complex Vulnerabilities and limited team provision, the scope to implement the strategy has been limited. However, the positive work completed and reported on within the report, is reflected within the aims of the strategy.

Vision of the Mental Health strategy

Staff within Dudley Group Foundation Trust will have the skills and understanding to support, identify and provide care for patients with a mental illness. The Trust will promote a positive Mental Health Culture, reduce barriers and inequalities and ensure the mental health of patients are given equal priority to their physical needs.

7.7 Emergency Department Mental Health Risk Assessment – consolidate with new SOP

In response to a serious incident, the former Mental Health Lead developed a Mental Health Risk Assessment Tool for use in ED triage. The risk assessment tool is used for all patients with suspected mental health related problems and includes reviewing their presentation regarding capacity/co-operation/agitation/abscond risk, review of suicide risk, possession of weapons, and immediate triage plan resulting from these details. This is a rapid assessment based on available data which is on Sunrise. The guidance that this sits within is the Mental Health Referral Process Standard Operating Procedure. This became live following ratification on 17.02.25.

7.8 Right Care Right Person

Right Care, Right Person (RCRP) has been introduced within the West Midlands via West Midlands Police in collaboration with local stakeholders. RCRP forms part of a national government agenda with each police force rolling this out through local pathways. RCRP provides a threshold to assist police in making decisions about when it is appropriate for them to respond to incidents, including those which relate to people with health and social care needs as well as mental health needs.

RCRP has been introduced via a number of phases. Phase 3 and 4 introduced changes to police response to conveying and transfer of patient care who are subject to section 135 and 136 of the MHA. Under RCRP the expectation is that the handover of a patient from police to a health care professional under a section 136 will be within one hour. This handover hour commences following arrival at a place of safety. Police

will hand over the responsibility of the patient to appropriate healthcare staff who can maintain the safety of that patient, ensuring that they are not able to harm themselves or others or to leave the location.

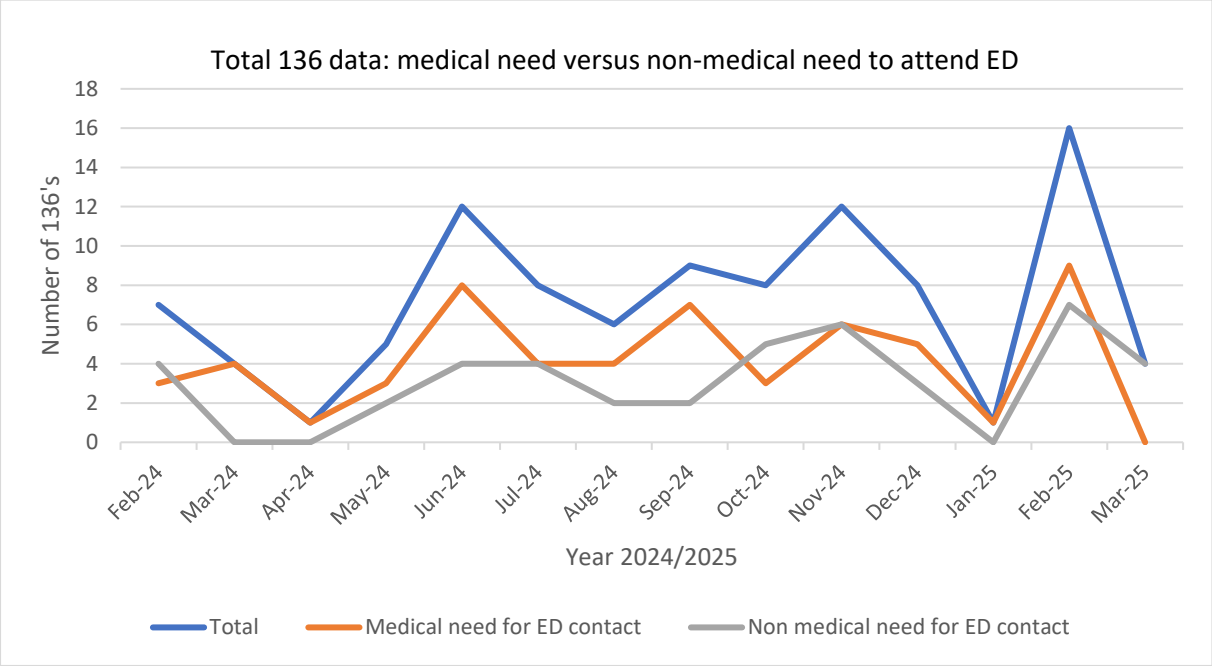
Phase 3 and 4 was introduced to the West Midlands area as of 18.11.2024. Police officers are required to complete handover paperwork for the patient and provide those details to the relevant Place of Safety. This should include all the information that is requested, but also any additional information the police have been made aware of by the patient during the time the officers have spent with them.

The Emergency Department (ED) is a Place of Safety, where patients with physical health issues who have been detained under a section 136 by the police, or may potentially require ED due to there being no available mental health-based place of safety, will be accessing ED. This requires ED staff to be familiar with the process and its application.

The changes in process have been collaborative across the system, with the overall aim to reduce the number of people that are detained under a section 136 to reduce the level of restrictions for people, reduce the treatment of patients in distress and acute mental health crisis from a perception of criminality when the police are involved, and reduce the number of patients that access ED when there are no physical health issues.

The approach has enabled improved working relationships across the system due to consistent contact via MS Teams and in person, with future projects now in process. This includes a review of suitable mental health-based place of safety for children and young people across the Black Country Footprint and the lack of availability of mental health-based place of safety for adults when they are converted into an inpatient bed due to bed pressures.

The impact of RCRP on the Trust has been varied. A longer period of review will allow a greater understanding of its impact on ED. The below chart provides an initial data review of the varying numbers of section 136's to attend ED, and whether there was a medical need to attend ED:



7.9 Collaborative work with Black Country Healthcare NHS Foundation Trust

The Lead for Mental Health and Complex Vulnerabilities has been part of a working group concerning issues with clozapine continuing to be prescribed for patients with mental health needs that are admitted to the Trust. This has been a collaborative effort between the pharmacy teams at the Trust and Black Country Healthcare NHS Foundation Trust (BCHFT), Mental Health Liaison Services (MHLS), the clozapine clinic at BCHFT and the Lead for Mental Health and Complex Vulnerabilities. The workstream has developed Patient Safety Bulletin (PSB) to highlight what clozapine is, the process for continued prescribing, the contact number of who to gain information and the risks to patient physical and mental health if the medication is stopped being prescribed and/or the patient having a treatment gap of 48 hours between medication doses. The PSB is part of the medical staff's induction webpage. The working group highlights the issues that arise from this medication and focuses on ways to address these issues.

8.0 Dementia and Delirium

Dementia is an umbrella term for a range of progressive conditions that affect the brain. NHS England reports that dementia is a growing challenge. As the population ages and people live for longer, it has become one of the most important health and care issues facing the world. In February 2025, there were 735,842 people aged 65 and over, estimated to have dementia in England. Of these, 481,375 have been formally diagnosed and added to the risk register. Data from the Alzheimer's Society identifies that with the UK having an ageing population, the number of people living with Dementia in the UK will reach 1.6 million by 2040.

Dudley Social Services identify that within Dudley, one in five people are over the age of 65 which is higher than the England average of one in six. In terms of local Dudley dementia diagnosis rates, 3.74% of the population have a diagnosis as of 2020 with an annual estimated percentage growth in people 65+ with dementia of 2.61%. This does not account for the population who are experiencing cognitive decline who are yet to be diagnosed with dementia.

NHS England identified that there are around 540,000 carers of people with dementia in England. It is estimated that one in three people will care for a person with dementia in their lifetime. Half of carers are employed, and it's thought that some 66,000 people have already cut their working hours to care for a family member, whilst 50,000 people have left work altogether.

8.1 Dementia and Delirium Team

The specialist Dementia and Delirium Team, work 5 days per week and focuses on supporting patients with Dementia and Delirium. The team assists in recognising and identifying early diagnosis for patients with cognitive concerns and referring for further follow-up on discharge. The team supports the wards in recognising and managing restrictive practices, including quality assuring Deprivation of Liberty Safeguards (DoLS) applications and submission to the Local Authority. The team supports and advises family and carers of patients who have a diagnosis of dementia/cognitive deficits and supports the wards concerning management of behaviours that challenge for patients with dementia and delirium. The Mental Health Lead maintains an oversight of mental health activity within the Trust in line with the new Mental Health Act Administration Managers.

The Dementia and Delirium Team work closely with the Black Country Healthcare NHS Foundation Trust (BCHFT) Mental Health Liaison Team (MHLS) to improve care delivery and ensure clearly defined roles and responsibilities. MHLS provides support for patients under 65 within their core 24 service, all referrals for patients over 65 with a functional mental illness are also referred to MHLS. The Dementia and Delirium team is the first point of call for patients with complex vulnerabilities, such as Dementia, Delirium, Korsakoff's and behaviours that challenge to offer support and advice.

8.2 National data collection

The national aspiration from the Department of Health and Social Care is that two-thirds (66.7%) of people estimated to be living with dementia should have a formal diagnosis. This reflects the 2015 prime minister's challenge to increase the numbers of formal diagnosis of dementia.

Dementia screening is important for the following reasons:

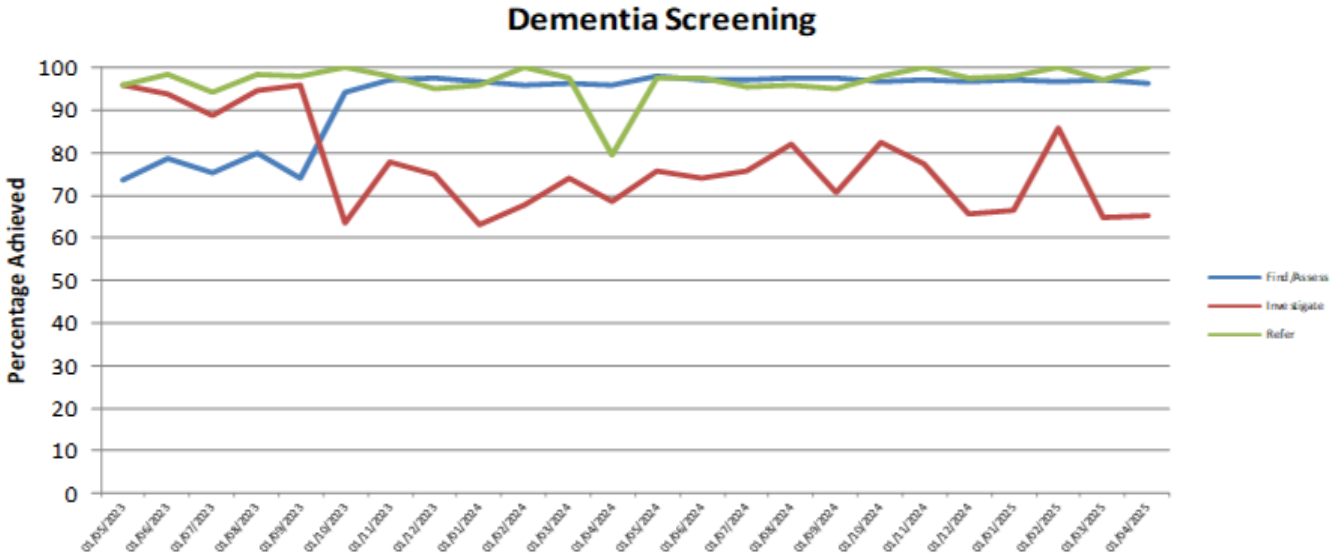
- Early diagnosis
- Early treatment
- Early care / support planning
- Early considerations of social and emotional elements
- Planning for the future
- Supporting family, friends, and colleagues to understand the changes and how they can support.
- Allows time to review financial aspects e.g. benefits, reviewing Lasting Power of Attorney and legal affairs.

The work that the Trust completes in terms of the AMT4 assessment dementia screening tool fits in with the plan of early diagnosis. The screen is completed for patients aged seventy-five and over within seventy-two hours of admission with a required Trust compliance of 90% and above. This is to support early identification of cognitive decline as per the "Find" element of the screening process. Any concerns in this area will initiate the screening outcome to be passed to the Dementia and Delirium Team who will review failed AMT4 screens and complete further assessments and onward referral where required as per their "Investigate and refer" element.

Last year's annual report detailed the issues that the Trust had with compliance of the screening tool. The Find element was recorded as having response rates consistently below 80%. A project was implemented to improve compliance rates. This consisted of:

- Trust communications including a Patient Safety Bulletin, screensaver and raising the issue within In the Know to raise awareness.
- Engagement with Lead Nurse meetings which helped to identify the possible gaps.
- A focus within Dementia and Delirium training including post graduate training.
- Identifying issues within Sunrise that impact on completing the screening tool.
- Reviewing the Dementia Portal and data collection tools that generate the compliance levels.

Through following these processes, it became clear that the data collection was the primary factor for poor compliance. A new data collection set was implemented from the inpatient document which created Find and Assess compliance rates of 97.14% for March 2025. The review of data took place from March 2023 which is when the screening was digitalised. On this basis, compliance has been achieved from October 2023, which accounts for embedding a new process.



There are however areas within screening that still need to be addressed. This includes replacing the AMT4 screening tool with the 6CIT which is a more sensitive screening tool. This was paused due to the priority to address the compliance levels. This will be an objective for 25/26.

Quality of the screening is also important in terms of when this is completed and promoting patients to be in a position when they are at the optimal presentation to engage, to promote an accurate result.

8.3 Dementia and Delirium Team development

The Dementia and Delirium Team has consisted of 1 full time nurse for the majority of the last 12 months with the previous Dementia and Delirium Nurse who worked 0.6 of full-time hours left the team. This has had an impact on the service. The investigate and refer compliance element of the dementia screening has reduced since the "Find" data compliance was resolved. The impact is that not all referrals to the service will be reviewed prior to discharge as there is not the service availability to meet all referrals.

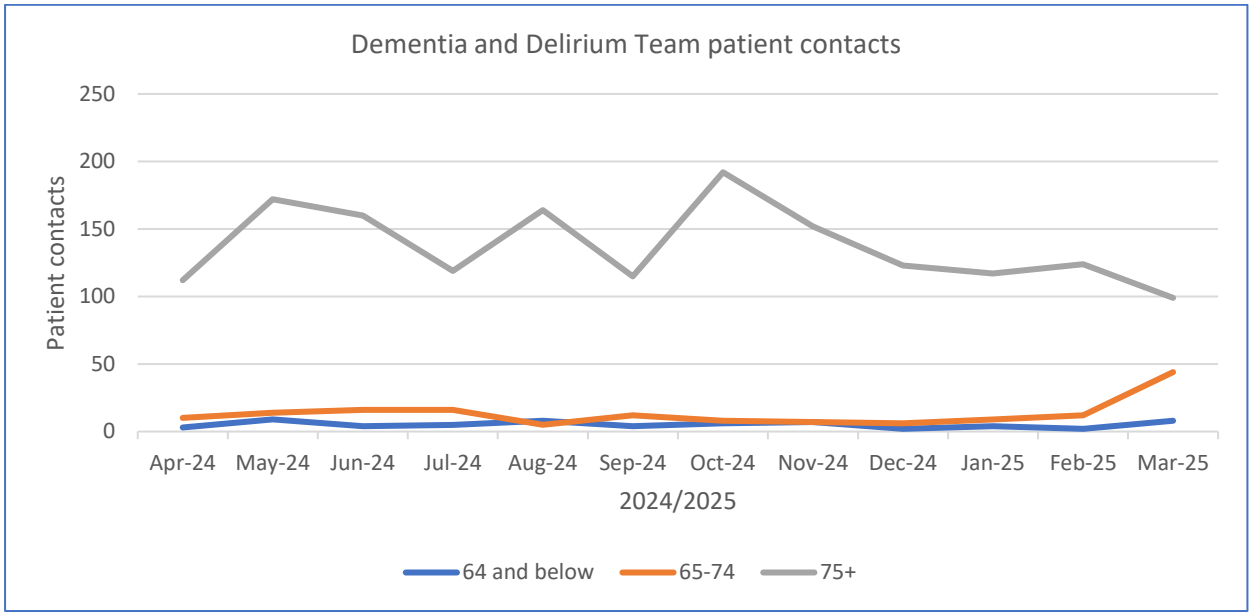
To consider the best means of recruitment and retention, the 0.6 WTE vacancy was changed to a Nursing Associate working 0.8 WTE. This supports the team with increased hours and offers more opportunities for recruitment.

The team expansion will support staff with:

- Promoting the effective application of dementia screening
- Supporting staff with the digital process of dementia screening
- Education for staff on their power to make a positive difference to a patient life by completing the screen

The Dementia and Delirium Team work across the entire acute hospital, including the Emergency Department (ED) and outpatients. It should be noted that not every contact is reported, as there will be other work that takes place with clinical staff concerning Mental Capacity Act/Deprivation of Liberty Safeguards (MCA/DoLS) support/guidance/applications and maintaining DoLS processes. Whilst some of these elements are due to transfer to the Safeguarding Team within quarter 1 2025/2026, the Dementia and Delirium Team will remain vital in continuing to advocate for patients' human rights and advocating for the use of the MCA and DoLS where required.

The below chart demonstrates the contacts that the team has made between April 20224 and March 2025 and the variety of age groups:



8.4 Training

It has been noted that there has been increased interest and attendance within quarter 3/4 for Dementia Awareness training. The compliance level across the Trust is 89.7%. This training has increased from 30 minutes to 1 hour as of December 2024 following the Learning Disability training being stepped down due to the introduction of the Oliver McGowan training. The training takes place twice per month on different days and times to encourage attendance.

The increased length of training is allowing for greater scope within the teaching session. The training before was a brief introduction to dementia, how this can present on the ward and focusing on patient centred care. The training is now providing an introduction in the AMT4 screening, including where to locate the tool, how to complete it, the benefits to patient care and the importance of clinical staff undertaking this.

Post-graduate training also takes place once per month where the Dementia and Delirium Team provides a 1-hour teaching session. Training is also offered directly to departments as required when they have audit days.

Both training sessions also include educational aspects on delirium including what this is, how this presents, the impact on patient care and patient outcome and the importance of identification and management.

8.5 World Delirium Awareness Day

The Dementia and Delirium Team supported promotion of World Delirium Awareness Day on 12.03.25. The aim was to promote conversation with clinical staff on the wards as well as staff and patients from the volunteer's desk. Several promotional items were collated to promote awareness, including the submission and publication of a Patient Safety Bulletin. Key themes discussed included:

- What is delirium?
- The symptoms
- Causes of delirium
- Consequences of delirium
- Treatments
- Trust guidance and support

A quiz was completed with staff and a prize for the winner. The event supported a litmus test of staff knowledge about delirium and most staff had an awareness of this, how it presents in clinical areas and the causes of delirium. There was limited knowledge about the 4AT screening tool. The event raised that clinical staff do understand delirium, its cause and presentation in patients. This raises the following queries:

- Labelling patients as having dementia when the presentation is likely to be delirium.
- Identifying patients to be having a psychotic episode when the presentation is likely to be delirium, particularly concerning when patients have no history of mental illness.

As a result, referrals are incorrectly being made to Mental Health Liaison Services to review a patient for an organic cause, creating further demand on an already limited team. It also delays the right diagnosis and treatment for the patient which creates:

- Increased risk of developing dementia
- Increased hospital stays / recovery
- Increased risk of hospital-acquired complications, such as falls and pressure ulcers, malnutrition, dehydration, continence issues
- Increased readmission rates
- Distress to patient and family
- Increased risk of requiring long-term care placement following hospital stay
- Increased mortality

To continue this conversation, the delirium patient story that was raised at a previous ISB meeting was discussed at the medicine and surgery divisional meetings. Following this, a Trust delirium poster is being created to display across the hospital to promote awareness and highlight the pathway to follow.

The Lead for Mental Health and Complex Vulnerabilities has also developed an audit as part of the Trust Core Service Review with the Compliance Team about delirium. This is a regular audit of clinical areas and will promote discussions and review of delirium identification and care to identify gaps in practice and promote best practice.

Contact has taken place with the Undergraduate centre to identify educational elements of support, and conversations are still in process. This element could become part of the Enhanced Therapeutic Observations and Care (ETOC) project within the Trust being led by Corporate Team Nurse for Improvement.

The team plan to support World Delirium Awareness Day as an annual event, but the matter needs to be an ongoing conversation to support quality improvement.

8.6 Cross Trust working

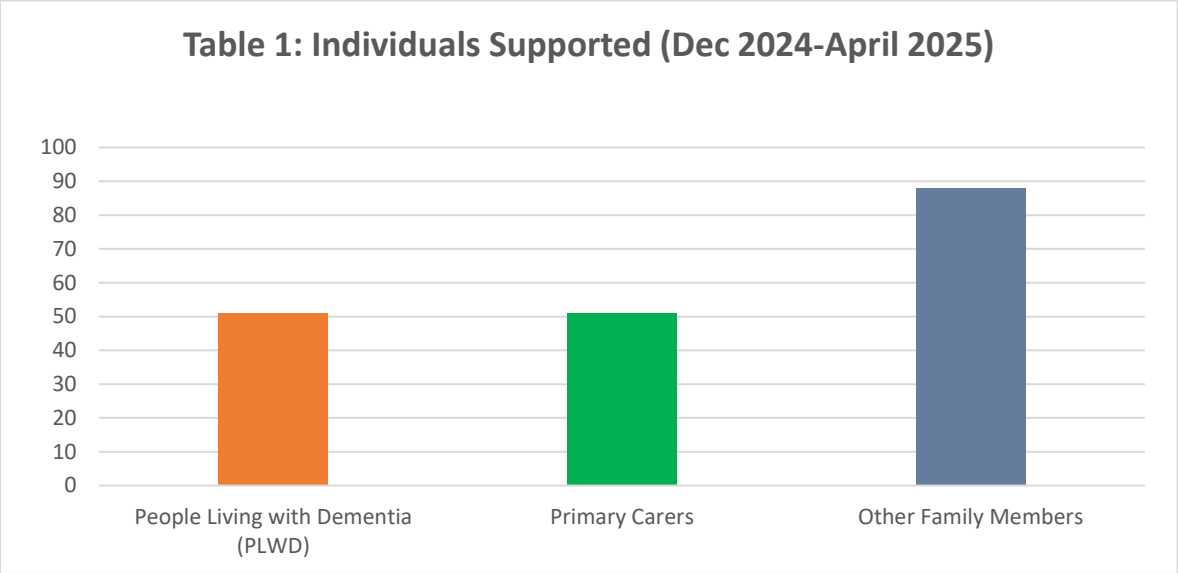
The Dementia and Delirium Team has begun to engage with other acute Trusts in the Black Country area: Sandwell and West Birmingham Midland Metropolitan Hospital, Walsall Healthcare Trust and University Hospitals Birmingham. The specialist dementia teams meet tri-monthly to share new ideas, ways of working and how to promote best practice in the hospitals.

9.0 Admiral Nurse Service

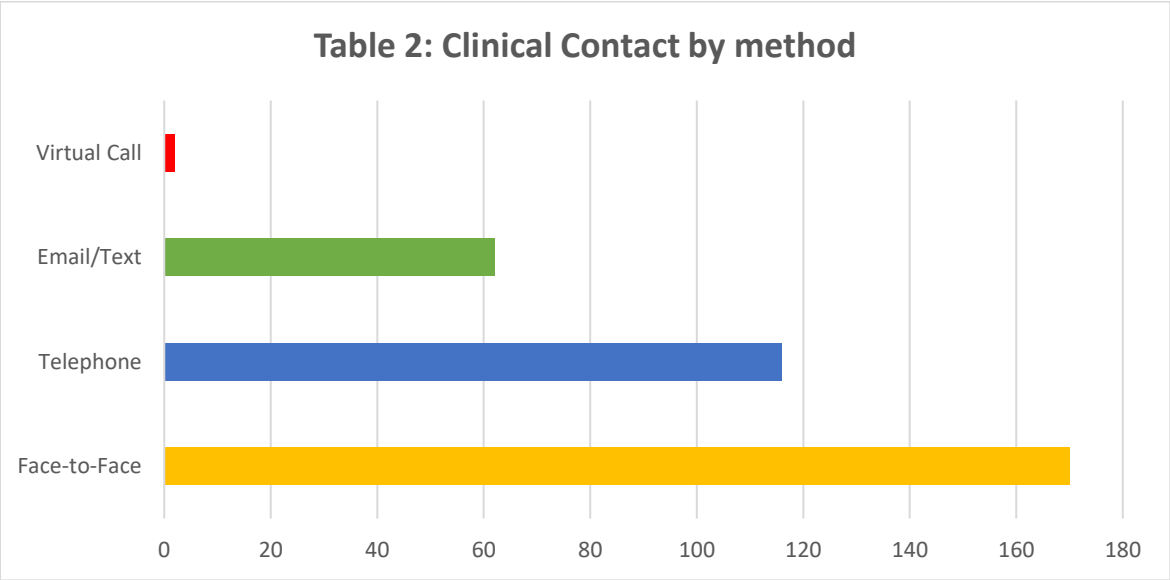
9.1 Patient and family service activity

Since its introduction in December 2024 in partnership with Dementia UK, the Admiral Nurse Service has become a vital component in the hospital's approach to supporting people living with dementia (PLWD) and their families. Initially launched across five inpatient wards—FMNU, C3, B2, B4, and C1—the service has focused on complex dementia presentations and carer support, delivering a person-centred, emotionally intelligent model of care within an acute setting.

Between December 2024 and April 2025, the service directly supported 190 individuals (Table 1). This included 51 people living with dementia, 51 primary carers, and 88 additional family members. Support was tailored and compassionate, ranging from face-to-face consultations to emotional reassurance, information sharing, and practical guidance during what are often deeply challenging admissions.



Over this same period, the Admiral Nurse completed 350 clinical contacts with families and carers (Table 2). The majority (170 contacts) were face-to-face, providing personalised support and active listening. The remaining contacts were conducted via telephone (116), email or text (62), and a small number through virtual calls (2), reflecting the service's flexibility in meeting people's needs in real time.

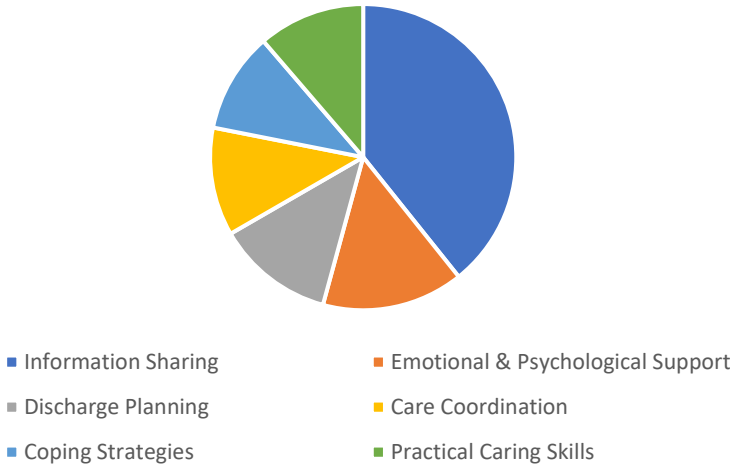


Alongside direct family work, the Admiral Nurse undertook 385 professional liaison activities. This included 250 face-to-face multidisciplinary discussions with healthcare professionals across the five

wards. These meetings enabled close partnership with nurses, doctors, dementia and delirium specialists, and discharge facilitators, ensuring collaborative care plans were created and followed through.

A total of 1,184 clinical interventions were delivered over the five-month period (Table 3). This included sharing information (278 interventions), offering emotional and psychological support (106), supporting discharge planning (88), coordinating care (81), helping carers develop coping strategies (75), and teaching practical caring skills (80). These interventions targeted key areas such as reducing carer distress, navigating care transitions, and understanding the trajectory of dementia.

Table 3: Clinical Interventions Delivered



In response to the need for continuity after hospital discharge, the Admiral Nurse introduced a structured three-day follow-up phone call. This innovation has proven impactful in identifying early concerns, offering reassurance, and in some cases preventing unnecessary readmission to hospital.

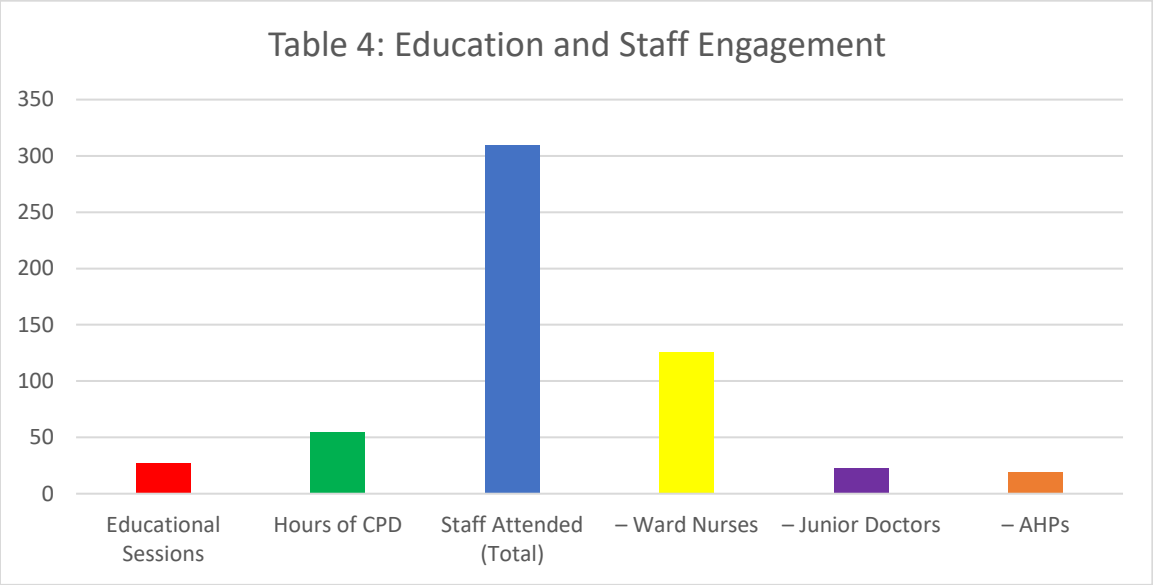
To ensure longer-term support, the service facilitated 81 onward referrals and 45 signposting actions. Referrals included onward contact with ward doctors (12), Russells Hall carer support service (12), and the palliative care team. Signposting was often directed toward community organisations and other Admiral Nurse services, ensuring wraparound, community-based care was accessible.

Feedback from families has been consistently strong, with many describing the Admiral Nurse as the first professional who truly listened and understood their circumstances. Themes of improved communication, reassurance during discharge, and feeling emotionally supported have been consistently highlighted in qualitative comments.

9.2 Staff education

The service has also contributed to improved dementia awareness across the Trust through 52 ‘best practice’ activities (Table 4). These included 27 educational sessions, providing 55 hours of professional development for 309 staff members. This delivery has focused primarily on ward nurses (126), junior

doctors (23), and allied health professionals (19). These sessions focused on dementia-sensitive communication, carer engagement, and person-centred planning.



To complement this, dementia care tools such as the "This is Me" booklet and "Take the Time" resource have been introduced and embedded within ward practice. Sensory resources, sourced through community partnerships, were also distributed to enhance the wellbeing and comfort of patients with dementia.

The Admiral Nurse also offered meaningful support to staff within the Trust who are carers themselves. Five members of staff accessed one-to-one sessions relating to their caregiving responsibilities, while a further eight engaged in supervision or resilience-focused support. This has helped embed a dementia-aware culture not only for patients, but also for staff navigating caring roles.

Patient story

MP, an 76-year-old patient, living with dementia (diagnosed in 2022), was admitted to RHH. MP was previously fully independent and mobile without aids. The patient lived with their spouse , DP, in an over-55s warden-assisted facility. Prior to admission, MP was not receiving any formal package of care.

The Admiral Nurse was referred to support the family with navigating difficult conversations, managing any potential distressed behaviours and de-escalation techniques, education and discharge planning. A review was held on the ward with DP and daughter YP, during which emotional and practical guidance was provided. DP, aged 78, was committed to caring for MP at home and had LPOA for health and finance alongside their son. Discussions covered future care

needs, strategies for managing distress, and the impact of caring long-term. MP's preferences and background were explored to ensure person-centred support.

Resources were provided including a "This is Me" booklet, "Take the Time" care sheet, and information on delirium, sundowning, and communication strategies. The family was also made aware of support from Dementia UK, Alzheimer's Society, and Royal British Legion services. Signposting offered to organise and arrange a face-to-face clinic appointment with an Admiral Nurse via the nationwide clinics collaboratively working with Dementia UK. A post-discharge follow-up call was arranged, and LPOA documentation was requested for hospital records. Behavioural triggers were noted and shared with ward staff to support consistent, informed care.

Following this support, the family expressed heartfelt thanks, stating that without the Admiral Nurse's involvement, MP's discharge would have been delayed. They praised the service as "amazing" and "a wonderful new service," and confirmed MP's return home was now in place with equipment, transport, and planned date for a package of care to commence. The patient experience leaflet was given to the family alongside the Dementia UK QR feedback code to capture the support received.

10.0 Mental Capacity Act 2005

The Mental Capacity Act (MCA) established in 2005 provides a statutory framework for decision-making on behalf of people who are unable to make decisions for themselves. It defines when and how decisions can be made on behalf of others. There is a duty on all health and social care practitioners to follow this framework when providing care and treatment for vulnerable people.

Poor compliance with the MCA is currently on the corporate risk register. The Trust are at risk of regulatory, civil, and criminal actions by failing to follow the safeguards and processes set out in the MCA. The lack of compliance with the MCA is currently on the corporate risk register as a medium risk. This risk has recently been changed from a 9 to a 12 following the death of a patient who self-neglected in hospital, and staff did not consider executive mental capacity issues or carry out any formal mental capacity assessment to support decision making around provision of care.

The MCA is central to good quality care and improvement, ensuring care is delivered in a person-centred approach and patients voices are heard. MCA is being embedded throughout the Trust through intense training packages, an array of practical support, governance, and assurance.

The Trust have an MCA Lead Nurse in post to support staff with this process and ensure any new caselaw adaptions to the way the law is interpreted is implemented within the Trust. This report details some of the work that has been undertaken this past year.

10.1 Training and Support

There is a wide range of MCA training, support and guidance available throughout the Trust. This includes:

- Advanced Mental Capacity Act training – 2 ½ hour training for senior staff which provides a theoretical and practical application of MCA in for complex mental capacity issues.
- Basic Mental Health Law training (incorporates MCA)– mandated for all staff.
- Ward visits to promote MCA and discuss common misconceptions and address knowledge gaps.
- Bite-size training for different aspects of MCA in each area.
- Mental capacity hub page with a range of useful resources, such as example assessments, best interest and Deprivation of Liberty Safeguards (DoLS) applications paperwork. Links to relevant caselaw, policies and documentation.
- Electronic ward DoLS folders.
- MCA Lead Nurse support when required with specific patient cases involving mental capacity issues.
- Patient Safety Bulletins in relation to specific areas of MCA.
- Targeted support for clinicians when poor practice has been identified.
- E-Consent programme with mandated mental capacity assessment and best interest documentation.

In addition to this, various other teams, who have an enhanced understanding of MCA, frequently promote the use of the MCA within their roles. This includes the Dementia and Delirium team, Learning Disabilities team, Lead for Mental Health, Safeguarding team, Admiral Nurse, Palliative care team, Nutritional Nurses and inpatient Professional Development Nurses.

Over the past year, the MCA Lead Nurse has been requested to support with more complex mental capacity issues. These include:

- Complex mental capacity assessments and best interest decision for decisions in relation to discharge and serious medical treatment, and the withdrawal of treatment.
- Working with safeguarding, ward staff and community teams to support patients who self-neglect.
- Understanding Lasting Power of Attorney status.
- Issues with fluctuating mental capacity for a variety of decisions.
- Understanding the interface between the MCA and Mental Health Act (MHA).
- Liaising with Independent Mental Capacity Advocate for advice regarding referrals.

There are 4 advanced mental capacity training sessions delivered each month, and extra sessions are organised for specific staff groups if requested. So far 1479 staff have attended this training since June 2022:

July 2022 – March 2023	220
April 2023 – March 2024	631
April 2024 – March 2025	628

This training is unique to Dudley Trust and consists of real-life scenarios to aid understanding and learning. It is delivered in a range of ways, days and times to ensure it is accessible to all staff.

Compliance for the basic Mental Health Law training is on average consistently over 80% (with exception of recently integrated staff from Dudley Integrated Health and Care NHS Trust).

	August 2024	Sept 2024	December 2024	Feb 2025	March 2025
Clinical Support	91%	92%	93%	94%	93%
Corporate/management	88%	83%	80%	81%	76%
Dudley Place	-	-	-	23%	25%
Medicine and Integrated Care	87%	86%	84%	85%	85%
Surgery	83%	84%	83%	82%	81%
Overall	86.5%	86.3%	85.3%	83.3%	82.4%

This training is delivered during the statutory and mandatory training days. Extra sessions are organised on request, and 5 Professional Development Nurses across the Trust have received extra training to allow them to deliver basic Mental Health Law education in their areas of work.

10.2 Governance and Assurance

To support staff and assure compliance with MCA, there are a range of policies, guidance and tools available. These include:

- MCA Policy
- Deprivation of Liberties Policy
- Best Interest Meeting template
- Advanced Care Planning Policy
- Independent Mental Capacity Advocate Policy
- MCA assessment recording tool available on Sunrise and the Hub
- MCA Best Interest decision-making recording tool on Sunrise and the Hub.
- Form 1 Deprivation of Liberties urgent authorisation/standard application available on the hub.
- DOLS ward request form (new document).
- E-Consent programme with mandatory MCA assessment and Best Interest recording tool.
- DOLS patient information leaflet (new document).
- Annual review of the NICE MCA benchmarking guidance.
- Annual MCA Audit

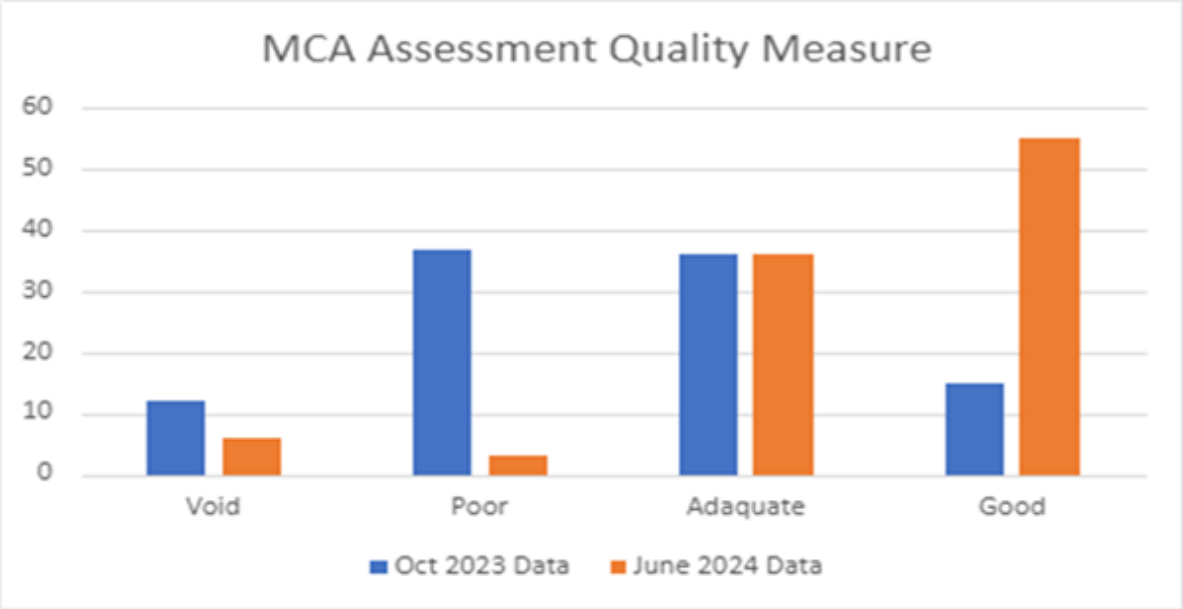
The Trust is also part of the Birmingham and Black Country Integrated Care Board MCA Forum and regional NHS England MCA steering committee. Information is fed to and from these groups to share good practice, embed consistency with our neighbouring Trusts, offer assurances to commissioning bodies and gain up to date information on case law and Government updates.

MCA Annual Audit

Key findings from the second Annual MCA audit completed in June 2024 include:

- A steady increase in the use of the MCA process and tools throughout the hospital. However, there is still a lack of use of the MCA for treatment and investigations.
- Best interest decisions are now routinely recorded following a mental capacity assessment. There is still a lot of work to do to ensure all staff are routinely assessing mental capacity when there is a reason to doubt patients cannot make their own decision.
- A few assessments and best interest recordings had been completed by the same staff member for each area indicating that the use of the MCA is sometimes dependent on that staff member being on shift.
- Areas that have benefited from extra support from external teams produce good quality mental capacity assessments and best interest decisions.

The quality of the audits carried out demonstrated an improvement in quality between audit carried out in June 2023 and June 2024:



This audit also demonstrated a direct link between training and support, and those staff who are completing mental capacity assessments:

There are limitations to this audit. It focuses on the mental capacity assessments carried out but there are still decisions being made for patients that have not had mental capacity assessments or best interest decisions recorded appropriately.

Overall, it does demonstrate an increased understanding and use of the MCA. However, there are still gaps in knowledge and culturally held misconceptions at all levels of staff that need to be addressed before this risk can be removed from the risk register.

10.3 Deprivation of Liberties

Deprivation of Liberties Safeguards (DoLS) are part of the MCA (2005). DoLS ensure people who cannot consent to their care and treatment arrangements in hospital are protected if those arrangements deprive them of their liberty.

There is a centralised DoLS system in place in Russell's Hall. This supports the process by:

- Recording all DoLS raised.
- Monitoring progression.
- Ensuring applications are sent to the correct Local Authority (LA).
- Prompts extension and standard requests to Local Authorities.
- Prompts clinical reviews.
- Informs Local Authorities if prioritised.
- Prompts Local Authority notifications when DoLS is no longer required.
- Records Care Quality Commission (CQC) notification.

This system has evolved over the past few years to ensure this legal process is correctly followed. Recent changes include:

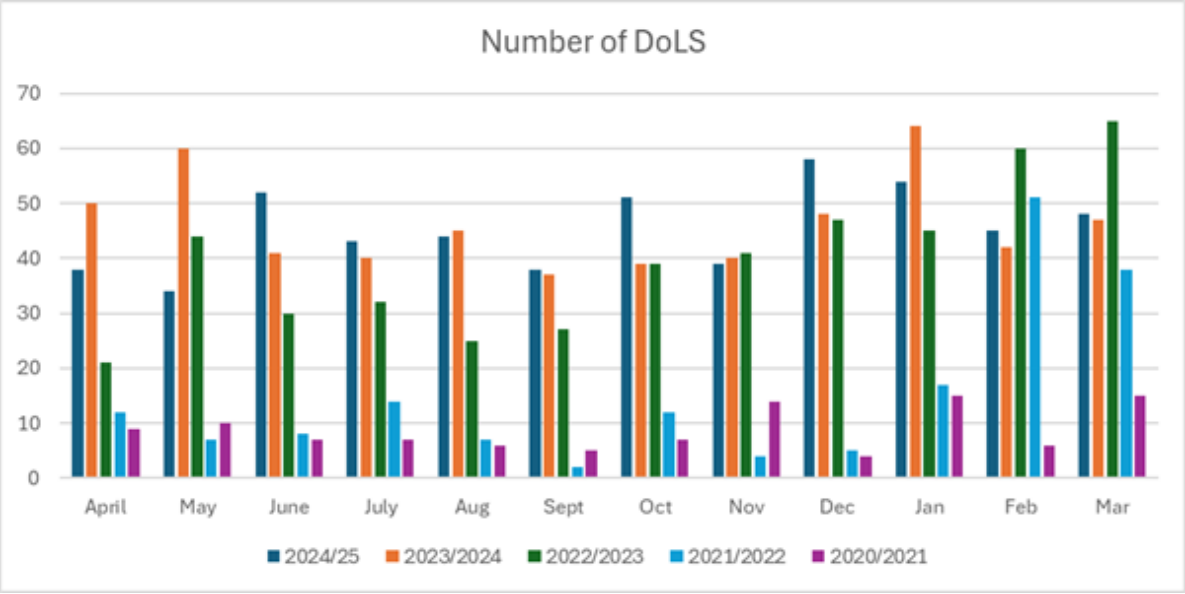
- Uploading of all DoLS to sunrise.
- Explanation notes uploaded to sunrise.
- Discussions with ward staff about restrictions in place, and less restrictive practice.
- Requesting a formal mental capacity assessment and best interest decision if one has not been formally completed.
- Ensuring the DoLS is regularly reviewed and recorded on spreadsheet.
- Local authority postcode checks to ensure the correct Local Authority receives the DoLS.

The responsibility of maintaining this spreadsheet has recently been taken over by the Safeguarding Administrator who has taken on the non-clinical aspects of the DoLS system. This has reduced some of the clinical staff workload and ensures there are no delays in the process.

The majority of the hospital DoLS applications are sent to Dudley Local Authority (LA). Dudley LA introduced a new electronic portal system in June 2024. This meant the DoLS form 1 is no longer emailed to them. This gave us the opportunity to create a new DoLS request form. This can be used instead of the form 1 for patients who are a potential deprivation of liberty, which reduces ward staff workload.

The number of DoLS applications has been consistent month to month. Wards receive a great deal of support to help them recognise when they are depriving someone of their liberty. The Dementia and Delirium team visit the wards every day and monitor a daily enhanced observation ward list. The Dementia and Delirium team along with the MCA Lead Nurse also support the centralised system for DoLS.

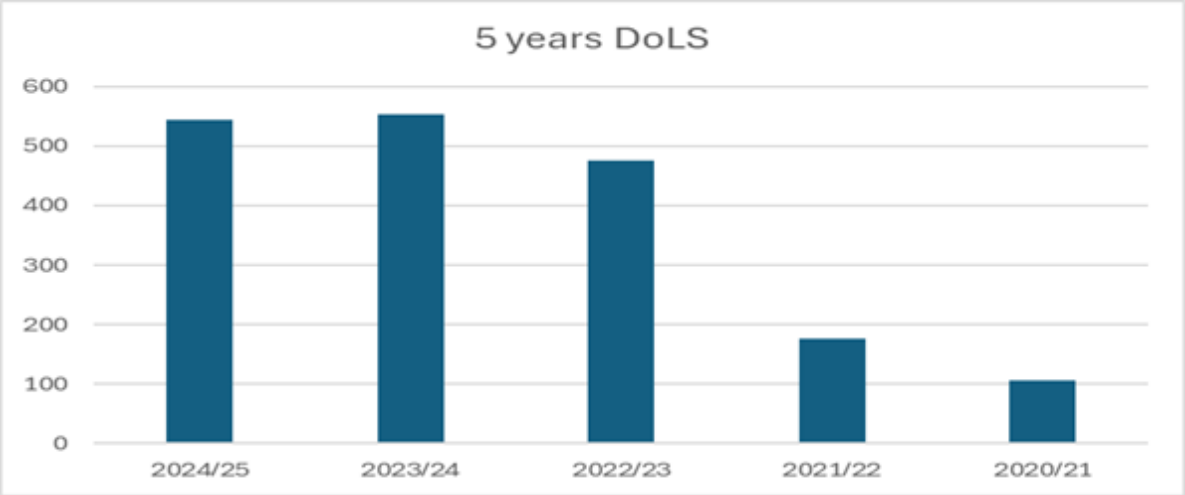
This chart shows the number of DOLS each month from 2020/21 to 2024/25:



The number of DoLS urgent authorisations and standard applications have been consistent over the last two years – 544 2024/25 and 553 2023/24. Prior to this the number increased year on year. Some staff still only raise a DoLS when prompted although the supporting team do not have the resources to scope

for more DoLS (or manage them). By this reasoning, it is likely there are patients not on DoLS who should be.

Number of DoLS over a 5-years period:



In the past year, only 5 standard authorisations have been received. This is not unusual for acute hospital Trusts. The Local Authority do not routinely prioritise hospital DoLS. To mitigate this risk, regular reviews of a patient waiting for a standard authorisation are completed by the hospital DoLS supporting team and prioritised to the LA accordingly.

A Dudley Trust patient DoLS information leaflet has been produced and is available on the Trust patient leaflet page. This leaflet supports staff to informs the patient, or family /friends if appropriate, what it means to be on a DoLS and what rights they have.

10.4 Liberty Protection Safeguards

In May 2019, amendments were made to the MCA through Parliament. This introduced Liberty Protection Safeguards (LPS), a new process for authorising deprivation of liberties. The LPS should eventually replace the current Deprivation of Liberties Safeguard (DoLS). Implementation of LPS was planned for April 2022 but was delayed due to the COVID pandemic.

Unfortunately, LPS has been further delayed. It is unknown when, or if, it will be implemented. The last Government briefing released in March 2023 states that LPS would not be implemented during the lifetime of the previous Parliament. There have been no further updates. In the meantime, the previous Government stated it would be prudent to continue raising awareness and confidence in the current MCA and processes. This includes assessments, best interests, and recognising an actual or potential deprivation of liberty.

Patient Story

MCA Empowering and protecting the patient.

AB was a 75 year old patient that was admitted to hospital following deterioration in health. AB. AB was admitted from a care home who would not take her back due to funding issues. AB owned their own house but had not been there for long periods of time due to health needs over the past few years. The house was not considered to be in a habitable state, and it was reported that AB had been self-neglecting for a long period of time. AB was often non-compliant for nursing care. AB was bed-bound, needed to be turned frequently and treated for skin sores and personal hygiene.

To assess or not?

A was a very charismatic characte0r who spoke eloquently and taken on face value, appeared to have the cognitive ability to make decisions about care, treatment and accommodation. At times, AB would often become very agitated and verbally abusive towards staff who tried to provide care. This proved a dilemma for staff: if a patient has capacity to make a decision **(principle 1 MCA, always assume a patient has capacity),** even if it is considered unwise **(principle 3 MCA**) and impacts negatively on health, they could not enforce treatment. On the other hand, even if AB was found to lack capacity in relation to treatment, this does not mean treatment can just then be enforced as **principle 4 and 5**, best interest and less restrictive practice need to be considered. The trauma on AB if treatment was given by force would have to be considered as this could result in a loss of trust with healthcare professionals and further hinder support. This was an issue, with or without a capacity assessment.

Owning care

It was decided to concentrate on **principle 2** of the MCA in the first instance, and support AB to make their own decisions in relation to their personal care, ensuring they had the right information to do so. The Ward Lead Nurse spent a lot of time with AB ensuring they had the right information to make informed choices and explored decision-making with them. While doing this, a person-centred care plan was developed in collaboration with AB. The Ward Lead Nurse supported AB to take ownership of this care plan and listened to how they wanted it done. The care plan detailed how staff should approach AB and offered explanations and direction to staff when caring for them.

A reason to doubt?

An assessment of capacity should only be carried out if there is a reason to doubt a patient can make that decision themselves. A reason to doubt should not be based solely on a patient's condition or unwise decision-making. A reason to doubt AB's ability to make the decision about his care and treatment was developed due to a seeming inability to recognise their care needs through on-going conversations, and past issues of self-neglect. A mental capacity assessment found AB lacked capacity for his care needs and by utilising the care plan developed with them, ensured staff could deliver care consistently and in the less restrictive way, with AB's views and wishes listened to throughout.

The Golden Thread

Throughout AB's journey at RHH, by following the principles of the MCA, their voice was heard, and staff (following the Ward Lead Nurse example) did all they could to uphold his human rights:

- Right to choose and make decisions (even if not considered wise!)
- His right to be heard
- His right not to be discriminated against due to his condition.

The principles of the MCA ensured we empowered AB and protected them when decisions had to be made for them. Each principle was considered in AB's care each step of the way, showing that the MCA process should not be seen as a one-off activity as each decision is needed, but as an on-going flexible process woven throughout the patient journey: the golden thread.

11.0 Learning Disabilities

A Learning Disability is a life-long, reduced intellectual ability and difficulty with everyday activities such as reading, cooking or communicating. People with a Learning Disability tend to take longer to learn and may need support to develop new skills, understand complicated information and interact with other people.

The Department of Health and Social Care defines a Learning Disability as 'a significantly reduced ability to understand new or complex information, to learn new skills (impaired intelligence), with a reduced ability to cope independently (impaired social functioning), which started before adulthood (Mencap, 2021).

A Learning Disability is different for everyone. The degree of disability can vary greatly, being classified as mild, moderate, severe or profound. In all cases, a Learning Disability is a lifelong condition.

A Learning Disability is different to a learning difficulty, which is a reduced intellectual ability for a specific form of learning and includes conditions such as Dyslexia (reading), Dyspraxia (affecting physical co-ordination) and Attention Deficit Hyperactivity Disorder (ADHD). A person with a Learning Disability may also have one or more learning difficulties.

Additionally, there are several conditions and neurological disorders that often involve, cause or co-exist alongside some type of Learning Disability, including Down's Syndrome, Autism, Meningitis, Epilepsy, or Cerebral Palsy.

11.1 Learning Disabilities Team

The Learning Disability Team support patients at all Trust sites, ensuring that reasonable adjustments are put in place to make their visit to hospital easier for them to manage. Referrals are made to the team by patients, their carers, schools, community teams and hospital staff. Reasonable adjustment assessments are carried out with all patients to establish their needs, and a "One Page Profile" is completed which is shared with the team who will be providing direct care to the patient. The Team support both inpatients and outpatients from preadmission to post discharge.

11.2 Vision of the Learning Disability Strategic Delivery Plan

The Learning Disability Strategic Delivery Plan represents the commitment of Dudley Group NHS Foundation Trust to improving the care and treatment of people with Learning Disabilities when accessing Trust services. It is designed to support all hospital staff in delivering high quality, person centred, and safe acute hospital services for people with Learning Disabilities.

The plan, revised in 2025, lays out our commitment to:

- Ensure that all patients with a diagnosed Learning Disability are in receipt of exceptional care, that their rights are upheld, and that the care is delivered in response to the individual need.
- We pledge to provide staff across the Trust with relevant training designed specifically to meet the needs of them and their teams. Giving staff the knowledge and skills to support people with Learning Disabilities in the best possible way.
- We will ensure that staff know our team and how to make contact when our specialist support is required to further enhance the patients care.
- We will build and improve partnerships across Dudley and the wider region to ensure that patients with a Learning Disability, their carers, families, and the staff that support them have access to specialist advice and support both within the hospital environment and on discharge.

11.3 Learning Disabilities and physical health

There are approximately 1.5 million people with a Learning Disability in England, this figure reflects the most up-to-date data from Mencap. The number of people with a Learning Disability recorded in health and welfare systems is much lower. Those known to Learning Disability services are likely to be people with a more significant Learning Disability.

The Trust has its own digital alert on Oasis and Sunrise to show that a person has a Learning Disability. This alert is added by the team when it is confirmed, using medical records, that the person has a diagnosis of Learning Disabilities. There are currently 1700 patients with a Learning Disability flagged within the Trust, 266 of which are children.

People with a Learning Disability have worse physical and mental health than people without a Learning Disability. On average, women with a learning disability die **23 years younger** than women in the general population. Men with a learning disability die on average **19 years younger** than men in the general population (LeDeR, 2023; ONS, 2022).

10.4 Learning Disability Mortality Review (LeDeR)

National Context

The Learning Disabilities Mortality Review programme (LeDeR) was established to support local areas across England to review the deaths of people with a Learning Disability, to draw out learning from those deaths and to put that learning into practice. People who have a diagnosis of Autism without a Learning Disability have been eligible for a review under the Learning Disability Mortality Review programme (LeDeR) since June 2021. In the 2022/23 LeDeR Report it was found that 42% of deaths of people with learning disabilities were avoidable and LeDeR reviews examine the causes of those deaths so that learning can be put into place to improve.

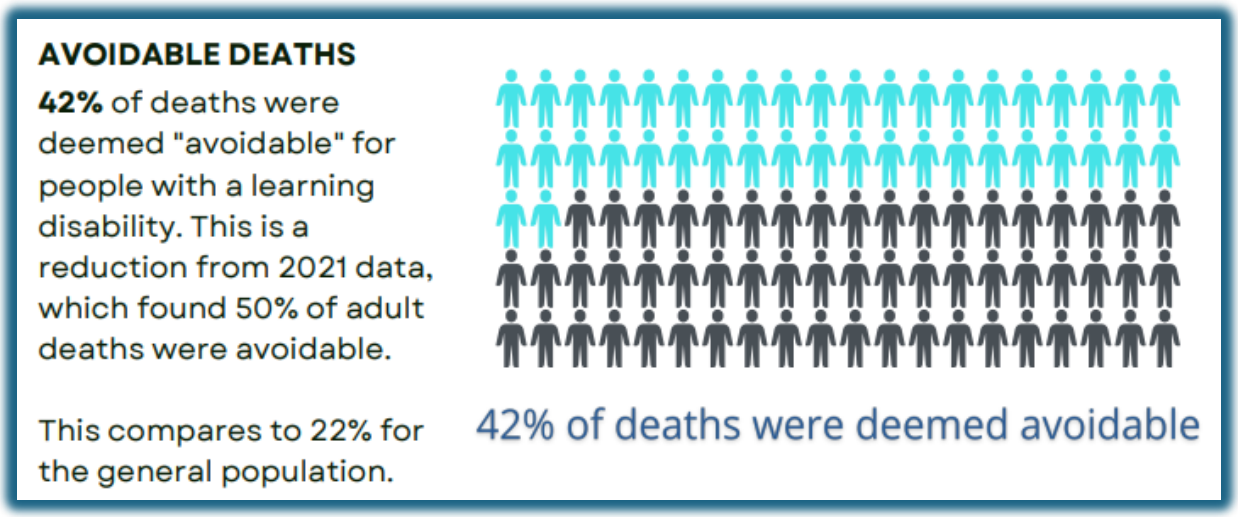


Figure 1 LeDeR 2022/23

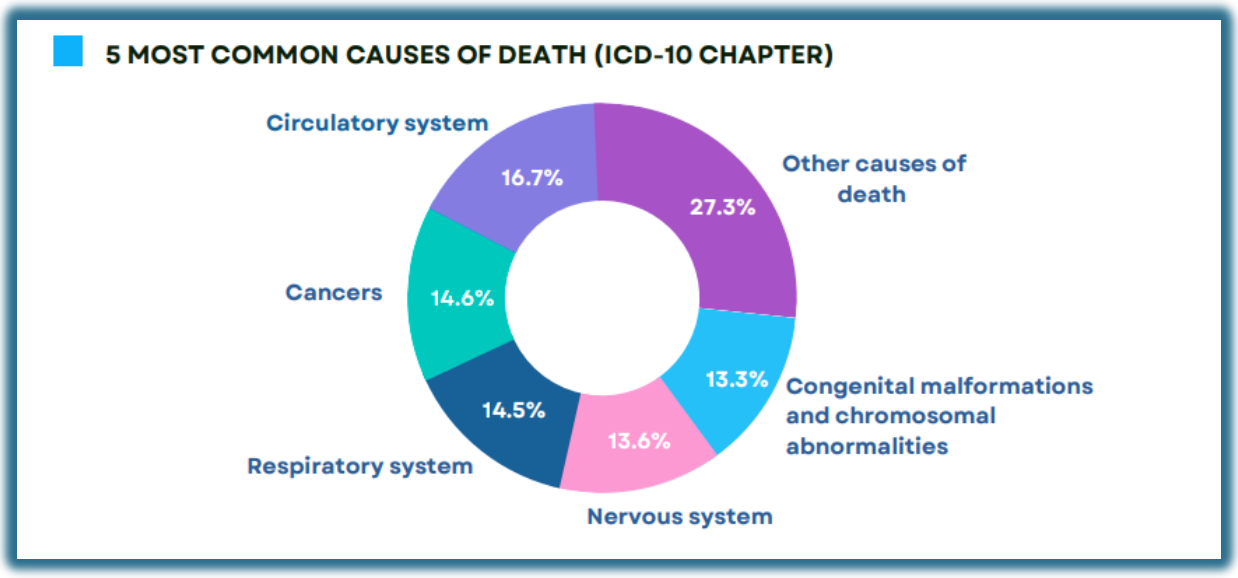


Figure 2 LeDeR 2022/23

ICB LeDeR Steering Group

LeDeR steering groups are part of the ICB quality governance structures. The role of the LeDeR Steering Group is to:

- View reports of completed reviews presented by the reviewers or Local Area Contact (anonymised)
- Support the identification and sharing of best practice in the review process.
- Monitor actions and outcomes.

- Respond to recommendations to improve service provision and reduce likelihood of premature deaths.
- Recognise and share best practice and innovation.
- Demonstrate the impact of changes.

The Lead Nurse attends this quarterly Steering Group to ensure that the Trust has oversight for any learning relevant to the Trust. On a local level there is a requirement from each provider organisation to identify actions from the reviews and demonstrate how learning is embedded into the organisation. The Steering Group holds a dashboard of thematic analysis to allow for assurance and accountability.

The Team recently attended the Black Country LeDeR Stakeholder Event where over 80 representatives from a range of local services met to discuss LeDeR and that the work that is being done to improve services for people with Learning Disabilities. The Trust's Learning Disability Team spoke about the the One Page Profiles used in Trust which provide vital information to staff about the reasonable adjustments that they can provide for patients and the Trust Learning Disability Trees which are used around the Trust to make staff aware that the patient has a learning disability.

The most recent LeDeR report is yet to be released, but early analysis shows that Aspiration Pneumonia is the biggest cause of death for our patients. The Learning Disability Team and Trust Mortality Co-ordinator have commenced work create an Aspiration Pneumonia Steering Group within Trust to examine ways to minimise the risk of this in our patient group and throughout the Trust as a whole.

Local LeDeR panel

The Lead Nurse is a member of the Dudley LeDeR Review Panel. This is usually a monthly panel which reviews the outcomes of the Dudley LeDeR reviews and monitors trends. The panel makes recommendations and shares learning across the local health economy. There are recommendations from each death which are monitored via an Action Plan developed by the LeDeR manager.

Outcomes are reported into the LeDeR steering group, any recommendations for the Trust are taken by the Lead Nurse and reported via Internal Safeguarding Board and the Mortality Surveillance Group.

During 2024/2025 findings from local LeDeR reviews have been;

Findings	**Actions**
Ward staff require learning disability training to compliment the Oliver McGowan training.	The Trust mandatory Learning Disability Awareness training has been replaced with Oliver McGowan Mandatory Training. The Learning Disability Team now contact individual wards and department to offer bespoke training. This has been delivered to several departments including; surgery, ophthalmology and pharmacy.
There was no end-of-life care considered or initiated when patient began to deteriorate	The Learning Disability Team and the Palliative Care Team have met and discussed ways in which we can ensure that referrals are made. The Team now recommends to ward teams when they feel that the patient would benefit from a referral. We also refer to community teams when the patient is discharged.

Discriminatory language used in DNARCPR documentation	The Learning Disability Team carried out an audit examining completion of DNACPRs. Subsequently, the team now provide training to Junior Doctors and have released a Patient Safety Bulletin to support this. The Team continues to monitor all LD patients DNACRPS and challenge where necessary.
Ward staff using unsafe methods to hoist transfer a patient	The Learning Disability Team have raised these concerns with The Professional Development Team who have now ceased using champions on the wards due to concerns that this was beyond their scope of capability. All manual handling training is now completed directly by the Professional Development Team.

LeDeR National Action from learning report 2022/23

In addition to the work completed work on local LeDeR reviews, work has been completed on recommendations from the National LeDeR Team: -

Reasonable Adjustment Flags

- The implementation of the Reasonable Adjustments Flag should be monitored, and research conducted to consider how it is used to guide adaptations to care, and whether this can be improved.

Under the Equality Act 2010, organisations have a legal duty to make changes in their approach or provision to ensure that services are as accessible to people with disabilities as they are for everybody else. These changes are called Reasonable Adjustments. The legal duty of Reasonable Adjustments means that adjustments should be made prior to a person presenting for care at any service.

The Reasonable Adjustment Flag was developed by NHS England in the NHS Spine to enable health and care workers to record, share and view details of Reasonable Adjustments across the NHS, wherever the person is treated. In compliance with this, the Trust Learning Disability Team add Reasonable Adjustment flags to the National Care Records System (NCRS) record of every patient with a diagnosis of Learning Disabilities who is an inpatient.

Individualised management plans

- How can we ensure that people with a Learning Disability who have multiple long-term conditions receive an individualised management plan and what mechanisms can be used to best co-ordinate care for people who are involved with different health professionals?

The Learning Disability Team carry out reasonable adjustments assessments with patients, their carers or family to establish what can be done to ensure that their needs are met. This information is then added to a One Page Profile which allows hospital staff to see what reasonable adjustments they can put into place to support the patient. One Page Profiles are used as paper document at bedside and added to patients Sunrise records to ensure that all relevant teams are able to access the information.

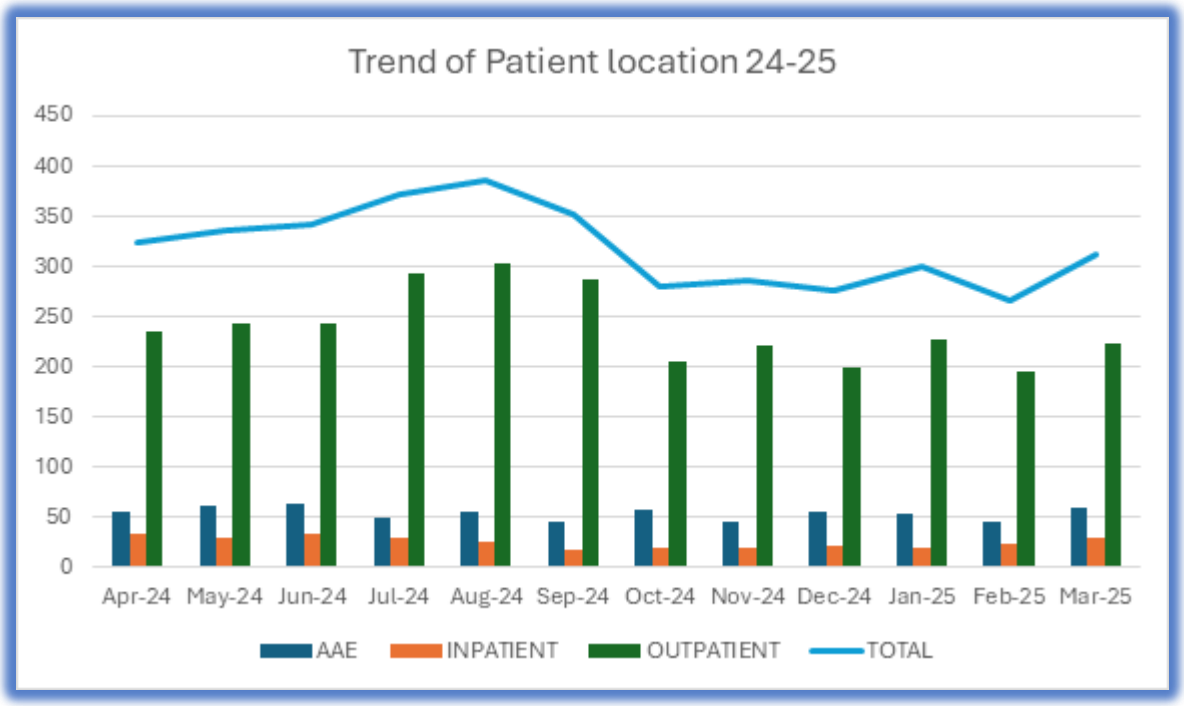
11.5 Activity and Performance 2023/24

The activity and performance of the Learning Disability Team is shown in the tables below, highlighting referral source and the location that the patient was in when they were supported by the team. The flagging system in Trust remains the highest referral source, this is linked to the PAS system in Trust for admission. Internal referrals are received from ward areas, imaging departments, consultants, consultant secretaries and outpatient booking teams. These can be made via Sunrise, by telephone or by email. The Learning Disability Team engage in complex admissions, outpatient appointments and emergency department attendances to ensure person centred care is given and reasonable adjustments are made to meet assessed need.

Source of referrals during 24/25

	AAE	INPATIENT	OUTPATIENT	TOTAL
Apr-24	56	33	235	324
May-24	62	30	244	336
Jun-24	64	34	244	342
Jul-24	49	29	293	371
Aug-24	56	26	303	385
Sep-24	46	18	288	352
Oct-24	57	19	205	281
Nov-24	45	20	221	286
Dec-24	56	22	199	277
Jan-25	53	20	227	300
Feb-25	46	24	196	266
Mar-25	60	30	223	313
Total	**650**	**305**	**2878**	**3833**

The referral rate has increased by 27.5% from 2023/24 records, with the most significant rise in referrals to the team from within the outpatients' departments – a rise of 851 referrals. The majority of outpatient referrals originate from the team routinely following up patients, this enables the team to establish whether they will be coming for another appointment.



The graph shows the location that patients are seen by the team, outpatient contacts are by far the most frequent as this includes all Trust sites and outpatient departments.

11.6 Good news and achievements

The Learning Disabilities Team were kindly given a large donation from friends and family of one of our patients who sadly passed away in 2023. Funds have also been secured from the Trust Charity. This has enabled purchasing of new DVD players, CD Players and headphones as well as exciting new 'Calm Bags'. The bags, bearing the teams 'tree' logo will be filled with items to suit the individual patient's needs. Some patients will enjoy using colouring pens and books, others may enjoy squishy toys or fidget spinners. We've already started to give the bags out and we've had some lovely feedback from our patients and carers.

Figures 3&4 Our 'Calm Bags'

11.7 Oliver McGowan Training

From the 1st July 2022 there is a statutory requirement under the Health and Care Act 2022 for the Trust to ensure all staff receive learning disability and autism training appropriate to their role.

The Oliver McGowan Mandatory Training is the standardised training that was developed for this purpose and is the government's preferred and recommended training for health and social care staff.

All staff must complete the e-learning awareness package and an additional training session (either Tier 1 or Tier 2) dependent on their role.

The E-Learning training currently sits within the Trust Priority 4 training requirement. The training compliance for the e-learning was 73% at the end of Q4. There is an agreement with the Head of Learning and Development for this to be moved from Priority 4 to Priority 1 when compliance reaches 80%.

Tier 1 training has not yet been introduced onto staff's individual SMT training requirements due to extremely limited availability of training places, meaning reaching compliance targets would be extremely challenging. Despite this, approximately 300 staff are reported by the ICB to have already completed Tier 1 training. The link for staff to complete the training is on the Learning and Development Hub pages.

Additional training has become available, and these dates are shared via the Learning and Development Hub Page.

Patient Story

Patient QT was first referred to the LD team for support to facilitate an appointment with a paediatrician. The team liaised with relevant professionals in the community and established that the patient had a significant learning disability with an impairment of behaviour. There were several concerns highlighted.

The patient had unfortunately had some previously unsuccessful visits to another hospital and had found it difficult to enter the hospital and not able to tolerate any form of examination. Entering the hospital was a significant difficulty for them and resulted in stress, anxiety and displays of physical aggression as a coping mechanism.

The team completed reasonable adjustment assessments and attempted for QT to be seen by a paediatrician in a relaxing space in the Trust. By completing the reasonable adjustment assessment, the team were able to consider the risks and remove any objects which could pose a risk to the patient or others. On arrival at the department however, the patient would not leave the family car, therefore the paediatric assessment was carried out in the car.

Not long after the consultation, the patient was admitted to the ward. QT had required a significant amount of medication to be administered to enable tests to be completed on the ward. The Learning Disability team offered support on the ward and attended MDT meetings with the ward and wider community colleagues to try to plan for his treatment.

Plans were made for the patient to return to the hospital for further investigations under a general anaesthetic. The Learning Disability team worked with the MDT to plan the admission. Information about QT's needs were forwarded to relevant departments.

The MDT was held with the patient's parents and other internal and external professionals. The MDT focused holistically on QT's needs with an emphasis on trying to ensure they received the necessary treatment, with the least trauma.

To cause the least anxiety QT was provided with sedation whilst remaining in the car, ensuring all appropriate professionals and equipment were available to support this. Once settled QT was then transferred into the hospital, with their parents, and the procedure was completed.

The patient's family were very grateful for the support that they had received, and the patient recovered well and was discharged.

The LD team received a message of thanks from the anaesthetic team as well as a Greatix for the work that had been done. The LD team reciprocated a Greatix to the anesthetic team for their support and commitment to the plan.

Learning

- Establishing information prior to admission is crucial in being able to identify barriers to achieving good health care and plan for overcoming these.
- Successful planning can achieve great outcomes for patients and reduce stress for patients and their relatives/carers.
- Reasonable adjustments and a wider team who are committed to applying these enabled a successful outcome for this patient and his family.

11.8 The Learning Disability improvement standards for NHS Trusts – NHS Improvements 2025/26

National Context

Registrations for the seventh year of The Learning Disability improvement standards for NHS Trusts has been completed for the Trust. The Learning Disability Improvement Standards are a central part of the NHS Long Term Plan, with providers expected to deliver services in line with the guiding principles outlined in the Improvement Standards.

Local Context

In late 2024 a Learning Disabilities Steering Group was established to identify priorities for the Team. The priority of the Steering Group is to present a position report to map the gaps in Trust compliance with the standards to the Internal Safeguarding Board. The second meeting will be taking place in May.

12.0 Restrictive Interventions

Restrictive intervention are clinical interventions that restrict or limit what a patient can do or where they can go in order to protect themselves and/or others from harm. These can include physical, mechanical, chemical, environmental, cultural and psychological restraint.

All forms of restrictive interventions must be reported via the Trust internal reporting system to ensure that the incident is evaluated for effectiveness and to identify if alternatives to the restrictions could have been utilised. The Complex Vulnerabilities staff raise awareness of this during their walkabouts and via attendance at divisional governance meetings and will continue to support this intervention.

The Trust Restrictive Intervention Group (RIG) continues to meet as per the previous annual report. The purpose of the Group is to ensure that the Trust operates safe and effective systems and practices for the monitoring of restrictive practices. This is guided by the latest legislative and best practice guidance. The

Group reports into the Trust Internal Safeguarding Board. The RIG does struggle with attendance due to competing demands for clinical staff, but the core staff from the complex vulnerabilities and Patient Safety Lead have continued the work streams.

12.1 Mitie Security body worn camera audit

Following a request from the former Chief Nurse to review the interventions of the Mitie security staff when they are applying physical restrictive interventions to patients, a formal process has been established. Mitie security, as per their policy for using body worn cameras, activate these to:

- Assist with violence and aggression related incident management.
- De-escalate violence and aggression related incidents.
- Provide a record of restrictive interventions utilised during a violence and aggression related incident on Trust premises, that would support any future incident investigation.

The audit of security body worn camera images standard operating procedure was created to support a formal review of such episodes, with the process becoming live as of 17.10.24. The Lead for Mental Health and Complex Vulnerabilities completed the physical restrictive intervention programme that Mitie security complete, Maybo, to support with the audit process. The footage reviewed is for incidents where there has been a high-level intervention, viewing 50% of the incidents. The mean number of incidents per month is 7. The audits have taken place each month since October 2024. It has highlighted positive practice carried out by Mitie Security Staff who demonstrate kindness and respect to patients, practice restraint within the Maybo guidance and ensure restraint is appropriate and least restrictive. There is some improvement in practice required by Trust staff, including the need to ensure they lead and coordinate the situation, ensure they are not involved in the actual physical restraint of patients for which they are not trained to do, understand their role in de-escalating events.

This work is feeding into a current work stream outside of the RIG group in terms of how to support staff to access appropriate training concerning violence and aggression to meet their role.

12.2 Mitie security Restraint Assessment Record

Mitie Security raised concerns that they are not always made aware of the legal framework under which they are expected to carry out restraint. Ultimately, applying physical holds to anybody without their consent is assault, unless there is legal framework for this to take place without the person's consent. Mitie introduced the Mitie Security Restraint Assessment Record or RAR form within other hospital settings to detail the legal framework in place to support each incident of physical restrictive intervention. It was agreed through RIG and Internal Safeguarding Board that these forms would also be introduced to the Trust. The RAR form is now well established with a copy of the form filed in the patient notes. This supports transparency and a record of the legal framework for each intervention within the patient record, but more importantly, promotes conversations with clinical staff to consider what action they are taking, why, and how they are justifying this legally.

The Datix system is being developed to allow Mitie security to input into a specific restrictive intervention section within the incident report. This will detail the physical restrictive intervention that took place, detailing which holds were used on which body part. As Mitie security are the staff trained in this area,

they are best placed to provide this report. This is currently in development and due to go live in Quarter 1 of 2025/26.

12.3 Incident reporting

There continues to be concerns that staff are not reporting incidents of restrictive intervention via Datix. This has been a major workstream of the Restrictive Intervention Group with a suite of actions being undertaken to improve this. This remains a risk to the Trust and is on the Safeguarding Risk Register. The Trust needs to evidence all restrictive intervention episodes to ensure adequate reporting, review and monitoring and support transparency about patient care. Part of this strategy is to improve staff awareness of what restrictive interventions are. To support this, a Restrictive Intervention Roadshow took place on 3.12.24 to promote education to clinical staff about this topic. The approaches included:

- A stand in the hospital foyer with staff with relevant restrictive intervention posters and examples of restrictive intervention measures that are commonplace in the hospital
- There was an online quiz about restrictive interventions that staff were supported to complete, again promoting conversation. This had a prize for the winner.
- Staff walked around the wards with the quiz, posters and pens and sweets to encourage communication.
- A patient safety bulletin was launched in 2 parts: what are restrictive interventions and what is chemical restraint.

The event was successful and will be repeated annually. This is however just a small part of the ongoing conversations and education that staff require. This element is supported daily by the complex vulnerabilities staff who engage with clinical staff about this topic.

The recognition of restrictive intervention and reporting this appropriately via Datix is an area under review daily. Each Datix that indicates some form of restrictive intervention is reviewed by the Lead for Mental Health and Complex Vulnerabilities daily and feedback given to the staff member and senior leadership team. Due to the competing demands for the Lead for Mental Health and Complex Vulnerabilities, there is no capacity to follow this up and therefore a system is being developed to allow an “at a glance” review of the reports to allow follow-up. Anecdotally, there appears to be more forms with the restrictive intervention section completed than without. However, a formal audit is required to review further.

12.4 Correlating incident reports with the Mitie security Restraint Assessment Record

To further drive the completion of incident reports on the Trust system, Datix, Mitie security have provided access to their online cloud where the RAR forms are uploaded and saved. This enables cross checking and prompts to be sent to wards and departments for them to submit the Datix in retrospect. There have been some positive responses from staff to complete these. The monitoring of the number of incidents reported and the quality of these will continue to be monitored and reviewed in RIG. It is anticipated that over the next 12 months we will be able to demonstrate improvements in the governance of these incidents.

12.5 Chemical restraint

Chemical restraint is not always an unplanned event, as some patients are prescribed sedation to be used on an “as required basis.” Anecdotal information from the walkabouts made by the Dementia and Delirium teams has highlighted that it is not aways clear why PRN sedation has been prescribed or that it

has been administered only after other least restrictive options have been tried. The lack of governance, scrutiny and monitoring around the use of PRN sedation is a risk on the Trust Safeguarding Risk Register.

The Restrictive Intervention Group has also continued its review of chemical restraint, in terms of what medication is used in various clinical areas. The review has commenced with a review of STAT doses of medication which identified the following key themes:

- High use for patients with a background of dementia/frailty/delirium.
- Capacity not formally reviewed when a reason to doubt capacity
- STAT medication is being prescribed and given, but it is not documented what this treatment is for.
- Incidents of using chemical restraint are not reported via Datix. This prevents the Trust from having transparency of its actions with patient care.
- Alternatives are not considered or evidenced before medication is prescribed.

A further review is planned for PRN medication in key ward areas to identify the themes. This will help inform the process to consider the use of and recording of chemical restraint within the Trust.

12.6 Training

Conflict resolution training is via an e-learning package and is Trust wide and has a compliance of 96.6%.

De-escalation and breakaway training was provided within Trust as a non-mandated event and was originally aimed at supporting staff working on FMNU to care for confused patients but was subsequently offered out Trust wide. Following a full review of this programme, a report was submitted to the ISB identifying the following challenges with the training: -

- Poor attendance with the training (2023: 21 staff, 2024: 14 staff).
- Difficulty with trainers being released from their clinical work to deliver the training.
- Training being cancelled at the last minute due to non-availability of trainers due to a variety of factors.
- Focused on breakaway techniques which staff never utilised and therefore presented a greater risk to staff during times of violence and aggression.
- Limited content on de-escalation techniques which is the best way to reduce violence and aggression
- Training should have taken place annually for trained staff, which was not achieved.

There are Trust wide conversations in place to review the training options for staff concerning the safe management of violence and aggression, with a focus on:

- Recognition of the early signs of agitation, irritation, anger, and aggression.
- Understand the causes of aggression or violence, both generally and for each service user.
- Use techniques for distraction and calming, and ways to encourage relaxation.
- Recognise the importance of personal space.
- Respond to a service user's anger in an appropriate, measured and reasonable way and avoid provocation.

Whilst the Lead for Mental Health and Complex Vulnerabilities has outlined the gaps and needs within reports for the Trust, the decision sits outside the scope of the Complex Vulnerability service and key stakeholder are being identified to take this work forward.

13.0 Achievements

• Provision of a Mental Health Act Administration service to improve scrutiny and quality of MHA service provision.
• A contract to provide a Responsible Clinician with Black Country Healthcare for patients that are detained to the Trust.
• Provision of Mental Health Act Awareness and section 5(2) training to clinical staff.
• Responding to CQC concerns following the MHA visit and implementing the requirements needed.
• Cross system work as part of Right Care, Right Person, supporting the implementation of a new process to release police from mental health focused interventions.
• Reviewing and resolving the dementia screening compliance issues to demonstrate to the Board that the required standards are being met.
• Commitment to developing the Dementia and Delirium Team.
• Commitment to improving the quality of dementia and delirium training, offering flexibility with its provision.
• Promoting awareness of delirium every day and through World Delirium Awareness Day.

• Embedding the audit of Mitie security body worm camera footage to provide transparency of physical restrictive intervention that take place in the Trust.
• Embedding the process of Restraint Assessment Records to promote communication and understanding of legal frameworks before physical restrictive interventions are applied.
• Supporting the Trust agenda to promote improved reports of incidents of Restrictive Interventions, including through a Restrictive Intervention Roadshow.
• The Lead Nurse for Mental Health and Complex Vulnerabilities and the Admiral Nurse being nominated for Committed to Excellence Awards.
• The Complex Vulnerabilities and Safeguarding team being nominated for the Committed to Excellence Awards.
• Developing a new Admiral Nurse service within the Trust.
• Commencing a soft role out in the acute Trust of the Admiral Nurse, making it live for PLWD and their families.
• Creating a data set for Admiral Nurse activity to measure service development.
• The Admiral Service providing specialist dementia education for acute hospital staff, delivered on the wards.
• The Admiral Nurse Service receiving positive feedback from multiple families supported from the service, demonstrating the impact of the service in a short time frame.
• The MCA Lead Nurse has been requested to support with more complex mental capacity issues, demonstrating increased staff awareness supporting this need.
• Consistent advanced MCA training from last year.
• MCA audit demonstrates improved implementation of MCA processes within the Trust.

• Robust Trust reporting and recording process of DoLS by the hospital team that manages this process.
• Consistent DoLS applications on in 2024/2025 compared to 2023/20224.
• Development of the Learning Disability Strategic Delivery Plan
• Embedding Reasonable Adjustment flags being added to patients with a Learning Disability as per LeDeR national guidance.
• The continued provision of personalised care for patients with a Learning Disability with a "One page profile" to enhance patient care.
• The increased referral rates to the Learning Disability team service, demonstrating the need for the specialist service.
• The funding and provision of the new 'Calm Bags' for patients with Learning Disabilities.

14.0 Conclusion

There remains ongoing focus to improve the quality and standard of patient care for patients with dementia and delirium. This includes supporting staff to recognise the importance of screening for dementia and delirium and the impact that this can have a patient's quality of life following discharge. Supporting staff to meet the complex needs of this patient group outside of the medical model to provide holistic care through care planning and role modelling can potentially reduce length of stay. Supporting safe discharges for patients with dementia and delirium is key for reducing readmission rates and failed discharges.

The development of new processes concerning the use of the MHA within the Trust has created new gaps in process. The systems need to be embedded to improve adherence to the processes and transparency for reporting. The new contract with WHT for the MHAA allows ongoing analysis of data, themes to review and improving quality of the service and implementation of the MHA. A key focus is for staff to engage in the training that is provided for MHA awareness which will inform these processes. Monitoring the increasing demand of mental health activity within ED and supporting the Trust in responding to this issue is a key focus. This includes reviewing the impact of RCRP and if this reduces demand.

Restrictive Intervention work needs to continue with ongoing focus on improving Trust reporting of restrictive interventions, and for this to happen, divisional leadership teams need to be engaged and support this agenda alongside continued work towards improving staff awareness and recognition of restrictive interventions. Chemical restraint is an area that has had limited review due to needing to ascertain the level of this use and in what scenarios to formulate an agreed plan on how the Trust reports

this. The ongoing audit of Mitie security body worn body camera footage and restraint assessment records will continue to highlight gaps in practice to inform the Trust on how to meet these needs regarding training provision. This work will continue to be led by the Restrictive Intervention Group.

The Learning Disability team have continued to strive towards providing a service which addresses and meets the needs of people with a learning disability when they access hospital services. The team remain committed to continue to embed changes in Trust and continue with the progress noted in the report. The service continues to drive referrals to the service to ensure that service users achieve the support that they require and provide individualised care through a national recommendations and local strategies.

The advanced Mental Capacity Act training continues to have positive outcomes and feedback with consistent training levels in comparison to 2023/2024. There has also been more awareness in the Trust of the need to address and support complex mental capacity issues, seeking guidance from the MCA Lead. This is demonstrated by MCA audits where there is improved recording of the MCA process and the Trust systems. This evidences the ongoing work to educate and support staff in this area. The focus for 2025/2026 will be to continue to improve and consolidate this practice.

The Admiral Nurse service began its roll out in the acute Trust from December 2024. The impact of this service in a short time frame has been significant, offering high level support during inpatient care and discharge for PWLD and their families with high complexity. The support that the service can also offer the clinical staff is also significant in improving quality of specialist care. The service will continue to develop, and its impact will be reviewed in line with Dementia Uk.

The Complex Vulnerabilities Service will ensure that the Trust has appropriate support for the most vulnerable patient group, and the Trust are committed to supporting our colleagues to be part of a culture change which sees compassionate and equitable care at its core.

15.0 Key objectives for 2025/26

Key objectives for 2024-2025

Areas for focus and improvements	**How?**
Strengthen governance of Mental Health Act use	• *Highlight the MHA awareness and section 5(2) training to the Trust to improve reporting of MHA activity in line with required processes* • *Embed the new MHA processes to support streamlined and timely reporting of MHA activity* • *Review the MHA escalation process and highlight unforeseen gaps in process* • *Develop a robust means of recording the escalation process* • *Develop an MHA database within Sunrise for a live view of MHA activity, embedded within patient notes*

	• *Review and develop Mental Health strategy.* • *Monitor RCRP 136 impact on ED*
Workforce development	• *Bitesize training on Dementia Care* • *Provision of Dementia Friends training in line with the Alzheimer's Society* • *Compliance with Oliver McGowan Training* • *Implementation of TNA for MCA Advanced training to support review of gaps and focus training.* • *Compliance with Advanced MCA Training.* • *Continue to embed the MCA process and robust application of.* • *Review staff training options concerning conflict resolution and de-escalation training*
Strengthen governance around Restrictive Interventions	• *Annual Restrictive Intervention roadshow to highlight the presence of this within the Trust* • *Daily walkarounds by the Dementia and Delirium team and the MCA Lead to highlight observed restrictive interventions in relation to DoLs.* • *Continued monthly audit of security body-worn camera footage for high level physical restraint to highlight areas of concern and good practice by Mitie security and clinical staff* • *Continue weekly review of Restraint Assessment Record against Datix reporting* • *Completion of PRN sedation audit with outcomes to inform practice.* • *The Restrictive Intervention Group to continue to meet monthly to review key themes from audits and guide on work streams*.
Learning Disabilities Service Improvement	• *Embed the Learning Disability steering group with divisional representation to review Learning disability Standards within the Trust and addressing gaps.* • *To raise awareness in the Trust of the importance to add a Learning Disability flag added to applicable patient records.* • *To take part in ward rounds so information about the needs of our patients are shared with the MDT to improve patient care.* • *To develop an Aspiration Pneumonia pathway in response to LeDeR findings around common causes of death for people with Learning Disabilities* • *Continue to strive to provide a supportive and reliable service to meet the needs of people with Learning Disabilities*

Dementia Service Improvements	• *Review and update Trust Dementia Strategy* • *The Dementia and Delirium team to link with the Dudley Health and Care Partnership dementia steering group to inform service development: dementia diagnosis Is a partnership KPI.* • *Continued work with the Trust Older People Governance meeting to support dementia service development with key stakeholders* • *Review and update the Trust dementia pathway and embed within Sunrise to improve engagement with staff* • *The Dementia and Delirium Team to provide holistic support for key patients and guidance for associated staff to improve patient quality of care.* • *To implement a new dementia screening tool within Sunrise to improve screening quality.* • *Support World Delirium Awareness Day.*
Admiral Nurse Service Improvements	• Continued rollout of the service to the acute inpatient service • Review service impact through audit of patients that have been readmitted with support through a patient flagging system. • Lead on Dementia Action week • Launch a regular support offer for staff carers • Begin scoping a Transition Admiral Nurse model to bridge inpatient support with community follow-up. • Embed the Standard Operating Procedure for the service. • Launch a structured carer support offer for staff • Improve service feedback and evaluation, using QR codes, case stories, and collaboration with Dementia UK for quarterly reporting. • Staff resilience education and awareness. • Dementia bite-size training

ACCESSIBILITY COMPLIANT

The Dudley Group NHS Foundation Trust

Patient Experience Annual Report 2024/2025 for Public Trust Board of Directors 10th July 2025.

Report title:	Patient Experience Annual Report 2024/2025
Sponsoring executive:	Martina Morris, Chief Nurse
Report author:	Jill Faulkner, Associate Director of Patient Experience Tracy Cross, Patient Experience and Engagement Lead

1. Summary of key issues

This annual report reflects the significant focus given to improving the experiences of our patients, their families, and carers. All Trust teams are committed to complying with this active engagement to ensure 'our patient views' are kept at the heart of what we do. It has been a great year for the Patient Experience Team and a number of positive outcomes have been reported that have enhanced the patient experience.

Summary of key issues:

Quality Priorities 2024/2025

The Patient Experience Team actively carried out real-time survey with patients on the ward to identify areas where improvements can be made to enhance patient experience and overall quality of care.

Gathering feedback

We worked with teams and departments to develop ways encourage feedback to ensure we meet the needs and expectations of our patients, their families:

- Friends and Family Test (FFT)
- Real-time surveys (face-to-face surveys)
- Local surveys
- Patient Reported Experience Measures Survey (PREMS)
- NHS Choices and Patient Opinion online reviews
- National surveys including the national inpatient survey
- Listening events, patient panels and focus groups
- Feedback Friday
- Compliments
- Talk to Us Trolley

These methods highlight more than **77,476** opportunities for us to listen to our patients' views in 2024/2025.

Friends and Family Test (FFT)

The Trust received a total of **56,518** responses from FFT during 2024/2025 The patient experience team has ensured that every part of our community is able to provide feedback about their experience of care received from the Trust.

Patient Reported Experience Measures Survey (PREMS)

A total of **12,175** patients/carers responded to the PREMS survey in 2024/25. The findings were very positive with respondents receiving a good experience in terms of being treated with dignity and respect, for feeling that staff were understanding of their individual needs and that the environment in which they received their care was comfortable.

Real-time Inpatient Surveys

Patients were positive about their experience of arriving on the ward, having confidence and trust in the nurses and doctors who treated them, for their condition being explained in a way they could understand. Where the question was applicable patients were positive about being supported with their pain management.

Scores were less positive for patients feeling involved in decisions about their care and treatment, communication about what was going to happen to them and regarding their discharge. Overall, 98% of patients would rate their overall experience of the wards as 'very good/good'.

Local Patient Survey Feedback

We have designed and facilitated a number of local surveys via online links and QR codes to improve the accessibility for patients to provide feedback on their experience of services. The feedback highlights that patient were positive about the staff involved in their care and treatment. Areas for improvement focussed on communication.

National Survey monitoring of action plans to drive service improvement.

We have supported divisions to develop action plans to translate feedback into local actions. We meet regularly with divisions to ensure monitoring and that action taken is reported to the PEG to share learning to improve the patient's experience, and to highlight good practice and ideas. We have seen an increase in positive scores in our National Inpatient survey 2023 and the Cancer Patient Experience survey 2023.

All divisions are required to give a presentation at the Patient Experience Group meeting on how they have embedded the Patient Experience Strategy into the core business of their division to improve services for our patients to measure outcomes against the objectives of our strategy.

Encouraging patient feedback and sharing success

Throughout 2024/2025, we have continued to build on our 'What Matters to You' campaign across the Trust and via social media channels. This campaign aims to raise the profile of patient experience across the Trust, capture feedback and share successes.

Supporting our emergency portals

The patient experience team have been assisting with making drinks for patients and relatives in the A&E Department during busy periods. The team have attended Same Day Emergency Care (SDEC), Acute Medical Unit (AMU) 1/2, the Discharge Lounge and Accident and Emergency (A&E) asking patients about their experience. Where surge beds have been put in place the team have been talking to patients about if their privacy and dignity has been respected.

Engagement

We increased our engagement activity throughout the Trust including partnership working with our staff, patients, visitors, and stakeholders, as described throughout this report. We have improved communication, through listening, learning, and giving our patients, families, and communities more opportunities to provide feedback on their care and treatment. We work with staff to promote learning and implement changes to enhance the patient experience.

Future Plans

Our 2024-2027 Improvement Plan focusses on increased engagement activity for the next three years through partnership working with our stakeholders, local Healthwatch and voluntary and community groups and organisations:

We have developed a plan of activities to enhance engagement with our staff, patients, visitors, and stakeholders to ensure that our services meet the needs of our local people and that the views of our patients and their loved ones help to shape a health and care system that's right for them.

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

3. Report journey
Annual Quality Committee Public Trust Board of Directors

4. Recommendation(s)
The Patient Experience Group (PEG)
The Group is asked to receive the patient experience annual report 2024/2025 and to review the assurances presented in how patient feedback is used and learning is implemented.

5. Impact

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

PATIENT EXPERIENCE

ANNUAL REPORT

2024-25

Patient Experience Annual Report 2024/2025

1.0 Introduction

The Dudley Group NHS Foundation Trust's strategic vision is to deliver 'excellent healthcare, improved health for all'. Our aim is to provide an excellent patient experience alongside effective and safe care that results in positive health and wellbeing outcomes.

Putting patients first and working together to deliver exceptional care, each and every time is paramount. This report sets out our achievements and ongoing work to ensure that patient experience is prioritised and underpins everything we do.

The 'Patient Experience Annual Report 2024/2025' provides an overview of how we have gathered feedback from our patients on their experience of care, our achievements, what patient experience feedback tells us, and our plans for the coming year for patient experience.

Our Trust collects patient experience feedback from multiple sources and works in partnership with patients, carers, the wider public and local partners to ensure that the services are representative of our population. In accordance with our 'Patient Experience Improvement Plan 2024-2027' we are committed to actively engaging and involving patients, their relatives, and carers in order to listen and to act on feedback to ensure the continuous improvement in the experience of care and the overall quality of care that is provided.

The Patient Experience Group (PEG) oversees the operational implementation of this Improvement Plan to ensure the outcomes improve service quality and further meet the needs of patients.

Our values are 'C*are, Respect and Responsibility'* underpins everything we do. Our values are about us all helping each other to deliver a great patient experience more consistently involving people who use our services, their relatives, carers, staff and partners in continuing to improve the care we deliver.

This annual report provides a summary of the patient's experience from different sources, taking into consideration feedback that was reported directly to the Trust, and other feedback received via Healthwatch, Care Opinion and NHS Choices.

2.0 Our Priorities

Patient experience is one of our key quality priorities and specific targets have been set on each of the quality priorities. These are:

Priority 1 of 2024/2025: Patient experience

To improve our patient experience National Inpatient Survey results in the following areas (priorities set were based on the results from 2022 survey):

1. Pain
2. Nutrition and hydration
3. Discharge

1. Pain

The National Inpatient Survey 2023 shows an improvement in scores around pain. The Trust scored 8.6 out of ten in 2023 in comparison to 8.2 in 2022. Overall, 71% of patients who completed a real-time inpatient survey from April 2024 to March 2025 stated 'yes definitely' that staff did all they could to help control their pain. The results for 2024 are due to be received end of August 2025.

2. Nutrition and hydration

The National Inpatient Survey 2023 found:

Question	2023 score	2022 score	Movement
Were you offered food that met any dietary needs or requirements you had?	8.1	8.1	→
How would you rate the hospital food?	6.7	7.0	↓
Did you get enough help from staff to eat your meals?	6.8	6.4	↑
Were you able to get hospital food outside of set mealtimes?	5.1	5.5	↓
During your time in hospital, did you get enough to drink?	9.2	9.1	↑

Real-time inpatient survey feedback shows that 80% of our patients stated they had enough to drink. 81% of patients felt they were always offered a choice of food. Where the question was applicable 28% felt that their dietary needs were met and 57% rated the food as 'very good/good'.

3. Discharge

Question	2023 score	2022 score	Movement
To what extent did staff involve you in decisions about you leaving hospital?	6.2	6.2	
To what extent did hospital staff involve your family or carers in discussions about you leaving hospital?	5.2	4.9	
Were you given enough notice about when you were going to leave hospital?	6.0	6.1	

Real-time inpatient survey feedback shows that 49% of our patients stated that someone had spoken to them regarding their discharge and 39% of our patients stated they had been informed of their discharge date.

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

We have included a number of specific examples of the quality initiatives our staff are undertaking across the Trust and what patients have said about the care they have received from us:

- A pain working group was set up in 2024 with the aim of producing actions to improve the National Inpatient survey experience. The group has met monthly, and the actions generated have demonstrated a marked improvement. A monthly report is presented at PEG for assurance and monitoring. There has also been a significant reduction in complaints/FFT regarding pain management. The group will continue to meet bi-monthly for the next six months to ensure sustainment of improvements.

- A Nutrition and Hydration Group was established in 2024 to focus on ensuring patients receive adequate nutrition and hydration to support their overall well-being.

- The Eat, Drink, Dress, Move (EDDM) initiative launched on 4 November 2024. The initial pilot focussed on Ward B6, Ward C3 and the Forget Me Not Unit (FMNU) before being rolled out across the Trust. This will further strengthen the multi-disciplinary focus on ensuring our patients receive sufficient nutrition and hydration during their stay in hospital alongside embedding a culture of supporting movement and independence as part of the ward team ethos and practices.

- The Trust is supporting a new research study being undertaken by the therapy department and the University of Southampton. The PIVOT Study – to promote increased physical activity in hospitalised older adults with trained volunteers. The purpose of this study is to find out if the use of trained volunteers to help promote increased physical activity among older patients in hospital is possible and acceptable. Volunteer training is now underway.

- The first mealtime champion meeting took place in March 2025 with attendance of 12 clinical support workers and two registered nurses from across surgery and medical in-patient wards. The lead AHP support worker will be working with the group to establish the role of the mealtime champion across the organisation and ensure the team are fully equipped and supported to lead on quality mealtime experiences for our patients.

- A 'Discharge Improvement Group' launched in October which includes workstreams to support timely hospital discharge and admission avoidance, allowing patients who are well enough to return to their place of residence or a community setting safely and as soon as they are medically optimised for discharge.

- In the discharge lounge/surge lounge a Multi-Agency Discharge Event (MADE) has taken place to support discharges to reduce escalation capacity across the division. During times of extreme pressure, a functional discharge lounge for same day discharges has been set up which had a hugely positive impact on staff morale and patient experience.

3.0 Patient Experience Feedback

The Trust actively encourages feedback to help us ensure we meet the needs and expectations of our patients, their families and carers, our staff, and our stakeholders. This section provides a summary of how we gather feedback from patients on their experience of care and what the feedback tells us. We gather feedback in a number of ways:

- Friends and Family Test (FFT)
- Real-time surveys (face-to-face surveys)
- Local surveys
- Patient Reported Experience Measures Survey (PREMS)
- NHS Choices and Patient Opinion online reviews
- National surveys including the national inpatient survey
- Listening events, patient panels and focus groups
- Feedback Friday
- Compliments
- Talk to Us Trolley

The examples detailed below demonstrate the quantity of feedback received during the year and more detailed information about some of the methods. These methods alone highlight more than **77,476** opportunities for us to listen to our patients' views in 2024/2025 (in comparison to 84,217 in 2023/2024).

Table 1. Patient Feedback April 2024 to March 2025

Method	Total	Method	Total
FFT – Inpatient (Inc. day case)	**19,825**	NHS Choices/Patient Opinion	**66**
FFT – Emergency department	**15,333**	National surveys – Women's Experience of Maternity Services 2024 (published November 2024)	**121**
FFT – Maternity	**1,625**	National surveys - Adult Inpatient 2023 (published August 2024)	**455**
FFT – Community	**5,894**	National surveys - Urgent and Emergency Care 2024 (published November 2024)	**337**
FFT – Outpatients	**13,841**	National surveys - Children and Young People 2023 (due to be published May 2025)	**0**
Real-time surveys	**510**	Cancer Patient Experience 2023 (published July 2024)	**786**
Patient Reported Experience Measures Survey (PREMS)	**12,185**	Other local/department surveys	**2,513**
		Compliments	**3,985**

3.1 Friends and Family Test (FFT)

The FFT is made up of a single mandatory question (overall, how was your experience of our service?') followed by two free-text questions to drive service improvement:

1. What was good about your visit?
2. What could have made it better?

The Trust continues to monitor how many surveys are completed for each service/department to ensure that the process is being followed. The results are published on the national NHS England website. The scores, which are updated monthly, are displayed on our website and prominently in our wards/departments for all patients, staff, and visitors to see.

The FFT survey provides valuable data to inform local actions to improve the patient experience. FFT is firmly embedded within the Trust with all patients given the opportunity to complete the survey after each episode of care and treatment in all areas of the organisation. Feedback is captured through a variety of methods; paper survey, SMS and QR code and online.

We monitor our performance compared to that of our neighbours in the Black Country. We submit our data to NHS England and Improvement monthly for national benchmarking to monitor performance against the national average.

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

Below is an example of the FFT card for our Cardiac Assessment Unit:

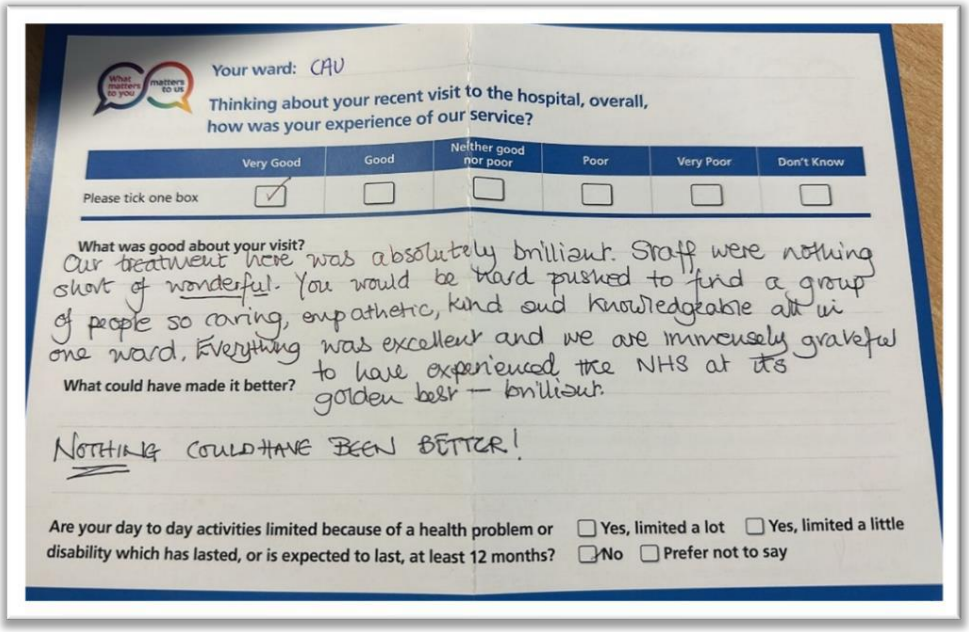


Table 2. Friends and Family Test Total Number of Responses by Division (April 2024 to March 2025)

Total number of responses April 2024 to March 2025	
FFT – Inpatient (Inc. day case)	**19,825**
FFT – Emergency Department	**15,333**
FFT – Maternity	**1,625**
FFT – Community	**5,894**
FFT – Outpatients	**13,841**
TOTAL	**56,518**

As shown in table 2, the Trust received a total of **56,518** responses from FFT during 2024/2025 (in comparison to 59,772 during 2023/2024). The patient experience team has ensured that every part of our community is able to provide feedback about their experience of care received from the Trust.

Table 3. Friends and Family Test Positive Ratings (April 2024 to March 2025)

Dept.	*Overall rating 'Very Good/ Good' (% Positive Score)*	*Overall rating 'Very Poor/poor) (% Negative Score)*
A&E	**70%**	**15%**
Community	**90%**	**2%**
Inpatient (including transfers/day case)	**89%**	**3%**
Maternity	**82%**	**1%**
Outpatients	**84%**	**4%**
AVERAGE TRUST TOTAL	**83%**	**5%**

Table 3 shows that in 2024/2025 the number of patients rating their overall experience of their care and treatment for the Trust overall as 'very good/good' was 83%, no change from 2023/2024. The number of people rating their experience as 'very poor/poor' for the Trust overall is 5% in 2024/2025 and improvement of 1% in comparison to the previous year. Community services received the highest positive mean score for the year and the Maternity Department received the lowest number of patients rating their overall experience as 'very poor/poor' during 2024/2025.

The Accident and Emergency (A&E) Department received the highest percentage negative scores with 15% of patients rating their overall experience as very poor/poor an increase from 2023/2024 (14%).

Table 4. Percentage very good/good FFT Scores (April 2024 to March 2025)

Percentage very good/good FFT Scores	April 24	May 24	June 24	July 24	Aug 24	Sept 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	March 25	Mean average % score
Inpatient (Including day case)	**91%**	**89%**	**89%**	**90%**	**88%**	**90%**	**89%**	**89%**	**88%**	**87%**	**88%**	**88%**	**89%**
National	95%	95%	94%	95%	95%	94%	94%	95%	94%	95%	**	**	95%
A & E	**72%**	**70%**	**68%**	**67%**	**74%**	**71%**	**68%**	**69%**	**68%**	**74%**	**69%**	**66%**	**70%**
National	79%	78%	79%	80%	83%	79%	79%	77%	76%	80%	**	**	79%
Maternity Antenatal	**96%**	**60%**	**94%**	**81%**	**93%**	**92%**	**96%**	**81%**	**96%**	**91%**	**100%**	**92%**	**69%**
National	92%	91%	92%	91%	91%	91%	91%	93%	92%	92%	**	**	92%
Maternity Birth	**84%**	**81%**	**97%**	**93%**	**91%**	**87%**	**81%**	**78%**	**85%**	**93%**	**91%**	**88%**	**87%**
National	93%	93%	94%	94%	92%	94%	94%	91%	92%	91%	**	**	93%
Maternity Postnatal Ward	**75%**	**72%**	**80%**	**92%**	**72%**	**78%**	**59%**	**72%**	**79%**	**73%**	**87%**	**61%**	**75%**
National	92%	93%	92%	93%	92%	92%	91%	92%	92%	92%	**	**	92%
Maternity Postnatal Community	**0%**	**85%**	**100%**	**57%**	**0%**	**0%**	**0%**	**0%**	**0%**	**0%**	**0%**	**25%**	**22%**
National	93%	94%	93%	93%	92%	91%	92%	91%	94%	93%	**	**	93%
Community	**92%**	**91%**	**91%**	**88%**	**90%**	**92%**	**92%**	**92%**	**90%**	**89%**	**87%**	**88%**	**90%**
National	93%	94%	94%	94%	95%	94%	94%	94%	94%	94%	**	**	85%
Outpatients	**85%**	**84%**	**83%**	**82%**	**84%**	**83%**	**84%**	**85%**	**84%**	**84%**	**85%**	**84%**	**84%**
National	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	**	**	94%
Place	**	**	**	**	**	**	**94%**	**90%**	**91%**	**89%**	**93%**	**89%**	91%
National	91%	91%	91%	91%	92%	92%	93%	92%	92%	92%	**	**	92%

***denotes areas where no national data is available.*

Table 4 shows that the mean average percentage positive score by division was the highest for Community at 90% over the year. Community have achieved 90% and higher for eight out of 12 months. All scores are below the national average.

Table 5 – Friends and Family Positive/Negative Comments by Department

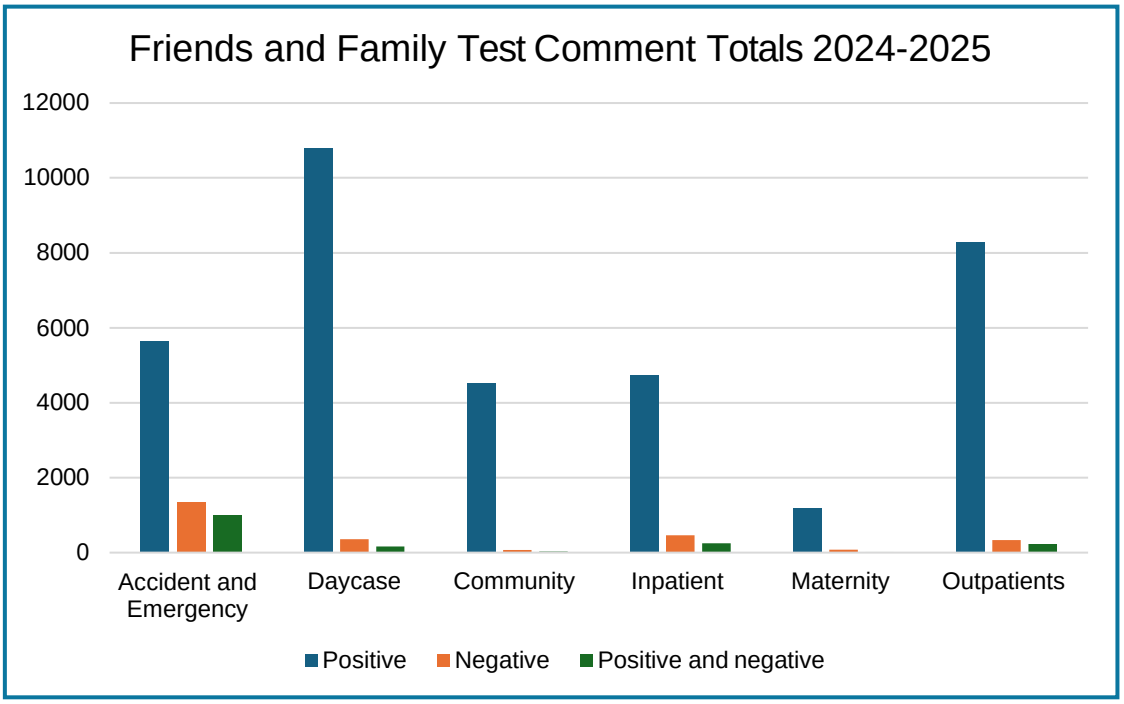


Table 5. shows that a total of **42,509** comments were received from patients during 2024/25 regarding what was good about their visit and what could have made it better (in comparison to 37,701 in 2023/2024). 83% of comments from patients and relatives were positive. The Day Case Department received the greatest number of responses at 11,320, and the highest number of positives scores (10,797). The A&E Department received the most negative comments (1,362) for 2024/2025, with the main theme being around waiting times.

A thematic review of the comments demonstrate that patients were very positive about the kind, caring nature of the staff involved in their care and patients felt that staff were understanding and supportive, a recurring theme from the previous year. Areas for improvement focussed on communication, appointment delays and cancellations and waiting times to be seen.

Examples of patient/carer comments from the Friends and Family Test:

What was good about your visit?

- **Accident and Emergency -** All hospital staff were friendly, helpful, caring & thorough in listening & doing appropriate tests to ensure I was ok in a very busy department.
- **Own Bed Instead -** Friendly and professional. Felt I was listened to, and input was valid and taken on board. Perfect.
- **Day Surgery Unit, Russells Hall** - Staff were all friendly and helpful. Although there was a long delay, they explained the reason and kept us updated.
- **Ward B4** - The fact that I was made to feel as if I mattered, my care from staff was excellent, housekeeping staff were all very caring.
- **Maternity Birth** - The midwives were awesome. I felt supported and the information they provided was super helpful. Everybody helped us and answered all our questions. I am very grateful.
- **Cardiology** - My visit was very good no pressure from any one Doctor was excellent it could not have been any better.
- **C4 Oncology -** The staff are remarkably cheerful and friendly. They make what could be a tedious day into a comfortable and tolerable session.
- **MECU -** I was treated with high levels of care and empathy. Nothing was to much trouble for the staff. The overall standards were 'second to none' Thank you
- **Maternity (Birth) -** All staff were very accommodating and friendly. They took time to talk me through the situation and help me navigate my way through.
- **Ophthalmology -** First ever visit to ophthalmology and was impressed with punctuality and the care in particular. Good start.

What could have made it better?

- **Accident and Emergency** - The nurses taking observations and doctors were brilliant however the staff behind reception in the emergency department were exceptionally rude.
- **Own Bed Instead** - Better communication
- **Day Surgery Unit, Russells Hall** - It was a long four-hour waiting time for a 20 mins procedure.
- **Ward B4** - Not being pushed from one ward to another and back again only to end up being admitted to the second ward undignified.
- **Maternity Birth** - Whilst in labour, I was not checked in on for four plus hours. Medication/pain relief was requested but delivered too late to make any impact. Discharge after birth extremely slow.
- **Cardiology** - The nurse was very friendly and put me at my ease. The doctor did not introduce himself properly, so it was hard to know who he was and if he was a registrar or consultant etc. He answered my questions ok but didn’t seem that interested in my issues and seemed dismissive.
- **C4 Oncology -** Whoever chose the colour pink in the waiting room has never sat in it it’s a really sickly colour doesn't make you feel relaxed.
- **MECU -** The food was the worst. I have ever come across. No choices and if you don't like chicken that's too bad.
- **Maternity (Birth) -** Not being ignored - Requested to be checked for dilation, five times before actually being checked this led to me crying and over stressing.
- **Ophthalmology -** Receptionist always rude at every visit ignore you - Chat to themselves make you feel that you are an inconvenience.

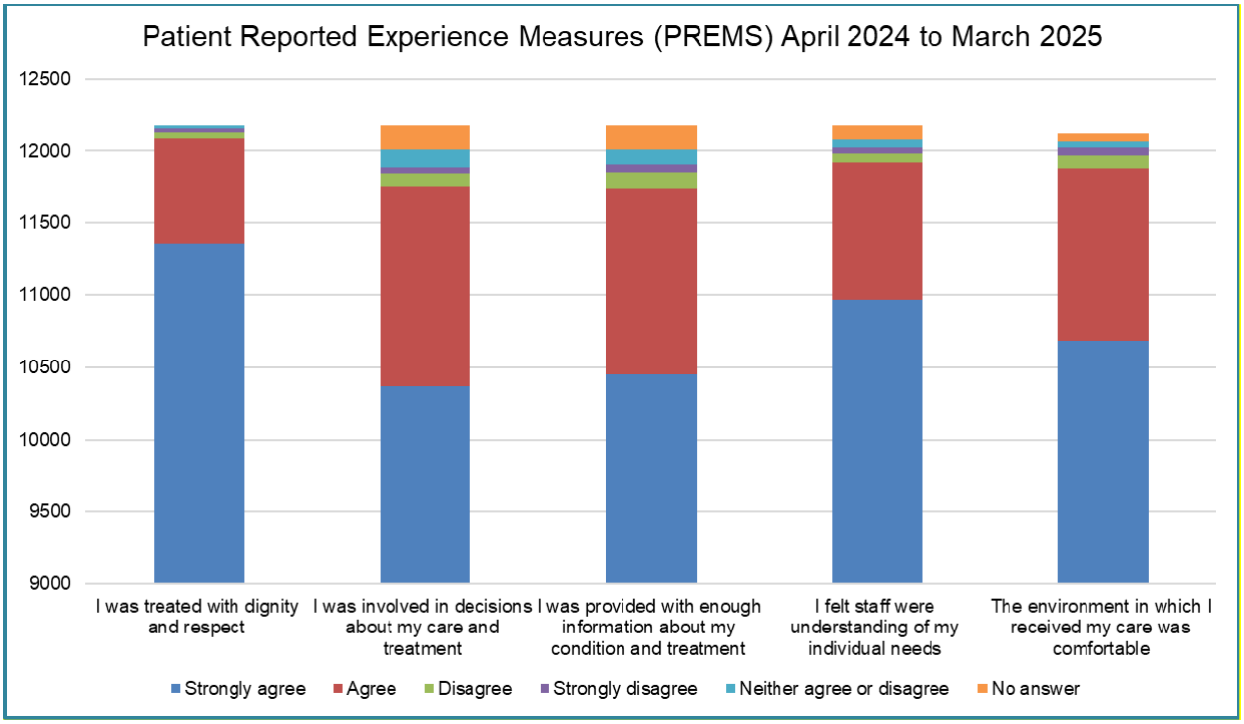
3.2 Patient Reported Experience Measures Survey (PREMS)

The PREM survey aims to capture, understand, and use patient experience in a consistent way, cross referencing the findings with the FFT (included on the back of the card), as an overall satisfaction score.

A total of **12,175** patients/carers responded to the PREMS survey in 2024/25 in comparison to 14,890 in 2023/24. As shown in table 6. below, for the Trust overall findings were very positive with respondents receiving a good experience in terms of being treated with dignity and respect, for feeling that staff were understanding of their individual needs and that the environment in which they received their care was comfortable.

Patients feeling that they were not provided with enough information about their condition and treatment and feeling involved in decisions about their care and treatment were the lowest scoring questions.

Table 6. Patient Reported Experience Measures Survey (PREMS) Totals scores April 2024 to March 2025



Departmental scores show that all respondents were positive about being treated with dignity and respect by staff involved in their care and treatment and felt that staff were understanding of their individual needs. This demonstrates that the Trust is particularly 'caring' and 'responsive'. These were the highest scoring questions for all departments. The lowest scoring questions for each department were for patients being given enough information about their condition and treatment, and for feeling involved in decisions about their care and treatment, highlighting an area for improvement.

Table 7. Number of positive/negative responses by Department April 2024 – March 2025

Department	Total Responses	% Strongly Agree/Agree	% Strongly Disagree/Disagree
A&E	151	87%	8%
Community	1745	98%	1%
Day Case	4635	100%	0%
Inpatients	3018	96%	2%
Maternity	862	98%	1%
Outpatients	1764	95%	1%

As shown in the table 7. above, the Day Case Department received the highest number of responses and the highest number of positive scores, and the lowest number of patients who strongly disagreed/disagreed with the questions which demonstrates a positive patient experience overall. Patients were less positive about their experience of the A&E Department (although the number of responses received was low).

Results are shared with teams to highlight areas of good practice and to ensure any areas for improvement are actioned as required. They are monitored through divisional updates at the quarterly PEG.

3.3 Real-time Surveys

A total of **510** patients participated in our real-time surveys during 2024/2025. The real-time survey provides the opportunity for patients to give feedback about their experience as an inpatient at the hospital. These surveys compliment the FFT, and the results are reported in a combined report to wards and specialties, allowing them to use valuable feedback from patients in a timely manner and to use patient views in our service improvement planning.

Table 8. shows that patients were positive about their experience of arriving on the ward. The lowest scoring question was around communication with 34% of patients stating that they were not told what was going to happen to them.

Table 8. Realtime Inpatient Survey – Admittance to the Ward April 2024 to March 2025

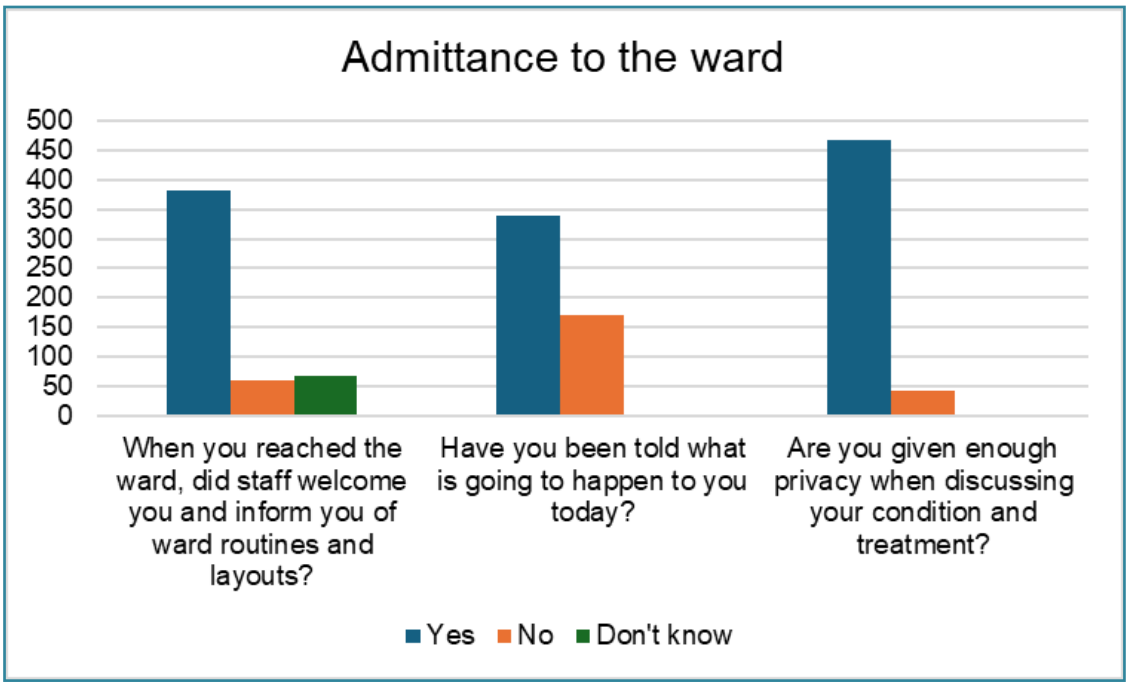


Table 9. Realtime Inpatient Survey – Care and Treatment April 2024 to March 2025

Care and Treatment	Yes, definitely	Yes, to some extent	No	N/A
Were you involved as much as you wanted to be in decisions about your care and treatment?	374	90	46	0
Has your condition been explained in a way you can understand?	397	68	45	0
Do you have confidence and trust in the nurses treating you?	454	46	10	0
Do you have confidence and trust in the doctors treating you?	429	59	22	0
Do you think the hospital staff do/did everything they can/could do to help control your pain?	365	33	15	97

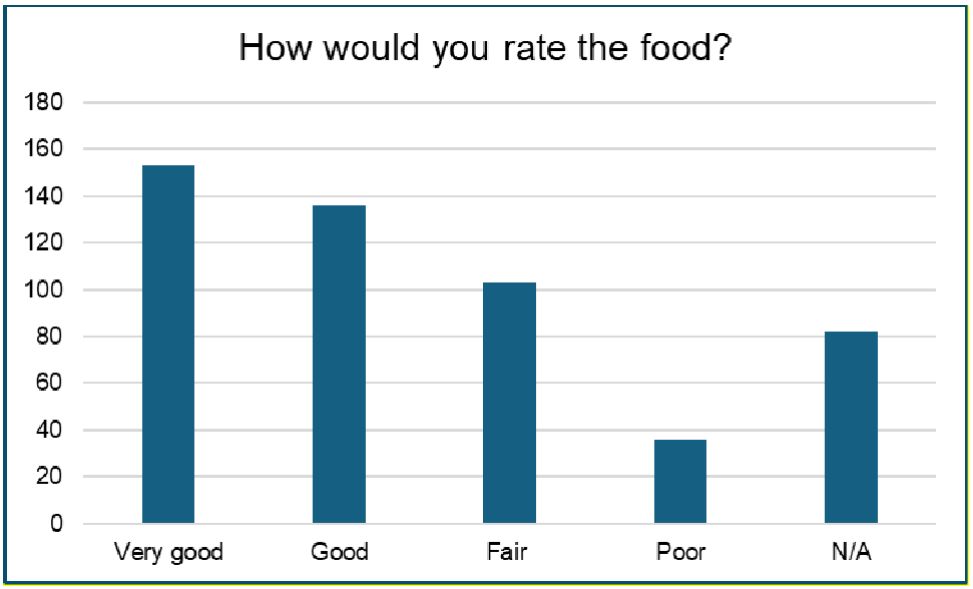
Table 9 demonstrates that patients were particularly positive about having confidence and trust in the nurses and doctors who treated them. Scores were less positive for patients feeling involved in decisions about their care and treatment and for their condition being explained in a way they could understand. Where the question was applicable patients were positive about being supported with their pain management.

Table 10. Realtime Inpatient Survey – On the Ward April 2024 to March 2025

On the Ward	Yes, definitely	Yes, to some extent	No	N/A
If you used the call button, was it answered in a reasonable time?	255	66	26	163
During your time in hospital, did you get enough to drink?	410	38	6	56
Were you offered a choice of food?	413	48	17	32
If you have special dietary needs, do you feel that these have been met during your stay?	141	21	27	321

Patients were complimentary about their experience on the ward.

Table 11. Realtime Inpatient Survey – Food Scores April 2024 to March 2025



Overall, 57% of patients rated the food as ‘very good/good’ in 2024/2025.

Table 12. Realtime Inpatient Survey – Discharge April 2024 to March 2025

Discharge	Yes, definitely	Yes, to some extent	No	N/A
Has someone spoken to you about your plan to get well enough to go home?	251	78	122	59

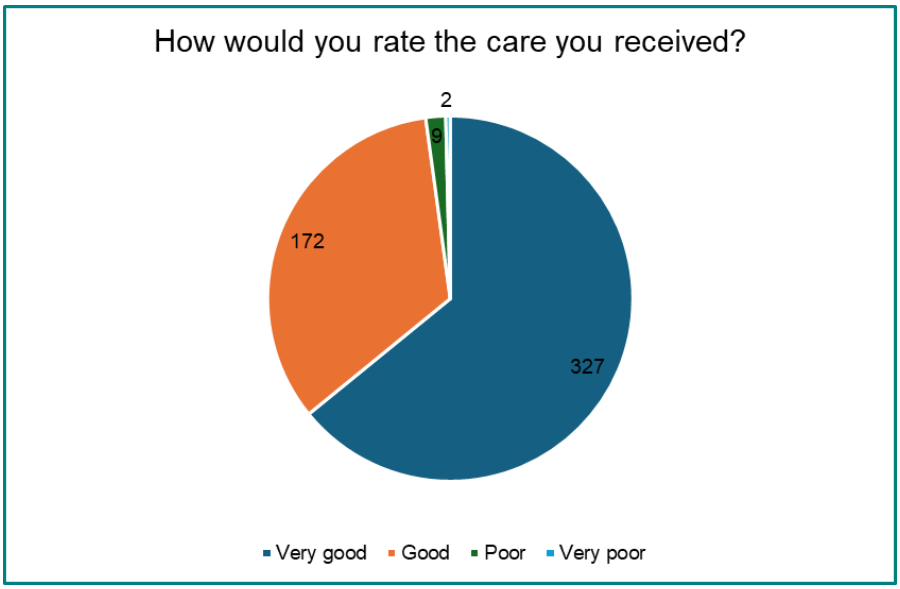
Scores for discharge highlight an area for improvement. 24% of patients stated that were not spoken to regarding their discharge plan (table. 12).

Table 13. Realtime Inpatient Survey – Discharge April 2024 to March 2025

Discharge	Yes	No	N/A
Have you been told when you are going home?	197	224	89

Table 13 shows that 44% of patients on the wards were not informed about their date of discharge.

Table 13. Realtime Inpatient Survey – Overall Rating of Care April 2024 to March 2025



Overall, 98% of patients would rate their overall experience of the wards as 'very good/good'.

What was good about your stay?
"Staff very helpful" "Brilliant" "Ward is amazing" "The nurses and doctors are really good" "When they see that she needs help she gets it" "Everyone has been fabulous from start to finish, nurses are very patient, attentive and kind. Couldn't wish for better care". "The nurses have been brilliant" "My main consultant was brilliant and the anaesthetist"
Overall is there anything we could have done better?
"Nursing staff should not be diagnosing and telling patients what is going to happen before the doctor/consultant has seen the patient" "Staff talk about you in the corner - They make things up"

"Wrong medication"
"Would have been very good but disappointed with the weekend doctors"
"Excellent could not be more thankful"
"Cannot get prescribed medication melatonin"
"Night staff are lazy"
"Nurses were lovely but not to happy with weekend doctors"
"Felt welcomed but can't remember if introduced"

3.4 Local Surveys

We have designed and facilitated a number of local surveys via online links and QR codes to improve the accessibility for patients to provide feedback on their experience of services. These are promoted on the new patient experience boards and tablets across the Trust.

We received **2,513** pieces of feedback from our local surveys during 2024/2025 (in comparison to 1,786 in 2023/2024).

- Alcohol Care Team
- Anaesthesia Post-Op Recovery Survey
- BCG Questionnaire
- Birth reflection Clinic evaluation form
- Breast Screening Survey
- Cancer Services Patient Experience Survey
- Community Musculoskeletal MSK Assessment and Physiotherapy Survey
- Complaints evaluation form
- Dudley Rehabilitation Service case managers
- Endoscopy Unit Patient Experience Questionnaire
- Epilepsy nursing service
- Lung Cancer Screening Programme Patient Survey
- Inpatients Food Survey
- Monitoring baby movements
- National Audit of Care at the End-of-Life Quality Survey
- Nutrition and Hydration survey
- Pain Management Survey
- Specialist Adult Asthma Patient Satisfaction Survey
- Specialist Palliative Care Survey
- Speech & Language Therapy
- TB Patient Satisfaction Survey
- MSK First Contact Practitioner Survey

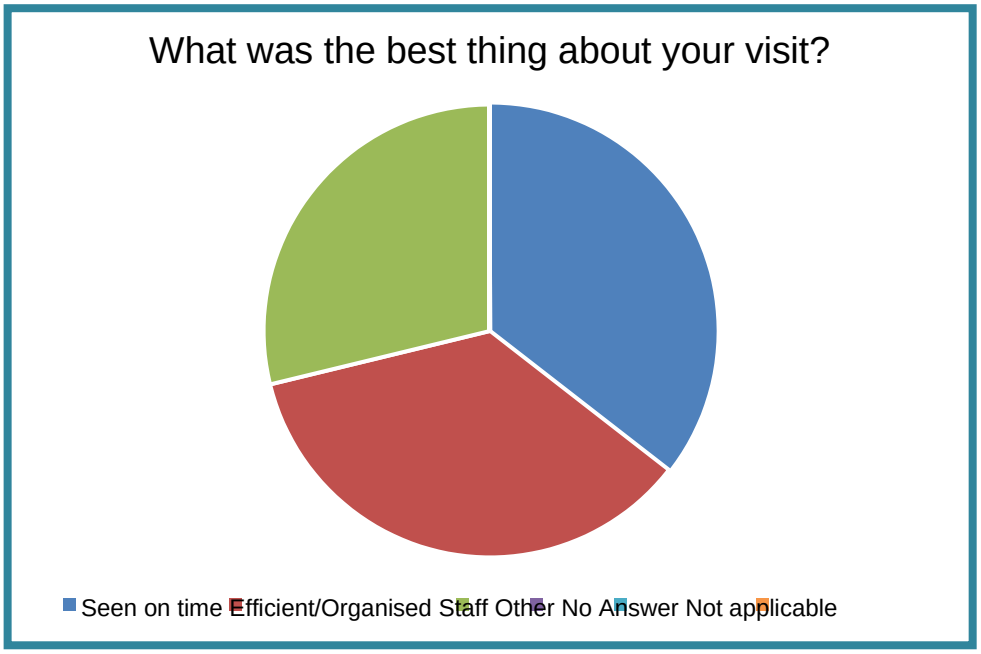
Some e*xamples of feedback from our patient experience local survey feedback 2024/2025 are shown below:*

Breast Screening Survey – Your Opinion Matters

There were **1456** responses received during 2024/2025 (in comparison to 1386 survey responses received during 2023/2024).

The results from the survey were very positive regarding communication, including explanations about the procedure and when results would be received (although scores were slightly lower for this question). All respondents who answered the question would encourage a friend/colleague/relative to attend for breast screening.

Table 14. Breast Screening Survey April 2024 to March 2025 – What was the best thing about your visit?

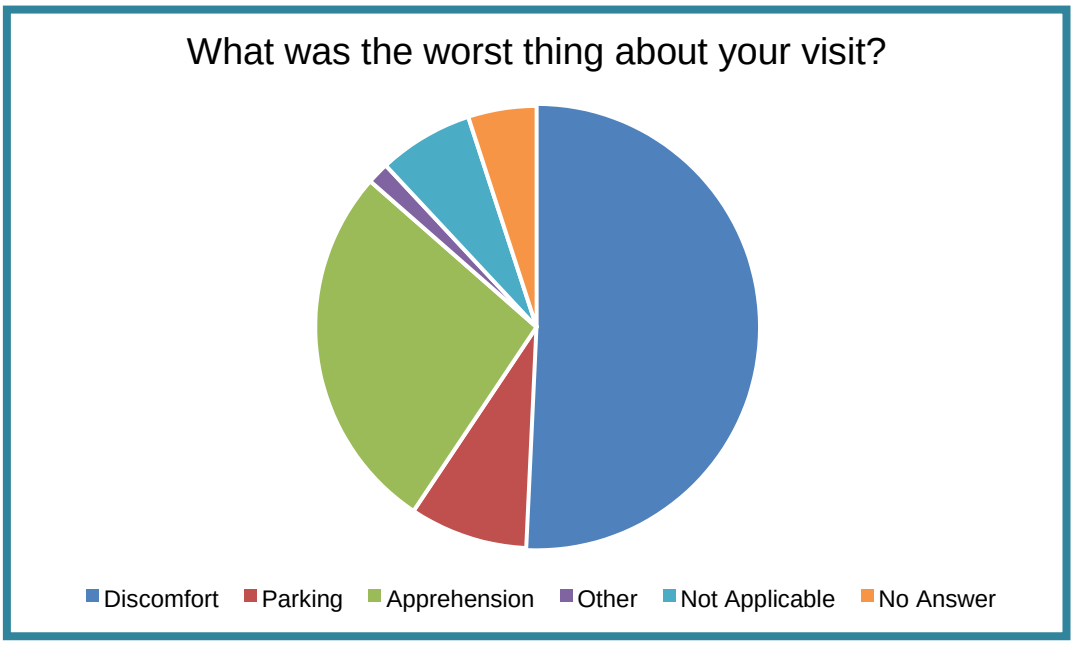


When asked what the best thing about their visit was, most women said being seen on time, the staff, and the organisation and efficiency of the service were recurring themes each quarter. The free-text comments show that patients were positive about the kind and caring nature of the staff and regarding the waiting time to be seen on the day:

- “Seen quickly, reassured and staff are friendly.”
- “Before time which is good.”
- “I was very early, and the team was very happy to see me, a very big thank you, because it was raining. Well done team.”
- “Seen earlier than Appointment time”.
- “Very impressed with the organisation and a very caring, friendly radiographer”.

- “Staff were very respectful”.
- “Polite staff and efficient”.
- “Radiographer was very friendly and professional”.
- “Arrived 10 mins early and was seen straight away”.

Table 15. Breast Screening Survey April 2024 to March 2025 – what was the worst thing about your visit?



The free-text comments were extremely positive with most women stating ‘nothing’ when asked about what the worst thing about their visit was. Discomfort was highlighted as a concern.

- “The atmosphere lacked the human touch. It was more mechanical”.
- “Discomfort with shoulder it was not the best”.
- “Could not fault it in anyway”.
- “None - I expected a bit of discomfort”.
- “Everything was fine”.
- “Nothing at all”.
- “Nothing bad about my appointment”.
- “Nothing parking was good it was comfortable”.
- “The nurse who did the screening was not overly friendly or polite. As it was my first time, I could have used a more friendly experience”.
- “Nurse was not patient neither was she friendly”.
- “Unpleasant approach to the unit - back of a supermarket a bit dark and dingy”.

Musculoskeletal Community MSK Assessment MSK First Contact Practitioner (FCP) Survey

451 responses were received during 2024/2025. The feedback demonstrates a positive outcome has been received by most patients:

- How good was your health professional at Involving you as much as you wanted to be in decisions about your care and treatment? **(99%)**
- How good was your health professional at making you feel listened to? **(99%)**
- How good was your health professional at explaining things to you in a way that you could understand? **(99%)**
- How good was your health professional at giving you enough time? **(99%)**
- How good was your health professional at treating you with care and concern? **(98%)**
- Did you have confidence and trust in the health professional you saw or spoke to? **(95%)**
- Did you agree or review a care plan with your health professional? **(78%)**
- Did you receive sufficient information about your condition or self-care that was easy to understand? **(90%)**
- Did you feel that your care was well coordinated between health professionals? **(81%)**
- Did you feel your needs were met? **(82%)**

Patients were positive about communication, involvement, and the support received from the service. Scores were lower for patients agreeing a care plan and for coordination between health professionals. Overall, 98% of patient rated their overall experience of the service as ‘very good/good’.

The free-text comments show that patients felt that the staff were friendly, helpful, and supportive and their overall experience of the First Contact Practitioner Service was a positive one:

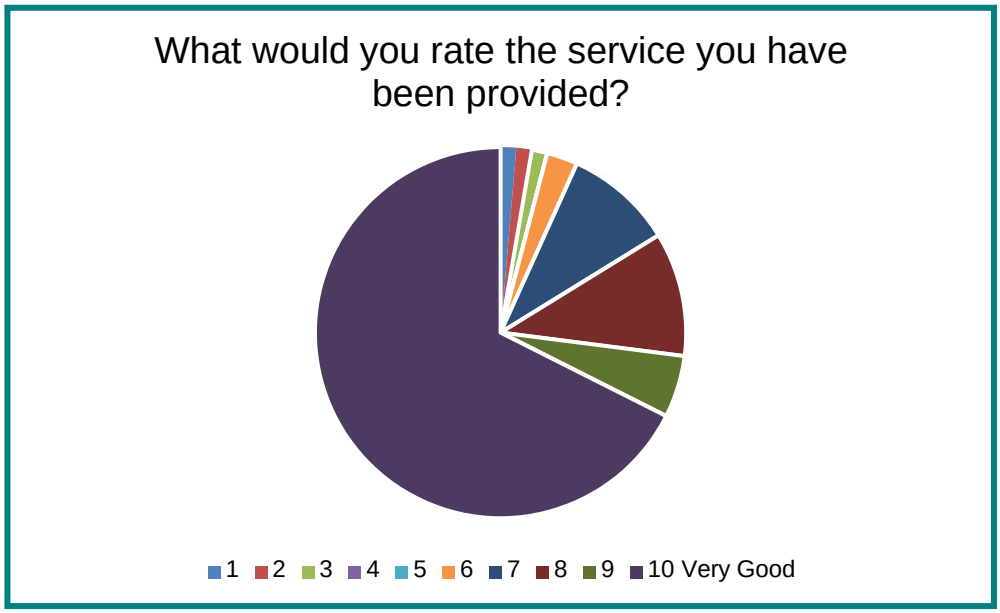
- “Staff member went the extra mile to ensure I will receive the required treatment”.
- “Excellent that there is a service for joint pain without a GP appointment, hope this continues. Very good”.
- “Physio took time and gave good advice”.
- “Appointment was informative, and examination was very thorough”.
- “Staff member was superb. He was very pleasant and easy to talk to. He listened to what I wanted to say without interrupting”.

Cancer Services Patient Experience Survey

451 responses were received during 2024/2025. The feedback demonstrates a positive outcome has been received by most patients. Patients were positive about having a main contact and for test results being done quickly. Areas for improvement focussed on coordination of care, signposting to additional services, communication, and feeling involved and supported:

- Did you have a main contact for the nursing team looking after you, this could have been a key worker, clinical nurse specialist or cancer navigator? **(81%)**
- Did you feel that your diagnostic tests were done quickly? **(92%)**
- Did you feel that you received your results in a timely manner? **(83%)**
- Did you feel that your care has been well coordinated? **(62%)**
- Were your results and treatments explained in a way that you could completely understand? **(68%)**
- Did you feel that you were involved when making decisions about your care? **(60%)**
- Have you felt supported during your diagnosis, treatment and/or follow up? **(61%)**
- Have you received appropriate verbal and written information during your care? **(71%)**
- Did you have confidence and trust in all the team looking after you during a stay in hospital (if applicable)? **(43%)**
- Were you signposted to additional support during your care? **(44%)**

Overall, 50 out of 74 patients rated their experience of the service as ‘very good’.



The free-text comments highlight that patients were positive about the staff involved in their care and their prompt test results and diagnosis. Areas for improvement focussed on communication and information, and being informed about chemotherapy sessions:

What was good about service?

- The service I have received has been the best I could have wished for going private wouldn't have been any better. Everything was quick on time always seen by the friendliest staff our NHS is the best in the word.
- Everyone has treated me with respect, kindness and professionalism through what has been a very difficult period.
- The promptness of referral to treatment. The care of the doctor and his team and subsequently the Haematology team. The way in which things were explained.
- Professional and caring.
- Prompt diagnosis of my prostate cancer, prompt dispensation of hormone treatment, communication.
- Prompt diagnosis of my prostate cancer, prompt dispensation of hormone treatment, communication.

What could have made the service better?

- Better communication between the doctors and nurses a couple of times the Doctor told me information about procedures or medication that the nurses knew nothing about.
- Communication from consultant re. results. Said she would write to me with results. I had a letter for an appointment - no clarification causing worry, stress and then trying to arrange an appointment during booked holidays.
- Being informed of results of chemotherapy.
- Maybe a few more explanations during chemotherapy sessions but as I am aware of most procedures
- Waiting for chemotherapy, gave a time but you could have been there most of day waiting for it
- Length of time between having biopsies and seeing clinicians for results / treatment plan. Having appointment cancelled without notifying me.
- Better information about different treatments.

3.5 NHS Choices and Patient Opinion online reviews

Patients, relatives, and carers can provide feedback about their experience of any of our services on the NHS Choices and Care Opinion websites. Comments can be posted anonymously, or individuals can choose to give their name. All comments are responded to online within 48 hours.

In the year 2024/2025 the Trust received 66 pieces of feedback via NHS Choices with 48 comments being positive, 15 negative and three both positive and negative.

The comments show that patients and relatives were positive about the care and treatment given by staff. Patients felt that staff were caring, kind and supportive. The main themes for improvement focussed on communication and appointments. The Radiology Department received the highest number of negative comments with appointments and attitude of staff as the main concerns.

Examples of comments posted on NHS Choices are shown below:

Positive Comments

- **Day Surgery Russells Hall -** I attended plastic surgery day case for removal of skin cancer everything went well staff were so lovely and caring thank you surgeon was so professional I felt completely at ease.

- **Ward B5 -** from the moment I came into the Emergency Department and then to Ward B5, I felt the staff did all they could to ease my pain and find answers. I am very grateful that most of the nurses and health care assistants were very patient and kind to me as there were times that I had gotten very overwhelmed, and I found it difficult to move around and talk because of my pain. They motivated and helped me to become independent again. Thank you.

- **Phlebotomy -** I was there for a routine blood test and as my veins were being shy this morning, I had to wait for another colleague to take the sample from my hand. This person was extremely warm and good natured and reassured me throughout. Overall, well done, very impressed!! Thank you all at blood tests, Corbett Hospital.

We are disappointed to hear of negative feedback for these areas:

- **Radiology Department** - I arrived only to be treated so rude by the sonographer, she was so angry and uptight. She interrogated me and very aggressive towards me and asking me medical questions I could not answer, when I could not answer them, she started to interrogate my GPs reasoning for requesting the scan. To which I replied I can only tell you my symptoms and that my GP requested the scans as a result of my symptoms. She was so unprofessional and so was her assistant. Disgusting service.

- **Emergency Department** - I was not fully satisfied with the care that I received whilst in the Emergency Department as they only assessed one issue which was my right ankle, but I also have pain in my knee which wasn't really dealt with at the time.

- **Phlebotomy -** my experience was a scary one as I was in a lot of abdominal pain. I had my bloods taken and was left to sit in the waiting room until the results came back. I was offered no pain relief at all until I asked for it. The nursing staff were congregated at the nursing station laughing and joking. Feel sorry for the patients there

3.6 National surveys including the National Inpatient Survey

During the year 2024/25, the Trust participated in the Care Quality Commission (CQC) national surveys programme with the following national patient surveys published during the period.

Survey name	Survey sample month	Trust response rate	National average response rate
2023 Adult Inpatient Survey (Published August 2024)	November 2023	41%	42%
2024 Women's Experiences of Maternity Services (Published November 2024)	February 2024	38%	41%
2024 Children and Young People Survey (Due to be published May 2025)	-	-	-
2024 Urgent and Emergency Care Survey (Published November 2024)	February 2024	28%	29%
Cancer Patient Experience Survey 2023 (Published July 2024)	April, May, June 2023	46%	52%

Participants for all national surveys are selected against the sampling guidance issued by the Care Quality Commission (CQC) for the months indicated in the table above.

What the results of the surveys told us:

Adult Inpatient Survey 2023

The Overall Patient Experience Score (OPES) ranged from the lowest score in England of 7.4 to the highest trust score in England of 9.2. The Trust score is 8.1 in 2023 and has seen an improvement from the previous year (7.8 in 2022). This score is performing 'about the same' as Trusts nationally.

The 2023 survey demonstrates an improved picture in comparison to the 2022 survey. All section scores are performing 'about the same' as the average of Trusts surveyed (in comparison to five sections that were performing 'worse' than the average of Trusts surveyed and two sections that were 'somewhat worse' in the 2022 survey).

Scores for eight out of 11 sections have seen an increase since the previous survey. Two sections have decreased (the hospital and ward, and operations and procedures). Scores for operations and procedures show the biggest decline from 8.0 in 2022 to 6.8 in 2023, however this score was previously performing 'somewhat worse than expected' and the Trust was in the bottom five regionally.

Scores for 'feedback on your quality of care' demonstrates the most improved score. Patients feeling that they were treated with respect and dignity was the highest scoring section overall at 9.1 (in comparison to 8.8 in 2022), a recurring theme from the previous year.

National Cancer Patient Experience Survey (CPES) 2023

Overall, there are three out of four questions in the 'your overall NHS care' section that are below expected range (no change from the previous year). The average rating of care scored from very poor to very good is 8.6 in 2023, an improvement since the 2022 survey (8.5). This score is in the lower expected range and below the national average score of 8.9.

The score for the care team working together has seen a decline since the 2022 survey and falls below the expected range at 85% in 2023 in comparison to 86% in 2022 and the national average score of 90%.

The score for administration of care is 83% in 2023 and shows an improvement since the 2022 survey (80%). This score remains below the expected range and the national average of score of 87%.

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

National Maternity Survey 2024

The survey demonstrates a much-improved picture in comparison to the 2023 survey. 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.

There are two questions that are performing 'better than expected' in 2024 in comparison to no questions in 2023, for women feeling that their decisions about how they wanted to feed their baby were respected and midwives provided enough information on how to feed their baby.

Questions about women being given information about any changes they might experience to their mental health after having their baby, and not being sent home during your labour when they were worried about themselves or their baby scored above the national average.

The section score for 'staff caring for you' has seen an improvement from 7.6 in 2023 where this section was performing 'worse than expected' to 8.4 in 2024 which is performing 'about the same' as Trusts nationally.

Antenatal Care

The main areas for improvement focussed on offering women a choice and providing enough information about where to have their baby and asking women about their mental health during antenatal check-ups. Scores fell below the expected range for these questions.

Labour and birth

Themes for improvement in comparison to the average of Trusts surveyed focussed on communication. The question for women feeling that the staff treating and examining them introduced themselves is performing 'somewhat worse than expected'.

Postnatal care

Areas for improvement focused on partners being able to stay as much as the women wanted, taking personal circumstance into account and asking women about their mental health.

Urgent and Emergency Care Survey 2022

The Overall Patient Experience Score for the Trust 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.

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).

The survey demonstrates a decline in performance in comparison to the previous year when benchmarked against trusts nationally. Scores for patients feeling that they were treated with dignity and respect, and for overall experience have seen a decline from the 2022 survey.

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).

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

Learning and Improvements

Action plans to address areas of concern and to highlight areas of good practice identified from the national surveys are developed and shared across the division for improvement and learning. Four core areas of concern were identified from the National Inpatient survey which were a quality improvement focus for the Trust in 2024/2025 (as described in section 2.0): pain management, nutrition and hydration, communication, and discharge.

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

3.7 Listening events, Patient Panels, Focus Groups and Engagement

The patient experience team captures patient experience feedback using a wide range of mechanisms and is responsible for reporting on this activity and facilitating organisational learning and improvement.

Building on our existing patient experience mechanisms and to provide wider interaction with patients, their families, and carers we deliver regular ‘listening into action’ events. These are about engaging all the right people to deliver better outcomes for our patients, our staff, and our Trust to ensure we continually seek feedback and review and improve services.

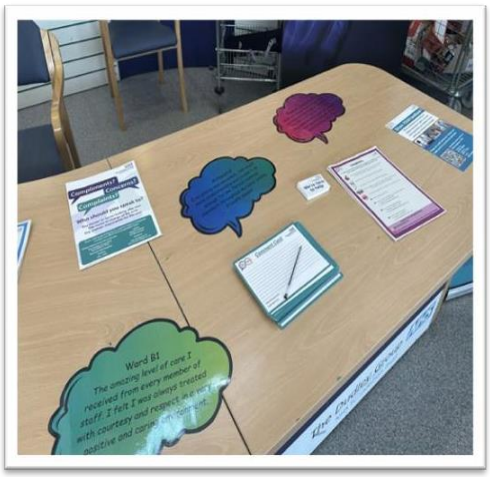
Patient Experience Champions Meeting

During 2024/2025, we hosted a number of patient experience champion meetings to share information and learning from Experience of Care week 2023. The champions shared their experiences of the work being undertaken in their area to improve the patient experience and were encouraged to get involved in Experience of Care week in 2024 to showcase good practice throughout the week.

We have shared the findings of the Patient Experience Annual Report, including successes from the year and improvements that services have made to enhance the patient experience. Champions were asked to discuss the objectives of the new Patient Experience Improvement Plan and how they will embed these objectives into the core business of their area.

Feedback Friday

During the year we have delivered several Feedback Friday sessions in the Hub in main reception to encourage patients to share feedback on the service they received to help us make improvements to their care and experience. Compliments and areas identified for improvement are shared with wards and teams following the event. Good practice is shared as part of our 'What Matters to You' campaign and via social media channels.



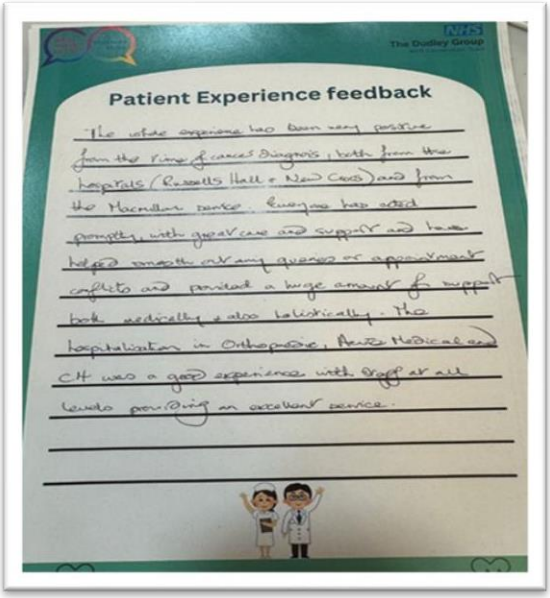
Thank You Thursday

On the 26 July, 31 August 2024 we delivered a ‘Thank You Thursday’ on 18 September in the Hub in main reception to encourage patients to share feedback on the service they received to help us make improvements to their care and experience. Compliments and areas identified for improvement are shared with wards and teams following the event. Good practice is shared as part of our ‘What Matters to You’ campaign and via social media channels.

Cancer Service Support Roadshow

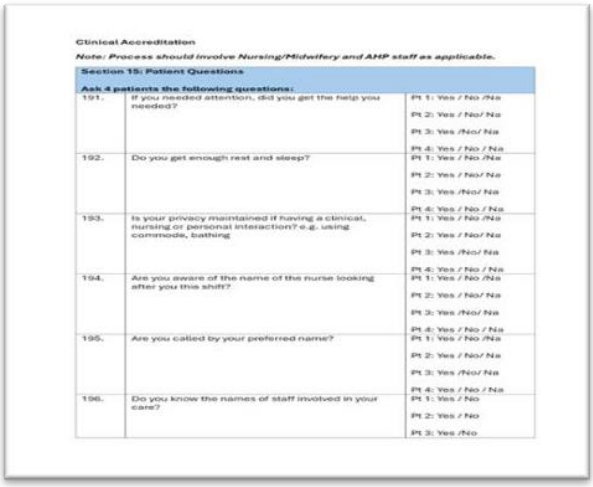
In July 2024, we supported the cancer service roadshow which aimed to signpost patients and carers to additional support services such as the White House Cancer Support, Community Outreach Queens Cross network DMBC, Macmillan Benefits, and Dudley Talking Therapies. We provided information on how patients can share their feedback on their care and treatment to help us make improvements to services.

A further roadshow was delivered in January 2025. We attended the event to gather feedback from those living with cancer and their relatives.



Clinical Accreditation Audit

We supported the clinical accreditation audit on Ward C7, Ward B4, Ward C1, B2 Trauma and AMU1. We spent time talking with patients to learn more about the care and treatment they received, including what is done well and what could be improved. Positive feedback from staff was included to highlight good practice that had been noted as part of the audit. This was a pilot project ahead of the programme in January 2025.


Clinical Accreditation

Note: Process should involve Nursing/Midwifery and AHP staff as applicable.

Section 15: Patient Questions		
Ask 4 patients the following questions:		
191.	If you needed attention, did you get the help you needed?	Pt 1: Yes / No /Na Pt 2: Yes / No/ Na Pt 3: Yes /No/ Na Pt 4: Yes / No / Na
192.	Do you get enough rest and sleep?	Pt 1: Yes / No /Na Pt 2: Yes / No/ Na Pt 3: Yes /No/ Na Pt 4: Yes / No / Na
193.	Is your privacy maintained if having a clinical, nursing or personal interaction? e.g. using commode, bathing	Pt 1: Yes / No /Na Pt 2: Yes / No/ Na Pt 3: Yes /No/ Na Pt 4: Yes / No / Na
194.	Are you aware of the name of the nurse looking after you this shift?	Pt 1: Yes / No /Na Pt 2: Yes / No/ Na Pt 3: Yes /No/ Na Pt 4: Yes / No / Na
195.	Are you called by your preferred name?	Pt 1: Yes / No /Na Pt 2: Yes / No/ Na Pt 3: Yes /No/ Na Pt 4: Yes / No / Na
196.	Do you know the names of staff involved in your care?	Pt 1: Yes / No Pt 2: Yes / No Pt 3: Yes /No

Experience of Care Week

Experience of Care Week took place from 29 April to 3 May 2024. This week allowed us to celebrate our staff and the good work happening to improve experiences of care for patients, families, carers, and staff.

Throughout the week we hosted a series of events on the Health Hub, including spotlight sessions to showcase all the good work that is taking place, completing thank you cards for our staff and distributing them throughout the Trust. We shared patient stories throughout the week on the Hub and messages from our patient experience champions. There was an appreciation station at North Block for patients, staff and visitors to leave a message of thanks and the patient experience team visited areas with our 'Talk to Us' trolley to give out cards and chocolates to staff on the wards and to encourage patients to complete a thank you message for staff looking after them. We were recognised by the Patient Experience Network (PEN) for the good work that took place throughout the week and the team were sent pin badges.

Patient Experience Inpatient Survey Engagement Event

In August 2024, the patient experience team facilitated a ‘helping us to drive improvement’ event, hosted by the chief executive and chief nurse. This was the first in a series of patient experience events to share the results from our national surveys to identify improvements that can be made to enhance the patient experience and share good practice that is taking place and celebrate success. Over 70 staff attended to share what patient experience means them.

The Dudley Deaf Focus Group

We attended the Dudley Deaf Focus Group in September 2024 to learn from concerns raised about the barriers and challenges faced by our deaf patients. Themes were raised around issues with car parking and phlebotomy services. Initiatives that were previously in place such as the vibrating pagers have since gone. The group made suggestions around having TV screens in waiting areas so that deaf patients can see their name for their appointments and being able to respond by to appointment reminders, cancellations or rearranging of appointments by text message. An update was provided at the February 2025 Dudley Deaf Group meeting on action taken following concerns raised around attending appointments.

We reported that we have been in contact with the Patient Management Centre who are currently reviewing their existing systems. The learning and development team will be attending the next meeting to discuss the development of customer care training for staff in the Trust to obtain their thoughts and ideas. The Trust are supporting the Black Country Integrated Care Board Involvement team in research they are undertaking on translation and interpreting services.

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Nutrition and Hydration event

We supported the Trust’s nutrition and hydration event. We developed a survey asking patients about their thoughts on the availability food for their friends and relatives and how easy it is to access food in the hospital, and what improvements could be made. We shared compliments and feedback from patients about the food that is provided.

The event aimed to promote the value of healthy eating and enabled staff, patients and visitors to share their views on what could be improved with the food and drink the trust provides.

Core Services Review Week

We participated in the Core Services Review Week in Critical Care in January 2025. Core service review utilise the skills of an multi-disciplinary team (MDT) of reviewers including nurses, medics, therapists, allied health professionals (AHPs), administrators, governors, non-executive directors and managers to enable us to get a picture of the quality and safety of different aspects of care provided within a core service including:

- Safeguarding
- Culture
- Medicines Management
- Infection Prevention and Control
- Documentation
- Environment
- Staff and Patient Satisfaction/ concerns
- Handover, rounds and Huddles
- Night-time care

Reports are put together in a Care Quality Commission (CQC) style document that are agreed with the leaders and are presented and agreed with the Trust Quality and Safety Group. Improvement plans are added to AMaT audit and are monitored at the Quality and Safety Group.

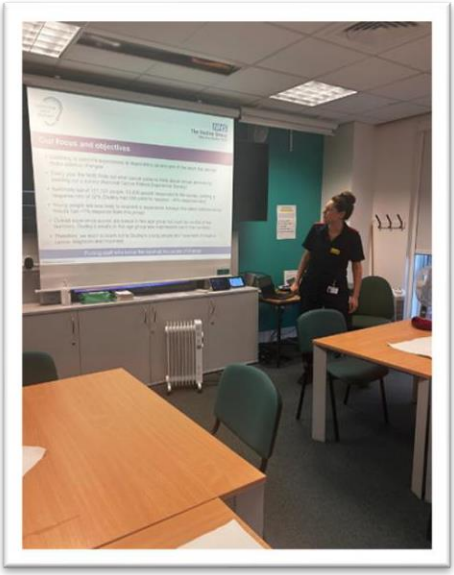
Meal-time Champions

We supported first mealtime champions meeting with attendance of 12 Clinical Support Workers and two registered nurses from across surgery and medical in-patient wards. The group received information in relation to the fundamentals of why high-quality nutrition and hydration is important to patient care and the work that has taken to date to improve provision.

The patient experience team gave an update on patient feedback and highlighted some of the trends and themes identified by patients about their experience and views of the food and drink offered.

Young Person Cancer Listening into Action Event

In March 2025 we hosted a young person's cancer listening into action event to listen to the views and experiences of Dudley's young people who have been through a cancer diagnosis and treatment. The aim of the event was to improve the experience of young people who are diagnosed with cancer. An action plan has been established to address areas of concerns and learn from what the service is currently doing well.



3.8 Talk to us trolley

We have continued to take out the 'Talk to Us' trolley across the Trust. This is taken out twice weekly and provides the opportunity for patients to give feedback about their experience as an inpatient. Healthwatch Dudley are in attendance once a month, to provide an independent champion for people accessing local health and social care services.

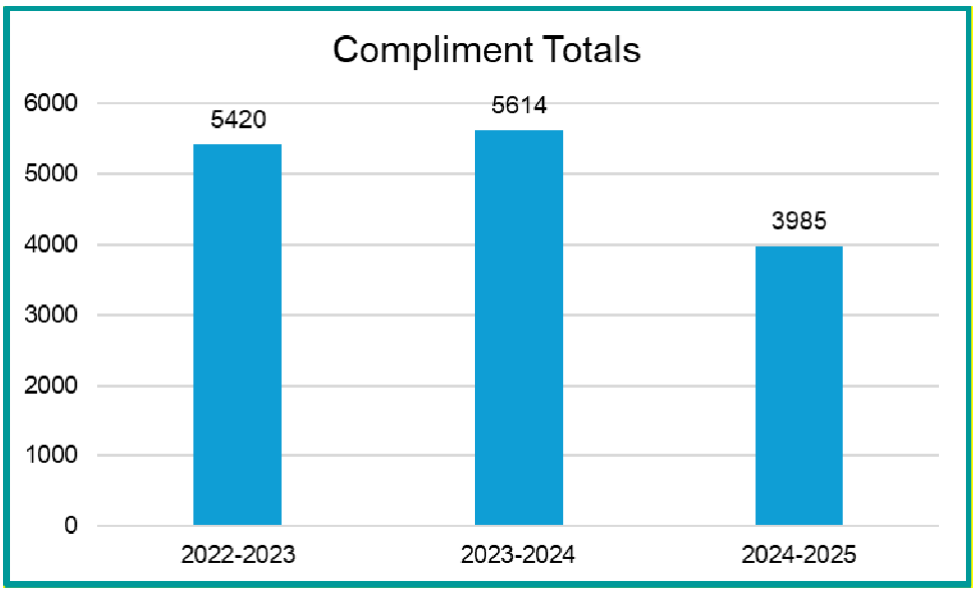
Ward reports are sent to matrons monthly and patient experience activity is presented through divisional updates at the PEG meeting.

Some examples of feedback received from patients below:

Ward	Comment
Acute Medical Unit 1 (RHH)	Staff very helpful
B2 Trauma (RHH)	Not enough time allowed to eat meals
B2 Trauma (RHH)	Better communication - lack of communication and incompetence
C8 (RHH)	They are being missed out on taking food orders because their beds are kept in the therapy room
C8 (RHH)	It's been really good, he has enjoyed staying here
C2 (RHH)	Can't fault the care.

3.9 Compliments

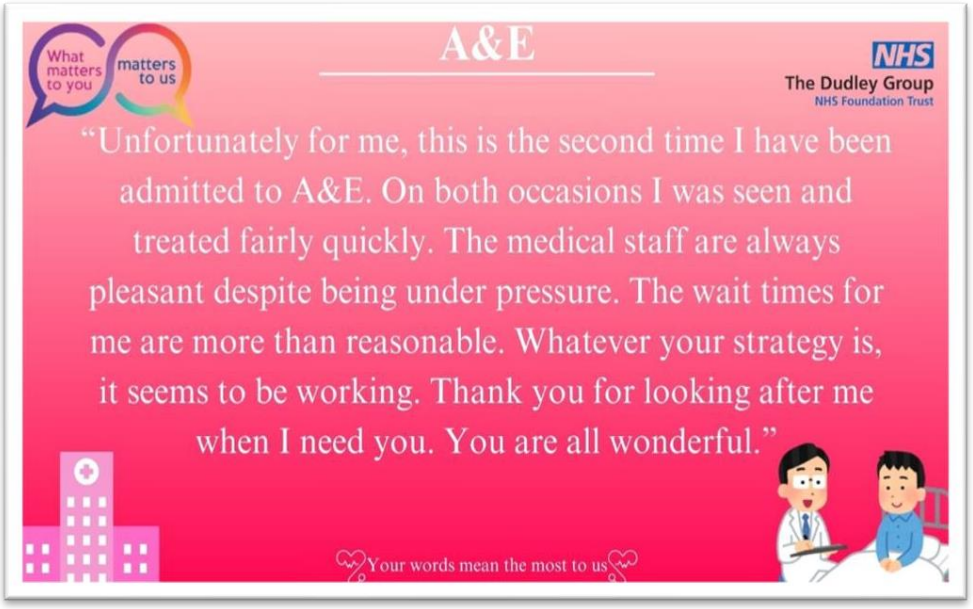
The total number of compliments received during the period April 2024 to March 2025 has decreased compared with previous years as detailed in the table below. The Trust received **3985** compliments during the year in comparison to 5614 in 2023/2024.



Ward C4 daycase received the highest number of compliments throughout the year receiving 403. All compliment letters received by the chief executive and chief nurse are personally acknowledged and shared directly with the individual and teams as appropriate, accompanied with a personal letter of thanks.

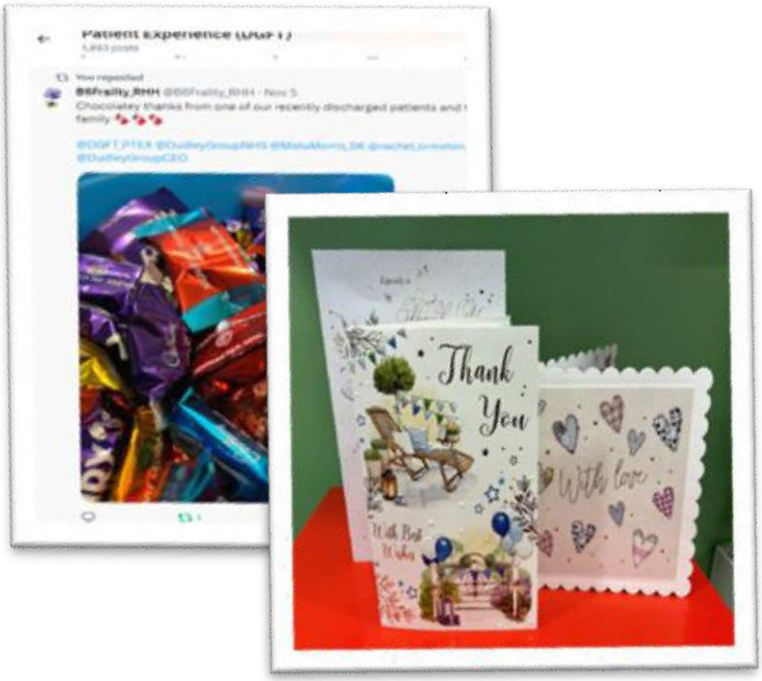
Compliments are shared on our social media and will be displayed on our new 'What Matters to You' patient experience boards and the In the Know (staff newsletter).

An example of the feedback can be found below:

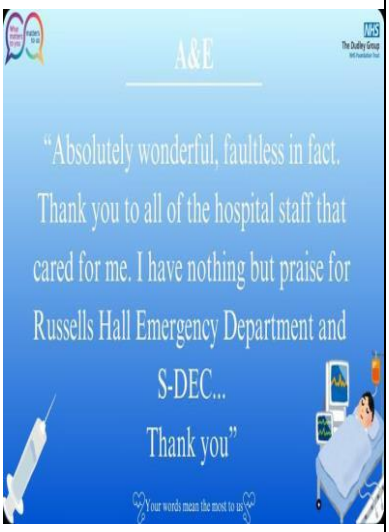


3.10 ‘What Matters to You’ Campaign

We share feedback via our ‘What Matters to You’ campaign across the Trust through social media channels and internal communications. This campaign aims to raise the profile of patient experience across the Trust, capture feedback and share successes to confirm that we listen, respond, and embed lessons learned.



An example of twitter activity for Q4 2024/2025:

Activity	January 2025	February 2025	March 2025
Followers from 1st of the month	717	720	731
New Followers	0	3	11
Top Tweet			

4.0 Improvements in patient experience

A priority of the patient experience team over the last year, and a continuing focus, is to enable and encourage more people to give feedback and to use the intelligence this generates to make changes that improve people's experience.

4.1 Acting on the feedback received

Every month the patient experience team sends out reports with patient comments/scores from FFT and real-time surveys. The 'you said' comments received form part of the patient experience reports, which are emailed to matrons and leads monthly. All managers are required to respond back with their 'we have' actions.

'You Said We Have' feedback highlights the impact patient feedback has across the Trust in real patient-led change. We work alongside frontline staff to translate feedback into local actions and ensure that the quality of care and patient experience improves:

The Trust has made several changes and improvements in response to patient feedback. Patient experience data is reviewed monthly to identify themes and trends across the Trust. This is then shared with the divisions and improvement actions and learning is put into practice and reported through the PEG, the Quality Group/committee and the Trust board.

Some examples of action taken from patient feedback during 20224/2025:

Area	You Said	We Have
Neonatal	A microwave or access to one to able to sterilise own bottle.	A microwave broke and a replacement is on order.
Nutrition and Hydration	We want more accessible information about healthy food and healthy eating	Nutrition and hydration posters have now been completed which includes the addition of a QR code. This is being put into place for ease of accessibility for staff/patients and family.
Chaplaincy	The Muslim women's prayer mat is in very poor condition.	The mat has been replaced and the room is being made comfortable with the addition of blankets.
Ophthalmology	We are not being informed about delays with appointments.	Nurses are now assigned to verbally inform patients and update them on delays.
Ward B1 Elective Surgery	Waiting for medication to take home takes too long.	Pharmacy have now had a controlled drugs cupboard fitted to assist with the delays around controlled drugs for patients ready for discharge.

Trauma and Orthopaedics	We are worried about being discharged and what will happen after joint replacements.	Staff now refer to virtual wards or to Own Bed Instead (OBI) if they feel that patients are not ready to go home. This aim is to reassure patients that they have support available.
Breast Screening	We are not offered a gown to wear while waiting to be screened and the waiting area is not always comfortable.	Some new chairs have been purchased for waiting areas and gowns for the mobile units.
Maternity	The rooms are too hot	New fans are being ordered.
Maternity	Overnight facilities for our partners are not satisfactory	New reclining chairs have been ordered.
Ward C2	Breakfast and evening meals are being served too late, and children would like to eat earlier.	Ward are reviewing the possibility of having snacks and liaising with Mitie to review times for meals.
Dietitians - Gastroenterology	Play person / entertainer for the children	A member of the play team from C2 now provides support during our neuro-disability clinics when there are three of them rostered to work.
Ward C5	Confusion over medication and delays from pharmacy	C5 now has a ward pharmacist and a rotational pharmacist commencing within the next eight weeks, this will help ensure robust discharge planning, patient education regarding medication and early escalation of To Take Out (TTO) medication.
Children's outpatients Department	I want more books please	Provided more books in the waiting area
Ward C5	More cups of tea/coffee.	Patients to be made aware during breakfast rounds that if they require additional hot drinks to the ones already provided then to call the nurses and drinks will be provided.

Main reception	There are not enough wheelchairs available in the hospital.	We have purchased 20 new wheels chairs for patient use.
Maternity	We want access to drinks and snacks 24 hours.	A trolley now in use to allow women to self-serve breakfast and hot drinks 24 hours.
Medical Enhanced Care Unit	The food has been hit and miss which is not great when you're on a restricted diet.	This has been fed back to the catering managers.

5.0 Our Achievements

5.1 Spotlight Sessions

We hosted a number of spotlight sessions in the Hub to showcase all the good work that is happening throughout the Trust to improve the patient experience. The events involved highlighting areas of good practice, sharing compliments from patients and provided an opportunity to learn more about the service.

Examples included below:

5.2 Focus groups and listening events.

The Trust has continued to support a growing number of listening events and focus groups hosted by departments and teams across the organisation. This enables the individual areas to use triangulated performance and feedback information to raise awareness with a focused group of patients, their carers, and families. The feedback from these events and the suggestions for improvement are used to develop action plans that provide a continual improvement approach to the patient experience.

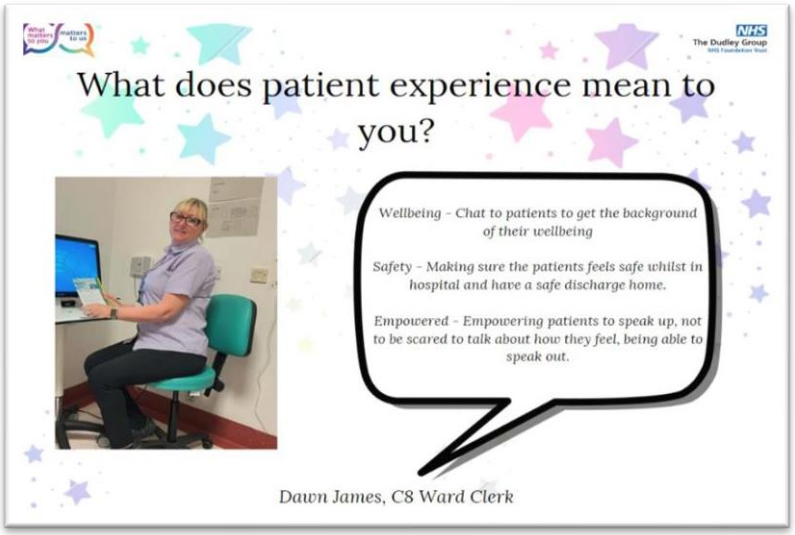
5.3 Information Hub

The Information Hub was opened in October 2024. The hub is a space aimed at providing support to the Dudley community, featuring services from The Dudley Group, Health and Social Care services from Dudley Metropolitan Borough Council and voluntary groups from across the Dudley borough. 284 people have visited the Information Hub since it's opening in October 2024 up to January 2025.

The information Hub is located in the main reception of Russells Hall Hospital, and services provide support and information to patients and visitors, carers and staff member.

5.4 Patient Experience Champions

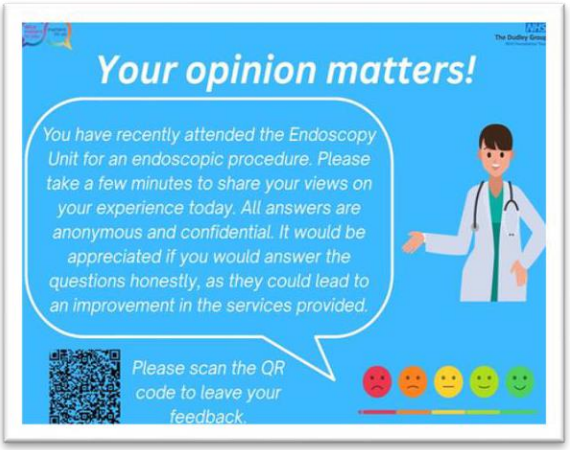
We have hosted several workshops throughout the year to share patient feedback and learning to support and develop the champions role. We have worked together to build partnerships and share information that will support our patients, and shared information on work that is happening within services to improve the patient experience.



5.5 Patient Voice Volunteers (PVVs)

Our PVVS have supported events and provided a patient perspective to the inpatient survey action plan, attended Trust Board, 'Experience of Care' week and the 'Talk to Us' trolley to engage with patients about the service they received.

5.6 Local survey development



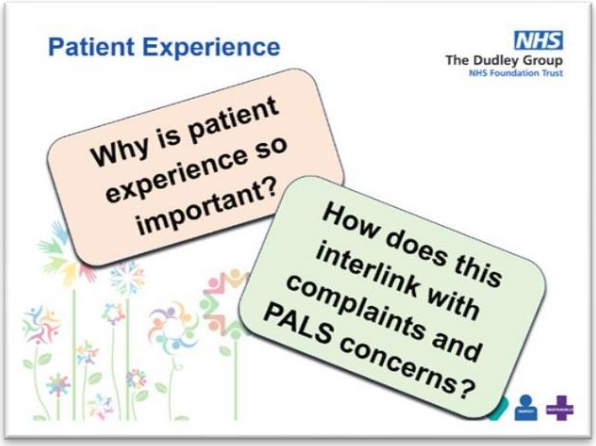
We have designed and facilitated a number of local surveys via online links and QR codes to improve the accessibility of giving feedback to allow patients to provide feedback on their experience of services. These are promoted on the new patient experience boards and tablets throughout the Trust.

5.7 Talk to Us Trolley

We have continued to take out the 'Talk to Us' trolley on the wards. This gives patients the opportunity to give feedback about their experience as an inpatient at the hospital. Healthwatch Dudley are in attendance once a month, to provide an independent champion for people accessing local health and social care services. Our Trust Governors attended throughout the year.

5.8 Training

We have continued to deliver customer care training across the Trust to raise the profile of patient experience and to highlight the importance of what matters most to patients.

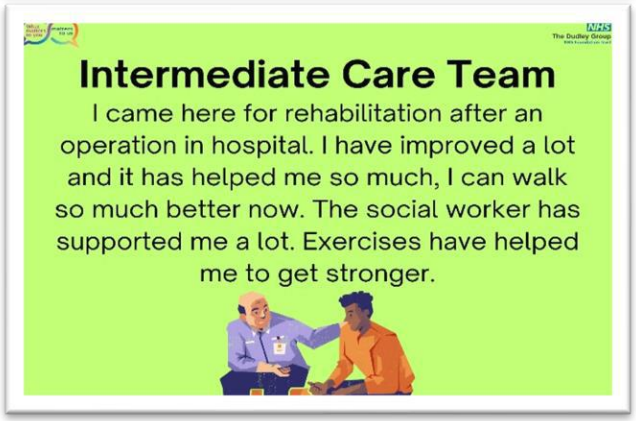


5.9 Feedback Friday

We hosted a ‘Feedback Friday’ event every month to gather feedback from people who use services and the public, to gather patient thoughts and implement changes to improve the services that we offer. Our ‘Feedback Friday’ sessions are held in the health hub at the end of each month (see section 3.8).

5.10 Encouraging patient feedback and sharing success

Throughout 2024/2025, we have continued to build on our ‘What Matters to You’ campaign across the Trust and via social media channels. This campaign aims to raise the profile of patient experience across the Trust, capture feedback and share successes.



5.11 Patient Experience – Winter

The Trust’s Associate Director of Patient Experience gave a presentation to Trust Board to highlight the feedback from our patients, sharing insights and outcomes gathered during the winter months.

The presentation showcased how the patient experience team and volunteers have supported and listened to our patients during the winter pressures, as well as ongoing projects and improvements aimed at enhancing the overall patient experience.

5.12 Experience of Care Week 2024

We celebrated Experience of Care Week 2024, which is an annual event that celebrates healthcare staff impacting patient experience every day. With the support of NHS England and NHS Improvement, it offered us the chance to celebrate the work that's happening to improve experiences of care with our staff, patients and their families and carers.

Throughout the week we shared feedback from our patients to highlight the importance of what matters most to patients, and to celebrate successes to demonstrate the great work that our staff do every day to ensure the best patient experience.

5.13 Supporting our emergency portals

The patient experience team have been assisting with making drinks for patients and relatives in the A&E Department during busy periods. The team have attended Same Day Emergency Care (SDEC), Acute Medical Unit (AMU) 1/2, the Discharge Lounge and Accident and Emergency (A&E) asking patients about their experience. Where surge beds have been put in place the team have been talking to patients about if their privacy and dignity has been respected.

Feedback from these has been mostly positive but some comments from patients included feeling cold and not being checked on during the night and not enough communication.

5.14 Patient Experience Newsletter and Communication Channels

We send out a quarterly newsletter to our staff which is shared through the Trust's weekly 'In the Know' bulletin. We update our 'What Matters to You' boards to display good news, 'You Said We Have' examples and other information to encourage patient engagement and enhance reputation of the Trust.

The Patient Experience Team

Quarter 3 – 2023/2024

Introduction

What matters to you

matters to us

Compliments

You Said, We Have

5.15 Supporting teams with the development of action plans and patient engagement projects.

We have continued to support teams to obtain feedback on their services to highlight areas of good practice and themes for improvement through LIA events, forums and focus groups and patient panels to ensure patients are involved in service development (see section 3.7 above).

5.16 Monitoring of action plans to drive service improvement.

We have supported divisions to develop action plans to translate feedback into local actions. We meet regularly with divisions to ensure monitoring and that action taken is reported to the PEG to share learning to improve the patient's experience, and to highlight good practice and ideas. We have seen an increase in positive scores in our National Inpatient survey 2023 and the Cancer Patient Experience survey 2023.

5.17 Patient Experience Engagement Plan

We developed a plan of activities to enhance engagement with our staff, patients, visitors, and stakeholders to ensure that our services meet the needs of our local people and that the views of our patients and their loved ones help to shape a health and care system that's right for them. We produced a calendar of events which focussed on increased engagement activity for the year.

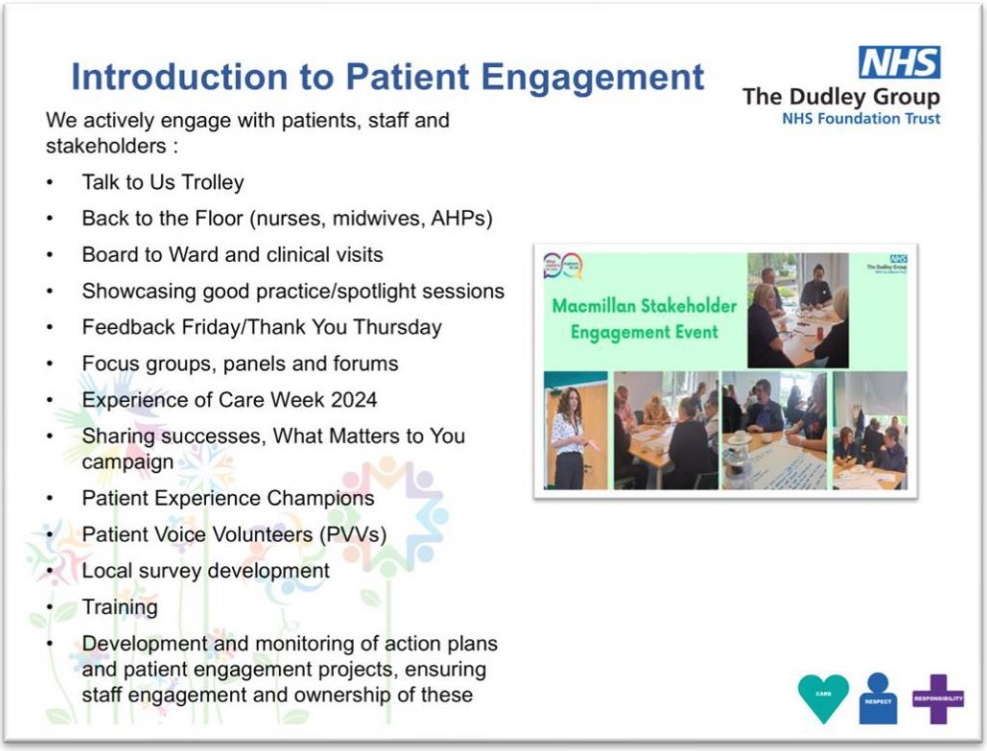
These included spotlight sessions to promote services and share good practice that is taking place, Feedback Friday, panels/forums, attending local community events and initiatives for collaborative working, and engaging with departments/teams to identify current methods used/gaps and develop further mechanisms for patient engagement that meet the needs of the client groups. This is evidenced throughout the annual report.

5.18 National Awareness Days and Campaigns

To build on our engagement activities we promote national awareness days and campaigns to highlight and raise awareness of specific health conditions to improve the health and wellbeing of our local communities.

5.19 Midlands Region Nursing & Midwifery Excellence Network

We presented at the Midlands Region Nursing and Midwifery Excellence Network to showcase the work of the Patient Experience Team and how we actively engage with patients, staff and stakeholders.



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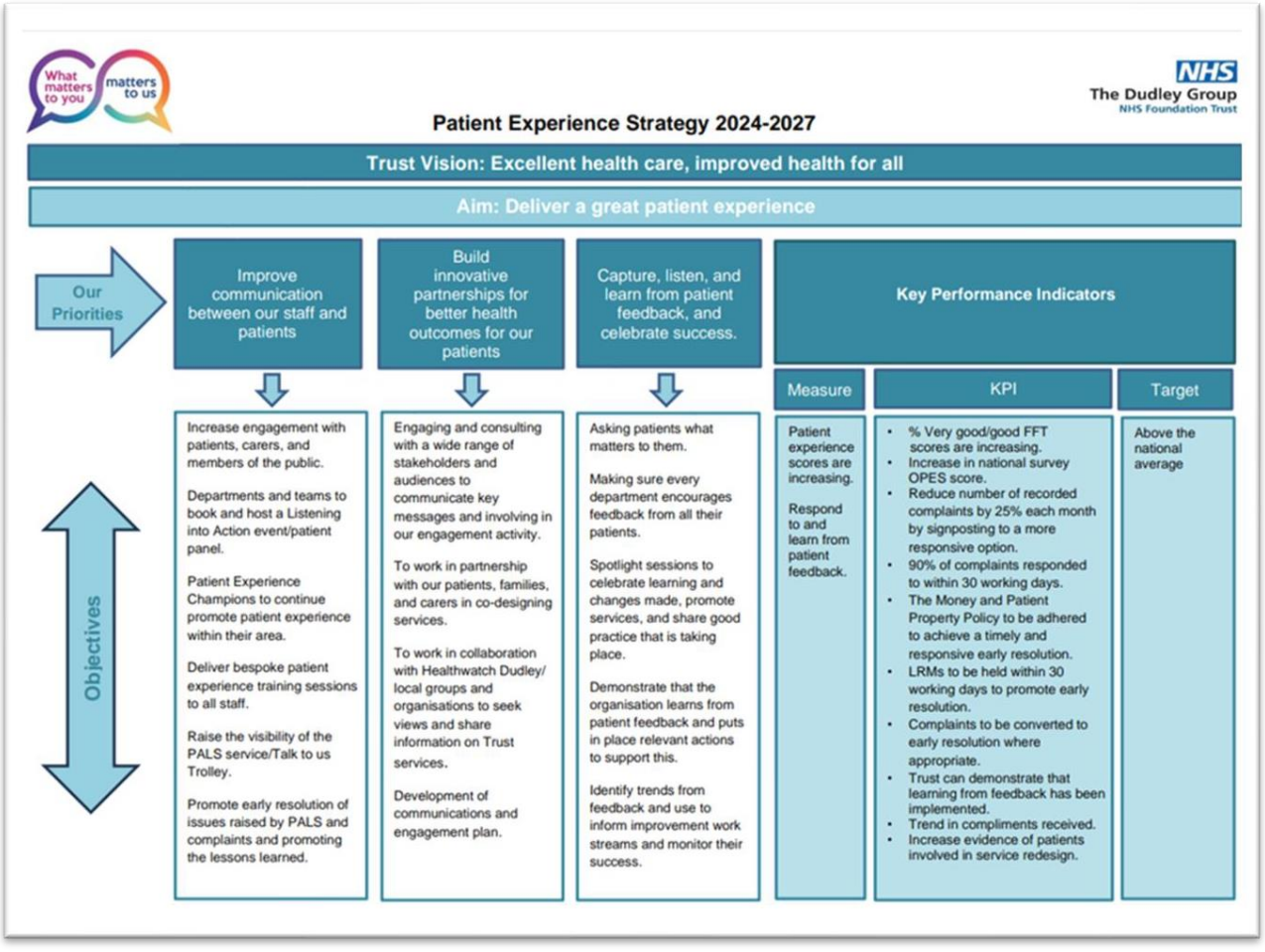
The feedback from attendees of the network was positive regarding the work that is being undertaken to support patient engagement:

> "I'm very proud of the teams' efforts and innovative approaches. It was great to see the fantastic work from Tracy as well, inspirational session. Thank you for keeping this fantastic network going".
>
> Deputy Chief Nursing Officer – NHS England

6.0 Future Plans 2024-2025

Our 2024-2027 Improvement Plan focusses on increased engagement activity for the next three years through partnership working with our stakeholders, local Healthwatch and voluntary and community groups and organisations:

We have developed a plan of activities to enhance engagement with our staff, patients, visitors, and stakeholders to ensure that our services meet the needs of our local people and that the views of our patients and their loved ones help to shape a health and care system that's right for them. We produced a calendar of events which focus on increased engagement activity for the next year. These include spotlight sessions to promote services and share good practice that is taking place, Feedback Friday, panels/forums, attending local community events and initiatives for collaborative working, and engaging with departments/teams to identify current methods used/gaps and develop further mechanisms for patient engagement that meet the needs of the client groups.



To deliver the objective of our Improvement Plan and measure progress against the outcomes achieved we have produced a plan of activity that aims to increase engagement with patients, carers, and members of the public, engage with local groups and communities to understand their needs and ensure that engagement activity is inclusive to all. To capture, listen and learn from patient feedback, increase awareness and embedding of the patient experience strategy, develop a work plan and training programme to support our PVVs and build on the 'You Said/We Have' process.

Patient Experience Patient and Public Participation Plan:

Aim	Objective		Action	Measure
Feedback	**Improve communication between our staff and patients**	Ensuring patients, carers and families feel listened to and understood. Ensure insight and feedback is representative of our communities. Ensuring feedback mechanisms are accessible. Supporting our Patient Experience Champions and teams and departments to capture feedback in their areas.	Publicise the range of feedback mechanisms across all services. Engage with services to encourage staff to hold Patient Participation and Involvement workshops/panels/forums and help staff understand the different ways of involving patients and the public effectively. Support and influence staff to consistently engage with their patient groups and external stakeholders; developing their understanding of how best to undertake patient experience surveys and involving patients on the identified actions from the feedback. Increase positive experience through on-going customer care training that increases staff awareness of the part they play in delivering high quality, positive experiences for people who use our services.	Patient experience KPIs Evidence of promotion of engagement opportunities. Evidence of action resulting from feedback

Involve	Build innovative partnerships for better health outcomes for our patients	Involve patients and the public in service improvements and developments to ensure all our services are designed around the needs of our patients and communities. Engage with groups protected by equality legislation to ensure their views are heard	Strengthen and widen the diversity of the Trust's engagement and collaboration within the local community through direct and indirect outreach work. Stakeholder mapping exercise to be carried out. and panels to review and improve the quality of services. Engage with wider teams within the Trust to support quality improvement and service development. Strengthen our Patient Voice Volunteer model, so they have a clear work schedule that can be managed and monitored, and ensure they are embedded within all the clinical teams.	Patient experience KPIs Evidence of promotion of partnership and engagement opportunities Increased membership of quarterly panels that are representative of the wider community
Inform	Capture, listen, and learn from patient feedback, and celebrate success	Keep our communities informed about changes to services Promoting 'you said, we have' via our 'What Matters to You' campaign and branding to share improvements and learning in response to patient feedback.	Continue to utilise information and feedback from compliments more effectively so that patients and staff are aware of the great work undertaken in the Trust. Quarterly You Said We Have newsletter, celebrating success communications for teams and departments. Spotlight sessions and patient experience celebration events to highlight successes and showcase good practice.	Patient experience KPIs Patient feedback is routinely considered and included in service redesign. Increased membership of quarterly panels and numbers of people getting involved with the Trust

We will continue to work with each division to ensure that all action plans are monitored regularly, and these are reported to the PEG to share learning to improve the patient experience, and to highlight good practice and ideas. The patient experience team will work alongside frontline staff to translate feedback into local actions for national and local surveys.

We will continue to monitor patient feedback, with a focus on overall rating of our services and supporting teams with action plans and analysis of feedback and development of the 'You Said, We Have' process. This will ensure actions are being reported and patients are being given the opportunity to share their experiences. Improvements made to services will be monitored and reported through divisional updates at the quarterly PEG. The measurement of patient experience at an organisational level will demonstrate improvements in positive experience.

7.0 Conclusion

This annual report reflects the significant focus given to improving the experiences of our patients, their families, and carers. The year has seen many improvements to support a good patient experience, which are detailed in this annual report.

The Trust recognises that to create a patient-centred organisation there needs to be meaningful engagement and involvement with patients, carers, the community, and stakeholders. The importance of obtaining feedback using a range of methods is critical and can provide information which can be used to influence change and improve services. We have produced a plan of activity that aims to increase engagement with patients, carers, and members of the public, engage with local groups and communities to understand their needs and ensure that engagement activity is inclusive to all.

The Dudley Group
NHS Foundation Trust

Paper for submission to the Public Board of Directors
10th July 2025

Report title:	Safeguarding Annual Report
Sponsoring executive:	Martina Morris, Chief Nurse and Director of IPC
Report author:	Julie Mullis – Associate Director for Safeguarding and Complex Vulnerabilities

1. Summary of key issues

Whilst there has been a decrease in the number of safeguarding referrals submitted this year for both adult and children, the level of complexity of the safeguarding cases presenting in Trust has increased, with many adults and children being subject to multi-faceted abuse. The safeguarding team have worked hard to meet the additional support that staff require to manage these cases and have set objectives to continue this work into the coming year.

There has been a significant increase in domestic abuse related work and acknowledgement of risk to the Trust and patients with staff not always recognising or asking about abuse. There is an improvement plan to address this risk.

This year has seen a reduction in the number of Section 42s caused to the Trust, with an improving picture around discharges and pressure area care. The safeguarding team continue to support this work and have developed a system to ensure all areas of learning are captured and monitored appropriately.

Work around robust management of allegations has continued, and a safeguarding lens is applied to all areas of concern for medical, non-medical, non-registrant and non-patient facing staff. Partnership working and transparency continues to add strength to these processes.

The safeguarding team have taken on additional responsibilities with the transfer of services from Dudley Integrated Health and Care. This has provided opportunities to work in a more efficient way and prevent duplication of work. The team recognise the need to develop closer working partnerships with primary care services that have been transferred.

Reaching Trust compliance targets for safeguarding level 3 training continues to be a challenge. The safeguarding team continue to provide accessible training via face-to-face MS Teams sessions and e-learning. The team are cognisant that not all training and teaching is captured via mandatory training, and the team continue to offer teaching opportunities via ward visits, patient stories, feedback via the internal reporting system and supervision.

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

3. Report journey

Internal Safeguarding Board
Quality Committee
Public Board of Directors

4. Recommendation(s)
The Quality Committee is asked to:
Note the information provided regarding trends, themes, achievements, and challenges in the work supporting patients with complex vulnerabilities during 1st April 2024 to 31st March 2025
To gain assurance with respect to compliance with statutory responsibilities and contractual standards.

5. Impact		
Board Assurance Framework Risk 1.1	x	Deliver high quality, safe person-centered care, and treatment
Board Assurance Framework Risk 1.2	x	Achieve outstanding CQC rating.
Board Assurance Framework Risk 6.0	x	Build innovative partnerships in Dudley and beyond
Board Assurance Framework Risk 7.0	x	Achieve operational performance requirements

EXECUTIVE SUMMARY

The Trust Safeguarding Annual Report has been developed to provide assurance to the Board that the Trust is compliant with their statutory responsibilities under the legislative frameworks relevant to protecting people from abuse and neglect.

The report:

- Provides a picture of strong compliance with statutory responsibilities including robust governance processes and acknowledges the work that is required to improve the Trust's ability to demonstrate learning from internal and external incidents.
- Acknowledges the complexities of safeguarding cases where patients are often subject to multiple categories of abuse which requires additional support from the safeguarding team and robust partnership working with other agencies.
- Demonstrates positive assurance that learning from internal and external reviews are acted upon and embedded in safeguarding practice.
- Evidences the growth of domestic abuse related work the team is undertaking and the commitment to improving the Trust response to victims of domestic abuse, including to staff experiences domestic abuse.
- Evidences the breadth and depth of partnership work undertaken by the safeguarding team to offer assurance to the Safeguarding Partnership and influence multi-agency actions and services in line with the needs of patients within the Trust are heard.
- Acknowledges the need for the safeguarding team to be visible, proactive and able to identify support required at an early stage.
- Demonstrates a reduction in the number of safeguarding enquiries caused to the Trust in relation to care provided by Trust services.
- Demonstrates the progress of the managing of allegations against staff process which is providing increased assurance that where allegations arise these are responded to in a timely manner, with clear and transparent decision making and partnership working.
- Demonstrates progress made in supporting the priorities of the Trust and the Dudley People's Partnership priorities in delivering right care every time and protecting patients across the lifespan from abuse and neglect.
- Provides areas for focus and improvement in the coming year.

Safeguarding Annual Report

2024-2025

CONTENTS		
1.0	Foreword	Page 2
2.0	Introduction	Page 3
3.0	National Guidance and Key Legislation	Page 3
4.0	The Dudley Group NHS Foundation Trust Safeguarding Team	Page 4
5.0	Governance	Page 5
6.0	Safeguarding Children	Page 15
7.0	Maternity Safeguarding	Page 26
8.0	Safeguarding Adults	Page 35
9.0	Position of Trust	Page 44
10.0	Prevent	Page 45
11.0	Conclusion	Page 46

1.0 Foreword

The Dudley Group NHS Foundation Trust (DGFT) recognises that everybody has the right to be safe, free from abuse and protected from harm, no matter who they are, or what their circumstances. The term 'safeguarding' encompasses all activities to assist children, young people, and adults to live a life that is free from abuse and neglect and to enable independence, wellbeing, dignity and choice. Safeguarding includes the early identification and/or prevention of harm, exploitation, and abuse by using national guidelines, local multi-agency procedures and by disseminating 'lessons learnt' and promoting best practice from serious incidents to improve future service development for patients and staff.

Safeguarding means protecting a citizen's health, wellbeing and human rights; enabling them to live free from harm, abuse and neglect. It is an integral part of providing high-quality health care. Safeguarding children, young people and adults is a collective responsibility – NHSE

2.0 Introduction

This annual report reflects the arrangements to safeguard and promote the welfare of children, young people and adults at risk within Dudley Group NHS Foundation Trust for the period April 2024 to March 2025.

The report highlights areas of priority and activity and those areas requiring further focus and development to strengthen the safeguarding processes and ensure the Trust is working within legal frameworks to protect children and adults from harm. The report demonstrates the Trust's commitment to work in an honest, open and transparent manner with our commissioners and partner agencies.

The report provides patient stories to reflect work undertaken by staff to keep patients safe from abuse. All patient details have been changed to maintain confidentiality

3.0 National and local safeguarding Context, Guidance and Key Legislation

Safeguarding is an increasingly complex and challenging environment. For vulnerable adults there is the need to balance the rights and choices of an individual with the Trust's duty to act in their best interest and protect them from harm. Children and young people continue to experience abuse from within and outside their families, including criminal and sexual exploitation, gang related abuse and on-line harm. These are areas of multi-faceted abuse which are often hidden and can be difficult to identify and monitor. As a Trust we have recognised that specific groups of adults and children present with complex vulnerabilities which can leave them at increased risk of harm and we have been responsive to this by establishing an integrated safeguarding and complex vulnerabilities service.

3.1 Dudley Safeguarding People's Partnership Board (DSPPB)

Dudley Safeguarding People's Partnership has embraced a life course approach to their arrangements, with a focus on an integrated adult and children's agenda and emphasis on transitional arrangements to ensure young people reaching adulthood continue to receive the care and support they need.

The priorities 2024-2026 for the Partnership are: -

Priority 1: Mental Health of Children, Young People and Adults with care and support needs, including the impact of parental mental health
Priority 2: Transitional Safeguarding
Priority 3: Exploitation, ensuring effective multi-agency practice to protect those at risk of exploitation, in all its forms

The safeguarding team has reflected these priorities via training, learning events, supervision and audit.

The Trust has been involved in the planning and development of the partnership arrangements for services for children and adults in Dudley. The Trust is represented at the Dudley Safeguarding People's Partnership Board (DSPPB) sub-groups and is an integral decision maker in the development and progression of the local safeguarding agendas. The Trust representatives play a key role in informing the multi-agency board on the development of safeguarding initiatives specifically related to health.

The Dudley Group NHS Foundation Trust recognises that safeguarding children, young people and adults with complex vulnerabilities cannot be done in isolation; it is only truly effective when we work collaboratively and restoratively with partner agencies to "Think Family" and protect all those at risk of harm, abuse or neglect. The Safeguarding team represent the Trust at the partnership working and planning groups and provide a commitment to work with partners to ensure the best outcomes for children and adults at risk of harm.

3.2 *Key Legislation*

- Children Act 1989
- Human Rights Act 1998
- Sexual Offences Act 2003
- Female Genital Mutilation Act 2003

- Data Protection Act 2018
- United Nations Conventions on the rights of the child 1990
- Children Act 2004
- Children and Social Work Act 2017
- Mental Health Act 1983
- Human Rights Act 1998
- Article 5 - Right to Liberty and Security
- Article 8 - Respect for Private and Family Life
- Article 14 - Prohibition of Discrimination
- Mental Capacity Act 2005 and Mental Capacity Amendment Act 2019
- Health & Social Care Act 2008
- Deprivation of Liberty Safeguards 2009
- Care Act 2014
- Counter Terrorism and Security Act 2015
- Serious Crime Act 2015
- Modern Slavery Act 2015
- Domestic Abuse Act 2021

3.3 ***National Guidance***

- Working Together to Safeguard Children 2018
- PREVENT Duty Guidance 2015
- CQC Fundamental Standards Statement on CQC's Roles and Responsibilities For Safeguarding Children and Adults June 2015
- FGM Enhanced Data Set 2015
- RCN 2018 Intercollegiate Document - Safeguarding Adults: Roles and Competencies for Healthcare Staff
- Child Death Review - Statutory and Operational Guidance 2018
- RCN 2019 Intercollegiate Document Safeguarding Children and Young People: Roles and Competencies for Health Care Staff
- NHS England Safeguarding Children, Young People and Adults at Risk in the NHS: Accountability and Assurance Framework updated in 2023.

4.0 The Dudley Group NHS Foundation Trust Safeguarding Team

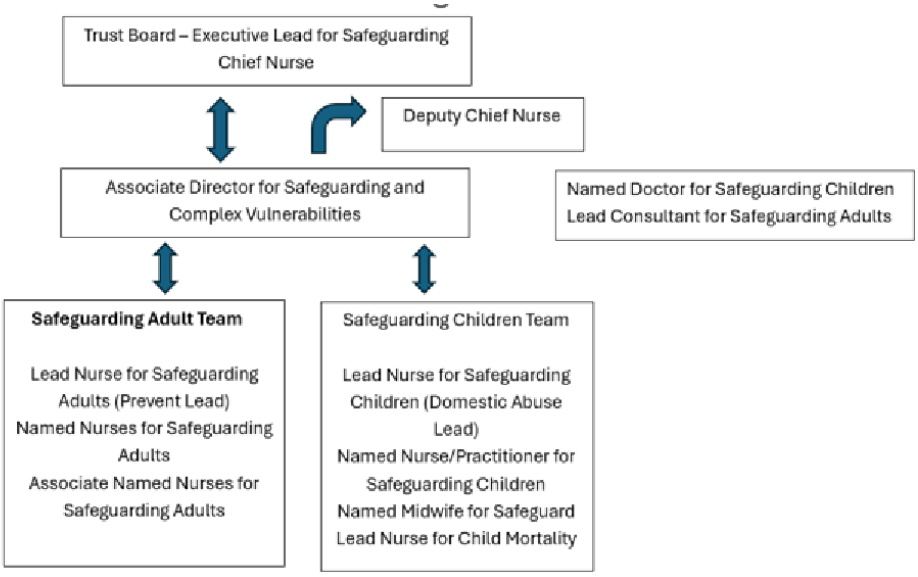
4.1 Safeguarding Team - April 2024 – March 2025

The Safeguarding Team is made up of a diverse and multi-professional team who provide specialist and expert training, advice, support and supervision to all Trust employees to enable them to fulfil their safeguarding responsibilities and provide high quality care. This includes the use of appropriate legal frameworks which protect the rights and dignity of our patients, and that patients at risk of harm always remain in our 'line of sight', that we 'hear their voice' and that they remain at the centre of all we do.

4.2 Transfer of DIHC resources

There have been some additional resources gained within the team due to the transfer of safeguarding services from Dudley Integrated Health Care (DIHC). This has provided a leadership position within the safeguarding adult team which had been a gap in terms of development and progression of the service. An additional band 7 post has also been transferred from DIHC which ensures the additional safeguarding commitments that have transferred can be met and provides increased resilience within the team during times of leave and absence. The administration role from DIHC was not recruited to and the additional associated work has been absorbed by the current safeguarding administrators.

Safeguarding Team Structure



5.0 *Governance*

The Safeguarding Team is led by the Associate Director for Safeguarding and complex Vulnerabilities, and the Chief Nurse is the Trust Executive Lead for Safeguarding, providing Board oversight of safeguarding arrangements. The Deputy Chief Nurse holds safeguarding services within their portfolio.

The Named Professionals provide the organisation with operational advice, support and input. The professionals are committed to supporting the workforce in understanding safeguarding, embedding it into 'everyday business' and improving outcomes.

The Trust oversees the governance arrangements through the monthly Internal Safeguarding Board (ISB), which is chaired by the Chief Nurse. The Safeguarding Board is held monthly, with alternate agendas between safeguarding and complex vulnerabilities. The ISB gains assurance on behalf of the Trust Board that its legal and statutory duties are met in relation to safeguarding of adults, young people and children. The ISB is attended by a safeguarding representative from the Designated Nurse Team in the Integrated Care Board (ICB) and senior leaders of Trust departments whose role is to offer scrutiny and challenge and cascade learning to their areas. Areas for escalation from the ISB are reported to the Trust Quality Committee. The Internal Safeguarding Board monitors progress against the:

- Annual work and audit plan
- CCG key performance indicators and contractual standards
- Risk register
- Incident reporting
- Local and National learning from Domestic Homicide Reviews, Safeguarding Adult Reviews and Child Safeguarding Practice Reviews
- Performance against statutory standards

To strengthen governance processes, the ISB have introduced submission of Directorate assurance reports on a rota basis. This will commence in May 2025 and provides senior nurses with the opportunity to share challenges in their safeguarding practice, celebrate good practice and identify what additional support their departments require from the safeguarding team.

5.1 Risk Register Review

A robust Risk Register is required to ensure safe, effective and comprehensive management of risks in relation to safeguarding of children, young people and adults. The identification of risks to the Trust in being able to provide their statutory safeguarding duties, is fundamental to ensuring appropriate mitigations are in place and actions are taken for continued improvement of safeguarding practice.

There have been 3 key areas of risk associated with the safeguarding adult and children's agendas during the last 12 months:

1. Non-accidental injuries (NAI) to non-mobile children – *risk closed December 2024*

Following a significant amount of improvement work in this area, all actions were completed and the risk score reduced, with closure of the risk in December 2024. This report will demonstrate that the learning has been embedded and that there is an increased recognition of NAI and staff are taking the correct action.

2. Ability of the adult safeguarding team to develop and progress the service due to increasing pressures of completing MASH lateral checks and lack of leadership role within the team – *risk closed November 2024*

Work has been completed, with support of the ICB, to streamline the completion of lateral checks for MASH questionnaires. A safeguarding adult lead role was introduced and recruited to with additional resources transferred from DIHC

3. Poor recognition and referral for victims of domestic abuse including staff who are experiencing domestic abuse – risk opened October 2024 – current risk score = 12 (Moderate)

This risk was identified as a result of: -

- A local Domestic Abuse Related Death Review (DARDR) that the Trust has participated in
- An audit within ED
- Low number of reported incidents of identified domestic abuse cases
- Low numbers of referrals to the Trust Independent Domestic Abuse Advocate (IDVA)

The risk sits on the Corporate Risk Register. An improvement plan is in progress and further work in this area is reported within the annual review.

*5.*2 Partnership working

During 2024/25 the Trust has contributed to engagement and effective partnership working with agencies across Dudley and the wider Black Country footprint.

5.2.1 Dudley Safeguarding People's Partnership

Dudley Safeguarding People's Partnership Board (DSPPB) oversees the safeguarding arrangements for Dudley. The Head of Safeguarding attends the Dudley Safeguarding Adult Group. The Designate Nurses within the BCICB Dudley Place are the health representatives within the Children Group, although future meetings in 2025 will also be attended by senior representation from health provider organisations. The Adult and Children Group report to the Executive Board of the DSPPB. The Trust provides representation at the DSPPB four subgroups around operational systems, learning and improvement and exploitation (children's and adults).

The safeguarding team participate in Multi-Agency Assurance of Practice Audits for children and adults on a quarterly basis.

The Trust are also represented by the Safeguarding Team at the Dudley Domestic Abuse Local Partnership Board, Domestic Abuse Related Death Review (DARDR) Governance Group, DARDR Panel Meetings, Violence Against Women and Girls (VAWG) Strategic Group and DA/VAWG Forum which are led by Dudley's Community Safety Partnership-Safe and Sound.

The Trust is a virtual member of the Multi Agency Safeguarding Hub [MASH] for adults & children. This process is for the multi-agency sharing of information where a safeguarding concern arises and facilitates effective collaboration.

The safeguarding team also actively contributes to Dudley Safeguarding Adult Reviews, Domestic Homicide Reviews/Domestic Abuse Related Death Reviews and Child Safeguarding Practice Reviews, both in terms of scoping, Individual Management Reviews and Panel procedures.

The safeguarding team attend and share information at the Multi-Agency Risk Assessment Conference (MARAC) to work in partnership with other agencies to protect people at risk from domestic abuse.

The Lead and Named Nurses for Children and Adults also attend:

- Child Exploitation Partnership Group.
- Exploitation Panel Meeting
- Local and regional PREVENT partnership events to ensure the Trust has robust and up to date systems in place to report issues around radicalisation. The Executive Lead role for the Trust is held by the Deputy Chief Operations Officer.
- Safeguarding Children and Adult MASH Operational and Strategic Forums
- Safeguarding in Suicide Working Group
- Serious Violence Duty Steering Group

5.2.2 Joint Targeted Area Inspection (JTAI)

JTAIs are joint inspections carried out by Ofsted, the Care Quality Commission (CQC), Her Majesty's Inspectorate of Constabulary and Fire and Rescue Services (HMICFRS) and Her Majesty's Inspectorate of Probation.

The inspectorates jointly assess how local authorities, police, health, probation and youth offending services are working together in an area to identify, support and protect vulnerable children and young people.

The scope of a JTAI is to look at multi-agency arrangements, including the quality and timeliness of assessments, and to carry out a 'deep dive' investigation of the response to specific children and young people (usually described as the 'theme' of the inspections).

The Trust has undertaken work with partner agencies this year to prepare for a JTAI inspection. The Multi-Agency JTAI Prep Group meets monthly and DGFT have completed two self-assessment audits in relation to Front Door/Early Help and Domestic Abuse. DGFT is also a member of the Health JTAI Group to ensure we have evidence required when an inspection is carried out.

5.2.3 Child Protection Information System (CP-IS) - Phase 2

The Child Protection - Information Sharing (CP-IS) service helps health and social care workers share information securely to better protect children and young people who are known to social care because they are:

- looked after
- or have a child protection plan

CP-IS links IT systems across health and social care in England to help organisations share information securely.

Currently the Trust access CP-IS within the unscheduled care settings of ED, Paediatric Assessment Unit and unscheduled maternity care.

Phase 2 of CP-IS is aimed at its use in some scheduled care settings. For the Trust, this is within the community paediatric clinics and the 2 Trust GP Practices. Prior to children being seen by the paediatrician, CP-IS will be checked to identify if children are subject to a child protection plan or are looked after children. Work is underway to progress this, and the Associate Director for Safeguarding attends the ICB led forum to update on this workstream.

5.3 Trust activity contributing to DSPPB Priorities for Dudley 2024-2026

Priority	Action Taken
Mental Health	• Submission of data to the partnership to support analysis of themes and trends • Lead for MH has provided training to staff in ED to support with therapeutic 1 to 1 observations of patients with MH in ED

	• All incidents reported relating to patients with mental health concerns are reviewed by the safeguarding team and advice given to staff if missed opportunities are evident. • DGFT have a mental health and safeguarding referrals pathway for children to direct staff to complete appropriate referrals. • DGFT have a direct referral link with Barnardo's to offer support to children with raising self-esteem, building resilience, mindfulness, relaxation techniques, behaviour techniques, coping with bereavement, managing emotions and staying safe strategies. • Patients in mental health crisis are seen within the hospital by either the Mental Health Liaison Service or CAHMS (dependant on age of the patient). • The trust offers a Perinatal Mental Health Service alongside specialist midwives to support with mental health during the perinatal period. • The safeguarding team maintain a spreadsheet of mental health attendances within ED to monitor trends, referrals and potential contextual safeguarding concerns. • The Children's safeguarding team have contributed to the DSPP Multi-agency Assurance of Practice Audit with a theme of mental health. • Adults that present to ED with mental health concerns are asked within mandated questions in ED regarding children and whether they have any caring responsibilities so appropriate onward referrals can be completed. • Adults who present with parental risk factors including mental health, are reviewed by the safeguarding team daily to ensure assurance within trust that a think family approach is being considered. Referrals are completed by the safeguarding team when missed and appropriate feedback given to departments. • The Children's safeguarding team completed an online harms roadshow in February 2025 including cyber bullying. • Parental mental health is a theme within children's safeguarding supervision.

Transition	• Lead Nurse for Transition- coordinates transition service for CYP at DGFT
	• Youth worker will take referrals for young people aged between 13-25 years living with a long-term health condition, accessing the hospital and meet the following criteria:
	  • Acceptance of diagnosis
	  • Struggling/Nonadherence with condition and/or treatments
	  • Isolation, lack of peers and/or interests/hobbies
	  • Building positive relationships
	  • Coping strategies
	  • Emotional health and well being
	  • Education, employment or training
	  • Identity and self-awareness
	  • Risk taking behaviour
	  • Social skills/engagement
	  • Healthcare transition
	• DGFT Transition from Paediatric to Adult Services Policy
	• Transition clinics- joint clinics across paediatrics and adult specialities. This commences when the young person is 14 years old utilising the Ready, Steady, Go model and NHS Health Passport
	• St Giles in the Emergency Department accepting referrals where there are exploitation concerns (up to 25yrs)
	• Learning Disabilities Team work across paediatrics and adult specialities within DGFT

	• Mental Capacity Lead Nurse who can advise/support 16–17-year-olds when required where there are concerns regarding capacity • The Children's Safeguarding Team review a daily report which details where 16-17year olds are across the trust to ensure any safeguarding needs are met • Adultification is a theme covered within level 3 safeguarding training. • Maternity services have a referral process with the Family Nurse Partnership to complete referrals for expectant mothers until the age of 19.
Exploitation	• The Adult safeguarding team have produced a Trust wide Safety Bulletin on exploitation this will be circulated in April 2025. • The Adult Safeguarding team worked with the DSSP to produce an Exploitation podcast; this has been shared with trust staff. • The All-Age Exploitation screening tool has been launched in trust. This has been shared via the In the Know (newsletter), promoted via mandatory training sessions and available on the trust's safeguarding team information page. • Exploitation will remain on the agenda for Safeguarding Champion Forum • This is currently a level 2 children's safeguarding topic however will become a level 3 children's safeguarding topic by the end of April. • The children's safeguarding team completed online harms roadshow covering online exploitation. • Referrals are made to St Giles Trust workers by the safeguarding team where there are concerns regarding criminal exploitation. • DGFT have a referral pathway for children who consume alcohol and substances and attend the ED department involving other agencies such as Hear4Youth. • The Safeguarding team collate data for alcohol; substance use and peer on peer violence. • The Children's safeguarding team have completed a child exploitation audit which is due to be delivered at the Internal Trust Safeguarding Board. • Child exploitation is a theme within children's safeguarding supervision. • The Children's safeguarding team attend CEOG, Child Exploitation Panel and send research for MACE. • The Children's safeguarding team are in the process of creating an alert flag on our systems for children that are at medium/high/former risk of child exploitation to prompt professional curiosity.

5.4 ***Safeguarding Training***

<u>Safeguarding Training Compliance (end of Q4)</u>

Reaching Trust compliance targets for safeguarding level 3 training continues to be a challenge. The safeguarding team continue to provide accessible training via face-to-face MS Teams sessions and e-learning. The team are cognisant that not all training and teaching is captured via mandatory training, and the team continue to offer teaching opportunities via ward visits, patient stories, feedback via the internal reporting system and supervision.

Topic/Level	CCG Contractual Compliance Standard	Compliance % Q4 2021/22	Compliance % Q4 2022/23	Compliance % Q4 2023/24	Compliance % Q4 2024/25
Children Level 1	90%	90%	92%	93%	95%
Children Level 2	90%	76%	76%	83%	84%
Children Level 3	90%	60%	83%	75%	76%
Children Level 4	90%	100%	100%	100%	100%
Adults Level 1	90%	90%	92%	91%	95%
Adults Level 2	90%	75%	78%	84%	87%
Adults Level 3	90%	61%	80%	87%	83%
Adults Level 4	90%	100%	100%	100%	100%
Prevent Basic Awareness	90%	92%	91%	94%	94%
Prevent WRAP	90%	87%	88%	94%	94%

5.4.1 Safeguarding Children Level 3

Compliance with this training sees a trend of significant drop in compliance during Feb/March of the last 2 years. This has occurred following the safeguarding team providing mass training events in Feb/March 2023 in response to a CQC inspection in 2023 where safeguarding children training compliance was identified as a significant risk. Subsequently, as this level of training is an annual rather than 3 yearly compliance, this dip occurs at this point in the year. The training requirement for this training changed from a from being a 3 yearly compliance to being an annual compliance in September 2022. The Intercollegiate document guidance states that staff should be complete a minimum 8 hours of training over 3 years and as staff advised that it was difficult for them to take a whole day out of practice to complete, the annual compliance means that staff only need to complete 2-3 hours a year, making it easier for them to accommodate alongside their clinical responsibilities. However, staff are failing to book onto face to training or complete the eLearning in a timely fashion, meaning they are non-compliant before they think about rebooking.

The Divisional leadership team are responsible for ensuring their staff understand their responsibilities in completing their mandatory training and holding staff to account for failure to complete the training in a timely manner.

The safeguarding team provide 2 different options for levels 2 and 3 training with face to face over MS Teams and e-learning. As mitigation to associated risks of poor training compliance, the safeguarding team are visible within the ED daily, provide regular supervision to ED nurses and the process of paediatric liaison identifies any missed opportunities. The fact that the compliance is annual, does mean that staff who are not compliant have had safeguarding training within the last 12-24 months which is in line with the intercollegiate guidance, however, the number of hours they have completed falls outside the guidance.

The safeguarding team are awaiting the results of the national review of Statutory Mandatory Training and will adjust training in line with these recommendations when available. It is hoped that there will be increased scope for flexibility of training needs analysis and content in order for the team to deliver training that is relevant and necessary to the needs of the organisation.

In addition, there is ongoing work across the system to explore aligning training needs analysis, and delivery of safeguarding training at all levels.

5.5 Audit and benchmarking

5.5.1 Single Agency Audits

Title	Purpose	Outcome	Actions Taken
Children – ED Safeguarding Risk Assessment	Ascertain that the safeguarding risk assessment is completed	• The safeguarding checklist is not consistently completed	1.Audit results shared with ED Clinical and Nursing Leadership Teams 2.Safeguarding team completing daily visits to ED and completing spot checks

	consistently accurately	• Where the checklist was completed, it did not accurately reflect the presentation of the child	on the completion of the risk assessment 3.Liaison with IT to prevent safeguarding risk assessment being bypassed on Sunrise
Professional Curiosity	Re-audit following CQC findings	• Evidence of staff completing risk assessments and demonstrating sufficient questioning and probing to ascertain potential risks • Staff were able to recognise and refer safeguarding concerns based on questioning and probing • Good recognition of the voice of the child and speaking to the child alone when appropriate • There were a small minority of 16–17-year-old patients where CP-IS had not been checked by ED receptionists	1.Results shared with clinical and nursing leadership teams 2.Reminders sent to receptionist staff regarding checking CP-IS for children seen in Majors
Was Not Brought	Ascertain if staff are aware of and process for reporting cases of neglect for children who are not brought to their medical appointments	• Overall staff had a good awareness of the WNB process • There were some gaps in relation to staff knowing all parts of the process for considering risk associated with not being brought to appointments	1.Missed appointment notification forms placed on the front of the records when a child attends Children's Outpatients Department. 2. WNB flowchart on the wall in each clinic room in Children's Outpatients Department and Trauma and Orthopaedics. 3.WNB discussed in Paediatric Peer Review session
C2 – Non-Accidental Injury (NAI)	Ascertain staff awareness of learning from recent SI/CSPR and knowledge of responding to signs of NAI	• 89% of staff were aware of the learning from SI/CSPR • 93% of staff aware of significance of bruising in a non-mobile child • Good awareness from staff of what to do when children present with	Continue with NAI as topic for level 2 and level 3 safeguarding training and within supervision sessions Result of the audit shared with staff in ED and C2

		injuries/bruising with no clear explanation	
Child Neglect	Ascertain staff awareness and knowledge of child neglect	• Staff have a very good understanding of neglect in children, particularly around signs of physical neglect, there was less awareness of neglect due to lack of emotional warmth and lack of supervision • Staff knowledge consistent with their level of safeguarding training • Good awareness of need to discuss concerns with safeguarding team	Patient safety bulletin Safeguarding training updated to include parental risk factors impacting on parenting capacity
Professional Curiosity (2nd audit)	Re-audit following CQC findings	• Significant improvement in documentation, completion of risk assessments, gaining the voice of the child and observing parent/child interactions	Audit results shared with clinical/nursing leadership
Chaperone audit	Ascertain if staff are following the Trust Chaperone Policy	• There is poor compliance with the policy. Staff are not documenting that they have a chaperone present for intimate examinations and where it is documented it is not sufficiently detailed	The audit has been shared with Divisional governance groups Divisions asked to provide assurance of how they will address gaps in practice Awareness raising activities planned throughout 2025-26 The Trust is participating in the national review of chaperoning being led by NHSE
Domestic abuse audit	Are staff recognising and supporting victims of domestic abuse in line with the Trust policy?	• There is poor compliance with the Domestic Abuse Policy, Safeguarding Children	Poor compliance with the Domestic Abuse policy has been added to the risk register Domestic abuse Improvement and Action Plan in place

		Policy and Safeguarding Adults Policy	The audit has been shared with Divisional governance groups
Quality of safeguarding referrals for Unborn's	To assess the quality of information shared on the Multi Agency Referral Form (MARF)	• Quality of referrals were overall good in terms of gaining consent and providing clear details of the risks to the unborn baby • Whilst risks were clearly identified, the analysis of risk was lacking	Learning shared during supervision and training Staff receive feedback regarding quality of the safeguarding referral via Datix™ Findings of audit shared at Maternity governance meeting
Birth and discharge plans for unborn babies open to Dudley Children's Social Care	To determine if DGFT maternity services are in receipt of formal birth and discharge plans prior to birth	• More than half of the cases audited identified that there was no formal birth/discharge plan provided by Children's Social Care • In the absence of a formal plan, there was evidence in some cases of informal plans discussed and documented between midwives and social worker	Audit findings shared with Head of family safeguarding at Dudley Children's Services and request made for formal monthly meeting to be attended by the Named Midwife for pre-birth planning
Maternity booking documentation audit	To ascertain if the correct information is being recorded during booking appointment to support safeguarding risk assessments	• Overall documentation was good but detail regarding fathers was missing and only a minority of midwives were making checks via the GP systems to inform their safeguarding risk assessment	Learning shared during supervision and training

5.5.2 Multi-Agency Assurance of Practice Audits

Title	Purpose	Positive	Improvements Required	Actions Taken
Providing help, support and protection to children in Dudley	To measure the effectiveness of the safeguarding system to ensure children and families are	'Was Not Brought' pathway was followed	None noted	No actions for DGFT

	receiving the right level of support	Safeguarding referral process was followed Good liaison/communication with police and social care		
Domestic Abuse	Joint Targeted Area Inspection (JTAI) Theme- multi-agency response to children who are victims of domestic abuse	Routine enquiry completed in pregnancy and disclosure was actioned appropriately Good professional curiosity demonstrated in the hospital records Considered other children in the household and the impact on their health and development	Midwives to ensure they enquire regarding paternal substance misuse/alcohol at booking	Awareness raised in huddles and safeguarding supervision
Children's Mental Health	DSPP priority area	Completion of Mental Capacity Assessments and followed the Absconding Patients pathway Safeguarding referral and information sharing pathways were followed Child exploitation alert on the electronic record was not considered or recognised	Speaking to children alone Voice of the child to be documented at all contacts with CYP to include presentation, behaviours and interactions with caregiver Recognition and response to child exploitation Children who present to ED with mental health concerns must have a referral to CAMHS or Barnardo's prior to discharge	Discussions with staff during safeguarding supervision regarding the importance of speaking to CYP alone and documenting voice of the child Raise awareness of the exploitation screening tool in safeguarding supervision and training Raise awareness of the mental health pathways during safeguarding supervision and training

Self-neglect	DSPP Priority Area	Recognition of self-neglect Appropriate referrals Patient's wishes and feelings considered	Use of MCA	Ongoing work across the Trust relating to MCA
Financial	DSPP Priority area	Use of MCA	Professional curiosity	Ongoing work across the Trust relating to professional curiosity

5.6 Assurance visits/reports and external peer reviews

5.6.1 Assurance to Black Country Integrated Care Board

The Associate Director for Safeguarding has a quarterly 1 to 1 meeting with the designate nurses within the BCICB Dudley Place to update on risks and provide assurance. The Associate Director for Safeguarding also attends the monthly BCICB led Safeguarding Assurance Group and provides a verbal update on safeguarding activity, themes, trends, concerns and positive practice. This is a system wide meeting and provides a valuable opportunity to learn about practice in other areas and share resources and insights.

The team provide updates and reports via the Contractual Quarterly Review Meetings. A monthly safeguarding dashboard is completed and submitted to the ICB with data around activity and compliance with contractual standards.

5.6.2 NHSE Safeguarding Integrated Data Dashboard

All NHS provider organisations are now required to submit the following data via the NHS England's Data Collections Framework (DCF):

- Provider Safeguarding Commissioning Assurance Toolkit (P-SCAT)
- Prevent Duty data

Following initial errors within NHSE, the Trust did not have the correct channels on the database to submit this data, therefore a benchmarking exercise was completed against all areas of the assurance toolkit. The Trust are compliant with all areas of the assurance tool and now have access to submit data via the portal.

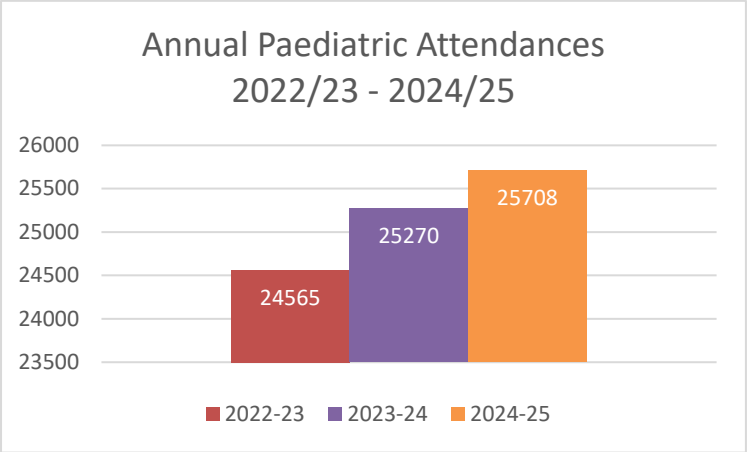
5.6.3 Assurance to the Dudley Safeguarding People's Partnership

The Associate Director for Safeguarding has presented an extensive assurance report to both the DSPP in respect of demonstrating embedding of learning from local SARs and CSPRs within the Trust. The assurance presentation was reviewed and scrutinised by partner members including adult social care, children social care, the police and education. The presentation of the work was well received and feedback from partners was that the Trust was able to demonstrate a high level of assurance of how learning is embedding and evidencing the impact of this on children and adults. The assurance piece was held up to other agencies of an example of how assurance should be provided.

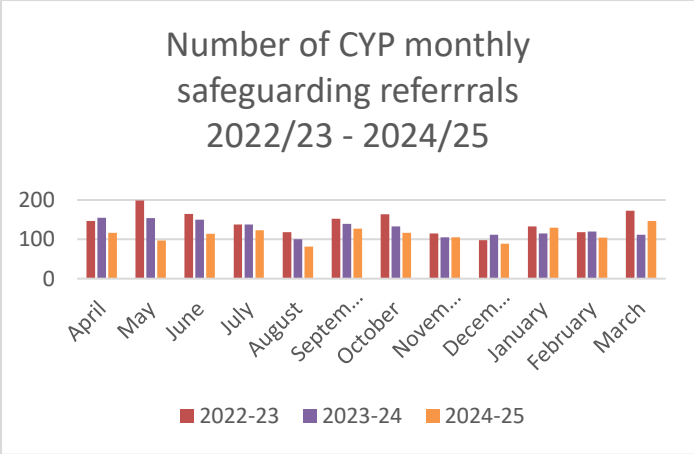
6.0 Safeguarding Children

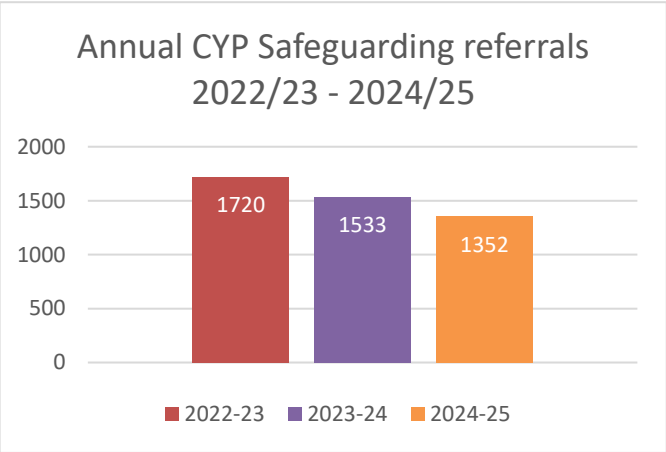
6.1 Safeguarding Activity and Performance for 2024/25

Emergency Department Paediatric Attendances



Source: Trust Safeguarding Dashboard





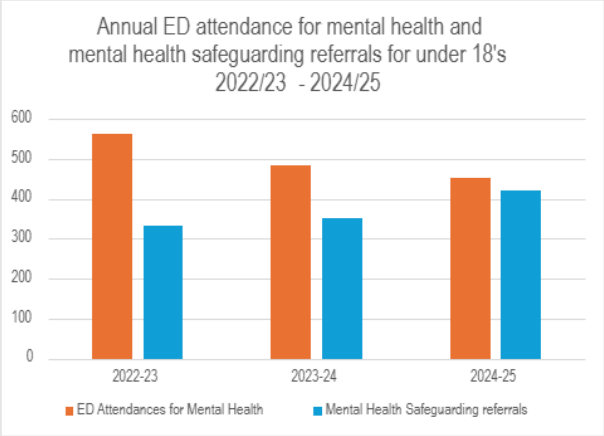
Source: Trust Safeguarding Dashboard

Over the last 3 years there has been a steady decline in the number of children safeguarding referrals made by the Trust to Children's Social Care. This is as a result of ongoing work by the safeguarding team with staff in paediatric ED to ensure they are making appropriate referrals. The named nurse attends the Dudley Safeguarding Children Operational Group where concerns were raised that a significant proportion of safeguarding referrals submitted by ED staff were not appropriate and the concerns raised should have been referred to other support services such as mental health services, youth violence reduction services, primary care services and alcohol and drug services. The safeguarding team have developed tools and pathways to support staff in making referrals to these alternative services. The team have worked with the ED staff to ensure they are employing professional curiosity and risk assessment skills to inform when it is appropriate to refer to Children's Social Care. The feedback from Dudley Children's Social Care has been positive.

6.1.1 Themes and trends

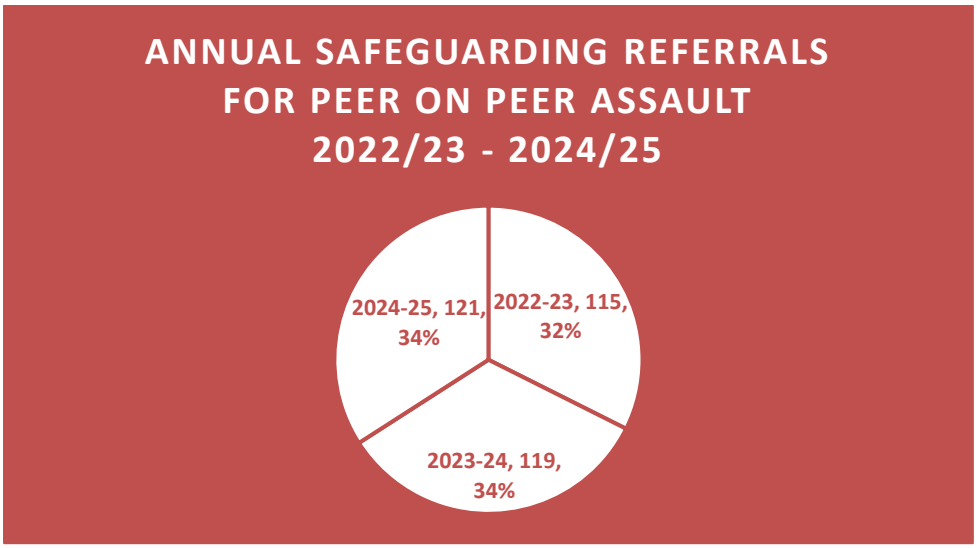
Mental Health

Following a national and local increase of child and adolescent mental health concerns following the Covid 19 pandemic, the graph below shows a slow but steady decline in the number of CYP attending ED with mental health issues. Despite this, the number of safeguarding referrals as a percentage of the attendances has increased, this is because CYP are attending with more significant and complex cases of mental health which are often multi-faceted and requiring support from children's social care to manage and reduce risks. The safeguarding team have oversight of all these referrals and are assured that they are all relevant and appropriate referrals.



Source: Trust Safeguarding Dashboard

Peer on Peer Assault

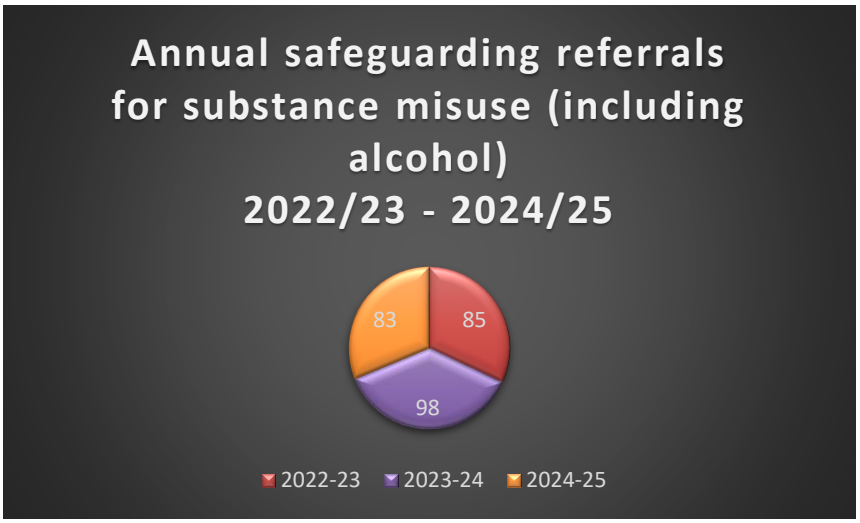


Source: Trust Safeguarding Dashboard

Peer on peer assaults can indicate signs of exploitation. It is acknowledged that staff are not always employing appropriate professional curiosity and risk assessment skills when making safeguarding referrals and this is an area of work which the team will continue to support.

Substance Misuse

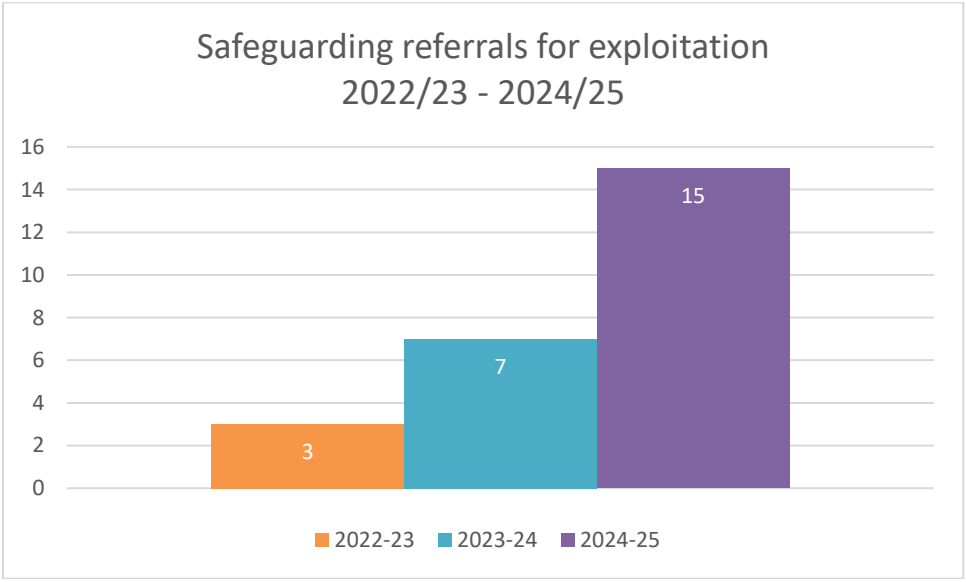
The slight increase in the number of safeguarding referrals in respect of substance misuse reflects the increase in attendance overall in ED this year. In addition to safeguarding referrals, staff will refer to youth substance misuse support services to ensure CYP are in receipt of specialist support.



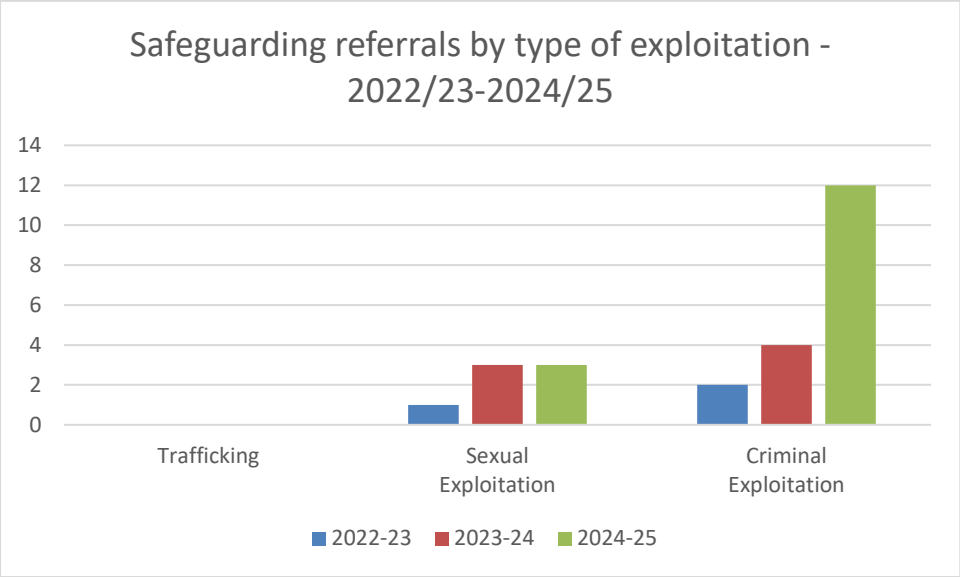
Source: Trust Safeguarding Dashboard

Child Exploitation

Child exploitation is when someone uses a child for financial gain, sexual gratification, labour or personal advantage (Home Office, 2022). The graph below demonstrates that staff are improving in their ability to identify signs of exploitation which can often be quite subtle e.g. mental health/substance misuse and require staff to engage children in conversation and ask pertinent questions to ascertain whether exploitation is a concern. This professional curiosity has resulted in double the number of safeguarding referrals being made this year due to concerns around exploitation and there has been good evidence that some staff in ED are using the exploitation screening tool to support them in their assessments. The increase has come from staff recognising criminal exploitation, but criminal exploitation is rarely experienced in isolation to other forms of exploitation.



Source: Trust Safeguarding Dashboard



Source: Trust Safeguarding Dashboard

Intra-familial abuse

Intrafamilial abuse is the term given to maltreatment of children within a family unit or setting. It is a broad term that can incorporate many different forms of abuse including sexual, physical and emotional abuse, domestic violence - including the effects of a child witnessing it - and neglect linked to parental social and health problems. The graph below shows the incidents of reporting these categories of abuse over the last 3 years.

The graph below demonstrates that there has been a significant increase in the number of intrafamilial cases of abuse being identified and referred this year compared to the previous 2 years. The 2 main areas of significance for this are in respect of parental risk factors and NAI/Physical Abuse.

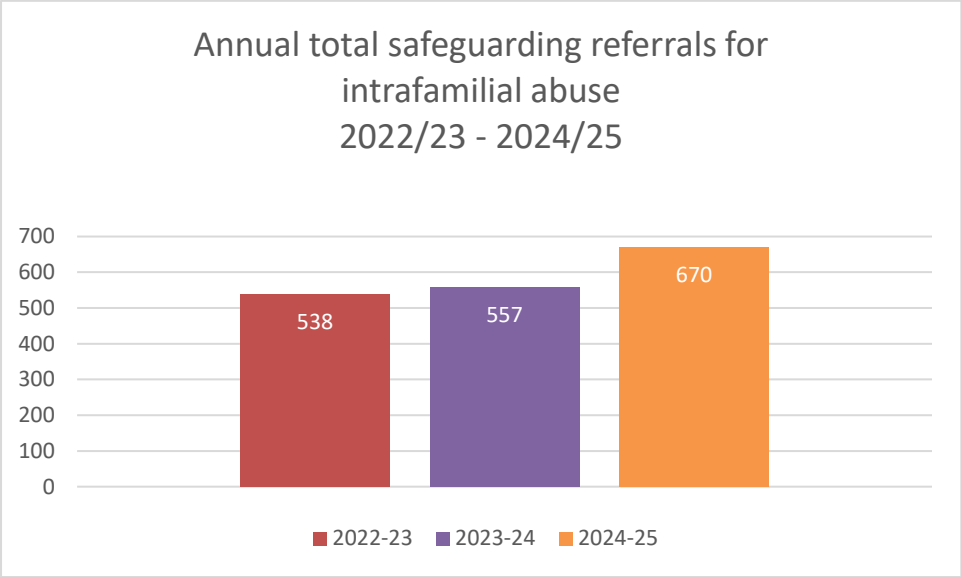
The safeguarding team have worked closely with the nurse leaders in ED to support staff recognising that where adult patients attend with either: -

- Domestic Abuse
- Mental Health concerns
- Substance misuse

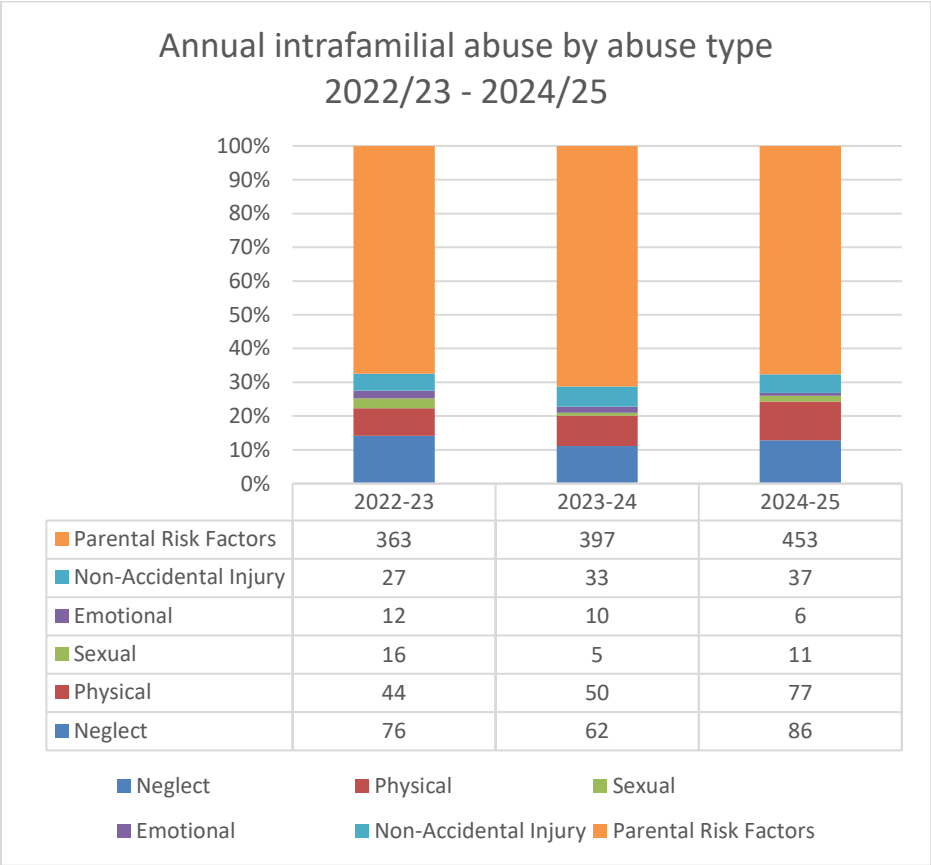
they must always ascertain whether the adult has caring responsibilities for a child and if so, make a safeguarding referral for the child. This is because these elements of parental wellbeing are known as the trio of vulnerabilities which can impact significantly on their ability to care for children, and they are known to be present in over 60% of child abuse cases which have led to serious injury or death.

Physical abuse and NAI referrals have also increased. The safeguarding team have again worked closely with staff in ED to ensure they are aware of the correct procedures to follow in these cases, and there have been some positive examples over the year where staff have responded appropriately to ensure the safety of the child. There was one incident of a potential case of NAI being missed in Q2. Following investigation, there was additional clarification of roles and responsibilities within ED and paediatric service and the pathways for referral were strengthened. The missed NAI was identified via the safeguarding team completing the paediatric liaison notification process, and appropriate action taken to safeguard the child.

The safeguarding team have worked closely with the police and children's social care to address concerns regarding discrepancies in multi-agency responses following non-accidental injuries. Working collaboratively with partners, the team are assured that improvements can be made and that there will be improvements in partnership working and adherence to statutory frameworks and local policy and procedures.



Source: Safeguarding Dashboard



	2022-23	2023-24	2024-25
Parental Risk Factors	363	397	453
Non-Accidental Injury	27	33	37
Emotional	12	10	6
Sexual	16	5	11
Physical	44	50	77
Neglect	76	62	86

Source: Trust Safeguarding Dashboard

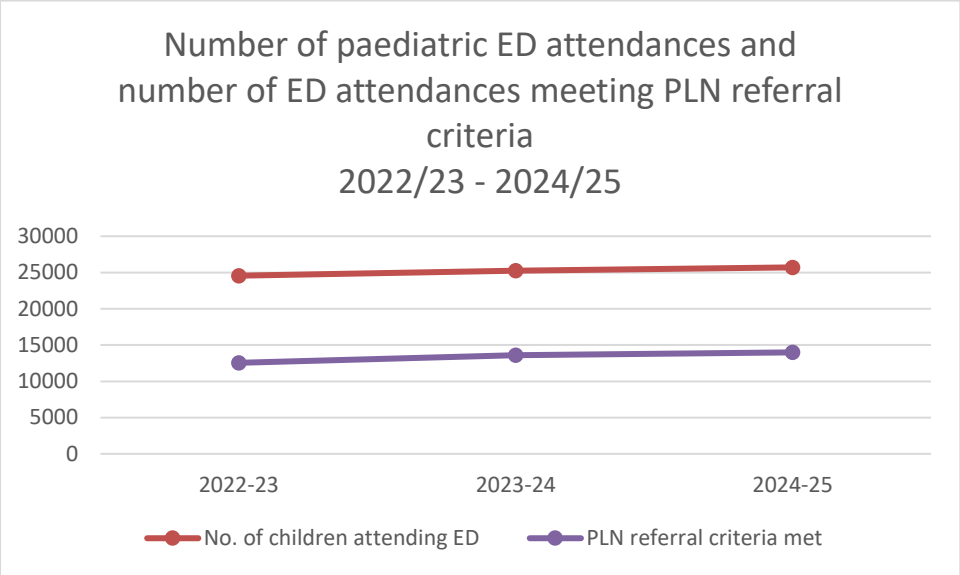
6.2 Paediatric Liaison Notification (PLN) process

Safeguarding liaison between acute and community healthcare settings has been identified as playing an important part in protecting children and young people from harm. Following the Laming Inquiry into the death of Victoria Climbie (DOH 2003) recommendations were made that information relating to a child's attendance at the Emergency Department, discharge from hospital and follow up appointments should be shared with primary care and community services to ensure an effective handover of care and provision of services.

To ensure there is a robust link between the Trust and community and primary care services, information is shared daily with our partners regarding the attendance of children and young people to the Trust Emergency Department. There is also a daily review of all adults with caring responsibilities who attend the ED due to either mental health or substance misuse issues or domestic abuse, in recognition that this may impact on their caring abilities.

The Trust Safeguarding Children's Team review attendances to the Emergency Department via a comprehensive daily report taken from the ED electronic system, Sunrise. The attendances are checked against a set criteria and relevant information is sent to health partners.

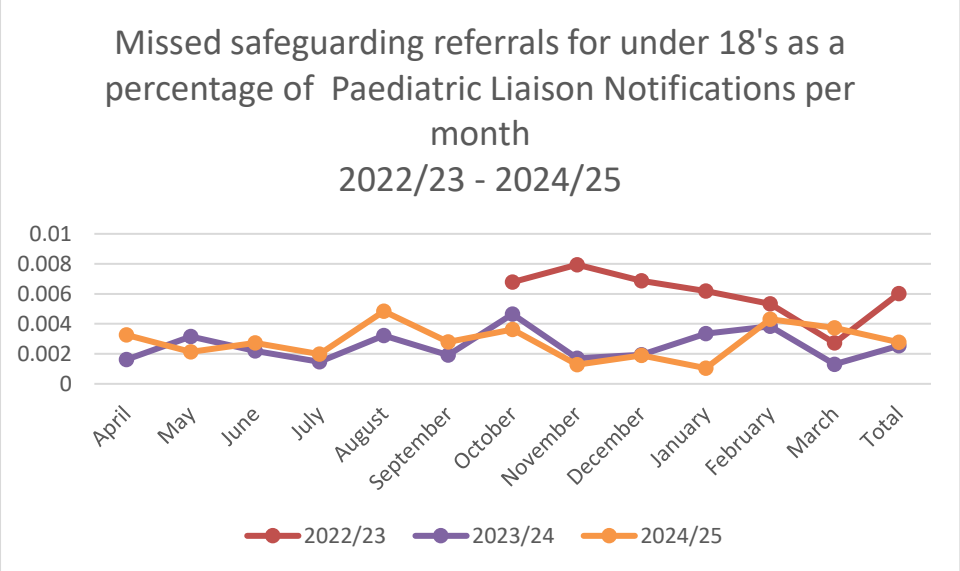
Paediatric attendances between April 2022 and March 2025



Source: Trust Safeguarding Dashboard

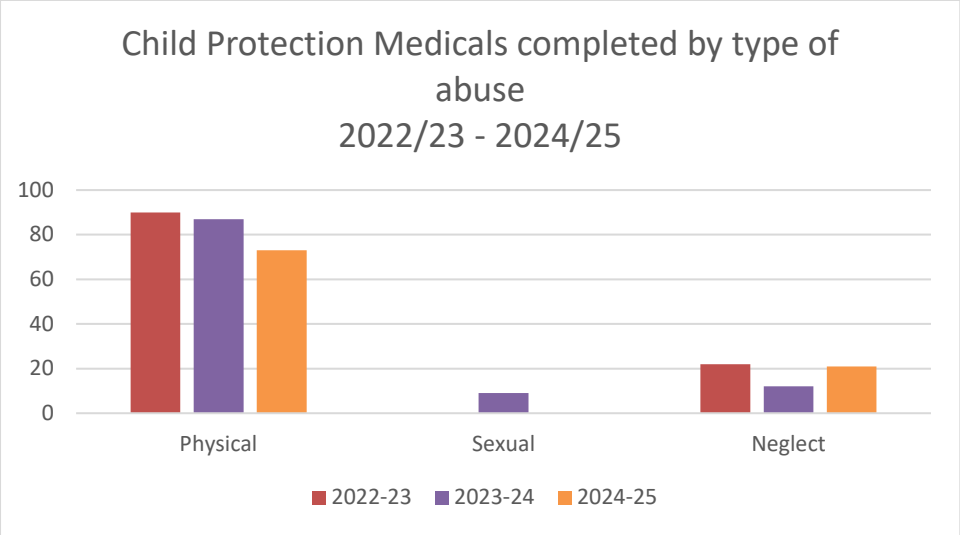
A secondary role of the PLN process is to provide monitoring and scrutiny of safeguarding practice within the ED. This allows the safeguarding team to review attendances which meet the criteria for sharing information and ensure the correct safeguards have been put in place. The ongoing professional curiosity audits identify that where there were missed opportunities to safeguarding children, every case was picked up by PLN and the correct action was taken to safeguard the children involved. There was one significant event where a potential NAI was missed and was identified via the PLN process. The safeguarding team provide feedback and allocate actions to the staff in ED to ensure practice is improved and lessons learnt.

Since October 2022, the safeguarding team have been monitoring the number of missed opportunities to safeguard that the PLN process has identified and subsequently actioned. The graph below shows that the percentage of cases where the attendance met the criteria for a paediatric liaison and there was a missed opportunity to make a safeguarding referral. Missed opportunities remains below 1% of all ED attendances and continues to be significantly lower than the period inspected by the CQC in February 2023.



Source: Trust Safeguarding Dashboard

6.3 Child Protection Medicals – 2022/23 - 2024/25



Source: Trust Safeguarding Dashboard

The Named Doctor for Safeguarding reviews all Child Protection Medical reports completed by members of the Paediatric Doctors to ensure quality and that clear medical opinion is given regarding likelihood of abuse as part of the report. The Trust has signed up to a National Audit around child protection medicals, this is an audit requested by the Royal College of Paediatricians regarding the 12 standards for Child Protection Medicals. Participation in the audit will help the Trust identify any gaps against the standards and drive improvement across the Trust.

6.4 Safeguarding Supervision

The Trust is committed to ensuring that all staff have access to advice and support from competent safeguarding professionals. Safeguarding Supervision is mandatory for all registered clinical staff working directly with children and adults at risk of harm

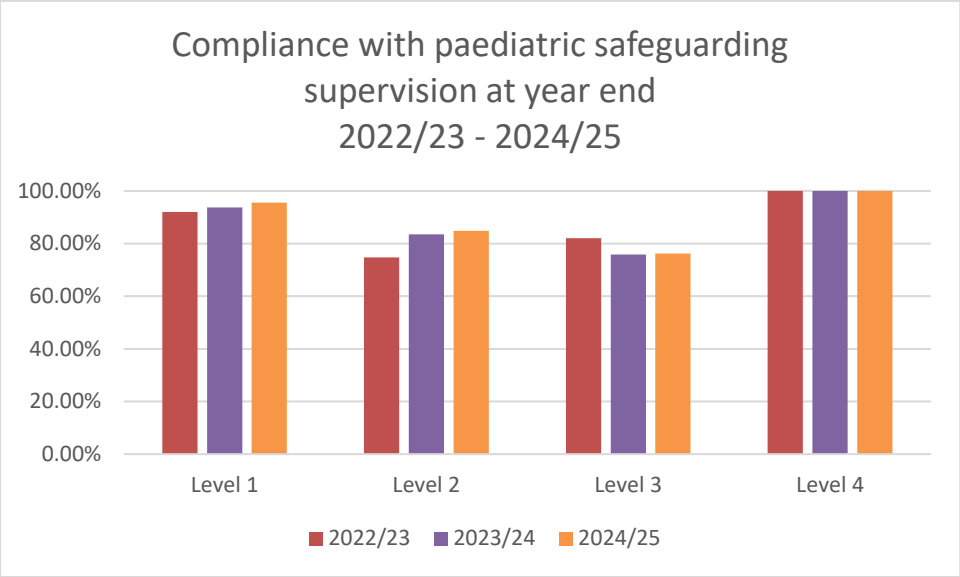
"It is important that staff working with children and families are effectively supervised to support them and to promote good standards of practice in safeguarding children. In line with Working Together, supervision should include reflecting on, scrutinising and evaluating the work carried out, assessing the strengths and weaknesses of the member of staff and providing coaching, development and support" CQC 2009

Supervision can also be accessed in group sessions or on an ad-hoc basis. One-to-one safeguarding supervision is offered for Community midwives and is a mandatory requirement for them to attend quarterly.

Paediatric Nurses - Safeguarding Supervision

Nursing staff in the Neonatal Unit, ED, OPD, Learning Disabilities and C2 receive quarterly group supervision. Specialist paediatric nurses receive one-to-one supervision due to the complexity of the caseloads they hold.
in receipt of safeguarding children supervision are made up of staff from:

- ED
- C2
- Children's OPD
- Learning Disability Nurses
- Specialist Paediatric Nurses



Source: Trust Safeguarding Dashboard

Safeguarding supervision provides an opportunity for key messages and learning to be shared with staff. Staff are asked to bring case studies to discuss and analyse. The safeguarding nurses encourage discussion, reflection, and peer support. Supervision offers an alternative provision of learning which means staff keep up to date with key themes between their mandatory training sessions. The safeguarding team liaise closely with senior nursing staff to offer flexibility and accessibility to staff to support them completing their supervision. It is often challenging for staff to take the time away from clinical practice, but departments are clear that they understand the importance and work with the team to support compliance.

6.5 Safeguarding Children Case Study

The case study below outlines

- 15-year-old child attended ED following a road traffic collision. A thorough ED triage was taken and there were concerns that this child had been with 2 other young people who had fled the scene, the patient was intoxicated and had taken illicit substances and there was involvement from children's social care due to risk of abuse.

There is clear documentation demonstrating that the patient's voice throughout their care. Conversations were thoroughly documented, and appropriate mitigations were made. A senior nurse was assigned to chaperone the doctor during the examination to ensure the patient felt comfortable. This allowed the patient to consent to the examination, which was necessary to rule out life-threatening injuries.

Whilst in the department, staff noted the patient's appearance, clothing and behaviour. The patient had a phone, vape and bag which they appeared protective over.

ED staff contacted the patient's mother and comprehensively documented the conversation. Staff also documented concerns raised by the patient, stating they had been drinking for two years, initially because they wanted it but now because they felt they needed it.

ED staff displayed excellent professional curiosity by asking the patient if they were sexually active and for details of these partners although they declined to disclose this information. The patient's risk of Child Sexual Exploitation (CSE) was quickly and clearly identified by staff due to their interactions with older adults, alcohol use, substance use and sexual activity. As a result, a CSE screening tool was requested.

There was strong evidence of communication with children's social care with documentation of contact numbers and staff consulted. There is also evidence of critical thinking by ED staff.

Concerns raised by the patient's mother on attendance are also well documented including the patient's increased alcohol use and non-compliance with oral antibiotics for an infection.

A MARF was completed with consent from the patient's mother and an Exploitation Screening Tool completed. Comprehensive documentation was seen by a clinical support worker to support with risk analysis of the concerns. The patient was discharged following a discussion with CSC into the care of their mother.

This is an excellent example of how exploitation risks are considers as well as correct processes being followed by all members of staff within the department. The team demonstrated excellent professional curiosity and ensured the child's voice was heard during their interactions. Whilst additional questions could have been asked regarding the underlying factors of the patient's alcohol consumption and sexual activity, the team ensured ongoing support within the community on discharge by completing the MARF, Exploitation Screening tool and comprehensive communication with the patient's mother.

6.6 Children Safeguarding Practice Reviews (CSPRs)

The Children and Social Work Act 2017 introduced a new legal framework in respect of local safeguarding arrangements for children. Responsibility of how a system learns lessons from serious child safeguarding incidents now rests with the new National Child Safeguarding Practice Review Panel and the three Safeguarding Partners (Local Authorities, Police and Clinical Commissioning Groups).

Over the past 12 months the Trust has participated in 3 rapid reviews with 1 progressing to a Local CSPR. There is one outstanding Health Single Agency Review from 2023 that has not yet been signed off by the partnership. No CSPRs have been published by the DSPPB this year.

Learning/recommendations from the rapid reviews for the Trust: -

Learning theme	Action
Neglect • Acknowledgement of home conditions and utilisation of screening tools during home visits • Lack of recognition of disguised compliance across maternity services • No evidence of communication between midwifery and community professionals	• DSPP Think Family Hoarding Toolkit shared via the Trust newsletter and safeguarding supervision • Information shared with staff via safeguarding newsletter, Patient Safety Bulletin and safeguarding supervision • DSPPB Safer 7 Disguised Compliance distributed to maternity staff • Patient Safety Bulletin on DNA process in maternity services • Antenatal Defaulter Guideline shared with maternity staff • Disguised compliance in pregnancy is included in safeguarding supervision with maternity staff
Physical abuse/Neglect • Virtual appointments should not be offered where there are safeguarding concerns/previous was not brought	• Was Not Brought flow charts in all paediatric outpatient clinic rooms • Was Not Brought pathway is currently being updated to include guidance in relation to telephone/virtual appointments

Child Exploitation and Neglect • Child used as an interpreter for parent • No recognition of parental mental ill health and potential safeguarding concerns for the children	• DGFT Interpreting Policy has been updated since the attendance • There is a mandated question at ED triage regarding parenting/caring responsibilities when an adult attends due to mental health concerns

7.0 Maternity Safeguarding

The Named Midwife supports the Head of Safeguarding in providing assurance that the Trust is meeting its statutory safeguarding duties set out in The Children Act 2004, Working Together to Safeguarding Children 2018 and the Care Quality Commission Core Standards.

They provide specialist advice, training and supervision to staff within the maternity services and work closely with the Safeguarding Adults and Children's Named Nurse Team to ensure there is an effective and robust interface between unborn and neo-natal babies, children and adult safeguarding. Their work includes driving forward recommendations, actions and learning from internal and external reviews in relation to maternity and neo-natal services, ensuring they are promoted and embedded within the Trust through fostering close working relationships with senior staff, and partner agencies from across region.

The Named Midwife provides daily attendance to the maternity and neo-natal units, attendance at training events and via one-to-one supervision, the role has had a positive impact on midwives and the neo-natal team in recognising safeguarding concerns and taking responsibility for making referrals.

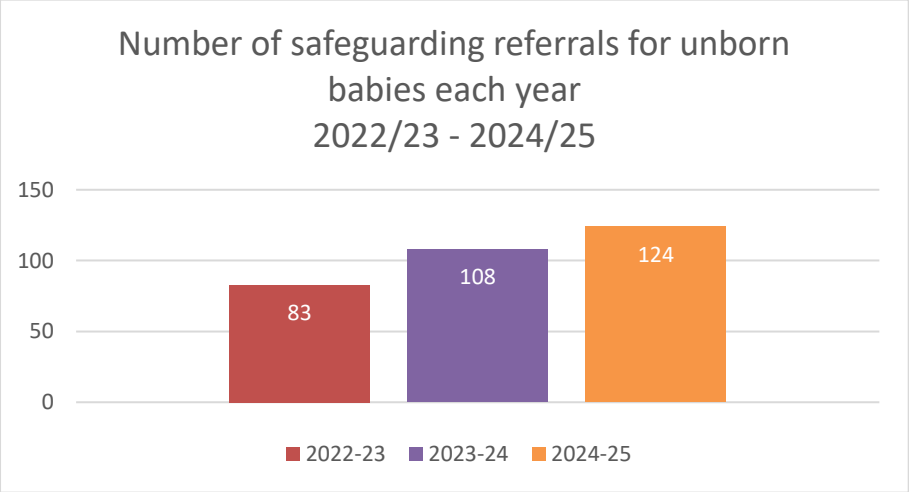
Maternity staffing remains a significant issue particularly regarding the consistency of care provided in the community. The Named Midwife works alongside the Team Leaders and Community Matron to ensure safeguarding activity is covered.

7.1 Maternity Safeguarding Activity

Supporting Vulnerable Families – Incident Reporting

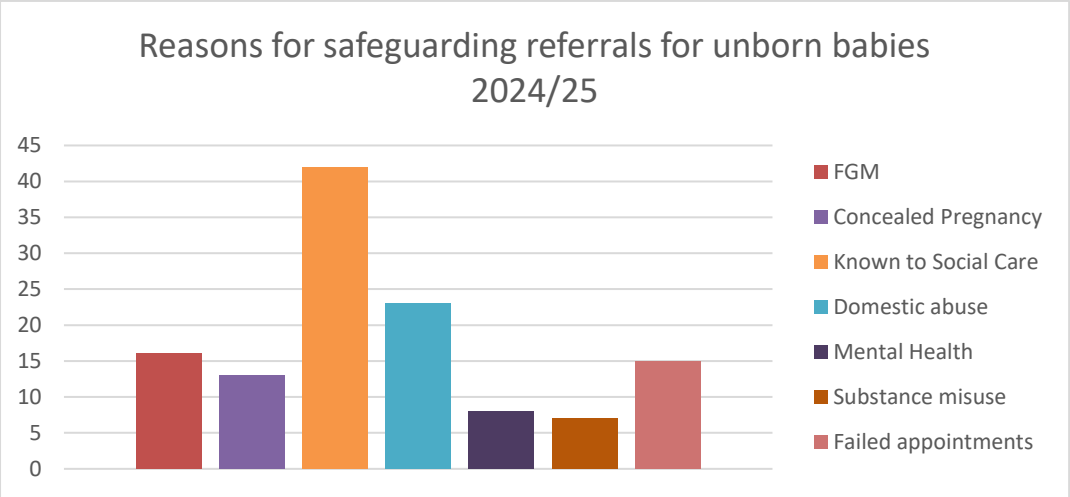
Recognising potential safeguarding concerns and additional support requirements for families is a vital part of a midwife's role. Appropriate referral to other agencies, including Children's Social Care ensures an early response to risk assessment and meeting the needs of babies and families.

Number of Safeguarding Referrals

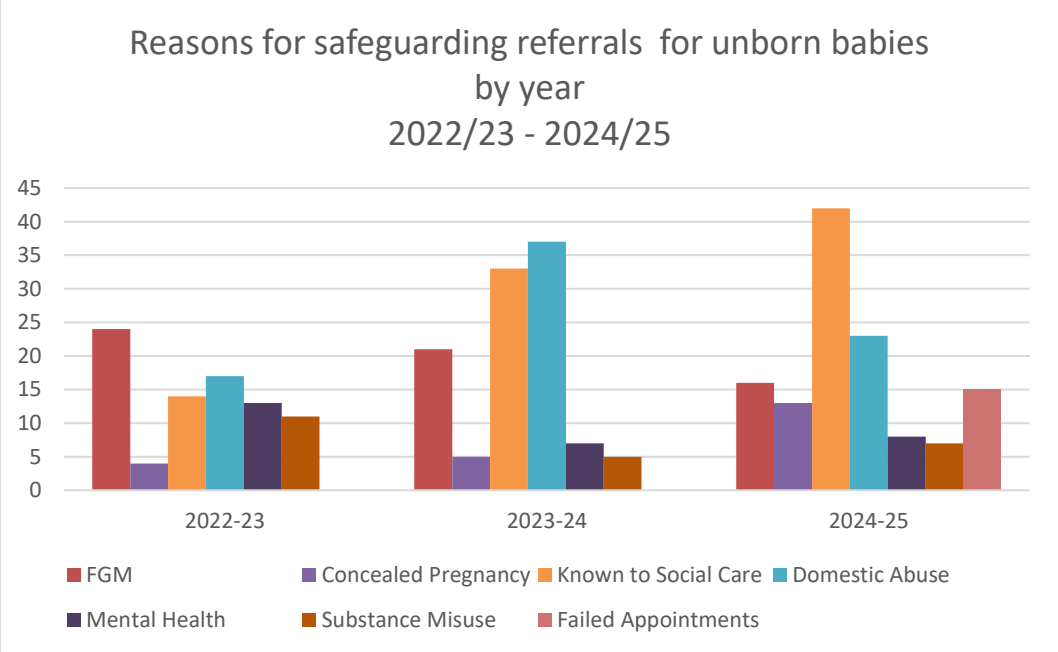


Source: Trust Safeguarding Dashboard

There has been a slight increase in referrals in comparison to the previous two years for unborn babies. The data is reliant on midwives internally reporting their referrals via Datix™ and there is some evidence from audits to suggest that this has not been happening, and the named midwife is working with staff and senior leadership team to improve this.



Source: Trust Safeguarding Dashboard

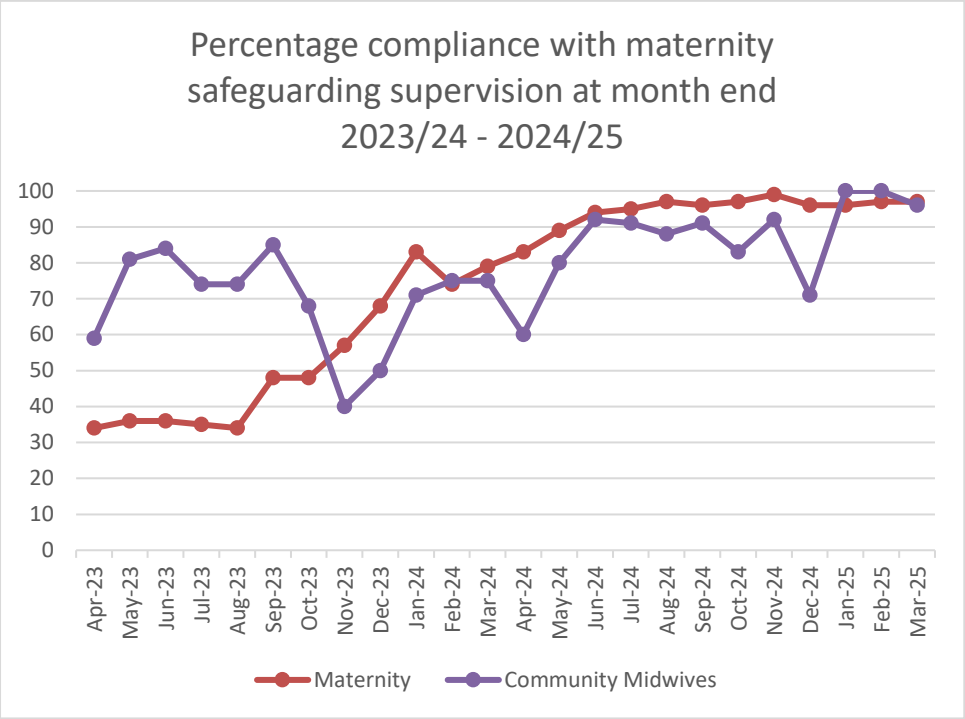


Source: Trust Safeguarding Dashboard

Mental Health and substance misuse are two of the trio of vulnerabilities which research evidences as being present in over 60% of child safeguarding practice reviews where children die or are seriously harmed as a result of abuse.
It is not clear why referrals regarding maternal mental health and substance misuse are lower in the last 2 years when compared to 2022-23. It is likely that this is again in relation to staff not submitting a Datix™ when they have completed a safeguarding referral, and this will continue to be monitored.

7.2 Maternity Supervision

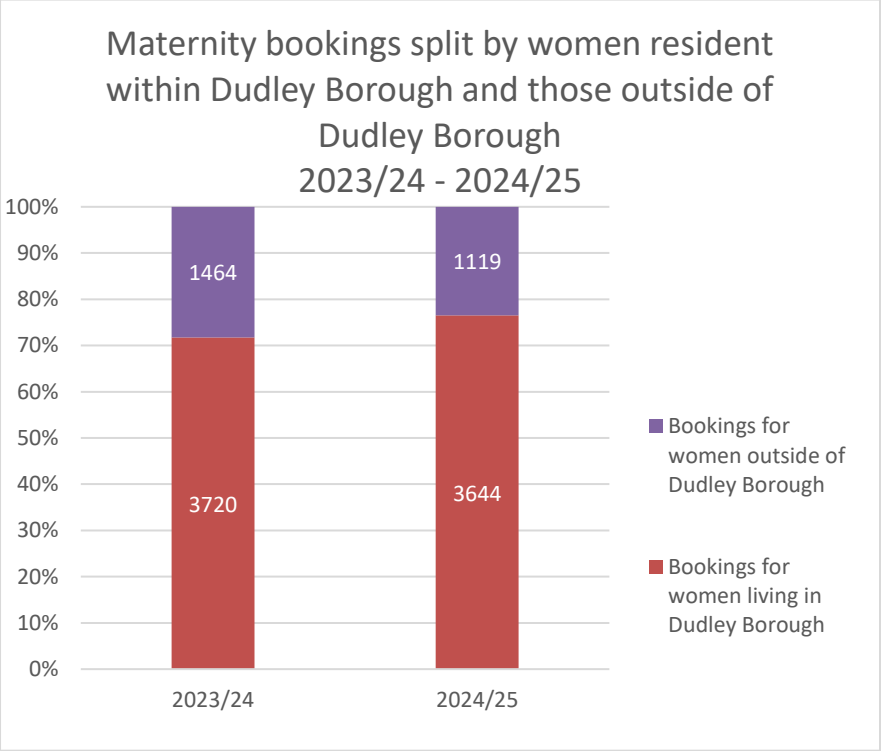
All midwives are required to receive safeguarding supervision. All Community Midwives and Specialist Vulnerability Midwives receive quarterly supervision with the Named Midwife on a 1 to 1 basis and all other midwives receive group supervision twice a year. Compliance for supervision has been a challenge due to ongoing capacity issues within the Maternity service. There have been some positive improvements towards the end of the year and the named midwife will continue to work with the senior leadership team to ensure compliance



Source: Trust Safeguarding Dashboard

7.3 Information Sharing

The Trust maternity services provide care for resident women in and outside of Dudley. The chart below provides a breakdown of this over the last 2 years.



Source: Trust Safeguarding Dashboard

For women who book at the Trust outside of the Dudley borough, the need for information sharing between the areas and the NHS providers is imperative. The named midwife for safeguarding for the Trust attends fortnightly pre-birth meetings with Sandwell Children's Services to review individual child protection and child in need plans for unborn babies. This has ensured that appropriate multi-agency safety plans are in place before the birth of a child and has improved the co-ordinated response to the birth of a child who is deemed at risk of harm, ensuring parents are informed and prepared and that safe discharge plans are in place. The Named Midwife has worked diligently with Dudley Children's Services over the last 12 months to try to secure a place at similar meetings for Dudley unborn

babies. This has been set with challenges, but by the end of the year, Dudley Children's Services have identified a suitable forum with plans for this to be completed early in 2025/26.

7.4 Domestic Abuse

Midwives continue to screen for domestic abuse throughout pregnancy; however, such incidences are rarely reported. It is recognised that midwives are not reporting any positive disclosures via Datix™, however in addition there is further work needed to review how midwives are asking about domestic abuse and ways to increase opportunities for enquiring about this. It is important that women understand that domestic abuse is not just about physical violence and midwives require further support to ensure they are clear in the terminology they are using and ensuring women understand what domestic abuse is.

Currently the standard question on Sunrise (electronic patient records system) relates to 'domestic violence' and not 'domestic abuse'. This is not in line with Trust policy or the West Midlands Domestic Abuse Standards which recommend that patients are asked about domestic abuse as this encompasses all elements of abuse and not just physical violence. It is likely that only asking women about domestic violence will reduce the number of disclosures received. This concern is being progressed by the named midwife and maternity senior leadership team.

In addition, whilst the routine enquiry questioning is now mandated on the Trust electronic Sunrise system; this is on the booking document only, therefore there are no additional prompts at other contacts between midwives and pregnant women. West Midlands Domestic Abuse Standards advises that every contact with a woman in pregnancy should be an opportunity to ask about domestic abuse and this should be recorded in the women's records. This action will be progressed in 2025/26.

The role of the IDVA is discussed within staff supervision and the IDVA attends the Specialist Midwife optional training day. Discussion around domestic abuse takes place in group supervision and training to encourage staff to think about how they would manage concerns around domestic abuse. The associate nurses who currently support the Named Midwife provided a short training session in January 2025 with the Sonography department to increase their knowledge around domestic abuse, routine enquiry and safeguarding responsibilities as they are identified as being in a good position to also screen for domestic abuse.

Domestic abuse is a risk recorded on the Corporate Risk Register, and there is a suite of actions planned to improve the overall Trust response to domestic abuse and includes specific work within maternity services.

7.5 Maternity Safeguarding Case

At Adult Z's 12-week maternity booking appointment, she disclosed to the midwife that she had other young children who had current support from Children's Social Care. Adult Z advised that she had a history of depression but had never been medicated for this. Adult Z was not booked to deliver at Dudley Group NHS Trust maternity unit, but had opted for delivery at a different hospital outside of Dudley

In line with the Trust Safeguarding Policy, the midwife submitted a Multi-Agency Referral Form to Children's Social Care to advise of the new pregnancy. The outcome of the referral was that the unborn baby was allocated a social worker for a pre-birth assessment. The Community Midwife contacted the allocated social worker to receive an update and share her contact details for communication purposes. Adult Z attended Dudley Group Maternity Triage despite being booked to birth at a different hospital. The community Midwife contacted Adult Z's out of area Hospital's Safeguarding Team to ensure they were aware of Adult Z and informed them of the current Children's Social Care involvement. The health visitor was also notified by the community midwife.

A strategy meeting was held which resulted in a section 47 Child Protection enquiry. The Community Midwife attended the Initial Child Protection Conference (ICPC) which concluded that improvements had been made by Adult Z. Adult Z also had identified support from family and was working closely with Black Country Women's Aid. The outcome of the ICPC concluded that the unborn baby and the other children were made subject to a Child in Need Plan. Good communication was evident as information regarding the ICPC was shared with the out of area Hospital's safeguarding Team.

Just prior to delivery of the baby, Adult Z's maternity care was transferred to Dudley Group maternity unit and her baby was born later that month. The children's social worker was informed of the delivery of the baby by the registered midwife caring for Adult Z and a clear plan had been established from the social worker that the baby was able to be safely discharged home with Adult Z.

Adult Z was seen at home on her day 5 postnatal follow up and no concerns were raised. At the subsequent Child in Need meeting the children remained on a plan. Adult Z and baby were discharged from community midwifery into the care of Health Visiting.

Whilst seemingly simplistic in terms of the information sharing that took place, without this important communication, which can be a gap when women live in one area and book at a hospital outside of their residency, support for this woman and her family could have resulted in missed opportunities to provide the right level of support and to reduce potential risks to the unborn baby and siblings.

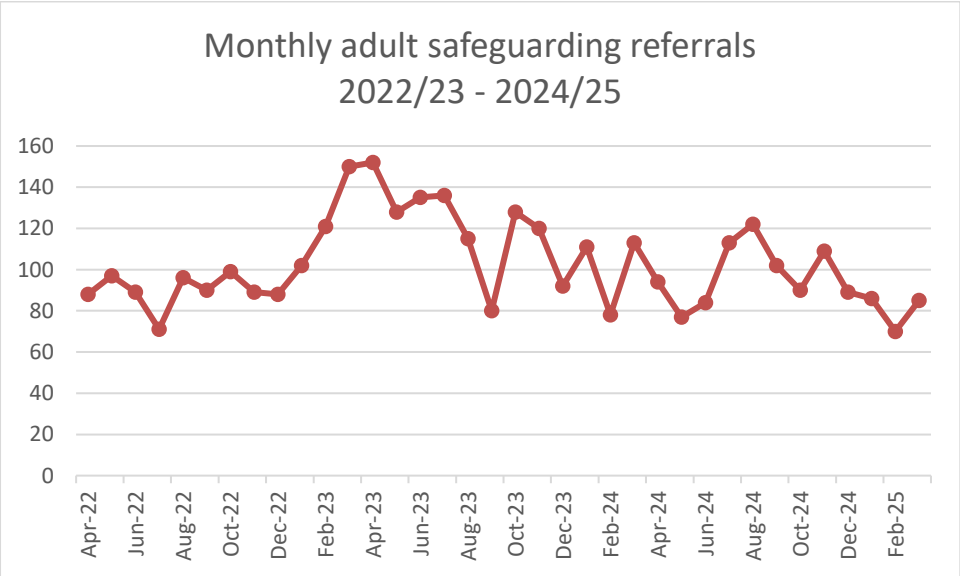
8.0 Adult Safeguarding Activity and Performance 2024/25

For the first time in 5 years, there has been a slight decrease in the number of: -

- safeguarding referrals
- internal reporting of safeguarding concerns

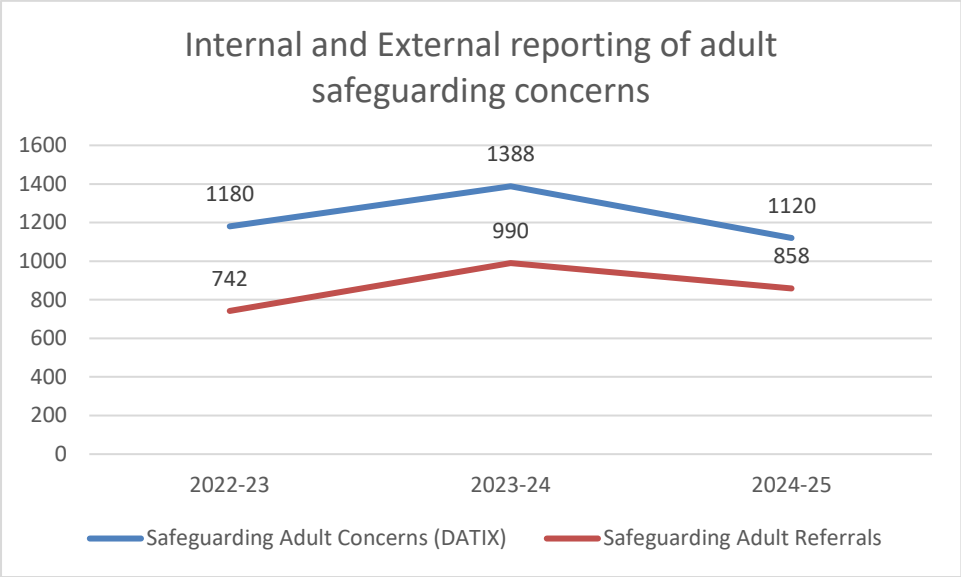
Adult Safeguarding Referrals and Internal Reporting – Comparative Data

Safeguarding Adult Referrals



Source: Safeguarding Dashboard

In Q3 of this year, Dudley Adult Social Care MASH team reported that 53% of all referrals made to the Dudley MASH from all agencies, were not safeguarding concerns and should have been sent to other adult social care departments (DSPP Adult Safeguarding Dataset). The impact of MASH receiving referrals for non-safeguarding events is recognised by the Trust and the safeguarding team have worked closely with staff to ensure referrals are being sent to the correct adult social care department. The safeguarding team review all internally reported incidents of abuse and neglect and ensure that where referrals have been made to MASH for non-safeguarding events, staff receive feedback and rationale for why this would not meet MASH criteria and advise on where these concerns would be better referred to. The team have shared a recent blog post by Adult MASH in the Trust "In the Know" communications to support staff understanding. There has been a slight downward trend in the number of referrals, but it is too early to evidence that this is a direct result of staff considering whether their concern can be best be met by submission of a safeguarding referral.



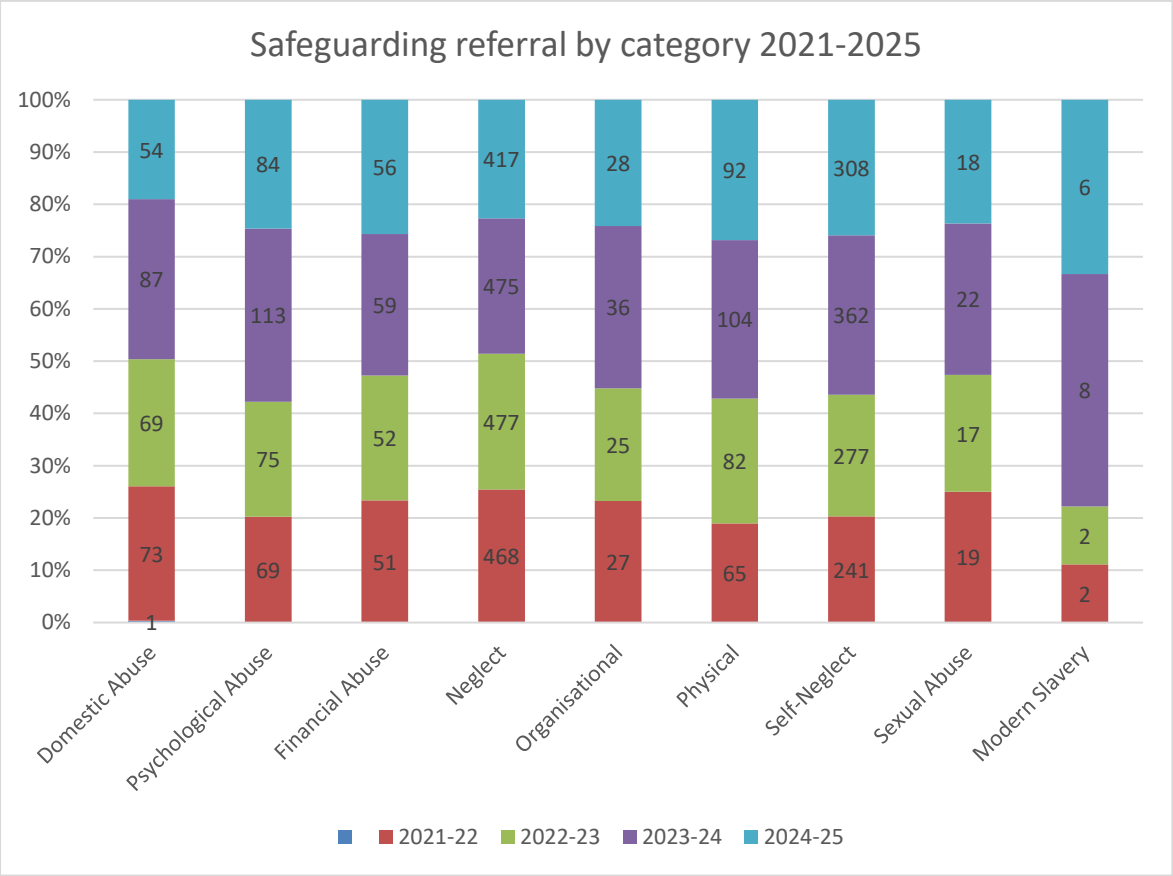
Source: Trust Safeguarding Dashboard

The numbers of adult safeguarding referrals alone do not give a complete picture of safeguarding activity in the Trust. Staff submit a Datix™ for all safeguarding concerns, whether they result in a safeguarding referral or not. Other risk management activities may take place in conjunction with the views and wishes of the patient that may prevent the need for a safeguarding referral to be made. Therefore, analysis of Datix™ reporting alongside the number of safeguarding referrals provides a more comprehensive view of safeguarding within the Trust and the level of response and scrutiny the safeguarding team will provide in ensuring all appropriate actions have been taken. The table above does demonstrate that there has been a closer correlation between internal and external reporting this year, again the safeguarding team are ensuring that this has not occurred due to staff misunderstanding when a safeguarding referral needs to be made to adult MASH and when a concern should be referred to another department.

It is not just the quantity of referrals and incidents that require analysis and understanding. The complexity of the safeguarding cases continues to increase with many patients experiencing multi-faceted categories of abuse that requires extensive liaison with other agencies, in-depth assessments around mental capacity alongside consideration of human rights, and comprehensive and dynamic risk management. The staff in the Trust often require the specialist knowledge of the safeguarding team to support them with this work. The capacity of the safeguarding team to meet the increased demand from this work is challenging.

8.1 Themes and Trends

The graph below demonstrates the most prevalent safeguarding categories that are reported via Datix™ from services across the Trust. Every category of abuse has seen a decrease. Neglect and Self-Neglect continue to be the biggest reasons for safeguarding, and these are the cases that bring the most complexity to managing and negating risk.



Source: Trust Safeguarding Dashboard

Self-Neglect and Mental Capacity

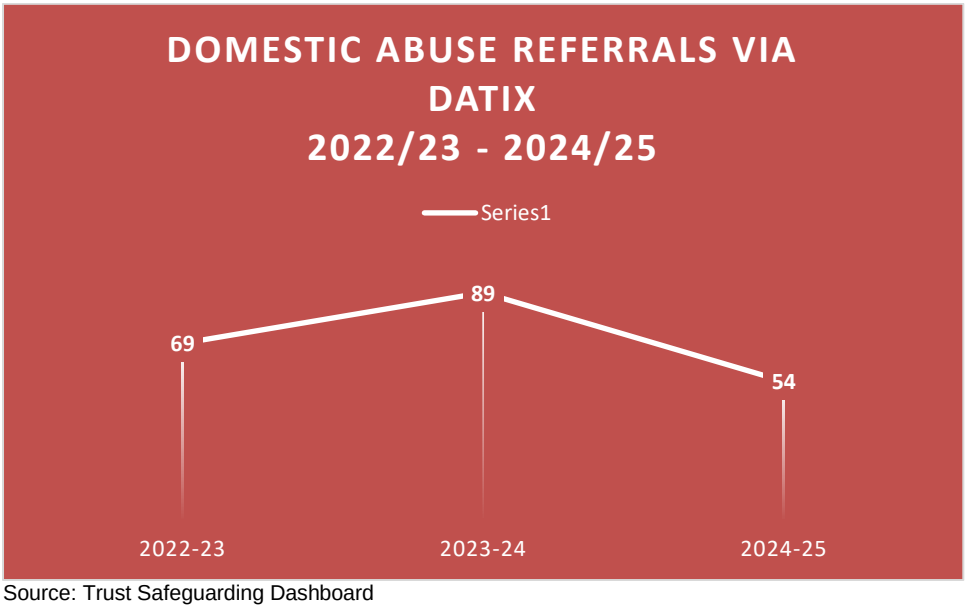
One area of complexity which staff seem to be challenged by is in relation to self-neglect and mental capacity. The safeguarding team have completed comprehensive work with community staff to support their decision-making but following a serious incident around this subject matter, this work needs to be replicated in wards and departments. The team recognise that this an extremely complex area of safeguarding and are calling on wards to seek specialist advice and support at the very earliest stage. There is also recognition that the safeguarding team need to develop a system of recognising these complex cases at an early stage and are working with patient safety team to see if such a system can be developed via Datix™.

Domestic Abuse

"Domestic abuse is a public health epidemic and health must be part of the solution. We must meet victims where they are. We know four of five victims do not call the police. We have to go to them: where they feel supported, where they feel safe and free from stigma." Safe Lives: A Cry for Health, 2016

Domestic violence now has a statutory definition enshrined in the Domestic Abuse Act 2021 and increasing prominence in national and regional strategy. The Domestic Abuse Commissioner, Nicole Jacobs, has said that health must be central to strategic thinking, noting that health settings are trusted environments which can reach people "from every background and walk of life subjected to domestic abuse". It is therefore "critical" to ensure awareness about domestic abuse is embedded in the practices of all health settings.

Reporting



Source: Trust Safeguarding Dashboard

Reporting of domestic abuse via internal reporting has decreased significantly this year and presents a risk to the Trust and patients that victims of domestic abuse are not being recognised or receiving the right support.

On average 250 patients attend the Trust Emergency Department each month due to mental health concerns. SafeLives, the UK-wide charity dedicated to ending domestic abuse, states that over 50% of victims report having mental health issues and that 7% of victims report that they have considered or attempted suicide as a result of the abuse, and 17% report self-harming. Considering these figures, it would be expected that staff would be identifying many more cases of domestic abuse.

An audit was undertaken in Q3 2024/25 to establish if selective and targeted enquiry around domestic abuse was completed when adults attended the Emergency Department with potential indicators of domestic abuse. The audit aimed to identify if enquiry had been completed, appropriate action had been taken when there was a positive response, information in relation to domestic abuse had been documented in the patient electronic record and safeguarding referrals had been completed where indicated. The audit identified that overall, there was poor compliance the Trust Domestic Abuse Policy, NICE Quality Standards in relation to Domestic Abuse and the West Midlands Domestic Abuse and Sexual Assault and Abuse Standards 2024-28. Staff were not recognising signs of domestic abuse and not enquiring about potential domestic abuse where there are obvious and more subtle signs of abuse. The low number of domestic abuse referrals and incidents throughout the Trust, suggests that this is not just an issue within ED. This represents a risk to the Trust, patients and staff and is being monitored via the Trust Corporate Risk Register and a domestic abuse improvement plan is in progress.

16 Days of Action to end Violence Against Women and Girls (VAWG)

This is an international campaign that runs each year from November 25th (The International Day for the Elimination of Violence Against Women) – December 10th (Human Rights Day).

Throughout the 16 days, the safeguarding team and IDVA visited wards and departments across the Trust, raising awareness of different forms of domestic abuse and how we can support and signpost those who are experiencing abuse. The IDVA attended early and late daily huddles in the ED throughout the campaign, to raise awareness of targeted enquiry, IDVA referral pathway and non-fatal strangulation.

The Information Hub was utilised and representatives from the National Centre for Domestic Violence (NCDV) and Churches Housing Association Dudley District (CHADD) also attended the Trust to support the safeguarding team and promote their services. The roadshow was well received by staff and the public.

Trust Independent Domestic Violence Advocate

The Independent Domestic Violence Advocate (IDVA) is based within the Emergency Department. They primarily see victims who present to the Emergency Department but will see anyone across the Trust who makes a disclosure if

required. The IDVA provides specialist support to victims/survivors of domestic abuse which is tailored to their needs. They help with risk assessments, safety planning, referrals to MARAC and help to understand the criminal justice process. In 2024/25 the IDVA received 145 referrals from staff across the Trust, predominantly from the ED but also included self-referrals from staff and referrals from other wards and departments. This is an increase of 4% when compared to 2023/24.

Staff as victims of Domestic Abuse

The safeguarding team also support line managers whose staff are disclosing to them that they are victims of domestic abuse. Anecdotally, these requests for support appear to increase each year. This data is not currently collected but as part of the domestic abuse improvements, there are plans for numbers (not personal data) to be collected. A report by the Cavell Trust in 2016 revealed that nurses, midwives and healthcare assistants are three times more likely to have experienced domestic abuse by a partner or ex-partner in the last year than the average person. The Trust Workplace Domestic Abuse Policy has been updated, and the safeguarding team work closely with Human Resources and the Trust IDVA to ensure staff are supported. This includes risk assessment of their work area and implementation of adjustments to ensure their safety whilst at work. This is in line with the Trust's statutory responsibility as employers under the Domestic Abuse Act 2021.

It has been identified in learning from a recent local Domestic Abuse Related Death Review (DARDR) that more work needs to be completed regarding domestic abuse in the workplace. Awareness raising with staff regarding the Workplace Domestic Abuse Policy has been completed during Q3 2024 and work is ongoing in collaboration with Learning and Development, People Team and IDVA to develop a training package and toolkit for staff and line managers to enable improved recognition and response when staff are experiencing domestic abuse.

Training

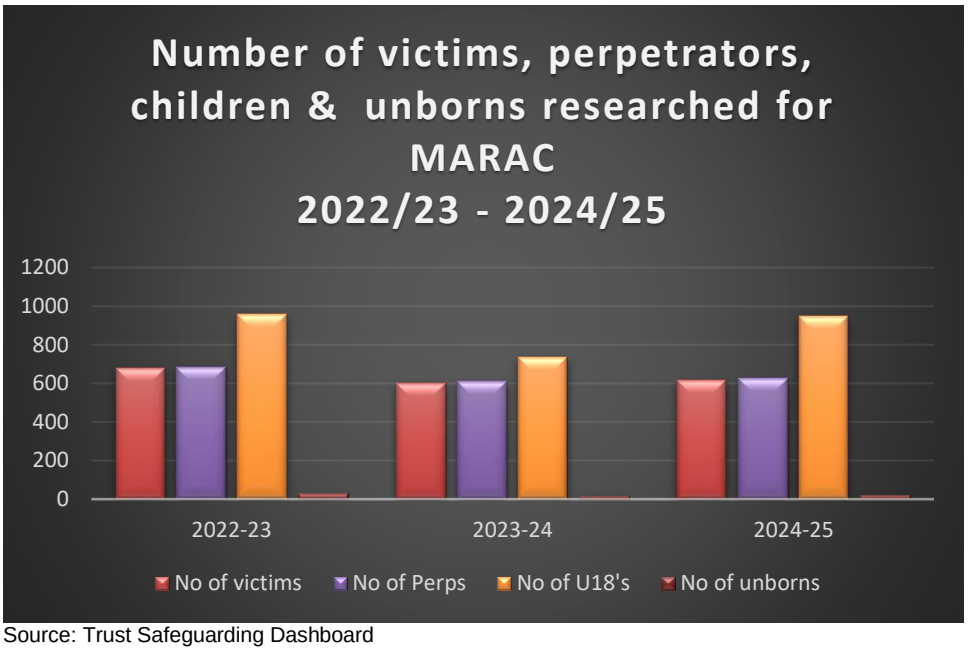
Domestic abuse training is within both level 2 and level 3 adults and children safeguarding training. Level 3 training now utilises a DARDR as a learning case and the feedback from staff has been positive with some good examples given of how they will utilise their training in their practice.

The IDVA has delivered bespoke training to medical staff across the Trust in relation to recognition and response to domestic abuse and non-fatal strangulation.

IRIS (Identification and Referral to Improve Safety) is a General Practice (GP) based domestic violence and abuse training support and referral programme. It is aimed at training GPs and practice staff to better support individuals experiencing domestic abuse. The two GP practices within DGFT will require this training to enable them to complete referrals for patients experiencing domestic abuse.

Multi-Agency Risk Assessment Conference (MARAC)

MARAC is a local, multi-agency victim-focused meeting where information is shared on the highest risk cases of domestic violence and abuse between different statutory and voluntary sector agencies. MARAC is held twice monthly. The safeguarding team undertake research on the victims, perpetrators and children heard at each meeting to support the multi-agency risk assessment.



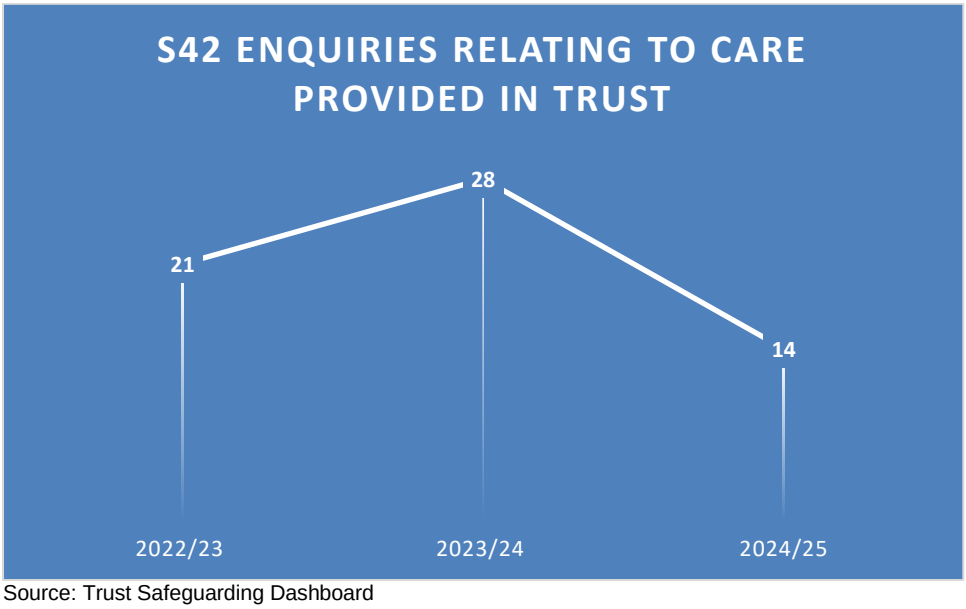
Source: Trust Safeguarding Dashboard

This year the safeguarding team have committed to attending MARAC. In previous years, due to capacity issues, the team did not attend but undertook the research on Trust contacts with perpetrators and victims and submitted relevant information for sharing at MARAC. In recognition that there is no other health agency represented at Dudley MARAC the safeguarding team send a representative to every MARAC which takes place weekly. The team are not able to take on all health agency actions, and other health agencies do share their own health information. Whilst attendance at MARAC is a significant commitment of resources, the team have identified the value of their attendance, and this has also been recognised by multi-agency partners.

The preparation, research and attendance for these meeting requires a significant amount of named nurse time. On average the team research 183 patients each month, 42 patients each week to provide information to MARAC. Whilst not all patients are known to the Trust, many are, and the research takes at least 7.5 hours of named nurse time every week. The safeguarding team commit 15 hours per week on average to MARAC research, attendance and completing any actions for DGFT.

8.2 Section 42/Enquiry Requests

The Care Act 2014 (Section 42), Care & Support Statutory Guidance Chapter 14 and the Adult Safeguarding Multi-Agency Policy and Procedures for the Protection of Adults with Care and Support Needs state that a local authority can ask any agency to undertake a Safeguarding Adults Enquiry – Section 42/Other Enquiry – on its behalf. The local authority and other partners must co-operate with each other to ensure the effective safeguarding of the adult experiencing or at risk of abuse or neglect.



Source: Trust Safeguarding Dashboard

Categories of concerns

	2022/23	2023/24	2024/25
Neglect - Pressure area care	2	4	5
Unsafe Discharge	10	11	6
Neglect/ Acts of omission	5	10	2
Sexual	1	2	0
Physical	3	1	0
Other	0	0	1
TOTAL	21	28	14

There has been a significant decrease in the number of Section 42 enquiries charged to the Trust in respect of care provided to patients, particularly around unsafe discharge and neglect/acts of omission, although concerns regarding pressure ulcer care have seen an increase for 3 consecutive years.

Learning from Unsafe discharges

- Communication between staff teams
- Failure to communicate with community care providers
- Poor documentation
- Review of patient's functional ability if there are changes prior to discharge
- Appropriate escalation of complex cases
- Lack of professional curiosity and risk analysis

Learning relating to pressure area care

- Monitoring of patients' observations when a deteriorating wound was identified
- The deteriorating patient not recognised
- Pain management
- Appropriate follow up and handover
- Incorrect equipment

Neglect

The one case of neglect was an extremely complex case that involved a patient with complex health needs and concerns regarding a family member's behaviour towards the patient and staff. There was no learning identified from this case. All care given to the patient was found to be excellent and the staff continued to work on communication with the family member.

The second case was in relation to medication administration. There was some learning identified regarding communication between nursing staff and care home staff and actions were taken to address this.

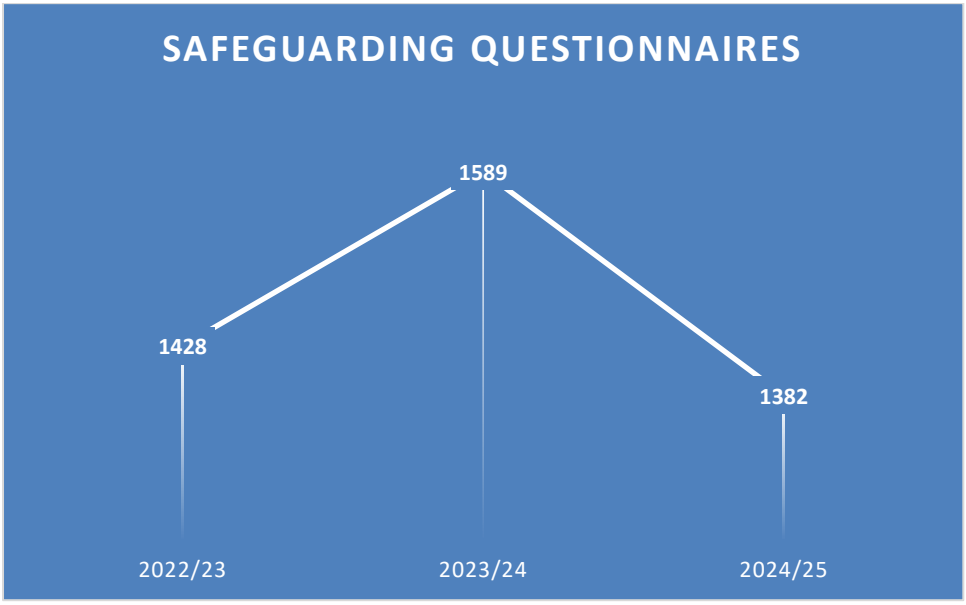
All actions to address learning have been completed. All Section 42 enquiries are monitored via the Trust internal reporting system and reported to the Trust Internal Safeguarding Board. The Lead Nurse for Safeguarding Adults has worked with the patient safety team to set up a system of adding all actions for the Trust identified via Section 42 investigations to one single improvement plan. This will enable closer monitoring to ensure actions are completed, identify themes and trends to prevent duplication and ensure more robust governance around actions being embedded.

8.3 Multi-Agency Adult Safeguarding Hub (MASH) Questionnaires

MASH electronic questionnaires are sent out to Partner Agencies who do not have a 'physical' presence in the Hub. The questionnaire is a means of gathering information to inform the local authority whether a safeguarding concern meets the threshold for a Planning meeting and/or an investigation is required.

Questionnaires are RAG rated in the MASH based on the level of concern and perceived risk to a person.

RED	-	4 working hour response – immediate/substantial risk identified
AMBER	-	8 working hour response – potential section 42 enquiries where further information is required from partners to accurately determine level of risk
GREEN	-	72 hour response – non section 42 "other" enquiries where low/managed risk is identified



Source: Trust Safeguarding Dashboard

For the first time in 5 years, the number of MASH questionnaires completed by the team has decreased.

With the transfer of DIHC services, the safeguarding team now have responsibility for completing MASH questionnaires for all Dudley GP practices. These checks are completed via the shared care record system and as many patients are also known to the Trust, there has been a decrease in duplication within Dudley in completing these questionnaires.

8.4 Safeguarding Adult Reviews (SARs)

The Care Act 2014 (section 44) requires Safeguarding Adults Boards to arrange Safeguarding Adults Reviews (previously known as Serious Case Reviews) if there are concerns that agencies could have worked more effectively to protect an adult from serious harm or abuse; whether the adult has died or not.

The purpose of a Safeguarding Adults Review is to establish whether lessons can be learnt from the circumstances of a case that may improve practice or the way in which agencies and professionals work together to safeguard vulnerable adults.

There are currently 3 open SARs which the Trust are participating in, 1 in relation to Dudley resident and 2 in relation to residents outside of Dudley. All 3 SARs were opened during this current year and remain ongoing

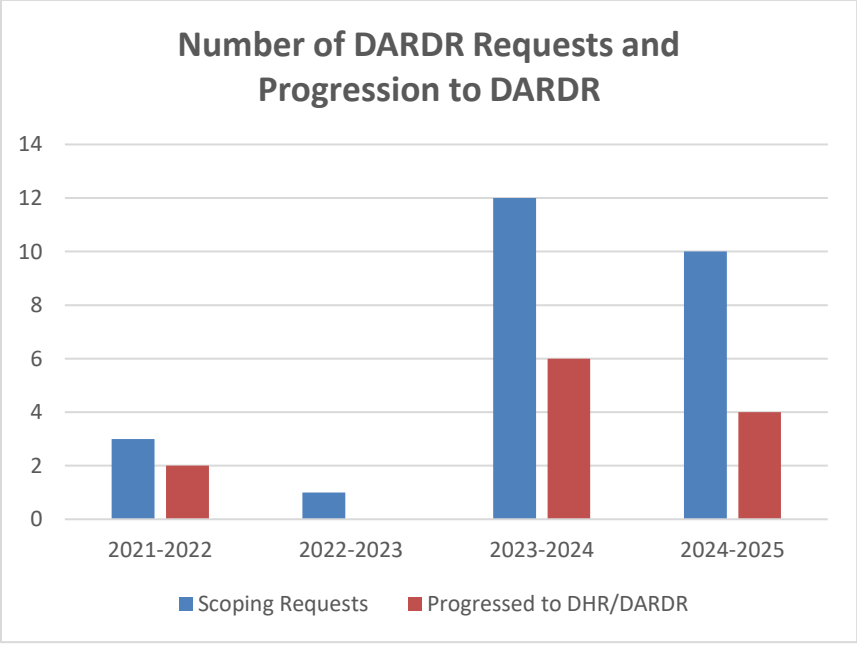
During 2024/25 The DSPP have published 1 SAR. The learning themes for the Trust are: -

Theme	Recommendation
Professional curiosity	Promoting a "Think Family" approach when working with carers of disabled patients particularly in relation to carer wellbeing and mental health
Action Taken: Supervision and training include consideration of the wellbeing of carers	
Supervision	Ensuring practitioners who conduct home visits have access to safeguarding supervision
Action Taken: Supervision needs analysis updated	

8.5 Domestic Abuse Related Death Reviews (DARDRs)

Domestic Homicide Reviews (DHRs) were established on a statutory basis under Section 9 of the Domestic Violence, Crime and Victims Act (2024). The Victims and Prisoners Act 2024 gained Royal Assent in May 2024, and these reviews will now be referred to as Domestic Abuse Related Death Reviews (DARDRs). This is to reflect learning from deaths linked to domestic abuse, including instances where the victim has completed suicide. The purpose of a Domestic Abuse Related Death Review remains the same and is to establish learning points on how agencies can work individually and together to safeguard victims.

There are 11 ongoing DHRs that the Trust is currently contributing towards, 2 are currently on hold due to parallel investigation and 4 are new DHRs this year. There have been 2 published reviews in 2024/25. The chart below demonstrates the number of scoping requests received for information and conversion to DARDR. There has been a significant increase in this work since the guidance was updated to include completed suicides. The requests for information have increased by 800% since 2022-23.



Source: Trust Safeguarding Dashboard

Emerging Themes

The new DHRs are in relation to 3 completed suicides and 1 homicide where there is a long history of domestic abuse.

The emerging themes in relation to learning for DGFT are mirror the findings in the domestic abuse audit.

8.6 Adult Safeguarding Patient Story

Adult X is a 46-year-old with care and support needs.

The safeguarding team received an advice call from the from radiology in 2023 with concerns that Adult X had had attended with multiple fractures. The patient notes indicated that there was potential misuse of alcohol. The department had noted from the medical records that previous domestic abuse concerns had been recorded.

Staff were advised to raise a safeguarding concern. The safeguarding team subsequently received a lateral check from Adult Social Care MASH in response to the referral, following this adult MASH confirmed the case was closed.

Another lateral check was completed by the safeguarding team later in the year due to concerns raised by community staff that there were multiple cameras in the home that had been installed by Adult X's partner

In 2024, Adult X's multiple attendances at ED were heard at the Trust High Intensity Service User (HISU) meeting. Adult X had attended the hospital emergency department approximately 80 times in the previous 6 years. The named nurse for safeguarding shared at the HISU meeting that there have been concerns raised regarding domestic abuse

Following the meeting, Integrated Plus who provide the Trust with a High Intensity User Service, conducted a home visit. The workers were concerned following the visit as they observed cameras all over the house and controlling behaviour witnessed by Adult X's partner. A safeguarding referral was made, and information of concerns shared with the Trust Independent Domestic Violence Advocate (IDVA).
Adult X had an outpatient appointment (without their partner). Arrangements were made for the Black Country Women's Aid Disability IDVA to meet Adult X at this appointment. The IDVA talked to Adult X about their experiences with their partner and discussed options available to them. Adult X was also given the contact number for the IDVA.

This story demonstrates the strength of multi-agency information sharing and partnership working to support a victim of domestic abuse. Initial concerns identified by Radiology, highlights the importance of professional curiosity and reviewing patients' historical information to build a picture of their experience and identify safeguarding concerns.

9.0 Person in Position of Trust (PiPoT)

The PiPoT framework and process applies to concerns and allegations about:

- a person who works with adults with care and support needs in a position of trust, whether an employee, volunteer, or student (paid or unpaid); and
- where those concerns or allegations indicate the person in a position of trust poses a risk of harm to adults with care and support needs.

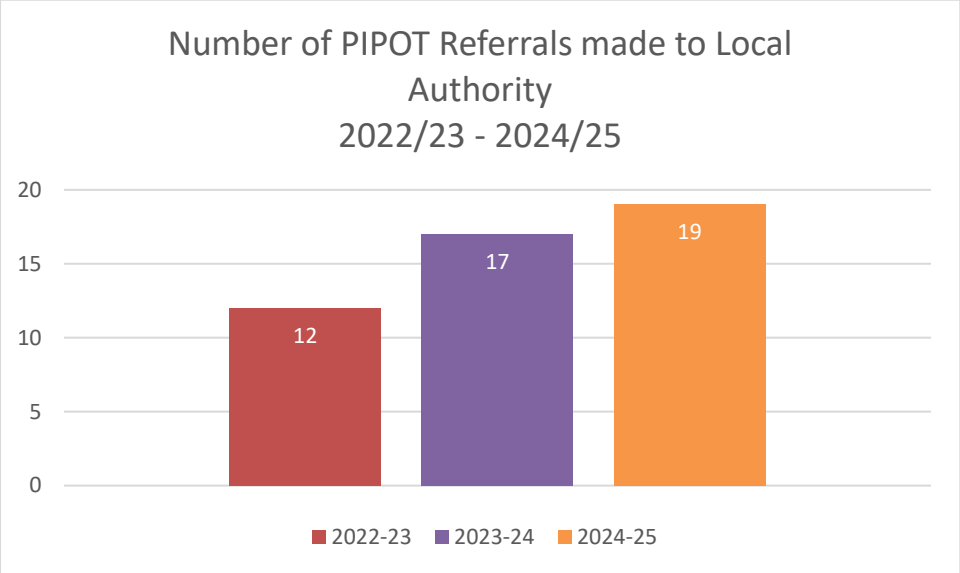
These concerns or allegations could include, for example, that the person in a position of trust has:

- behaved in a way that has harmed or may have harmed an adult or child.
- possibly committed a criminal offence against, or related to, an adult or child.
- Behaved towards an adult or child in a way that indicates they may pose a risk of harm to adults with care and support needs.

Number of Position of Trust referrals made to the Local Authority

Managing safeguarding allegations against staff working with children and adults with care needs is required under the Children Act (1989/2004) and the Care Act (2014). Working Together to Safeguard Children and Young People (2015) and the Safeguarding Accountability and Assurance Framework (2019) set out expectations that all statutory organisations will have a procedure for managing allegations against staff

Where an allegation is made against a member of staff, the Trust follow the Managing Allegations Against Staff Policy which is informed by the West Midlands Adult Position of Trust Framework and Local Authority Designated Office (LADO) Procedures.



Source: Trust Safeguarding Dashboard

- Allegations of abuse against children

5 referrals were in respect of allegations of abuse against children. The allegations against children were in respect of the staff members' children. One case remains ongoing and the other 4 cases were closed following liaison with children's social care and risk assessments updated.

- Allegations of abuse against adults

There were 13 cases in relation to adults: -

- 2 referrals were in relation to staff activities outside of the workplace
- 3 cases were referred to the staff member's professional body
- 4 allegations were not upheld
- 3 cases were unsubstantiated
- 1 substantive staff member has been moved to non-patient facing role
- 1 staff member received a written warning
- 2 staff members received additional training
- 1 DBS referral made

All allegation cases are subject to a Decision-Making Group which is initiated at the outset of the allegation. This is chaired by the Divisional Chief Nurse/AHP/Divisional Chief Clinician responsible for the staff member and is attended by HR, the Associate Director for Safeguarding and other relevant staff. Information regarding the allegation is bought to the meeting, robust risk assessments are completed, and decisions are made on actions to be taken. This has proved an effective way of overseeing allegations and ensuring robust risk assessment and decision making.

In all the above cases, investigations were undertaken in line with Trust procedures and guidance from the Dudley Safeguarding People's Partnership to ensure the immediate and ongoing safety of patients, staff, visitors and the wider public. The Associate Director for Safeguarding works closely with Human Resources and the Chief Nurse/Medical

Director/Divisional Chief Nurses/Divisional Chief Clinician to ensure all appropriate investigations and assessments are completed.

The Associate Director of Safeguarding sits on both the medical and non-medical concerns meetings to ensure there is a safeguarding lens on all cases and appropriate safeguarding actions are taken.

The Associate Director for Safeguarding meets with the Local Authority PIPOT manager on a bimonthly basis to review and discuss progress of cases. The support of the PIPOT manager is crucial in ensuring that where there is a criminal element to the allegation, the police are responding in a timely manner to support risk assessments.

10.0 The Counter Terrorism and Security Act 2015

The Trust recognises that all members of staff have a duty under the Counter Terrorism and Security Act (2015) to have due regard to the need to prevent people being drawn into terrorism and to act positively to report concerns.

10.1 Prevent Activity 2024-25

There have been no Prevent referrals this year.

The Named Nurse for Safeguarding Adults is the Prevent Lead with Deputy Chief of Operations being Executive Lead. The safeguarding team attend the Dudley Prevent Delivery Group and receive Local intelligence from the Counter Terrorism Unit Officer via the Safe and Sound community forum. Local mandatory training is updated as required to reflect new information.

The Safeguarding team provide advice and support to staff to aid recognition of protentional signs or vulnerabilities in relation to radicalisation. In the event any concerns are recognised in an individual, an incident related to Prevent is reported via the Trust internal incident reporting system. This is reviewed by the Prevent lead or a member of the Safeguarding team the next working day. This is to ensure all appropriate actions were taken and to facilitate further discussions with the CTU, if required. The Prevent lead will complete any required referrals to ensure quality and appropriate information is shared which is free from discrimination and prejudice. Each Prevent related incident is reported to the Internal Safeguarding Board on a quarterly basis. This is also reported monthly to the ICB. Assurances that statutory duties are being met are submitted quarterly to the Internal Safeguarding Board. The report includes any incidents relating to Prevent and training compliance. The Prevent lead will report if there are any exceptions or changes in guidance that affects the Trust. The Prevent lead also submits information on a quarterly basis to NHS England via the National Prevent Duty Data Set. This includes information on the Organisation, its leads, training compliance, policies and referrals. The Trust has a standalone policy for Prevent which provides guidance, direction, processes, and procedures for staff to meet their Prevent duties. The Internal Safeguarding Board has oversight of the Trust Prevent policy.

11.0 Conclusion

Whilst this year has seen the first reduction in safeguarding incident numbers for 5 years, the complexity of safeguarding work for children, adults, and unborn babies continues to be challenging. Many cases of abuse are multi-faceted and demand specialist skills in supporting staff to undertake challenging conversations, robust risk assessments, and utilise local and national legislation and guidance to support decision making and seek resolution to professional disagreements.

The safeguarding team strive to provide a proactive and responsive service to support staff in fulfilling their safeguarding responsibilities. There have been challenges with covering maternity leave and vacancies which has at times impacted on the ability of the team to be visible and proactive. There is a need for the team to be able to identify complex cases at an earlier stage so that they can provide timely and specialist advice to wards and departments. Safeguarding work is complex and challenging and whilst safeguarding is everyone's responsibility, it is naïve to assume that non-specialist staff have the in-depth knowledge and skills to manage the ever-growing complexities without support. It is for this reason that it is essential that the safeguarding team are proactive and visible, but also that staff understand our roles and responsibilities, seek help at the earliest opportunity and continue to seek support as complexities develop. Together we can ensure that our patients are kept safe from abuse and neglect.

The safeguarding team continue to work closely with their colleagues in the Complex Vulnerability Team as many patients at risk of abuse have additional vulnerabilities associated with capacity issues such as learning disabilities and dementia, which again add to the complexities of safeguarding work. The value of this collaborative work should not be underestimated, the work is closely aligned, and the integrated team work together to resolve complex safeguarding and vulnerability issues providing a co-ordinated and collective approach to offer protection from harm and abuse.

11.1 Objectives for 2024-2025 – Outcomes

Last year we set the following objectives. The table provides an update on progress made this year

Areas for focus and improvements	Progress
Increase visibility and proactive work of the safeguarding team	Reviewed safeguarding workstreams, roles and responsibilities Completed a "Stop, Start, Continue" review Developed a Safeguarding Adult Improvement Plan Worked collaboratively with partners to streamline MASH lateral checks Developed and delivered on a programme of awareness raising events Undertaken quality review visits to the wards and departments as part of the clinical accreditation programme
Ensuring a skilled and competent workforce	Ongoing work with Black Country Partners to review and align safeguarding training and consider collaborative and consistent approach to training across the system. Used role modelling, supervision, incident feedback and awareness raising events to supplement training opportunities
Managing complex safeguarding cases where patients are subject to multiple categories of abuse which impact on a person's ability to stay safe from abuse and neglect.	Increased visits to wards and departments Utilising incident reporting mechanisms to identify complex safeguarding cases Initiated multi-agency meetings to share information, risk assess and action plan
Support identification of hidden harm	Provided supervision, training and feedback from incidents to support staff in developing skills to have meaningful conversations with patients, utilising professional curiosity and questioning skills
Evidence learning from internal and external reviews	Development of a single action plan for actions and learning from S42 enquiries Undertaken in depth review of learning from external reviews and provided assurance to multi-agency partners that learning has been embedded

11.2 Objectives for 2025-2026

Areas for focus and improvements	How we will do this
Improve Trust response to victims of domestic abuse	• Trust Domestic Abuse Improvement Plan
Improve the safeguarding team's ability to make early identification of complex safeguarding cases to ensure timely provision of support and advice to wards and departments	• Raise awareness of the roles and responsibilities of the safeguarding team • Work collaboratively with the patient safety team to develop system on Datix to support early identification

	• Increase visibility of the teams in wards and departments
To actively identify, acknowledge, and promote examples of good safeguarding practice, reinforcing a culture of learning, accountability, and continuous improvement	• Use of Greatix • Trust Safeguarding Newsletter • ISB reports • Assurance reports to ICB/DSPPB • Share with divisional governance groups • Participate in the Trust Clinical Accreditation visits
Strengthen integration of the safeguarding team to support the 'Think Family' approach and enhance transitional safeguarding, in alignment with DSPP priorities and provide seamless, holistic care across all age groups	• Team away day to scope new ideas and ways of integrating systems and workstreams • Joint improvement plans • Opportunities for movement of staff within the teams • Joint roadshows and learning events • Annual appraisals to consider development of skills across the team
Provide accessible and supportive training and resources to strengthen staff's response to safeguarding incidents	• Continue to work with ICB partners to align training across the system • Review current training package • Develop quick reference and useful "how to" tools • Provide "bitesize" topic focused training • Strengthen Safeguarding Champion forum • Bi-monthly information sharing for Lead Nurses to deliver at huddles • Extend offer of safeguarding supervision • Strengthening working relationships with Dudley Place and GP surgeries

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Performance KPI's

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June Report (May 2025 Data for National Performance & April 2025 Data for Cancer & VTE)

Karen Kelly, Chief Operating Officer

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

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Constitutional Performance

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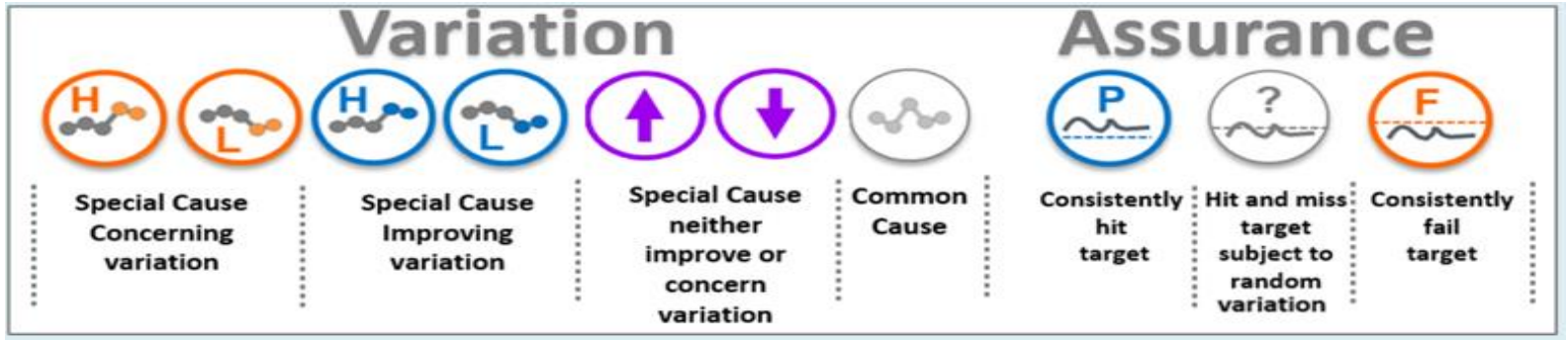
Constitutional Standard and KPI		Target	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	In-month Target		
Emergency Access Standard (EAS)	Combined 4hr Performance	78.0%	81.6%	79.9%	83.6%	81.2%	81.9%	81.9%	78.1%	77.8%	78.7%	80.5%	78.3%	79.1%	78.0%	H	?
Triage	Triage - All	95.0%	80.2%	73.3%	75.9%	81.4%	78.1%	84.3%	73.0%	76.4%	73.6%	76.1%	83.3%	81.3%	N/a		F
Referral to Treatment (RTT)	RTT Incomplete	92%	58.6%	58.6%	57.2%	57.5%	58.3%	59.2%	58.2%	58.7%	58.9%	59.9%	61.4%	62.2%	60.3%	H	F
Diagnostics	DM01 - Diagnostics achieved within 6 weeks	85%	86.9%	88.3%	86.3%	86.2%	89.2%	90.4%	85.8%	85.2%	87.8%	86.5%	85.5%	84.1%	90.9%	H	?
VTE	% Assessed on Admission	95%	99.0%	99.1%	99.2%	99.1%	99.1%	99.1%	98.9%	98.7%	98.9%	98.8%	98.7%	N/a	N/a	L	P



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Ambulance Handovers 60+ Mins

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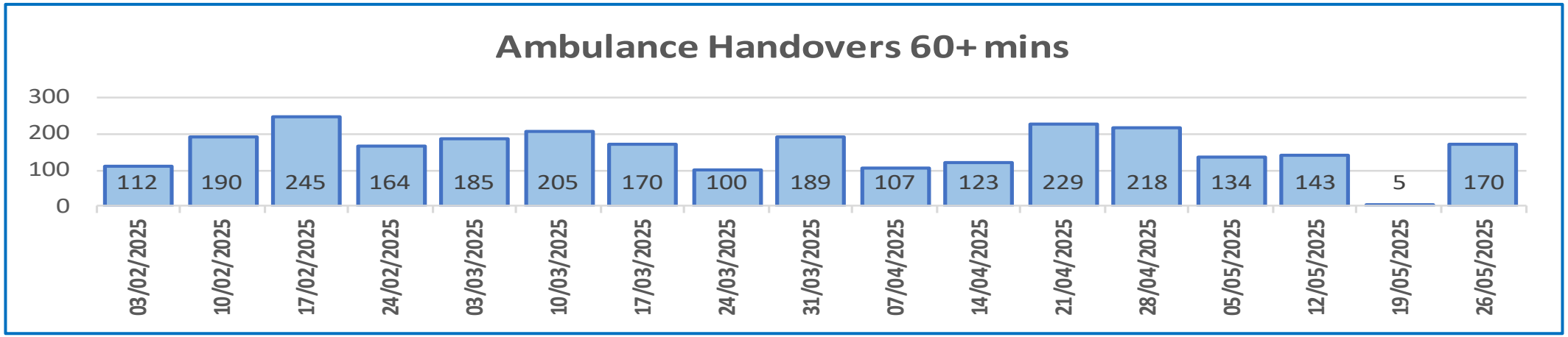
NHS Foundation Trust



Performance

This month's activity saw 10,129 attendances. This has increased when compared to the previous month of April with 9,541.

21 out of the 31 days saw >350 patients.

3,088 patients arrived by ambulance; this shows a decrease from the 3,122 ambulances that attended last month.

356 of these offloads took <1hr (12%). This is an increase in our performance when compared with last month's performance of 16%

Over the month, the average length of stay (LOS) in ED was 204 mins for non-admitted patients and 410 mins for those waiting for a bed following a decision to admit. This represents an improvement compared to last month where the LOS was 215 mins and 450 mins, respectively.

Action

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

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ED Performance

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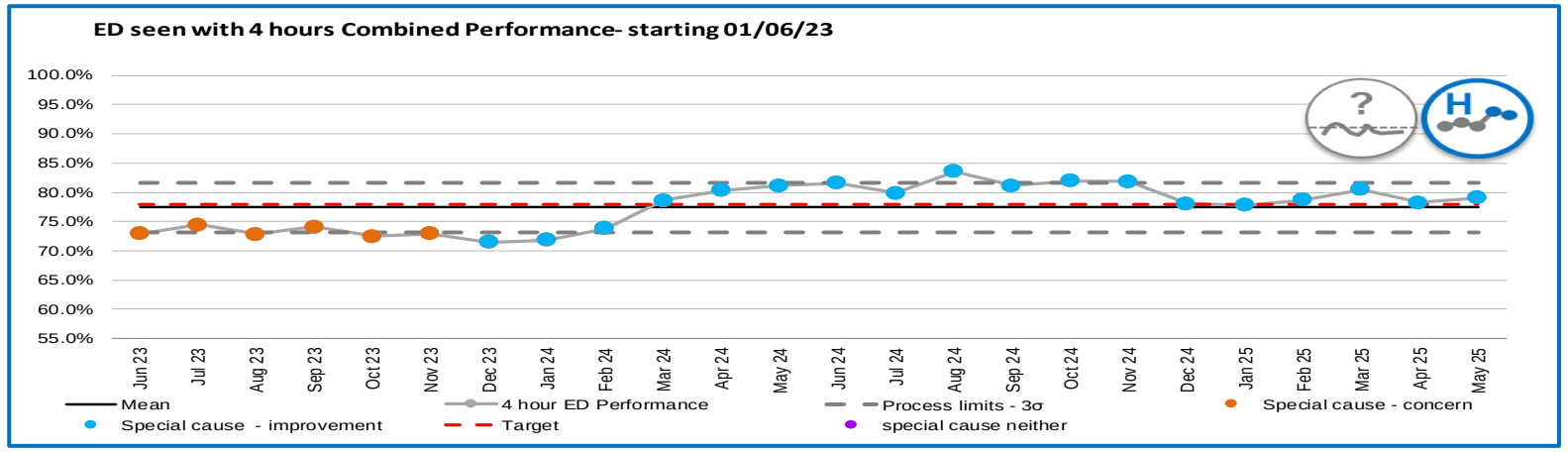

Latest Month 79.1%	Latest Month 144	3rd for May 2025
EAS 4 hour target 78% for Type 1 & 3 attendances	DTA 12 hour breaches – target zero	DGFT ranking out of 13 West Midlands area Trusts

Performance

RHH ED Performance for March is 3rd in the black country despite high ambulance and walk-in attendance when compared to our regional neighbours.

ED 4hr Performance for May is 79.11%

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

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

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

Action

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

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ED 4 Hour Waits Benchmarking

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National 4 hour EAS Target Comparison

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

May 2025

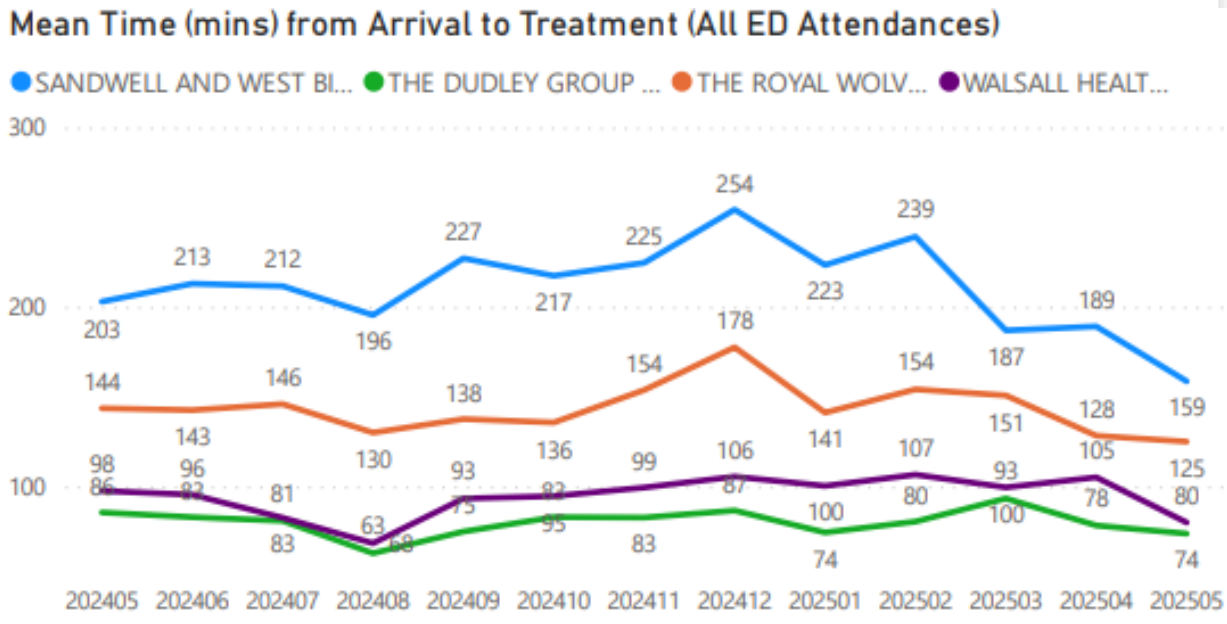
Latest Refresh
12/06/2025 10:55:54

Name	Value	National Rank
The Royal Wolverhampton NHS Trust	81.53%	11
Walsall Healthcare NHS Trust	79.53%	14
The Dudley Group NHS Foundation Trust	79.11%	20
Birmingham Women's And Children's NHS Foundation Trust	78.80%	26
Sandwell And West Birmingham Hospitals NHS Trust	78.02%	32
University Hospitals Coventry And Warwickshire NHS Trust	72.77%	60
South Warwickshire NHS Foundation Trust	71.18%	69
University Hospitals Of North Midlands NHS Trust	70.03%	82
George Eliot Hospital NHS Trust	68.22%	90
Worcestershire Acute Hospitals NHS Trust	65.07%	102
University Hospitals Birmingham NHS Foundation Trust	60.54%	112
Wye Valley NHS Trust	60.37%	113
The Shrewsbury And Telford Hospital NHS Trust	49.49%	121

DGH

Ranking out of 122 Trusts

Source: Daily EAS - Power BI



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ED 4 Hour Wait Number of Breaches

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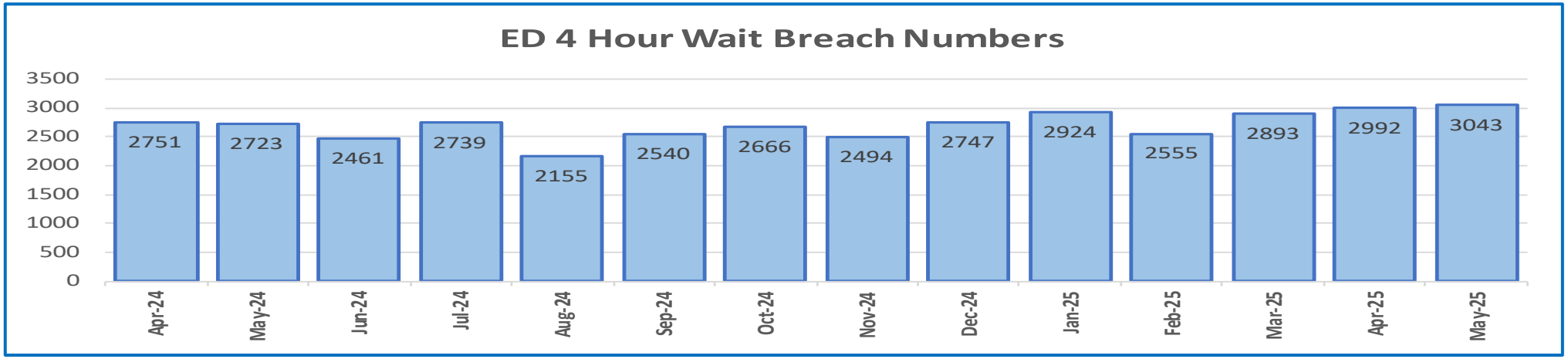
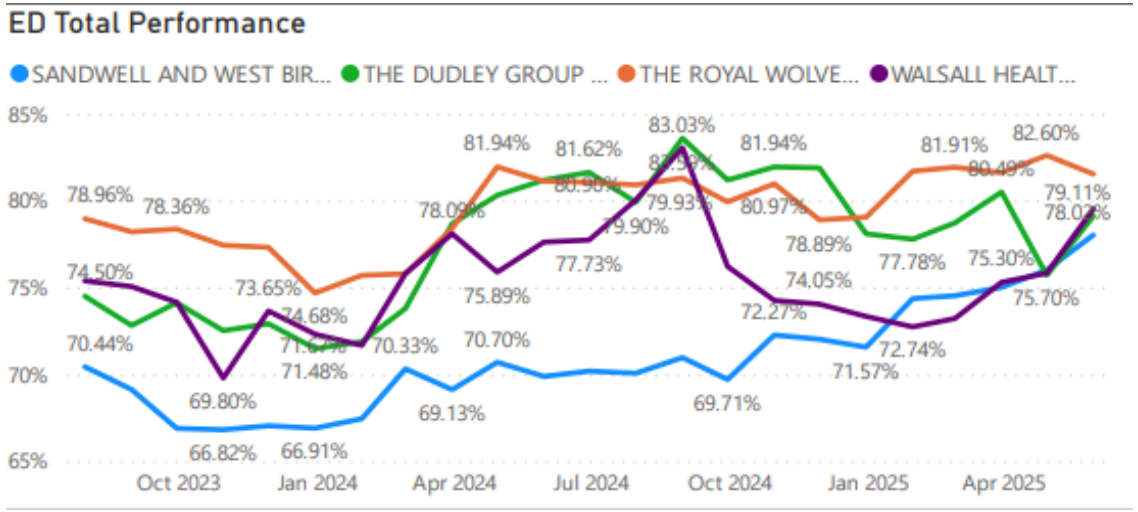
NHS Foundation Trust



Date	No. Breaches
Apr-24	2751
May-24	2723
Jun-24	2461
Jul-24	2739
Aug-24	2155
Sep-24	2540
Oct-24	2666
Nov-24	2494
Dec-24	2747
Jan-25	2924
Feb-25	2555
Mar-25	2893
Apr-25	2992
May-25	3043

Performance

ED remains 3rd in the black country and in the top 20 nationally



Action

The ED performance for May was at 79.11% vs the national target of 78%.

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

- GP letter patients straight to SDEC/Surgical SDEC.
- Agree new streaming template with UCC for patients with letters to go direct to Speciality.
- Joint working with Surgery to ensure proactivity to take patients from ED even when full.
- Organizational agreement that specialties must take patients directly and not wait to assess them in ED.
- Extra Validation resource.

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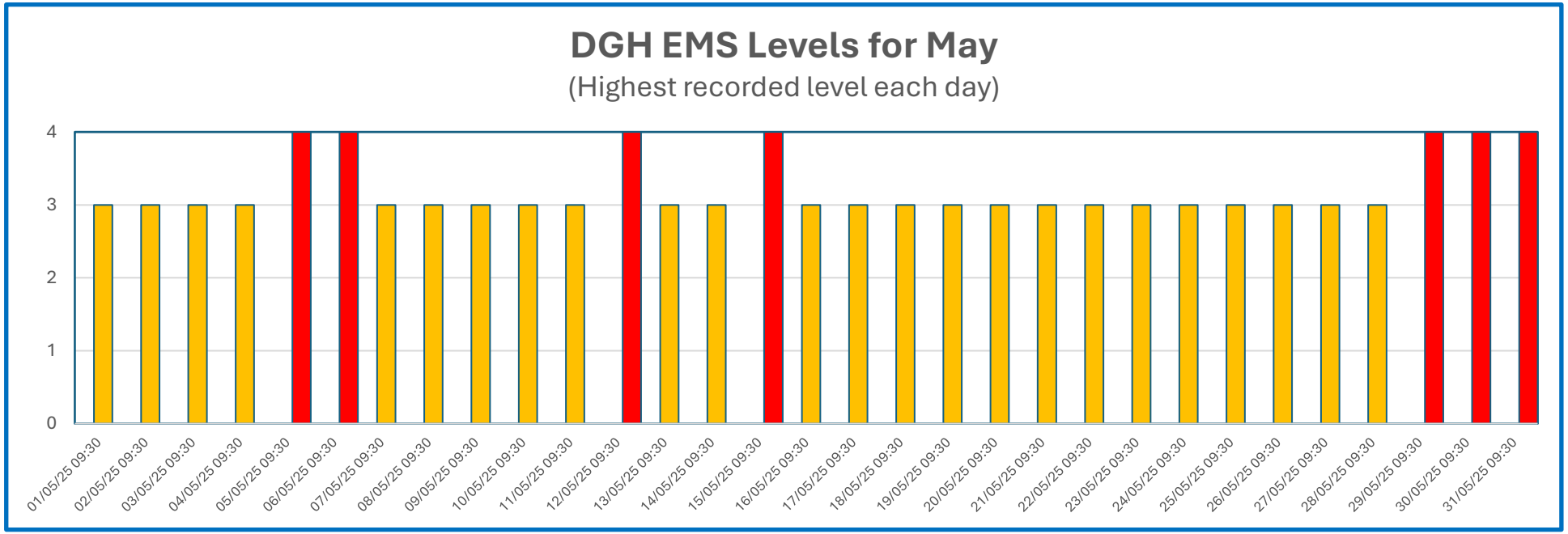
EMS Level for last month

The Dudley Group NHS Foundation Trust



Performance

EMS Levels 4 during May.

3,088 patients arrived by ambulance; this shows a decrease from the 3,122 ambulances that attended last month.

356 of these offloads took <1hr (12%). This is an increase in our performance when compared with last month's performance of 16%

In terms of capacity the trust continues to be impacted by medically optimised for discharge patients, which is further exacerbating flow issues and leading to pressure at both the front and back door.

Action

To continue to utilise non-admitted pathways wherever possible.

Maintain step downs from acute areas to ensure provision available for the highest acuity patients.

Focus now on NHSE's 5 priority ED improvement initiatives

- Streaming & Redirection
- Rapid Assessment & Treatment
- Maximising UTC use
- Improving Ambulance Handover process
- Reducing the time in department

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ED Triage

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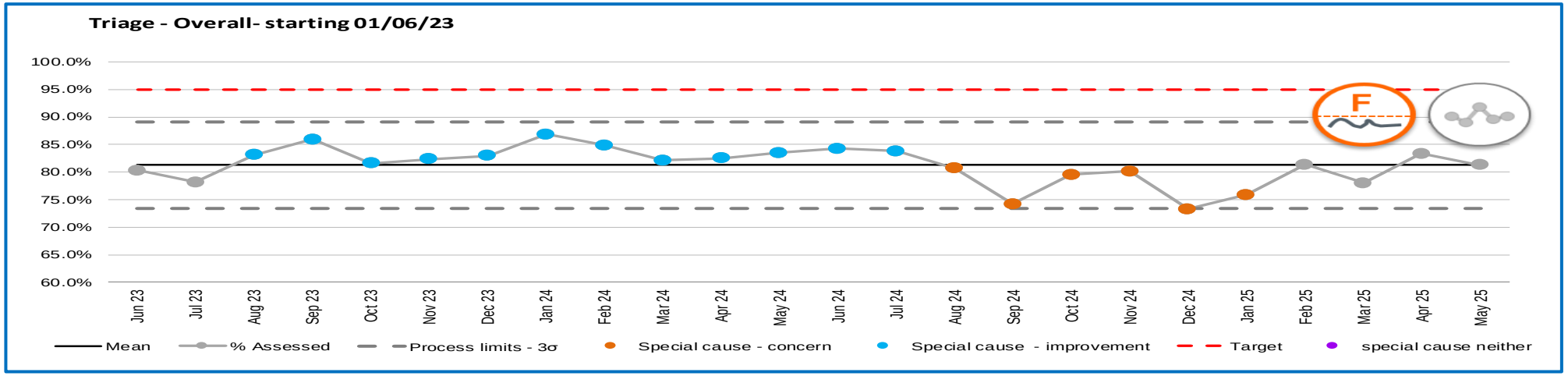

Latest Month

81.32%

Triage – target 95%

Performance

ED have reconfigured the treatment areas following the floor works and ahead of the planned building works and now have a dedicated triage space and we are monitoring performance daily- completed

Action

- Deputy Matrons continue to lead on Triage improvement
- ED assurance report now submitted monthly to Execs.
- Daily triage continues to be monitored by the Deputy Matrons.
- Front door triage demand continues to be higher than the available capacity of area and staff.
- More nurses have received their ESI training with additional codes which have been purchased.

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ED Triage

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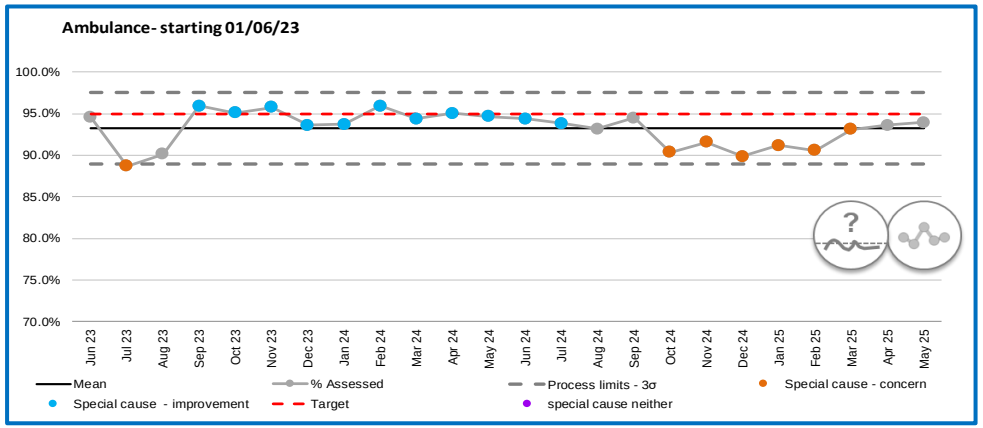
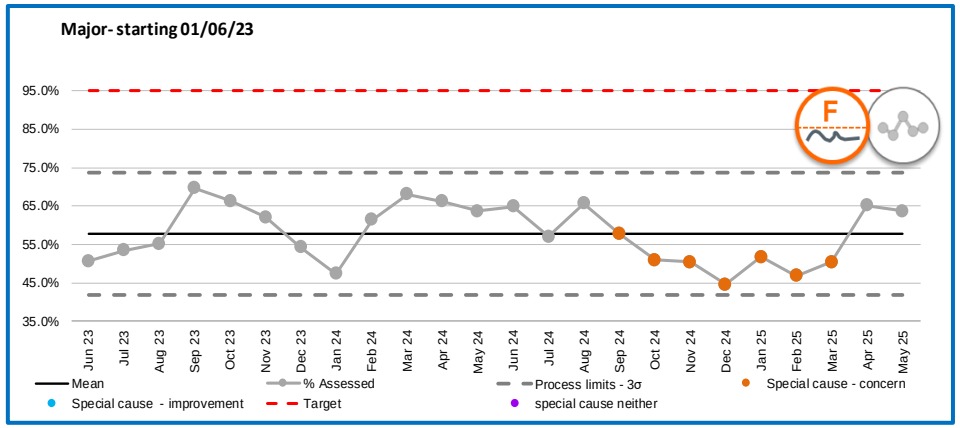


Latest Month

94.0%



Latest Month

63.7%

Performance

ED have reconfigured the treatment areas following the floor works and ahead of the planned building works and now have a dedicated triage space and we are monitoring performance daily

Action

- Time spent in triage continues to be monitored
- Increased focus in direct to speciality patients being sent from UCC rather than being triaged in ED

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ED Triage

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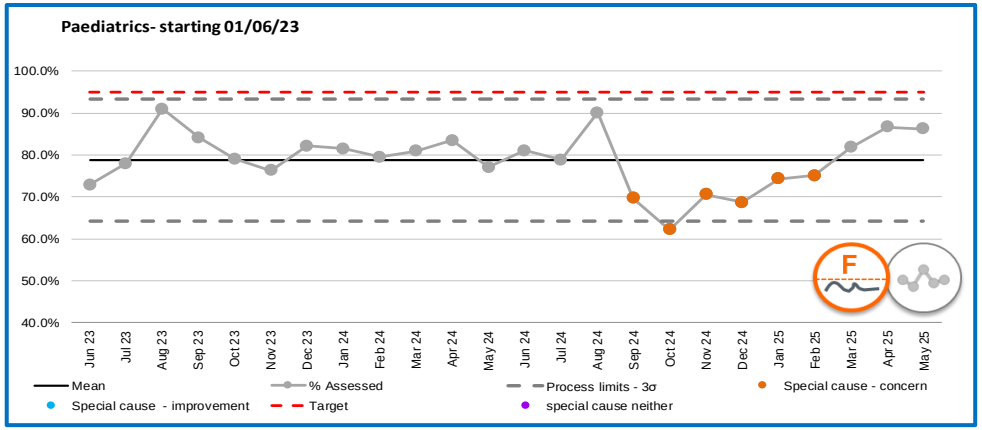
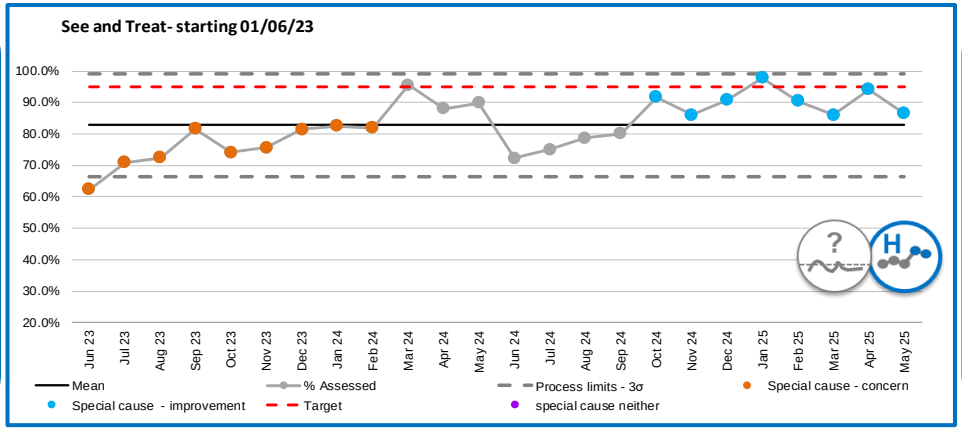


Latest Month

86.2%



Latest Month

86.6%

Performance

ED have reconfigured the treatment areas following the floor works and ahead of the planned building works and now have a dedicated triage space and we are monitoring performance daily

Action

- Paeds daily huddles continue to good effect and triage performance and escalations are discussed.
- Develop process for quickly monitoring and altering when minor's patients need to begin having early "eyes on" assessments rather than just seeing and treating patients all in one go – this is being developed and supported by Nurse/ENP/Medical teams.

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Cancer

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	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25
28 Day Combined (75%)	83.3%	81.9%	81.6%	83.6%	82.0%	81.2%	81.9%	84.2%	81.6%	87.3%	86.5%	84.6%
31 Day Combined (96%)	92.5%	90.2%	94.1%	89.9%	90.8%	93.1%	92.1%	93.9%	88.9%	93.2%	93.6%	96.6%
62 Day Combined (85%)	67.2%	71.1%	74.4%	72.6%	71.7%	76.6%	71.1%	80.7%	75.2%	70.2%	71.7%	76.4%

Latest Month	Latest Month	Latest Month
84.6%	96.6%	76.4%
All cancer 28 Day FDS waits – Target 77%	31 Day Combined Target 96%	62 Day Combined Target 70%

Performance

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

28-day Faster Diagnosis Standard (FDS)

- Performing well at 84.6% and remains above national target of 80%.. Increased focus on individual tumour site pathways.

31 day combined

- 31 day combined achieved 96.6% against national target of 96%. Surgical and diagnostic capacity and BCPS reporting delays impact performance. 31 day trajectory to achieve 96% submitted to ICB. Renal and skin are tumour sites most challenged.

62 day combined

- Achieved 76.4% above monthly NHSE trajectory of 71.4% and remains above NHSE target of 75% by end of March 2026 (this target does not supersede the 85% constitutional standard but set to support tiering measures for cancer performance).
- Late Tertiary referrals closely monitored. Primarily urology, colorectal and lung. Actions in place to reduce. Cancer performance is reviewed at Regional Performance Tier Calls with NHSE.

Action

28-day FDS

-Performance to be sustained. Forecast shows continued achievement.

31 day combined & 62 combined

- Gynae: remains challenged. ICB aware and teams are working on extra capacity. HRT pathway continues to progress..
- Urology and skin currently challenged. Prostate: straight to test pathway commenced and increased capacity for first appointment with nurse. LATP training almost complete for urology nurses with plan to expand once competency logs complete. Dermoscopy: capacity for skin referrals has increased.
- Recent increase in complex colorectal patients requiring Endoscopy following imaging is in focus
- 2025/26 monthly trajectories submitted to ICB and NHSE for 28 FDS, 31day and 62 day targets and actively monitored.
- New Cancer Waiting Times guidance changes from July 2025 has recently been issued by NHSE for review and implementation.
- Funding approved by NHSE in June for Urology and Gynae CDC pathway development

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Cancer Performance – 104 Day – Harm Review

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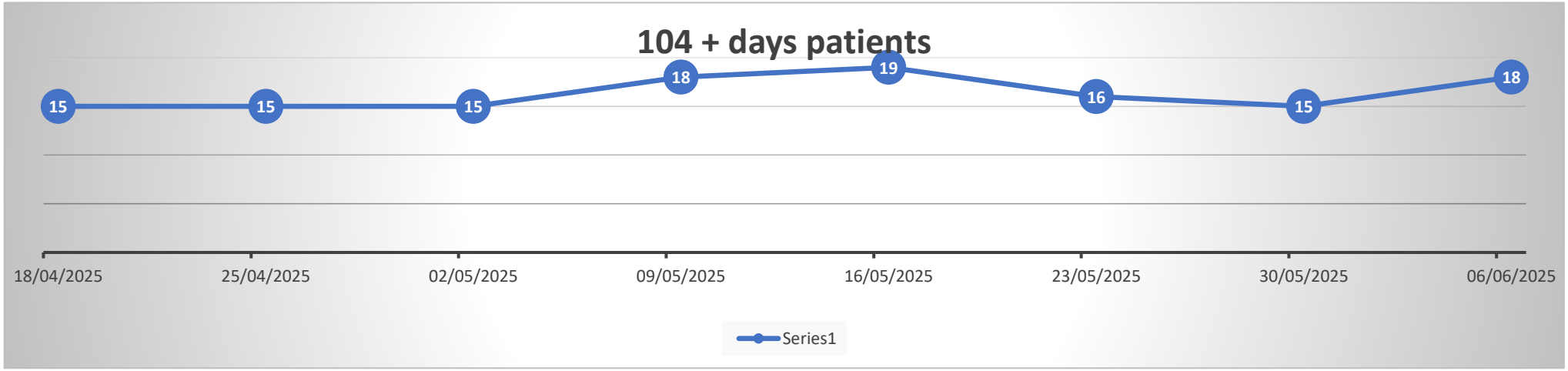

Latest Week (06/06/25)

18

All 104 week waits

Target - 10 Patients

Performance

• Of the 18 over 104 days patients, the most challenged tumour sites are Gynaecology and Urology with 8 patients waiting over 104 days.

• 12 of the 18 have treatment plans / treatment dates. Those without treatment plans were awaiting surgery dates, best interest meetings or further investigations.

• In April we treated 14 patients waiting over 104 days at DGFT and tertiary centres

Action

- Monthly harm review undertaken for patients waiting over 104 days on the cancer pathway
- Focus on reducing the backlog of 104 day waits to release treatment capacity for 31 day and 62-day targets continues. Improve patient engagement earlier in the pathway
- It is anticipated that actions taken to improve combined 62-day performance will support the reduction of patients waiting over 104 days
- Tertiary Referrals: Lung requires multiple diagnostics. PET scans and histology are causing main delays, and this is being addressed. Prostate biopsy capacity is in scope.
- Engage with Urology, Gynaecology and colorectal team to monitor Kidney patient's waiting over 62 day's to stop tip in's over 104 days.

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Cancer Benchmarking

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28-Day Faster Diagnosis Standard vs Planning Trajectory

	Apr-25		May-25		Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Target	
	Plan	Unvalidated	Plan	Unvalidated	Plan	Plan	Plan	Plan	Plan	Plan	Plan	Plan	Plan	Plan	25/26	No's to meet Target
	28d FDS															
WHT - FDS	82.4%	87.4%	83.6%	79.4%	85.9%	85.8%	85.2%	85.1%	86.0%	86.2%	82.7%	82.7%	83.1%	83.2%	80%	
RWT - FDS	80.0%	80.0%	80.0%	73.6%	80.1%	80.0%	80.1%	80.1%	80.1%	80.1%	80.1%	80.2%	80.3%	80.3%	80%	
DGH - FDS	82.0%	84.6%	83.0%	77.3%	83.0%	82.0%	83.0%	82.0%	82.0%	83.0%	82.0%	82.0%	82.0%	83.0%	80%	
SWB - FDS	76.8%	73.5%	77.8%	69.6%	77.5%	78.0%	77.8%	78.6%	79.3%	78.5%	79.3%	79.1%	79.6%	80.1%	80%	50

31-day CWT Trust Trajectory Progress

	Apr-25		May-25		Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Target	
	Plan	Unvalidated	Plan	Unvalidated	Plan	Plan	Plan	Plan	Plan	Plan	Plan	Plan	Plan	Plan	25/26	No's to meet Target
	31d															
WHT -31d	96.6%	98.7%	98.1%	98.7%	100.0%	97.6%	96.8%	100.0%	97.5%	100.0%	97.3%	97.4%	97.4%	100.0%	96%	
RWT - 31d	91.8%	90.8%	92.4%	86.4%	93.5%	93.9%	94.8%	95.6%	96.0%	96.0%	96.2%	96.1%	96.1%	96.2%	96%	5.4
DGH - 31d	94.2%	96.8%	94.4%	94.1%	94.5%	94.8%	94.9%	95.0%	95.1%	95.5%	95.7%	95.6%	95.7%	96.0%	96%	
SWB - 31d	96.5%	89.5%	96.7%	95.0%	96.4%	96.4%	96.6%	96.1%	96.8%	96.5%	96.6%	96.3%	96.2%	96.4%	96%	10.6

62-day CWT Trust Trajectory Progress

	Apr-25		May-25		Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Target	
	Plan	Unvalidated	Plan	Unvalidated	Plan	Plan	Plan	Plan	Plan	Plan	Plan	Plan	Plan	Plan	25/26	No's to meet Target
	62d															
WHT - 62d	79.4%	75.8%	79.4%	83.6%	80.0%	75.7%	75.7%	76.6%	76.1%	76.7%	75.4%	76.4%	76.7%	76.0%	75%	2.2
RWT - 62d	70.5%	68.2%	70.6%	46.1%	71.9%	71.9%	72.8%	73.5%	75.3%	75.4%	75.4%	75.2%	75.2%	75.2%	75%	5.1
DGH - 62d	71.4%	74.9%	71.6%	67.6%	72.2%	72.3%	73.0%	73.1%	73.6%	74.1%	74.2%	70.0%	74.5%	75.3%	75%	
SWB - 62d	73.3%	73.4%	71.8%	67.3%	72.3%	73.0%	77.1%	73.3%	73.8%	71.4%	72.0%	72.7%	74.5%	75.4%	75%	

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RTT Performance

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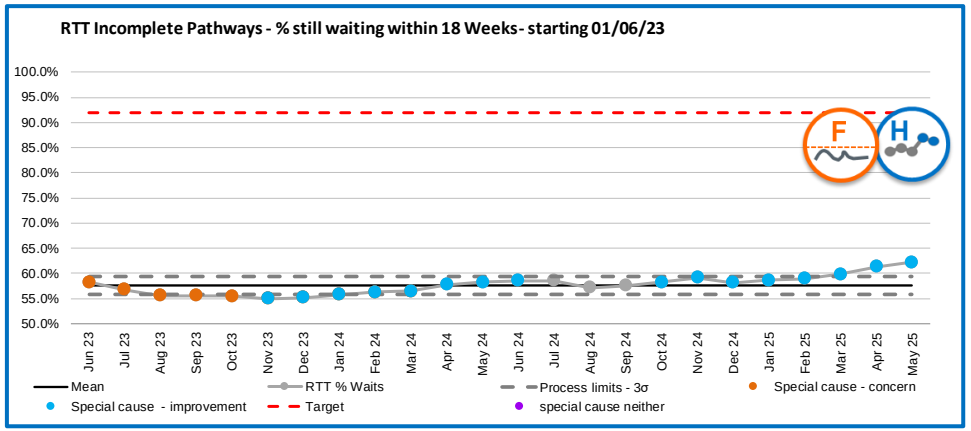
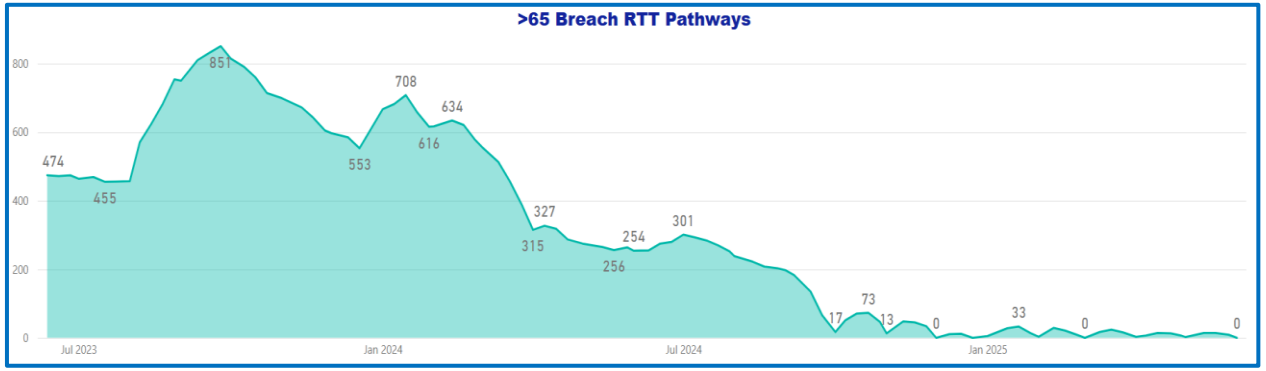


Latest Month

62.2%

RTT Incomplete pathways target 92%



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

Performance

18 weeks - has shown continued improvement in RTT performance, with the proportion of patients treated under 18 weeks rising marginally from 62.1% to 62.2%. We are currently 1.7% ahead of our trajectory.
52 weeks -Through the annual planning process, the ICB requested a revised trajectory for 52-week delivery. This has extended the trajectory to end of Q2. Due to pressures across a number of specialties, the end of May position was 62 behind plan Corrective actions are in place to recover the forecast position by the end of June.
65 weeks – No 65-week breaches for May.

Total Waiting List size continues to show sustained growth, due to increase in referrals from since March in March and April. Initial analysis highlights a potential shift in referral patterns from Dudley and Sandwell GPs on the border. Our waiting list size is currently 2452 patients behind plan, i.e. 5.58% larger than expected.

Participating in NHSE validation sprint – excellent performance to date – currently 5016 clock stops ahead of baseline position (£33 will be received per additional clock stop)

Action

The high-risk specialties for 52-week delivery are Gynaecology and Trauma and Orthopaedics. Key mitigations as follows:

Gynaecology – Key risk relates to long waits for first outpatient appointment. 3 locum consultants have been appointed but will not commence until August. These doctors will have a significant outpatient commitment in job plans. This will address the longest waits. Consultant Connect have been engaged to provide enhanced triage for patients who have not yet been allocated a first appointment. The current return rate to GPs (with detailed management plan) is 22%. Options for mutual aid and outsourcing being explored.

Trauma and Orthopaedics – key risk relates to waits for inpatient treatment. Additional waiting lists planned for June and July. Mutual aid being sought from Black Country Providers.

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RTT Benchmarking

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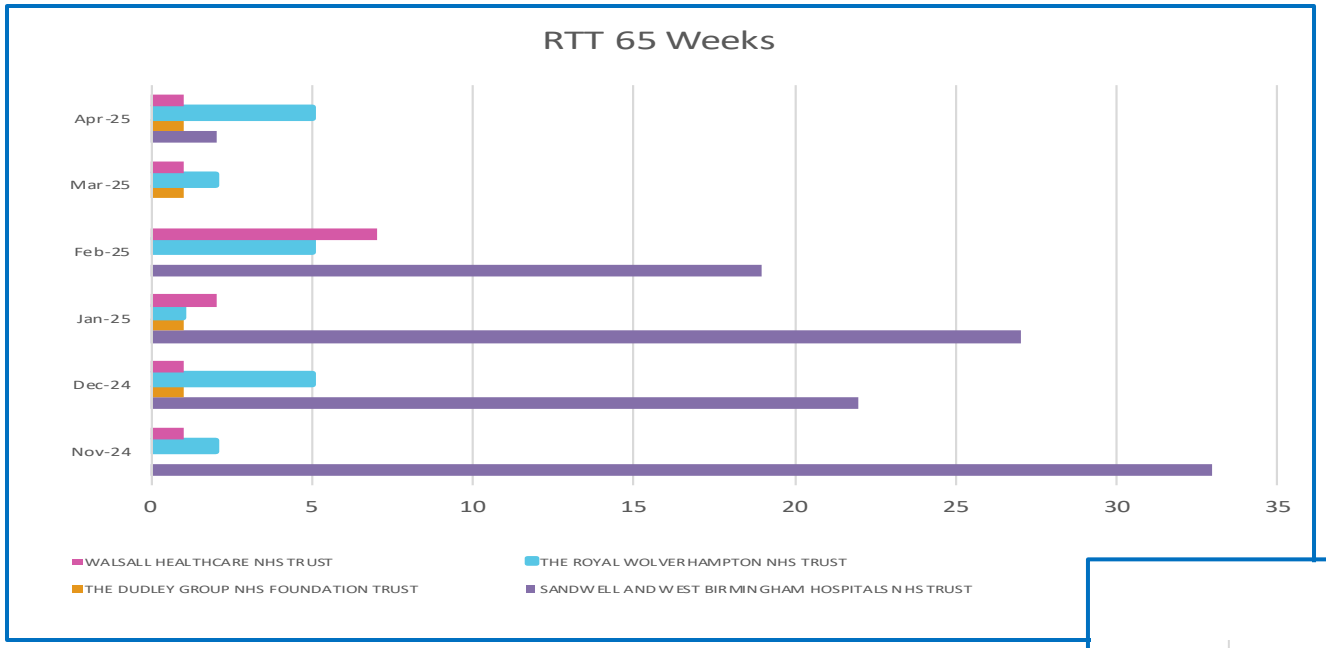

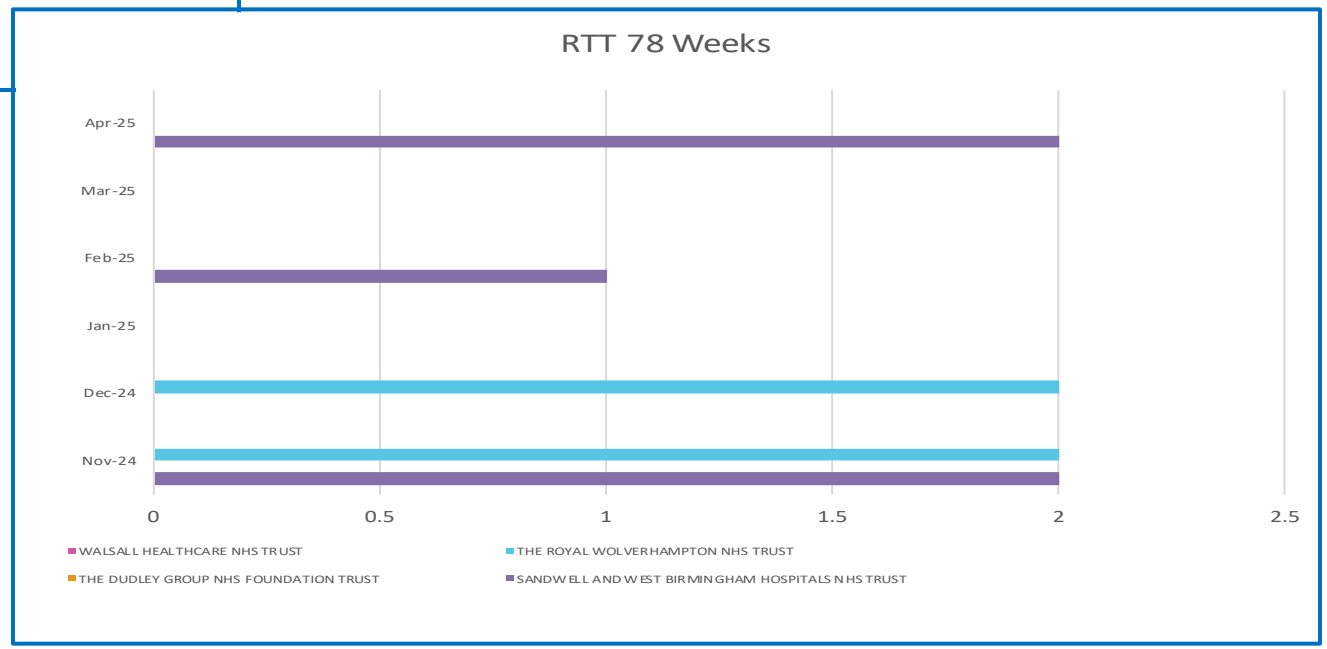

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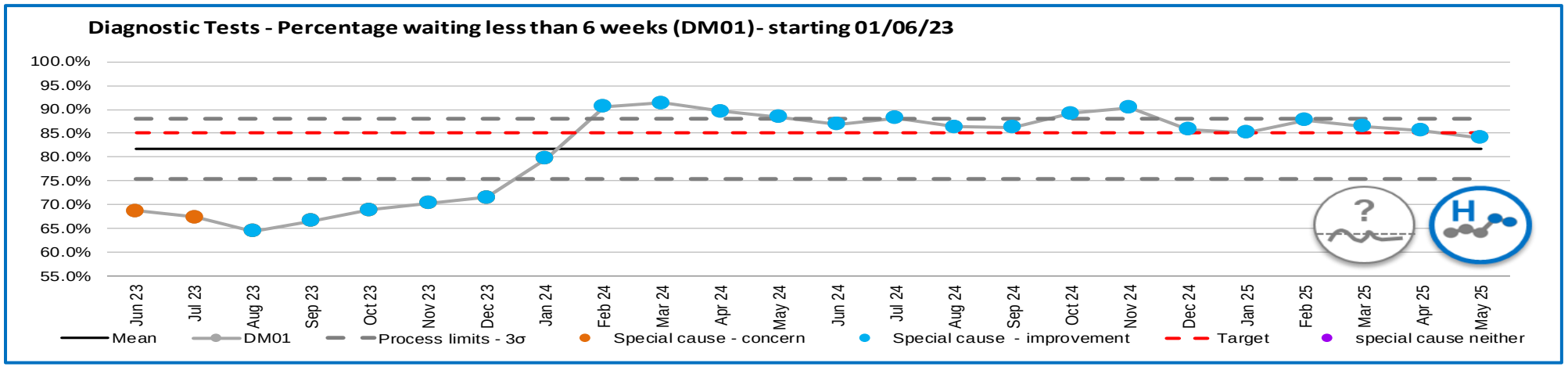
DM01 Performance

The Dudley Group NHS Foundation Trust



Latest Month

84.1%

DM01 combining 15 modalities - target 85%

Performance

- May DM01 performance achieved 84.1%. Sleep Studies significantly impacted overall DM01 with performance of 37.14%.
- Dexa, Endoscopy, Cardiology and Ultrasound continue to perform well.
- MRI overall has seen an improvement from 93.11% in April to 95.45% in May. Cardiac MRI is improving as a result of continued mutual aid . CT breaches are all cardiac, this adversely affects DM01 performance.as total CT waiting list.is relatively low
- Audiology performance saw a slight improvement in May with actions taken to improve.
- Of the 288 breaches waiting over 13 weeks in May, 275 were for Sleep Studies.
- Cardiac MRI over 13 week breaches have reduced from 28 in April to 9 in May with plan to clear by end of July 2025.
- Patients waiting between 6 and 12 weeks remain an area of focus.
- Diagnostic activity plan for 2025//26 submitted to ICB and NHSE actively monitored

Action

- New Sleep Studies equipment and additional workforce will provide extra capacity. Increase in activity to 25 slots per day commenced from 16th June.. Recovery plan and trajectory will clear 6+ week backlog by end of August 2025. Respiratory to commence at CDC over coming weeks. Suitable space for services to operate is in progress.
- Cardiology and Imaging working in collaboration to increase capacity. Mutual aid from RWT although limited is supporting. Further additional mutual aid requested. Increased capacity on CT scanner at Guest to be maximised. Return of Head and Neck Sonographer from maternity leave will provide additional support for ultrasound.
- Audiology have been impacted by staffing challenges. Plan to improve performance includes new audiologist completing training in June to enable them to work autonomously and locum commenced during May to partially cover 2 members of staff on maternity leave.
- Diagnostic performance is reviewed with NHSE on fortnightly system tiering call.

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DM01 Benchmarking

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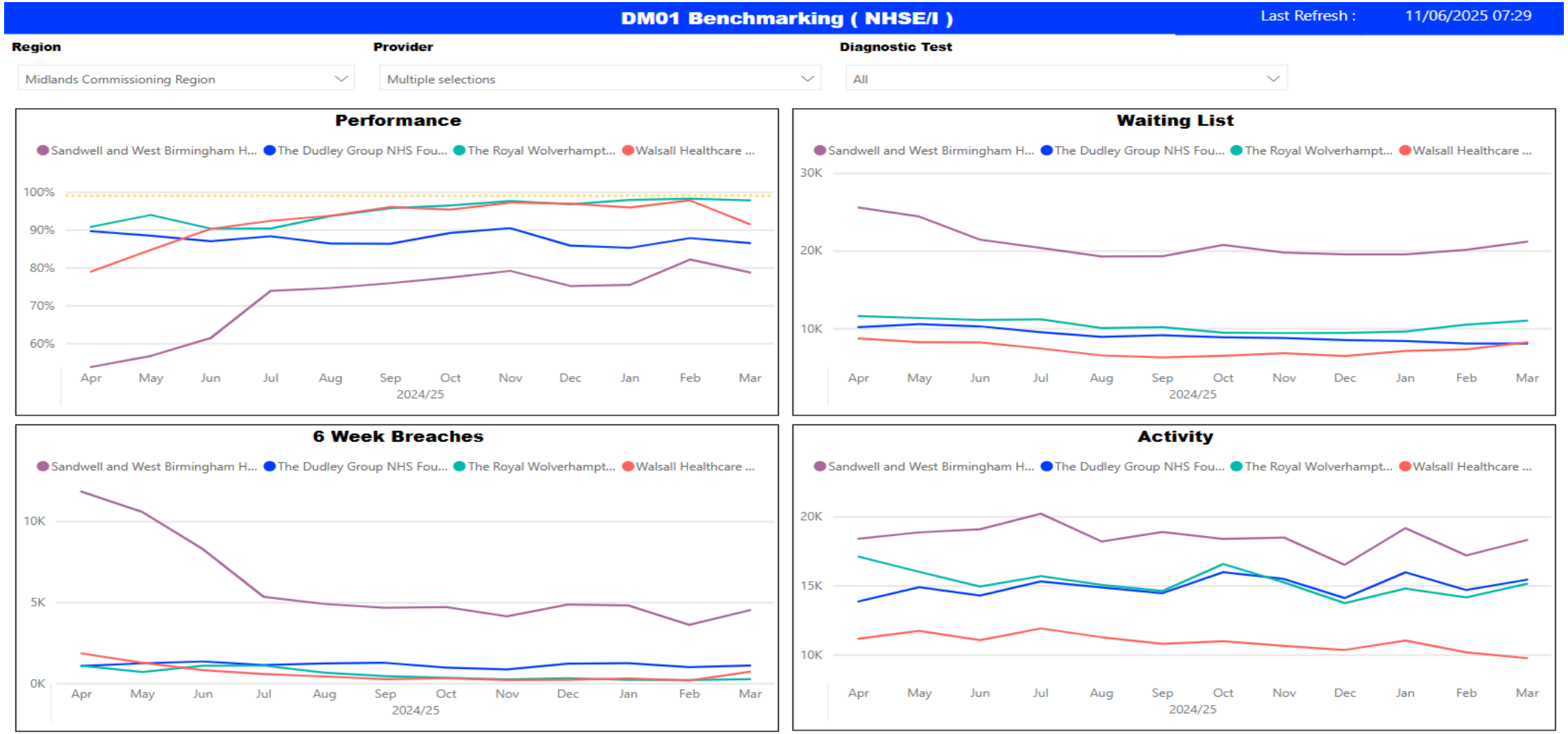

Source: Imaging Cardiology CRIS Dashboard - Power BI

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VTE Performance

Please note: VTE figures now run 1 month in arrears

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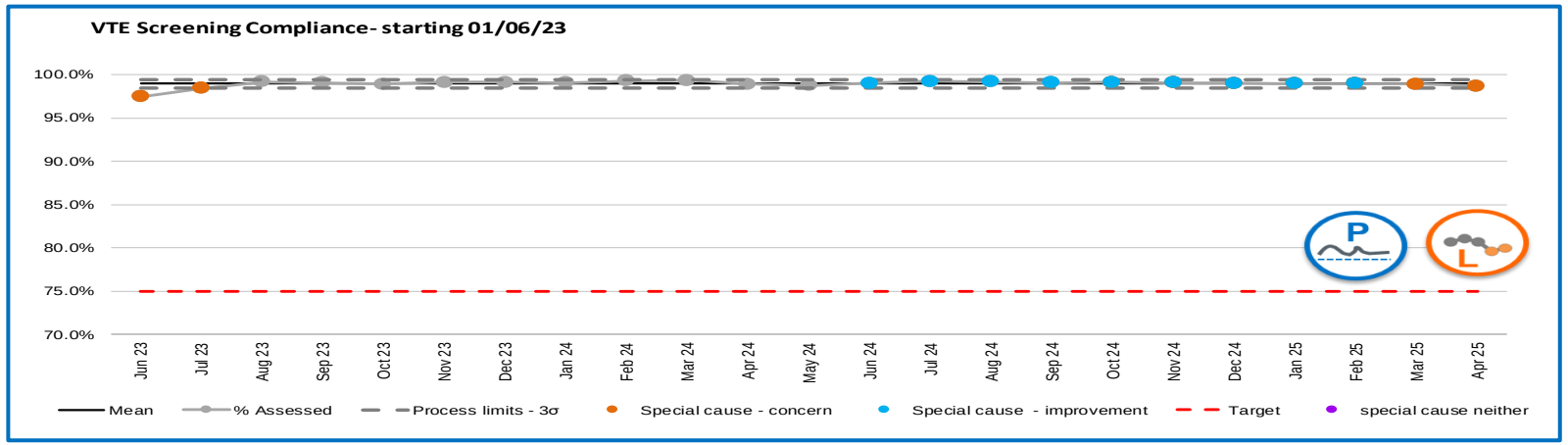

Latest Month	Latest Month	Latest Month
98.7%	99.1%	98.2%
Trust Overall Position	Medicine & IC	Surgery, W & C

Performance

VTE performance sustained above the standard of compliance in consecutive months since March 2023.

Action

Ward level reporting is available, and this is being monitored as part of the ward performance reviews.

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Screening Programmes

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Description	Comments	Reference	From	On Mat Dashboard	Target	Q1	Q2	Q3	Q4
NHS Abdominal Aortic Aneurysm Screening Programme (AAA) 2023/24 (@ ICB level)	Percentage of abnormal screens reviewed ≤ 21 days of the initial screen date within the reporting period.	AAA-S12	Karina Lloyd, BCO AAA Screening	No	Acceptable: ≥60.0% Achievable : ≥95.0%	16.67%	29.41%	47.80%	62.50%
NHS Breast Screening Programme 2023/24 (@ ICB level)	The proportion of eligible women who have a technically adequate screen less than or equal to 6 months from date of first offered	BSP-S03a	Joanne Essex	No	Acceptable: ≥70.0% Achievable : ≥80.0%	69.00%	77.00%	68.31%	
NHS Colposcopy Intervention/treatment 6 week appointment 2023/24	Proportion of women who are offered a colposcopy within 6 weeks of referral due to a positive HR-HPV test and negative cytology OR borderline changes or low-grade dyskaryosis.	CSP-S11	Jo Malpass / Sharon Turner	No	>=99% Green <99% Red	87.00%	100.00%		
NHS FASP Trisomy screening 2023/24	Indequate samples for Downs/Edwards/Patau screening a) Combined samples	FA4	Newborn Screening KPI Submission	Yes	To be Set	0.70%	1.20%	0.50%	
NHS FASP Trisomy screening 2023/25	Indequate samples for Downs/Edwards/Patau screening a) Quadruple samples	FA4	Newborn Screening KPI Submission	Yes	To be Set	0.70%	2.00%	0.80%	
NHS Infectious Diseases in Pregnancy Screening 2023/24	The proportion of pregnant women eligible for human immunodeficiency virus (HIV) screening for whom a confirmed screening result is available at the day of report	ID1(IDPS-S01)	Mel Bullas, Antenatal and Newborn Screening KPI Submission	Yes	>=99% Green 95%-99% Amber <95% Red	99.80%	99.90%	100.00%	
NHS Infectious Diseases in Pregnancy Screening 2023/24	The proportion of pregnant women eligible for hepatitis B screening for whom a confirmed screening result is available at the day of report	ID3(IDPS-S02)	Mel Bullas, Antenatal and Newborn Screening KPI Submission	Yes	>=99% Green 95%-99% Amber <95% Red	99.80%	99.90%	100.00%	
NHS Infectious Diseases in Pregnancy Screening 2023/24	The proportion of pregnant women eligible for syphilis screening for whom a confirmed screening result is available at the day of report	ID4(IDPS-S03)	Mel Bullas, Antenatal and Newborn Screening KPI Submission	Yes	>=99% Green 95%-99% Amber <95% Red	99.80%	99.90%	100.00%	
NHS FASP Fetal Anomaly scan 2023/24	The proportion of pregnant women eligible for NIPT screening for whom a conclusive screening result is available at the day of report.	FASP NIPT-S01	Mel Bullas, Antenatal and Newborn Screening KPI	No	Thresholds are not set for this metric	81.00%	80.00%	75.00%	
NHS Sickle Cell and Thalassaemia screening 2023/24	The proportion of pregnant women having antenatal sickle cell and thalassaemia screening for whom a screening result is available ≤10 weeks + 0 days gestation	ST2	Mel Bullas, Antenatal and Newborn Screening KPI Submission	Yes	>=75% Green 50%-75% Amber <50% Red	43.20%	50.10%	52.50%	
NHS Newborn Blood Spot screening 2023/24	The proportion of first blood spot samples that require repeating due to an avoidable failure in the sampling process	NB2 (NBS-S06)	Mel Bullas, Antenatal and Newborn Screening KPI Submission	Yes	<=1% 1%-2% Amber >=2% Red	0.80%	1.00%	1.10%	
NHS Newborn Hearing Screening 2023/24	Coverage	NHSP-S01 & KPI NH1		Yes	>=99.5% Green 98%-99.5% Amber <98% Red	98.50%	98.40%	98.90%	
NHS Newborn and Infant Physical Examination screening 2023/24	Coverage	ANNB NIPE NP1		Yes	>=97.5% Green 95%-97.5% Amber <95% Red	96.60%	95.90%	97.10%	
NHS Newborn and Infant Physical Examination screening 2023/24	Timeliness	ANNB NIPE NP3		Yes	>=95% Green 90%-95% Amber <90% Red	85.20%	91.40%	54.90%	
Child Vision screening commenced in September						Not Yet Avaialble			

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Kitemark Explanation

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

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

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

Click HERE for full kitemark explanation & policy

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Quality KPIs – June 2025 (May 2025 Data)

Martina Morris Chief Nurse
Dr Julian Hobbs Medical Director

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Contents/Icon Key

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Friends and Family	Page 3
Complaints	Page 4 -5
Incidents	Page 6-7
Safer Staffing	Page 8-9
Mixed Sex Accommodation	Page 10
TES Incidents	Page 11
Dementia	Page 12
Mental Health	Page 13-15
Falls	Page 16
Pressure Ulcers	Page 17-19
Safeguarding	Page 20
Infection Control	Page 21
Stroke	Page 22
Gold Standard Framework Metrics	Page 23
VTE	Page 24
Cardiac Arrest / MET Calls	Page 25
Sepsis	Page 26
Vital Signs Compliance	Page 27
Quality KPI Dashboard	Page 28
Chief Nurse Dashboard	Page 29
Kitemark Explanation	Page 30

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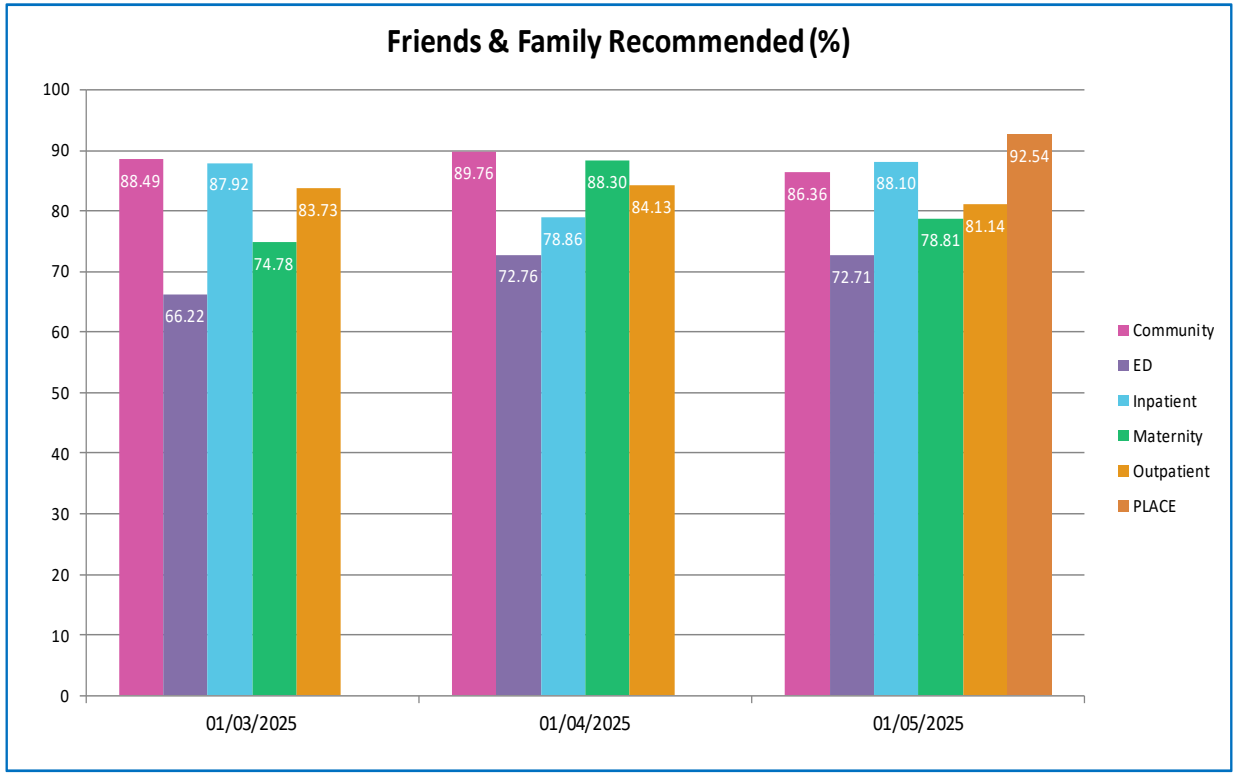
Friends and Family - Recommended

The Dudley Group NHS Foundation Trust

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

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



What are the charts showing us

Overall, 82% of respondents have rated their experience of Trust services as 'very good/good' in May 2025, a small decline since April 2025 (83%). A total of 5% of patients rated their experience of Trust services as 'very poor/poor' in May 2025, no change from the previous month.

In May 2025, the percentage very good/good scores for the A&E Department remain the lowest at 73% (no change from the previous month). The 'very poor/poor' scores for the A&E Department have seen an improvement again this month at 11% (in comparison to 12% in April 2025). The Inpatient Department received the highest positive ratings in May 2025 at 88%. The percentage very good/good scores have declined for all departments in May 2025 apart from the A&E department where the score has remained the same as the previous month. The Maternity Department have seen the biggest decline in percentage positive scores at 79% in May 2025 in comparison to 88% in April 2025.

Areas Impacting on Compliance

FFT percentage very good/good scores remain below the national average for all divisions. All percentage positive scores for all departments have seen a decline in May 2025.

Mitigations / Timescales / Blockers

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

Risk Register

No

Key Points to Note

To note the improvement in percentage 'very poor/poor' scores for the A&E Department, and a decrease in the number of patients rating their overall experience as 'very good/good' for all departments.

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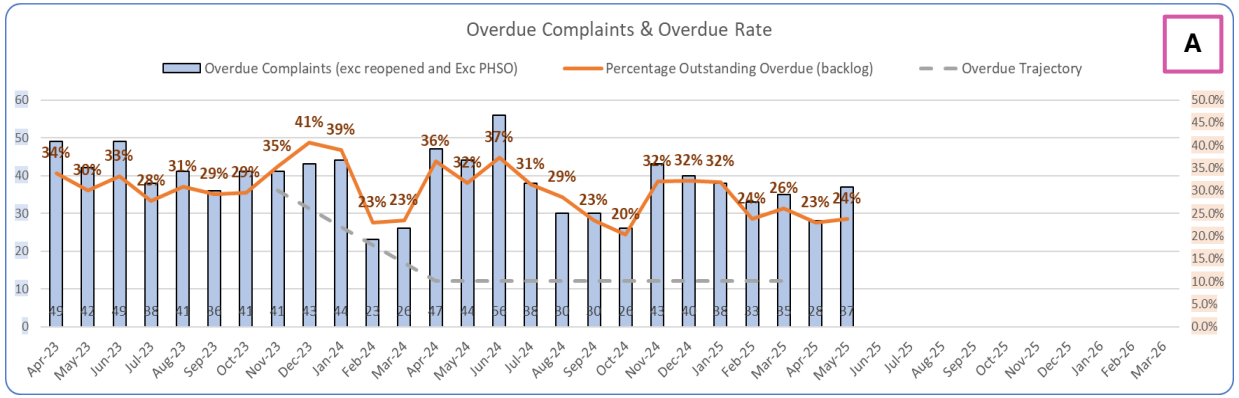
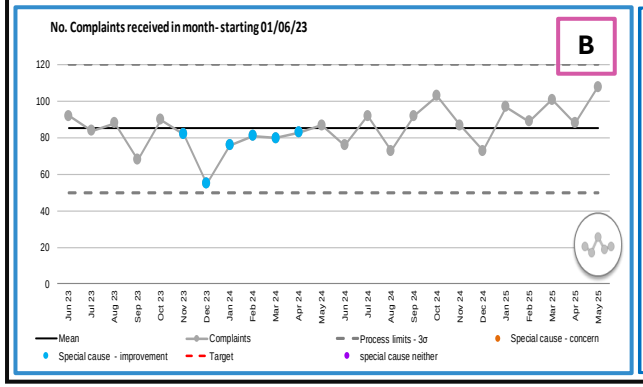
Complaints

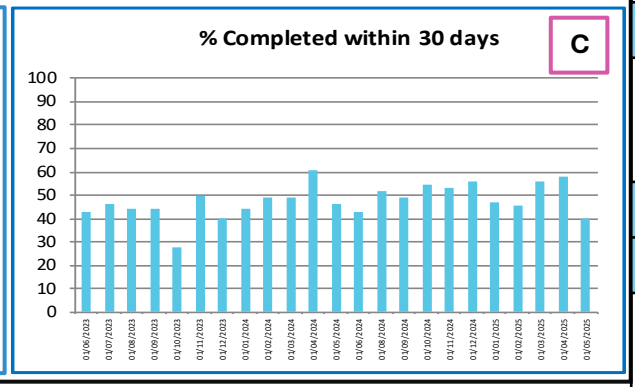
The Dudley Group NHS Foundation Trust

Background	*Monitoring compliance against complaint responses*

Date	May 2025
Trust Performance	A) 37 & 24% B) 108 C) 40.3%
Performance Target / KPI	49.3% against KPI of 90% response rate







What are the charts showing us

In May 2025, PALS received 293 concerns, 8 comments and 152 signposting contacts totalling 453 compared to 427 in April 2025. The main theme being appointment delays and cancellations.
Six PALS concerns were escalated to a complaint.
The Trust received 108 new complaints in May 2025 compared to 88 for April 2025. Of the 108 complaints received, all were acknowledged within 3 working days. The main theme for complaints for May 2025 was patient care.

In May 2025, the Trust closed 77 complaints (excluding Ombudsman cases (no Ombudsman cases closed for May 2025) compared to 105 in April 2025. All complainants are given a 30-working day timeframe. Of those 77 closed, 31 (40.2%) were closed within 30 working days. Not including re-opened complaints and Ombudsman cases, there were 72 complaints closed (first response) and of those 72 complaints, 29 were within 30 working days (40.2%), which is a decrease of 17.9% on last month's response rate of 58.1% (first response complaints). The Trust is not attaining its 90% response rate KPI.

As of 31 May 2025, there were 178 complaints open in total (this includes reopened complaints and Ombudsman cases) with 59 in backlog (33.1% in backlog). There were 156 complaints open (excluding reopened complaints and excluding Ombudsman cases) with 37 of those in backlog (23.7%). Of those 156 complaints; 13 are local resolution meetings, 31 are with complaints (including those in the final stages of review), three are under patient safety review, and 108 are with divisions (including those for response, queries and approval).

Areas Impacting on Compliance

The response rate of 90% remains a challenge, along with the backlog. The complaints team continue to monitor and escalate to senior management when complaints have been open longer than 20 working days without a response from division(s). There have been a large number of complaints received for May 2025.

Mitigations / Timescales / Blockers

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

Risk Register – no longer on the Risk Register

Key Points to Note

A large number of complaints have bene received for May 2025 and this will impact the amount open and potentially the number of complaints tat may breach.

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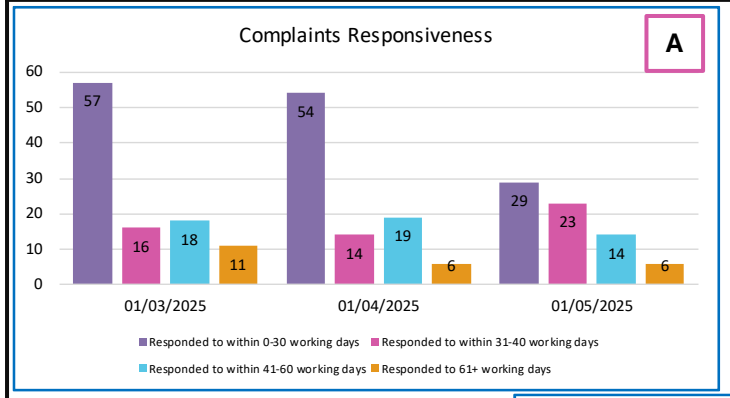
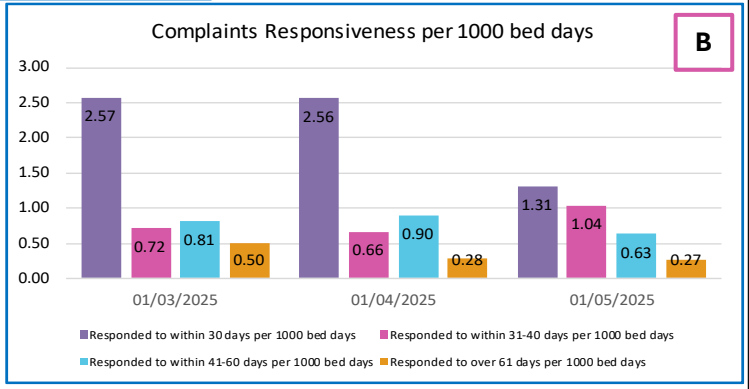
Complaints

The Dudley Group NHS Foundation Trust

Background	*Monitoring compliance against complaint responses*

Date	May 2025
Trust Performance	A) B)
Performance Target / KPI	





What are the charts showing us

Chart A shows the Trust continues to respond to a large proportion of complaints within 30 working days. However, it does show this responsiveness has decreased over the last three months. Response rate for all complaints activity was for March 51.2%, April 54.2% and May 40.2%. For first response complaints (not including reopened complaints and Ombudsman cases), this was for March 55.8%, April 58.1% and May 40.2%.

Areas Impacting on Compliance

Areas of impact- Responding to complaints by division within 20 working days due to clinical commitments, the large volume of complaints received for these months. The average number of complaints for 2024/25 increased to 87 complaints per month from 79 in 2023/24. For May 2025, annual leave within the complaints team has impacted compliance.

Mitigations / Timescales / Blockers

Please see the complainant responsiveness report (appendix). Various suggestions have been put forward as part of an improvement plan. These include reviewing the response rate KPI, reviewing how local trusts handle their complaints and their responsiveness, working with divisions to monitor breached complaints and providing additional training where poor responses from staff have been received.

Risk Register – no longer on the Risk Register

Key Points to Note

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

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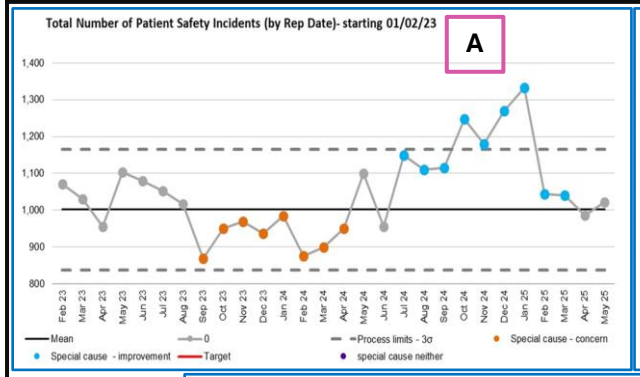
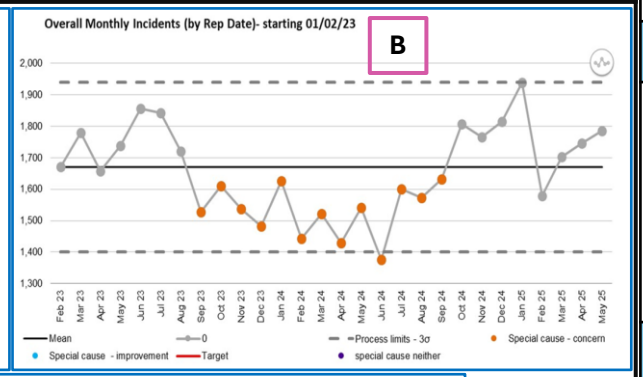
Incidents

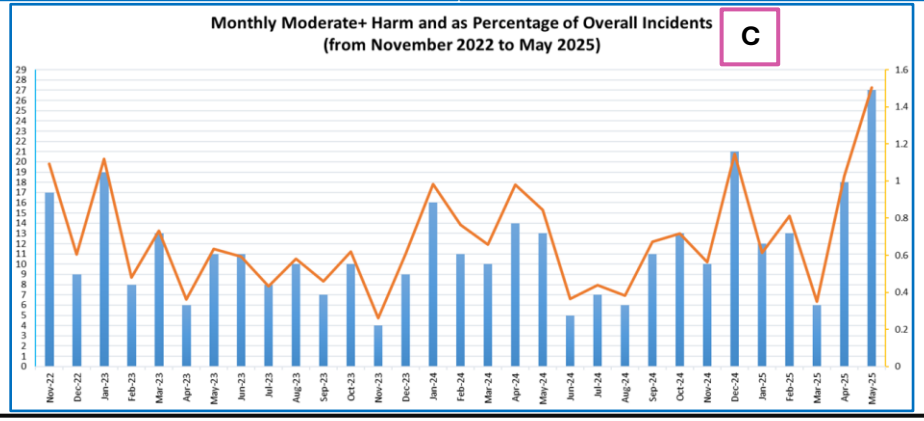
The Dudley Group NHS Foundation Trust

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

Date	May 2025
Trust Performance	A) 1024 B) 1786 C) 1.51% (27)
Performance Target / KPI	N/A







What are the charts showing us

The overall number of incidents reported in May has continued to **increase** following a fall in reporting in February with numbers more in line with the Q3/4 period; reporting is above the rolling average and within expected limits/natural variation. The number of patient safety incidents reported in May has increased slightly and numbers are now just above average but within natural variation.
The number of incidents reported to result in significant harm (moderate/severe/death) **are still under review** and are likely to reduce following incident review and investigation. Historical monthly data sets will be refreshed upon collation of each report with harm levels (numbers of incidents and percentage) falling significantly in February, March and April following the recent refresh.

Areas Impacting on Compliance

The slight increase in overall incident and patient safety incident reporting is likely to reflect natural variation with no significant concerns or trends. The increase in reporting was seen across the majority of the divisions.
The Patient Safety Team continue to work to promote reporting through communication plans and training schedules

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

Mitigations / Timescales / Blockers

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

Risk Register

N/A

Key Points to Note

n/a

Our Patients
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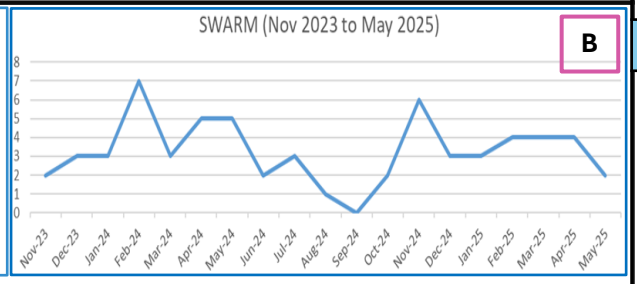
Incidents

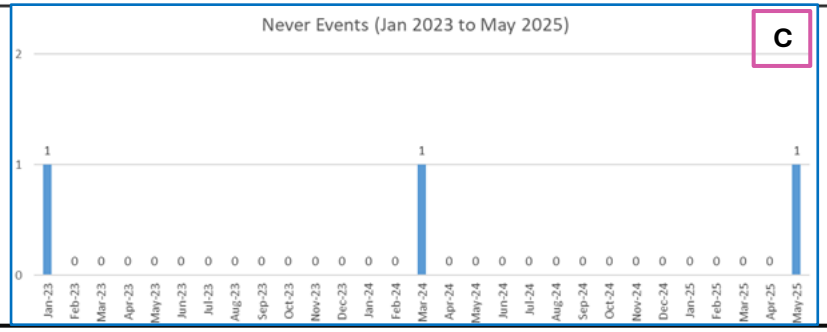
The Dudley Group NHS Foundation Trust

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

Date	May 2025
Trust Performance	A) 7 B) 2 C) 1
Performance Target / KPI	N/A



Doc Compliance (12 Months)	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Total
Compliant	6	11	7	4	11	8	16	26	10	10	10	5	124
In Progress											1	4	5
Total	6	11	7	4	11	8	16	26	10	10	11	9	129



What are the charts showing us

Chart A illustrates the monthly number of full investigations (PSII) commissioned under the Patient Safety Incident Response Framework (PSIRF). There were 7 new PSII/ full investigations launched in May. This represents a notable increase compared to April however this is likely to reflect natural variation; close monitoring continues.
Chart B illustrates the monthly number of Swarm responses launched; Swarm responses are designed to be initiated as soon as possible after an incident and involves an MDT discussion to gather information about what happened and why it happened and what needs to be done to reduce the risk of reoccurrence. There were 2 new Swarm reviews commissioned in May; consistent with reporting patterns across the period.
Statutory duty of candour compliance is being closely monitored to ensure appropriate enactment can be evidenced. There are no breaches in the regulation however at the time of report writing there are 5 incidents where the notification is in progress. These have been appropriately chased and escalated vis the Governance Framework

Areas Impacting on Compliance

The number of PSII responses launched has increased, themes in reporting include:
- 3 incidents involved the care of paediatric patients (2 delays in care and 1 never event – detailed below)
- 2 incidents involve concerns around discharge processes

In addition to the planned incident responses, the trust has formalised forums for both the discharge process and the acutely unwell child which will support and oversee the improvement work linked to these incidents.

Both swarm reviews involve gynaecology patient care; the findings of these reviews will feed into the single improvement plan for the service and will be utilised to assess the effectiveness of previous improvement workstreams.

Mitigations / Timescales / Blockers

Decisions regarding the requirement for PSII, swarm or other reviews under the PSIRF are made collectively as part of the Incident Decision and Learning Group. Immediate assurances were shared, and initial concerns will be fully explored as part of the review process. Response timeframes are a challenge, the number of ongoing responses and staff availability to attend investigation meetings impact negatively on the Trust's timeliness.

Risk Register

nil

Key Points to Note

There was 1 new Never Event reported in May, an increase compared to previous periods; this resulted in no harm. This incident involved a child chest/neck entrapment in a non-compliant NPSA bed. This is being thoroughly reviewed and immediate assurances in terms of risk assessment completion have been sought. The delivery of compliant beds has been chased again with suppliers, and these are anticipated to be delivered in August. A full review of the NPSA safety alert for medical beds/trolleys has been undertaken and is due to be reviewed at Risk and Assurance Group.

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Safer Staffing - Dashboard

The Dudley Group
NHS Foundation Trust

Date	May 2025

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

Ward	Day RN Plan	Day RN Actual	Day CSW Plan	Day CSW Actual	Night RN Plan	Night RN Actual	Night CSW Plan	Night CSW Actual	RN Day %	CSW Day %	RN N %	CSW N %	Sum 24:00 Occ	Actual CHPPD Registered	Care staff	Total
B1	127	111	65	56	64	63	57	41	87%	86%	98%	72%	450	4.39	2.47	6.86
B2(H)	123	98	194	183	93	85	181	172	80%	94%	92%	95%	733	3.00	5.68	8.68
B2(T)	124	116	150	127	93	87	130	116	93%	85%	94%	89%	732	3.32	3.99	7.31
B3	197	175	192	184	188	184	163	158	89%	96%	98%	97%	1,174	3.59	3.49	7.09
B4	227	180	249	206	187	179	199	187	79%	83%	96%	94%	1,295	3.26	3.65	6.91
B5	249	200	169	147	238	221	103	94	81%	87%	93%	91%	960	5.38	2.93	8.32
B6	98	78	66	62	63	62	66	61	80%	94%	98%	92%	493	3.34	2.99	6.32
C1 A	127	133	132	102	93	91	101	96	105%	77%	98%	95%	739	3.54	3.22	6.76
C1 B	129	126	133	126	93	89	98	87	98%	94%	96%	89%	742	3.39	3.36	6.75
C2	282	238	65	54	280	236	63	57	84%	84%	84%	91%	524	10.61	2.50	13.12
C3	219	216	391	372	186	173	380	375	99%	95%	93%	99%	1,601	2.92	5.48	8.40
C4	210	173	79	64	125	93	75	93	82%	82%	75%	124%	674	4.61	2.70	7.32
C5 A	121	92	137	131	93	92	106	104	76%	96%	99%	98%	740	3.02	3.82	6.83
C5 B	161	146	126	115	155	153	93	92	90%	92%	99%	99%	738	4.76	3.36	8.12
C6	97	98	105	89	93	92	78	71	101%	85%	99%	91%	575	3.88	3.34	7.22
C7	216	173	207	177	156	151	198	187	80%	85%	97%	94%	1,112	3.42	3.92	7.34
C8	259	244	233	216	217	208	196	186	94%	93%	96%	95%	1,332	3.98	3.62	7.60
CCU_PCCU	249	239	62	55	217	216	31	30	96%	89%	100%	96%	785	6.81	1.30	8.10
Critical Care	541	443	126	90	528	445			82%	72%	84%		512	20.79	2.12	22.91
AMU	549	512	465	415	495	527	466	440	93%	89%	106%	94%	2,478	4.93	4.14	9.07
Maternity	847	777	266	198	528	517	155	124	92%	74%	98%	81%	1,356	9.16	2.78	11.93
MECU	94	93	37	32	95	92			99%	86%	97%		231	9.61	1.52	11.13
NNU	387	286			268	241			74%		90%		404	15.60	0.00	15.60
TOTAL	**5,633**	**4,947**	**3,648**	**3,201**	**4,547**	**4,296**	**2,939**	**2,772**	**88%**	**88%**	**94%**	**94%**	**20,380**	**5.23**	**3.48**	**8.71**

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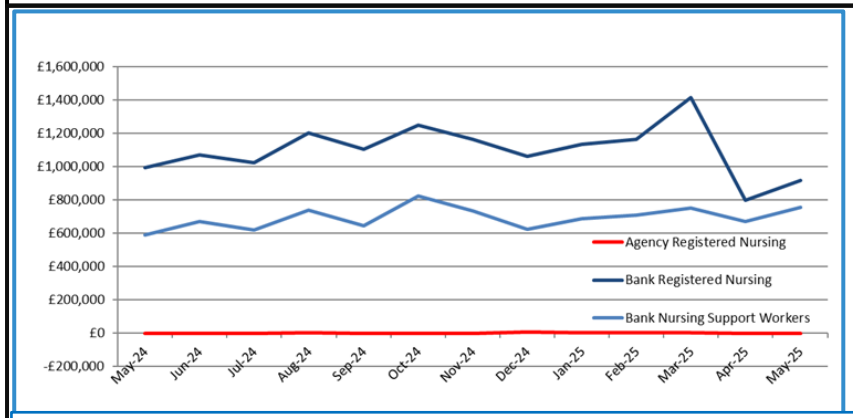
Safer Staffing

The Dudley Group NHS Foundation Trust

Background

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



A - Bank Usage

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

Area	Nursing Vacancy %	Agency Registered Nursing	Bank Registered Nursing	Bank Nursing Support Workers	Grand Total
Emergency Department Nursing	21%	£0	£87,501	£53,572	£141,072
Ward AMU 1	21%	£0	£38,146	£52,359	£90,505
Ward C8	19%	£0	£31,673	£47,211	£78,884
Ward AMU 2	5%	£0	£38,373	£38,487	£76,860
Theatres Weekend Lists		£0	£45,902	£27,139	£73,041
I.T.U.	5%	£0	£46,103	£13,619	£59,722
Ward B4	11%	£0	£21,531	£28,810	£50,341
Discharge Lounge	9%	£0	£29,725	£20,609	£50,334
Ward AMU Assessment	23%	£0	£23,511	£26,476	£49,987
Ward C7	15%	£0	£23,573	£23,814	£47,388

What are the charts showing us

- Safe staffing % and CHPPD are around the same for May as compared to April 25
- Chart A – May has seen a slight increase of registered nurses and support workers since April. Working group continues to aim to reduce the bank usage.
- Table B - - bank remains high in areas with increase vacancy rates especially in ED and Medical emergency wards

Areas Impacting on Compliance

Unfunded additional capacity in AMU 1&2 with 10 additional beds and TES area in ED continues to be utilised.

Mitigations / Timescales / Blockers

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

Risk Register

Key Points to Note

Work is underway for the transition of the CSW with re-banding the aim to proceed with the transition of the new roles by 1st August. Then to start the appropriate training to upskill the new band 3 with the appropriate clinical skills and competencies.

Recruitment and Retention of staff –
Work continues to support our third-year students into recruitment in current vacancies in the trust, with interview techniques and application process

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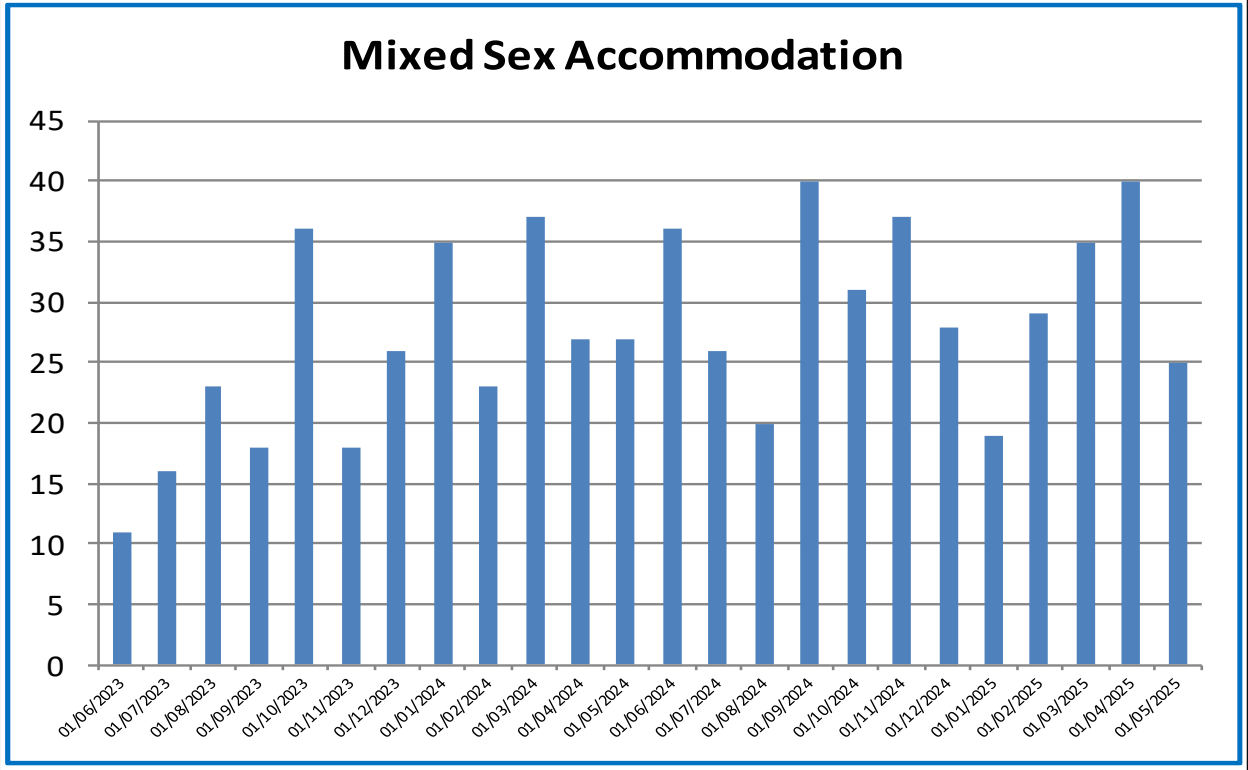
Mixed Sex Accommodation

The Dudley Group NHS Foundation Trust

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

Date	May 2025
Trust Performance	25
Performance Target / KPI	0



What are the charts showing us

Mixed sex breaches have seen a decrease in May 2025 to 25.

Areas Impacting on Compliance

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

Mitigations / Timescales / Blockers

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

Risk Register

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

Key Points to Note

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

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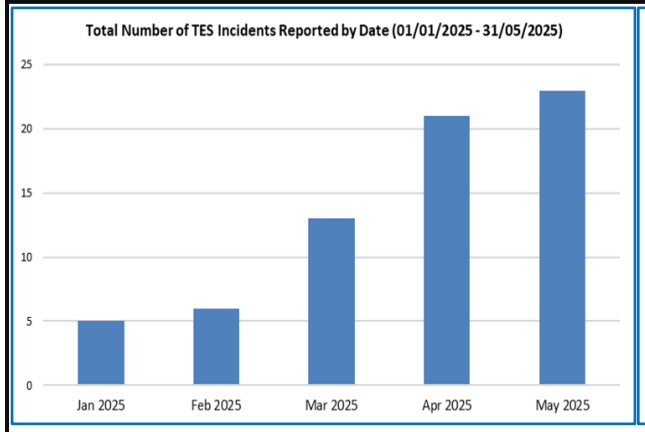
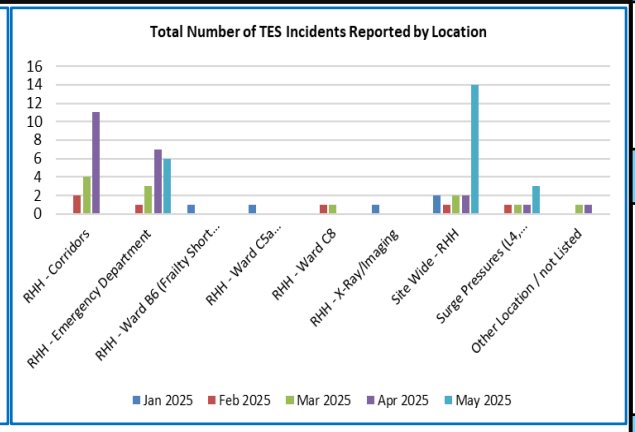
Temporary Escalation Space (TES) Incidents

The Dudley Group NHS Foundation Trust

Background

Date	May 2025
Trust Performance	See Graph
Performance Target / KPI	





* Incidents reported as 'Surge Pressures/Other Location' relate to Site Wide TES incidents

	Number of TES Incidents Reported	Risk Assessment Completed	Investigation Completed on Datix
Jan 2025	5	5	5
Feb 2025	6	6	6
Mar 2025	13	13	13
Apr 2025	21	20	20
May 2025	23	20	18

What are the charts showing us

The number of Temporary Escalation Space (TES) incidents reported during May 2025 has increased (23) when compared to the previous month (21). There has been a significant increase in the number of incidents reported since January 2025, showing an upward trend. Most incidents reported in May were related to TES spaces opened Site Wide (60.8%) and the Emergency Department (26.1%).

Areas Impacting on Compliance

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

Mitigations / Timescales / Blockers

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

Risk Register

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

Key Points to Note

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

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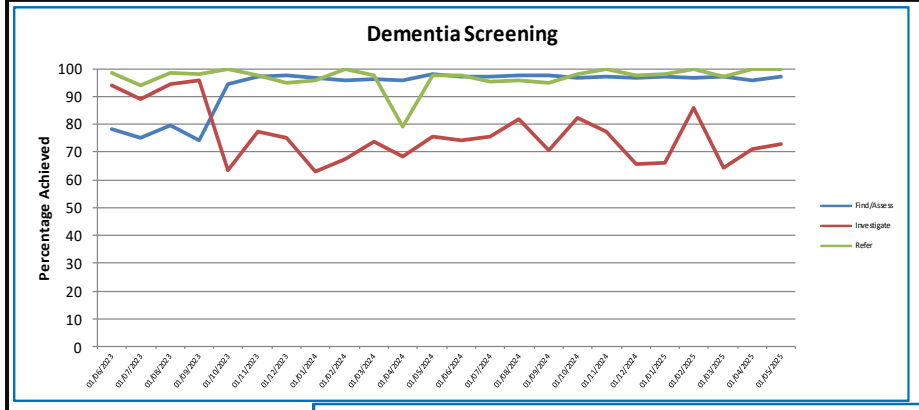
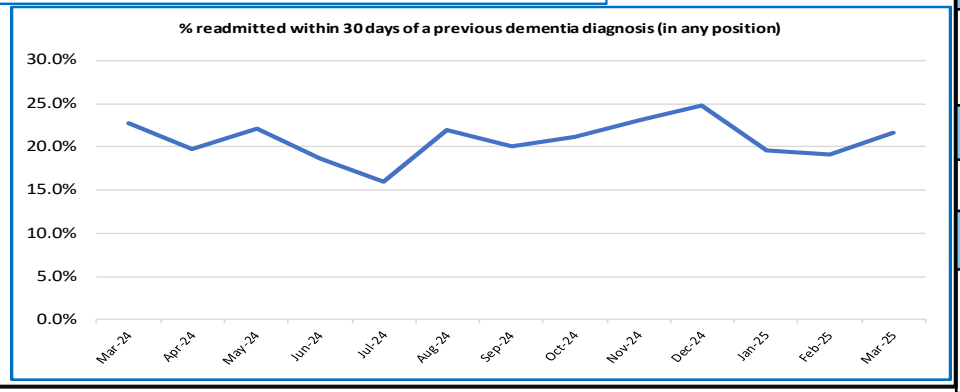
Dementia

The Dudley Group NHS Foundation Trust

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

Date	May 2025
Trust Performance	Find) 97.03% / Investigate) 72.73% / Refer) 100%
Performance Target / KPI	90%





What are the charts showing us

The first chart provides data regarding the number of patients who have been screened for dementia by inpatient staff using the AMT4 and the subsequent investigation and referral by the Dementia and Delirium Team using the FAIR process (Find, Assess, Investigate and Refer).
The Find completed by the wards is compliant at 97.03%.
The Dementia and Delirium Team who complete the Investigate is non-compliant at 72.73% but it is an increase from April 2025. The Dementia and Delirium Team who refer the patients that they have investigated is compliant at 100%.
The second chart shows the number of patients with dementia who were readmitted within 30 days of discharge. The latest available data is for March 2025 where there is an increasing trend of readmission.

Areas Impacting on Compliance

The Dementia and Delirium Team has been increased by an addition of a Nursing Associate working 0.80 WTE who commenced their post 20.04.25. Their impact with compliance levels has been limited as they have been completing their induction process.
Investigate compliance levels are impacted by the team availability such as sickness and leave, which have been minimal during May, hence increased compliance. As the team has been working at reduced capacity, they do not have the ability to respond to every referral before a patient is discharged, hence compliance levels not being achieved. Despite this, the patients that they do work with have a high level of input regarding support and referral, hence the high rate of refer levels for the patient population that they have contact with.
A review of the reasons for readmission has been investigated. From this, there are common themes for readmission and are following national trends, including a reduction over the summer months and an increase over the winter period. The March data for 2025 is comparable with data for March 2024.

Mitigations / Timescales / Blockers

The Dementia and Delirium Team has had a vacancy filled by 1 Nursing Associate and are embedding their role. This should create an improvement in the Investigation rate as increased staffing should see a response to referrals before patients are discharged. The data will be under review. If there is not an increase in investigation levels, a review of how the data is recorded may have to be take place.

Risk Register

Key Points to Note

Our Patients
Our People
Our Place

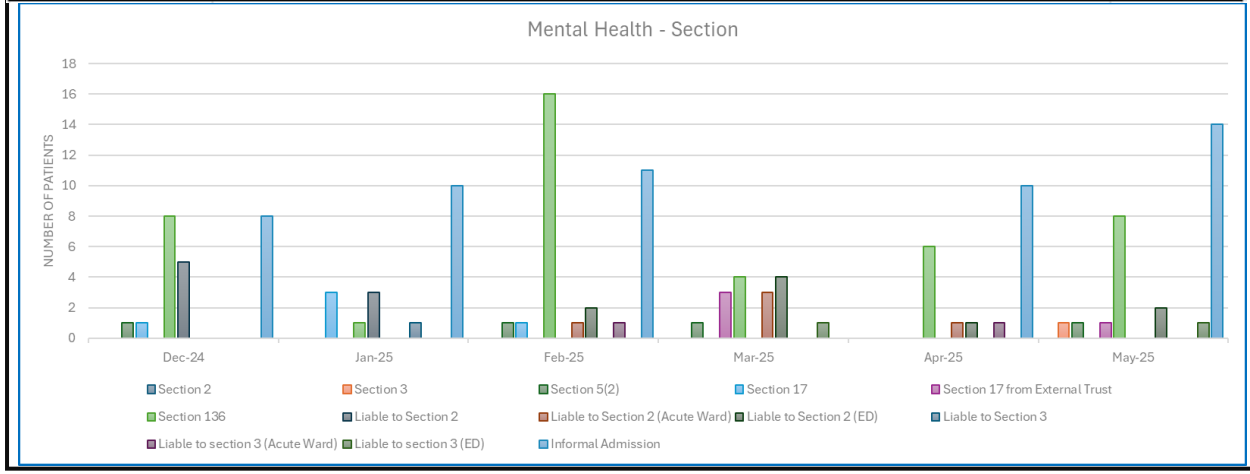
Mental Health

The Dudley Group NHS Foundation Trust

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

Date	May 2025
Trust Performance	
Performance Target / KPI	CQC compliant

Date of Admission	Section (Locate details C/O Rio if not on Sunrise and upload docs to Sunrise)	Amount
May-25	Section 5 (2)	1
May-25	Section 3 To DGFT	1
May-25	Section 17 from External Trust	1
May-25	Informal Admission to MH units from ED	14
May-25	Section 136 - 4x discharged home, 3x Section 2, 1x Informal	8
May-25	Liable to Section 2 - ED	2
May-25	Liable to Section 3 - ED	1



What are the charts showing us

There has been 1 patient detained to DGFT on a section 3 due to their dual poor physical and mental health and need to have ECT within an acute hospital setting. This followed the Trust escalation process for the detention to be accepted.
1 patient was detained on a section 5(2) during May 2025. The patient had an MHA assessment and was made an informal patient.
There has been 0 patients liable to be detained on section 2 or 3 within the inpatient Trust.
All liable patient activity took place in ED as patients were awaiting admission to a MH hospital. The detention become active when they were admitted to a MH hospital.
There has been 1 patients recorded as having visited the acute hospital on section 17 leave. They were admitted to the acute hospital and remain in hospital. Patients may have visited RHH from a mental health unit, but this would be as a voluntary patient with no MHA detention in process. This is not currently recorded.
There has been 8 section 136's in ED which is an increase from April 25. One of these was CYP.
In terms of informal activity, there were 14 patients in ED who were awaiting a bed in a MH hospital as an informal patient.

Areas Impacting on Compliance

There are concerns that not all patients on section 17 leave to the acute hospital are being captured as they are not being reported as standard. They are identified either by chance, when reviewing ED data on the new Power BI database or the occasional Datix.
MHA awareness training for all staff in Trust is available weekly. Section 5(2) bite size training is available daily and has been advertised via In the Know and the Mental Health Hub Page. It is accessed via a QR code and so pre-booking does not need to take place. Attendance for this training has been very low, often with no staff attending.
The patient who was admitted to the Trust under a section 3 was supported to have their rights and restrictions given to ensure that due process is followed.
Copies of section paperwork is placed in the patient notes following the MHA Administrators scrutinising the documentation and there have been no uncorrectable errors. The section 3 paperwork was accepted by a staff member outside of the clinical site team who has not been trained. There was an error on the H3, but this was able to be re-written by the MHA Administrator.
136 activity review identified that only 1 patient had physical health issues that required ED attendance. Other cases clearly identify that there was no MH based place of safety or this was unclear. This has been taken back to the police and BCHFT to review as part of Right Care Right Person.

Mitigations / Timescales / Blockers

Risk Register

Key Points to Note

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

Our Patients
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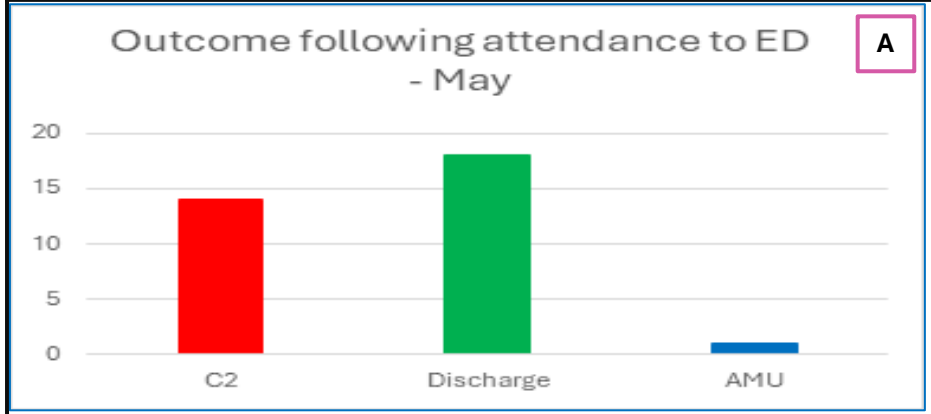
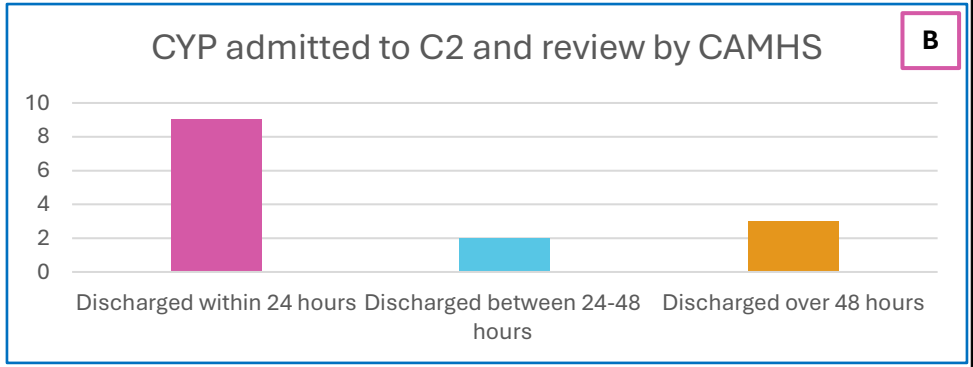
Mental Health - CYP

The Dudley Group NHS Foundation Trust

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

Date	May 2025
Trust Performance	A) C2,14 D/C, 18 AMU, 1 B)<24, 9. 24-48, 2. >48, 3
Performance Target / KPI	CQC compliant





What are the charts showing us

Chart A details that during May, 33 children with mental health concerns attended the Trust. Of which, 18 CYP were reviewed within Paediatric ED and were discharged. The remaining 15 went to Children's Ward (14) or to AMU (1). This information includes all attendances and does not differentiate if they attended multiple times.
Paediatric ED were able to discharge 18 CYP when they were medically fit, who did not require admission to the Trust. There were 3 self-discharges during May, which were from Paediatric ED. This includes advising staff that they did not want to wait (completing DAMA form) and leaving before being seen (not completing DAMA form).
There were 1 CYP that attended Paediatric ED who was under a section 136 and was discharged home following a MHA assessment.
Chart B details that C2 saw 14 CYP being admitted following review within paediatric ED. 9 CYP were discharged within 24 hours of admission. 2 patients remained for 24-48 hours. There were 3 CYP that remained on C2 for over 48 hours. Those with over 24-hour discharge times is due to treatment requirements.

Areas Impacting on Compliance

Mental health reasons for CYP attending ED in May include:

- Deliberate self-harm
- Overdose
- Suicidal ideation
- Behavioural concerns
- Attempted suicide
- Anxiety

All children were discharged when they were medically fit and had been reviewed by a member of the CAMHS team and a community plan put in place.

Mitigations / Timescales / Blockers

The older CYP (16-17 years) continues to remain the higher attendances of the 4 age range categories. There has been a month-on-month reduction across the age ranges since March for CYP patients attending ED with mental health concerns.
However, the total number of CYP attending paediatric ED with mental health concerns is comparable to April. There is an increase seen in the number of children who require admission to the ward over the 2 months. Consideration still needs to be taken into account for home/family life and out of school influences which may be affecting their mental health. GCSE's are currently being undertaken which may show an increase in the number of 14-15 year olds attending over the next couple of months.
CYP who attend the Trust outside of Dudley include Sandwell, Wolverhampton and Birmingham. Sandwell patients are continuing to have a greater representation within the Trust with 9 of the 33 children being from this area. This may be due to RHH being closer to patients homes then then new 'MET' hospital that has been built.

Risk Register

Key Points to Note

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

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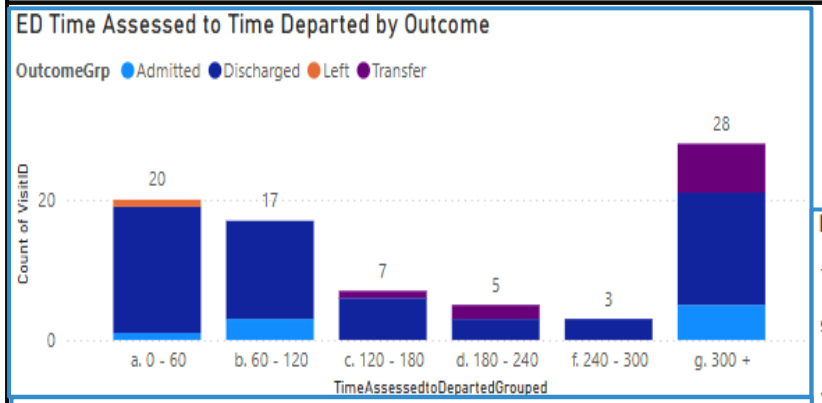
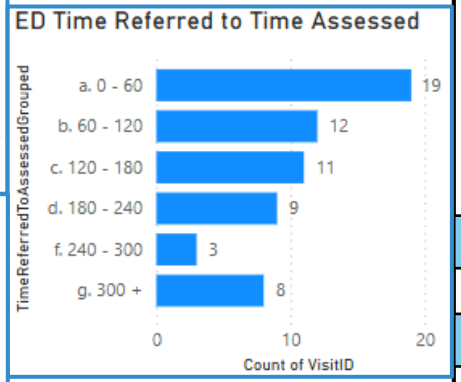
Mental Health – ED

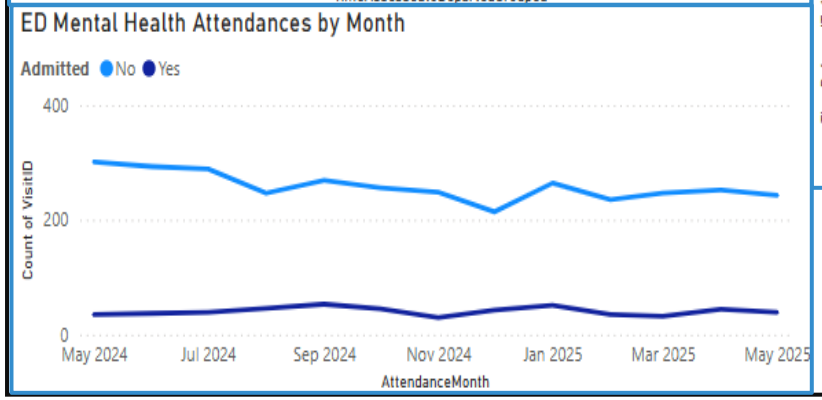
The Dudley Group NHS Foundation Trust

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

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







What are the charts showing us

Chart A details the breakdown of patients with mental health issues contacting ED. The longer time frame for ED Departure are linked with awaiting mental health beds for admission to MH hospitals and assessments requiring admission within DGFT.
Chart B details the waiting time for patients to be seen by Mental Health Liaison Services. This indicates that 62 patients were seen outside of the 1-hour timeframe directed by Core-24 guidance. This is an increase from April 25 (48).
Chart C details that there is a consistent low number of patients who require admission to the Trust due to mental health needs. There has been an uplift in the number of patients that do not require admission since December 24.

Areas Impacting on Compliance

There have been patients that have been assessed as requiring admission to an inpatient MH hospital that have had extreme waits.

- 2 patients awaiting informal admission to MH hospitals waiting in ED for over 5 days
- 1 patient awaiting informal admission to a MH hospital waiting in ED for over 50 hours
- 1 patient awaiting detention to a MH hospital under section 2 waiting in ED for over 48 hours
- 9 patients awaiting informal admission to MH hospitals waiting in ED for over 24 hours
- 1 patient awaiting detention to a MH hospital under section 3 waiting in ED for over 24 hours

MHLS are contracted to respond to a referral within one hour. A response consists of a review to decide on the type of assessment needed and arranging appropriate resources for the assessment. A full biopsychosocial assessment should take place within 4 hours.
It is not clear where the data for the delays for MHLS to review is obtained as the data does not represent the documentation when a deep dive of patients notes took place:

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

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

Mitigations / Timescales / Blockers

Risk Register

Key Points to Note

Core 24 identifies that the assessment need for physical and mental health should be a parallel process, and the assessment should commence with MHLS if the patient is accessible to commence this. NICE guidelines identify to not delay the psychosocial assessment until after medical treatment is completed. Challenge needs to take place to MHLS / BCHFT, but Trust data needs to be more accurate to support this challenge.

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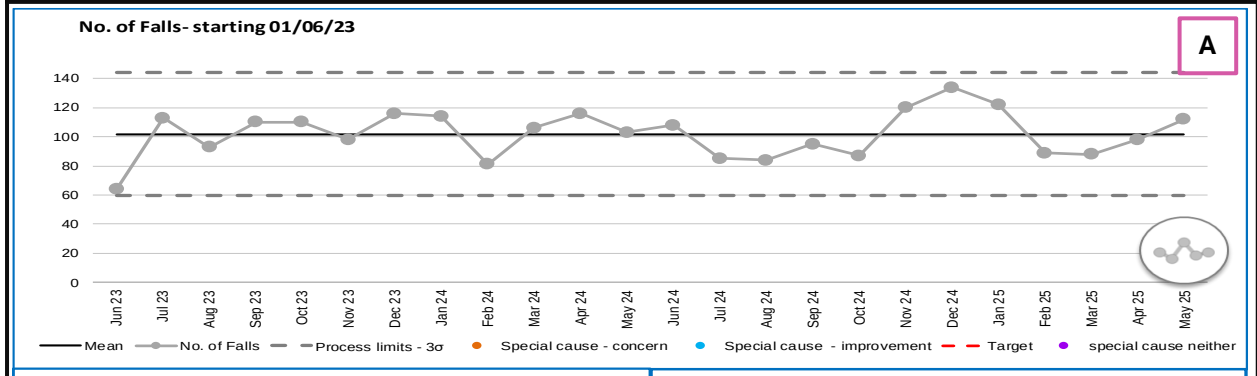
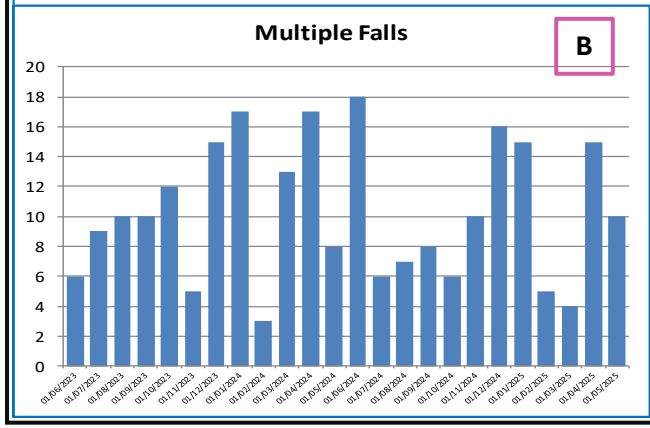
Falls

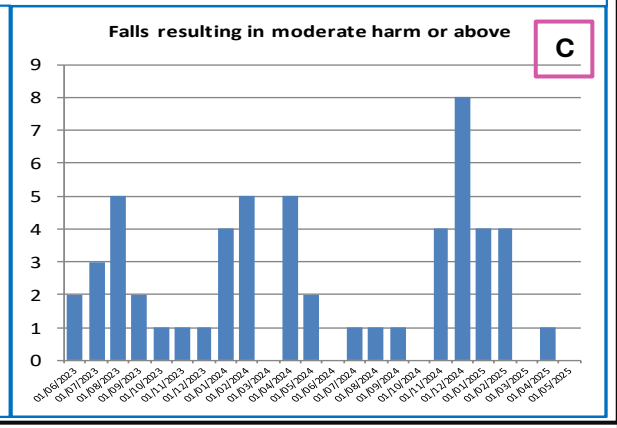
The Dudley Group NHS Foundation Trust

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

Date	May 2025
Trust Performance	A) 112 B) 10 C) 0
Performance Target / KPI	







What are the charts showing us

The overall number of inpatient falls have inclined from April which were at 98 to 112 in May. There has been 0 moderate harm incidents reported however, 1 After Action Review (AAR) incident reported at low harm in May. The slight increase in inpatient falls may be linked to additional capacity and demand. Subsequently, recurrent falls have decreased by 33% since last month.

Areas Impacting on Compliance

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

Mitigations / Timescales / Blockers

- Bedrail policy drafted to include acute and community to mitigate NPSA alert – presented at R&A on 11/6/25 – to be ratified.
- Bedrail and bed lever risk assessment for the community approved at R&A, community to commence training on 17/6/25
- New e-learning module for bedrails and bed levers training to be launched in June
- Falls campaign "Call don't fall" posters discussed at Falls prevention and management group to be launched June.
- EDDM to collaborate with falls to prevent deconditioning
- ETOC linked to the falls (SIP)

Risk Register

There are no risks related to falls

Key Points to Note

June e-learning module for bedrails and bed levers will be launched to accelerate training compliance to be above trust target.

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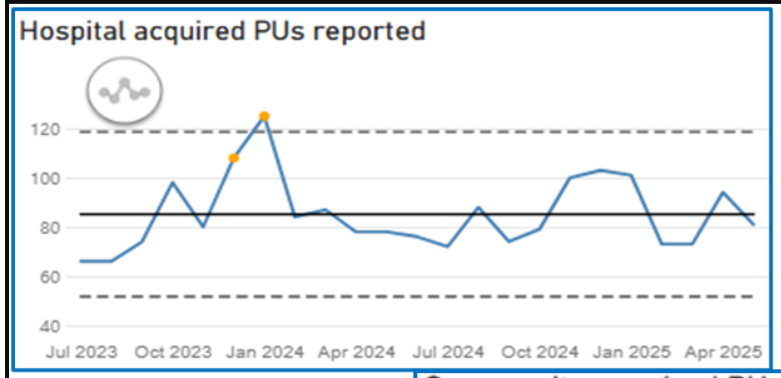
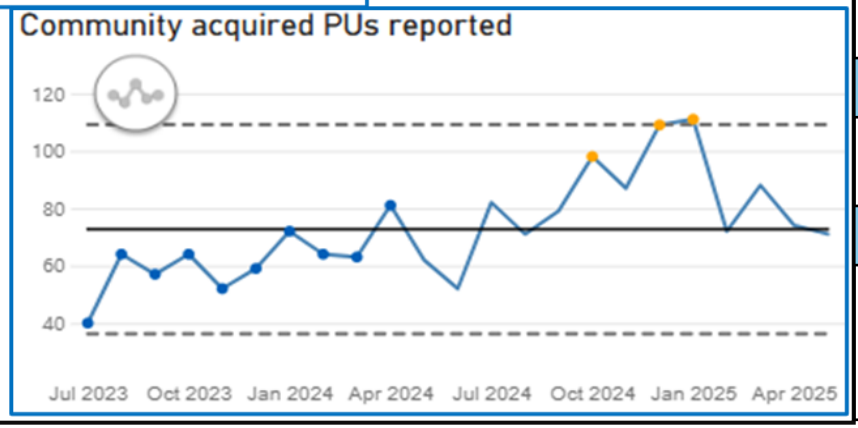
Pressure Ulcers

The Dudley Group NHS Foundation Trust

Background	Trend against pressure ulcer prevention performance

Date	May 2025
Trust Performance	See chart
Performance Target / KPI	





What are the charts showing us

There has been a decrease in all Trust acquired Pressure Ulcers (exc MASD and external) from April where we saw 170, to May where we had 152. Both acute and community have seen a decrease in month, acute had 81 acquire pressure ulcers and community had 71 acquired pressure ulcers.
We continue to work collaboratively with system partners to explore opportunities to further drive down pressure ulcers.
Informatics are exploring how they can pull a report for patients that are acquired a PU who were long stays in the ED departement.

Areas Impacting on Compliance

Workforce challenges.
Capacity and demand
Wait time ambulance and ED

Mitigations / Timescales / Blockers

Following acceptance of the problems and opportunities statement, 3 meetings have been held with the digital IT team. Several stages are involved including scoping, converting paper document to electronic, testing etc before they can provide a go live date. Community is a separate IT project.

Risk Register

Workforce limitations on risk register has been reviewed and closed. B6 0.4 has rtw on phased return and B6 due to start September. Will need induction period to be fully functional in role.

Key Points to Note

A PU benchmarking data meeting was held with Wolverhampton, Walsall and Sandwell as Dudley figures are higher on comparison. The different data sets were discussed and potential reasons for differences. Further work needs to be done on this.

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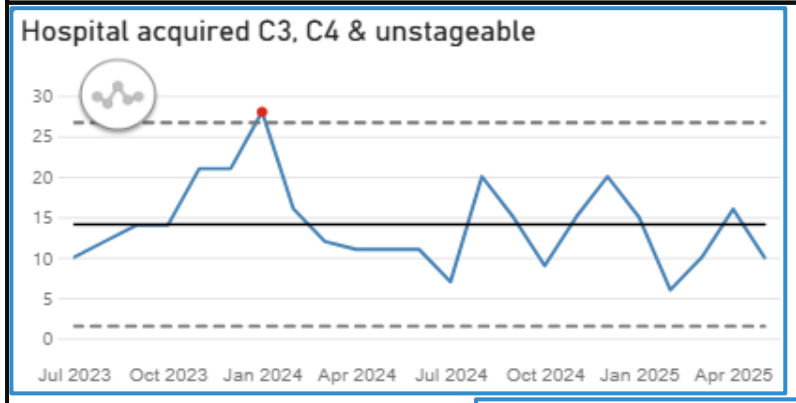
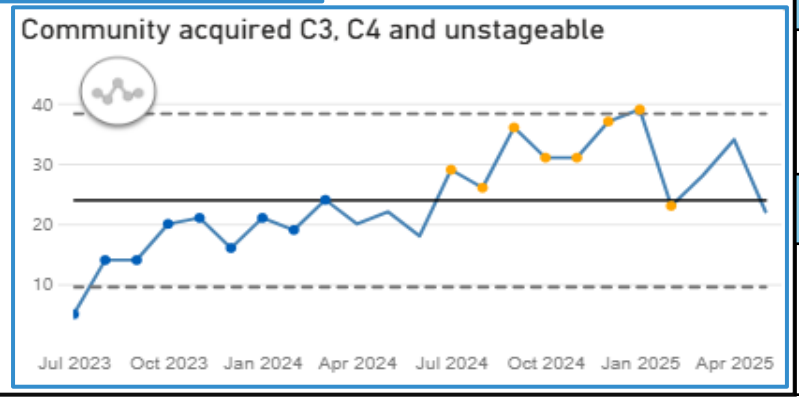
Pressure Ulcers

The Dudley Group NHS Foundation Trust

Background	Trend against pressure ulcer prevention performance

Date	May 2025
Trust Performance	See chart
Performance Target / KPI	





What are the charts showing us

See detail on slide 15

Areas Impacting on Compliance

as per slide 15

Mitigations / Timescales / Blockers

As per slide 15

Risk Register

As detailed on previous slide

Key Points to Note

TV service provision now across hospital and community and full program of education planned and in process of delivery. Matrons update session provided. Aim to have ELFH modules available for trust staff to utilise.

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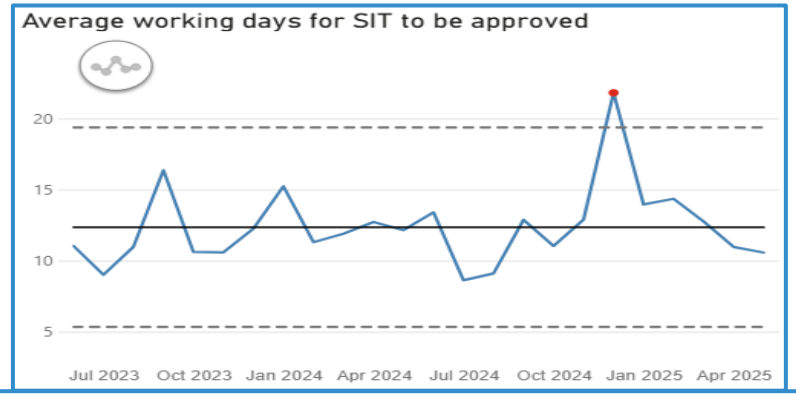
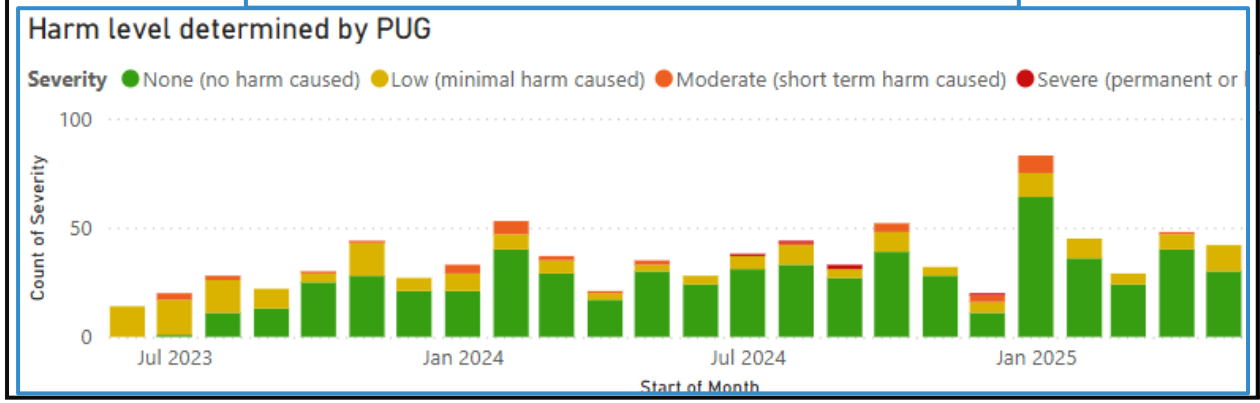
Pressure Ulcers

The Dudley Group NHS Foundation Trust

Background	Trend against pressure ulcer prevention performance

Date	May 2025
Trust Performance	See chart
Performance Target / KPI	





What are the charts showing us

Of the 152 PU incidents reported, 42 resulted in the completion of a short investigation tool (SIT) which were presented at the Pressure ulcer Group (PUG). The average working days for SITs to be approved is approx.10 days between reporting and approval. 30 of these were agreed to be no harm and 12 low harm. Key themes were Waterlow not completed/ incorrect Waterlow, Delay in escalating concerns, lack of trained visits (on community).

Areas Impacting on Compliance

Workforce challenges across all teams and capacity issues

Mitigations / Timescales / Blockers

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

Risk Register

As detailed on previous slide

Key Points to Note

- Equipment spend in community remains high due to a variety of reasons. Meeting held with ICB commissioner to look at processes around equipment provision in acute/community to identify problems that can be avoided in new tender/contract. Also scoping equipment provision to homes across black country and how this process can be tightened with a view to homes buying their own equipment.

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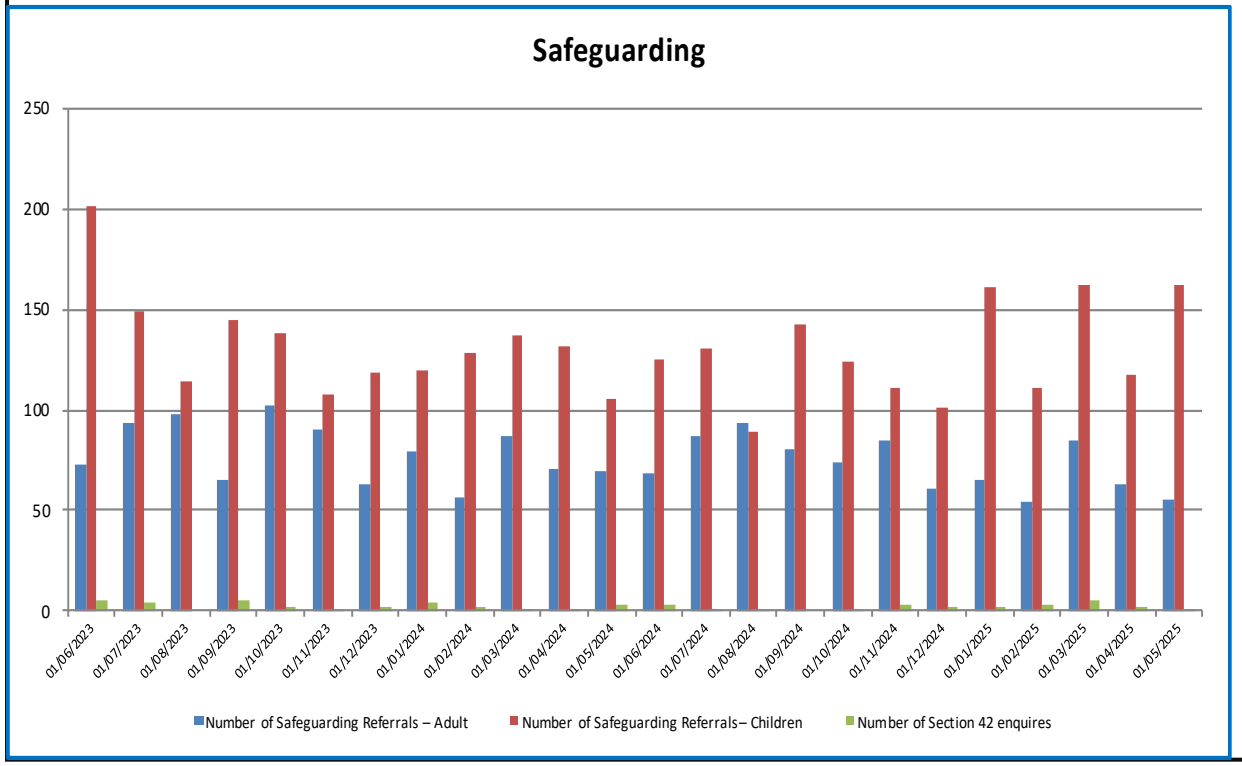
Safeguarding

The Dudley Group NHS Foundation Trust

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

Date	May 2025
Trust Performance	Adult) 55 / Children) 162 / Section 42) 1
Performance Target / KPI	



What are the charts showing us

The charts provide information regarding the number of safeguarding referrals for children and safeguarding incidents reported via Datix for adults (not all adult incidents of safeguarding will result in a referral). The information provides an indication that staff have recognised potential or actual abuse of adults or children. The data also provides the number of safeguarding enquiries against the Trust regarding standards of our care.
There has been an increase in safeguarding referrals for children, this is due to an increase in mental health attendances which are more complex in presentation, increase in physical abuse cases, including peer on peer abuse and children being at risk due to parental risk factors.
There have been no S42 enquiries raised regarding concerns of care provided by the Trust.

Areas Impacting on Compliance

There were 5 missed safeguarding referrals for children of adults who attend ED with parental risk factors such as domestic abuse, substance abuse and mental health concerns. The SG Team are working with ED Deputy Matron to target training at Lead Nurses in ED where many of the missed opportunities are occurring.
Safeguarding Children Level 3 training is 70% Trust wide. This is a significant concern particularly in key areas such as Maternity, Paediatric medical staff and O&G medical staff. The SWC division has been instructed that this requires immediate attention with a plan to be sent to the AD for SG by 20th June and compliance reported into ISB.

Mitigations / Timescales / Blockers

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

Risk Register

- Risks associated with poor safeguarding training compliance sits with Divisions
- There has been an increase in the risk score regarding implementation of the MCA from 9 to 12 following a serious incident where a patient was self-neglected and there was poor understanding and use of the MCA

Key Points to Note

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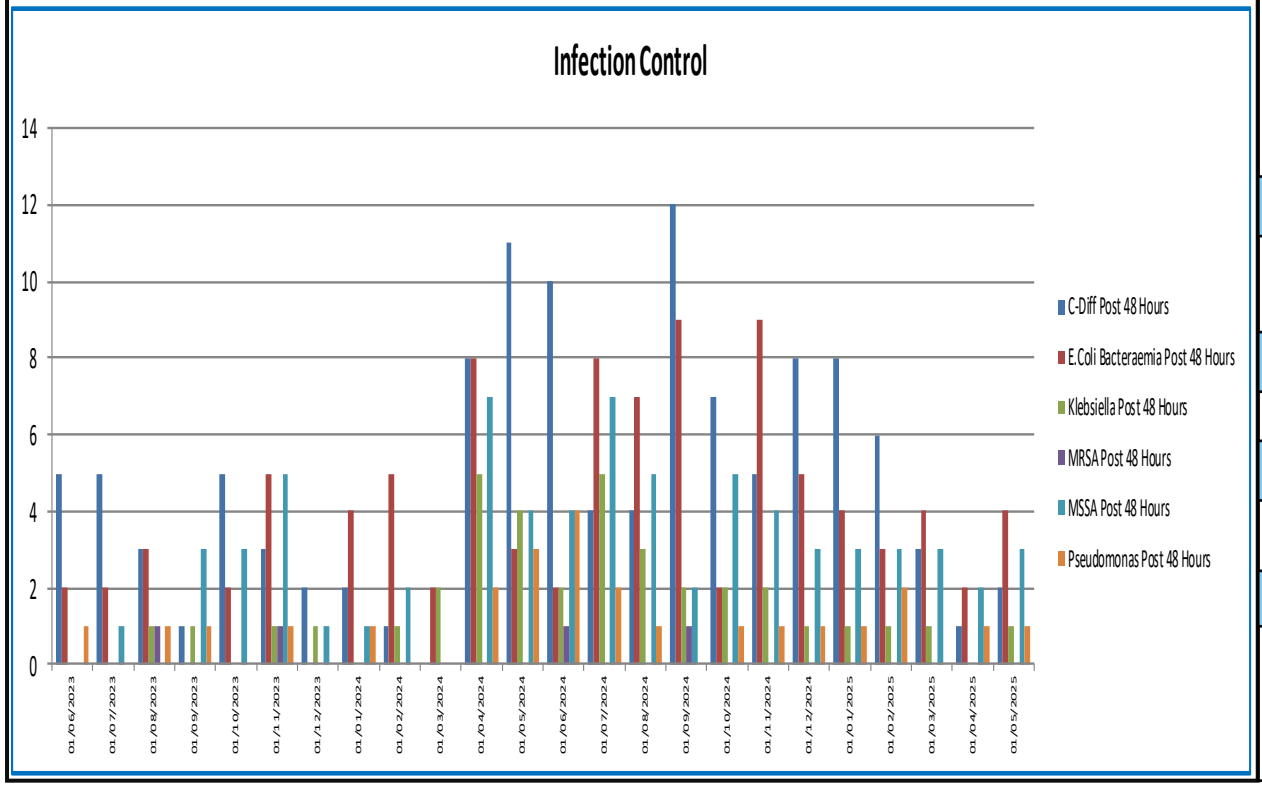
Infection Control

The Dudley Group NHS Foundation Trust

Background	IPC Healthcare Associated Data

Date	May 2025
Trust Performance	Threshold for blood stream infections for 2025/2026 not yet received
Performance Target / KPI	HCAI reportable infections



What are the charts showing us

The Trust receives thresholds for reportable HCAI's from NHSE . The IPCT report on HOHA and COHA cases. The thresholds for 2025/2026 have now been released

	2025/2026 Threshold	HOHA May	COHA May	Cumulative Total 25/26
CDI Toxin	72	2	5	15
E.Coli	68	4	2	9
Klebsiella	19	1	1	2
Pseudomonas	12	1	1	4
MSSA	N/A	3	1	10
MRSA		0	0	0

In line with the PSIRF Agenda the IPC team carry out post infection reviews on all HOHA cases. Common themes and learning outcomes are identified.

Areas Impacting on Compliance

A cleaning and disinfection of the environment policy has been agreed alongside PFI partners.
Hand hygiene compliance is <94% across trust – our Q1 25/26 initiative is to focus on effective hand hygiene including our patients not visitors while reducing glove use

Mitigations / Timescales / Blockers

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

Risk Register

The trust has a risk on the Trust and system risk registers for CPE screening. The Trust has a CPE policy in place.
The trust cleaning risk is being reviewed in relation to cleaning standards across the trust.

Key Points to Note

The Trust reported 1 Norovirus outbreaks and 0 COVID19 outbreaks during May
Due to all thresholds being exceeded for 2024/2025 the IPC team are developing a BSI improvement plan for 2025/2026 to run alongside the existing CDI improvement plan.
Alongside the trusts collaboration with MMUH the DDIPC from MMUH will be supporting the IPC team at DGFT two days a week

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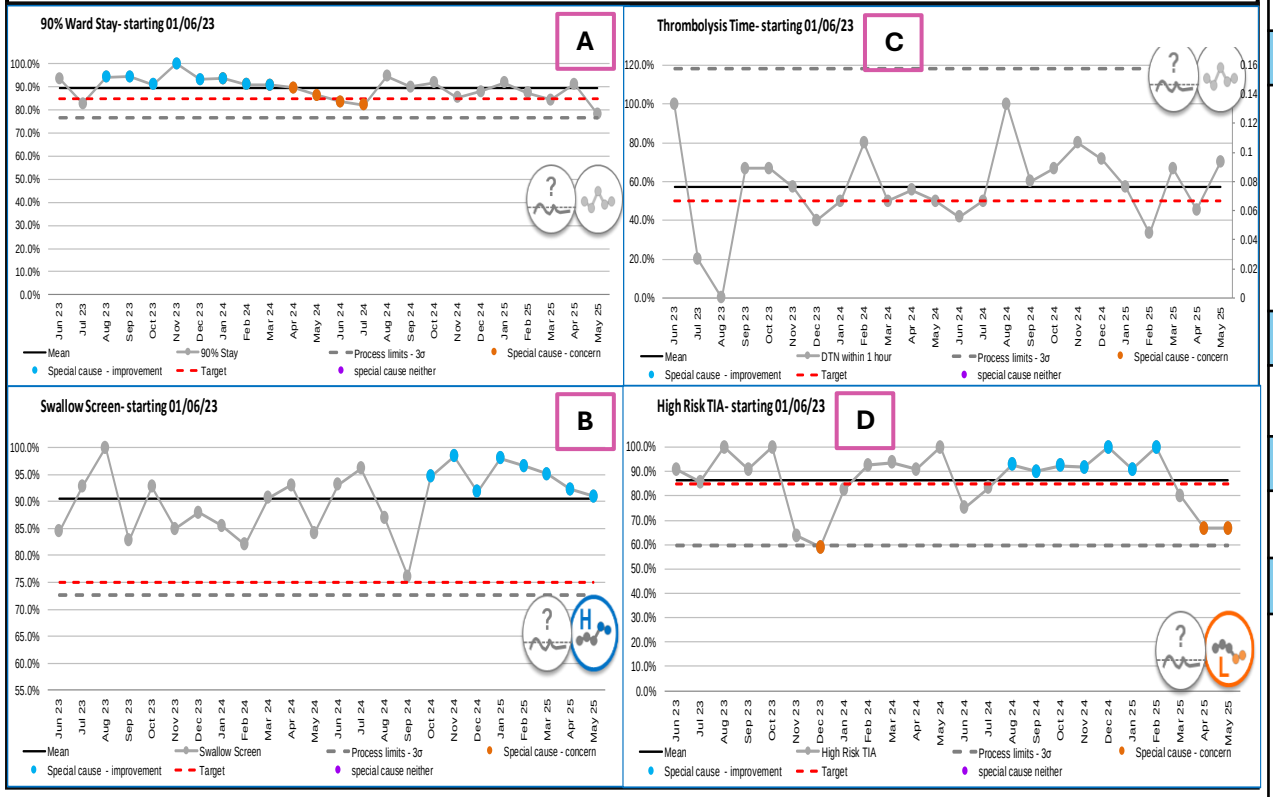
Stroke (latest 2 months are provisional)

The Dudley Group NHS Foundation Trust

Background	Progress against National Stroke targets

Date	March 2025 / April 2025 / May 2025
Trust Performance	March Validated A) 84.4% / B) 95.1% / C) 66.7% / D) 80.0% Apr/May Unvalidated A)91.3% & 78.2%/ B)92.2% & 90.9%/ C)45.5% & 70.0%/ D) 67.0%/67.0%
Performance Target / KPI	85% / 70% / 50% / 85%



What are the charts showing us

- Chart A shows that 90% ward stay achieved 84% in March and is non-compliant with the 85% target.
- Chart B shows that swallow screen performance is compliant with the 70% performance target and achieved 95% which is SSNAP level A.
- Chart C shows that thrombolysis was compliant with the 50% performance target in March and achieved 67% which is a SSNAP level A.
- Chart D shows that the HR TIA performance is non-compliant in March and achieved 80% vs 85% target.

***April and May data is currently unvalidated and are provisional**

Areas Impacting on Compliance

<u>90% Ward stay</u>

- patients being admitted to AMU/other wards prior to being admitted unto stroke ward
- No Stroke beds available (lack of capacity on Stroke ward)

<u>HR TIA</u>

- Patients rescheduling appointments; as per TIA guidelines patients with HR TIA symptoms should be seen within 24 hrs of referral, SSNAP rules do not exempt patient reschedules.

Mitigations / Timescales / Blockers

DGFT Stroke team are part of the Thrombolysis Acute Stroke Collaborative (TASC) network and will be working together over the next 12 months to identify further improvements that could improve processes to enable DGFT to improve the thrombolysis pathway.

Risk Register

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

Key Points to Note

- **New SSNAP Metrics have been included in the SSNAP KPI's which could cause our overall SSNAP score to reduce.**(Awaiting new scoring and metrics to be published). As of Q2 RHH achieved a SSNAP score of 77 which is SSNAP level B.

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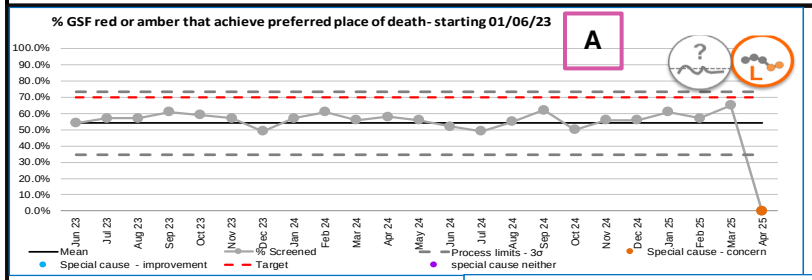
Gold Standards Framework (one month in arrears)

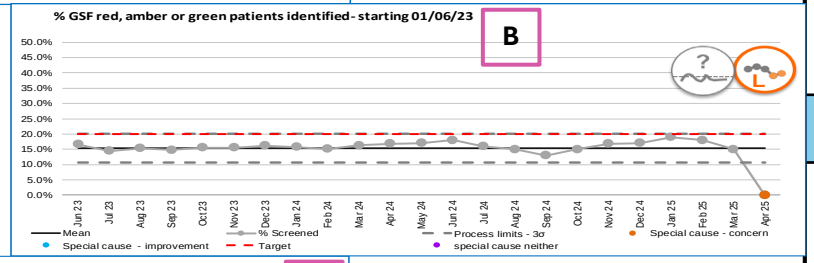
The Dudley Group NHS Foundation Trust

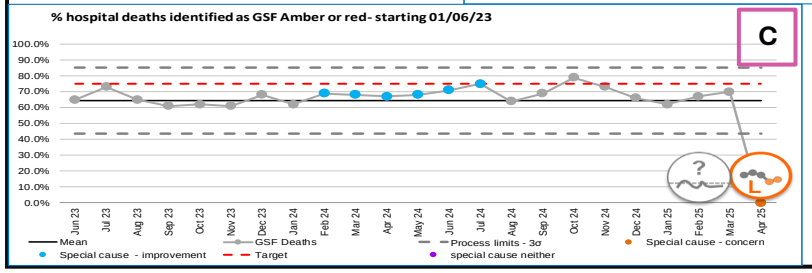
Background	KPI based on Nacel and Nice Guidance

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



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





What are the charts showing us

The target for identification of patients GSF (Green/Amber/Red) is currently set at 20%, unfortunately there has been a decrease from 18% in February down to 15% for March.
Local and national evidence/research/ reviews/audits all support that 30% of adult inpatients are in the last year of life.

During the migration to the new flowsheets, we are now validating the data and are not currently able to report on April 2025 metrics. Once the data is validated this will be provided retrospectively. We are meeting weekly with the data analyst. All configuration issues have now been resolved.

Areas Impacting on Compliance

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

Mitigations / Timescales / Blockers

- GSF bundle on sunrise to replace GSF document –launched 16th April there have been some issues with the implementation that are being addressed with weekly meetings with configuration and data analyst.
- Please note therefore, during the migration to the new flowsheets and validation of metrics we are not able to report April 2025 figures. Once we have validated the data this can be provided retrospectively.

Risk Register

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

Key Points to Note

Need to engage with divisions to improve identification of GSF patients
Fast track on the risk register and regular agenda item on Trust EOLC group

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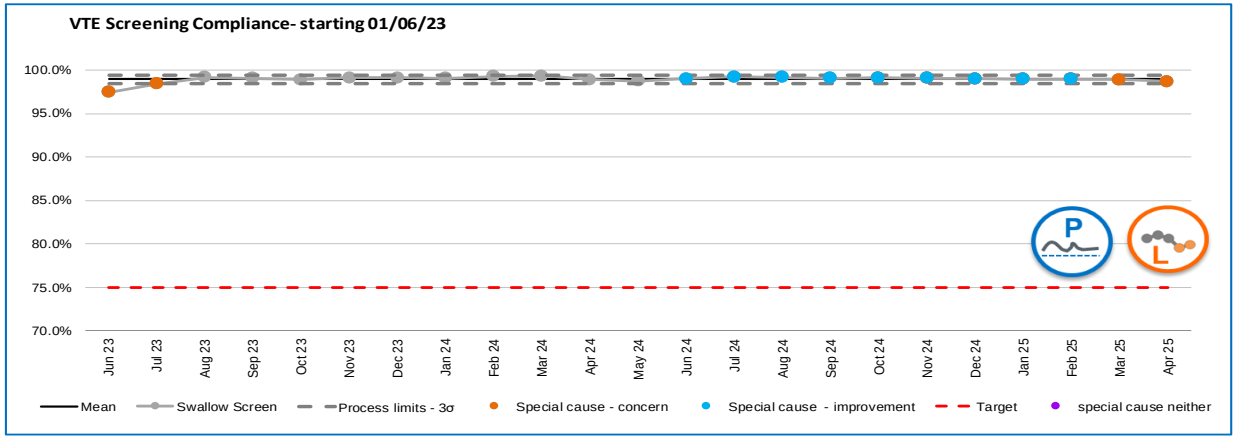
VTE (one month in arrears)

The Dudley Group NHS Foundation Trust

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

Date	April 2025
Trust Performance	98.7%
Performance Target / KPI	95%



First Assessment +/- 12 hours from Admissions

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

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

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

What are the charts showing us

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

Areas Impacting on Compliance

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

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

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

Mitigations / Timescales / Blockers

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

Risk Register

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

Key Points to Note

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

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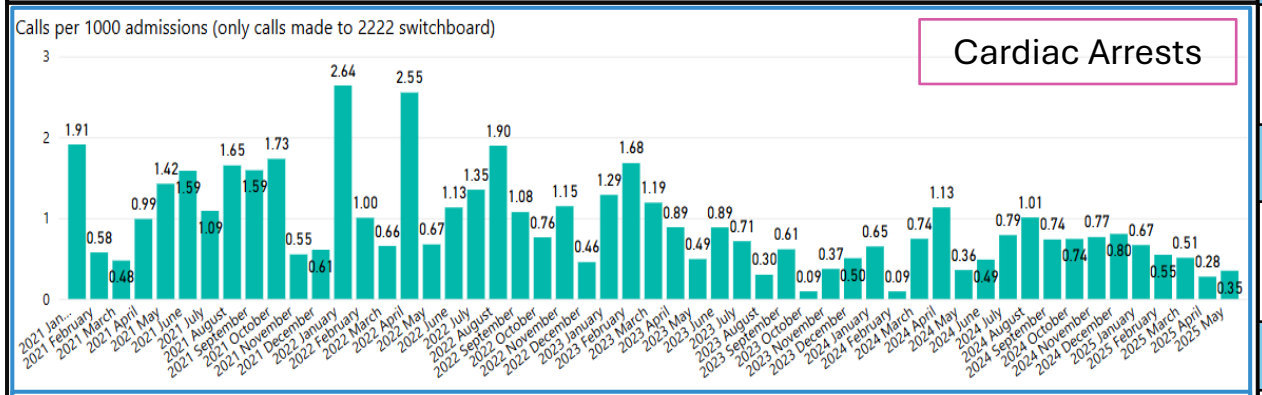
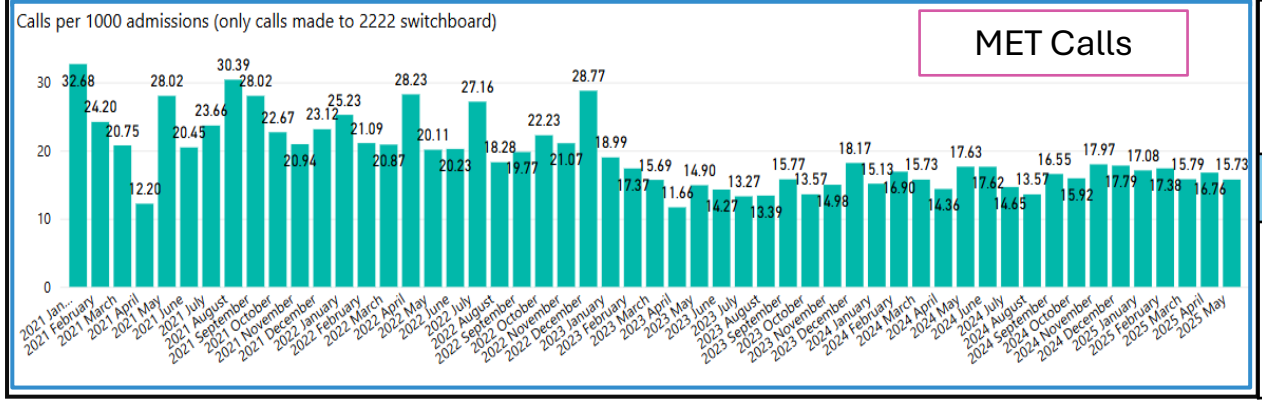
Cardiac Arrests / MET Calls

The Dudley Group NHS Foundation Trust

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

Date	May 2025
Trust Performance	Cardiac arrests 0.35 /MET calls 15.73
Performance Target / KPI	N/A





What are the charts showing us

Of the six cardiac arrests in May, only one occurred during the Mon-Fri 0900–1700-time frame. Two were out of hours Mon-Fri 1701-0000 one of these was in the car park of a patient trying to get to ED by family car and three were on a Saturday.
23% of the medical emergency calls occurred within the Mon-Fri 0900–1700-time frame, 23% occurred Mon-Fri 1701-0000, 23% Mon-Fri 0001-0859 & the remaining 31% Sat & Sun

Areas Impacting on Compliance

An increase from 39.96% to 43.81% (of 1317 inpatients) had a documented treatment, escalation & resuscitation plan (TERP) in April, of which 82% of the documents contained DNACPR decisions (36% of all inpatients) and 17% were for full active treatment (7% of all inpatients).

Mitigations / Timescales / Blockers

- 57% of patients triggering on the deteriorating patient pathway (DPP) received a senior clinical review within 60 mins of trigger in May, increasing from 54% in April.
- 23% of patients triggering on the DPP received a TERP as a result of the review at the point of deterioration.

Risk Register

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

Key Points to Note

- Nine x 2222 calls to Corbett outpatient centre in May
- Two x 2222 calls to Guest outpatient centre in May, one patient requiring a 999 call and transfer to ED.
- The cardiac arrest in the car park is the 3rd patient in 6 months conveyed by car rather than wait for WMAS arriving on site in cardiac arrest.

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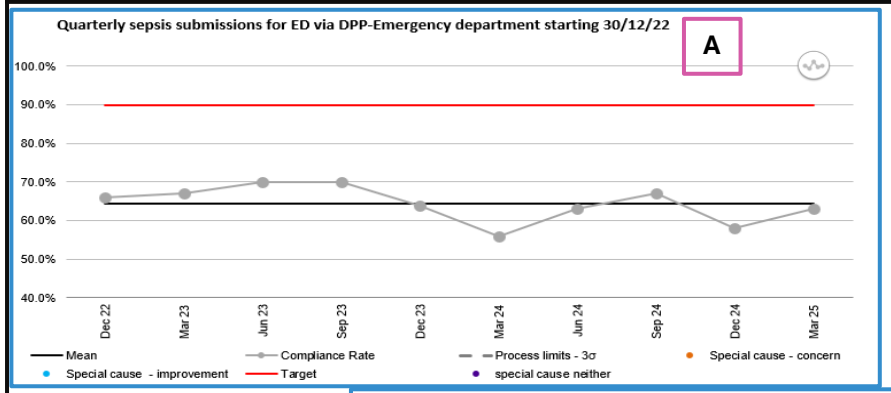
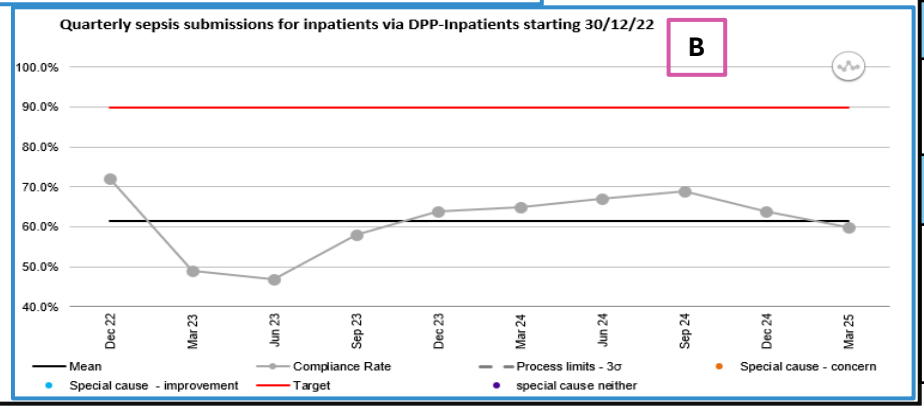
Sepsis

The Dudley Group NHS Foundation Trust

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

Date	May 2025 (Q4 2024/2025)
Trust Performance	A) 63% B) 60%
Performance Target / KPI	>90%





What are the charts showing us

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

Areas Impacting on Compliance

- Delays of documentation of vital signs at the point of care impacts the time left in the golden hour to treat
- Delays in commencing screening tool at time zero
- Delay in senior clinical review will impact time available to administer antibiotics after the prescription, sepsis PGD available but rarely used in inpatient areas due to already being on oral antimicrobials. ED senior staff do not want it to be used in the department.
- Increase in additional patients to standard ED and ward formats are impacting on timeliness of treatment of inpatients with suspected sepsis

Mitigations / Timescales / Blockers

- All elements of the sepsis six delivery within ED are currently on an upward trend in compliance for May. Notably compliance for IVAB administration in resus & majors cubicles are both >94% (national target >90%), treatment in the waiting room has a significant increase from 42% in April to 83% and a reduction in patients requiring treatment there. The cohort of patients being treated on board the ambulance remains the largest group 84/148 with IVAB in 66% in < 60 mins from trigger.

Risk Register

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

Key Points to Note

- May data for IVAB in <60 min in ED has increased to 78% from 72% in April (from total 148 patients in May v 188 patients in April)
- May data for IVAB <60 min for inpatients has decreased to 67% from 73% in April (from total 73 patients in May v 63 in April)
- 63% (118/188) were treated on the ambulance with 58% within 60 minutes.

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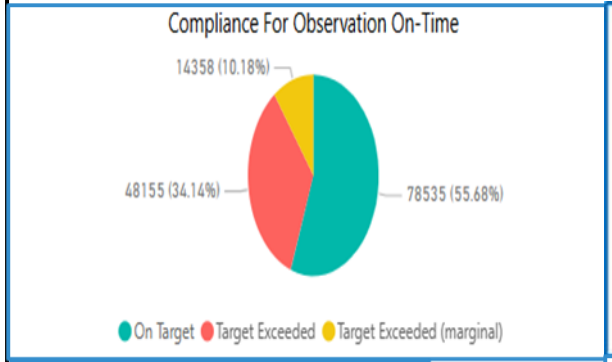
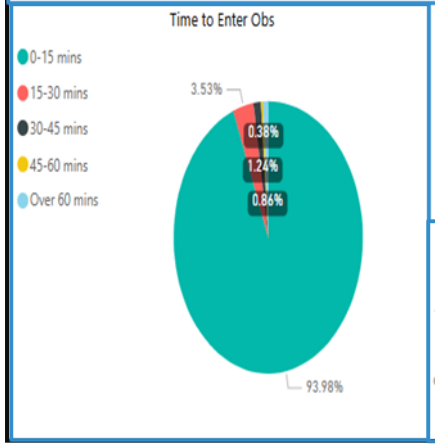
Vital Signs Compliance

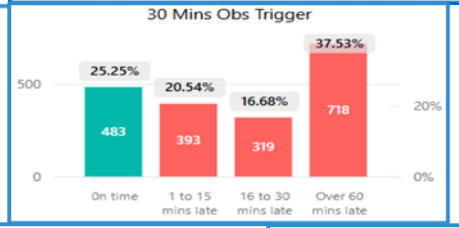
The Dudley Group NHS Foundation Trust

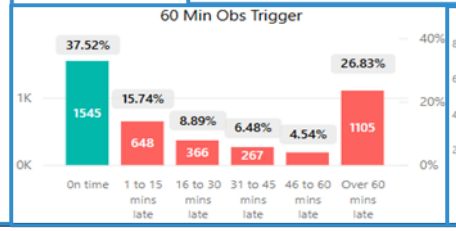
Background	Vital signs should be documented at the point of care (within 6 mins of recording) and frequency according to risk level from early warning score (EWS)

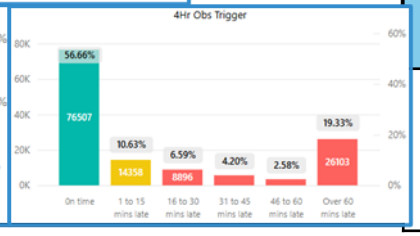
Date	May 2025
Trust Performance	55.68% on target/93.98% in 0-15mins
Performance Target / KPI	Vital signs recorded on time(via EWS risk level)











What are the charts showing us

- The compliance for observations (vital signs) on time demonstrates an increase in compliance from 53.97% to 55.68% of all vital signs recorded in May.
- The clinical risk dictates the frequency required for vital signs set out by national guidelines (NEWS2, NPEWS, MEOWS) and will change depending on the latest score.
- **High clinical risk**, 30 min vital signs = 25.25% (NEWS2 ≥7, NPEWS≥9 & MEOWS=red) an increase from 23.1% in April.
- **Medium clinical risk**, 60 min vital signs = 37.52% (NEWS2 5-6 or single trigger 3, NPEWS 5-8 or single trigger 4, MEOWS 2+ ambers, healthcare or patient/parental concern) an increase from 33.7% in April.
- **Low clinical risk**, 4 hourly vital signs = 56.66% an increase from 55.1% in April.

Areas Impacting on Compliance

- Vital signs are on the dashboard for compliance are grouped to display 4hrly, 8hrly, 12hrly and daily all in the 4hrly heading. Informatics are working to separate out these different times to capture more insight from the data.
- The policy allows band 6 and above to decrease the frequency from 4hrly vital signs after 48hrs of green vital signs (NEWS2 <4), staff are voicing a reluctance in confidence in decreasing the frequency meaning more patients stay on 4hrly vital signs than necessary.

Mitigations / Timescales / Blockers

- Four areas are being target for education by DPT, safety huddles and deep dives by their leads as part of a pilot for improvement and to determine what common themes are found in delays (AMU1, B3, C2 & C5). B3 have made a significant improvement in charting their vital signs at the point of care having been the previous worst performer with may taking longer than one hour from taking to be documented.

Risk Register

ASM2413, UC2350

Key Points to Note

- The eObs working group are targeting improvement methods in 4 pilot areas: AMU1, B3, C2 & C5 – Lets get Ob-Sessed comms campaign to start in July.
- Informatics are working on dividing the data displayed as 4hourly on the dashboard to separate out 8hrly, 12hrly & daily from this section.
- Matha's rule (Call for concern) was activated for 10 patients in May across 9 clinical areas, a decrease from 21 in April

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Quality KPI Dashboard

The Dudley Group NHS Foundation Trust

Background	Monitoring of key patient care quality indicators

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

Audit	Frequency	Compliance over last 6 periods					
Tissue Viability SKIN audit (CQUIN 12)	M	97.6%	96.3%	97.3%	97.4%	96.6%	96.9%
Hand Hygiene '5 moments' audit (v2)	M	98.6%	98.3%	98.7%	99.2%	97.9%	99.0%
Matron In Patient Audit	M	90.5%	90.8%	89.9%	88.5%	89.9%	89.5%
Matron Audit - Out Patient Areas	M	96.7%	97.0%	95.4%	96.6%	96.6%	97.4%
Lead Nurse In Patient Audit	M	94.2%	93.2%	93.4%	93.7%	93.9%	92.9%

What are the charts showing us

Although all audits are now returning a green overall RAG rating, individual questions within them that prevent attainment of 100% compliance are summarised below.

Areas Impacting on Compliance

- Safer care tool completion not fully completed *(Associate Chief Nurse – Workforce addressing this with Division Leads)*
- Missing emergency equipment checks *(Divisions addressing with wards, reminders sent to ward leads daily)*
- Sepsis screening and IV antibiotics standards below 90% *(IV antibiotics is reliant on doctors prescribing the treatment, dashboard alerts ward staff to sepsis screening data)*
- E-obs not completed within 30 minutes *(Regular task and finish group meetings held, action plan in place)*
- Mandatory training below 90% for priority 1 and 2 subjects *(Lead nurses addressing, two weekly reminders to individual staff via email)*
- AMaT audit actions not completed as expected *(some audits have been removed as confirmed n/a for certain wards)*

Mitigations / Timescales / Blockers

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

Risk Register

Nil reported

Key Points to Note

- AMaT action plan compliance improved by 24% since last month, moving from red RAG to amber RAG rating.
- E-obs compliance, although still red RAG rated, has improved by 12% since last month.
- Mandatory training compliance remains red RAG rated but has improved by 13% since last month.

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Chief Nurse Dashboard (Inpatient areas only)

The Dudley Group NHS Foundation Trust

Date	May 2025

WardGroup	Budget WTE	Contracted WTE	Vacancy %	Sickness %	All Unavailability %	Parenting	All Unavailability	Total CHPPD	Mandatory Training %	%FFT Inpatient, Good & VeryGood	Open Complaints (at the end of previous month)	Pressure Ulcer - Cat3, 4, Unstageable	Pressure Ulcers (Cat 3 & above)	Moisture Associated Skin Damage	Falls with Harm	Cardiac Arrest Calls	Total Positive C-Diff Cases	Patient Observations Completed On Time %
AMU	215.6	194.7	9.7%	6.2%	25.1%	9.6	49.0		92.9%	100%	8	4	0	1	0	1		51%
CCU	54.1	48.1	11.1%	4.9%	23.6%	2.9	11.3		92.1%			0	0	5				46%
Critical Care	119.1	125.9	-5.7%	7.1%	38.5%	10.6	48.5		92.9%	95%		1	0	1	0			51%
Discharge Lounge	11.9	11.9	-0.3%	12.8%	40.5%	1.0	4.8		91.7%	95%								8%
ED	188.3	161.8	14.1%	9.0%	34.3%	13.1	55.5		94.0%		41	1	0	0	0	1		87%
ESH	73.1	73.6	-0.8%	3.3%	21.9%	3.2	16.1		95.6%	89%	2	0	0	0	0			53%
FMNU	44.6	42.1	5.5%	4.1%	19.9%	1.2	8.4		93.2%		1	0	0	0	0			22%
Maternity	164.9	163.2	1.0%	6.8%	33.7%	10.4	55.1		90.9%		12							50%
MECU	21.4	20.6	3.9%	5.6%	18.3%		3.8		96.9%	90%	1	0	0	1				38%
Neonatal Unit	62.0	58.5	5.7%	4.7%	33.7%	3.1	19.7		94.1%	100%								
Renal Unit	37.5	36.3	3.2%	13.5%	29.5%	1.4	10.7		93.1%									30%
SDEC	71.0	66.0	7.0%	6.3%	22.3%	1.1	14.8		92.0%	96%								64%
Ward A2																		84%
Ward B1	29.4	30.4	-3.6%	6.6%	28.0%	3.0	8.5		97.5%	88%	2							67%
Ward B2 Hip	49.6	48.2	2.8%	6.3%	20.8%	2.4	10.0		92.6%	71%	1	0	0	0	0			27%
Ward B2 Trauma	41.7	39.4	5.6%	7.0%	26.4%	1.0	10.4		97.0%	65%	1	0	0	0	0			28%
Ward B3	62.9	63.6	-1.0%	11.6%	28.1%	1.3	17.8		93.5%	72%	2	0	0	7	0	1		60%
Ward B4	77.5	76.6	1.1%	5.2%	30.3%	4.2	23.2		92.9%	93%	2	1	0	6	0			48%
Ward B6	25.2	23.7	5.8%	7.1%	34.3%	2.2	8.1		91.7%			0	0	0	0			33%
Ward C1A	35.4	33.8	4.4%	6.3%	32.3%	4.8	10.9		92.6%	43%	1	1	0	0	0			33%
Ward C1B	38.1	34.6	9.1%	6.2%	24.1%	0.1	8.3		95.9%			0	0	0	0			21%
Ward C2	58.7	54.1	7.8%	8.1%	27.8%	0.7	15.0		91.7%	89%	1				0			72%
Ward C3	56.5	53.3	5.7%	6.9%	27.6%	1.9	14.7		93.7%	90%	1	1	0	0	0			27%
Ward C4	65.2	63.9	2.0%	6.9%	28.9%	4.9	18.4		93.6%	40%		1	0	1				50%
Ward C5A	40.6	36.0	11.4%	7.3%	19.6%	1.0	7.1		93.2%	68%	1	0	0	2	0			40%
Ward C5B	45.9	42.7	7.0%	3.7%	25.9%	3.6	11.1		97.0%		4	0	0	4	0			44%
Ward C6	32.9	34.8	-5.6%	9.5%	29.9%	0.9	10.4		89.4%	72%	1	0	0	1				47%
Ward C7	63.1	59.1	6.3%	7.6%	29.2%	4.3	17.2		95.2%	86%	3	0	0	0	0			39%
Ward C8	80.9	70.8	12.5%	7.5%	25.1%	3.2	17.8		95.5%	100%	3	1	0	2	0			24%
Total	1,866.8	1,767.4	5.3%	6.9%	28.7%	97.1	506.6		93.3%	86%	88	11	0	31	0	3		52%

WardGroup	Hand Hygiene 5 moments audit (v2)	Hand Hygiene Environment Audit - Monthly	Lead Nurse In Patient Audit	Matron In Patient Audit	Tissue Viability SKIN audit (CQUIN 12)
AMU	100.0%	98.7%	89.7%	93.1%	98.4%
CCU	100.0%	100.0%	n/a	87.7%	100.0%
Critical Care	100.0%	100.0%	95.9%	96.8%	100.0%
Discharge Lounge	100.0%	100.0%	n/a	91.5%	100.0%
ED	96.3%	97.2%	n/a	n/a	n/a
ESH	96.8%	100.0%	94.7%	87.9%	100.0%
FMNU	100.0%	100.0%	85.2%	n/a	96.4%
Maternity	78.8%	100.0%	n/a	n/a	85.7%
MECU	100.0%	100.0%	96.4%	92.5%	100.0%
Neonatal Unit	100.0%	100.0%	n/a	n/a	n/a
Renal Unit	98.9%	100.0%	n/a	n/a	n/a
SDEC	100.0%	100.0%	n/a	n/a	n/a
Ward A2	n/a	100.0%	n/a	n/a	n/a
Ward B1	100.0%	100.0%	98.8%	98.3%	100.0%
Ward B2 Hip	100.0%	94.7%	96.8%	89.7%	96.4%
Ward B2 Trauma	100.0%	94.4%	89.8%	78.0%	95.5%
Ward B3	90.2%	94.4%	87.8%	81.0%	90.2%
Ward B4	97.3%	100.0%	n/a	86.4%	n/a
Ward B6	100.0%	100.0%	93.8%	n/a	95.0%
Ward C1A	97.7%	94.7%	95.8%	100.0%	100.0%
Ward C1B	87.5%	89.5%	98.8%	96.7%	100.0%
Ward C2	93.3%	100.0%	n/a	n/a	n/a
Ward C3	94.4%	100.0%	n/a	n/a	98.5%
Ward C4	100.0%	100.0%	87.3%	n/a	n/a
Ward C5A	100.0%	100.0%	98.9%	81.4%	92.1%
Ward C5B	100.0%	94.7%	98.6%	85.0%	100.0%
Ward C6	99.0%	89.5%	n/a	86.4%	n/a
Ward C7	98.1%	100.0%	n/a	79.3%	91.4%
Ward C8	93.3%	88.9%	80.3%	94.9%	93.2%
Total	97.9%	98.0%	92.9%	89.5%	96.5%

WardGroup	Has a falls risk assessment been completed?	MUST or MUAC completed	Waterlow completed
AMU	100.0%	n/a	n/a
CCU	n/a	n/a	n/a
Critical Care	100.0%	n/a	n/a
Discharge Lounge	n/a	n/a	n/a
ED	n/a	n/a	n/a
ESH	80.0%	n/a	n/a
FMNU	100.0%	n/a	n/a
Maternity	n/a	n/a	n/a
MECU	90.0%	n/a	n/a
Neonatal Unit	n/a	n/a	n/a
Renal Unit	n/a	n/a	n/a
SDEC	n/a	n/a	n/a
Ward A2	n/a	n/a	n/a
Ward B1	100.0%	n/a	n/a
Ward B2 Hip	100.0%	n/a	n/a
Ward B2 Trauma	100.0%	n/a	n/a
Ward B3	100.0%	n/a	n/a
Ward B4	n/a	n/a	n/a
Ward B6	100.0%	n/a	n/a
Ward C1A	100.0%	n/a	n/a
Ward C1B	100.0%	n/a	n/a
Ward C2	n/a	n/a	n/a
Ward C3	n/a	n/a	n/a
Ward C4	50.0%	n/a	n/a
Ward C5A	100.0%	n/a	n/a
Ward C5B	100.0%	n/a	n/a
Ward C6	n/a	n/a	n/a
Ward C7	n/a	n/a	n/a
Ward C8	80.0%	n/a	n/a
Total	94.4%	n/a	n/a

The data in this table reflects inpatient areas only

- Sickness: seasonal illness has reduced with sickness absence reducing from 15.9% in March to 6.9% in May.
- A task and finish group to review patient observations completed on time continues, with the group continuing to explore digital solutions to improve performance. Pilot wards have been selected for focussed action: AMU; B3; C2; C5. **'Let's get 'Ob'-sessed'** campaign launches 1st – 31st July across the Trust to: Increase on-time observation compliance to at least 75% in 3 months; Improve understanding of why observations matter to patient care; Promote the correct use of digital recording systems.
- Matron inpatient audit 'E-Obs on time' question continues to contribute to red and amber overall audit results for some ward areas.
- The 'hand hygiene environment audit' has been updated by IPC Team and renamed 'infection prevention and control audit' effective from 1st June 2025, bringing the Trust audits in line with the ICB audits. Informatics are aware and are working towards changes required for the dashboard to show this data in reports from 1st July onwards.
- Whilst usually green RAG rated for falls risk assessments on admission, reduced compliance on 3 wards is noted in May – Division Leads are aware and taking relevant action in their areas.
- MUST and Waterlow scores have not pulled through onto the dashboard due to changes in the reporting structure following MUST changes from 6 hours to 24 hours (in line with national guidance). Informatics are working to correct this.

Our Patients
Our People
Our Place

Kitemark Explanation

NHS
The Dudley Group
NHS Foundation Trust

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

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

Insufficient

Insufficient, but under active review/management

Sufficient

Not Yet Assessed

Click HERE for full kitemark explanation & policy

The Dudley Group NHS Foundation Trust

Appendix 2 – Lessons learned from Winter 24/25

Paper for submission to the Board of Directors on 18th March 2025

Report title:	Lessons Learned from The Dudley Group Winter Plan 2024/25
Sponsoring executive:	Karen Kelly, Chief Operating Officer
Report author:	Rory McMahon, Director of Operations, Medicine

Summary of key issues using Assure, Advise and Alert

Assure
The operational divisions at The Dudley Group have conducted a post winter review and thorough learning exercise, chronologically examining the planning and execution process of the winter plan 2024/25.

The lessons learned should form key maxims relating to future Winter Plans, and relate to securing robust capacity which can flex in times of extreme pressure for the coming winter 2025/26.

Advise
Lessons have been learned around forecasting, workforce, planning, and system resilience which are detailed within this paper

Alert
Winter 2024/5 was challenging for all at the Dudley Group. As with any process, however, value has been drawn from the review and reflection on last year's plan – and the ability to subsequently apply the learning to future processes to attain maximum efficiency.

For 2025/26 the national expectation as part of the new Urgent and Emergency Care plan is that all organisations and systems will need to have the winter planning signed off by the end of summer. The lessons learned included in this paper will be incorporated into the plan, alongside shared learning from our system partners and delivered to the Trust Board in September 2025.

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

3. Report journey
18/3 – Trust Executive

4. Recommendations
The Public Trust Board is asked to:
a) **Review** and Discuss the performance of the winter plan 2024/25
b) **Review** and Discuss the performance of the trust's key metrics over winter
c) **Discuss and Accept** the Winter Plan Lessons Learned

5. Impact		
Board Assurance Framework Risk 1.1	X	Deliver high quality, safe person centred care and treatment

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

Report to Board of Directors

Lessons Learned from The Dudley Group Winter Plan 2024/25

Contents:

1. Executive Summary – High level lessons learned
2. Summary of Winter Plan
3. Performance Context
    a) Operational Performance
    b) Staff Experience
    c) Patient Experience
4. Reactive Divisional Interventions
    a) Medicine Division
    b) Surgery Division
    c) Place Division
    d) CCCS Division
5. ICB Modelling
6. Success and failure of interventions in Winter Plan

1. Executive Summary – High Level Lessons Learned

During the winter of 24/5, the trust planned to pilot a 'Community First, Hospital when necessary' approach to the management of acute admissions and thus bed pressures at DGFT.

The mitigations scheduled within the winter plan, for a number of reasons detailed within this paper did not provide the expected level of mitigation against the number of extra patients who presented at the trust

The following learning points have been identified following a review process:

Lesson 1: Adherence to the organisational plan is important. The decision to deviate from the community hub model piloted by Enfield, a decision which was made at Divisional level, compromised the effectiveness of the winter plan. The intervention was worth 39 beds, and paring down the model from a cost of £1.1m to £400k ultimately led to its abandonment, as the new, untested model did not work, and gave executives no choice but to stand it down.

Lesson 2: Plan independently of Integrated Care Board (ICB) for winter pressures. ICB modelling was, as openly acknowledged by the ICB, not entirely accurate – from the magnitude of the peak to the timing of the peak, to the geographical nature of the patients presenting at the front door. Partnership working and focus on local knowledge of past winters is crucial to getting this right next time.

Lesson 3: Build in Super surge Capacity. Optimised systems do not work at 100% operationalisation at all times. According to the Kings Fund, the optimal capacity position for a trust is 94.5% of the commissioned bed base. DGFT have spent all winter above 100% - and as of the date of writing, are at 98.5% even in summer months.

Future plans should include extra, unanticipated contingency capacity in this regard. All efforts, as per the advice from the NHSE national team led by Chris Morrow-Frost, should be made to avoid the bedding of SDEC. There is a further requirement to initiate a robust system approach to planning across all services, which and links to EPRR teams and other trusts. The trust's proposed move to a community-based model of care, specifically as part of a future AMRAT model, should offset this.

Lesson 4: Improve Clinical Engagement. The winter plan was operationally led, and did not sufficiently engage our clinicians at the trust; as a result valuable feedback was not ascertained and thus not acted upon. This is planned to be managed differently this coming year.

Lesson 5: Focus on the Quality Impact: there was insufficient focus on quality metrics within the plan – including not only the quality of environment delivered for patients, but also for staff. Our Chief Nurse, Martina Morris, has offered valuable guidance in this regard.

2. Summary of Winter Plan 2024/25

The winter plan was based on an ethos of community first; that is a range of interventions based in the community, virtual wards and a community hub offer that extended to care homes and ambulances.

During the summer of 2024, The divisions worked together in order to maximise admission avoidance to the DGFT bed base, and came within 15 beds of the assurance required by the ICB in terms of combined winter and Midland Metropolitan University Hospital (MMUH).

The Executive Committee and Board were sighted on the governance surrounding the development and reporting of the MMUH impact modelling and mitigations planning which informed the winter plan .

Figure 1: Winter and MMUH plan mitigations

The two pie charts above show the plan and gap relative to the 65 beds that the trust had internally calculated that MMUH would cause (as opposed to the ICB calculated total of 29); and the 76-bed gap the ICB had calculated to the winter plan. Both figures were to peak.

Distinct interventions included

- A 10-bed virtual acute ward
- 24 extra beds released through rationalisation of the community hub funding (above) ; i.e. the extra beds released due to lowering of the unit cost within the same cost envelope
- 15 beds released through adherence to the 35/20 Complex Discharge KPI; that is to say that the trust will achieve 35 complex discharges on a weekday, and 20 on a weekend day.
- 18-bed frailty virtual ward
- 11-bed estate at Rowley

The combined cost for both plans was anticipated to be £2,637k, with a notional split of £1,581k for MMUH and £1,057k for winter. Of this, £1.1m was badged against the most impactful scheme – community hub admission avoidance.

Divisional Interventions

In addition to the plan, each division identified during the winter and subsequently implemented a separate set of interventions to reduce bed occupancy. These included the below

a) Medicine Division

The medicine division bedded large sections of its surge and Ambulatory Emergency Care (AEC) Same Day Emergency Care (SDEC) areas, as well as installing ten extra curtained cubicles in AMU. In addition to this, between the hours of 8 and 6, a temporary escalation space, staffed by all divisions on a rota, was

devised in order to expedite offloads from ambulances within the mandated 45 minute timeframe. The trust used space as flexibly as possible to deal with the large extra number of patients required.

In addition to this the medical division participated into multiple deep dives into the ward and bed base in order to liberate every possible bed and aid flow. Acute medical in reach into ED occurred on a daily basis.

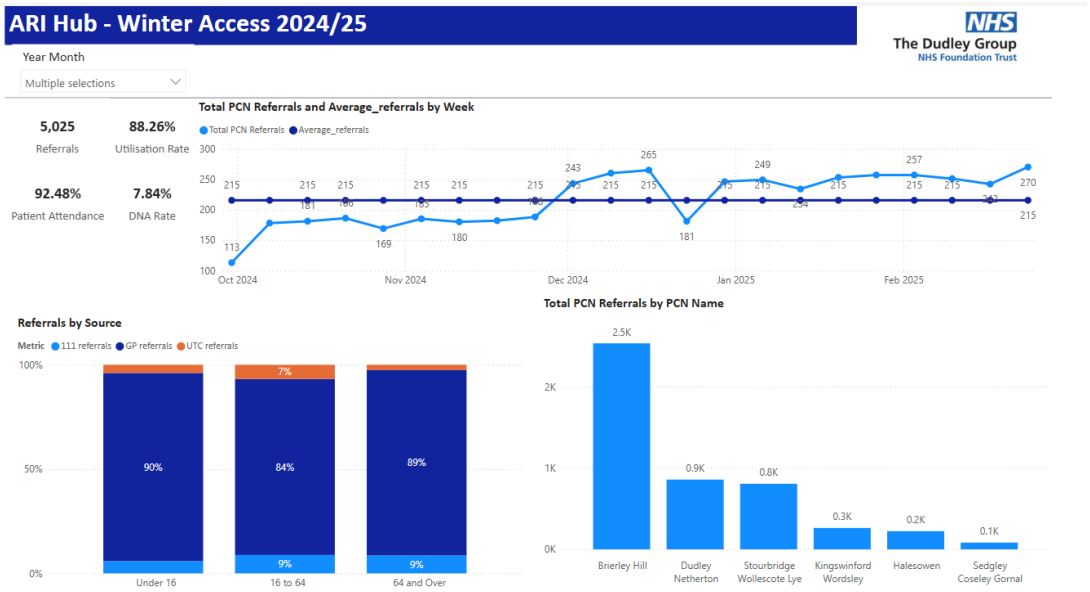
b) Surgery Division

The surgical division cleared beds to allow the trust to outlie to whenever possible. Space was used flexibly to house additional patients in the majority of ward areas.

c) Place Division

The Acute Respiratory Infection (ARI) Hub was commissioned between 1st October 2024 and 31st March 2025 to provide additional GP appointment capacity to support Dudley Place system resilience this Winter. The service operated Monday – Friday 9am – 1pm and Saturday 10am – 2pm between 1st October 2024 – 30th November 2024 and 1st March – 31st March 2025 providing an additional 192 GP face to face appointments each week. Then from 1st December 2024 to 28th February 2025 the service operated Monday – Friday 9am – 6pm, Saturday 10am – 2pm providing an additional 272 appointments each week with additional capacity over the Christmas bank holiday period. The service had direct referral pathways from Dudley GP practices and 111 with redirection pathways from both the UTC and Dudley Clinical Hub taking place.

Figure 15: Acute Respiratory Infection RI Hub Utilisation



d) Community with Core Clinical Services (CCCS) Division

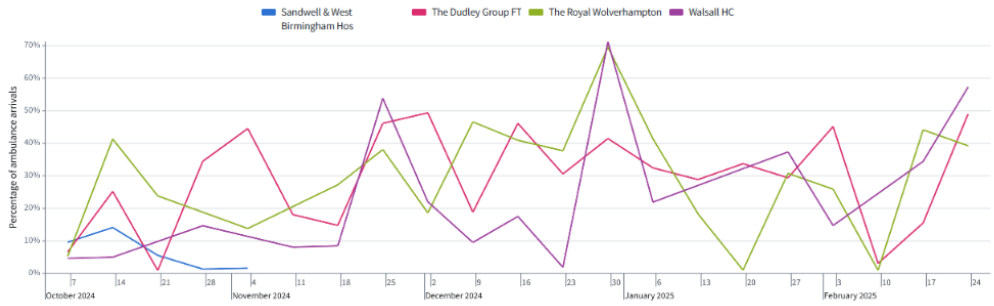
CCCS Division, to support the reduction of bed occupancy, and to support the discharge decision making at ward and board rounds. implemented the bringing forward of patients for CT scanning every evening (17.00-20.00) and revised the phlebotomy rotas where possible to ensure all wards had been attended by a phlebotomist by 12.00. The division also sought to increase the number of discharge facilitators in the Complex Discharge Team, to allow for one Discharge Facilitator per ward each weekday, and increasing workforce numbers at the weekend, to further strengthen ward based MDT working and aiding planning admission on discharge. The IV/OPAT team extended their services to enable the AMU VW to facilitate the continuation of IV treatment at home and support the reduction of the length of stay on AMU

3. Performance Context

The winter of 24/5 was a challenge clinically, operationally, and financially to the trust. The trust saw a high level of ambulance handover delays versus our Black Country partners, caused by high occupancy. This was in part driven by the opening of the Midland Metropolitan University Hospital (figure 4).

Figure 2: Ambulance Breaches over the hour versus Black Country partners, Winter 24/5

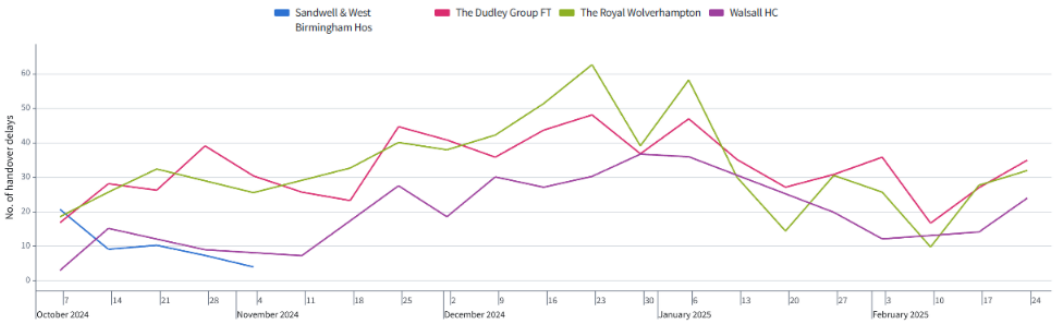
An average of one in every three ambulances at the trust went over the hour in winter 24/5.



NB: Sandwell data not available

Figure 2: Distinct number of ambulances breached by day, versus partners, Winter 24/5

Dudley were consistently worse than our partner trusts, when breaches are adjusted by bed base



NB: Sandwell data not available

There has been a sharp increase in ambulance attendances at RHH since the closure of Sandwell Hospital and the opening of MMUH in October 2024. Data shows that this has had a marked effect on the number of one-hour breaches occurring

Figure 4: Number of Ambulances, April 2024 to April 2025

NB – Average ambulances 96 per day pre MMUH; 102 post

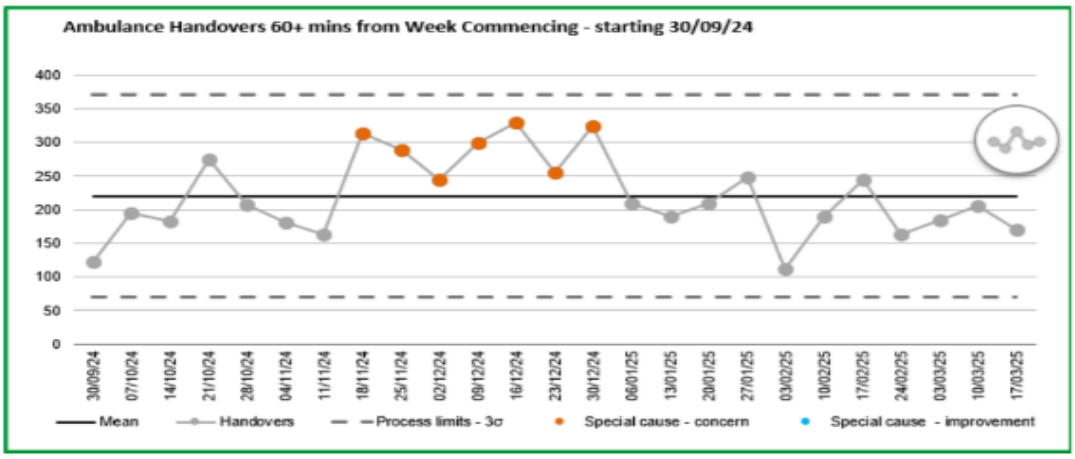
The below details from which postcodes those extra ambulances were constituted. This has now been addressed with a reallocation of Non-elective funds from MMUH to DGFT.

Figure 5: Constitution of additional ambulances

	Patient Postcode Areas			
	Dudley	Sandwell	Walsall	Wolverhampton
Baseline period pre-MMUH opening	65.27	15.97	1.50	2.22
7 Days post-MMUH opening	67.50	20.75	1.00	2.14
Increase/Decrease since Baselined	3.42%	29.96%	-33.33%	-3.36%

NB: summary: +2.23 Dudley Postcode, + 4.78 Sandwell Postcode, - 1.01 Remainder (BC & OOA)

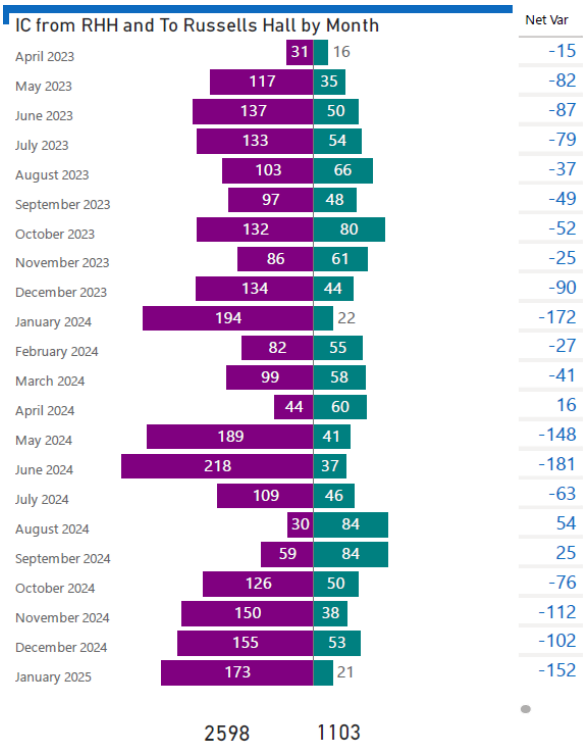
Figure 6: Ambulance handovers over the hour, winter 24/5



This performance was supported with an increase in strategic conveyance away from the Russells Hall site by West Midlands Ambulance Service. This placed additional pressure on our system partners and resulted in patients not always being placed in the hospital closest to their residence.

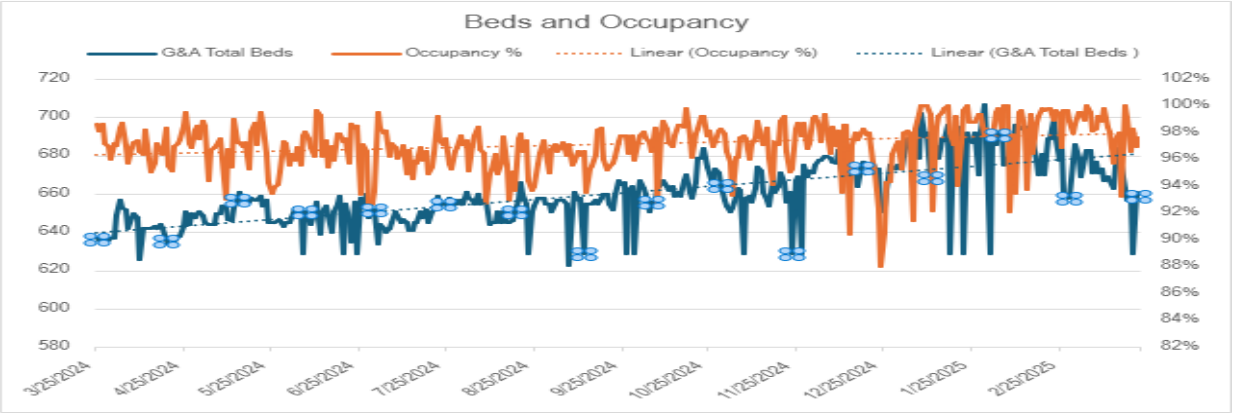
The opening of Surge beds also supported this performance, at a cost tothe trust over £300,000 per month during this period.

Figure 7: Intelligent Conveyancing and performance of RHH site in January 2025



This was driven by an increase in occupancy at the trust over and above the bed base. In the initial stages, SDEC and AEC as permanently bedded, and additional patients were in situ on wards where discharges had been identified for later in the day.

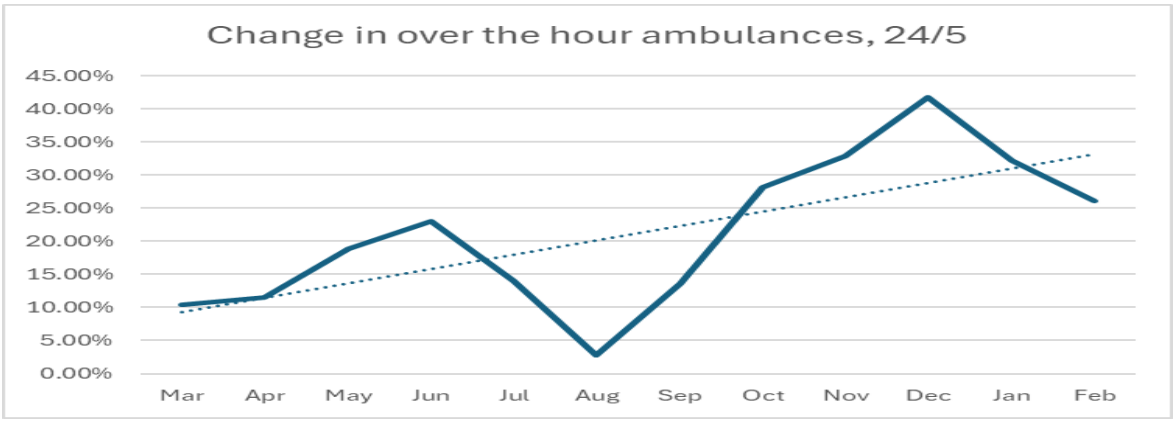
Figure 8: beds versus occupancy at DGFT, Winter 24/5



The trust has developed an occupancy scale (communicated to commissioners July 2024) which accurately predicted the levels of handover delay at the actual levels of occupancy.

Based on trust modelling, the trust could have expected between a 26% and 35% increase in over-the hour conveyances based on occupancy, and experienced 26, indicating an accuracy of prediction.

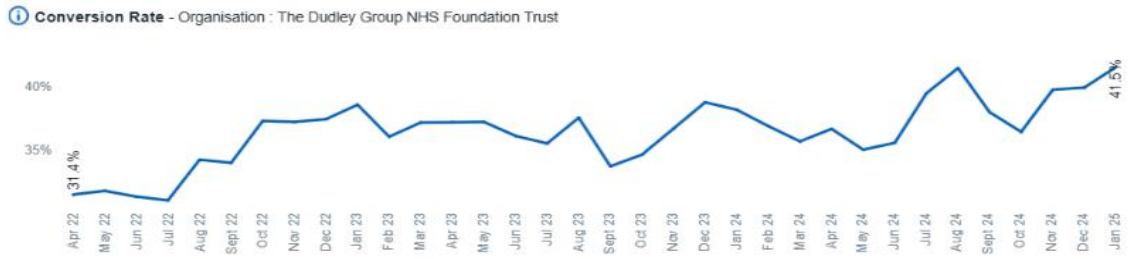
Figure 9: Change in over the hour ambulances, Mar 2024 to Feb 2025



Length of stay stayed fairly static throughout the winter period - However conversion rate rose (as it does every winter) to roughly 2% more than winter 24/5. This is roughly in line with the expected increase in acuity year on year of 1.5% DGFT has seen at the front door.

Figure 10: Conversion rate, ED (non UTC filtered) attendances, April 22 to Jan 25

Trust AVERAGE Occupancy	Handover Delays Over the Hour	Average 4 Hour Performance ED Only	Actual # over the hour delays per month	Source
95%	7%	76%	203	Actual
96%	14%	76%	406	Actual
97%	18%	75%	522	Actual
98%	22%	74%	638	Actual
99%	28%	74%	812	Actual
100%	31%	73%	899	Actual
101%	36%	73%	1032	Forecast Based on Volumes
102%	40%	72%	1166	Forecast Based on Volumes
103%	45%	72%	1299	Forecast Based on Volumes
104%	49%	71%	1433	Forecast Based on Volumes
105%	54%	71%	1566	Forecast Based on Volumes
106%	59%	70%	1699	Forecast Based on Volumes
107%	63%	70%	1833	Forecast Based on Volumes
108%	68%	69%	1966	Forecast Based on Volumes
109%	72%	69%	2100	Forecast Based on Volumes
110%	77%	68%	2233	Forecast Based on Volumes



Despite this, 4 hour performance stayed largely resilient, this is as a result of good performance in non-admitted pathways compensating for long waits for patients to be admitted into the bed base.

Figure 11: DGFT 4 hour performance by year, 2023/4/5

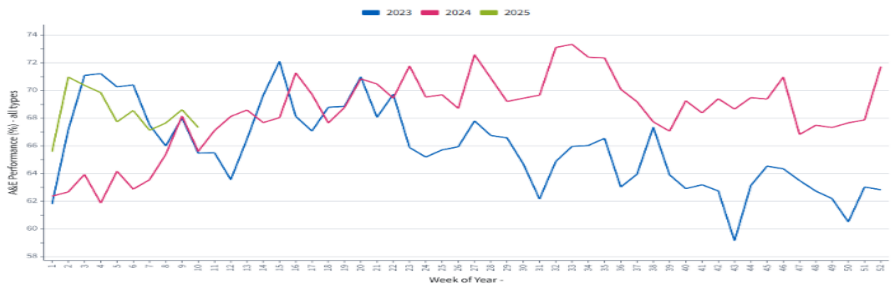
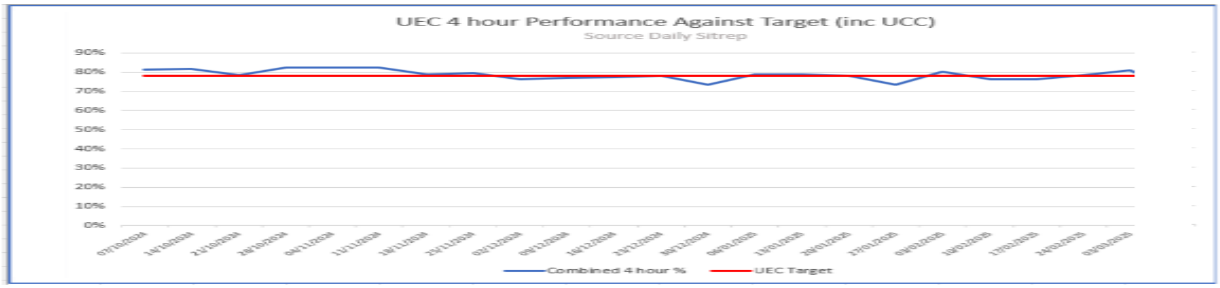


Figure 12: Performance vs Four Hour Standard



Urgent and emergency care (UEC) Performance was largely over or around the 78% standard, with the trust currently sitting at over 79.8% for the full year.

Patient Morale

Morale In ED in the period, according to the NHS' friends and family test was on average similar to the prior year

24/5 – ED Patient Morale

Emergency Department (% Very Good/Good)				
Oct-24	Nov-24	Dec-24	Jan-25	Feb-25
68%	69%	69%	74%	69%

Emergency Department (% Very Poor/Poor)				
Oct-24	Nov-24	Dec-24	Jan-25	Feb-25
17%	16%	16%	13%	15%

Emergency Department Mean Average Score	
Overall positive score	Overall negative score
70%	15%

23/4 – ED Patient Morale

Emergency Department (% Very Good/Good)				
Oct-23	Nov-23	Dec-23	Jan-24	Feb-24
69%	70%	70%	69%	72%

Emergency Department (% Very Poor/Poor)				
Oct-23	Nov-23	Dec-23	Jan-24	Feb-24
16%	14%	15%	16%	13%

Emergency Department Mean Average Score	
Overall positive score	Overall negative score
70%	15%

With Trust wide patient morale Scores following a similar, static pattern

24/5 – Trust wide Patient Morale

Trust Score (% Very Good/Good)				
Oct-24	Nov-24	Dec-24	Jan-25	Feb-25
82%	83%	83%	83%	82%

Trust Score (Very Poor/Poor)				
Oct-24	Nov-24	Dec-24	Jan-25	Feb-25
7%	6%	6%	6%	6%

Trust Mean Average Score	
Overall positive score	Overall negative score
83%	6%

23/4 – Trustwide Patient Morale

Trust Score (% Very Good/Good)				
Oct-23	Nov-23	Dec-23	Jan-24	Feb-24
82%	84%	83%	82%	83%

Trust Score (% Very Poor/Poor)				
Oct-23	Nov-23	Dec-23	Jan-24	Feb-24
6%	5%	6%	6%	6%

Trust Mean Average Score	
Overall positive score	Overall negative score
83%	6%

Staff Morale

Staff morale rose amongst ED nursing, but fell back amongst ED Medics

Figure 13: Staff Survey results, DGFT, versus prior years

Staff Survey Results Morale				
Department	**Trust Average**	**2024/5**	**2023/4**	**2022/3**
AMU 1	5.7	5		
AMU 2	5.7	6.3		
AMU Assessment	5.7	4.6		
ED Nursing	5.7	5.3	5	4.6
ED Paediatrics	5.7	4.9		
ED Minor Injuries	5.7	4.8		
ED Medical Staff	5.7	5	5.3	4.5

4. ICB Modelling

The ICB's modelling is below, at figure 14 Line C, below, indicated the required level of ICB assurance. The level of mitigation forecast was only marginally lower than this, and Line C was, for the majority of winter, around 35 beds clear of the level of anticipated activity at the Trust.

The reality was unfortunately markedly different. Almost immediately upon the closure of MMUH, the trust moved to open 57 surge beds, later increased to 67 once 10 extra beds were opened on AMU.

Line D (Figure 15) represents the number of beds at the trust actually opened during winter.

Figure 14: Dudley total and peak bed requirement and ICB assurance winter 24/5

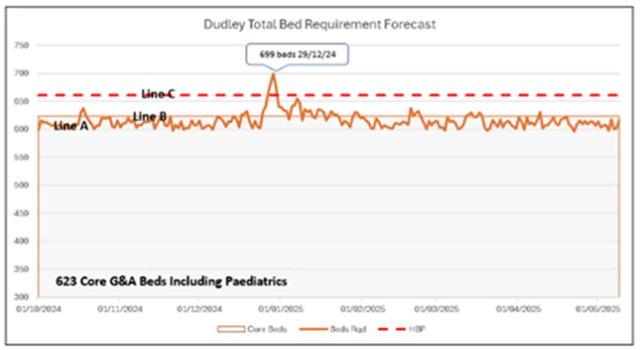
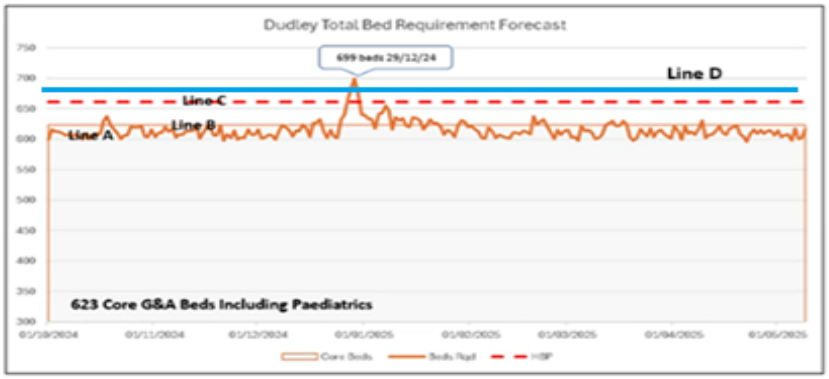
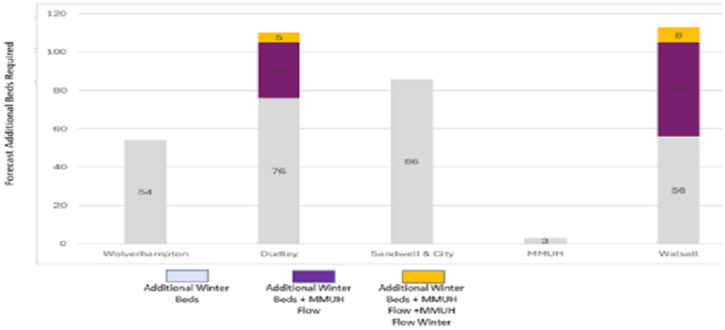


Figure 15: Beds open at trust, winter 24/5



The below graphic represents the ICB modelling of the peak, and cause attribution

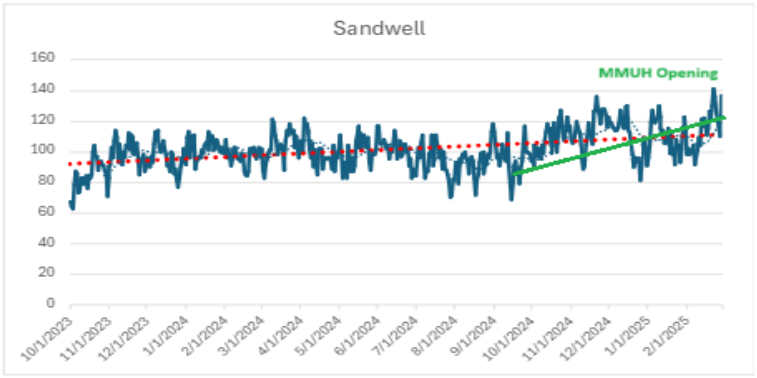
Figure 16: ICB peak modelling winter 24/5



The reasons for this include unanticipated Sandwell patients in the bed base, a low number of complex discharges, and a heightened number of MOFD in the bed base at DGFT. The above modelling RE: DGFT and MMUH impact was incorrect, as will be demonstrated below.

The below section details the patients which the winter plan was expected to mitigate against.

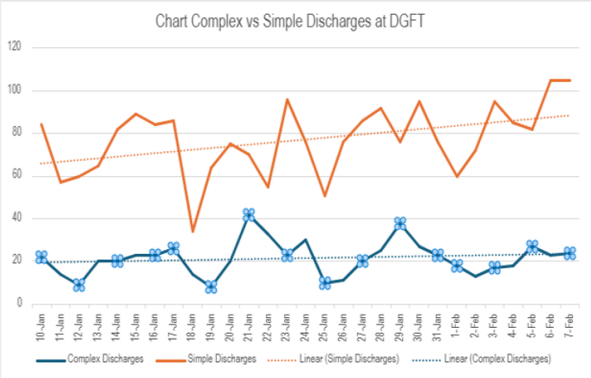
Figure 17: Sandwell patients in bed base pre and post MMUH.



- The data in figure 6 shows roughly 26 more patients in the bed base in the period Oct ’24 to feb ’25 – with a marked upward trend in that period compared to previously. Further data analysis showed
- The 'natural' rate of increase of Sandwell patients in the Dudley bed base (between 22/3 and 23/4, so no MMUH impact) is circa 5%.
- The rate between 23/4 and 24/5 (so MMUH Impact) is upwards of 25%
- Average 26 pts with a Sandwell Postcode in bed base more than 23/4 in 24/5
- Looking at Jan and Feb, the worst day was 19th February when we had 39 more Sandwell patients in the bed base
- This is a roughly 4.5% pressure on our bed base

Complex Discharges also significantly lagged the anticipated level (Data extract from report in feb), creating an Excess of MOFD. An excess of complex MOFD (Medically Optimised Fit for Discharge) at the Trust, which sits at between 23 and 27% (25% was the figure identified in the recent Trust census led by our Medical Director). The national average is 16.6%; An exemplar, such as our neighbour and ICB Partner Walsall, is 9-10%. This manifests in 50-60 extra MOFD within the Trust bed base, the causes of which (and the solutions to which) are multifactorial and involve multiple divisions and external agencies.

Figure 18: Complex versus simple discharges (Jan-Feb 2024/5)



5. Success and failure of interventions in Winter Plan

a) 10-bed virtual acute ward extension

This was successful, and was in fact over-capacity all winter. This facet of the mitigative plan was particularly successful at times of high congestion within ED; it was on occasion possible for consultants to discharge 4 patients at any one time from ED cubicles into the AMU virtual ward.

The board has now served its purpose and is likely to be shrunk back to a smaller number in order to make its continued running more financially viable for the trust.

b) 39 extra beds released through community hub funding of admission avoidance (above)

It was initially planned that the trust would look to replicate new model of care developed in Enfield whereby clinical teams with advanced skill sets would man the community hub 24 hours per day and link into an urgent community response team partially staffed by GP's and consultants which would go into care homes and realise the significant opportunity which the place division have subsequently calculated in preventing admissions from care homes.

This was initially costed at £1.1 million. The reason for this costing was to make the model commensurate with the Enfield model to achieve the number of visits and contacts necessary to prevent the admissions and thus to realise admission avoidance.

After looking into how this could be adopted, DGFT proposed an augmentation of the model. This reduced the funding envelope to £400,000. After a pilot, it was concluded that the model did not work as expected and was therefore stood down, This was crucial to the winter plan as it involved 35 beds worth of admission avoidance – that is nearly half the surge capacity of the trust.

The abandonment of this initiative ultimately led to the failure of the winter plan due to the disproportionate impact of this one intervention on the portfolio of mitigations

c) 15 beds released through adherence to the 35/20 Complex Discharge KPI; The trust will achieve 35 discharges on a weekday, and 20 on a weekend day.

The KPI for complex discharges to improve upon the MOFD position detailed earlier in this paper was not realised. Complex discharges did not improve from the pre winter position and thus no bed savings were made as a result of this initiative.

d) 8-bed frailty virtual ward

It was planned, as per instruction, the 18 bed frailty virtual ward extension must be staffed using bank. Unfortunately during the start of the winter period the frailty specialty suffered a number of long term absences within the band 7 nursing line. The directorate explored everything that it could in terms of the utilisation of staff from other trusts, but none were available.

e) Eleven bed estate at Rowley

The stroke rehabilitation estate at Rowley was opened on the 1st of February after extensive negotiation and recruitment into the roles. Although it is now open and full, the facility served to alleviate a small part of

the MOFD problem (patients waiting for pathway 3 packages of care), and the MOFD problem grew all winter and thus consumed this element of the mitigation without benefit.

6. Lessons Learned

Lesson 1: Don't deviate from the plan blueprint.

The key strength of the Enfield Model was that it would deliver proven outcomes - and that we had a contact at the Enfield team whom we could ask questions in order to iron out practicalities and take learning from. The revised plan did not realise the benefits required and therefore did not mitigate the number of beds required.

Lesson 2: Plan independently of ICB for winter pressures. modelling was incorrect – from the magnitude of the peak, to the timing of the peak, to the geographical nature of the patients presenting at the front door; our mitigations within our own community were not designed to mitigate Sandwell patients.

Going forward all winter plans should be formulated using a greater degree of collaboration, using trust data. DGFT did model what we felt MMUH related pressures would be and communicated them to the ICB in June of 2024, but this did not affect the ICB's modelling either in terms of magnitude or peak.

Assurance, cumulatively at trust level and not ICB level should just be the driving factor in creating robust winter plans going forwards bearing in mind the lessons learned regarding the inadequacy of ICB modelling in winter 24/5. DGFT are, subsequently, not the only trust to contest the modelling – Wolverhampton and Walsall have both requested learning exercises.

Lesson 3: Build in Supersurge Capacity

The DGFT Non-elective Workstream for 2025/26 has acknowledged this as a central pillar, and is building in winter resilience and capacity to new models of care.

Lesson 4: Improve Clinical Engagement.

By placing clinical leaders at the helm of winter planning, healthcare organisations can ensure that strategies are informed, practical, and focused on delivering high-quality patient care even under the strain of heightened demand.

The DGFT plan was operationally led, and more specifically led by the DGFT medical division. This deprived clinicians of the chance, in good time, to collaborate and grow solutions; True clinical leadership promotes collaboration between various specialties and departments, ensuring a comprehensive approach to addressing the complexities of winter demand, including emergencies, hospital admissions, and outpatient care.

Clinically led planning can also facilitate better communication among clinical teams, management, and support staff. This is crucial during winter months when circumstances can change rapidly; and teams are often better equipped to respond swiftly to crises or spikes in patient volume, as they can make informed, effective decisions that prioritise patient safety and care.

Lesson 5: Focus on the Quality Impact

Insufficient focus was placed upon quality metrics and KPIs in the DGFT 24/5 winter plan. This is important for a number of reasons.

Winter periods often come with higher demand due to seasonal illnesses, such as flu or respiratory conditions. KPIs focused on safety help ensure that patient care remains a top priority, reducing the risk of errors, accidents, or infections. They track vital aspects of patient care and safety, such as infection control rates, fall prevention, and medication errors.

Winter months can strain healthcare systems, leading to longer wait times and reduced satisfaction. KPIs that track patient satisfaction, waiting times, and quality of care ensure that the patient experience does not suffer even during peak times. By focusing on quality, trusts can maintain high standards of care and improve patient outcomes.

Appendix 3 – Service level winter plans

Surgery Women and Children

The Surgery, Women, and Children (SWC) division has developed a proactive and multi-faceted winter plan for 2025/26, designed to sustain safe and effective care across all its services during periods of peak demand. Priorities include increasing vaccination uptake among staff and eligible patient groups, particularly to minimise the impact of seasonal illnesses. Hot clinic capacity will be expanded to provide timely access to urgent care and prevent unnecessary admissions, while careful planning of annual leave will ensure even distribution across the workforce to reduce service disruption in Quarter 4.

A focus has been placed early on maintaining elective flow throughout the winter period but increasing throughput pre winter by maximising the use of high intensity operation lists (HIT), use of Paediatric Super Saturday events and usage of vacant theatre space in other Black Country Trusts to minimise any unexpected impacts on elective throughput as a result of winter pressure.

A standard operating procedure for the roles and responsibilities of the daily capacity team ensuring that escalations for surges in demand and capacity are dealt with in timely manner and there is effective decision making in these high pressure periods reducing the reliance on holding patients within the Emergency Department.

The division is working to increase the availability of hot clinic appointments, exploration of the introduction of a surgical virtual ward, to fully embed the usage of estimated date of discharge and criteria led discharge. Work is also underway to look at right-sizing the surgical SDEC to ensure that the department is fully prepared to cope with the demand realised from the care navigation centre.

Within paediatric services, the division is placing emphasis on maintaining flow and capacity, particularly during surges in respiratory presentations typical of the winter period. This includes reinforcing discharge planning processes and ensuring there is adequate escalation and support for children with complex needs. Paediatric pathways will be monitored closely to respond flexibly to seasonal demand, with a continued focus on safe staffing and effective service coordination. A surge plan is also being developed to increase availability of space on the Paediatric Virtual Ward, this may require a small capital investment for further remote monitoring equipment.

Community and Core Clinical Services

Within Core Clinical Services, efforts are being concentrated on ensuring workforce resilience and operational flexibility. Plans are in place to maintain staffing levels across diagnostic and clinical support services, with particular emphasis on deploying resources dynamically to respond to surge demand. Diagnostics, including imaging and pathology, will offer increased availability to support timely clinical decision-making and reduce delays in patient progression. This will include moving as much elective diagnostic activity to the Guest and Corbett sites to ensure availability for emergency and inpatient diagnostics to be carried out on the Russells Hall Hospital site. Additional inpatient ultrasound capacity is to be provided on Saturdays and the phlebotomy service will be reviewed to offer a seven day service with all blood samples collected by 11am. Allied health professionals and therapy services are also being positioned to provide rapid assessments and early intervention to prevent unnecessary admissions and support recovery at home where clinically appropriate.

The Pharmacy service will play a central role in sustaining patient flow during winter. Prioritisation is being given to medicines optimisation and the timely provision of discharge medications to prevent avoidable delays. The TTO (To Take Out) process is being streamlined with workforce plans designed to maintain extended pharmacy hours where required. This approach aims to ensure medication safety while supporting swift transitions of care across hospital and community settings. Where necessary outpatient services will be instructed to use FP10 prescribing forms when the Trust is on OPEL 4 to enable patients to access community pharmacies for dispensing of hospital outpatient medication allowing the pharmacy department to focus on the provision of medication for inpatients and prioritisation of timely medication for discharge.

The staffing model within the mortuary is being reviewed to ensure that there is a robust on call roster with annual leave having been taken evenly throughout the year to ensure that there are no staffing shortfalls

during Q4 when seasonal variations in death rates increase the uptake on mortuary services. There will also be a process to call for mutual aid across the system if required.

Care Navigation Centre is aiming to be operational by September 2025, with the objective of enhancing patient care coordination, minimising unnecessary hospital conveyances and attendances and providing alternative pathways to support urgent care response.

Impact from September 2025 of the project will concentrate on:

1. Referrals into CNC from WMAS, Primary care, NHS 111 and all health and care professionals, with Phase 2 opening to patients and carers.
2. Service Provision 12 hours 8 am - 9pm, 7 days a week including bank holidays, to include band 6 triage clinician – Nurse/Paramedic to be placed in ED.
3. Establish new pathways that can support patient flow from community services/Primary care to SDEC/Hot clinics and VWs and reduce footfall to ED e.g. DVT pathway within Community, direct step up into hot clinics/Virtual Ward's as clinically appropriate.
4. The CNC workstream will revise the strategy with West Midlands Ambulance Service (WMAS) concentrating on the 'Call Before Convey' model and focus on Primary Care and Care Homes to increase the utilisation of the Hub and prevent attendances and admissions into ED. Work is also underway to look at the provision of a single CNC across the Black Country hosted by Wolverhampton as currently offer a 24hour service provision.

In addition to this system wide schemes are also in development and should positively support winter readiness:

- Development of a single Out of Hours (OOH) UCR SPA in the Black Country to support review and safe stacking of patients on the CAD portal. Wolverhampton to host this OOH SPA with a pilot starting on 16th of June for the hours of 6.30-8am.
- Collaboration with Sandwell to develop a single point of access for the south in line with the single point of access for Wolverhampton and Walsall. Scoping has already started with 1st meeting being held with Sandwell on 20th June 25.
- Working with Sandwell to review provision of wider community services and cross border cover, including District Nursing services and IV therapy.
- To work with the Rapid Enablement, Assessment, Care, Coordination, Therapy and Treatment (REACCT) and Care Transfer Hub (CTH) models to ensure discharge pathways are set up with the CNC to facilitate turning patients around from front door and discharges back into the community.

PLACE

PLACE have focused on ensuring that patients are accessing care in the most appropriate facility in primary care where possible and also supporting patients to be discharged from the organisation in the most timely way possible into suitable care settings.

The division is contributing significantly to the development of the Care Transfer Hub supporting a more integrated approach to the management of pathway 1, 2 and 3 discharges aiming to improve patient outcomes, reduce delays and strengthen system collaboration. This will improve communication, accessibility and escalation across the whole of the local health and social care sector in relation to safe patient discharge.

Weekly long stay reviews will be implemented within community bed settings to ensure that delays are minimised alongside regular liaison with infection control to ensure good practice is maintained within these settings to ensure that bed availability is not impacted by closures as a result of infection outbreaks.

The GP services that fall within our management, High Oak and Chapel Street Surgery will be implementing improved training for reception teams to ensure that we are maximising care navigation and that GP appointments will be preserved for those patients that require them and that there is reinforcement

of patients accessing alternative professionals where appropriate including the Community Pharmacy, Opticians, Dental services and utilisation of electronic requests for non-urgent matters such as FIT notes and prescription requests. The Acute Respiratory Infection Hub (ARI) will be launched in October with increased capacity available from December onwards to provide appointments for patients with respiratory symptoms allowing them to be directed away from frontline GP appointments. The Urgent Treatment Centre and NHS 111 will be able to refer directly to this service.

A project to ensure all care home residents have appropriate RESPECT documentation in place where indicated will be completed by the end of September 2025. This will support patients who do not wish to be conveyed to hospital or are at the end of life with symptoms that could be well managed in the community are not inappropriately conveyed to hospital.

Medicine and Integrated Care

Meeting the 45 min standard for Ambulance Offload, meeting 12 hour performance and eliminating corridor care.

Reducing ambulance offload delays, 12-hour breaches (primarily linked to delays in admission), and the use of corridor spaces remains a key priority for the winter period. These issues are predominantly driven by consistently high bed occupancy. The Emergency Department (ED) will focus on the timely transfer of patients once a bed is allocated, and ensure efficient clinical ownership and turnaround within the department.

As part of the Non-Elective (NEL) workstream, 22 beds within AMUA will be stood down to facilitate the creation of a dedicated 6-bay ambulance handover area, with an additional side room. This initiative is designed to expedite triage and improve flow at the front door. Operational considerations, including staffing and safe clinical management of this space, require further planning and discussion.

Further capacity will be created through the relocation of minor injuries services to Therapies, allowing the ED to create three additional assessment spaces. While the addition of three trolleys will have a limited overall impact, it provides crucial extra assessment space and enables more efficient patient stepdown from Majors. Space constraints make the inclusion of 8 recliner chairs unfeasible.

To streamline clinical processes, a single clerking document will be implemented across ED. This will reduce duplication, support faster diagnosis and treatment, and improve bed turnover, ultimately helping to meet the 45-minute ambulance offload target.

A potential innovation under review includes converting the ED intubation room into a Mental Health (MH) assessment bay in partnership with Black Country Healthcare. This would provide dedicated, staffed space for patients awaiting mental health admission and prevent unnecessary delays.

The NEL workstream's community hub and other diversionary initiatives are expected to reduce ED attendances by approximately 80 patients per month, according to the CCCS business case for the Community Navigation Centre (CNC). However, this figure is currently anecdotal, and no formal pilot or outcome data yet substantiates this projection.

ED will continue to redirect appropriate GP referrals directly to specialties from Malling Health Streamer. This requires commitment from specialty assessment areas to accept patients without additional pre-transfer investigations, which previously led to a breakdown in this pathway due to unrealistic expectations placed on Malling.

A fully operational discharge lounge remains a critical component in enhancing patient flow and reducing bed occupancy, with a direct impact on improving ambulance handover times and eliminating corridor care.

The Rapid Assessment and Triage (RAT) model will continue throughout the winter to identify patients suitable for streaming away from ED at an early stage.

Maintaining 4 hour performance for Paediatric Emergency Care

Paediatric ED has consistently maintained a four-hour performance of 92%. Sustaining this level will be achieved through close collaboration with the community division, with an emphasis on shifting care into the community and preventing default referrals to ED from other specialist services.

A clinical Band 7 nurse will continue to support flow and address any emerging capacity issues within the department.

Plans are in place to increase Virtual Ward (VW) capacity and expand existing pathways. A full review of current ED and Paediatric Assessment Unit (PAU) pathways is also underway, with the aim of identifying waste and inefficiencies.

Increased on-site senior presence, including a PAU consultant available from 09:00 to 21:00, will further support performance and decision-making.

Maintaining 4 hour performance overall

The trust has maintained performance above 79%, and will continue efforts to achieve the minimum standard of 78% throughout winter. ED will maintain strong clinical ownership and active tracking of patients approaching the four-hour breach mark.

Collaboration with Mental Health (MH) services remains a key focus, with internal escalation processes in place to prevent delays exceeding 24 hours. To enhance the interface with MH services, the trust will:

- Develop clear, standardised protocols for triaging and managing psychiatric emergencies.
- Ensure early involvement from MH providers upon patient arrival.
- Implement rapid screening tools to determine severity and disposition needs.
- Provide direct access to MH specialists, either on-site or remotely.
- Integrate mental health with real-time bed tracking via the new bed management system.
- Deliver regular staff training on MH conditions, de-escalation, trauma-informed care, and correct use of MH protocols.

A professional standards audit will be conducted to support quality and consistency in patient care.

Reducing length of stay for Emergency Medical Admissions staying one night

The trust is targeting a minimum 0.4-day reduction in length of stay (LOS) for patients with overnight medical admissions. This will be achieved through several key initiatives:

- Early senior clinical review (consultants or experienced registrars) within the first few hours of admission to accelerate diagnosis and care decisions.
- Timely involvement of Allied Health Professionals (AHPs), such as physiotherapists, occupational therapists, and social workers, to support early discharge planning. The REACT team is expected to play a significant role here, pending proof of concept and mobilisation.
- The new bed management system and integrated electronic health record (EHR) platform will support clinicians by prompting evidence-based pathways and discharge criteria.

Appendix 4: Social Care and Dudley Metropolitan Borough Council

Dudley Metropolitan Borough Council (DMBC) Social Care is committed to a proactive and integrated approach to prevent avoidable admissions, support timely discharges, and enable recovery through person-centred care. Our priorities focus on early intervention, system collaboration, and maintaining operational resilience throughout winter pressures.

1. Seven-Day Discharge Operations

We will maintain a fully staffed, 7-day social care discharge service, ensuring continuous support for safe and timely discharges via the Discharge to Assess (D2A) model. This will be underpinned by integrated working across preventive services, informal carer support, telecare, and reablement, all aimed at reducing reliance on long-term care and improving outcomes. A strong emphasis will be placed on staff wellbeing, with training, rest and recovery workshops, and active participation in seasonal vaccination programmes.

2. Timely and Flexible Care Offers

To minimise discharge delays, care packages will be secured swiftly, supported by flexible rotas and responsive services including evening and weekend coverage. A strengths-based approach to care planning will be prioritised, empowering individuals to regain independence as quickly and safely as possible.

3. Escalation and Surge Planning

During periods of heightened system pressure, we will proactively bring forward planned discharges. Through real-time data analysis and effective escalation protocols, we will work in close collaboration with health partners to ensure individuals ready for discharge are prioritised without compromising safety or quality.

4. Medication Oversight

In partnership with health colleagues, we will support medication screening and reviews to prevent overprescribing and reduce medication-related readmissions. Ensuring that all necessary reviews are completed before discharge is a core part of our safe discharge process.

5. Transfer of Care Hub (TOCH) Engagement

Social care will maintain a strong presence in the TOCH, contributing to integrated, patient-centred discharge planning. As the model evolves, we remain agile and committed to ensuring that social care perspectives are embedded in daily decision-making.

6. Robust On-Call System

We will operate a reliable 7-day on-call system to support urgent social care needs and facilitate escalation when required. Strong communication pathways with all system partners will be upheld to enable real-time coordination and problem-solving.

7. Urgent Care Attendance Avoidance

Through our Urgent Care Attendance Avoidance Team, we will provide rapid response services 7 days a week. Working alongside community health teams and GPs, this approach will prevent unnecessary hospital admissions by managing risk in the community and delivering timely interventions.

8. Participation in System-Wide Initiatives

Social care will continue to engage in key system-wide initiatives such as Multi-Agency Discharge Events (MADE) and local development programmes. This collaboration will drive system learning, service improvements, and shared accountability.

9. Hospital Avoidance Beds

Five dedicated hospital avoidance beds will be used to support individuals with urgent social care needs in a non-hospital setting. These placements offer an environment for stabilisation, assessment, and short-term recovery – helping prevent unnecessary admissions.

10. Access to Therapy Equipment

Access to essential therapy equipment, available 7 days a week, will be maintained to facilitate safe

discharges and ongoing recovery at home. Social care teams will work closely with therapy services to ensure timely provision and installation.

11. Support to FAU and ED
Responsive social care support will be available to both the Frailty Assessment Unit (FAU) and Emergency Department (ED). These interventions will enable front-door discharge where appropriate, reducing length of stay and easing pressure on acute services.

Appendix 5 – Communications Plan

Communications plays a key role during winter. Last year our Black Country communications community responded well, having a robust plan in place, detailing our approach, messages and target audiences. Together, we developed and localised communication toolkits which allowed for consistent and timely communications to patients, public, our workforce, primary care and wider stakeholders. This work was overseen by the Black country UEC Programme Board.

Building upon the success of that collaborative approach, in 2025/26 our Trust will work with the ICB and partners across health and care to maximise the reach of our messaging which will be tailored to achieve the following goals:

Goal 1: Educate and inform the public to help reduce inappropriate unheralded ED and UTC attendance.

- Seasonal Vaccinations: Promote uptake among vulnerable populations, work to dispel myths, reduce hesitancy and overcome messaging fatigue.
- Self-care messages: Encourage people to manage minor illnesses (like colds, sore throats) at home or through pharmacy.
- "Choose well" campaign to educate people on when to use A&E, UTC's (if standalone) NHS 111, pharmacies, or GPs.
    - Promote pharmacy first/minor ailment schemes including late night opening
    - Promote access to mental health care teams when an existing service user is in crisis
    - Promote 24/7 mental health helpline for Black Country residents who are or have a loved one who is struggling with their mental health
- Cold weather health advice: Provide tips to prevent cold-related illnesses and protect vulnerable individuals.
- Promote NHS 111 as a first point of contact for non-life-threatening issues.
- Work with local authorities, UKHSA, and other healthcare partners to ensure consistent and coordinated messaging (speak with 1 voice)

Goal 2: Support NHS staff and maintain operational effectiveness.

- Promote staff flu vaccinations to keep our workforce well.
- Support staff to improve discharges 'where best next'
- Support awareness of virtual wards and community pathways for admission avoidance
- Disseminate winter preparedness plans, staffing updates, and infection control protocols.
- Boost morale through recognition and support messaging.
- Provide up-to-date information during severe weather or service disruption.

Goal 3: Maintain trust and clarity during periods of high pressure (crisis & incident communication).

- Communicate clearly to those who need to take new actions.
- Maintain trust and confidence in the NHS during peak periods of demand.
- Coordinate messaging during extreme weather.
- Work with local and national media to manage expectations and reduce panic.

Media handling: We will take a proactive approach to media handling and will participate in a press briefing for late November with representatives from organisations across the system. The briefing will be an important opportunity to share how the system is working together to prepare for winter, as well as explain the external factors influencing pressures on the NHS to set expectations. Relationship building through this process will also support our ability to rapidly rebut inaccurate or misleading information. If needs arise, regular Q&A sessions can be established to ensure accurate messaging is featured in media reporting.

Branding: The development of a 'Think Which Service' brand in 2023, ensured a consistent look and feel across campaign messages related to winter, we will utilise this again this year but add to the products with new, engaging content.

Promotion: Whilst the ICB may have a small amount of advertising spend there is no discretionary funds identified at the Trust for any paid content or materials. Whilst this limits the marketing mix in terms of promotion we can still utilise the following channels.

- GP waiting room screens
- Trust and partner social media channels/ websites
- Local news outlets
- Our health and care workforce, volunteers, members and governors
- Local councillors and our networks of community, voluntary and faith-based partners
- Trust estate

Targeting & segmentation: Work is now underway to establish the target messaging and population segmentation. We are working with operational colleagues to understand key data sets to establish the key geographic, demographic and condition related issues that are contributing to the unheralded and inappropriate demands placed on urgent care services. This insight will support us to target our communication efforts at key messages to the right people to shift behaviours.

Example communication material that was demonstrated as successful last winter is planned for use again this year:

Image 1: Think Which Service Black Country branding

Image 2: pharmacy bags

Appendix 6 – Infection Prevention and Control Plan

DGFT will continue to adhere to current up to date Infection Prevention and Control (IPC) guidance, with ongoing emphasis on staff and public compliance with fundamentals such as hand hygiene, bare below the elbow requirements for the staff. This will continue to be closely monitored, and non-compliance addressed. Established audits and monitoring processes will continue to identify any non-compliance early, hence focusing on prevention of infections.

The IPCT will continue daily ward rounds across acute medicine to assist with flow and patient safety, identifying patients who may require isolation and screening.

Screening:

- National guidance for COVID-19 remains unchanged. All respiratory symptomatic patient cases will have a PCR test. Point of Care Testing (POCT) remains within the emergency setting and this is currently led by ED staff. If there is a significant surge in respiratory cases, the service provisions will be reviewed with the medical division.

- Influenza and RSV screening will recommence during the winter period in conjunction with local trends. A specific start date is yet to be agreed (this will include POCT).

Isolation:

- ED/AA isolation – following diagnosis, patients will be moved directly into single sideroom isolation with an ensuite bathroom, patients may be required to be moved to AA to assist with ED flow.

- Patients with the same diagnosis (viral respiratory infections or norovirus) may be co-horted in bays – patients will remain in their current speciality / settings where possible. In the event of a significant surge in respiratory cases, placement of patients maybe specific to an area / ward.

Outbreaks will continue to be declared internally and externally as per the requirement, and meetings will be held in line with PSIRF to identify common themes and learning.

Personal Protective Equipment:

- Viral respiratory infection prevalence is continually monitored. A surge in cases will result in a risk assessment lead by Director of Infection Prevention and Control (DIPC) in relation to FRSM wearing across trust. At present, FRSM is not mandated and is advised on a case-by-case basis.

- Health and Safety team are continually working towards staff being face fit tested – at present all divisions lead of face fit training.

- There are no current or expected supply issues regarding PPE stock.

Cleaning and decontamination:

- Cleaning is continually reviewed alongside trends and a change to chlor clean will be considered for all cleans if there is a surge in infection prevalence or incidence. Correct application of the reviewed cleaning and decontamination policy will be monitored via the Infection Prevention and Control Group and escalated in line with the established process.

Appendix 7: Staff Wellbeing and Support

Ensuring the wellbeing and resilience of our workforce remains a cornerstone of the Trust's Winter Plan. As winter pressures increase demand across the hospital, it is vital that we protect our staff from avoidable stress, burnout and the negative impact of prolonged operational pressure. This section outlines our proactive approach to supporting staff attendance, psychological safety, and sustainable working.

Key Actions for Winter 2025/26:

- **Targeted Wellbeing Communications**
  Regular, concise messages will be shared during peak pressure periods to promote self-care, encourage help-seeking, and signpost to resources. The new Employee Assistance Programme (EAP), which includes access to a dedicated support app, will be central to this campaign.

- **Launch of Enhanced Employee Assistance Programme**
  A new Trust-wide EAP will go live ahead of winter, offering confidential counselling and emotional support to all employees. The service will provide 24/7 access and flexible support channels, including digital options, ensuring timely and responsive help.

- **Drop-In Wellbeing Spaces and Virtual Safe Rooms**
  We will offer staff opportunities to decompress through drop-in wellbeing sessions and virtual "safe spaces." These will enable peer connection, reflection, and psychological decompression during high-pressure periods.

- **Mid-Winter Feedback and Responsive Planning**
  A short staff survey will be conducted mid-winter to understand how teams are coping and whether further support or adaptation is needed. This will allow for a real-time response to emerging issues.

- **Occupational Health Access Improvements**
  We have secured additional OH Physician capacity, meaning staff will experience improved access to appointments and faster, more effective occupational health support.
- **Wellbeing Champions**
  We will continue to develop and grow the network of wellbeing champions across divisions. These staff members provide localised peer support and act as conduits for wellbeing promotion and early escalation of concerns.
- **Promotion of Trust Wellbeing Offer**
  The existing suite of wellbeing tools and resources, available via the staff hub, will be promoted throughout the winter period to ensure high visibility and accessibility.
- **A review of meetings and non urgent admin activity**
  A review of meetings to reduce the length and attendance requirements from front line staff to maximise availability for all to provide front line patient care

These measures reflect our commitment to creating a compassionate, responsive and sustainable workplace. By prioritising staff wellbeing, we strengthen the Trust's ability to maintain safe and effective care throughout the most challenging months of the year.

Appendix 8: Winter Vaccination Plan

The staff vaccination programme will be operational throughout Q3 and Q4 2025/26, and it is not currently clear whether both, COVID-19 and Flu vaccines will be offered. Exact dates and detail of the roll out are yet to be agreed. We are cognisant that vaccine hesitancy affected vaccine uptake during 2024/25 and that current media coverage regarding the COVID-19 vaccine may affect the 2025/26 uptake, if made available.

To ensure high uptake and effective delivery of the winter vaccination programme, the Trust will implement a comprehensive and targeted approach. A bespoke, stand-alone vaccination team will be in place, comprising both substantive staff and bank support, dedicated solely to this programme.

All frontline staff, including those employed through Mitie, will be offered vaccination. A roving team will support accessibility by delivering vaccinations directly within clinical areas and across other Trust sites, reducing the need for staff to leave their work environments.

A robust communications campaign will underpin the programme, clearly outlining the benefits of vaccination—not only for staff themselves, but also for their families and the patients in their care. The campaign will also align with seasonal themes and key events, such as Christmas and Bonfire Night, to promote engagement and increase uptake through special vaccination events.

Progress will be monitored closely, with fortnightly compliance updates shared across the Trust to maintain visibility and momentum. In parallel, we will continue our focus on improving vaccination uptake among pregnant women, particularly in relation to flu and whooping cough, supporting the maternity service's public health responsibilities.

At present, national guidance on the scope of the 2025/26 winter vaccination programme is pending. The Trust will remain responsive to updates, including whether COVID-19 vaccinations will again form part of this year's delivery plan alongside flu.

Appendix 9: Discharge Improvement

Winter places considerable strain on hospital capacity, with increased emergency attendances, higher acuity, and limited flexibility within the system. During the 2024/25 winter period (November 2024 to March 2025), DGFT recorded an average of 122 patients per day delayed despite being medically optimised for discharge. These delays significantly reduced inpatient bed availability, contributing to emergency department overcrowding, prolonged ambulance handovers, and increased use of corridor care. Detailed analysis confirms that the majority of these delays were attributable to internal hospital processes, including therapy reviews, delays in completion of Transfer of Care (TOC) documentation, transport coordination issues, and the timely issuing of TTOs. A small proportion of patients were also inaccurately recorded as MFFD, further complicating visibility and decision-making.

In preparation for winter 2025/26, the Trust is implementing a system-led discharge model, aligned with Home First principles and national NHS guidance. The Care Transfer Hub will serve as the operational anchor for this approach, ensuring real-time oversight of complex discharges, integrated escalation, and a consistent 7-day presence. The core aim is to reduce discharge delays, increase same-day discharge performance, and proactively manage flow pressures across all discharge pathways, working alongside patients Estimated Discharge Date to forward plan.

To strengthen whole-system discharge coordination, the Trust will implement a single community bed tracker for Pathway 2 and 3 capacity, accessible to all partners. This will enable real-time visibility of bed availability, streamline referrals, and ensure estimated discharge dates (EDDs) are jointly monitored and actioned. In parallel, the Trust will continue to utilise its bridging pathway (Subject to funding) to enable same-day Pathway 1 discharges for Dudley patients in collaboration with the Council. Where the discharge teams complete TOC forms and documentation by 2pm, same-day discharge will be facilitated. This will reduce unnecessary internal waits, minimise weekend discharge backlogs, and improve the patient and family experience.

The Care Transfer Hub will operate 7 days per week, providing consistent multidisciplinary oversight of patients who are ready for discharge. The key operational priority will be the elimination of hospital process-related delays, which remain the most frequent cause of extended stays—accounting for an average of 18–24 patients per day in winter 2024/25. These delays often result from inconsistent pre discharge planning, delayed TTOs, transport bottlenecks, and incomplete documentation. If the Trust is able to eliminate this component of delay, it is estimated that approximately 18–20 inpatient beds could be released each day, creating vital capacity during the most pressured months. This will directly support safer patient care, improved ambulance flow, and greater resilience across the emergency care pathway. Key metrics will be monitored through the Care Transfer Hub dashboard and aligned with Better Care Fund (BCF) indicators to ensure consistency across the Dudley Place and wider system.

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Workforce KPI Report
May 2025

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Summary

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Metric	Rate	Target	Trend	
Absence – In Month	4.59%	<=5%	↓	**Sickness Absence** In-month sickness absence for May is 4.59% which is a decrease from 5.16% in April 2025. The rolling 12-month absence has decreased to 5.33% in May 2025 from 5.37% April 2025.
Absence - 12m Rolling	5.33%	<=5%	↓	
Turnover	7.16%	<=8%	↓	**Turnover** Turnover (all terminations) has decreased from 7.21% in April 2025 to 7.16% in May 2025. Normalised Turnover has increased from 3.03% in April 2025 to 3.08% in May 2025. Turnover (all terminations) is all terminations from the organisation. Normalised Turnover focuses on voluntary resignations and excludes dismissals, fixed-term contracts, redundancy, retirement and rotations.
Normalised Turnover	3.08%	<=5%	↑	
Retention (12 month)	92.04%	>=80%	=	**Retention** The 12-month retention rate has remained static at 92.4%.
Vacancy Rate	7%	<=7%	=	**Vacancy Rate** Vacancy rates in April were reported at 7% and the rate has remained static for May 2025 at 7%.
Mandatory Training	92.046 %	>=90%	↑	**Mandatory Training** Statutory Training increased from 90.96% in April 2025 to 92.04% in May 2025. Overall, it has remained above 90% target for a sustained period.

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Exceptions/Improvement/Actions

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METRIC	SUMMARY
Sickness	In-month sickness absence has reduced for the second month running and in May 2025 the in-month absence rate is lower than the Trust target of 5%. The rolling sickness absence figure continues to be above Trust target but has started to decrease in small amounts. If the Trust can sustain a lower sickness absence rate across the year the rolling 12-month absence figure should see an improved position. The taskforce group continues to work towards the action plan in place to reduce sickness absence.
Statutory and Mandatory training	Performance overall remains stable and above target although three subjects are red rated as are below 80%. Divisional Deep Dives are being presented during May-July to provide detailed recovery plans and mitigations in Divisions. Safeguarding Children Level 3 remains a concern as drop-offs during March have continued. This is an area of risk as it is a key element in any CQC monitoring. At system level, compliance is measured at 80% and performance is slightly below. Work has commenced with target communication to those currently non-compliant/persistently non-compliant.
Annual Reviews	The Annual Review window has now commenced (1st April – 30th June) and performance is currently 54%. Follow up with Divisions is underway to ensure they have plans in place to ensure the performance target of 90% is achieved by the end of June.

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Sickness Absence

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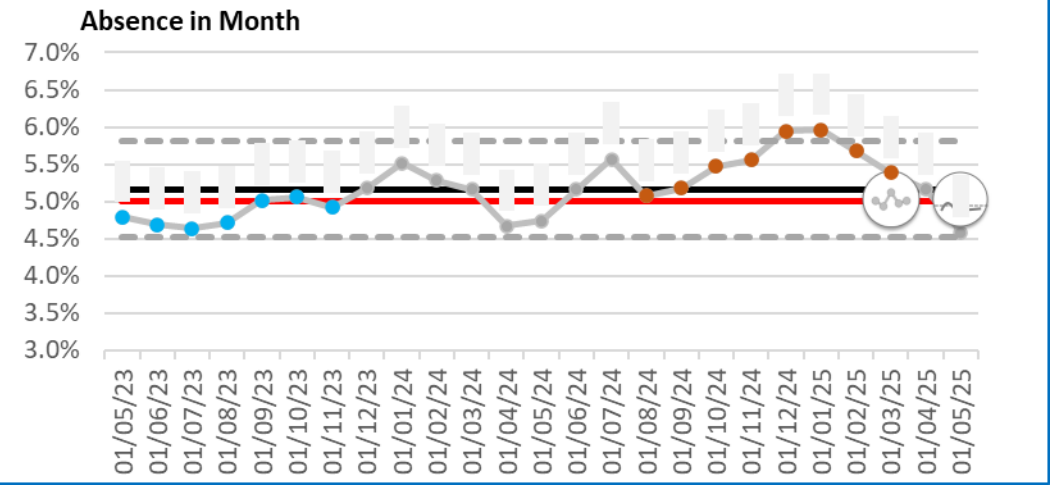
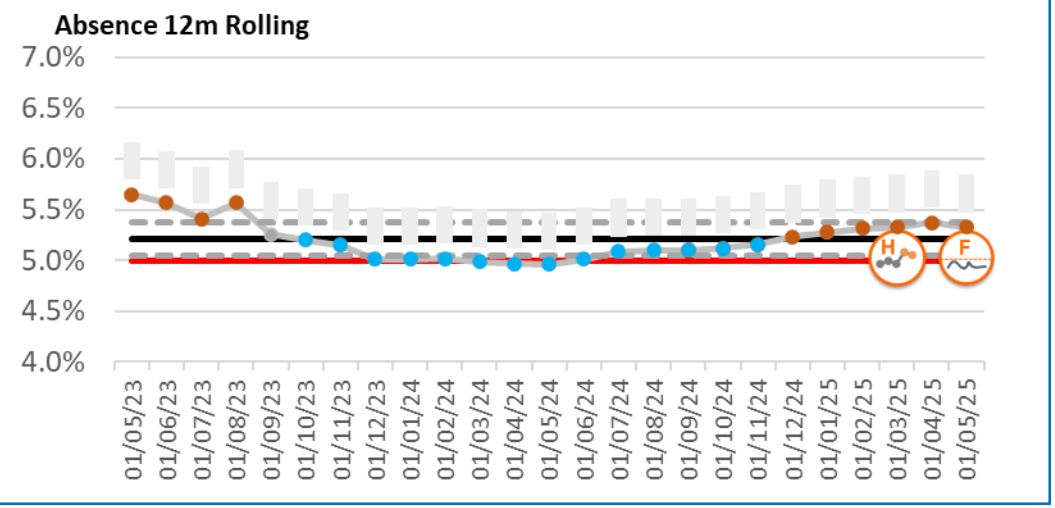




In-Month Sickness Absence

In-month sickness absence for May 2025 is 4.59%, a decrease from 5.16% in April 202.

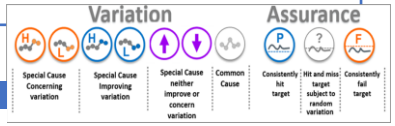
Rolling 12 M Sickness Absence

The rolling 12-month absence for May 2025 is 5.33%, a decrease from 5.37% in April 2025.

Assurance

There are a number of mitigations currently in place to support the continued reduction of absence:

- Recording sickness absence training launched in March with further dates scheduled in May.
- Supporting attendance workstream continues with a number of actions to work across teams to support managers and staff including manager toolkits, review of sickness absence policy and a review of recording of sickness absence on ESR.
- Hot spot areas – work continues with the three identified areas for short-term sickness each month. The HR team are auditing processes within the areas to ensure early intervention and timely management of long-term sickness cases.



	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25
Absence in Month	5.16%	5.57%	5.08%	5.18%	5.47%	5.56%	5.95%	5.96%	5.68%	5.39%	5.16%	4.59%
Absence 12m Rolling	5.01%	5.09%	5.10%	5.10%	5.12%	5.16%	5.23%	5.28%	5.31%	5.33%	5.37%	5.33%

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Long-Term and Short-Term Absence

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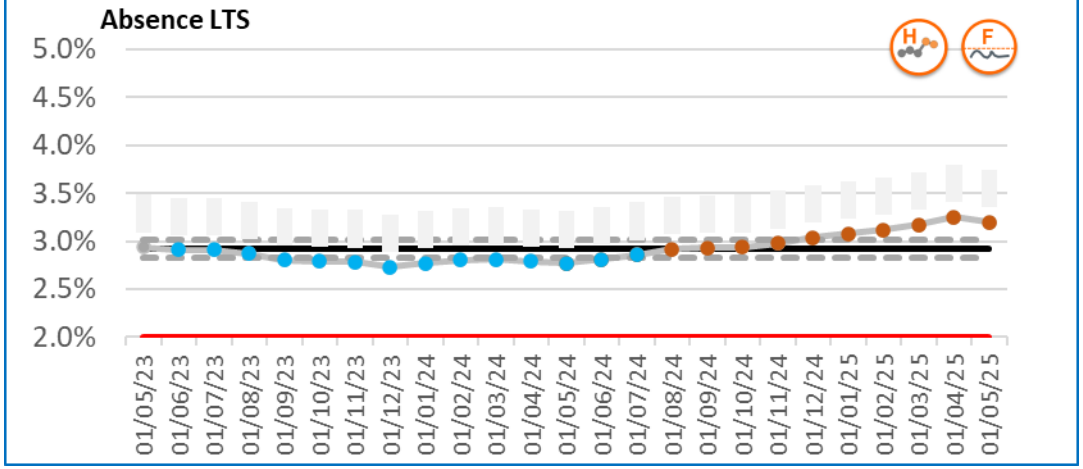

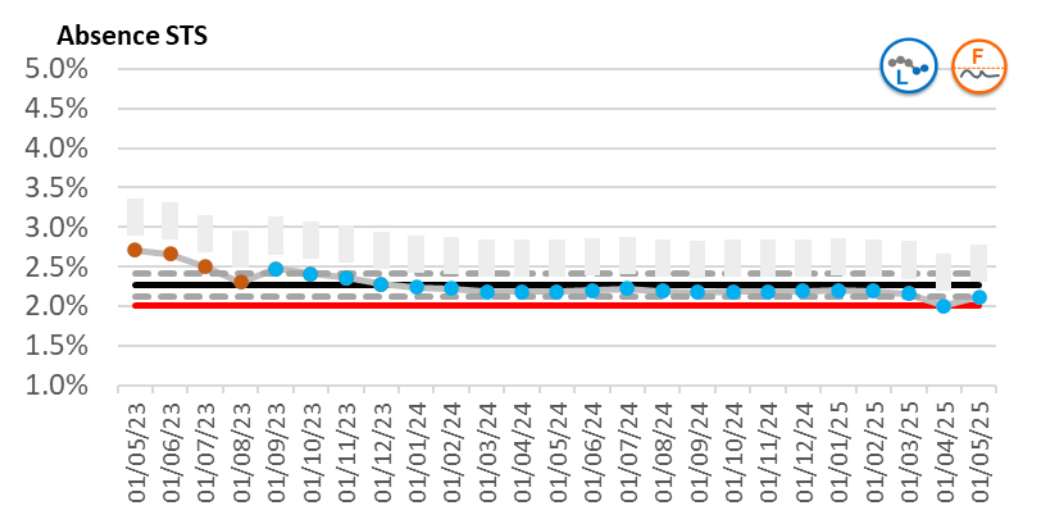

Long-term sickness absence has decreased to 3.20% in May 2025 from 3.25% in April 2025. Short-term has increased slightly to 2.12% in May 2025 from 2.00% in April 2025.

In May 2025 short-term absence accounted for 81% of all sickness absence episodes, with long-term absence (28 days +) accounting for 19% of absence episodes. Long-term absence accounted for 57% of all FTE days lost.

As of end May 2025 there were 154 long-term absences open across the Trust which is a reduction of 5 from April 2025.

- 130 cases are between 28 days and 6 months
- 20 cases between 6 months and 12 months
- 4 cases over 12 months in length

What next

- Education and training for managers on recording sickness absence continues working alongside managers to ensure return to work interviews are being completed in a timely manner and recorded.
- Develop and launch sickness absence page on the new Hub with useful resources and linked to wellbeing pages also.
- Continue to work with the next hot spot areas to develop bespoke intervention packages where needed.

	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25
Absence LTS	2.81%	2.86%	2.92%	2.93%	2.94%	2.98%	3.04%	3.08%	3.12%	3.17%	3.25%	3.20%
Absence STS	2.20%	2.22%	2.19%	2.17%	2.18%	2.18%	2.19%	2.20%	2.19%	2.16%	2.00%	2.12%

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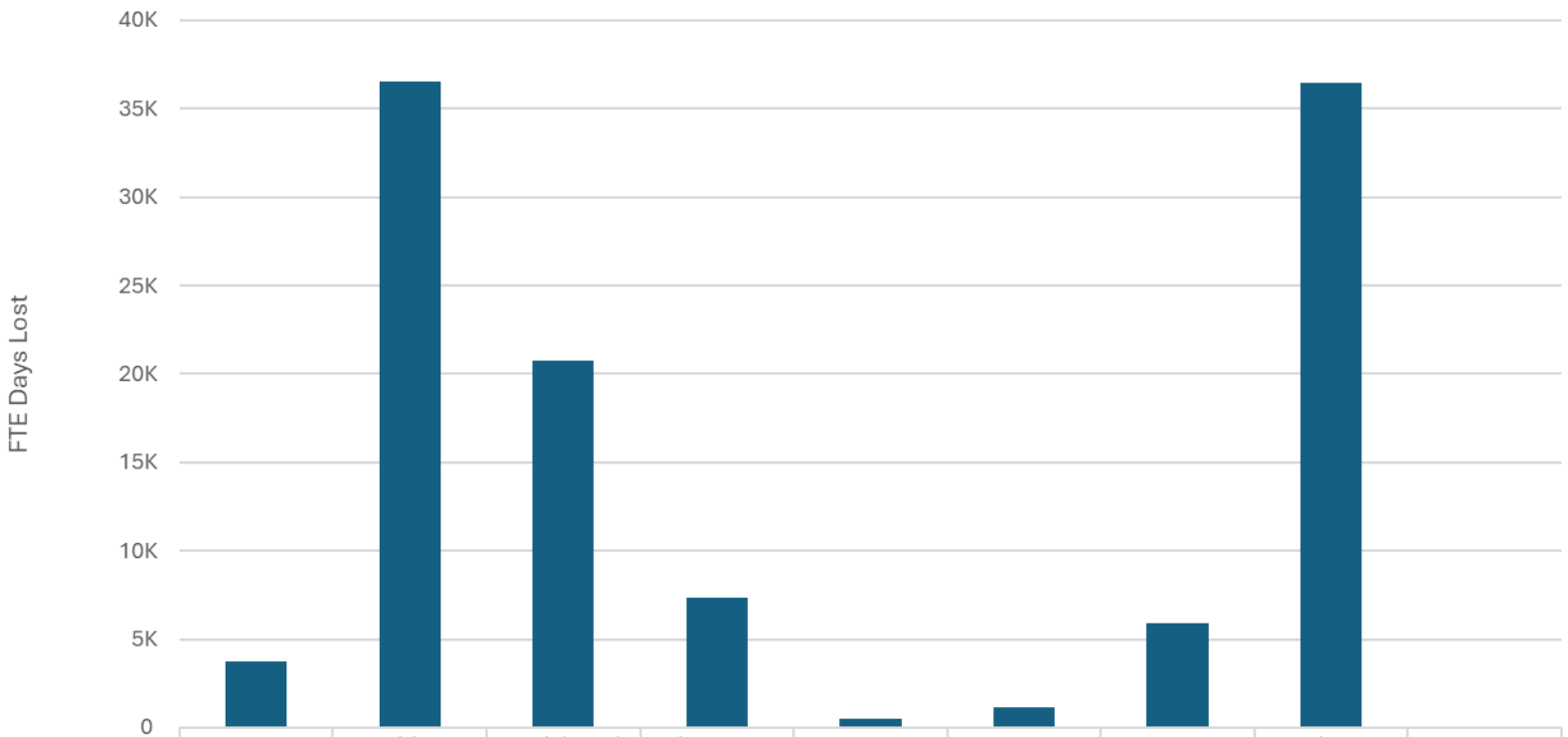
Sickness Absence – Staff Groups

The Dudley Group NHS Foundation Trust



	Add Prof Scientific and Technic	Additional Clinical Services	Administrative and Clerical	Allied Health Professionals	Estates and Ancillary	Healthcare Scientists	Medical and Dental	Nursing and Midwifery Registered	Students
Absence FTE	3,774.07	36,514.81	20,722.18	7,345.39	475.76	1,173.77	5,889.26	36,454.39	42.00

Year-to-date Nursing and Midwifery and Additional Clinical Services have lost the most FTE days as a result of sickness absence. Proportionately admin and clerical staff have a high rate of sickness absence.

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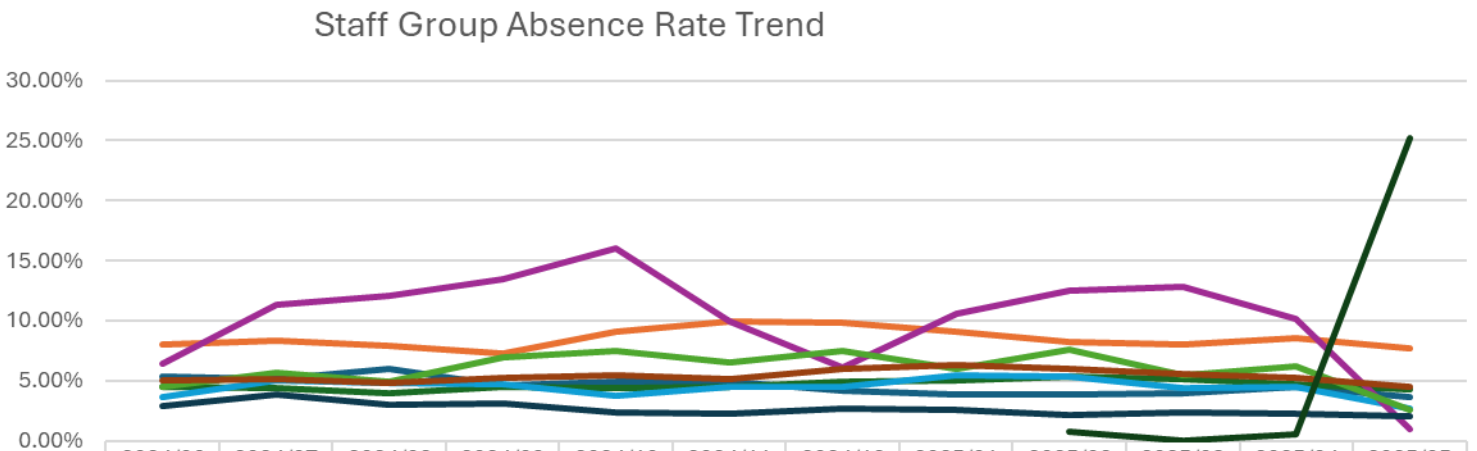
Sickness Absence – Staff Groups

The Dudley Group NHS Foundation Trust



	2024/06	2024/07	2024/08	2024/09	2024/10	2024/11	2024/12	2025/01	2025/02	2025/03	2025/04	2025/05
Add Prof Scientific and Technic	5.37%	5.14%	5.97%	4.61%	4.89%	4.91%	4.18%	3.88%	3.88%	3.99%	4.46%	3.61%
Additional Clinical Services	7.98%	8.35%	7.86%	7.22%	9.08%	9.90%	9.84%	9.07%	8.19%	7.97%	8.57%	7.71%
Administrative and Clerical	4.53%	4.34%	3.93%	4.47%	4.42%	4.52%	4.91%	5.06%	5.32%	5.10%	4.74%	4.27%
Allied Health Professionals	3.63%	5.05%	4.76%	4.73%	3.70%	4.49%	4.49%	5.43%	5.37%	4.37%	4.45%	2.69%
Estates and Ancillary	6.46%	11.28%	12.10%	13.45%	16.07%	9.89%	6.05%	10.53%	12.55%	12.83%	10.13%	1.01%
Healthcare Scientists	4.47%	5.67%	4.93%	6.98%	7.44%	6.56%	7.44%	6.01%	7.60%	5.48%	6.15%	2.61%
Medical and Dental	2.92%	3.89%	2.96%	3.09%	2.37%	2.22%	2.67%	2.59%	2.14%	2.39%	2.21%	2.00%
Nursing and Midwifery Registered	4.99%	5.12%	4.82%	5.24%	5.42%	5.12%	5.99%	6.30%	5.97%	5.54%	5.28%	4.53%
Students									0.71%	0.00%	0.55%	25.16%

In May 2025 absence rates for all staff groups decreased except for students, which increased from 0.55% to 25.16%. Students are small in terms of FTE and headcount and one long-term sickness case is affecting this rate.

The biggest decrease was Estates and Ancillary which. All staff groups are below the Trust target of 5% except students and Additional Clinical Services.

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Reason for Absence

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Top 10 Absence Reasons by FTE Days Lost

Absence Reason	Headcount	Abs Occurrences	FTE Days Lost	%
S10 Anxiety/stress/depression/other psychiatric illnesses	795	1,018	26,372.50	23.5
S13 Cold, Cough, Flu - Influenza	2508	3,366	12,436.89	11.1
S25 Gastrointestinal problems	2206	3,081	11,875.69	10.6
S12 Other musculoskeletal problems	559	713	10,264.90	9.1
S99 Unknown causes / Not specified	659	851	7,096.95	6.3
S30 Pregnancy related disorders	286	712	5,640.19	5.0
S28 Injury, fracture	224	238	5,616.44	5.0
S11 Back Problems	355	410	5,311.13	4.7
S26 Genitourinary & gynaecological disorders	383	492	5,204.35	4.6
S17 Benign and malignant tumours, cancers	41	57	3,221.05	2.9

Top 10 Absence Reasons by Absence Days

Absence Reason	Headcount	Abs Occurrences	Abs Days	%
S10 Anxiety/stress/depression/other psychiatric illnesses	795	1,018	31,505	24.0
S13 Cold, Cough, Flu - Influenza	2508	3,366	14,189	10.8
S25 Gastrointestinal problems	2206	3,081	13,508	10.3
S12 Other musculoskeletal problems	559	713	12,209	9.3
S99 Unknown causes / Not specified	659	851	8,435	6.4
S28 Injury, fracture	224	238	6,854	5.2
S30 Pregnancy related disorders	286	712	6,294	4.8
S11 Back Problems	355	410	6,229	4.7
S26 Genitourinary & gynaecological disorders	383	492	6,085	4.6
S17 Benign and malignant tumours, cancers	41	57	3,699	2.8

- Anxiety/Stress/Depression/Other Psychiatric illness continues to be the top reason for absence that causes the greatest number of FTE days lost and Cough Cold Flu is the second highest reason.
- Cough, Cold, Flu is the top reason for absence that has the highest number of occurrences followed by gastrointestinal problems.
- The taskforce groups are working with areas that have high short-term sickness absence and reducing the number of episodes through ensuring managers have the tools, support and resources to manage sickness absence at the earliest opportunity.

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Absence Benchmarking

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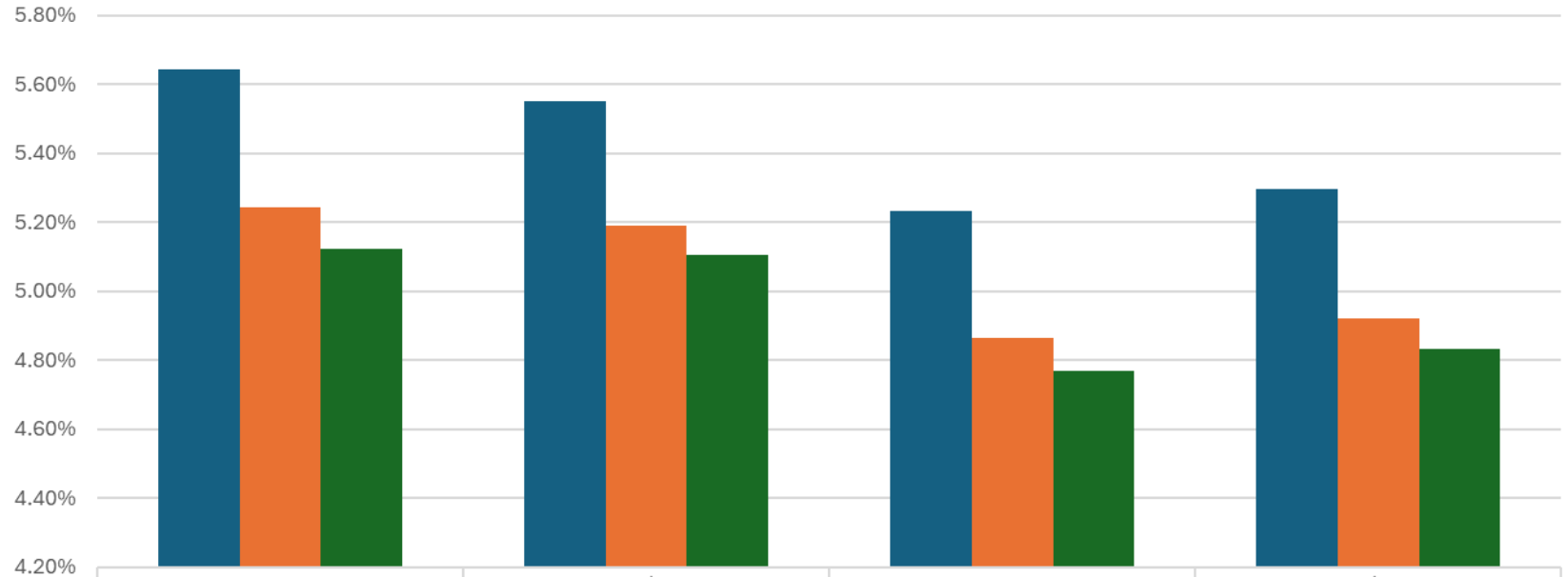

	Trust	Region	Country	National
MO11	5.64%	5.55%	5.23%	5.30%
MO12	5.24%	5.19%	4.86%	4.92%
MO01	5.12%	5.11%	4.77%	4.83%

- National and Regional benchmarking data is only available until end of April2025.
- Due to local differences in timeframes and methods used for recording sickness absences, national and regional comparative data is subject to change. DGFT absence includes COVID related absences and is refreshed each month twelve months in arrears.
- In April 2025 (M01) the Trust's sickness absence rate was higher than the Region, Country and Nationally.

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Recruitment/Vacancies/Turnover - TRUST

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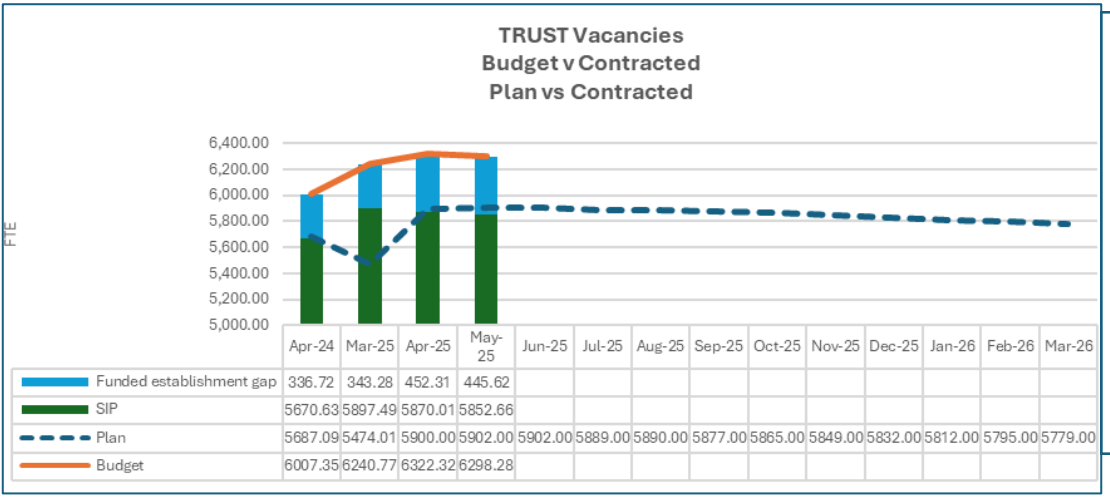
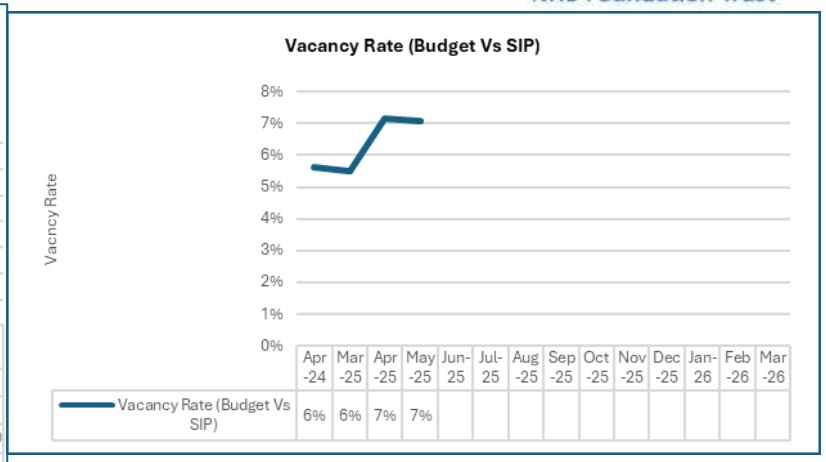
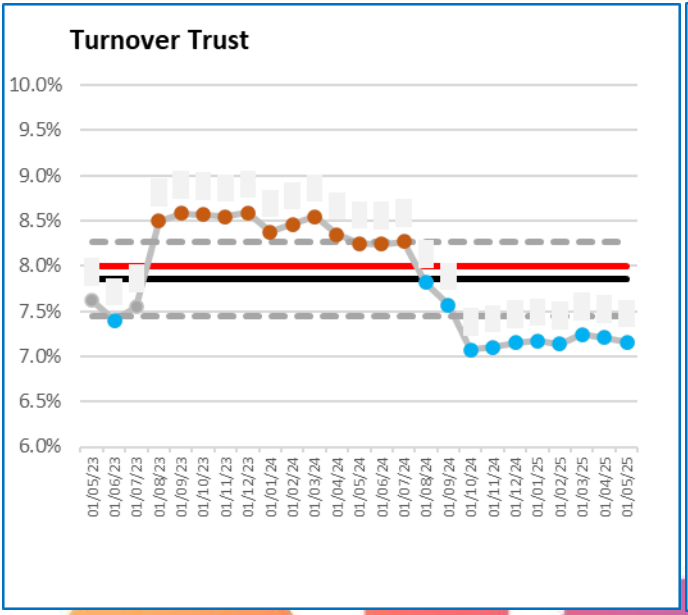
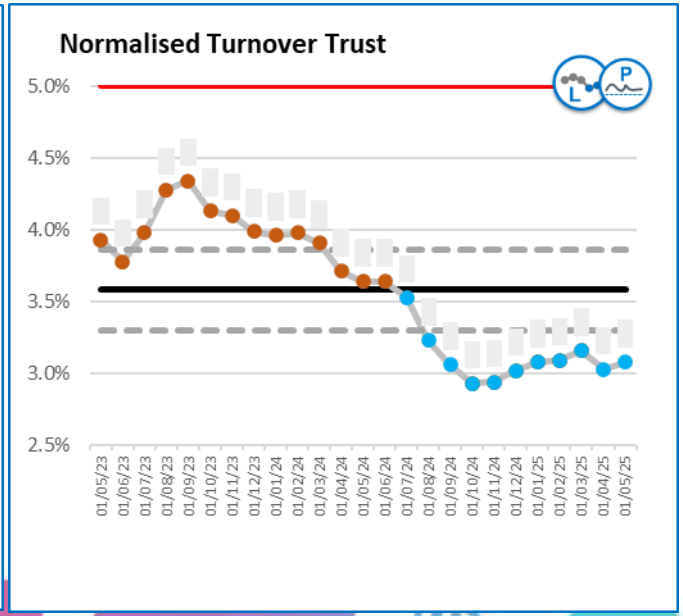


	Apr-24	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Funded establishment gap	336.72	343.28	452.31	445.62										
SIP	5670.63	5897.49	5870.01	5852.66										
Plan	5687.09	5474.01	5900.00	5902.00	5902.00	5889.00	5890.00	5877.00	5865.00	5849.00	5832.00	5812.00	5795.00	5779.00
Budget	6007.35	6240.77	6322.32	6298.28										



	Apr -24	Mar -25	Apr -25	May -25	Jun- 25	Jul- 25	Aug -25	Sep -25	Oct -25	Nov -25	Dec -25	Jan- 26	Feb -26	Mar -26
Vacancy Rate (Budget Vs SIP)	6%	6%	7%	7%										





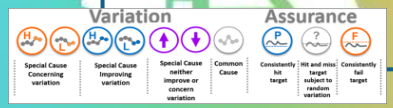
Contracted WTE staff has reduced from 5870.01 in April 2025 to 5852.66 WTE in May 2025.

For substantive staff this is 49.34 WTE below the workforce plan (less staff than we said we would have).

Total vacancies stand at 445.62 WTE in May 2025. This equates to a vacancy rate of 7%.

Overall staff turnover (rolling twelve months average) is at 7.16% with normalised turnover at 3.08% in May 2025.

	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25
Trust Turnover	8.24%	8.27%	7.82%	7.57%	7.07%	7.10%	7.15%	7.17%	7.14%	7.24%	7.21%	7.16%
Trust Normalised Turnover	3.64%	3.53%	3.23%	3.06%	2.93%	2.94%	3.02%	3.08%	3.09%	3.16%	3.03%	3.08%



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Recruitment/Vacancies/Turnover - Registered Nursing & Midwifery

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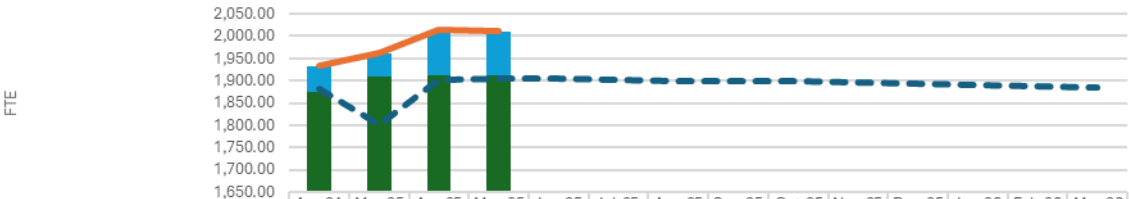
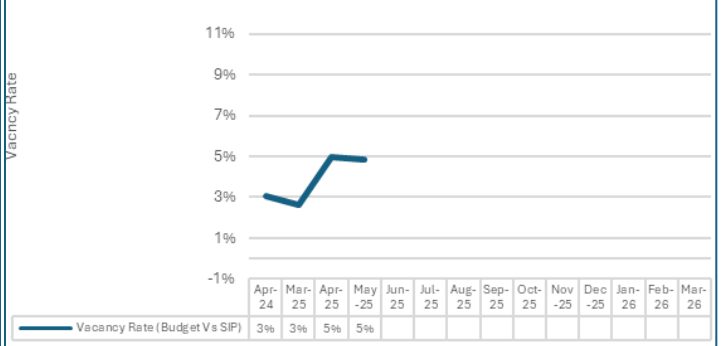
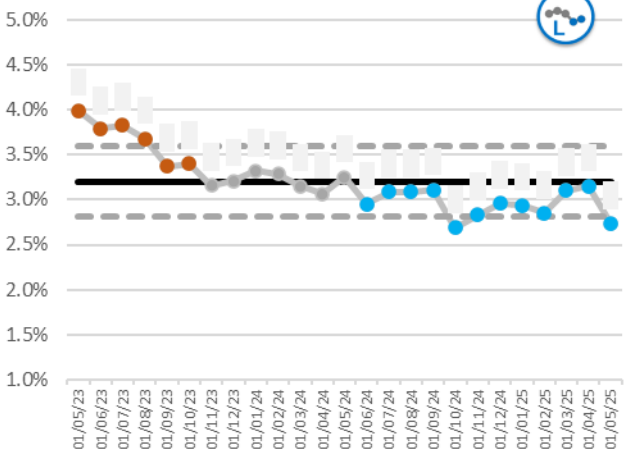
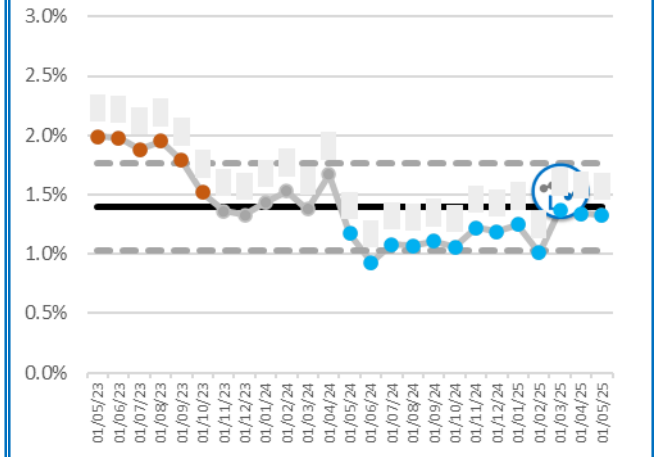


	Apr-24	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Funded establishment gap	59.13	51.55	100.61	97.69										
SIP	1874.52	1910.33	1912.45	1912.78										
Plan	1882.66	1800.56	1903.00	1904.00	1904.00	1902.00	1900.00	1898.00	1899.00	1896.00	1893.00	1890.00	1887.00	1884.00
Budget	1933.65	1961.88	2013.06	2010.47										



	Apr-24	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Vacancy Rate (Budget Vs SIP)	3%	3%	5%	5%										





Contracted WTE for nursing and midwifery staff in May 2025 was 1912.78 WTE, compared with 1912.45 WTE in April 2025.

This is 8.78 WTE above the workforce plan (more staff than we said we would have).

The total nursing and midwifery vacancies reported stands at 97.69 WTE, which equates to a vacancy rate of 5%.

Staff turnover for nursing (rolling 12 months average) is at 2.73%, with normalised turnover at 1.33% in May 2025.

	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25
Nursing Turnover	2.95%	3.09%	3.09%	3.11%	2.69%	2.83%	2.96%	2.94%	2.85%	3.10%	3.15%	2.73%
Nursing Normalised Turnover	0.93%	1.08%	1.07%	1.11%	1.06%	1.22%	1.19%	1.25%	1.01%	1.37%	1.34%	1.33%

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Recruitment/Vacancies/Turnover - Medical & Dental

NHS
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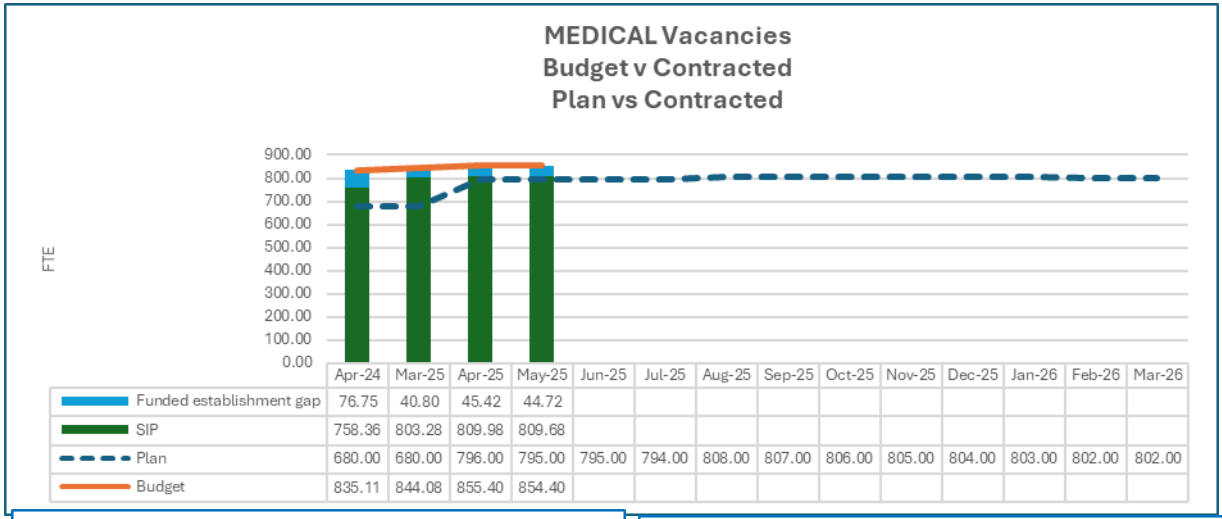
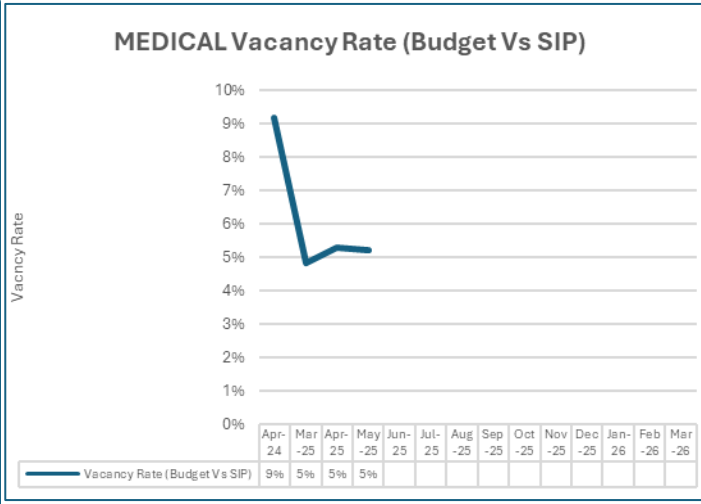
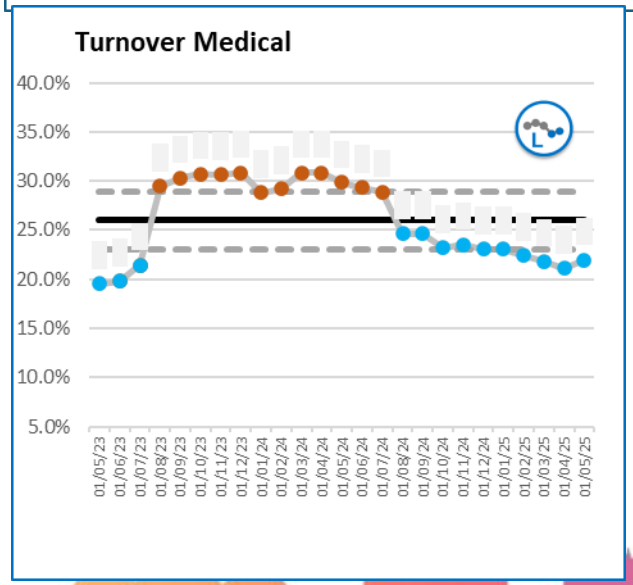
NHS Foundation Trust

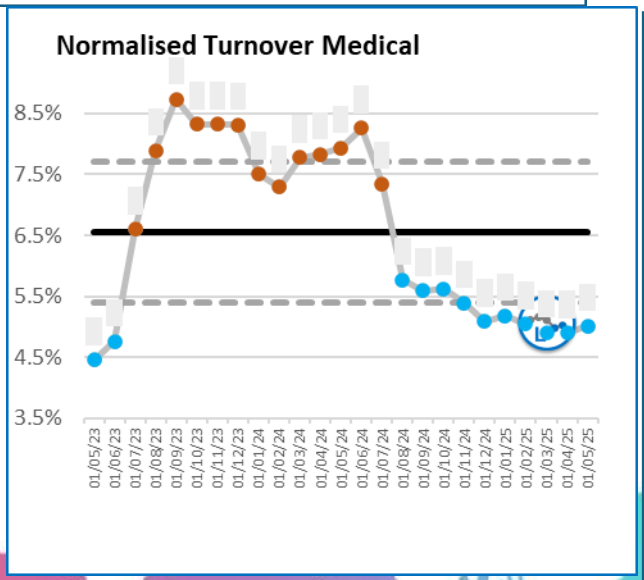


	Apr-24	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Funded establishment gap	76.75	40.80	45.42	44.72										
SIP	758.36	803.28	809.98	809.68										
Plan	680.00	680.00	796.00	795.00	795.00	794.00	808.00	807.00	806.00	805.00	804.00	803.00	802.00	802.00
Budget	835.11	844.08	855.40	854.40										



	Apr-24	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Vacancy Rate (Budget Vs SIP)	9%	5%	5%	5%										





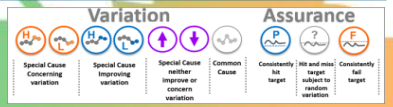
Contracted WTE for medical and dental staff in May 2025 was 809.68 WTE compared with 809.98 WTE in April 2025.

This is 14.68 WTE less staff when compared with the workforce plan.

The total medical and dental vacancies stands at 44.72 WTE. The vacancy rate is 5%.

Staff turnover for medical and dental (rolling 12 months average) is 21.96% with normalised turnover at 5.02%. It should be noted that Deanery rotations are included in overall turnover.

	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25
M&D Turnover	29.34%	28.86%	24.64%	24.66%	23.21%	23.53%	23.08%	23.09%	22.43%	21.83%	21.13%	21.96%
M&D Normalised Turnover	8.26%	7.35%	5.77%	5.59%	5.62%	5.39%	5.09%	5.18%	5.05%	4.91%	4.90%	5.02%



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Recruitment/Vacancies/Turnover - Allied Health Professional

NHS
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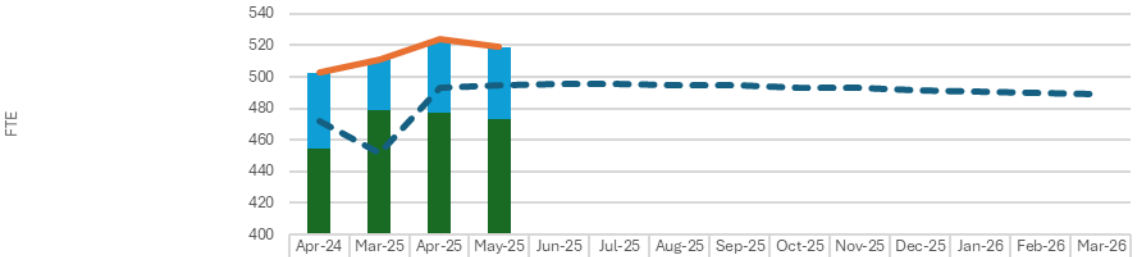
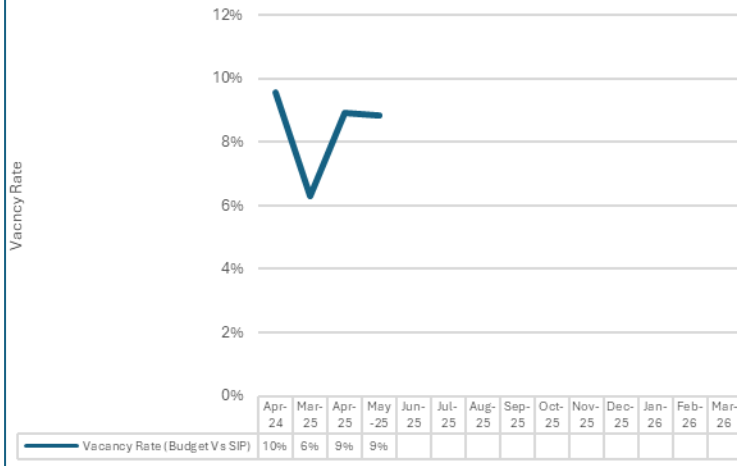
NHS Foundation Trust

AHP Vacancies
Budget v Contracted
Plan vs Contracted



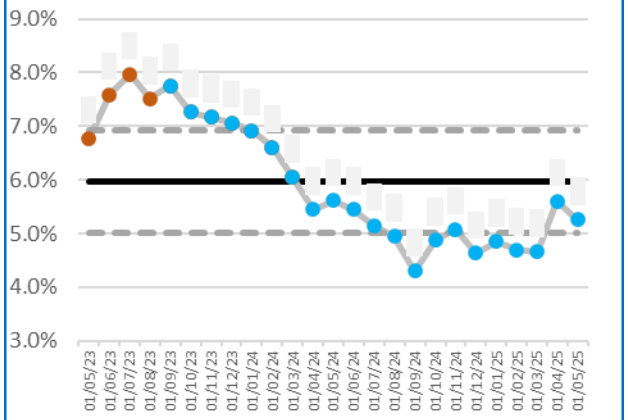
	Apr-24	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Funded establishment gap	48.14	32.25	46.69	45.79										
SIP	454.38	478.95	476.89	473.08										
Plan	471.59	451.22	493.4	494.7	495.3	495.3	494.7	494.7	493.4	492.8	491.5	490.9	489.6	489.3
Budget	502.52	511.20	523.58	518.87										

AHP Vacancy Rate (Budget Vs SIP)

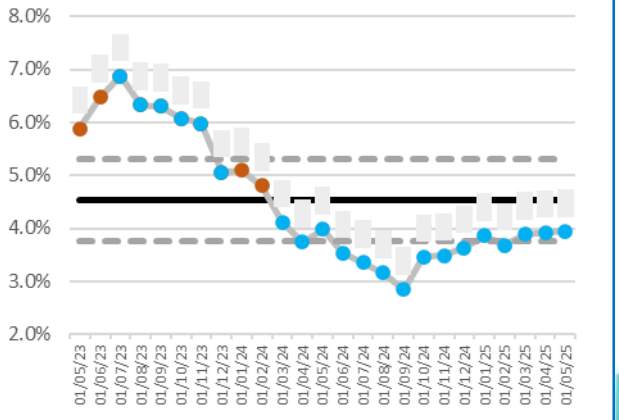


	Apr-24	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Vacancy Rate (Budget Vs SIP)	10%	6%	9%	9%										

Turnover AHP



Normalised Turnover AHP

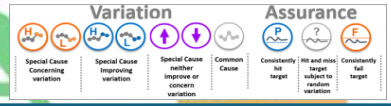


Contracted WTE for AHP's in May 2025 was 473.08 WTE compared with 476.89 WTE in April 2025

This is 21.62 WTE below the workforce plan (less staff than we said we would have).

The total AHP vacancies in May 2025 is 45.79 WTE this is a vacancy rate of 9%.

Staff turnover for AHP's (rolling 12 months average) is 5.26%, the normalised turnover is 3.94%.



	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25
AHP Turnover	5.45%	5.15%	4.95%	4.30%	4.87%	5.08%	4.63%	4.85%	4.70%	4.66%	5.60%	5.26%
AHP Normalised Turnover	3.53%	3.35%	3.16%	2.85%	3.46%	3.49%	3.63%	3.86%	3.68%	3.89%	3.92%	3.94%

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Starters and Leavers

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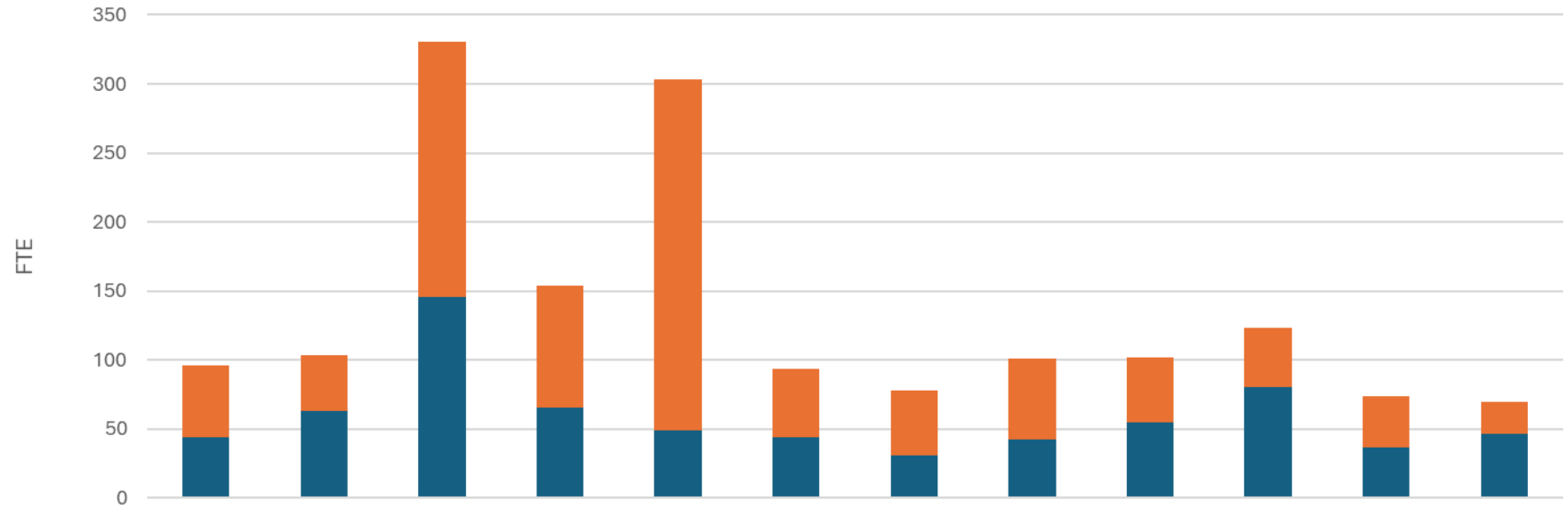

	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25
Starters FTE	52.59	40.54	184.76	88.73	254.59	49.03	46.87	58.71	47.06	42.88	37.33	23.49
Leavers FTE	43.66	62.61	145.51	65.12	48.58	44.25	30.94	42.05	54.63	80.42	36.07	46.12

Starters vs Leavers

- This month we have seen more leavers than starters in May 2025.

Assurance

- The Trust's recruitment and retention journey is now ratified and will be socialised through a new sub-group of People Committee. However, recruitment to roles continues to be subject to grip and control / Vacancy Control measures, which means a greater emphasis on retention.

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Retention

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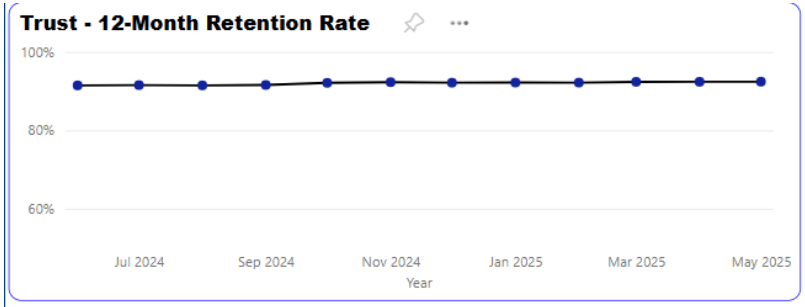

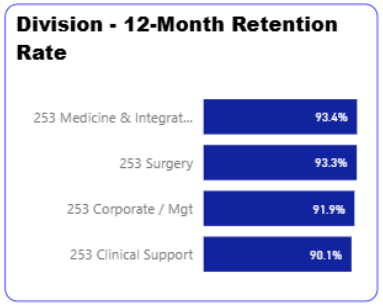

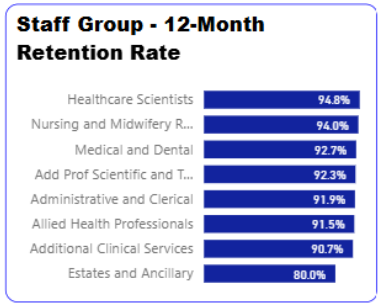

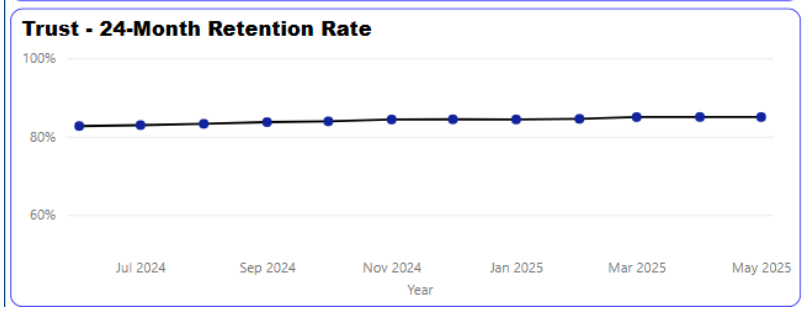

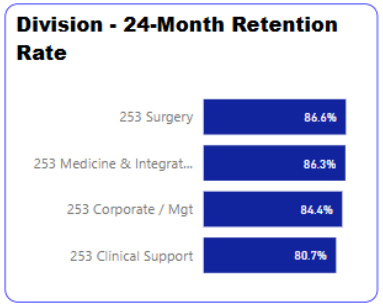

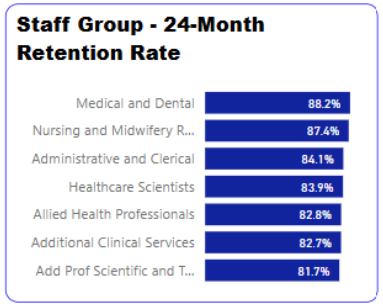

May 2025

12-Month	Trust 92.4%
24-Month	Trust 85.0%

The retention rate has remained static at 92.4% in May 2025.

The division with the lowest 24-month retention rate is CCCS at 80.7% and both Additional Professional, Scientific and Technical staff and Additional Clinical Services are two staff groups with the lowest retention rates. Additional Clinical Services has declined in its retention rate from previous months' reporting.

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Employee Relations

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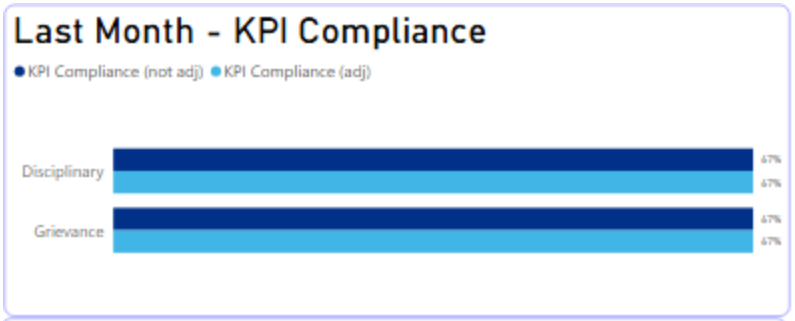

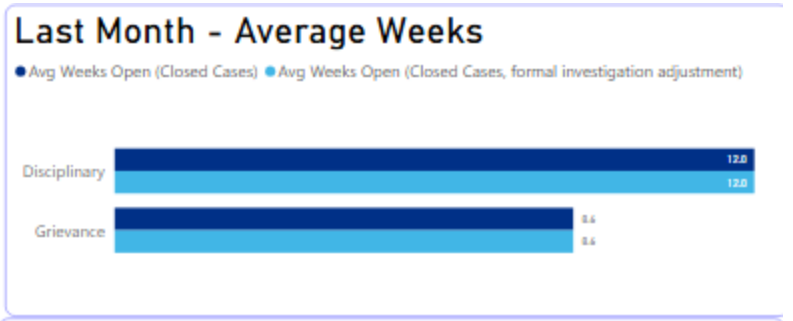

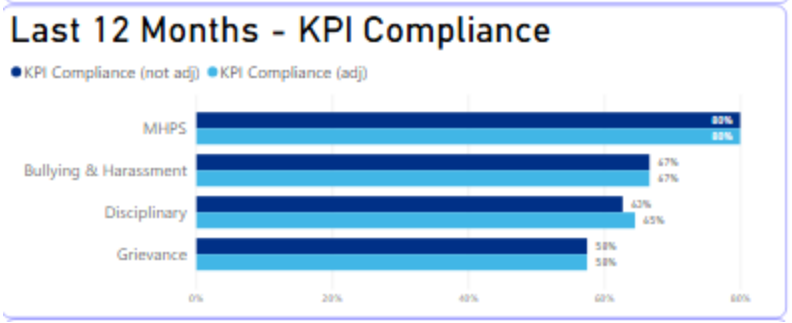

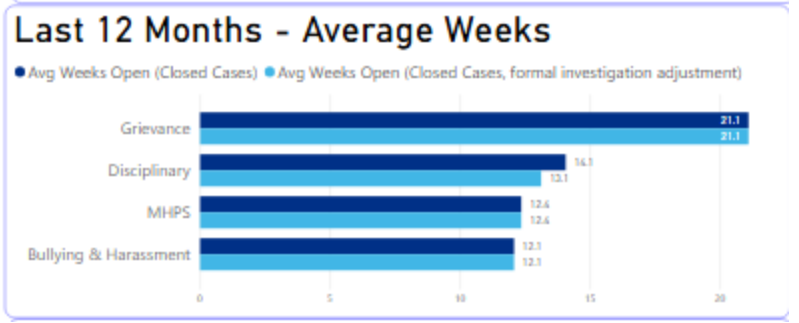

Our lowest compliance with investigation timescale KPI's is grievance at 58% compliance over the last twelve months and grievances now (on average) take the longest time to complete an investigation at 21.1 weeks. However, last month the average weeks to close a grievance dropped to 8.4 weeks.

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Bank and Agency use

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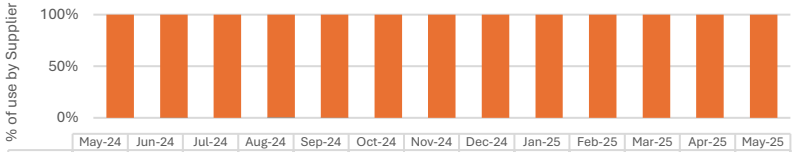
NHS Foundation Trust

Agency (actual use) by Framework Type

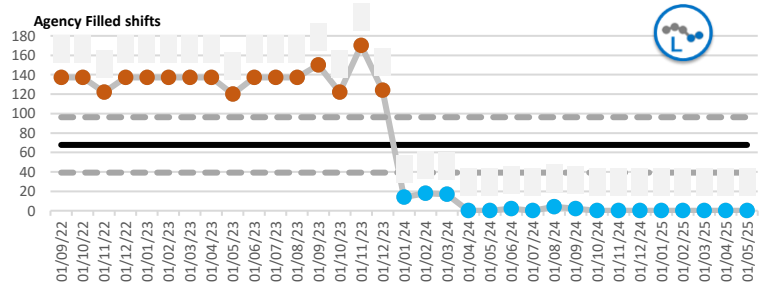


	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25
Bank	100.00%	99.98%	100.00%	99.50%	99.98%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Agency	0.00%	0.02%	0.00%	0.50%	0.20%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%

Agency - Filled / Unfiled

	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25
Unfilled Shifts	0	2	0	0	0	0	0	0	0	0	0	0	0
Filled shifts	0	2	0	4	2	0	0	0	0	0	0	0	0

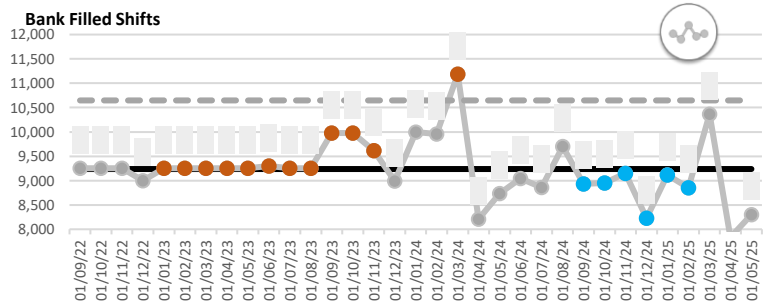
Agency Filled shifts



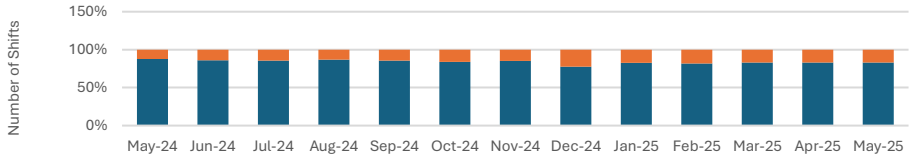
Bank v Agency (actual use) by Supplier Type

	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25
NFW	0	0	0	0	0	0	0	0	0	0	0	0	0
FW	0	2	0	4	2	0	0	0	0	0	0	0	0

Bank Filled Shifts



Bank - Filled / Unfiled



	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25
Unfilled Shifts	12%	14%	15%	13%	14%	16%	15%	22%	17%	18%	17%	17%	17%
Filled Shifts	88%	86%	85%	87%	86%	84%	85%	78%	83%	82%	83%	83%	83%

The Bank fill rate continues to be above the 80% target with May 2025 fill rate reported as 83%.
No agency has been used for non-medical since September 2024.

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Bank use by staff group

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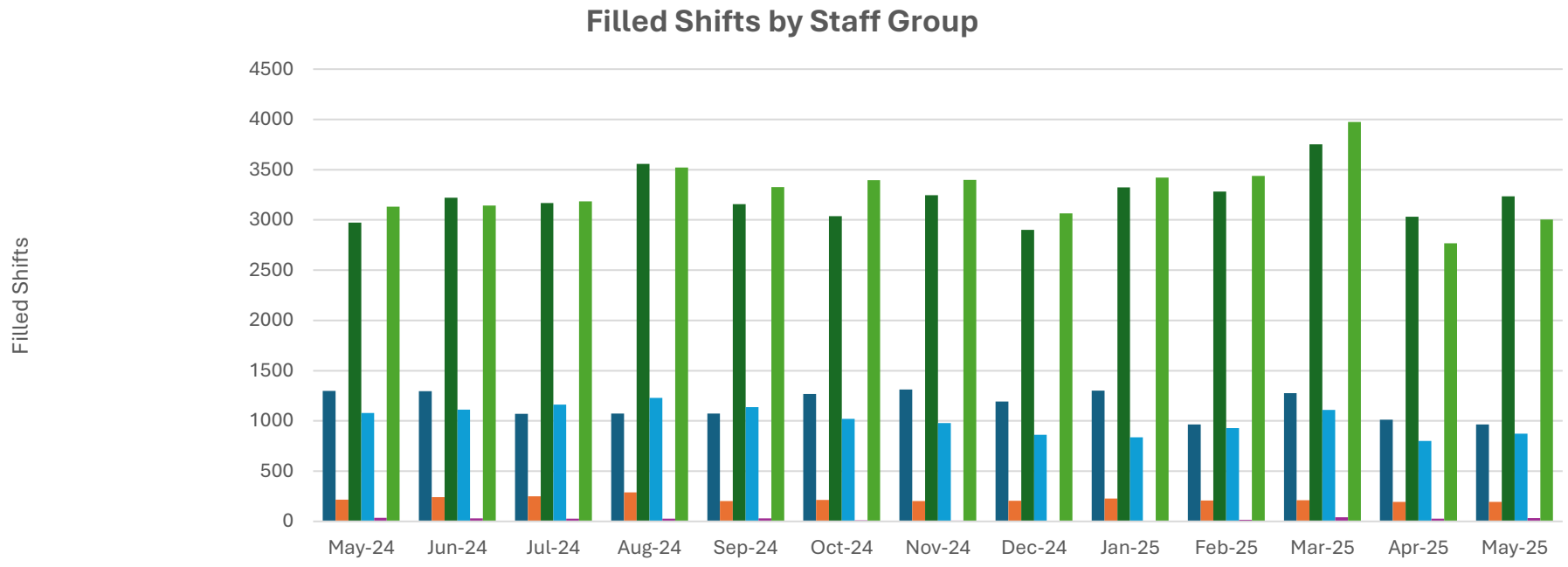

	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25
A&C	1299	1296	1069	1073	1073	1268	1312	1193	1300	965	1276	1013	965
Add Prof Scientific and Technic	215	242	249	288	202	213	202	206	228	209	211	195	194
Additional Clinical Services	2972	3221	3168	3558	3156	3036	3247	2901	3323	3283	3753	3032	3234
AHP	1078	1111	1161	1229	1138	1019	979	861	838	929	1110	800	872
Healthcare Scientists	36	30	28	28	31	11	8	4	4	17	40	26	33
Nursing & Midwifery Registered	3131	3144	3184	3522	3326	3396	3400	3065	3420	3437	3975	2768	3004

In May 2025, there was an increase in the number of hours worked by Additional Clinical Services AHP, Healthcare Scientists and Nursing and Midwifery registered.

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Bank fill rates

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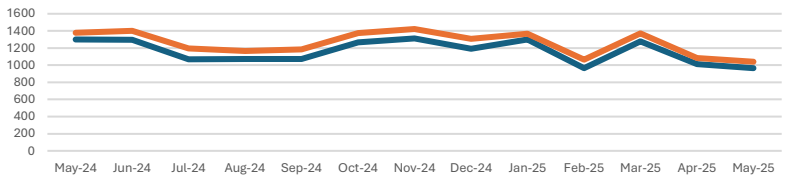
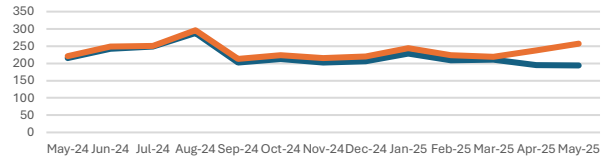
NHS Foundation Trust

Bank A&C Filled / Requested



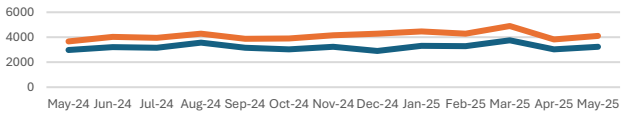
	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25
A&C Filled	1299	1296	1069	1073	1072	1268	1312	1193	1300	965	1276	1013	965
Total Request	1377	1401	1194	1166	1184	1373	1422	1308	1368	1065	1372	1084	1040

Bank Add Prof Scientific and Technic Filled / Requested



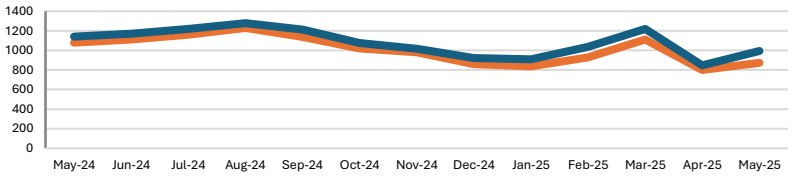
	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25
Add Prof Scientific and Technic Filled	215	242	249	288	202	213	202	206	228	209	211	195	194
Total Request	221	249	251	296	213	224	215	220	244	224	219	238	257

Additional Clinical Services Filled / Requested



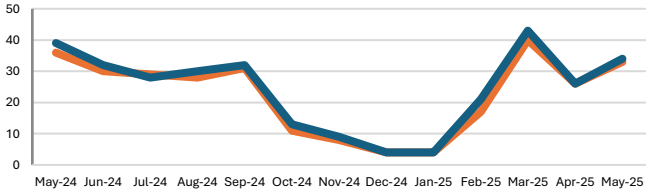
	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25
Additional Clinical Services Filled	2972	3221	3168	3558	3156	3036	3247	2901	3323	3283	3753	3032	3234
Total Request	3667	4019	3959	4293	3870	3904	4158	4275	4464	4289	4899	3820	4095

AHP - Filled / Requested



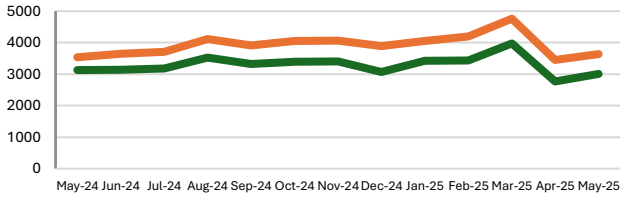
	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25
AHP Filled	1078	1111	1161	1229	1138	1019	979	861	838	929	1110	800	872
Total Request	1140	1170	1218	1278	1214	1074	1017	921	909	1037	1218	847	993

Registered Filled / Requested



	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25
Healthcare Scientists Filled	36	30	29	28	31	11	8	4	4	17	40	26	33
Total Request	39	32	28	30	32	13	9	4	4	21	43	26	34

Registered Filled / Requested



	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25
Nursing & Midwifery Registered Filled	3131	3144	3184	3522	3326	3396	3400	3065	3420	3437	3975	2768	3004
Total Request	3534	3649	3712	4112	3907	4049	4066	3890	4056	4193	4761	3451	3641

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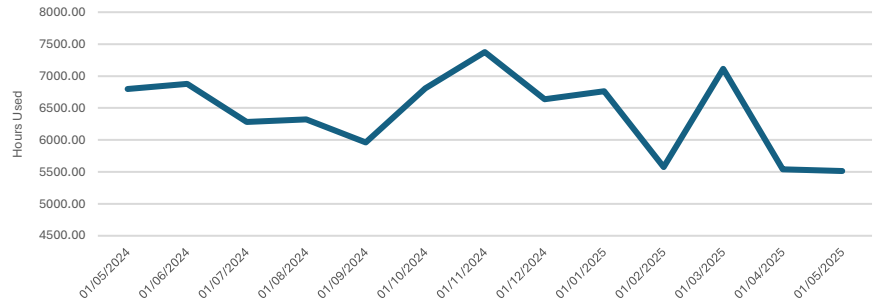
A&C Bank Use

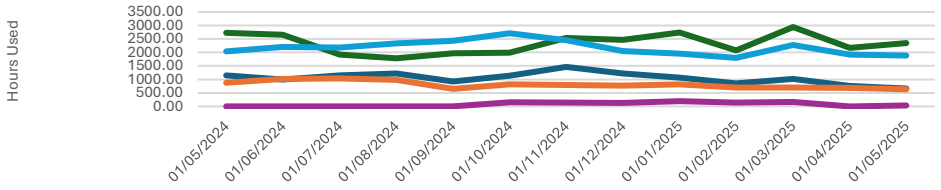
The Dudley Group NHS Foundation Trust

A&C Bank use (Hours)



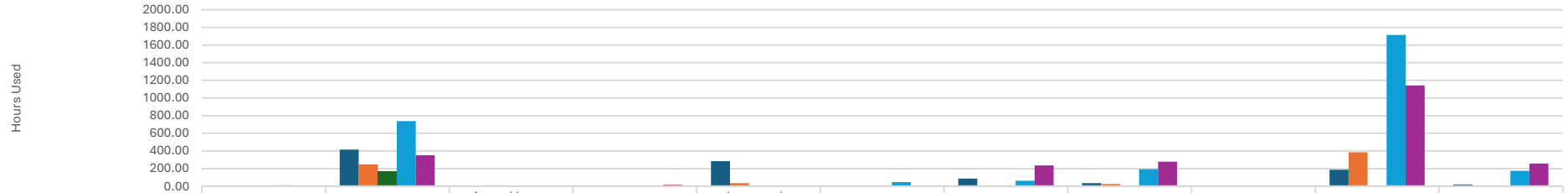
	01/05/2024	01/06/2024	01/07/2024	01/08/2024	01/09/2024	01/10/2024	01/11/2024	01/12/2024	01/01/2025	01/02/2025	01/03/2025	01/04/2025	01/05/2025
A&C	6798.75	6876.65	6283.42	6320.33	5962.47	6806.07	7375.88	6639.98	6764.63	5573.72	7112	5539.18	5513.65

A&C Bank use (Hours)



	01/05/2024	01/06/2024	01/07/2024	01/08/2024	01/09/2024	01/10/2024	01/11/2024	01/12/2024	01/01/2025	01/02/2025	01/03/2025	01/04/2025	01/05/2025
Clinical Support	1153.58	994.50	1143.58	1219.00	923.00	1137.67	1463.17	1220.33	1068.50	856.25	1024.41	760.50	661.42
Corporate / Mgt	879.50	1022.75	1036.58	981.33	647.50	818.00	788.67	772.00	815.25	699.67	701.96	682.00	634.33
Medicine & Integrated Care	2721.92	2656.15	1924.41	1782.66	1963.92	1992.17	2534.92	2467.32	2735.88	2076.30	2941.88	2172.02	2346.90
Surgery	2043.75	2203.25	2178.83	2336.58	2428.05	2711.15	2453.88	2045.83	1950.50	1798.75	2279.13	1922.67	1883.50
Dudley Place	0.00	0.00	0.00	0.00	0.00	147.08	135.25	134.50	194.50	142.75	165.00	2.00	37.50

Hours used by Division and Reason



	1:1	Additional Activity	Annual Leave (Overbooked/Emergency)	Extra Clinic	Increase in capacity - beds/patients	Maternity	Sickness Long Term	Sickness Short Term	Special Leave	Vacant Post	Waiting List Initiative
Clinical Support		415.50			283.17		87.50	33.50		185.75	19.00
Corporate / Mgt		247.00	10.00		35.67			25.00		384.25	
Dudley Place		165.00									
Medicine & Integrated Care	11.50	737.13				46.50	60.75	192.25	4.00	1715.25	174.50
Surgery		352.25		15.00			234.00	277.50		1142.38	258.00

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Rostering KPI

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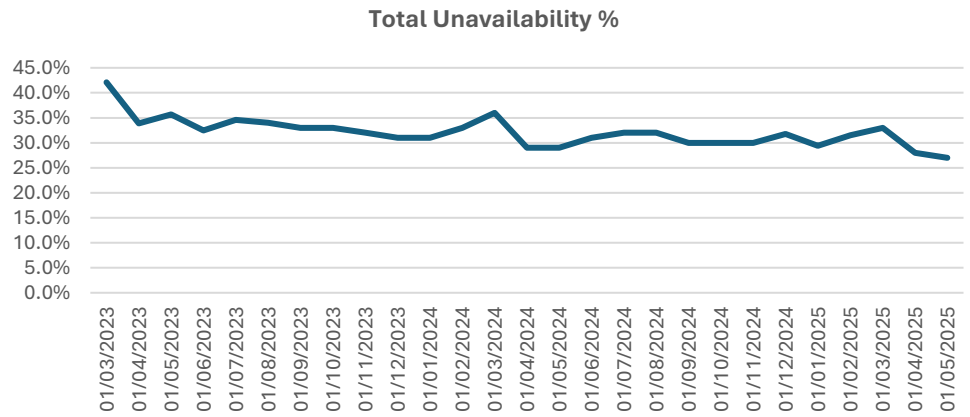
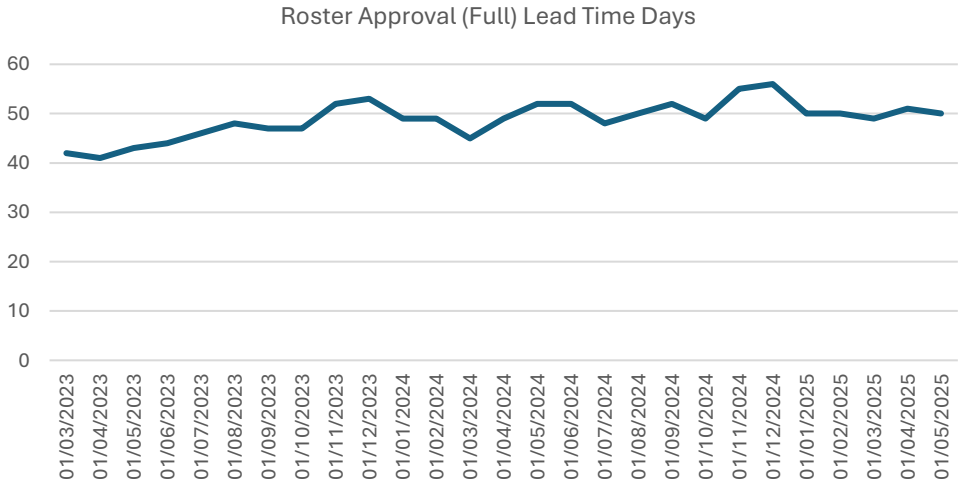


Unavailability is where staff are absent from their normal daily work but still consuming their contracted hours.

Budgeted percentage is 22%.

If actual unavailability is higher than budgeted, then either costs will exceed budgets (e.g. backfilling absence with temp staff), or units will be short staffed.



The number of days between the full approval (publishing) of the roster and the roster live date. Short lead times generate staff morale issues due to poor notice of their roster, and higher agency usage or unfilled duties as there is less lead time for the bank to fill gaps.

50 Days. Trust target is 55 days, NHSE minimum is 42 days.

This is trending in the right direction. Confirm & Challenge meetings along with frequent e-mail notifications now being used to improve compliance.

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Rostering KPI

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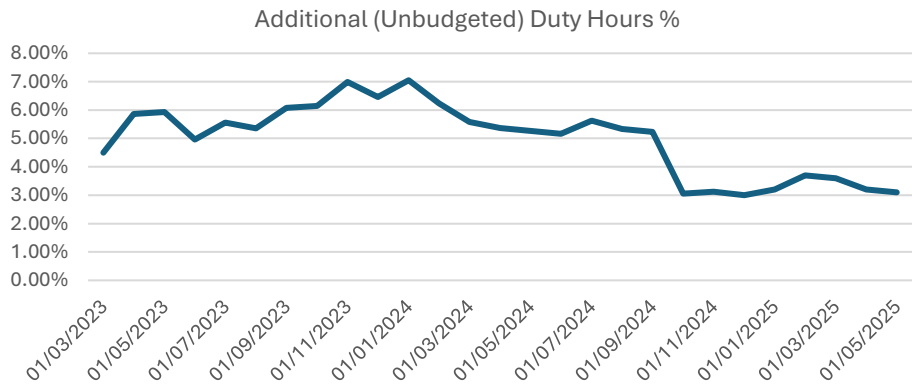
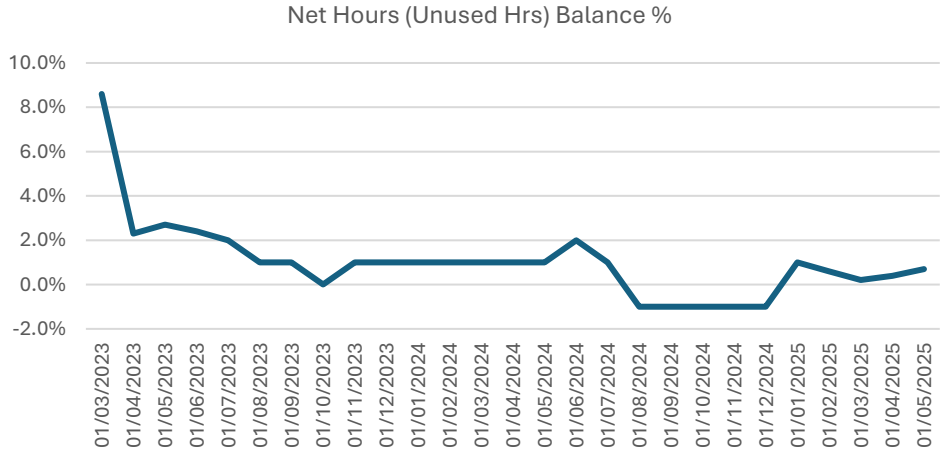


The % of assigned duty hours that are in addition to the budgeted demand e.g. 4 staff rostered when only 3 are budgeted. This may be due to legitimate increased demand (e.g. increased acuity)

Departments with the highest percentage of additional duty hours are Discharge Lounge, AMU 1, AMU 2 and Day Case Theatres

Most common reasons are Increase in Capacity and 1:1.



The % contracted hours left unused - e.g. if a staff member is contracted and paid for 150 hours but only works 144 hours there are 6 hours unused.

In January 2025 the Trust have implemented a rule that bank cannot be worked where there are hours owing.

Net unused hours increased in May 2025. Confirm and Challenge have discussed how to support managers to manage the operational pressures, alongside responsibilities to scrutinise rosters.

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Rostering - Loop app

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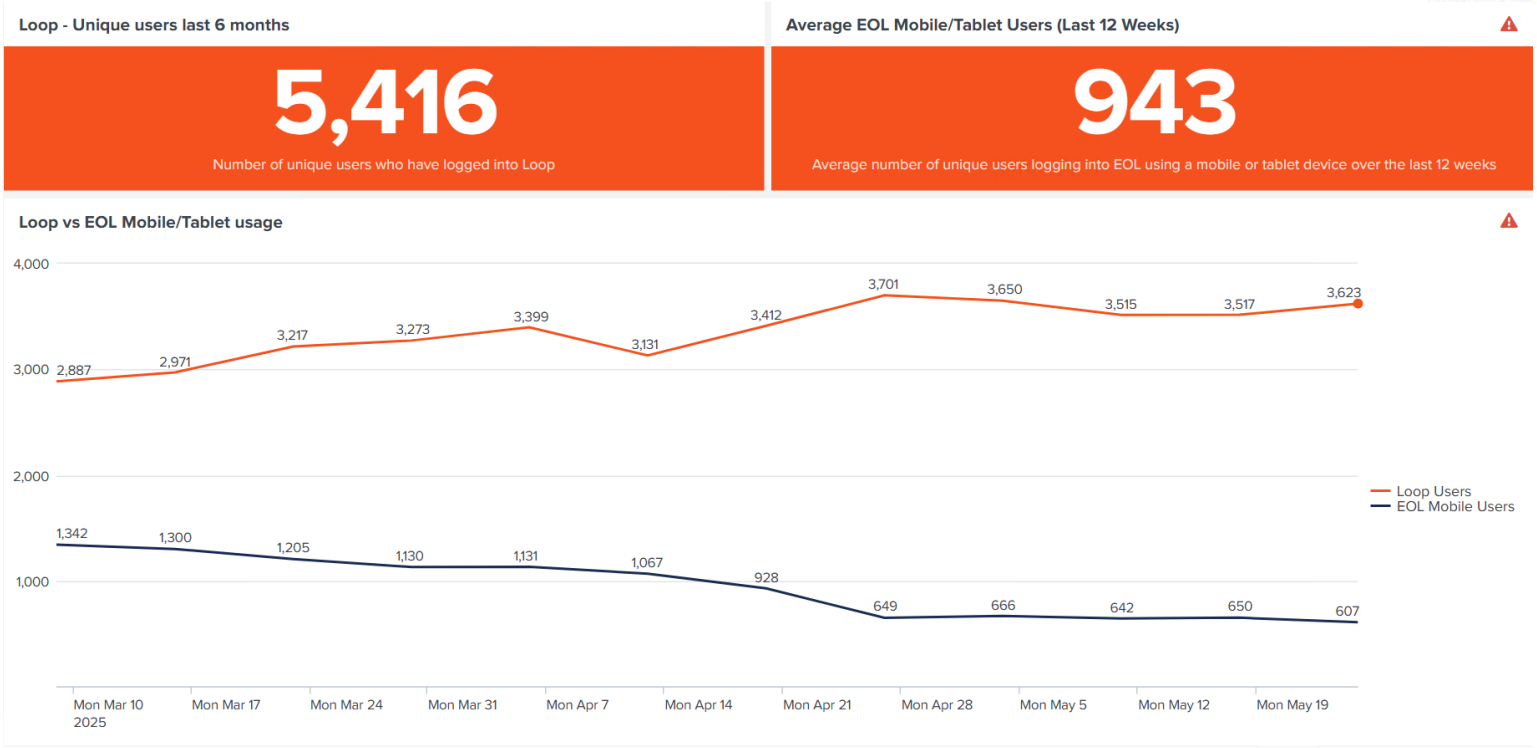

On 9th September 2024 we launched the new Allocate Loop app/website to replace the existing Employee Online (EOL) website which has now been shut down (2nd June) and as such the number of EOL users will be zero in the next reporting cycle (in 12 weeks time).

There has been an increase of approximately 1000 new users since last month. The team are offering a number support methods such as user guides, MS teams call and in person assistance to make the transition from EOL to Loop as easy as possible.

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Work Experience and Widening Participation

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I Can

ICan Phase 1 ended on 31st March 2025. Evaluation is in draft form and will be available during July.

Confirmation of 2025/26 funding has been received. However, detailed information on programme delivery and the structure and targets are subject to change as the funding stream has changed and contracts have not yet been formally signed. Year 2 activity has not started yet, we are in the planning stages, with numbers and funding to be confirmed.

Work Related Learning:

- There were no Behind the Scenes events during April – the next planned event is in July.
- A new 4-day classroom-based programme for secondary school students was piloted in May with 20 local students from the across the 4 Dudley Academies Trust secondary schools. This was hosted at the Dudley Institute of Technology and gave students hands-on practical experience via simulated clinical settings, of a range of healthcare professions including Speech and Language Therapy, Occupational Therapy, Podiatry, Operating Theatres, Critical Care and Maternity and learnt lifesaving skills in an Emergency Care session. The learners engaged in game-based exercises to understand the financial context of the NHS and met a range of non-clinical specialists in a Meet the Expert networking session.

Ambassadors

There are 82 active Careers Ambassadors in the Trust.

Careers Education Information Advice and Guidance (CEIAG)

There were 120 face-to-face engagements during May, and 3 online engagements (123 total). This consisted of two Careers events at local schools, and three online 1:1 careers advice and guidance conversations.

Work Experience

There was one dept-led placement that took place in May.

The centralised Work Experience programme ran for one week from 19th-23rd May. This was specifically for students interested in careers in Nursing, AHPs, Healthcare Science, and Midwifery. The programme consisted of two classroom days and three rotational placement days as well as a feedback debrief session. There were 17 students that attended (13 female and 4 male).

T-Levels

- Two additional Business Management and Administration 1st year T-Level students have started their Industry Placements with us on 13th May (from Halesowen College) . They will complete 315 hours/45 days placement with the Trust doing one day a week. This will mean a total of 8 students (as one has dropped out due to personal reasons).
- The Healthcare T-Level student programme will re-commence in September.

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Apprenticeships

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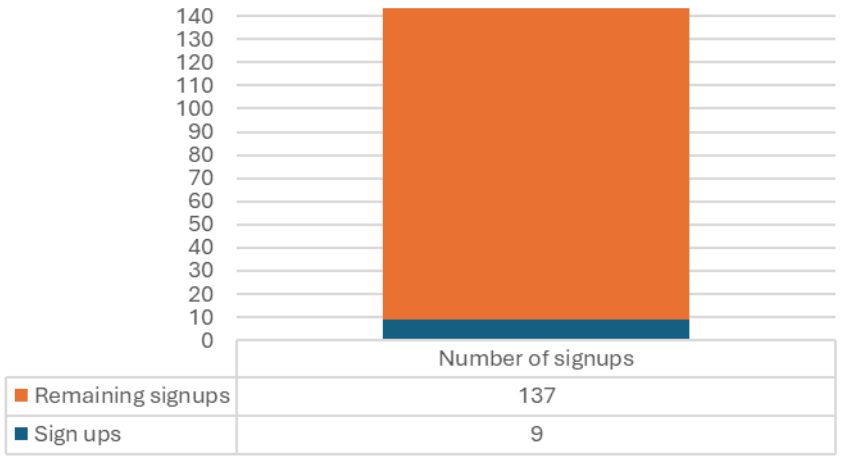
Apprenticeships - as of May 25

Number of Signups against year plan (146)



	Number of signups
Remaining signups	137
Sign ups	9

Total Active Apprenticeships : 226

Apprenticeship Levy	£
Expired Levy April 25	£29,290.18
Expired Levy May 25	£32,972.34

Apprenticeship activity and Levy Spend have been impacted by the recruitment freeze. This is likely to continue to have impact during 2025/26.

Levy funding has expired during April and May linked to this reduction in activity.

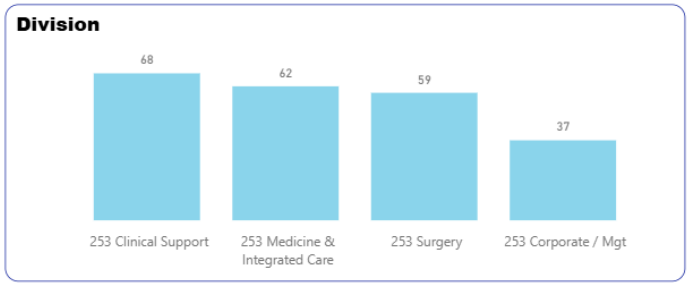
We are increasing the number of external apprenticeships being sponsored through our Levy Fund.

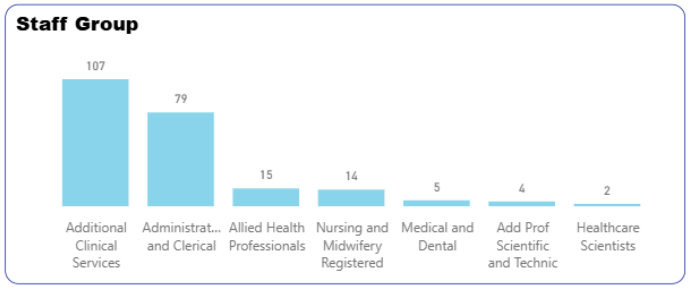
Work continues to promote internal apprenticeship opportunities to compensate for the lack of new apprentice opportunities.

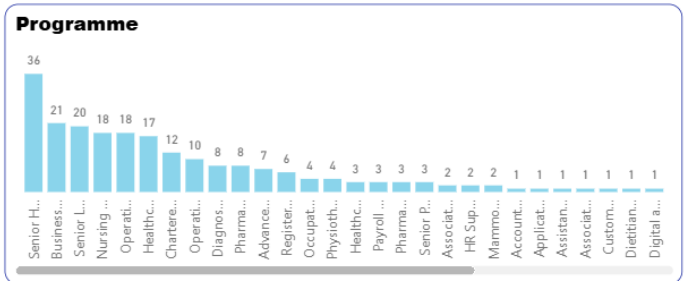
Details on changes to the Apprentice Levy to the Skills and Growth Levy are still not confirmed but are expected around September.

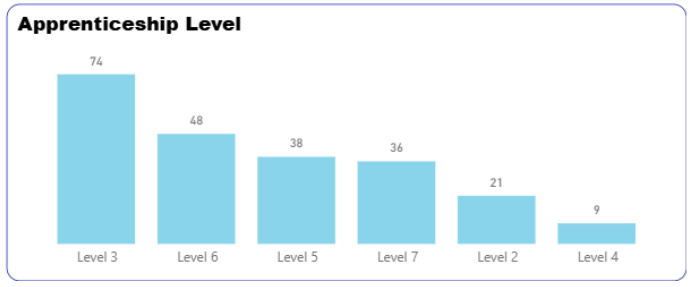
Once confirmed, these changes should provide increased opportunities to spend levy funds on approved activity.

Active Apprenticeships breakdown









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Mandatory Training

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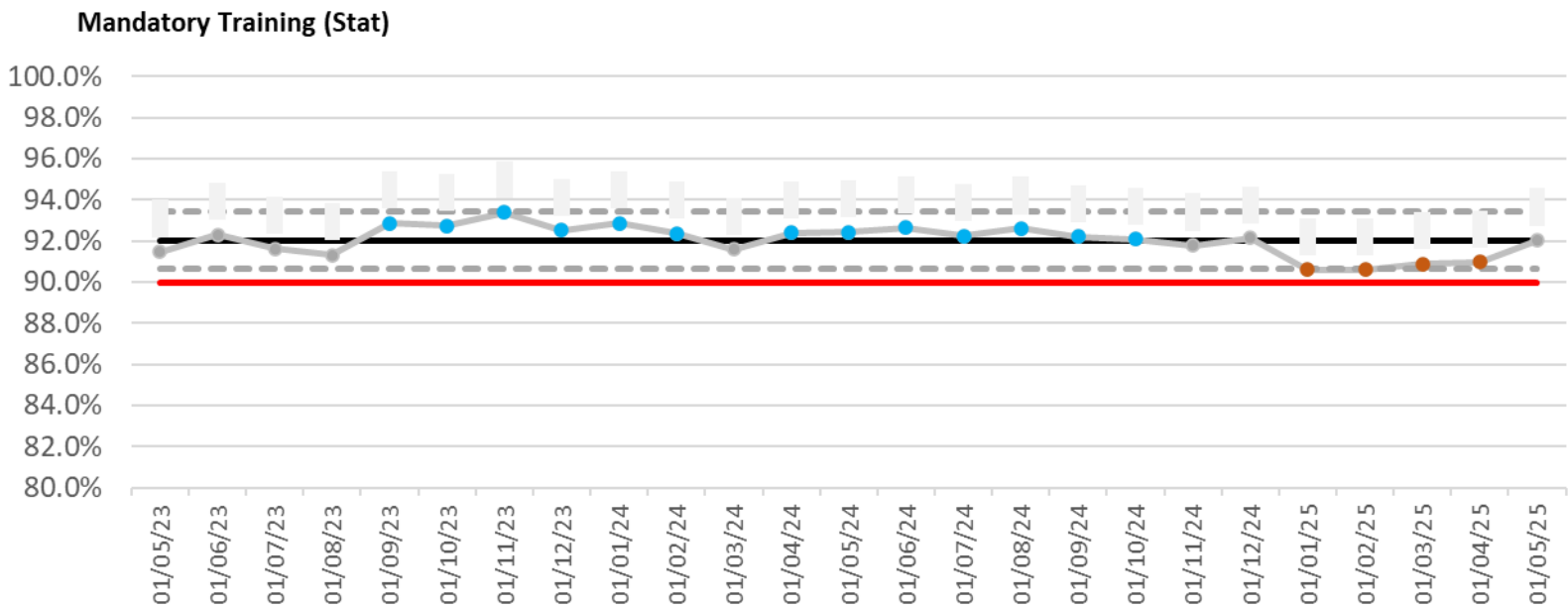
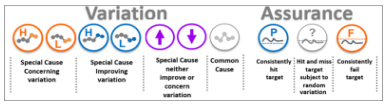


The overall rate has been maintained at above Trust target performance. However mid-month performance was below target at times - due largely to increased drop-offs of annual training courses. This improves as the annual review period commences and conversations are linked around performance and mandatory training compliance.
There remain challenges in compliance for the Place Division - but there are recovery plans in place and performance is steadily improving.

	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25
Mandatory Training (Stat)	92.65%	92.24%	92.60%	92.22%	92.09%	91.79%	92.16%	90.60%	90.59%	90.88%	90.96%	92.04%



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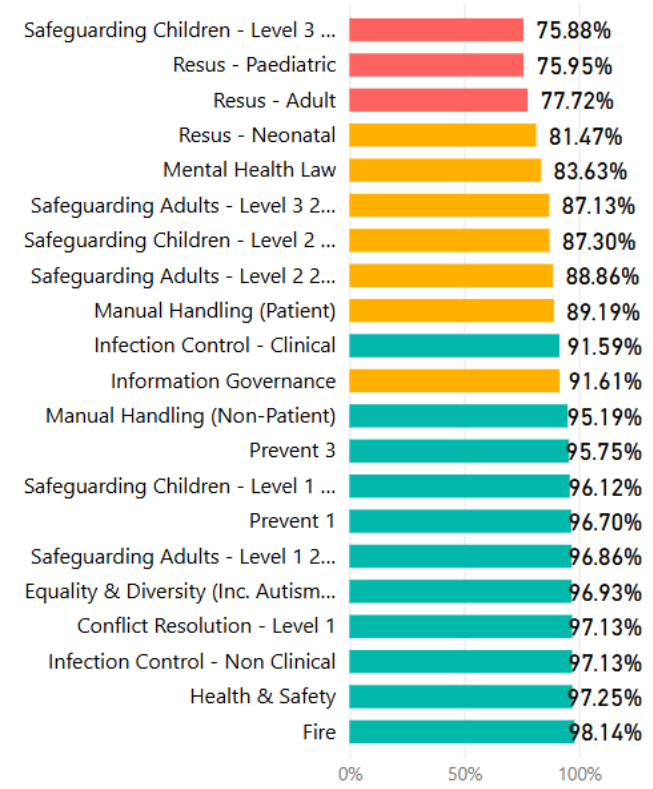
Mandatory Training – Priority 1

The Dudley Group NHS Foundation Trust

Month: May 2025	Trust	CS	Corporate	MIC	Surgery	Place
	92.04%	94.59%	94.46%	91.99%	91.73%	73.46%

Course Compliance

Course Compliance (based on selections)



Depts by no. required to achieve 90%

Ward/Service (based selections)

Group5Description	Actual	No. to Target	%' tage
253 General Surgery Medical Staff Serv	466	73	77.92%
253 GP Clinical Leadership/Advisor Serv	88	72	49.71%
253 CHC & Intermediate Care Serv	248	70	70.25%
253 Dudley & Netherton PCN ARRS Serv	156	69	62.40%
253 MOC Medical Staff Serv	373	69	75.96%
253 Enhanced Care Home Team Serv	58	58	45.31%
253 Halesowen PCN ARRS Serv	140	47	67.63%
253 Medical Staff (Vascular) Serv	147	47	68.37%
253 Medical Staff Cardiology Serv	223	47	74.33%
253 Medicines Management Serv	490	47	82.21%
253 Medical Staff (Older People) Serv	239	42	76.60%
253 High Oak Practice Serv	141	37	71.57%
253 Paediatric Medical Staff Serv	412	31	83.73%
253 Medical Staff - Respiratory Serv	315	30	82.24%
253 Medical Staff - Acute Medicine Serv	900	26	87.54%
253 Cardiology Clinical Measurement Serv	456	25	85.39%
253 Medical Staff GP Medicine Serv	84	24	70.00%
253 Medical Staff Renal Serv	85	23	70.83%
253 Plastic Surgery Medical Staff Serv	107	23	74.30%
253 Maxillofacial Surgery Medical Staff Serv	77	21	71.29%
Total	**64,966**	**-1441**	**92.04%**

Statutory Training remains above target across all divisions with the exception of the Place Division. This division continues to improve at pace.

There are currently three red rated subjects.

Persistent non-compliance for those subjects plus divisional pockets of low compliance are currently being followed up in Divisions through HR Business Partners.

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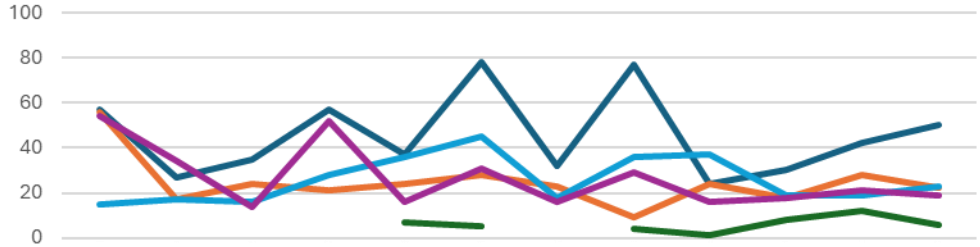
Organisational Development

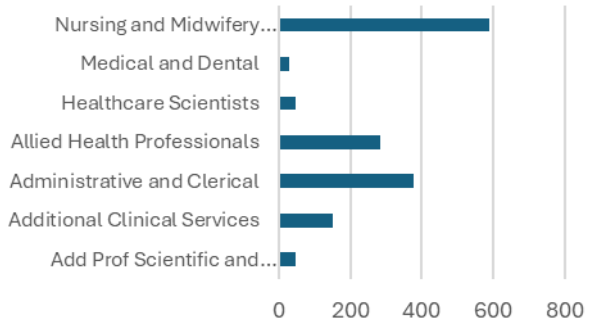
The Dudley Group NHS Foundation Trust

Training Activity By Division and Month



	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25
253 Clinical Support	57	27	35	57	37	78	32	77	24	30	42	50
253 Corporate / Mgt	56	17	24	21	24	28	23	9	24	18	28	22
253 Dudley Place					7	5		4	1	8	12	6
253 Medicine & Integrated Care	15	17	16	28	36	45	18	36	37	19	19	23
253 Surgery	54	34	14	52	16	31	16	29	16	18	21	19

Training By Staff Group (Jun 24- May 25)



Course	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Grand Total
253 Resilience Training						8							8
253 Admin Essentials		9					14	12					35
253 Annual Review Training	18									21	68	52	159
253 Bespoke Training	23	6		10		16			4	6	4		69
253 Coaching	7		7		4	8		7	8			9	50
253 Communications 1	13	10	3	11	13	11	10	4		2		9	86
253 Communications 2	21		13		15	7	7	7	20		5		95
253 Flexible Working		8		5									13
253 Leading People at Dudley	3	3	9	4	3	7		4		4			37
253 Leading with Confidence Introduction				8	12		19		17		8		64
253 Living The Values	24	11		2	13	26		67	2	10		22	177
253 Local Induction Training		6	17			14			2				39
253 Managers Essentials	35	10	12	39	19	35	17	15	35	21	20	15	273
253 Organisational Awareness & Report Writing										2			2
253 Report Writing and Presenting							3						3
253 Resolving Conflict & Honest Conversations						4					4		8
253 Welcome 2 Dudley Induction	7	5	12	21	19	12	2	9	8	8		7	110
253 Wellbeing 1	12	11	12	6	14	11	10	5	1	8	8	6	104
253 Wellbeing 2	9	10	4	10		15							48
253 Wellbeing 2 - Team Wellbeing for Managers								7		11			18
253 Wellbeing Adhoc	10			36				18					64
253 Wellbeing Champions		6			8	8	5						27
253 Workforce Planning				6		5	2		5		5		23
Grand Total	**182**	**95**	**89**	**158**	**120**	**187**	**89**	**155**	**102**	**93**	**122**	**120**	**1512**

Training update remains positive with over 1000 participants now having completed Manager's Essentials. Attendance is expected to increase across all courses following annual reviews in April-June. Work continues to review courses and to support increased attendance.

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Performance against 25/26 workforce plan – M2

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Month 2 Performance – Trust Overview

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	25/26 Apr	25/26 May	25/26 Jun	25/26 Jul	25/26 Aug	25/26 Sep	25/26 Oct	25/26 Nov	25/26 Dec	25/26 Jan	25/26 Feb	25/26 Mar
Total Substantive - Plan	5,900	5,902	5,902	5,889	5,890	5,877	5,865	5,849	5,832	5,812	5,795	5,779
Total Substantive - Actual	5,869	5853										
Total Substantive - Variance	-31	-49										
Total Bank - Plan	542	529	516	501	487	474	476	463	415	436	428	415
Total Bank - Actual	513	536										
Total Bank - Variance	-29	7										
Total Agency - Plan	7	7	6	6	6	6	6	6	6	6	6	6
Total Agency - Actual	13	17										
Total Agency - Variance	7	11										
Grand Total - Plan	6,449	6,438	6,424	6,396	6,383	6,357	6,347	6,318	6,253	6,254	6,229	6,200
Grand Total - Actual	6,395	6406										
Grand Total - Variance	-54	-32										

- The Trust performance in month 2 shows a positive variance against the total workforce planned position of 32 WTE under plan.
- Substantive workforce variance against workforce forecasted M2 position is 49 WTE below plan
- The bank workforce variance against workforce forecasted M2 position is 7 WTE above plan
- Agency workforce variance against workforce forecasted M2 position is 11 WTE above plan. Overall, agency remains very low with Trust with all usage relating to medical staff.

- Drivers of change for substantive staffing is the staggered effect of full vacancy freeze December and January and the on-going impact of the Divisional and Executive vacancy control process with CEO sign off.
- For Bank usage, there are improved reporting and additional controls in place.

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Month 2 Performance – Medicine Division

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Medicine	25/26 Apr	25/26 May	25/26 Jun	25/26 Jul	25/26 Aug	25/26 Sep	25/26 Oct	25/26 Nov	25/26 Dec	25/26 Jan	25/26 Feb	25/26 Mar
Total Substantive - Plan	1,889	1,886	1,883	1,880	1,881	1,878	1,879	1,875	1,869	1,864	1,858	1,853
Total Substantive - Actual	1,875	1866										
Total Substantive - Variance	-14	-20										
Total Bank - Plan	283	277	270	263	255	249	255	248	222	232	230	222
Total Bank - Actual	278	283										
Total Bank - Variance	-5	6										
Total Agency - Plan	3	3	3	3	3	3	3	3	3	3	3	3
Total Agency - Actual	8	9										
Total Agency - Variance	5	6										
Grand Total - Plan	2,175	2,166	2,156	2,146	2,139	2,130	2,137	2,126	2,094	2,099	2,091	2,078
Grand Total - Actual	2,161	2158										
Grand Total - Variance	-14	-8										

- Medicine divisional performance in month 2 shows a positive variance against the total workforce planned position of 8 WTE under plan
- Substantive workforce variance against workforce forecasted M2 position is 20 WTE below plan.
- The bank workforce variance against workforce forecasted M2 position is 6 WTE above plan.
- Agency workforce variance against workforce forecasted M2 position is 6 WTE above plan.

- Key Risk – Bank and Agency usage remain above against a reducing trajectory, which provides a risk of not delivering the plan in M3.

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Month 2 Performance – Surgery, Women's and Children's Division

The Dudley Group NHS Foundation Trust

Surgery	25/26 Apr	25/26 May	25/26 Jun	25/26 Jul	25/26 Aug	25/26 Sep	25/26 Oct	25/26 Nov	25/26 Dec	25/26 Jan	25/26 Feb	25/26 Mar
Total Substantive - Plan	1,944	1,942	1,940	1,935	1,938	1,933	1,927	1,922	1,917	1,911	1,906	1,902
Total Substantive - Actual	1,964	1961										
Total Substantive - Variance	20	19										
Total Bank - Plan	170	165	161	155	150	145	141	137	122	131	127	123
Total Bank - Actual	152	161										
Total Bank - Variance	-18	-4										
Total Agency - Plan	3	3	3	3	3	3	3	3	3	3	3	3
Total Agency - Actual	5	8										
Total Agency - Variance	2	5										
Grand Total - Plan	2,117	2110	2104	2093	2091	2081	2071	2062	2042	2045	2036	2028
Grand Total - Actual	2,121	2130										
Grand Total - Variance	4	-20										

- SWC divisional performance in month 2 shows a worsening negative variance against the total workforce planned position of 20 WTE above plan
- Substantive workforce variance against workforce forecasted M2 position is 19 WTE above plan
- The bank workforce variance against workforce forecasted M2 position is 4 WTE below plan.
- Agency workforce variance against workforce forecasted M2 position has worsened since M1 and is 5 WTE above plan.

- Key Risk – Substantive staffing and Agency are reporting above plan, with a reducing trajectory which provides a risk of not delivering the plan in M3.

Our Patients
Our People
Our Place

Month 2 Performance – CCCS

NHS
The Dudley Group
NHS Foundation Trust

CCCS	25/26 Apr	25/26 May	25/26 Jun	25/26 Jul	25/26 Aug	25/26 Sep	25/26 Oct	25/26 Nov	25/26 Dec	25/26 Jan	25/26 Feb	25/26 Mar
Total Substantive - Plan	1,210	1,216	1,221	1,220	1,221	1,221	1,217	1,214	1,211	1,206	1,203	1,199
Total Substantive - Actual	1,200	1198										
Total Substantive - Variance	-10	-18										
Total Bank - Plan	75.41	73	72	70	69	66	66	64	58	60	58	57
Total Bank - Actual	72	77										
Total Bank - Variance	-3	4										
Total Agency - Plan	0	0	0	0	0	0	0	0	0	0	0	0
Total Agency - Actual	0	0										
Total Agency - Variance	0	0										
Grand Total - Plan	1,286	1290	1293	1290	1290	1287	1283	1278	1269	1266	1261	1256
Grand Total - Actual	1,272	1275										
Grand Total - Variance	-14	-15										

- CCCS divisional performance in month 2 shows an increasing positive variance against the total workforce planned position of 15 WTE below plan.
- Substantive workforce variance against workforce forecasted M2 position is 18 WTE below plan
- The bank workforce variance against workforce forecasted M2 position is 4 WTE above plan

- Key Risk – Bank usage is reporting above plan, with a reducing trajectory which provides a risk of not delivering the plan in M3.

Our Patients
Our People
Our Place

Month 2 Performance – Corporate Services

The Dudley Group NHS Foundation Trust

Corporate	25/26 Apr	25/26 May	25/26 Jun	25/26 Jul	25/26 Aug	25/26 Sep	25/26 Oct	25/26 Nov	25/26 Dec	25/26 Jan	25/26 Feb	25/26 Mar
Total Substantive - Plan	680	680	680	676	672	668	665	662	659	656	653	650
Total Substantive - Actual	652	649										
Total Substantive - Variance	-28	-31										
Total Bank - Plan	11	11	11	11	11	11	11	11	11	11	11	11
Total Bank - Actual	10	13										
Total Bank - Variance	-1	2										
Total Agency - Plan	0	0	0	0	0	0	0	0	0	0	0	0
Total Agency - Actual	0	0	0	0	0	0	0	0	0	0	0	0
Total Agency - Variance	0											
Grand Total - Plan	691	691	691	687	683	679	676	673	670	667	664	661
Grand Total - Actual	662	662										
Grand Total - Variance	-29	-29										

- Corporate performance in month 2 shows a positive variance against the total workforce planned position of 29 WTE below plan,
- Substantive workforce variance against workforce forecasted M2 position is 31 WTE below plan
- The bank workforce variance against workforce forecasted M2 position is 2 WTE over plan.

- Key Risk – Bank usage is reporting above plan, with a reducing trajectory which provides a risk of not delivering the plan in M3.

Our Patients
Our People
Our Place

Month 2 Performance – Dudley Place

NHS
The Dudley Group
NHS Foundation Trust

Dudley Place	25/26 Apr	25/26 May	25/26 Jun	25/26 Jul	25/26 Aug	25/26 Sep	25/26 Oct	25/26 Nov	25/26 Dec	25/26 Jan	25/26 Feb	25/26 Mar
Total Substantive - Plan	177	178	178	178	178	177	177	176	176	175	175	175
Total Substantive - Actual	178	179										
Total Substantive - Variance	1	1										
Total Bank - Plan	2	2	2	2	2	2	2	2	2	2	1	1
Total Bank - Actual	1	2										
Total Bank - Variance	-1	0										
Total Agency - Plan	0	0	0	0	0	0	0	0	0	0	0	0
Total Agency - Actual	0	0	0	0	0	0	0	0	0	0	0	0
Total Agency - Variance	0	0										
Grand Total - Plan	179	181	180	180	180	179	179	178	178	177	177	177
Grand Total - Actual	179	181										
Grand Total - Variance	0	0										

- The Dudley Place divisional performance in month 2 shows a break-even position against the total workforce planned position

Our Patients
Our People
Our Place

Month 2 – Key Actions

The Dudley Group NHS Foundation Trust

- Sickness absence taskforce established - including a re-set of expectations/output undertaken, Sickness absence systems and recording training launched, hot-spot identification and targeted interventions and Hub page and resources developed. There have been 5 consecutive months of reduction with sickness absence reporting at 4.58% for May

- Initial scoping work has been undertaken to understand where shifts are being booked at the 'wrong grade' and the reasons for doing so. Initial discussions with Allocate indicate a total block would prevent Nurse leaders from working clinical shifts and being counted 'in the numbers.' There is a warning in place currently, but system workarounds are being explored to ensure this is implemented.

- AFC Bank rates are now reduced to the bottom of the pay band. Medical Bank Rates continue to be subject to collective bargaining.

- Continue to monitor and challenge agency reduction plans – All exit plans are being reassessed and rectifications plans devised.

The Dudley Group
NHS Foundation Trust

THE DUDLEY GROUP NHS FOUNDATION TRUST

ANNUAL REPORT AND ACCOUNTS 2024/25

Presented to Parliament pursuant to Schedule 7, paragraph 25 (4) (a) of the National Health Service Act 2006

CARE RESPECT RESPONSIBILITY

Front Cover captions

Isla at the launch of the Trust's refurbished C2 playroom

Caring for residents within the community

Corporate Services staff providing support behind the scenes

Contents

Welcome from the Chairman and Chief Executive

Welcome to The Dudley Group NHS Foundation Trust's Annual Report and Accounts for 2024/25. In this report, you will find information on how we have performed against a range of national and local standards and how we measure the quality of care we provide, alongside our financial accounts.

Over the past 12 months we have remained committed to delivering our vision of providing excellent healthcare, improved health for all. This hasn't been without its challenges and our colleagues, volunteers and partners have helped us work through a difficult winter, manage pressures across our sites and continued to deliver the national standards for planned and emergency care. Whilst also welcoming colleagues and services from Dudley Integrated Health and care NHS Trust who provide primary and community care.

We have also played our part in the Integrated Care System and continued to ensure we are at the forefront of decision making through the collaboration with providers within the Black Country in the Black Country Provider Collaborative.

As always, it's been a busy year at the Trust. In April we proudly launched 'Call for Concern', a safety service for inpatients that enables patients and/or relatives, carers, advocates to call for urgent help and advice when they are concerned that the patient's deteriorating condition is not being adequately recognised by the ward teams.

Our long awaited emergency department redesign work got underway, which will see the transformation of the Trust's resus department with a new state-of-the-art facility, which will include a dedicated paediatric area and isolation rooms to provide appropriate safe care in the event of future pandemics or outbreaks, as well as advanced technology and equipment, including a digital medicine system to improve the storing, usage and prescribing of drugs to patients.

The Trust also became one of the first in the UK to be awarded training status from the International Bowel Ultrasound Group allowing patients to receive a consultation, their bowel ultrasound scan and the results of that scan in a single outpatient appointment.

Our Board of Directors has seen some changes this year with the appointment of four new non-executive directors. Peter Featherstone, Dr Ita O'Donovan, Anne-Maria Newham MBE and Dr Mohit Mandiratta have all joined the board, bringing with them many years of experience in healthcare and local authority/government backgrounds.

The Dudley Group joined the NHS People Promise exemplar programme in 2024. The programme is a set of seven workstreams that can make the biggest difference in

Chief executive Diane Wake and Chair Sir David Nicholson on the site of our Emergency Department redesign

improving working in the NHS. Joining the exemplar programme has honed our focus to three areas for our People Promise work:

- We are safe and healthy
- We work flexibly
- We each have a voice that counts

One of the most significant changes for The Dudley Group has been the transition of colleagues from Dudley Integrated Health and Care NHS Trust into our organisation. This has brought new opportunities to strengthen collaboration between primary and secondary care services including a milestone achievement for the Trust with the acquisition of two GP practices – the first for The Dudley Group. This integration is helping us to deliver more seamless care for patients and ensure they receive the right support, in the right place at the right time.

Like many NHS Trusts, our financial position has been challenging. We've worked hard to maintain financial stability through eliminating waste, improving productivity and reducing premium rate spend. Some of this work has already been successful with our agency spend showing as the lowest in the country.

Our collaborative work across the Black Country continues and was further strengthened this year as I (Diane) was afforded the opportunity to take on the role of chief executive for Sandwell and West Birmingham NHS Trust alongside my chief executive role here at The Dudley Group. This is a wonderful opportunity for us to go further with collaborative opportunities for both organisations.

In addition, I (Sir David) was asked to continue my role as chair across the four Black Country NHS Trusts until March 2027. Over the past few years, I have seen first-hand the dedication, innovation, and commitment of our teams across the region, and I am excited to continue working to shape the future of healthcare in the Black Country.

Looking ahead to the future, the NHS is undergoing a significant period of transformation. The government's consultation on creating an NHS fit for the future is an important step in ensuring our health service can continue to meet the needs of our communities. With the outcome of a new 10-year plan expected in the coming months, we will be looking closely at what this means for our Trust and how we can adapt to deliver the best possible care for our patients.

In addition, the Trust continues to work towards university hospital status with our academic partners at Aston University. Increasing grant funding, expanding research within all professional groups and enhancing our training facilities are current priorities. The next step will also see an update to our identity as we fully embrace our university hospital status.

Finally, we would like to take this opportunity to thank all our staff and volunteers for their continued hard work, commitment and dedication.

Sir David Nicholson

Chair

… July 2025

Diane Wake

Chief Executive Officer

… July 2025

Who we are

The Trust is the main provider of hospital and adult community services to the population of Dudley, parts of the Sandwell borough and smaller but growing communities in South Staffordshire and Wyre Forest. Achieving Foundation Trust status in 2008, we provide a wide range of medical, surgical and rehabilitation services to a population of over 450,000 people from three main sites – Russells Hall Hospital, Guest Outpatient Centre in Dudley and Corbett Outpatient Centre in Stourbridge – and in people's homes from our community and primary care sites.

In 2021, we established an Imaging Diagnostics Centre based at the Corbett Outpatient Centre, with a satellite centre at the Guest Outpatient Centre.

We also provide a range of specialist services, some of which are accessed by patients from across the UK. These include vascular surgery, endoscopic procedures, stem cell transplants and specialist genitourinary reconstruction.

Since October 2024 the Trust also offers primary care services, hosting two General Practices, High Oak in Brierley Hill, with additional sessions in Pensnett, and Chapel Street, in Lye. This was part of the transition of staff and services from Dudley Health and Care Integrated NHS Trust.

Our staff are our greatest asset and, with a workforce of over 6,600 substantive staff, we provide a range of primary, secondary and tertiary services:

- Adult community services including community nursing, end of life care, podiatry, therapies and outpatient services are delivered from a range of community venues across the borough.
- Russells Hall Hospital in Dudley, which has more than 650 beds, including intensive care beds and neonatal cots, provides secondary and tertiary services such as maternity, critical care and outpatients and an Emergency Department (ED) with co-located Emergency Treatment Centre run by Malling Health.
- The Guest Outpatient Centre in Dudley and Corbett Outpatient Centre in Stourbridge provide a range of outpatient, therapy and daycase services.
- High Oak in Brierley Hill and Chapel Street in Lye provide GP services to local people in Brierley Hill, Brockmoor, Pensnett, Lye, Stourbridge and surrounding areas.

We are also proud to be the vascular services hub for the Black Country and have an active research and development team.

Our vision is to be a healthcare provider that provides '**excellent health care – improved health for all**'.

Our state-of-the-art equipment supports our clinicians to provide the best care for our patients

Complex Nutrition Virtual Ward, just one of several virtual wards at The Dudley Group

The year in review

We began the new year in April 2024 with a cracking appeal from our Trust charity. For the first time, our charity appealed to our local community and businesses for chocolate egg donations for our patients, to which they had an outstanding response with over 1500 eggs donated for patients across the Trust. We also held our second Leadership Conference at the Black Country Living Museum, bringing together leaders from across the Trust to hear about their experiences and share best practice and help us shape our goal of 'being a brilliant place to work and thrive'.

In May, our world-renowned Paediatric Virtual Ward welcomed its 1000th patient after launching as the first of its kind in March 2022. Celebrations went even further as the paediatric virtual ward team were also invited to the Royal Garden Party at Buckingham Palace in recognition of the incredible work they have done for patients across Dudley. The service helps support families to be discharged earlier and have support at home

The Trust's annual Committed to Excellence Awards took place in June with over 400 staff from across the Trust in attendance. Amongst the winners were Professor Sauid Ishaq, a consultant gastroenterologist who has been with the Trust for nearly twenty years and is renowned for his innovative endoscopic work and was awarded the Chair's Lifetime Achievement Award. The event also saw the introduction of two new awards for 2024 – the Sustainability Award and Best Use of Charitable Funds Award; the latter of which was won by the Forget Me Not Unit, who used their charitable funds to purchase equipment that can document a patient's photographs, their favourite music and even record a family member speaking, providing comfort to both patients with dementia and their relatives.

Our charity hosted their Superhero Fun Run event, with over 200 people attending and 90 runners taking part. The event raised £5000 in funds, for the children's ward at Russells Hall Hospital to support children and young patients while they are in hospital.

In early July we saw the first invitations go out to eligible patients as part of the Lung Cancer Screening Programme (formally Targeted Lung Health Checks); a new scheme designed to identify signs of cancer at an early stage when it is much more treatable – ultimately saving lives with 2422 scans completed between August 2024 and March 2025.

As the month progressed, we unveiled the children's ward playroom, which received a makeover thanks to the Dudley Group NHS Charity. The modernised playroom, which was funded through a combination of charitable funds and community grants, has been transformed with a bright and fun underwater theme. The welcoming room is equipped with activities and toys suitable for all young patients and there is now plenty of storage space for arts and crafts activities, a wet area, and a gallery where children's artwork can be proudly displayed. There is also a reading corner for those children who may need some quiet time.

Moving into August, celebrations were aplenty as two clinical wards both received Gold Standard Framework (GSF) accreditations, which is an esteemed national recognition of the high level of end-of-life care being delivered by those departments.

Ward C5 which specialises in Respiratory Care and Ward C6 which specialises in urology successfully managed to achieve the accreditation for the very first time. In addition, wards providing care in the areas of renal, oncology and frailty have cemented Gold Standards Framework re-accreditation, another huge achievement for the Trust.

The national staff survey launched across the Trust in August, with our campaign focusing on the 'Your voice matters, make it count' tagline. We also kicked off our winter vaccination boosters programme encouraging staff to have both their COVID-19 and flu boosters free of charge at the Trust.

As summer came to an end the Trust's charity unveiled their rebrand with a brand-new website and mascot thanks to a development grant from NHS Charities Together! The new strapline for the charity is 'Making every day better', reflecting the charity's aim to support the wellbeing and experience of patients, visitors, and staff of The Dudley Group NHS Foundation Trust. Dudley Group NHS Charity aims to make every day better for everyone in the community by providing services and facilities over and above what the local the Trust and the NHS can provide.

The charity also unveiled the newest member to their team, their new charity mascot. Aati the friendly fox was designed by eleven-year-old Laila Adams-Flash, who won a competition run by the charity for local children.

October was another hugely successful month for the Trust! We became one of the first NHS trusts in the country to be awarded training status from the International Bowel Ultrasound Group (IBUS). Dr Shanika De Silva, consultant gastroenterologist, established the Bowel Ultrasound Service at The Dudley Group earlier in the year following her successful completion of a training programme, thus gaining accreditation. Since the service's inception, Dudley has become one of the first active training centres for bowel ultrasound treatments within the UK.

Award success didn't stop there as pharmacist Nazir Hussain won a national award for developing a respiratory service that reduces hospital admissions. Nazir's 'one stop' respiratory clinic supports GP practices across Dudley, helping to improve diagnosis and treatments for patients with lung conditions such as asthma or chronic obstructive pulmonary disease (COPD). He was named 'GP or PCN Pharmacist of the Year' at the Chemist+Druggist (C+D) Awards 2024.

October also saw us officially open our new 'Information Hub'. Located in the main reception of Russells Hall Hospital the 'Information Hub' is a space aimed at providing support to the Dudley community, featuring services from The Dudley Group, Health and Social Care services from Dudley Metropolitan Borough Council and voluntary groups from across the Dudley borough.

We also welcomed colleagues from Dudley Integrated Health and Care NHS Trust as they transitioned to The Dudley Group, bringing with them our first two GP practices. Around 254 staff transferred bringing a wealth of skills and experience from a wide range of roles; integrating further primary and secondary care.

In November, our Trust charity held its annual Glitterball event inviting local businesses to join them in raising funds for the charity and also network with other like-minded Black Country businesses. Over £17,570 was raised at the event for the dementia appeal.

The charity also helped enhance patient experience, providing 16 large televisions across the Trust thanks to a generous charitable grant. The TVs, have been strategically placed in patient areas, offering both entertainment and a welcome distraction from the clinical setting.

We kicked off December with our annual Christmas market supporting local small business and our Trust charity. It also coincided with the switch on of the Trust's Christmas lights.

This was shortly followed by the official breaking ground of our emergency department redevelopment which will see the transformation of resus facilities at Russells Hall Hospital. The new state-of-the-art facility will include an enhanced resuscitation space, which will revolutionise

Providing care within the community at a local nursing home

the care given at the Trust's emergency department and is set to officially open in November 2025.

December was extra special as we hosted three 'Super Saturday' days at Russells Hall Hospital, with surgeries, morning until night, dedicated solely to children. By focusing on paediatric patients, the days allowed children to undergo various elective surgeries, relieving pressures on wait times and addressing the health inequalities for children awaiting surgery. Over the three days 79 children underwent surgical procedures ranging from tonsillectomies to squint surgeries.

We also celebrated over 4000 years of service at our Long Service awards which celebrated the careers of members of staff who had reached key milestones of 25, 30 and 40 years of service for the NHS in 2024.

The start of a New Year brought more success for the Trust as we supported a bid to establish one of the UK's new National Institute for Health and Care Research (NIHR) Commercial Research Delivery Centres (CRDCs), to 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.

February saw us out and about in the community as we hosted our first menopause café, bringing together healthcare professionals, and local residents to address the challenges and misconceptions surrounding menopause and highlight support systems available.

Our staff continued to succeed with healthcare clinical support worker Lisa Birch receiving a prestigious 'Chief Nursing Officer Award' for her commitment to outstanding patient care. Lisa who works on the Critical Care Unit at Russells Hall Hospital, was awarded in the 'working together for patients' category, and later featured on local radio station BBC WM to talk about her life and career in the NHS.

Over at our Stourbridge Health and Social Care Centre the pulmonary rehabilitation service was awarded PRSAS (Pulmonary Rehabilitation Services Accreditation Scheme) accreditation status from the Royal College of Physicians. The accreditation is awarded to services who have demonstrated exemplar model and best practice standards, including quality and safety, patient experience and workforce satisfaction.

Patient Experience team providing support to patients and loved ones

The charity also continued to ensure our patients receive the best possible experience when visiting the hospital with a cubicle refurbishment offering sensory support to nervous young patients. A £10,000 grant from the Tesco Bags of Help has funded the refurbishment of cubicle four transforming it into a sensory space to help calm and distract our younger patients.

Milestones continued into March as our ophthalmology team successfully completed a record achievement in its high volume, low-complexity cataract surgery service at Russells Hall Hospital. Performing an astounding 21 cataract operations in a single day, this initiative is a key part of the Trust's efforts to reduce the time patients wait for high-quality ophthalmic care in Dudley and the wider Black Country region.

Our cardiology team were also celebrating in March as they received full departmental accreditation awards from the British Society of Echocardiography following an immensely successful year. Successes of the service include securing commissioning for two trainees a year, accreditation in training, transthoracic, transoesophageal, stress, and emergency echocardiograph.

The Trust also made further steps to support our Green Plan as we were awarded £317,668 to install solar panels at Russells Hall Hospital, saving £34,705 a year and supporting investment into frontline care.

Throughout the year the Trust continued to provide mutual aid to system partners, including for diagnostics and we delivered on our financial plans and significantly reduced expenditure on agency staff.

We also marked numerous awareness days throughout year with our staff networks, including celebrating Women's History Month and much more!

Ronnie Littler Aged 7, who participated in the Trust's Super Saturday surgeries

Overview

Our strategy

Our strategic plan, called 'Shaping #OurFuture', was approved in 2021 and outlines how the Trust operates in the environment of our local health and care system. Our strategy has been refreshed and re launched during March to July and is being highlighted across the Trust through walkabouts.

Our vision is: 'Excellent health care, improved health for all'.

Our values remain: **Care**, **Respect** and **Responsibility**.

NEED ALT TEXT

We have five goals:

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

Underpinning implementation of the new strategic plan are three programmes:

- Black Country system service transformation including work to improve elective and emergency services and the collaboration between the four acute trusts in the Black Country.
- Local leadership to address health inequalities.
- Research and development, education and innovation.

Some notable achievements in delivering our strategy this past year include:

- Maintaining our overall vacancy rate below the target of 7% throughout the year with very low use of agency staff.
- Identification and delivery of cost improvement programme totalling £31.9m.
- Active participation and shaping of the partnership arrangements with other acute and community trusts in the Black Country. This includes the establishment of the trust as a specialist centre for renal cancer surgery following the introduction of surgical robots.
- Transfer of services of primary care support services and two GP practices to the Trust from Dudley Integrated Health and Care NHS Trust in October 2024.
- Provision of lung cancer screening from August 2024 which has already diagnosed cancers at an earlier stage. The plan is to cover the whole of Dudley borough by mid-2026.

Throughout this past year we have been reviewing our strategy and will publish changes following the publication of the government's 10-year health plan in the spring.

Risks to delivering our goals

As with any organisation, there are risks to the Trust's ability to deliver its goals and ensure patient safety. The Trust has to ensure it defines these risks, analyses them and identifies how to mitigate against them, and this is key to how the Trust manages risk.

The most significant risks are reported to the board each month, along with actions to manage them, and this information is available in the Trust's board papers on its website **www.dgft.nhs.uk**. The most recent reporting period at the time of production of this annual report was March 2025.

In relation to achievement of goals, the Trust faced the following major risks during the year which includes clinical and longer-term risks:

- Inability to discharge patients in a timely manner to support emergency patient flow and restoration of planned services.
- Increased demand for services resulting in the inability to deliver safe, effective services. We have regularly needed to use more beds than are funded to manage surges in demand especially during winter.
- Financial viability risks caused by legislative changes in the national and local health economy.
- Failure of the IT infrastructure/cyber incident causing widespread operational capacity issues.

The Trust has clearly identified the primary risks facing the organisation, and management and mitigation are set out in the Annual Governance Statement on page xx as well as under sections relating to clinical, operational and financial performance.

Incident management and never events

The Trust actively encourages its staff to report incidents, acknowledging that to improve patient safety it first needs for staff to recognise and report events in order to learn from them. To support a healthy reporting culture, the Trust continues to develop, strengthen and embed processes to ensure incidents are robustly reviewed and investigated in a fair and open manner, with learning shared across the organisation and embedded into practice to prevent recurrence.

During 2024/25 the Trust continued to demonstrate a healthy reporting culture, with a low proportion of incidents resulting in significant harm. Incidents resulting in potential or actual significant harm are subject to multi-disciplinary scrutiny in line with the Trust's Patient Safety Incident Response Plan (PSIRP) at the Incident Decision and Learning Group, where decisions are made regarding the response required to fully understand contributory factors, mitigate risk and support those involved and ultimately continue to improve patient safety.

2024/25 was the first complete year of working in line with national patient safety strategy, namely working to the Patient Safety Incident Response Framework and reporting incidents to the national Learning from Patient Safety Events System (LfPSE).

During this period the Trust has made significant progress with the development and embedding of this framework, implementing proportionate system-based approaches to incident review. Importantly the new processes are centred on engagement and support for those impacted by incidents; patients, families and staff, all of which have provided positive feedback on their involvement. Never Events remain a national priority incident when working under the Patient Safety Incident Response Framework. During 2024/25 there were no new Never Events reported; this represents a reduction compared to the previous year.

The Learning from Patient Safety Events (LFPSE) service is the new NHS service for the recording and analysing of patient safety events, replacing the National Reporting and Learning System (NRLS). During 2024/25, the Trust has continued its work as an early adopter with the Datix supplier and the National Patient Safety Team, reviewing and feeding back on system upgrades and associated functionality. The incident reporting form has been subject to significant change as a result of the introduction of this system which has been associated with negative impact on reporting culture across the NHS. The Trust has worked hard to ensure reporting forms are as streamlined as possible and have supported staff through training programmes and targeted communications. There was a decline in incident reporting following transition to the Learning from Patient Safety Events System, however during this annual period there has been a return to the pre-transition incident reporting levels range

In February 2025, the Datix system has been further updated to capture positive event reporting to support the Trust's promotion of a Safety II approach to patient safety and to comply with the national requirement for positive events reporting to the Learning from Patient Safety Events System.

How we manage our services

The day-to-day operational management of our hospitals and services is led by the Executive Director Team, under the leadership of the chief executive. This team is directly supported by a range of senior managers across various corporate and clinical departments, ensuring coordinated oversight and delivery of care across the organisation.

Our operational model is structured into four clinically led divisions, each supported by a range of corporate services. The divisions are:

- Surgery, Women and Children Division
- Medicine and Emergency Care Division
- Community and Core Clinical Support Services Division
- Place Division

These divisions are designed to work independently of each other but have strong links across patient pathways and services. Each division is managed by a dedicated triumvirate leadership team, comprising a chief of service, divisional director of operations, and a divisional chief nurse. These divisional leadership teams report to the chief operating officer, who in turn reports directly to the chief executive.

Corporate services provide essential support to all clinical divisions and include:

- Communications
- Estates and Facilities
- Finance
- Governance
- Human Resources
- Information Services
- Organisational Development
- Dudley Improvement Practice (Quality Improvement)
- Research and Development
- Information Technology (IT)

We operate a robust board committee structure to ensure effective governance, oversight, and strategic management. The Board of Directors holds overall responsibility for setting the strategic direction of the Trust, ensuring robust accountability mechanisms are in place, and fostering a positive organisational culture. The board meets on a monthly basis to review performance, risk, and progress against strategic objectives.

Key sub-committees of the board include:

- Finance and Productivity Committee
- Audit Committee
- Quality Committee
- People Committee
- Integration Committee
- Digital Committee (dis-established from May 2024)
- Joint Provider Committee

Going concern

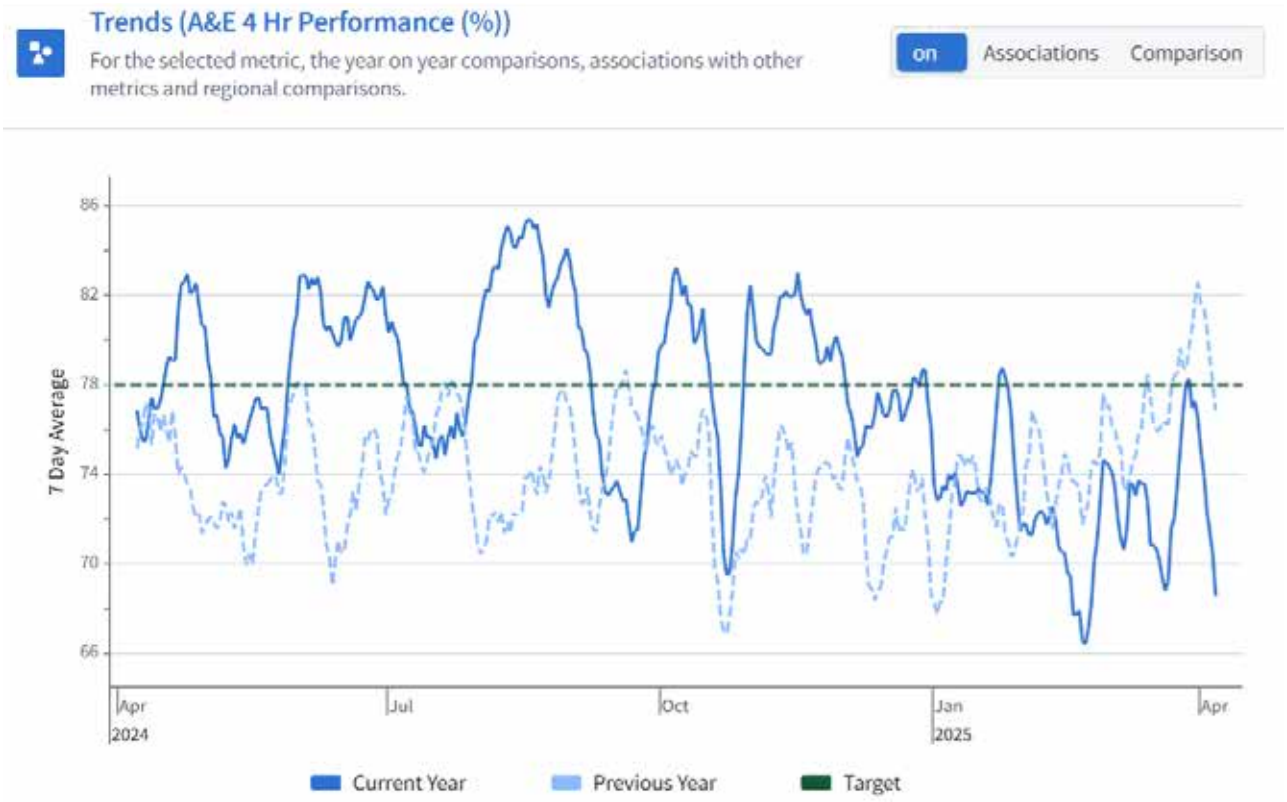
After making enquiries, the directors have a reasonable expectation that the services provided by the NHS foundation trust will continue to be provided by the public sector for the foreseeable future. For this reason, the directors have adopted the going concern basis in preparing the accounts, following the definition of going concern in the public sector adopted by HM Treasury's Financial Reporting Manual.

The Trust's recruitment team supporting our goal of 'being a brilliant place to work and thrive'

Performance summary and Emergency Access Standard

2024/25 has continued to be a challenging year with respect to the Emergency Access standard. Between May 2024 and November 2024, the Trust moved from 16th place nationally for 4-hour performance to 3rd, the 4-hour performance has continued to remain mostly above 75% however as the chart below demonstrates difficulties in flow and capacity have resulted in a deterioration in performance in the last quarter of the year.

The pressure around 4-hour performance is most significant in the admitted pathways where challenges in discharge of patients from the organisation reduces flow for these patients outside of the Emergency Department.



In order to provide additional capacity, to meet the acuity and footfall demand at the front door, the Trust opened additional capacity in the Acute Medical Unit, Discharge Lounge and Same Day Emergency Care reas. Successful partnership working between the Trust and local partners managed to end the requirement for bedded patients in the Same Day Emergency Care area at the end of the period.

As part of ongoing efforts to improve this performance, The Trust is exploring targeted measures, including:

1. Enhanced discharge planning and increased step-down care capacity to reduce inpatient bed blockages.
2. Optimised bed management strategies to ensure timely transfer of patients from Emergency Department to appropriate wards.
3. Improved cross-sector collaboration between hospital, social care, and community services to facilitate faster discharge pathways.
4. Strengthening Emergency Department operational oversight, with a dedicated real-time performance monitoring post, currently in the recruitment process, aimed at providing proactive intervention strategies to prevent breaches.

National Access Standards

This measures compliance against the national standards set by NHS England for patients waiting for appointments, treatments and /or surgical procedures.

We continue perform well for elective recovery having treated all patients above 78 and 65 weeks with a focus now on achieving the 52 week target, the current national focus from NHS England as part of the elective recovery programme.

We continue to provide mutual aid in collaboration with our partners across the Black Country system to ensure that patients are treated as quickly as possible.

Moving forwards the Trust is focusing on the return to the 18 week standard with a set trajectory to achieve this in line with the NHS England timeline, this means patients will begin to again receive timely care and treatment after a period of significant elective treatment delays.

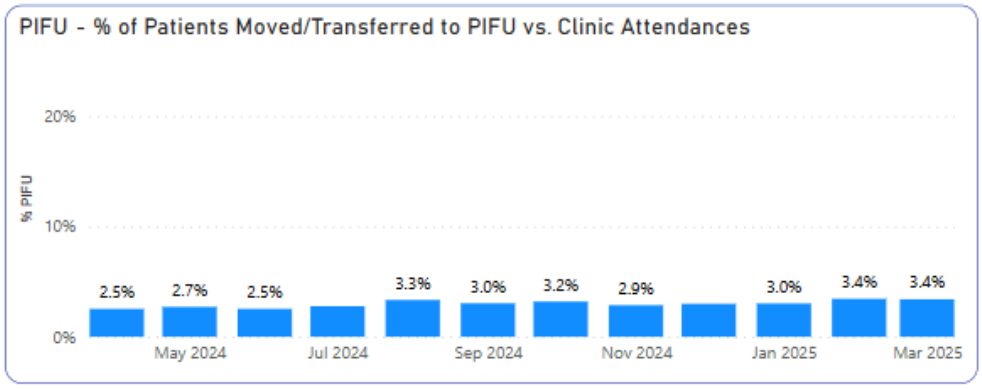
Outpatient Transformation

Patient Initiated Follow Up (PIFU)

Patient Initiated Follow Up is one of the key outpatient transformation initiatives in delivering elective recovery and driving follow-up reductions through the national Getting It Right First Time (GIRFT) Further Faster Programme. Patient Initiated Follow Up continued in 2024/25 and continues in the 2025/26 Priorities & Operational Planning Guidance.

Patient Initiated Follow-Up describes when a patient, or carer, can initiate follow-up appointments when they need one and aims to avoid unnecessary appointments while transforming the quality of outpatient services; ensuring patients are seen at the right time, as well as, empowering them to take control of their own health in line with the personalised care agenda.

2024/25 The Dudley Group Patient Initiated Follow Up Performance - 3.4% to March 2025



Getting It Right First Time Further Faster 20 Programme

Getting It Right First Time was first started in 2012 with the overall aim of reducing unwarranted variation between NHS Trusts in England. It is funded by the Department of Health.

The Further Faster 20 programme is part of the Getting It Right First Time (GIRFT) initiative.

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

The Trust continues to drive the Getting It Right First Time (GIRFT) Further Faster 20 Programme, as well as Specialty GIRFT Meetings since July 2023.

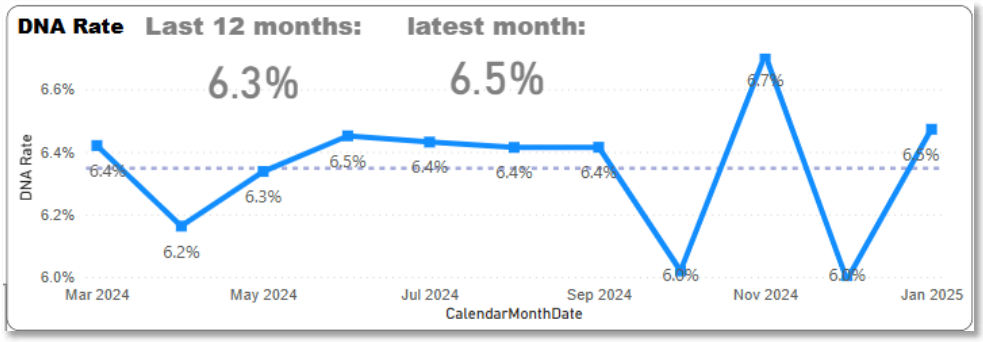
Key priorities include:

- Delivering on outpatient's pre-appointments
- Reducing and managing missed appointments (DNAs)

- Offering remote appointments
- Outpatient throughput by improving appointment flow
- Offering Patient Initiative Follow Ups across 17 core outpatient services.
- Improving Pathways through: - Diagnostics, Surgical Pathways and Theatres.

Did Not Attend (DNA's)

2024/25 DNA Performance - Trust Target for DNAs is 5% and at the end of March the Trust achieved 6%.



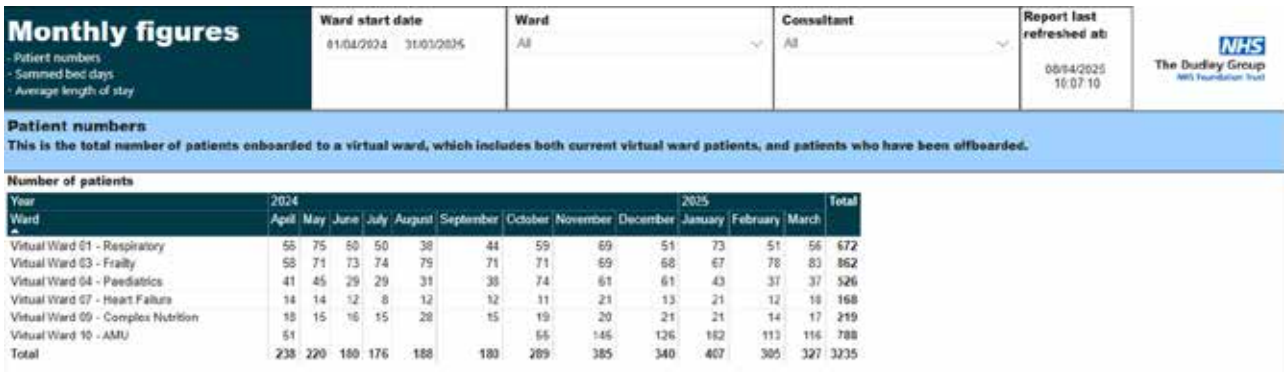
Ongoing Specialty / Divisional / Trust Actions during 2024/25:

- Clinic Outcome Forms completed.
- Text Reminder Service has been updated to send reminders seven days and four days before the scheduled event.
- Outpatient Department 642 Dashboard & Outpatient Clinic Efficiency Models support specialty deep dives to understand 'did not attend' themes / mitigation plans.
- Adhering to Trust Access Policy in managing 'did not attend' patients.
- Call same day 'did not attend' patients to convert to a Virtual Consultation where possible.
- 'Did not attend' Predictor Tool developed to support health inequalities.

Virtual Wards

The expansion of virtual ward capacity has been a key focus of the Trust during the last year. The chart below demonstrates the significant increase in Q3 and Q4 with 3235 patients admitted to the virtual ward in 24/25 compared to 2223 in the previous financial year.

The virtual ward is also focusing on the ability to 'step up' to the virtual ward as a tool for admission avoidance in addition to the traditional 'step down' from inpatient care approach and this has proved successful.

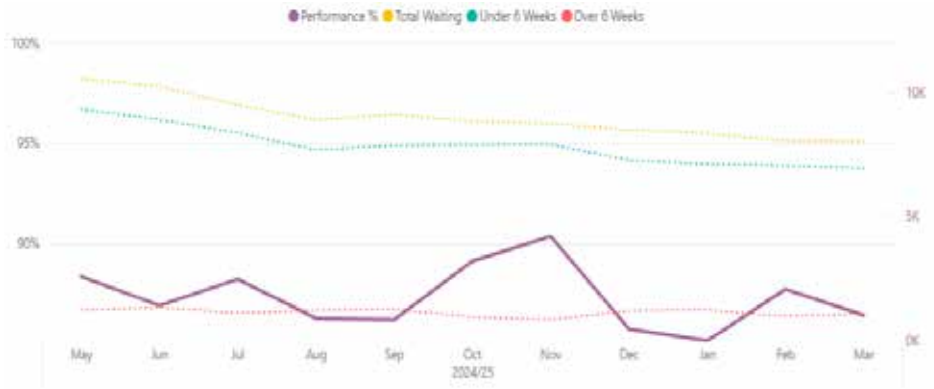


Year	2024									2025			Total
Ward	April	May	June	July	August	September	October	November	December	January	February	March	
Virtual Ward 01 - Respiratory	55	75	60	50	38	44	59	69	51	73	51	56	672
Virtual Ward 03 - Frailty	58	71	73	74	79	71	71	69	68	67	78	83	862
Virtual Ward 04 - Paediatrics	41	45	29	29	31	38	74	61	61	43	37	37	526
Virtual Ward 07 - Heart Failure	14	14	12	8	12	12	11	21	13	21	12	18	168
Virtual Ward 09 - Complex Nutrition	18	15	16	15	28	15	19	20	21	21	14	17	219
Virtual Ward 10 - AMU	51						55	146	126	182	113	116	788
Total	238	220	189	176	188	180	289	385	340	407	305	327	3235

Diagnostic DM01 performance measure

DM01 performance measures compliance for patients waiting six weeks or more for a diagnostic test at the end of each month. National target for 2024/25 was 95% of patients to be seen within six weeks by end of March 2025.

The Trust's performance against the standard is illustrated below:



Performance against this target shows continuous improvement in majority of modalities and achievement of year end trajectory, with exception of Sleep Studies and Cardiac MRI specialist scans. There are recovery plans in place for target to be achieved by both of these by end of June 2025.

Community Diagnostic Centre (CDC):

The Community Diagnostic Centre based at the Trust continues to be a great support to improve patient waiting times for diagnostic tests. The Centre has expanded further during 2024/25 with 231,584 diagnostic tests completed at our Community Diagnostic sites and additional services have commenced from April 2025. The Community Diagnostic Centre continues to provide improved patient access to urgent diagnostic tests, especially for cancer diagnoses and the Trust continues to provide system mutual aid for diagnostics.

Referral to Treatment

The Trust has been successful in reducing the number of patients waiting over 65 weeks for treatment, with the focus now moving to returning to the 18-week standard. A key focus of this achievement has been the utilisation of high volume and high intensity lists, increasing the number of patients that can be treated in a single session by improving preparation and optimising the staffing ratios. This has been particularly successful in General Surgery and Ophthalmology with other specialities looking to adopt similar processes.

The Trust also introduced the paediatric 'Super Saturday', converting all of the day case theatre space to paediatrics and increasing the number of patients being able to be treated in that area on a single day. The feedback received has been universally positive and is an initiative that is going to be continued moving forwards.

Cancer services

There are three main standards for cancer services:

1. 75% of patients diagnosed and told within 28 days of referral (28 Day Faster Diagnosis Standard).
2. 96% of patients diagnosed with cancer, irrespective of how they were initially referred, should start treatment within 31 days of decision to treat their cancer diagnosis.
3. 85% (75% by March 26 as per NHS England) of patients referred directly by their GP or following a referral via consultant or emergency admission to a cancer pathway who are then subsequently diagnosed with cancer should start treatment within 62 days of referral.

The achievement of cancer performance targets has been challenging during 2024/25 in line with our peers, and the NHS. Coming towards the end of 2024/25 we achieved our targets set by NHS England which were to achieve 77% 28 Day faster diagnosis standard of which we have finished on 85%. We were also asked to

achieve 70% for the 62 day referral to treatment, whilst the constitutional standard is set at 85% we achieved 71% in March 2025.

We continue to work towards achieving the 62 day standard as this remains a challenge for the Trust and within local and national providers. The national ask for March 2026 is to achieve 75% for this standard.

Our 31 day target for decision to treat remains close to 94% which is short of our 96% target with work ongoing to improve this and move us towards achieving this target.

We are working with the teams continually to improve waiting times and drive down the number of patients who have breached their 62 day target. Within this work we will aim to improve the pathways to achieve a higher volume of 62 day targets whilst still reducing the backlog currently on the patient tracking list (PTL). Whilst there isn't a target set for 25/26 regarding our 62 day backlog, we will continue to monitor locally and as part of the ICB.

Diagnostic performance

The constitutional performance standard for diagnostics, measures the percentage of patients able to access diagnostic tests within six weeks.

Achievement against this target shows continuous improvement in the majority of modalities and achievement of year end trajectory, with exception of Sleep Studies and Cardiac MRI specialist scans. There are recovery plans in place for the target to be achieved by both modalities by end of June 2025.

The Community Diagnostic Centre (CDC) at the Trust continues to be a great support to improve patient waiting times for diagnostic tests. The Centre has expanded further during 2024/25 with 231,584 diagnostic tests completed at our Community Diagnostic Centre sites year to date and additional services commencing from April 2025. The Community Diagnostic Centre continues to provide improved patient access to urgent diagnostic tests, especially for cancer diagnoses and the Trust continues to provide system mutual aid for diagnostics.

Patient flow

Patient flow remains one of the biggest challenges for the organisation.

The Trust made significant improvements in both 4-hour and 12-hour performance in the first half of the financial year but challenges in flow, throughout the organisation, meant that this deteriorated in the later part of the year particularly for patients on admitted pathways.

Ambulance handover times have also been a particular challenge, work to introduce a more rapid streaming and assessment process is underway that will allow for appropriate patients to be streamed away from the emergency department more quickly where possible.

Timeliness of discharge continues to be one of the most significant factors in achieving flow, with in excess of 100 patients who don't meet the national criteria to reside within our bed base. Close working relationships with our system partners is working to move patients to more appropriate care settings or home as quickly as possible. Moving forwards the introduction of a Transfer of Care Hub is being progressed, this will support ward areas and departments in recognising complex needs earlier in the patients journey to expedite discharge when a patient no longer requires hospital treatment. This will support the reduction of patients experiencing delayed discharge promoting flow.

Equality of service delivery

At The Dudley Group we firmly believe that diversity is a strength, and inclusion is the key to unlocking the full potential of our workforce and the communities we serve. We are dedicated to fostering an environment where everyone feels valued, respected, and empowered to contribute. This commitment forms part of our vision "Excellent healthcare, improved health for all". By embracing diversity and practising inclusion, we better serve our diverse patient population.

Patients and their families have the right to be treated fairly and be routinely involved in decisions about their treatment and care. They can expect to be treated with dignity and respect and will not be discriminated against on any grounds including age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex or sexual orientation.

To promote equality of service delivery in our organisation, we have a translation and interpretation service and we are improving on patient communication needs through implementing the Accessible Information Standards.

Other Trust provisions to ensure equity in service delivery include:

- Retaining our Disability Confident Leader status reflecting our commitment to employing disabled staff, enhancing the ability to meet the needs of disabled patients.
- The learning disability team helps improve the Trust's provision for patients with learning disabilities and their families, making it easier for patients with learning disabilities to access hospital services.
- Ensuring equality monitoring data of patients is collected which informs the Trust of uptake of services including screening services.
- Continue to ensure any service change adopts a review of health inequalities through carrying out Health Equality Assessments (HEAT).
- Supporting patients' faith, religion and spirituality needs through the Chaplaincy department.
- Implementing and improving the Equality Delivery System (EDS) performance, supporting the Trust to improve services provided to local communities.
- Continue to build on partnerships and interventions to further support patients at risk of health inequalities by collaborative working through Dudley Place.

Patient experience indicators

The NHS Friends and Family Test (FFT) scores remain a national focus, provide valuable benchmarking information and drive improvement of the patient experience. The Friends and Family Test is firmly embedded within the Trust. All patients are given the opportunity to complete this 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 and online). The Friends and Family Test is presented as the percentage of respondents that rate their experience as very good/good and the percentage of respondents that rate their experience as very poor/poor.

During 2024/25, a total of 51,879 (excluding March 2025 data) people responded to the Friends and Family Test in comparison to 59,772 in 2023/24.

The number of patients rating their overall experience of their care and treatment as 'very good/good' was 83 per cent in 2024/25, no change from 2023/24. The score for the number of people rating their experience as 'very poor/poor' has remained the same at six per cent. Community services received the highest number of positive scores overall for the year with 91% of patients rating their overall experience of our services as 'very good/good' in 2024/25.

Friends and Family Test 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 where required. Patient responses and feedback are shared with teams for learning and service improvement, comments and scores are sent to all members of staff and discussed in the daily huddles. 'You Said, We Have' actions are reported to the patient experience team.

To improve response rates, we have established a group of Patient Experience Champions who promote the Friends and Family Test in their area. We have distributed posters throughout the hospital displaying the links to the Friends and Family Test which has seen an increase in the number of patients completing the survey online. In addition, we produced stickers with online links/QR codes to improve response rates and to ensure that the Friends and Family Test is accessible to all.

The Trust delivers over 4700 babies a year

Infection prevention and control

We take infection prevention and control extremely seriously and monitor performance against a range of infections including Clostridiodes difficile (CDI), Meticillin Resistant Staphylococcus aureus (MRSA), Meticillin sensitive Staphylococcus aureus (MSSA), pseudomonas aeruginosa and Escherichia coli blood stream infections.

Our end of year figures for 2024/25 are displayed in the graphs below.

HOHA – Hospital Onset Hospital Associated (sample taken 48 hours or more after admission)

COHA – Community onset Hospital associated (sample taken within 48 hours of admission but the patient has been discharged from the Trust within the past 28 days)

All Hospital Onset Hospital Associated cases are reviewed by the Infection Prevention and Control Team, and any learning is disseminated throughout the Trust via team huddles, meetings, and service improvement plans.

No themes or trends have been identified.

Although we have exceeded our thresholds the Trust is not an outlier, other local hospitals are reporting similar increases.

C Diff threshold: 73

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

E.Coli threshold: 75

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

MSSA

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

MRSA threshold: 1

Month Name	COHA	HOHA	Total
April	0	0	
May	0	0	
June	1	0	1
July	0	0	
August	0	0	
September	1	0	1
October	0	0	
November	0	0	
December	0	0	
January	0	0	
February	0	0	
March	0	0	
Total	**2**	**0**	**2**

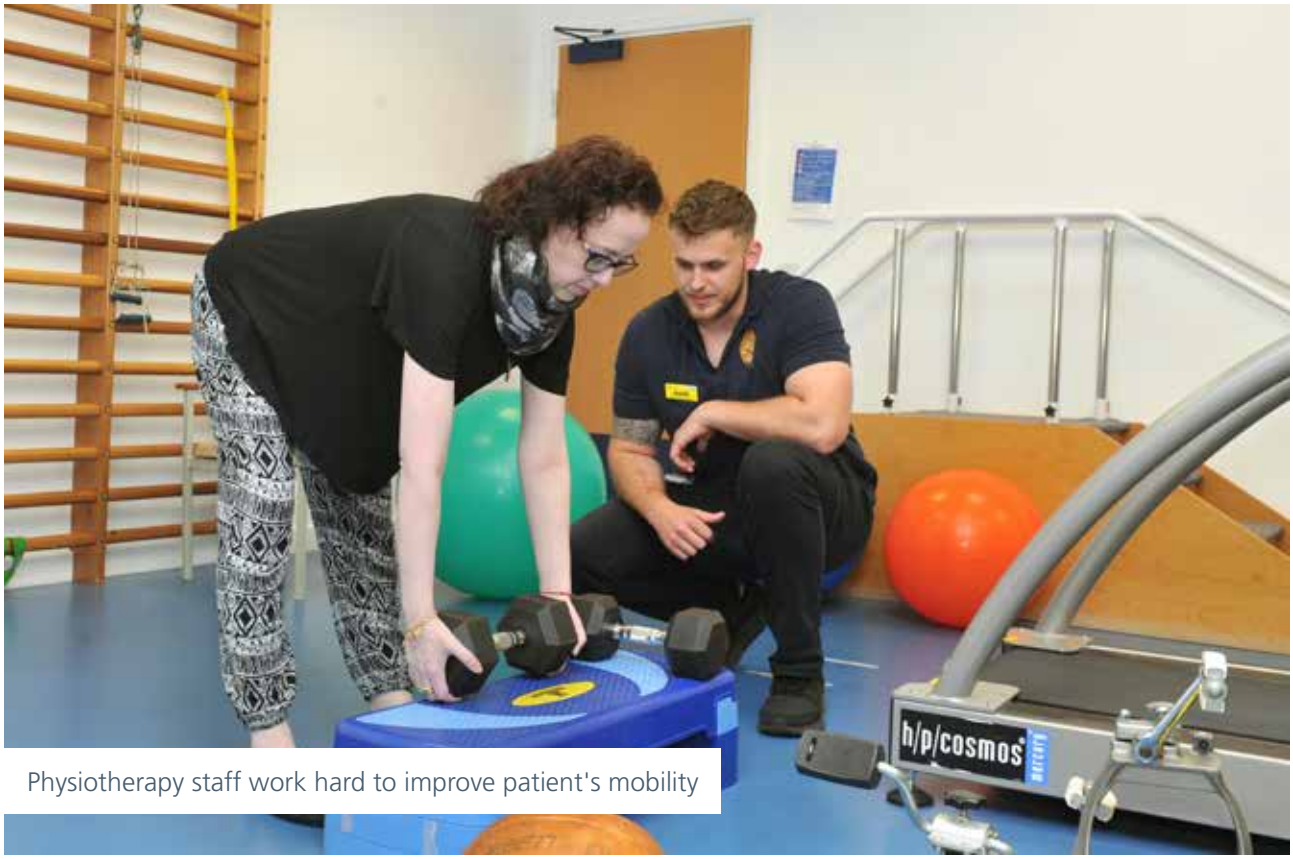
Klebsiella threshold: 19

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

Pseudomonas threshold: 12

Month Name	COHA	HOHA	Total
April	1	1	2
May	2	1	3
June	3	1	4
July	1	1	2
August	0	1	1
September	0	0	
October	0	1	1
November	1	0	1
December	0	1	1
January	0	1	1
February	0	2	2
March	0	0	
Total	**8**	**10**	**18**

TO RESET



Physiotherapy staff work hard to improve patient's mobility

Quality priorities

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 2024/25 demonstrated across all of the priorities. At year end the Trust achieved 14 green indicating achievement against target and seven ambers against targets set indicating improvements have been made but target had not been achieved.

Patient Safety - Management of diabetes across all services within the Trust has achieved three of the three targets. A diabetes dashboard is in development to create outpatient clinic capacity and capture data for National Institute for Health and Care Excellence (NICE) diabetes audit submission.

Clinical Effectiveness - Improve outcomes for our patients admitted with a fractured neck of femur with four out of five targets have been achieved. The Summary Hospital-level Mortality Indicator (SHMI) reduced from 133 to 113 but did not achieve the 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 in 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. A 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 Learning Disabilities champion in place.

QUALITY PRIORITIES - 2024 / 2025 update

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 National Institute for Health and Care Excellence 2023.

Where do we want to be?

- 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.
- Development of a dashboard that captures those patients that a digital solution to the management of their diabetes.

Who is responsible?

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 two 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?

- The aim is that the Trust will be back within the expected range of 100 within 12 months and maintaining this.
- 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.

Who is responsible?

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 the emergency department.

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.

Where are we now?

The starting position for Stroke SHMI was 135 and there was evidence of reduced SSNAP compliance for recent periods. We have identified lack of access to specialist Stroke beds and delays in CT head acquisition.

The latest data shows that we have now achieved SSNAP level C with prioritisation of a thrombolysis bed at all times and rapid vetting of CT head requests has been facilitated. There is still an issue with swallowing assessments being done on time, which is being reviewed by the senior AHP team.

Where do we want to be?

- 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.

Who is responsible?

Consultant and Service Lead for Stroke

SHMI 103 at time of report. This is now the national average for this condition.

Data shows that we achieved a SSNAP level B. Improvement to performance has been driven by implementing a B7 bed manager who liaises directly with the site team to enable stroke patients to be admitted to the unit within 4 hrs, prioritisation of a thrombolysis bed and the implementation of Rapid AI in May 2024 has enabled CT head reports to be available quicker which has enabled timelier treatment planning. Swallow assessments have shown improvement since the last update and has achieved the performance target of 100% in May 24.

AHP senior team are currently completing a workforce strategy plan to attract potential therapy students to the trust due to challenges with recruiting into vacant therapy posts. The AHP senior team have also implemented dual roles between physio, occupational and Speech and language therapists to work towards stroke patients receiving the additional therapy input as per the new Stroke guidelines.

Rapid AI was implemented in DGFT in May 24 and the % of patients who have received thrombolysis of all strokes has improved from 5% (Mar 24) to 18% vs 20% target (May 24). However, the Stroke team are working closely with Radiology colleagues and the Black Country ICB to enable the clinical teams at DGFT to receive training for CT perfusions via Rapid AI, which will improve access to mechanical Thrombectomy.

Where are we now?

The results of the 2021 Adult Inpatient survey were published on the Care Quality Commission 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 five 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.

- Pain
- Nutrition and hydration
- Discharge

Data to be captured each month through our volunteers and audits within AMaT. This will allow for triangulation of data with our RSO ensuring the voice of our patients is reflected in future developments.

The RSOs will report through patient experience on progress.

- The aim is to improve our overall scores through providing a better patient experience.

Who is responsible?

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 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.

Where are we 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:

- Appoint two admiral nurses to support the Delerium agenda.
- 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.
    - 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?

- Compliance of 90% for Oliver McGowan training.
- Develop champions in every area to support learning disability agenda
- 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.

The Learning Disability Standards action plan will be monitored through Internal Safeguarding Board (ISB) and report into Patient Experience Group.

Sensory items in calm bags.

Who is responsible?

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 Russells Hall Hospital.

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 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 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 Learning Disabilities Steering Group has taken place.
- Our calm bags have arrived and are being used throughout the Trust.

Financial performance

Collaborative working across the Black Country System was well embedded during 2024/25. As in previous years, finance discussions were undertaken jointly with funding transparently shared across the constituent partners. Significant non elective growth from outside the System resulted in a divergence from the mechanistic approach with external commissioners. This resulted in some recognition of the pressures being faced by Acute providers via the emergency portal.

Reduced real terms funding for the System resulted in a significant opening deficit of £120m. Of this sum, £32.6m related to The Dudley Group.

The start of 2024/25 included continued industrial action from resident doctors prior to pay awards ultimately being agreed nationally. Additional funding of £0.5m was provided to cover the associated costs incurred.

There was a continued requirement to deliver increased elective and outpatient activity in comparison to 19/20 (pre-COVID 19 baseline). Targets were set nationally for each commissioner/provider relationship. For activity delivered in excess of the targets, funding would be made available at full tariff (and vice versa for falling short). The Trust performed excellently against the set targets, delivering an over-achievement of £18.1m. This has been incorporated into the year-end figures.

Pay budgets included challenging assumptions for reduced substantive (4%), bank (25%) and agency (25%) staff numbers. Agency spend remains very low at 0.7% of the pay budget (versus national target of 3.2%). However, minimal progress was made against the substantive and bank intended reductions. The financial impact of this was fully mitigated by the increased levels of income noted above.

Mid way through the financial year, the Trust took over the majority of services previously provided by Dudley Integrated Health and Care NHS Trust. This equated to expenditure budgets of £8.5m and a staff transfer of 183 WTE into the newly formed Dudley Place Division.

The Trust set itself a challenging Cost Improvement Programme saving target of £31.9m (5.6%). Despite the shortfall against planned pay reductions this target was fully achieved (72% recurrently).

As referenced above, the Black Country System set an initial deficit plan of £120m. The validity of this financial position was corroborated by external consultants and subsequently, national deficit funding was made available to the System in order to deliver an overall breakeven position.

The Trust received £25.3m additional funding from this national allocation. In addition, the ICB added a further £5.7m funding by redistributing their planned surplus. This enabled the Trust to amend its plan from a £32.6m deficit to a £1.6m deficit. The Trust successfully delivered against this revised plan, achieving a final deficit of £1.5m. This helped to enable the System to achieve the overall financial breakeven.

Louise is our Transformation Business Partner and has consistently shown exceptional initiative in driving improvements across services

The numbers presented below relate to The Dudley Group financial performance, not including the charity.

	2024/25			2023/24	
	Plan £000	Actual £000	Variance £000	Plan £000	Actual £000
Income	£599,977	£622,021	£22,044	£561,093	£578,976
Pay	-£385,979	-£401,512	-£15,533	-£346,441	-£359,191
Non-pay	-£178,125	-£183,521	-£5,396	-£176,735	-£194,125
EBITDA	**£35,873**	**£36,988**	**£1,115**	**£37,917**	**£25,660**
Depreciation and Finance costs*	-£53,401	-£51,283	£2,118	-£33,674	-£55,971
NET Surplus/(Deficit)	**-£17,528**	**-£14,295**	**£3,233**	**£4,243**	**-£30,311**
Technical Adjustments	£15,938	£12,752	-£3,186	£176	£37,118
Final Surplus/(Deficit)	**-£1,590**	**-£1,543**	**£47**	**£4,419**	**£6,807**

* Figure includes impairment of £15.032m in 23/24 and £0.572m in 24/25 which are removed in the technical adjustments. There is also a gain on absorption of £2.503m following the transfer of Dudley Integrated Health and Care NHS Trust. This gain is also removed via the technical adjustments.

Diane Wake

Chief Executive Officer

… June 2025

Directors' report

The Board of Directors was established and constituted to meet the legal minimum requirements stated in the Health and Social Care (Community Health and Standards) Act 2003 and the requirements of the NHS Foundation Trust Code of Corporate Governance.

The Trust Board is a unitary board accountable for setting the Trust's strategic direction, vision and values, monitoring performance against annual objectives, ensuring high standards of corporate governance and helping to promote links between the Trust and the local community. The board consists of the shared chair, chief executive, deputy chair, six executive directors and eight non-executive directors (NEDs) all with voting rights, plus three other executive directors and two associate NEDs who attend board meetings in a non-voting capacity. As of 31st March 2025, there were no executive or non-executive vacancies. The Trust board seeks to reflect the local population it serves and, as part of succession planning.

Non-executive director (NED) appraisals for 2023/24 were conducted by the deputy chair on a one-to-one basis. The performance of each non-executive director (NED) was assessed against agreed objectives, specific strengths or areas for improvement, to note that the principal corporate objectives were fully met subject to COVID-19 restrictions which had to some extent precluded some of the opportunities to engage with staff, patients and other stakeholders on site. The appraisal findings were considered by the Council of Governors in September 2024.

The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 deals with the Fit and Proper Persons Test which came into force in November 2014 with guidance refreshed during the year. We have complied with this requirement both upon appointment and with annual re-checks.

Non-executive directors can only be removed by a 75 per cent vote of the Council of Governors following a formal investigatory process, and the taking of independent legal advice, in accordance with guidance issued by our regulators.

We are confident that our board members do not have any interests or company directorships which could conflict with their management responsibilities. A Register of Directors' Interests is held by the board secretary and is published on the Trust's website **www.dgft.nhs.uk**.

As an NHS foundation trust, no political or charitable donations have been made during 2023/24. During the year, we were not charged interest under the Late Payment of Commercial Debts (Interest) Act 1998.

As far as the directors are aware, there is no relevant audit information of which the auditor is unaware. The directors have taken all of the necessary steps to make themselves aware of any relevant audit information, and to establish that the auditor is aware of that information.

Section 43(2A) of the NHS Act 2006 (as amended by the Health and Social Care Act 2012) requires that the income from the provision of goods and services for the purposes of the health service in England must be greater than its income from the provision of goods and services for any other purposes. We confirm that we have met this requirement, and that income received in 2024/25 had no impact on our provision of goods and services for the purposes of the health service in England.

During the year, the Trust has continued to embed actions from recommendations arising from the external well-led review, reported in the previous year, that made assessments made against each of the Care Quality Commission well-led key lines of enquiry (KLOEs). The report concluded that the organisation had improved its service delivery and noted the significant progress in developing relationships and effective clinical leadership. The Trust is assimilating its self-assessment activity to reflect the refreshed CQC framework.

The Board of Directors is responsible for ensuring that we have effective governance arrangements supporting the delivery of our quality priorities. Reports on the Trust's progress against the established quality priorities are taken to both the Board of Directors and the Council of Governors by the chief nurse. Further information on progress against standards can be found on the Trust's website **www.dgft.nhs.uk**.

In the following pages you will find more information about the Board of Directors in post during the year 2024/25.

Our Board of Directors (alphabetical by surname)

Karen Brogan – Interim Chief People Officer

Karen first joined the Trust in 2019 and has worked in HR for just over 15 years. She has extensive experience of working within the NHS, having previously held roles at Birmingham and Solihull Mental Health NHS Foundation Trust and Coventry and Warwickshire Partnership NHS Trust.

Prior to joining the executive board, she held the role of director of operational HR, and has helped shape our Dudley People Plan, our staff health and wellbeing service and our behaviour framework. She has also helped to establish our important staff networks, which continue to have positive engagement across our diverse staff communities. Karen also led on the development of the vaccination programme for the Black Country.

Karen is passionate about the Trust's people strategies and successfully implementing these for the benefit of our staff and patients.

Gary Crowe, Non-Executive Director

Gary was most recently a university professor of innovation leadership at Keele University Management School. He previously held senior commercial positions in strategy, business transformation and risk and financial management as a director and management consultant in the financial services sector.

Gary holds a number of external board appointments and has served as an independent non-executive director with another NHS trust since 2015. He is a qualified chartered banker and fellow of a number of professional organisations and learned societies.

Peter Featherstone, Non-Executive Director

Peter joined the Board in June 2024 and is a pharmacist by background and an experienced non-executive director, who has previously held senior leadership positions across NHS bodies and local government authorities in transformation, service efficiency, service improvement, and corporate governance.

Residing and working within the West Midlands for the majority of his professional life, Peter has developed a nuanced understanding of the local health and social care landscape, including the specific challenges and opportunities it presents, and is passionate about improving health outcomes, addressing health inequalities, and improving access to care across diverse communities.

Jo Hanley, Non-Executive Director

Jo joined the Trust as a non-executive director in June 2023. A graduate of the University of Edinburgh, Jo has held a range of senior leadership positions across the Commercial Banking, Group Operations and Wealth/Private Banking divisions of Lloyds Banking Group where she worked for some 20 years.

Jo currently led the Data Office for the global Corporate Markets business, prior roles include leading risk, customer servicing and operations functions and also delivering large scale transformation and integration programmes. Prior to joining Lloyds Banking Group, Jo worked at the Black Country Chamber of Commerce advising businesses to trade internationally.

Jo has significant global experience having lived and worked in Belgium, the Netherlands, Spain and the United States in addition to working across Asia and Latin America. Jo has expertise in establishing and leading centres of excellence/shared service functions and outsourcing arrangements, strategy development, delivering regulatory change in addition to business and service improvement.

Jo is a diversity and inclusion advocate, currently co-chairing the Midlands Branch of Women in Banking & Finance (Social Enterprise) and is passionate about supporting and enabling people to realise their potential. Jo has a strong connection to Dudley having grown up in the area.

Professor Anthony C. Hilton, Associate Non-Executive Director

Anthony joined us from Aston University where he is currently Pro-Vice Chancellor and Executive Dean of the College of Health and Life Sciences.

A microbiologist by background, Anthony has held academic posts at the University of Birmingham and Aston University. Professor Hilton is a regular contributor to print and broadcast articles and has been recognised by several prestigious awards for his teaching and science communication activities. He is keen to bring his experience of training healthcare professionals and collaborative clinical research to the Trust.

Julian Hobbs, Medical Director

Julian joined the Trust from Liverpool University Hospitals NHS Foundation Trust where he had been deputy medical director. Julian has also been deputy medical director and lead for mortality for the Cheshire and Merseyside area team at NHS England.

Julian is a consultant cardiologist by background and has worked at Liverpool Heart and Chest Hospital alongside his current roles. He has had extensive experience in medical management roles for several years. Julian undertook his research at Manchester Royal Infirmary with support from the British Heart Foundation. He is a keen sportsman and beekeeper.

Catherine Holland, Non-Executive Director

Catherine is an author, speaker, coach/mentor and facilitator.

She published her first children's novel in 2021 and is currently writing more children's books. Catherine is former Chair of the Icelandic Horse Society of Great Britain and is a Parish Councillor.

As an associate consultant with Amara Collaboration, Catherine was a contributing author to Street Smart Awareness and Inquiry in Action, and co-designer and facilitator in transformational leadership development retreats.

A former social worker and trainer and assistant director in social services, Catherine worked for 14 years in the Probation Service, first as a director for corporate services and later as chief executive of Staffordshire and West Midlands (SWM) Probation Trust, the second largest probation trust in the UK.

Catherine designed and led West Midlands Probation through a successful performance and culture turnaround programme, and project managed the merger with Staffordshire Probation, the new trust going on to be recognised for excellence and awarded four stars by the British Quality Foundation.

Catherine led SWM Probation Trust through extensive and challenging changes brought about by the government's Transforming Rehabilitation programme, becoming chief executive of Staffordshire and West Midlands CRC, and later the newly formed Reducing Reoffending Partnership.

Liz Hughes MBE, Non-Executive Director

The Dudley Group welcomed Liz to its board in December 2019. Liz is a consultant in chemical pathology and metabolic medicine at Sandwell and West Birmingham Hospitals NHS Trust and honorary professor at the University of Warwick, University of Aston, University of Coventry, University of Bolton and visiting professor at Worcester University.

Professor Hughes established the physician associate role in the NHS, a role that many hospitals now have within their workforce, securing the first ever non-medical faculty at the Royal College of Physicians. She is proud that when it first began in 2015 there were 183 and now there are over 3,000 physician associates employed in the NHS. Her recent achievement is the approval of the medical degree apprenticeship allowing far greater access to study to become a doctor.

Medical education and training are a passion for Professor Hughes who has also established a GP training scheme with the Chinese government and developed speciality medical training within the Middle East.

Liz is a national expert in the treatment of inherited lipid disorders and is one of the founder members of the national charity HEARTUK with which she has worked extensively with multi professional healthcare professionals and patients

In 2016, the aviation profession honoured Liz for her contribution towards training doctors in aerospace-related medicine. She was the winner of the Improving Safety in Medicines Management category in the Patient Safety Awards 2013. She was awarded an MBE for services to healthcare education and training in 2020.

She has held a number of national roles including medical director for NHS England Workforce Training and Education, chair of Academic Careers and Research Evidence and is NHSE's disability champion.

Karen Kelly, Chief Operating Officer and Deputy Chief Executive

Karen joined us as chief operation officer (COO) in January 2018 from Barnsley Hospital NHS Foundation Trust where she held the post of executive director of operations.

A graduate of Keele University, Karen qualified as a nurse in 1993 and worked for more than 23 years at the University Hospital of North Staffordshire where she held a variety of roles including the first matron role for Urgent and Emergency Care before moving into managing the Directorate of Emergency Care.

Prior to joining us as a COO, Karen had been involved in overseeing a range of large-scale service developments and improvement projects. She became part of the transformation team tasked with turning around Mid Staffordshire NHS Foundation Trust – becoming head of nursing there in 2010. Following this, she held the post of medical nurse director, followed by deputy director of operations at The Royal Liverpool and Broadgreen University Hospital Trust.

Karen is passionate about leadership development and working alongside people to promote quality of care being delivered that ensures our patients are safe.

Dr Mohit Mandiratta, Non-Executive Director

Dr Mohit Mandiratta qualified as a GP through the Dudley VTS scheme in 2013. He has spent the last 10 years working at Feldon Practice in Halesowen, where he enjoys the role and responsibility as a GP partner.

His role in primary care has allowed him to gain invaluable insight into the health needs of local people and this has been furthered by his involvement in healthcare commissioning (in CCGs and the ICB) since 2016. Mohit enjoys educating our future doctors as a GP trainer and he also supports a national 'Rebuild General Practice' campaign where he has spoken to MPs in Westminster highlighting the issues which primary care currently face.

Mohit has held a variety of leadership roles including board-level positions and was a governor at the Trust between 2020 and 2024.

He is passionate to improve the health outcomes for the population and believes that influencing wider determinants of health is integral to achieving this, as such he has provided clinical advice to 'Thrive into Work' since 2018 to support those with long term physical and mental health conditions back into employment.

Martina Morris, Chief Nurse

Martina is originally from Slovakia, where she began her nursing career, qualifying as an adult nurse in 1994. Martina then worked in intensive care and operating theatres and in early 1998, moved to the United Kingdom (UK). In late 1999, Martina decided to settle in the UK and after completing a period of adaptation, she secured her first registered nursing post in the UK on critical care unit at the Wrexham Maelor Hospital in North Wales in late 2000. In 2005, Martina relocated to the Midlands region and developed her career focusing on practice development, quality, safety and standards, underpinned by robust governance. In her career, she has worked in a variety of senior roles in acute providers and regionally, within the Midlands and East region.

Martina prides herself in being an authentic and compassionate leader with a proven track record of quality improvement and change management skills, which have enabled her to deliver improvements to nursing and wider services and improve patient outcomes and experience. Her expertise includes, operational and strategic nursing and midwifery agendas, practice development, quality improvement, governance, patient safety, patient experience and engagement, workforce assurance and development.

Martina is passionate about ensuring that staff are supported, empowered and equipped in their roles to provide a high-quality patient care and experience and drive continuous and outcome focused improvements. She is also very keen on ensuring that patient voice is heard and opportunities for patient engagement and co-production are maximised.

To consolidate her nursing leadership and experience, Martina successfully completed the national Aspiring Directors of Nursing talent pipeline programme in 2020, facilitated by NHS Improvement and NHS Leadership Academy.

Anne-Maria Newham, Non-Executive Director

Anne-Maria joined the Board in June 2024 and has had previous roles that include executive director of nursing at Lincolnshire Partnership NHS Foundation Trust and has previously held the role of deputy chief executive at Nottinghamshire Healthcare NHS Foundation Trust.

She is currently chair of a healthcare company that provides care for children with life limiting illnesses in their own home. She was awarded a Florence Nightingale Leadership award and a travel scholarship, enabling her to learn from major institutions around the world on best practice for nursing care.

She was awarded a Churchill Fellowship and travelled to New Zealand to look at integrated care including end of life care and compassion in practice.

Anne-Maria has spoken at several international conferences including the Nursing World Conferences in Las Vegas and Rome. She was awarded an MBE in the Queen's Honours in 2018 for services to nursing.

Sir David Nicholson, Chair

Sir David Nicholson joined the Trust as chair on 1st September 2022. He is also currently chairman of the Royal Wolverhampton NHS Trust, Walsall healthcare NHS Trust and Sandwell and West Birmingham Hospitals NHS Trust. David stood down as chair of Worcestershire Acute Hospitals NHS Trust in August 2022.

Sir David Nicholson's career in NHS management has spanned more than 40 years and included the most senior posts in the service. He was chief executive of the NHS for seven years from 2006-2013 and then, following a major national restructure, became the first chief executive of the organisation now known as NHS England from 2013-2014.

Since his retirement from the NHS in 2014, he has taken on a number of international roles providing advice and guidance to governments and organisations focused on improving population health and universal healthcare coverage.

He has worked in China, Brazil, the USA, Europe and the Middle East, independently, and in association with the World Health Organisation, and World Bank. Sir David chaired the State Health Services organisation of the Republic of Cyprus and more recently was also the chairman of the Metropolitan Group of Hospitals, Nairobi.

Sir David was chairman of the Universal Health Coverage Forum of the World Innovation Summit for Health. Other roles have included adjunct Professor of Global Health at the Institute of Global Health Imperial College, Advisor to the British Association of Physicians of Indian Origin and Lancet Commissioner to Global Surgery.

His contribution to healthcare was recognised by the award of the CBE in 2008, and he was knighted by Her Majesty the Queen in 2010. He lives in Worcestershire with his wife and two children.

Andy Proctor, Director of Governance

Andy is our director of governance. He joined us from University Hospitals of Derby and Burton NHS Foundation Trust where he was their director of quality, clinical governance, risk and compliance.

He started his NHS career in the Ambulance Service in 2005 and undertook a range of clinical roles as a paramedic and then later in his career became assistant chief ambulance officer and director for quality improvement at West Midlands Ambulance Service.

Andy has also worked with the Care Quality Commission for eight years being involved in 19 inspections. Andy has extensive experience within governance, compliance and regulation and is passionate about patient safety and ensuring we provide high quality care.

Dr Ita O'Donovan, Non-Executive Director

Ita joined the board in June 2024 and is a social psychologist by background and a former local authority chief executive in unitary authorities in London and the Midlands. Most recently she was a full-time interim strategic director and corporate director with a city council.

Ita also has experience working with chief executives and leaders in Northern Ireland in 2014/2015 during the establishment of 11 new councils. Between 2011-2013 she was appointed as senior expert for the European Cooperation for Stronger Municipalities in Kosovo advising the Ministry of Local Government Administration, working with mayors and directors of eight municipalities in the Central Region.

Ita started her career as an academic at the School of Public Policy, University of Birmingham in 1985. There she undertook extensive consultancy in developing countries seeking to implement public sector reform projects at national, regional and local levels of government. She returned to this work from 2010-2019, working in China, Bangladesh and emerging economies.

Vij Randeniya, OBE, Non-Executive Director

Vij is an experienced non-executive director within the health service. He is deputy chairman of Birmingham Women's and Children's NHS Foundation Trust and sits on the governing body of Aston University. Vij is a trustee of the Royal Society for Public Health and former chief fire officer for West Midlands Fire Service. Vij has substantial experience of large-scale project management, leadership and change management.

Vij was awarded the OBE in 2006.

Kat Rose, Chief Integration Officer

Kat joined the Trust in April 2022, bringing with her more than 15 years of NHS experience in programme management, strategy implementation and delivering healthcare transformation.

Before joining the Trust, Kat held the role of programme director at Herefordshire and Worcestershire Health and Care, working on several million-pound projects. Prior to that she was associate director of strategy and planning at Shrewsbury and Telford Hospital NHS Trust where she worked closely with system partners and managed the strategy, PMO, improvement and planning teams. Prior to this she performed the same role at Birmingham Community Healthcare NHS Foundation Trust.

Kat began her career project managing large scale new builds for the NHS before moving into strategic planning and service transformation.

Kat lives in Worcestershire, just on the border of the Black Country, on her family farm and loves walking her dog in the countryside.

Adam Thomas, Executive Chief Strategy and Digital Officer and Deputy Chief Executive

Adam rejoined the Trust in 2009 and brings more than 15 years of NHS experience in clinical and senior management positions to his executive role.

A graduate of Aston University, Adam qualified as a pharmacist and proceeded to undertake postgraduate qualifications in clinical pharmacy, independent prescribing and digital healthcare leadership. He worked in medical oncology at The Dudley Group and brings a special clinical interest in improving cancer outcomes for the Black Country. He is also a registered IT professional, holding a Fellowship of the British Chartered Institute for IT professionals. Adam has recently completed a Masters degree in Digital Health Leadership, focussing on how intelligence can address population health inequality.

He is established as a digital leader within the region and a strong advocate for collaborative connected care systems. He continues to support strategic agendas as well as quality improvement. Adam is the provider collaborative board lead for digital, data and technology. He speaks at a national level on digital leadership, as well as digital-data strategy in health and care.

Diane Wake, Chief Executive

A nurse by background, Diane has worked in the NHS for over 40 years. She has been a chief executive in the NHS for over 12 years. She joined The Dudley Group NHS Foundation Trust as Chief Executive in April 2017.

Diane trained as a nurse between 1984 and 1987 and has an extensive background in nursing, occupying senior leadership positions in surgical specialties of urology, colorectal, vascular, and breast surgery. Diane has a wealth of experience in both clinical practice and leadership roles.

She was previously chief executive at Barnsley Hospitals NHS Foundation Trust from 2013 to 2017 and interim chief executive at the Royal Liverpool and Broadgreen University Hospitals NHS Trust, where she also worked as chief operating officer and executive nurse from 2007.

Diane has a passion for improvement, patient safety and high-quality care and has knowledge and expertise in implementing robust governance processes. She is inspired by making a difference for patients and staff.

She is committed to system working both within Dudley Place and at Integrated Care System (ICS) level. She is the senior responsible officer (SRO) for the ICS leading on cancer, elective and diagnostics. Diane is also the SRO for provider collaborative across the Black Country System where collaboration and partnership working has never been stronger.

Chris Walker, Interim Director of Finance

Chris Walker joined the Trust in 2009 as deputy director of finance and we are happy to announce that he joined the board as interim director of finance in January 2024, bringing with him over 30 years of experience working within the NHS.

Chris was born and educated in Dudley and continues to live locally. Chris began his career as a trainee accountant in 1992 with the West Midlands Regional Health Authority based in Birmingham.

Chris's first substantive role was with South Birmingham Health Authority and then in 1994, after Trusts were first established, went to work for Southern Birmingham Community Health NHS Trust as a financial accountant based at West Heath Hospital in Birmingham. In 1996 he moved to South Birmingham Mental Health Trust at Monyhull Hospital. During his time there, he qualified as an accountant and took on the role of deputy director of finance. Chris gained experience of working through various mergers involving the organisation as well as the Trust becoming a Foundation Trust.

In 2009 he joined The Dudley Group as deputy director of finance. Chris's role has expanded over the last fifteen years to include managing the Trust's estates team and leading on the management of the Trust's PFI contract. Chris became the Trust's operational director of finance in 2023 as well as taking the lead role for capital for the Black Country ICS.

Lowell Williams, Non-Executive Director

Lowell joined the board in December 2019. He was the former chief executive officer of Dudley College of Technology from 2008-2019 and led the college to an Ofsted Outstanding rating in the 2017 inspection. In January 2018, he was named as one of seven appointments to the government's advisory group, the National Leaders of Further Education, which is made up of principals from colleges who have been rated good or outstanding. Lowell led the creation of Dudley's Academies Trust which he chairs and is a director at the Transformational Technologies Partnership Ltd which oversees the Black Country & Marches Institute of Technology.

Lowell was also elected Councillor for Warwick District Council in 2023.

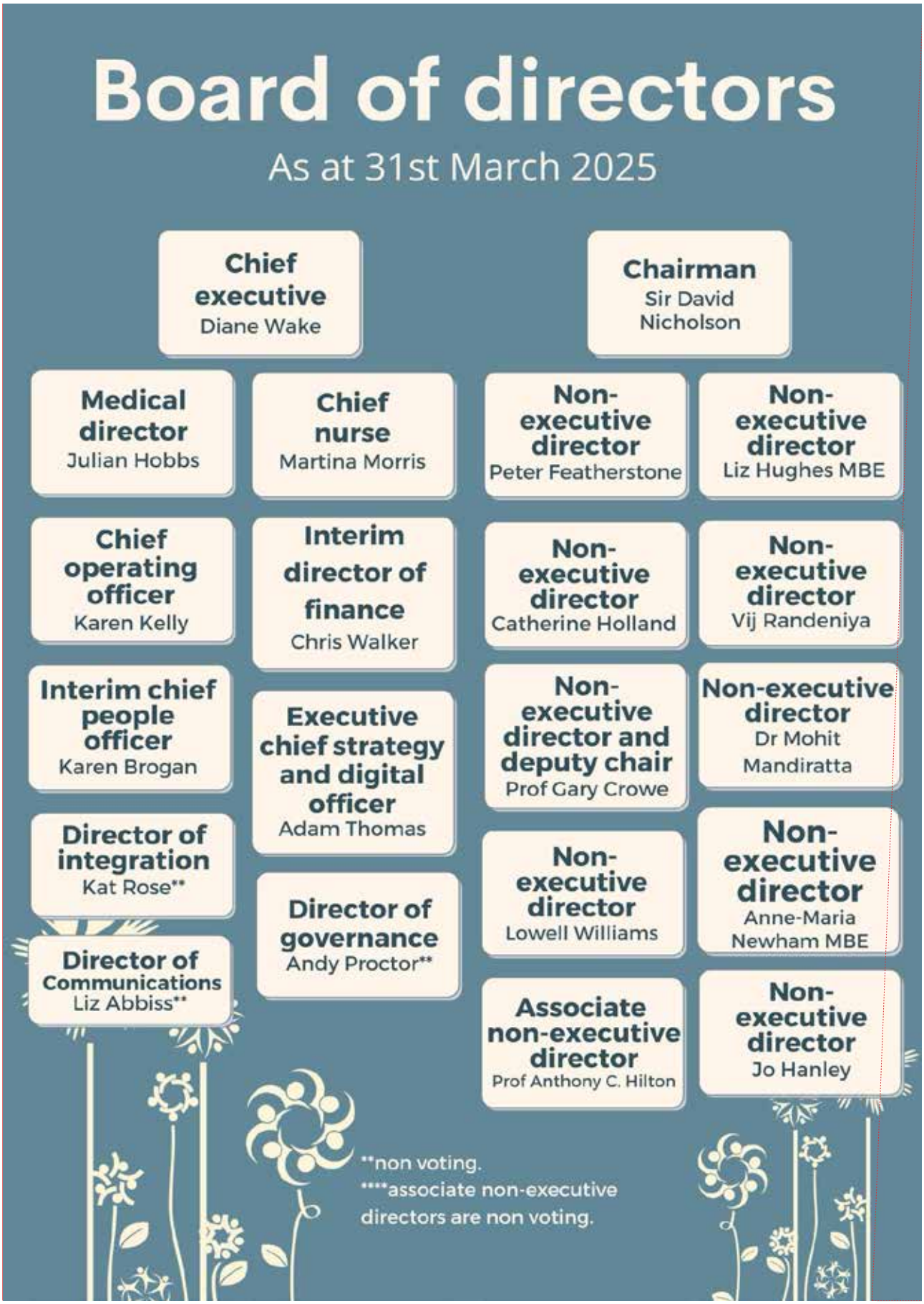
Board of Directors' attendance 24/25 meetings

Position	Name	Commencing	End	Attendance out of 8*
Chief executive	Diane Wake	03/04/17		7
Chief finance officer (interim)	Chris Walker	01/01/24		8
Chief operating officer	Karen Kelly	02/01/18		7
Medical director	Dr Julian Hobbs	02/10/17		7
Chief nurse	Martina Morris	03/03/24		7
Interim chief people officer	Karen Brogan	01/05/24		6
Chief people officer	£12,752	-£3,186	£176	£37,118
(Interim 20/6/22 – 1/7/23)	Alan Duffell	20/06/22	31/04/24	1
Chief integration officer (formerly director of strategy & integration)	Kat Rose**	18/4/22		8
Chief strategy & digital officer				
(formerly chief information officer)	Adam Thomas	01/09/19		8
Director of governance	Andy Proctor **	01/06/22	31/03/25	5/6
Director of communications	Liz Abbiss**	01/05/23		7
Chair	Sir David Nicholson	01/09/22	31/03/27	8
Non-executive director	Prof Liz Hughes	15/11/19	15/11/25	8
Non-executive director	Julian Atkins	04/01/16	31/05/24	2
Non-executive director	Catherine Holland	01/09/18	31/08/26	7
Non-executive director	Lowell Williams	01/12/19	31/03/26	8
Non-executive director	Prof Gary Crowe	01/07/19	01//07/25	4
Non-executive director	Vij Randeniya	20/11/20	31/11/26	4
Non-executive director	Gurjit Bhogal	13/05/21	31/05/24	1/2
Non-executive director	Joanne Hanley	01/06/23	31/05/26	7
Non-executive director	Anne-Maria Newham	01/06/24	31/05/27	5/6
Non-executive director	Peter Featherstone	01/06/24	31/05/27	4/6
Non-executive director	Mohit Mandiratta	01/06/24	31/05/27	5/6
Associate non-executive director	Anthony Hilton**	01/07/23	31/07/25	7
Associate non-executive director	Ita O'Donovan***	01/06/24	31/05/25	4/6
Associate non-executive director	Thuvarahan Amuthalingham**	13/05/21	31/05/24	1/2

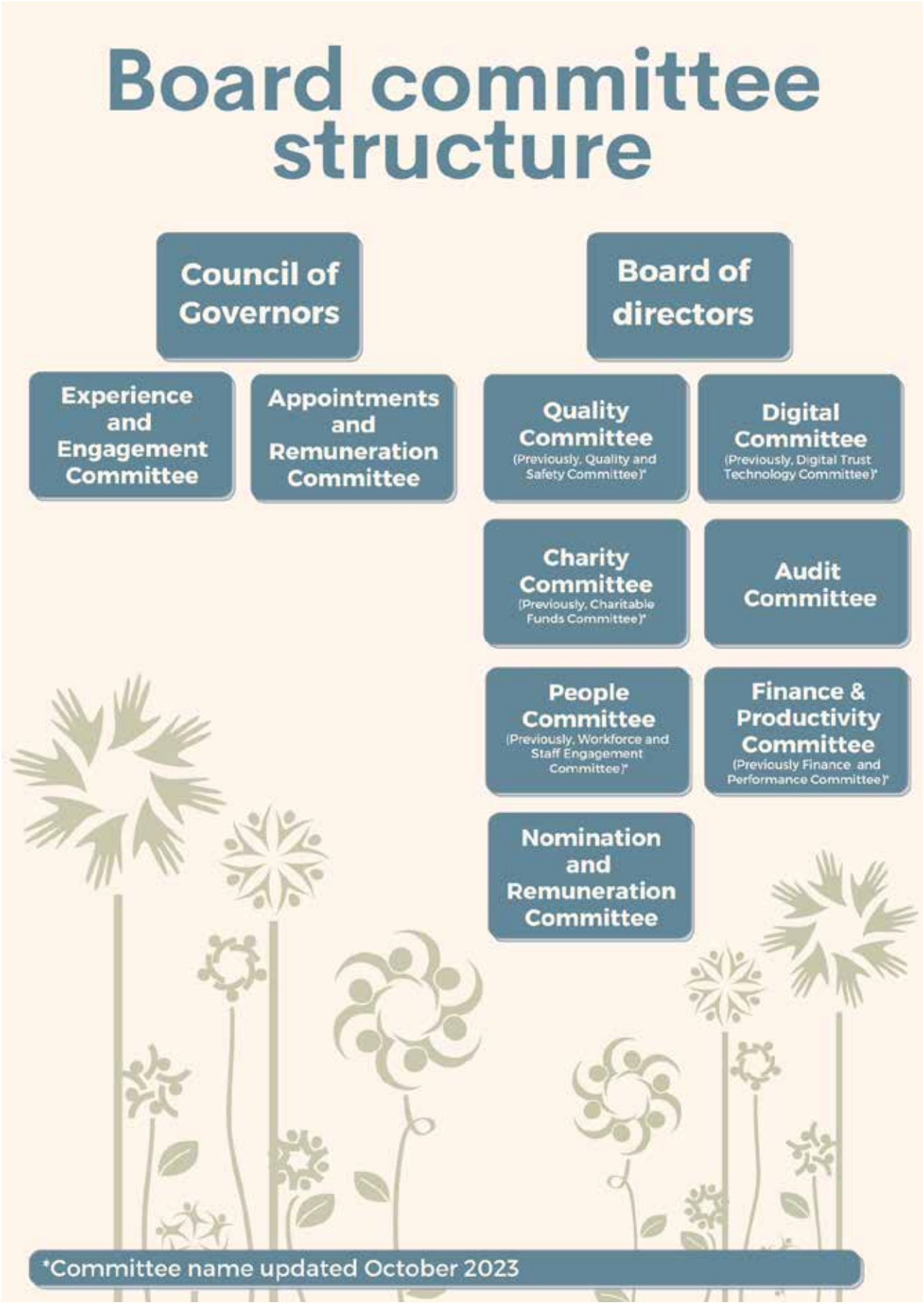
*There was one extraordinary meeting held in May 2024 and one extraordinary meeting held in March 2025.

**non-voting

Notice periods – the notice period for all executive directors is three months. Non-executive directors are appointees and do not have a notice period.



Digital committee disestablished from May '24


Board committee structure
Council of Governors
Board of directors
Experience and Engagement Committee
Appointments and Remuneration Committee
Quality Committee
(Previously, Quality and Safety Committee)*
Digital Committee
(Previously, Digital Trust Technology Committee)*
Charity Committee
(Previously, Charitable Funds Committee)*
Audit Committee
People Committee
(Previously, Workforce and Staff Engagement Committee)*
Finance & Productivity Committee
(Previously Finance and Performance Committee)*
Nomination and Remuneration Committee
*Committee name updated October 2023

Patient experience

There was an increase in complaints activity during 2024/25 (1053) from 2023/24 (956) by 10.1%.

The Trust received 3875 informal concerns and comments and 1486 signposting contacts (in total 5361 cases/activity) to the Patient Advice and Liaison Service in 2024/25, which is an increase from the previous year (2024/24) figures of 5142 in total (4144 informal concerns and comments and 998 signposting contacts). This is an increase of 219 total cases/activity (4.2%).

The increase in the number of complaints and Patient Advice and Liaison Service concerns received is reflective of the frustrations we hear from patients and their families with delays to procedures and appointments. Concerns continue to be raised regarding nursing care and the discharge process. The rise in signposting contacts is reflective of patients wanting to raise complaints about other organisations such as GP practices. The Patient Advice and Liaison Service team signpost patients to the correct organisation. Therefore, we can also see frustrations from patients regarding other NHS services.

Complaints and concerns are reviewed monthly to identify themes and trends across the Trust. These are shared with the divisions each month at their divisional governance meetings. Improvement actions and learning is put into practice and reported to the Patient Experience Group, the Quality Committee and the Board of Directors. Learning is shared through 'Learning from Experience' events held during the financial year.

Patient panels/focus groups

We have hosted a number of virtual 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 planning and development.

Patient experience champions

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 promote patient experience within their areas to help drive Trust wide improvements.

We have hosted several workshops throughout the year to share patient feedback and learning to support and development of the champions role. We have worked together to build partnerships and share information that will support our patients, and shared information on work that is happening within services to improve the patient experience.

Patient voice volunteers

A patient voice volunteer (PVV) is a non-trust employee who supports the hospital in improving patient experience. Our patient voice volunteers have supported events and provided a patient perspective to the inpatient survey action plan and have attended Trust board. In addition, they have supported Experience of Care week and used the Talk to Us Trolley to engage with patients about the service they received

Experience of Care Week

We celebrated Experience of Care Week, which is an annual event that celebrates healthcare staff impacting patient experience every day. This week allowed us to celebrate our staff and the good work that is happening to improve experiences of care for patients, families, carers, and staff.

Throughout the week we hosted a series of events on the Health Hub, including spotlight sessions to showcase all the good work that is taking place, completing thank you cards for our staff and distributing them throughout the Trust. We shared patient stories throughout the week on the Hub and messages from our Patient Experience Champions. There was an appreciation station at North Block for patients, staff and visitors to leave a message of thanks and the Patient Experience team visited areas with our 'Talk to Us' trolley to give out cards and chocolates to staff on the wards and to encourage patients to complete a thank you message for staff looking after them. We were recognised by the Patient Experience Network (PEN) for the good work that took place throughout the week and the team were sent pin badges.

Training

We have continued to deliver customer care training to newly qualified nurses and other staff within the Trust to raise the profile of patient experience and to highlight the importance of what matters most to patients.

Local survey development

We have designed and facilitated a number of local surveys via online links and QR codes to improve the accessibility of giving feedback, allowing patients to provide feedback on their experience of services. These are promoted on the new patient experience boards and tablets.

Encouraging patient feedback and sharing success

Feedback is received via a number of mechanisms that have been designed to enhance the patient experience and improve learning, including complaints, PALS, national and local surveys, focus groups, 'Listening into Action' events and the Friends and Family Test.

Throughout 2024/25, we have continued to build on our 'What Matters to You' campaign across the Trust and via social media channels. This campaign aims to raise the profile of patient experience across the Trust, capture feedback and share successes.

Weddings and additional support to teams

The patient experience team have arranged and supported a number of weddings on the wards for end-of-life patients. We contacted the registrar and chaplains, made decorations, and facilitated the events to ensure the patient, and their partners were able to celebrate this special occasion at such a difficult time.

We have continued to support staff and teams with the development of action plans and patient engagement projects.

We have continued to support teams to obtain feedback on their services to highlight areas of good practice and themes for improvement through 'Listening into Action' events, forums and focus groups and patient panels to ensure patients are involved in service development and this can be evidenced by our quality priorities for 2024/25..

Feedback Friday

The Trust hosts a 'Feedback Friday' event every month to gather feedback from people who use our services to gather their thoughts and implement changes to improve the services that we offer. Our 'Feedback Friday' sessions are held in the Russells Hall Hospital Health hub at the end of each month. To build on our engagement activities we promote national awareness days and campaigns to highlight and raise awareness of specific health conditions to improve the health and wellbeing of our local communities.

Talk to Us Trolley

We have continued to take out the 'Talk to Us' trolley on the wards twice weekly and provides the opportunity for patients to give feedback about their experience as an inpatient at the hospital. Healthwatch Dudley are in attendance once a month, to provide an independent champion for people accessing local health and social care services. Our Trust Governors attended throughout the year.

National Awareness Days and Campaigns

To build on our engagement activities we promote national awareness days and campaigns to highlight and raise awareness of specific health conditions to improve the health and wellbeing of our local communities. We have produced a calendar of campaigns for the next year.

Showcasing good practice

We hosted a number of spotlight sessions in the Hub to showcase all the good work that is happening throughout the Trust to improve the patient experience. The events involved highlighting areas of good practice, sharing compliments from patients and provided an opportunity to learn more about the service.

What matters to you campaign

We share feedback via our 'what matters to you' campaign across the Trust through social media channels and internal communications. This campaign aims to raise the profile of patient experience across the Trust, capture feedback and share successes to confirm that we listen, respond, and embed lessons learned.

The Information Hub is now up and running successfully. The hub is open 9am-3pm and is a space aimed at providing support to the Dudley community, featuring services from The Dudley Group, Health and Social Care services from Dudley Metropolitan Borough Council and voluntary groups from across the Dudley borough.

The Information Hub is located at the main reception of Russells Hall Hospital, and services provide support and information to patients and visitors, carers and staff member. 284 people have visited the Information Hub since it's opening in October 2024 up to January 2025 (of those where data was collected).

Stakeholder relations

Black Country Integrated Care System (ICS)

Healthier Futures - Black Country Integrated Care System (ICS) - statement from the independent chair

People are living longer, but with more complex conditions. Evidence shows that whilst access to good quality healthcare is vitally important, it is the wider aspects of people's lives – housing, income, employment, education and environment – that have the greatest impact on their health. Services that support people with these issues all have a role to play in improving people's health.

This means local government, the voluntary sector, the NHS and wider partners need to work together to create joined up health and care services that meet the needs of local people, focusing on prevention, better outcomes and on reducing health inequalities.

Integrated Care Systems (ICS) were created in July 2022 to encourage and enable this. They bring a wide spectrum of local organisations together with a duty to collaborate, to understand how the health and wellbeing of local people can be improved, agree priorities and strategies for achieving this, and plan different ways to deliver care.

Here at The Dudley Group we are proud to be part of the Black Country Integrated Care System (ICS) and are committed to working in collaboration and partnership with other health and care organisations to ensure the people we serve have improved life chances and health outcomes. This is in line with our vision/ strategic aim/ purpose to provide 'excellent healthcare, improved health for all'.

In the Black Country, in addition to our statutory organisations, our provider collaborative and our place-based partnerships, the two key elements of our ICS are the Black Country Integrated Care Partnership (ICP) and the Integrated Care Board (ICB):

1. The ICP is a statutory committee with membership from our four local authorities, the voluntary sector, police and fire services, education and the NHS. The ICP is responsible for working with health and wellbeing boards and developing a long-term strategy to improve health and social care services and people's health and wellbeing in the area.
2. The ICB is an NHS organisation responsible for planning health services for their local population. It manages the NHS budget and works with local providers of NHS services including hospitals, GP practices, community services, pharmacists, dentists and optometrists, to agree a joint five-year plan which sets out how the NHS will contribute to and deliver the ICP's integrated care strategy.

Together we have four key aims:

3. improving outcomes in population health and health care
4. tackling inequalities in outcomes, experience and access
5. enhancing productivity and value for money
6. helping the NHS to support broader social and economic development.

To find out more about the ICP and ICB, please visit the ICS website **https://blackcountryics.org.uk/**.

Anu Singh

NHS Black Country ICB and ICP Chair

Black Country Provider Collaborative (BCPC)

Over the course of 2024/25 the Trust has continued to work with Black Country Provider Collaborative (BCPC) partners across its agreed three key programmes of work:

- **Clinical Improvement Programme** – a focus on supporting and contributing to improvements in cancer health outcomes and elective care recovery.
- **Corporate Improvement Programme** – a focus on exploring and progressing opportunities for consolidation and delivery at scale resulting in better service productivity and efficiency.
- **System & Transformation Priorities** – a focus on identifying and progressing priorities at scale which would support and enable better service delivery and / or transformation.

We have continued to identify and progress key areas of joint work that align with the principles for collaboration, where unwarranted variation exists, where there is fragility, or in areas where modernisation and transformation to improve services are best undertaken once at scale.

Our progress has been outlined in the 18-month BCPC Annual Report. Some of our notable successes this year are as follows:

- Q**uality** – improvements made across critical care, orthopaedics, and skin networks by establishing consistent guideline for use across the system, in addition to improving access to care through work in driving down waiting times in the HVLC specialties and raising health outcomes by attaining or exceeding GIRFT metrics.

Furthermore, we have pursued a range of modernisation and transformative activities including the creation of elective hubs, ENT, general surgery, ophthalmology, and urology with plans being developed for progression very shortly.

- **Strategic Developments** – As part of our collaborative efforts across the Black Country, we are actively exploring opportunities to repatriate services, enabling patients to receive care closer to home and eliminating the need for out-of-area travel. This initiative aims to enhance accessibility, improve patient experience, and optimise resource utilisation within our regional healthcare network.
- **Engagement** – continued active engagement with our clinical and service leadership teams through Clinical Summits and dedicated away days for our Clinical Networks.

Our collaborative success stems from a strong focus on inclusion, engagement, and empowerment through partnerships. By building trust and relationships, we're transforming the long-standing culture of competition in our evolving healthcare environment.

The BCPC continues to grow and mature. This partnership enables us to pursue strategic priorities at scale, use system-wide resources more effectively, and make faster decisions—leading to quicker benefits realisation. We look forward to showcasing more positive impacts from our collaborative work in the coming months.

Dudley Health and Care Partnership

The Dudley Health and Care Partnership (DHCP) brings together all health and care partners across Dudley to make more effective use of the combined resources available in Dudley 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. It is a collaborative arrangement of equals supported by a programme director who drives the work programmes and the delivery of a shared set of objectives. The Partnership is the main place-based link to the Black Country Integrated Care Board and the Black Country Integrated Care Partnership and is responsible for overseeing local implementation of Black Country Integrated Care strategy.

The Partnership's mission is to provide health and care in the "community where possible; hospital when necessary" by working together, connecting communities, enabling coordinated care for our citizens to live longer, safer, healthier lives. The Trust is the vice chair of the partnership and the chair of the executive team which is the "engine room" of the partnership.

In April 2024 Shropshire Community Healthcare NHS Trust, who are the provider of our children's 0-19 years' service

joined our partnership, Dudley Integrated Health and Care NHS Trust was removed as a partner organisation following its dissolution in October 2024 although many personnel remained active partners through their new employment at The Dudley Group NHS Foundation Trust.

We continue to deliver against our agreed model of care which is a structured framework that outlines how Dudley's health and social care services are organised and delivered and how we are coordinating care across different settings and providers.

Its purpose is to:

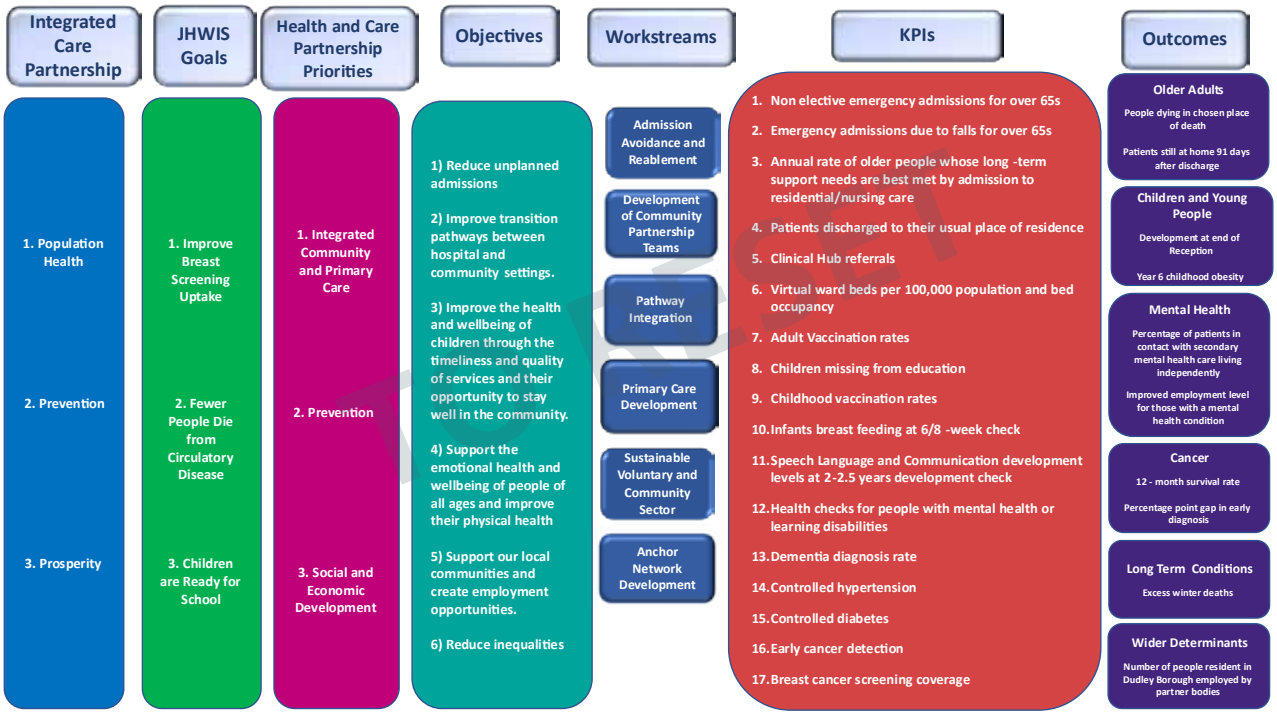
- improve the quality and efficiency of healthcare services.
- ensure that patients receive the right care at the right time in the right place.
- promote patient-centred care and improve health outcomes.

Key components are:

- interprofessional collaboration – working together to improve outcomes
- care coordination – how is the care journey managed and tracked

In order to deliver the commitments made in the Joint Forward Plan for 2023 – 2028 during this year we have been really focused and concentrated on our agreed priorities that all partners can contribute to and influence. These align with both the Dudley Health and Wellbeing Board Goals and the priorities of the Integrated Care Partnership. During this year we reduced to six workstreams from eight to streamline meetings, focus delivery and reduce duplication. The below diagram shows an overview of what the Partnership is looking to deliver and how this aligns with wider system priorities.

The following outcomes have been achieved during 2024/25:



Admission Avoidance and Reablement

Dudley Clinical Hub's falls community pickup service enables the Urgent Care Response Team and Own Bed Instead Team to attend an incident with the correct lifting equipment and skills to assess and treat a faller with the aim of preventing unnecessary conveyances to A&E. Since its launch in April 2023, referrals to the service have more than doubled with 2276 calls during 2024/25. 2170 fallers were supported to say in their homes, reducing attendance at A&E and admission to hospital.

In November we hosted the 2nd annual Dudley Clinical Hub Care Home Engagement Event with over 70 representatives from Care Homes. The event is aimed at building relationships and understanding of services provided by DGFT and the local authority. In the initial four-week period post the event there was an increase

in referrals to the Clinical Hub from 982 (November) to 1070 (December) an increase of just under 9%.

Community Partnership Teams

Neighbourhood Health - our "Community Partnership Teams" (CPTs) wrap around the population in all six of our Primary Care Networks and focus on people who have complex multi-morbidity long-term conditions, very often with frailty to support them in their own homes or usual place of residence. This will mean people will only go to hospital when their care or treatment can't be provided at home or as close to home as possible. We are currently in the process of mapping our CPT provision against the planning guidance (NHS England » Neighbourhood health guidelines 2025/26) and working with colleagues in the ICB to evaluate the impact of the CPTs.

A recommendation from a recent deep dive into Non-Emergency Admissions for over 65yrs from Care Homes, was to establish a Care Home CPT working with Chapel Street and Summer Hill as the two GP Practices with the majority of Care Home residents registered. This was established in January and will identify themes and learning to reduce unnecessary admissions for this vulnerable population.

Pathway Integration

We have been able to sustain the delivery of our **Integrated First 1001 Days Teams** to offer early intervention and support to families both universally and to those we need additional early help. The Family Hubs offer a clear, simple point of access for help and support; they connect families, services, professionals and wider communities to work better together and building on family strengths, supporting them to make sustainable changes. There have been 954 downloads of "**DadPad | The Essential Guide for New Dads | Support Guide for New Dads (thedadpad.co.uk)** which is an average of 35% of births per month.

The 2024/25 operational planning guidance asked integrated care boards (ICBs) to "establish and develop at least one **women's health hub** in every ICB by the end of December 2024 in line with the core specification, improving access, experience and quality of care." In Dudley there were already strong foundations in both primary and secondary care, so our proposal built additional capacity in community-based settings across the Dudley borough closer to home for Menorrhagia (heavy menstrual bleeding); Menopause; a Women's Health Hub Educational Programme and Educational Programme for Primary Care Clinicians. In January we launched the Black Countries Women's Health Hub in Dudley after securing funding from the ICB. The model aims to improve access to and experiences of care, improve health outcomes for women, and reduce health inequalities. We are offering nonclinical elements of the service at the heart of our communities in our Family Hubs with 37 women attending our first Menopause Cafés in Coseley and Brierley Hill.

Primary Care Development

Primary, Community, Secondary Care Interface – a recent review of the Principles of Collaboration and a stocktake of interface position and benchmark against NHS England Red Tape challenge concluded that we were thriving in many areas with strong leadership via a fortnightly meeting of senior clinicians and managers. In October a shared email inbox was established which has been received well.

A thematic analysis of the shared inbox inquiries identified five common themes relating to: communication; follow up; better management of shared workload; Fit Notes and Referral Forms. Clinician led workshops will convene to agree a way forward for each.

A Primary Care Development Plan for 2025/26 has been developed to outline Dudley's priorities. The plan aligns to the Black Country Primary Care Transformation Strategy and National Planning Guidance and sets out 15 work streams, with engagement and review highlighting priorities in relation to the development of Community Partnership Teams and a Single Point of Access for the Dudley Clinical Hub – both these work streams are seen as critical work streams within the plan for improving integrated care and managing population health. By developing the plan through extensive consultation with GP practices, PCNs, the Dudley Primary Care Collaborative and the ICB we have identified a number of areas where we can have significant impact, notable through back-office optimisation and improvements to unplanned care.

Sustainable Voluntary and Community Sector

Dudley Engagement Group has 140 members from a broad range of backgrounds and meets every six weeks. The group has been instrumental in supporting many involvement events and shows an amazing number of initiatives and opportunities available across Dudley, this insight has contributed to the development of the Black Country Integrated Care Partnership Strategy. The group has also provided an opportunity to network, share best practice and collaborate.

A work programme to recruit and develop leaders of not-for-profit organisations, who are often unseen, but fulfil a crucial role as the people entrusted with stewarding an organisation, has developed. A webpage hosted on Dudley Council for Voluntary Service website to encourage staff from the NHS and the Council to become leaders for the voluntary sector has been developed **Become a not-for-profit sector leader - Dudley CVS** and two events held for staff as an introduction to becoming a trustee/ senior leader within the sector. Concurrently Dudley CVS are working with not-for-profit organisations to ensure they have all the necessary good practice in place to recruit and retain trustees.

Anchor Network Development

The Trust's Head of Clinical Procurement has been published and recognised internationally for her "CritEcoCare" tool. The work will support Dudley and the NHS in getting to Net Zero faster.

ICan Dudley is a pilot that provides an opportunity to improve how we attract, recognise and retain local talent from a diverse range of backgrounds and test new ways of working across our place and organisations. During Phase 1 we offered 60 candidates "Into Work Programmes"; 30 "Paid Work Placements" 32 secured jobs; there are 16 currently training to be CSW's and 12 on the Skills Legacy Project. With a focus on health inequalities five candidates identified as Care Leavers. Three of those also declared a disability. Of the others, eight have declared a disability, which is 44% of the non-care leavers, and out of all 23 under-25 ICan participants, 48% have declared a disability. These include a broad range of disabilities, including ASD, mental health difficulties, and dyslexia alongside physical disabilities.

Universities and Colleges

We have continued to build relationships with local universities and colleges. Medical students from Birmingham University, Aston University and Three Counties Medical School have been placed in the Trust in 24/5. We continue to host overseas students from our long standing partnerships with St Georges medical School, Grenada.

The relationship with Aston University continues to grow with an associate non-executive director from Aston University sitting on the Board of Directors and trust staff being awarded honorary contracts by the University.

The Trust received a letter of no objection in our bid to become a University Hospital, with consultation ongoing as of May 2025 to agree a new Trust name.

We continue to build our working relationship with Dudley College and Dudley Institute of Technology. We are working with them on planning for delivery of the new Health Innovation Campus which is being constructed in the centre of Dudley with plans to deliver higher level qualifications in partnership with Worcester University. We anticipate that our staff will be able to access appropriate courses and access the educational facilities for ongoing training and development as well as promoting careers in the health service amongst the local population.

Work experience placements have been offered to local school students. The Trust hosted two 'behind the scenes' events for local secondary schools offering tours of different departments and introducing students to the range of careers available and entry routes such as apprenticeships. Staff from across the Trust are registered as ambassadors and offer their time to take part in different career events with local schools.

Audit Committee

During the year, the Audit Committee operated in accordance with its responsibilities as set out in its terms of reference, which included:

- To agree the audit plan, audit fee and approach (including areas of risk, fraud risk, misstatement and materiality), and receive findings of the external auditor in relation to the financial statements, value for money opinion, the Quality Accounts (where applicable), the report to those charged with

governance and to consider the implications of and management's responses to their work. More specifically, the Audit Committee considered the auditor's identified significant risks as part of their plan in relation to fraud in revenue recognition, management override of controls, and the valuation of property, plant and equipment. It has commented on its approach and attitude to fraud to the external auditor.

- To receive and approve the Annual Report and Accounts.
- To review, monitor the integrity (including the application of accounting principles and policies) and approve the financial statements and other reports when delegated by the board or in conjunction with the board and to provide assurance to the board.
- To review the systems which underpin the Trust's reporting including the establishment and maintenance of an effective system of integrated governance (including budgetary control), risk management and internal controls (including counter fraud measures) across the whole of the Trust's activities, both clinical and non-clinical, that support the achievement of the Trust's objectives, and in so doing;
- To ensure that there is an effective internal audit and Local Counter Fraud function that meets Government Internal Audit Standards and that provides appropriate independent assurance to the Audit Committee, chief executive and Board of Directors.

The key issues that the Audit Committee considered during the year were in relation to the following:

Delivery against the Internal Audit Plan and oversight of any management actions arising from the audit work that included:

Bank and Agency (Medics) – minimal assurance. Internal Audit identified some internal control weaknesses following audits undertaken and identified that there was not a standardised and formalised approach to Bank and Agency usage across the departments

National Waiting List Initiative, Payments and Retrospective Claims for Locums – partial assurance. Internal audit identified areas of improvement and strengthening in the Trust's current frameworks for additional payments.

Framework for Grievances, Bullying and Disciplinaries – Partial Assurance. The Trust has recently introduced the Decision-Making Group (DMG) and was awaiting the conclusion of the RSM audit to review its policies and procedures. Internal audit identified several policies and procedures that required attention, and guidance was provided by Subject Matter Experts (SMEs) on those areas.

Key Financial Systems, patient monies and properties – Partial Assurance; Internal audit identified that the Trust had a process design for managing and handling patient property and money in the form of a detailed policy, however identified issues of non-compliance with the application of the policy.

Other audit areas completed that received reasonable or substantial assurance included: Complaints Framework – Substantial Assurance, Patient Experience – Surveys and Outcomes – Reasonable Assurance, Workforce Controls – Vacancy Authorisation Request Process – Reasonable Assurance, Board Assurance Framework – Reasonable Assurance, Key Financial Systems – Income and Debt Recovery – Reasonable Assurance; and Framework for Grievances, Bullying and Disciplinaries (Part two) – Reasonable Assurance.

In each case, the Audit Committee considered the information and explanations from management, and sought assurance that actions were put in place to address the issues raised. More detail on some of these areas is included in the Annual Governance Statement.

The Head of Internal Audit Opinion for 2024/25 confirms that the Trust has an adequate and effective framework for risk management, governance and internal control. However, their work has identified further enhancements to the framework of risk management, governance and internal control to ensure that the framework remains adequate and effective.

The external auditor, Grant Thornton, provides a progress report to each Audit Committee meeting set against the audit plan. The Audit Committee measures the effectiveness of the external audit process, its timing and outputs against this plan.

The external auditor is appointed by the Council of Governors for a maximum five-year term following a competitive tender process against a set of quality and value for

money criteria and following the recommendation of a tender committee which includes executive, non-executive and governor representation. The most recent tender process in 2024 resulted in the appointment of Grant Thornton who have been the Trust's external auditors for the period covered by this Annual Report.

The Audit Committee held five meetings during 2024/25 with attendance as follows:

Audit Committee Membership		
Gurjit Bhogal	Non-executive director	1
Gary Growe	Non-executive director	2
Peter Featherstone	Non-executive director	4
Ita O'Donovan	Associate non-executive director	4
Anne-Maria Newham	Non-executive director	3
Joanne Hanley	Non-executive director (Committee Chair)	4

In attendance		
Liz Abbiss	Director of communications	2
Julian Hobbs	Medical director	5
Martina Morris	Chief nurse	2
Andy Proctor	Director of governance	3
Adam Thomas	Chief strategy & digital officer	5
Diane Wake	Chief Executive officer	2
Chris Walker	Interim director of finance	5

The Dudley Group NHS Foundation Trust has applied the principles of the NHS Foundation Trust Code of Governance 2014 on a comply or explain basis. The NHS Foundation Trust Code of Governance was recently revised in October 2022 and will be effective from 1st April 2023 and is based on the principles of the UK Corporate Governance Code.

Diane Wake

Chief Executive Officer

… June 2025

Annual statement on remuneration

(Information not subject to audit)

The Trust's Remuneration Committee comprises the chair and all non-executive directors and associate non-executive directors. The chief executive and the chief people officer usually attend meetings noting that one or more meetings during the year may be held without their attendance. The Nominations and Remuneration Committee operates to review and evaluate the board structure and expertise, as well as to agree a job description and person specification for the appointments of the chief executive and audit executive directors. The committee also identifies and nominates suitable candidates for such vacancies and recommends its proposed appointment for chief executive to the Council of Governors.

Interview panels for executive director appointments are usually made up of existing directors, governors and external stakeholders. The committee determines the appropriate levels of remuneration for the executive directors. Remuneration levels are normally determined by reference to such factors as those applying in equivalent organisations in the NHS, changes in responsibility, performance, salary increases agreed for other NHS staff and guidance issued by the Secretary of State.

During the year, an interim appointment was made for the posts of chief people officer and six-month extension was made for the interim chief finance officer post.

For the purpose of the Annual Report and Accounts, the chief executive has agreed the definition of a "senior manager" to be voting executive and non-executive directors only.

Evaluation of the Trust board

Executive directors were set objectives and were evaluated by the chief executive as part of the annual appraisal process and the chief executive's own performance was evaluated by the chair. The non-executive directors' objectives were set by the chair and their evaluations were carried out by the chair. Objectives were set by the senior independent director for the chair as part of the evaluation process.

Senior manager remuneration policy

(Information not subject to audit)

Remuneration for executive directors does not include any performance-related elements and there are no plans for this in the future. No significant financial awards or compensation have been made to past senior managers during the reporting period. There is no provision for the recovery of sums paid to directors or for withholding payments of sums to senior managers. Senior managers' service contracts do not include obligations on the Trust which could give rise to or impact on remuneration payments for loss of office. Senior managers' individual service contracts mirror national terms and conditions of employment and include notice periods and any termination arrangements. In the event of a contract being terminated, the payment for loss of office will be determined by the Nomination and Remuneration Committee. Payment will be based on contractual obligations.

Payment for loss of office will not be made in cases where the dismissal was for one of the five 'fair' reasons for dismissal.

In setting the remuneration policy for senior managers, consideration was given to the pay and conditions of employees on Agenda for Change. The Trust uses benchmarking data to ensure all salaries, including those over £150,000, are reasonable and provide value for money.

The Trust has not consulted with employees when determining the senior managers' remuneration.

Nomination and Remuneration Committee

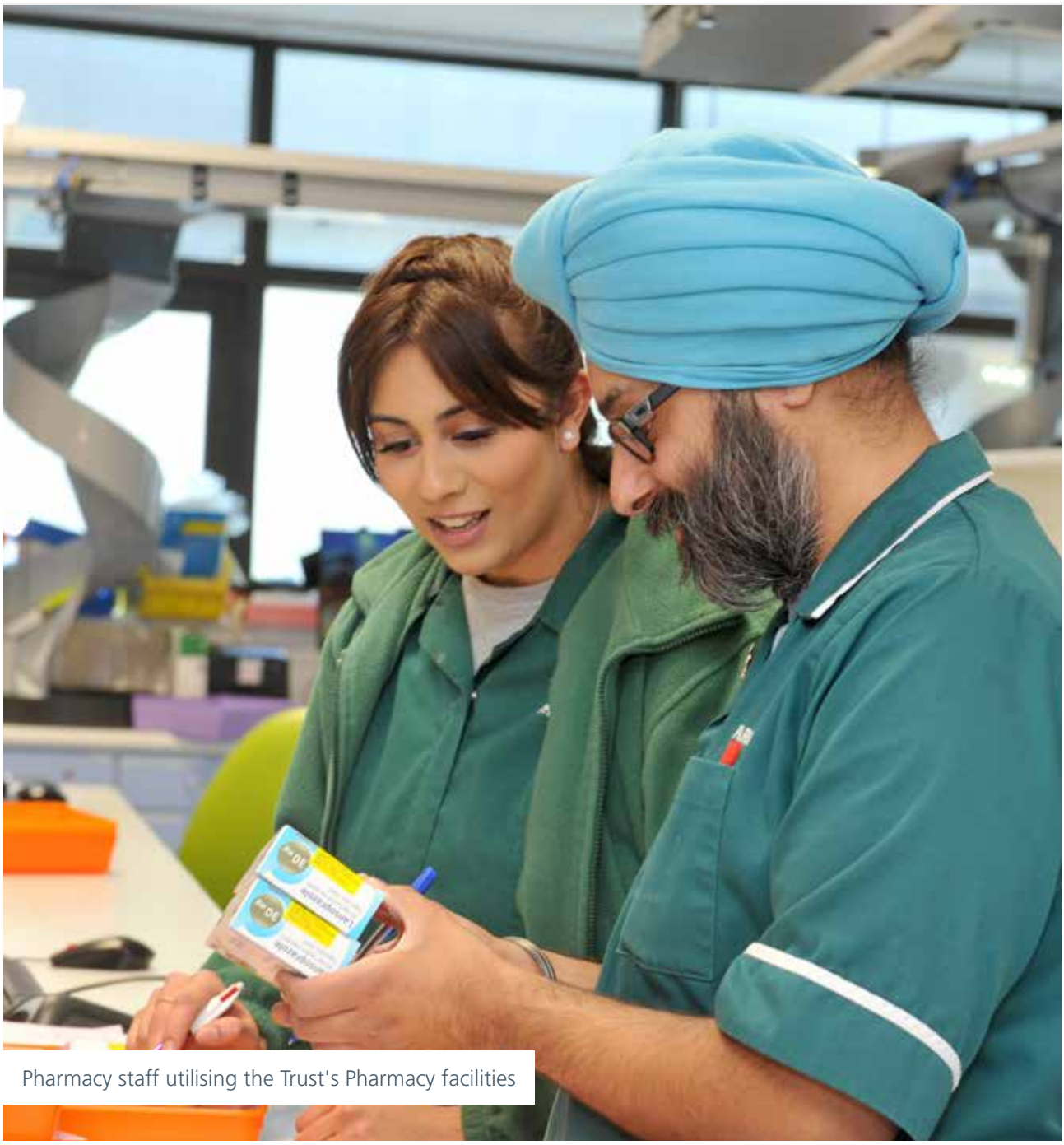
(Information not subject to audit)

The Nomination and Remuneration Committee is a sub-committee of the board and holds at least one meeting per year. During 2024/25, it held four meetings and attendance at meetings were as below. Executive directors also attend the Nomination and Remuneration Committee on occasion. The terms and conditions for the executive directors and senior managers of the Trust are included in their individual contracts of employment which includes notice periods and any termination arrangements.

The committee undertakes a review of its Terms of Reference each year as a minimum.

The Trust has an Equal Opportunity and Diversity Policy in place which was reviewed and approved in December 2022 and covers all aspects of the Trust's business.

Nomination and Remuneration Committee membership	Attendance (/4)
Gary Crowe, Deputy Trust chair	2
Catherine Holland, Non-executive director	3
Sir David Nicholson, Trust chair from 01/09/22	4
Vij Randeniya, Non-executive director, chair of committee	4
Lowell Williams, Non-executive director	2
Joanne Hanley, Non-executive director (Committee Chair)	4



Pharmacy staff utilising the Trust's Pharmacy facilities

Future policy tables

These set out the Trust's policy for future remuneration of senior managers.

Executive directors

	Salary and fees	Taxable benefits	Annual performance related bonuses	Long-term performance related bonuses	Pension-related benefits	Other remuneration
Description	Basic pay for executive role	N/A	N/A	N/A	The following are paid a payment in lieu of their pension through agreed Trust scheme: Chief Executive, Chief Operations Officer,	Medical Director paid under M&D terms and conditions. Medical Director remuneration paid as a pensionable responsibility allowance. Also in receipt of a working away from home allowance. Chief Operating Officer, Chief Nurse (Apr – Oct'23) and Medical Director receive a working away from home allowance.
How that component supports the short and long-term strategic objectives of the foundation trust	To ensure the Trust is well-led and all short and long term objectives are met, the salary for senior managers must be competitive in order to recruit and retain talented individuals.	DGFT has historically needed to secure recruitment to key roles from outside of the region. On this basis, the Trust's Remuneration Committee has approved a working away from home allowance, which is applicable to all posts where recruitment from outside of the area is required (this is not a VSM allowance).	N/A	N/A	This enables the Trust to recruit sufficient talent at executive director level and accords with custom and practice in the rest of the NHS.	This is essential to ensure a medically qualified person can occupy the role of Medical Director.
An explanation of how that component operates	Executive director salaries are determined by the Remuneration Committee of the Trust, informed by benchmark salary derived from established national NHS pay surveys. Executive directors are appointed on a permanent basis under a contract of service at an agreed salary.	Trust Expenses Policy applies to all staff, including senior managers. Taxable benefits incurred fell within the scope of this policy. Levels of benefits reflect national terms and conditions for other staff groups to ensure consistency	N/A	N/A	This is determined in accordance with NHS Pension Scheme Benefits. No additional payments are made.	As determined by national terms and condition of employment.
The maximum that could be paid in respect of that component	Fixed salary determined by Nominations & Remuneration Committee, in line with NHSE/I VSM pay guidance	N/A	N/A	N/A	As determined by NHS Pension Scheme Entitlements.	As determined by national terms and condition of employment.
Where applicable, a description of the framework used to assess performance	The performance of executives is reviewed through a formal annual performance process, which is led by the Chief Executive and involves input/feedback on executive performance from non-executive directors.	N/A	N/A	N/A	N/A	N/A

Non-executive directors

	Fee payable	Any additional fees payable for any other duties to the foundation trust	Such other items that are considered to be remuneration in nature
Description	Fee for the chair, deputy chair, senior independent director, chair of Audit Committee, and other non-executive directors	N/A	Expenses incurred in the course of their duties such as public transport, mileage and subsistence as determined by Trust policy. Chief Operating Officer, Chief Nurse (Apr – Oct'23) and Medical Director receive a working away from home allowance.
How that component supports the short and long-term strategic objectives of the foundation trust;	To ensure the Trust is well-led and all short and long term needs met, the fee for non-executive directors must be competitive in order to recruit and retain talented individuals	N/A	To ensure non-executive directors are appropriately compensated for those journeys they have undertaken on behalf of the Trust. The policy for non-executive director expenses is the same as that applying to other staff
An explanation of how that component operates	The chair and non-executive members are entitled to be remunerated by the Trust for so long as they continue to hold office as chair or non-executive member. They are entitled to receive remuneration only in relation to the period for which they hold office. There is no entitlement to compensation for loss of office. The level of remuneration is determined by the governors with due regard to the remuneration paid in other foundation trusts	N/A	Mileage and subsistence allowances for non-executive directors are set by the Council of Governors.
The maximum that could be paid in respect of that component	The rate of remuneration payable to the chairman of the Trust is £50,000 p.a. The deputy chair is remunerated at £25,000 p.a. The senior independent director is remunerated at £15,489 p.a. The chair of Audit Committee is remunerated at £15,079 p.a. The committee chairs of the Finance & Productivity, Quality and Integration Committees receive £15,190 p.a. The remuneration for the other non-executive directors is £13,190 p.a.	N/A	N/A
Where applicable, a description of the framework used to assess performance	Performance of non-executive directors is assessed by the chairman annually, and for the chairman, by the senior independent director.	N/A	N/A

Salary and pension entitlements of senior managers

(audited)

The following is subject to audit: Senior manager remuneration table, senior manager pension benefit table, and the ratio of the highest paid Director compared to the staff pay median. The remainder of the remuneration report is not subject to audit.

a). Remuneration

Salary entitlements of senior managers 2024/25 - unaudited

Name and Title	Note	Year Ended 31 March 2025					
		Salary (bands of £5,000)	* Expense payments (taxable) (to the nearest £100)	Performance pay and bonuses (bands of £5,000)	Long term performance pay and bonuses (bands of £5,000)	# All Pension Related Benefits (bands of £2,500)	Total (bands of £5,000)
		£000	£	£000	£000	£000	£000
Diane Wake, Chief Executive		250 - 255					250 - 255
Chris Walker, Interim Director of Finance		135 - 140				15.0 - 17.5	150 - 155
Julian Hobbs, Medical Director		245 - 250				80.0 - 82.5	325 - 330
Karen Kelly, Chief Operating Officer		190 - 195					190 - 195
Martina Morris, Chief Nurse		125-130					125 - 130
Alan Duffell Chief People Officer		5 - 10					5 - 10
Karen Brogan, Interim Chief People Officer	N	110 -115				20 - 22.5	135 - 140
Adam Thomas, Chief Information Officer		150 - 155				77.5 - 80.0	230 - 235
Sir David Nicholson, Chair	#	25 - 30					25 - 30
Julian Atkins, Non Exec		0 - 5	400				0 - 5
Gurjit Bhogal, Non Exec		0 - 5					0 - 5
Gary Crowe, Non Exec		20 - 25	1,700				25 - 30
Joanne Hanley, Non Exec		15 - 20					15 - 20
Anthony Hilton, Non Exec		10 - 15	200				10 - 15
Catherine Holland, Non Exec		15 - 20					15 - 20
Elizabeth Hughes, Non Exec		15 - 20					15 - 20
Vijith Randeniya, Non Exec		15 - 20	500				15 - 20
Lowell Williams, Non Exec		15 - 20					15 - 20
Anne-Marie Newham, Non Exec	O	10 - 15	900				10 - 15
Peter Featherstone, Non Exec	P	10 - 15	300				10 - 15
Mohit Mandiratta, Non Exec	Q	5 - 10					5 - 10

Salary entitlements of senior managers 2023/24 - audited

Name and Title	Note	Year Ended 31 March 2024					
		Salary (bands of £5,000)	* Expense payments (taxable) (to the nearest £100)	Performance pay and bonuses (bands of £5,000)	Long term performance pay and bonuses (bands of £5,000)	# All Pension Related Benefits (bands of £2,500)	Total (bands of £5,000)
		£000	£	£000	£000	£000	£000
Diane Wake, Chief Executive		240 - 245					240 - 245
Kevin Stringer, Director of Finance	A	85 - 90					85 - 90
Chris Walker, Interim Director of Finance	B	30 - 35					30 - 35
Julian Hobbs, Medical Director		230 - 235					230 - 235
Karen Kelly, Chief Operating Officer		180 - 185					180 - 185
Mary Sexton, Chief Nurse	C	90 -95					90 -95
Helen Blanchard, Chief Nurse	D	70 -75				15 - 17.5	85 - 90
Martina Morris, Chief Nurse	E	10 - 15				5 - 10	15 - 20
Alan Duffell Chief People Officer	F	90 - 95					90 - 95
Adam Thomas, Chief Information Officer	G	130 - 135					130 - 135
Sir David Nicholson, Chair	H	25 - 30					25 - 30
Julian Atkins, Non Exec	I	15 - 20	1,000				15 - 20
Gurjit Bhogal, Non Exec	J	10 - 15					10 - 15
Gary Crowe, Non Exec		20 - 25	1,400				25 - 30
Joanne Hanley, Non Exec	K	10 - 15					10 - 15
Anthony Hilton, Non Exec	L	5 - 10					5 - 10
Catherine Holland, Non Exec		15 - 20					15 - 20
Elizabeth Hughes, Non Exec		10 - 15					10 - 15
Vijith Randeniya, Non Exec		10 - 15					10 - 15
Lowell Williams, Non Exec	M	10 - 15					10 - 15

NEED RAW DATA TO RESET

The remuneration for Sir David Nicholson in 2024-25 is shared equally between The Dudley Group NHS Foundation Trust, Sandwell & West Birmingham NHS Trust, Walsall Healthcare NHS Trust, and Royal Wolverhampton NHS Trust. The value shown above represents the share paid by this Trust.

Notes:

Total remuneration includes salary, non consolidated performance-related pay, benefits in kind as well as severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions.

Only directors who are members of the pension scheme have pension related benefits in 2023/24 and 2024/25.

* Expense Payments relate to home to base travel reimbursement for Non Executive Directors.

The value of pension benefits accrued during the year is calculated as the real increase in pension multiplied by 20, less the contributions made by the individual. The real increase excludes increases due to inflation or any increase or decrease due to transfer of pension rights. This value derived does not represent an amount that will be received by the individual. It is a calculation that is intended to provide an estimation of the benefit being a member of the pension scheme could provide. The pension benefit table provides further information on the pension benefits accruing to the individual.

Changes to the Board	
A. Kevin Stringer started 1 June 2022 and left 31 December 2023	J. Gurjit Bhogal started 13 October 2022 and left 31 May 2024
B. Chris Walker started 1 Januay 2024	K. Joanne Hanley started 1 June 2023
C. Mary Sexton left 31 October 2023	L. Anthony Hilton started 1 July 2023 and left 31 July 2024
D. Helen Blanchard started 23 October 2023 and left 31 March 2024	M. Lowell Williams started 1 January 2022
E. Martina Morris started 3 March 2024	N. Karen Brogan started 1 May 2024
F. Alan Duffell started 20 June 2022 and left 31 April 2024	O. Anne-Maria Newham started 1 June 2024
G . Adam Thomas started 1 January 2022, and acted as Chief Operating Officer from 1 December 2022 to 31 March 2023	P. Peter Featherstone started 1 June 2024
H David Nicholson started 1 September 2022	Q. Mohit Mandiratta started 1 June 2024
I. Julian Atkins started x and left 31 May 2024	

b). Pension benefits

As non-executive members do not receive pensionable remuneration, there will be no entries in respect of pensions for non-executive members.

Name and Title	Real increase in pension at pension age (bands of £2,500)	Real increase in lump sum at pension age (bands of £2,500)	Total accrued pension at pension age at 31 March 2025 (bands of £5,000)	Lump sum at pension age related to accrued pension at 31 March 2025 (bands of £5,000)	Cash Equivalent Transfer Value at 1 April 2024	Real Increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 2025	Employer's contribution to stakeholder pension
	£000	£000	£000	£000	£000	£000	£000	£000
Diane Wake, Chief Executive	0	0	0	0	0	0	0	
Chris Walker, Interim Director of Finance *	0 - 2.5	0	45 - 50	125 - 130	1025	20	1059	
Julian Hobbs, Medical Director *	5 - 7.5	2.5 - 5	75 - 80	210 - 215	1792	99	1915	
Karen Kelly, Chief Operating Officer	0	0	0	0	0	0	0	
Karen Brogan, Interim Chief Operating Officer	0 - 2.5	0	30 - 35	0	433	14	462	
Martina Morris, Chief Nurse	0 - 2.5	0	40 - 45	100 -105	813	14	843	
Adam Thomas, Chief Information Officer *	2.5 - 5	5 - 7.5	35 - 40	85 - 90	613	61	693	

TO RESET

Note:

Figures shown reflect time in office during the year and include accrued benefits and contributions in respect of full salary, which will include both management and medical contributions.

Only directors covered by the pension arrangements during the reporting year are included in this table.

On 1 April 2015, the government made changes to public service pension schemes which treated members differently based on their age. The public service pensions remedy puts this right and removes the age discrimination for the remedy period, between 1 April 2015 and 31 March 2022. Part 1 of the remedy closed the 1995/2008 Scheme on 31 March 2022, with active members becoming members of the 2015 Scheme on 1 April 2022. For Part 2 of the remedy, eligible members had their membership during the remedy period in the 2015 Scheme moved back into the 1995/2008 Scheme on 1 October 2023. This is called 'rollback'.

The directors above identified above with an asterisk (*) are affected by this public service pensions remedy and their membership between 1 April 2015 and 31 March 2022 was rolled back into the 1995 to 2008 Scheme on 1 October 2023. Negative values are not disclosed in this table but are substituted with a zero.

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme, or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which the disclosure applies. The CETV figures, and from 2004-05 the other pension details, include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

Real Increase in CETV - This reflects the increase in CETV effectively funded by the employer. The figure excludes any increase due to inflation, and takes account of contributions paid by the employee (including the value

of any benefits transferred from another pension scheme or arrangement) and uses common market valuation factors for the start and end of the period.

The benefits and related CETVs in the above table reflect adjustments arising from the McCloud judgement.

Cash equivalent transfer value (CETV) figures are calculated using the guidance on discount rates for calculating unfunded -public service contribution rates that was extant on 31 March 2023. HM Treasury published updated guidance on 27 April 2023; this guidance will be used in the calculation of 2023/24 CETV figures.

Due to the lead time required to perform calculations and prepare annual reports, the CETV figures quoted in this report for members of the NHS Pension scheme are based on the previous discount rate and have not been recalculated.

Members of the NHS Pension scheme are entitled to claim payment of their benefits early from any age on or after their minimum pension age up to their normal pension age (this differs dependant on scheme). When taking actuarially reduced early retirement, pension is reduced to allow for the fact that it is being paid earlier than expected.

Where senior managers have left, changed working hours or had their pensionable pay otherwise modified, this has been communicated to NHS Pensions and any revised calculations have been completed and included in the 31 March 2025 disclosure items.

The Trust is required to disclose the expenses paid to Directors, Non Executive Directors and Governors.

The band of the expenses paid for 2024/25 was £2,500 - £5,000 (2023/24 £2,500 - £5,000).

Diane Wake

Chief Executive Officer

… July 2025

Fair pay disclosure

(unaudited)

NHS foundation trusts are required to disclose the relationship between the total remuneration of the highest paid director in their organisation and the lower quartile, median and upper quartile remuneration of the organisation's workforce.

The banded remuneration of the highest paid Director in the Trust in the financial year 2024/25 was £250,000 - £255,000 (2023/24 £240,000 - £245,000). This is a change between years of 4.12% (2023/24 -5.83%)

In 2022/23 the director occupying the position of the highest paid director received allowances which were not paid in 2023/24.

Total remuneration includes salary, non-consolidated performance-related pay, benefits-in-kind, but not severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions.

For employees of the Trust as a whole, the range of remuneration in 2024/25 was from £26 to £607,000 (2023/24 £3 to £534,000). The percentage change in average employee remuneration (based on total for all employees on an annualised basis divided by full time equivalent number of employees) between years is 5.40% (2023/24 9.26%).

The calculation of the percentage change for the highest paid director is based upon the change in the midpoint of the salary band, whereas for employees as a whole this is based upon the salary total for all employees divided by the total FTE, excluding the highest paid director.

2024/25	% change for highest paid director	% change for employees as a whole
Salary and allowances	4.12	5.40
Performace pay/bonuses	0	0

2023/25	% change for highest paid director	% change for employees as a whole
Salary and allowances	-5.83	9.26
Performace pay/bonuses	0	0

The remuneration of the employee at the 25th percentile, median and 75th percentile is set out below. The pay ratio shows the relationship between the total pay and benefits of the highest paid director (excluding pension benefits) and each point in the remuneration range for the Trust's workforce. 26 employees received remuneration in excess of the highest paid director (2023/24: 23)

2024/25	25th Percentile	Median	75th Percentile
	£	£	£
Total Remuneration	26,387	37,845	52,002
Salary component of total remuneration	22,502	32,456	48,526
Pay ratio	**9.7 : 1**	**6.7 : 1**	**4.9 : 1**

2023/24	25th Percentile	Median	75th Percentile
	£	£	£
Total Remuneration	25,373	36,404	49,131
Salary component of total remuneration	20,974	31,540	46,265
Pay ratio	**9.6 : 1**	**6.7 : 1**	**4.9 : 1**

The pay ratio between the highest paid director and each of the 25th percentile, median and 75th percentile has remained the same in 24/25 in comparison to 23/24. This follows a reduction in the previous financial year, due to the lowest paid members of staff being brought up to the top of band 2 and the highest paid director being within a lower band in comparison to 22/23.

The Trust believes that the median pay ratio is consistent with the pay, reward and progression policies for its employees taken as a whole.

Governor and director expenses

(Information not subject to audit)

During 2024/25, 21 individuals (2023/24, 20) were executive or non-executive directors for the Trust. Of these, six (2023/24, five) received expenses in the reporting period and the aggregate sum of expenses paid was £3,510.60 (2023/24 £2,485.83).

In addition, during 2024/25, 39 individuals (2023/24, 30) were governors for the Trust. Of these, one governor (2023/24, two) received expenses in the reporting period and the aggregate sum of expenses paid was £153.72 (2023/24, £238.44).

Better Payment Code of Practice

The Better Payment Code of Practice requires the Trust to aim to pay all undisputed invoices by the due date or within 30 days of receipt of goods or a valid invoice, whichever is later.

The Trust maintained its performance against the Better Payment Code of Practice in 2024-25 as high levels of compliance against the code was achieved in each of the 12 months.

	2024/25	2024/25	2023/24	2023/24
	Number	£000	Number	£000
Total non-NHS trade invoices paid in the year	52,867	331,556	48,689	304,310
Total non-NHS trade invoices paid within target	50,146	327,546	45,419	297,285
Percentage of non-NHS trade invoices paid within target	**95%**	**99%**	**93%**	**98%**
Total NHS trade invoices paid in the year	2,166	52,020	1,721	29,014
Total NHS trade invoices paid within target	2,070	51,167	1,598	28,456
Percentage of NHS trade invoices paid within target	**96%**	**98%**	**93%**	**98%**

The Trust can confirm that is has complied with the cost allocation and charging requirements set out in HM Treasury and Office of Public Sector Information guidance. This guidance discusses how public sector organisations should charge for information.

Diane Wake

Chief Executive Officer

… July 2025

Staff report

About our employees

In this section you will find a breakdown of the workforce profile, staff in post during the year and information about how the Trust promotes equality, diversity and inclusion and how it engages with its workforce.

The Trust employs 6,681 substantive staff by headcount as of 31st March 2025. An analysis of workforce statistics indicates they are comparable with the local Dudley population although a greater proportion of people from ethnically diverse groups choose to work at The Dudley Group NHS Foundation Trust. The higher proportion of female workers to male is typically reflected across other combined acute and community trusts, and across the NHS as an organisation.

Staff in post

Staff Group	Headcount*	FTE**
Add Prof Scientific and Technic	297	263.20667
Additional Clinical Services	1376	1167.90427
Administrative and Clerical	1402	1223.3283
Allied Health Professionals	542	470.22557
Estates and Ancillary	16	13.76
Healthcare Scientists	63	54.84693
Medical and Dental	795	743.41387
Nursing and Midwifery Registered	2160	1906.09736
Students	5	5
Grand Total	**6656**	**5847.78297**

* Primary Assignment Only

** Includes Secondary Assignments

Workforce Profile

Age Band	2024	2025
<=20 Years	1.06%	1.05%
21-25	7.94%	6.90%
26-30	14.91%	14.12%
31-35	15.11%	15.28%
36-40	13.50%	14.48%
41-45	10.78%	10.77%
46-50	9.88%	9.78%
51-55	11.13%	11.00%
56-60	9.63%	9.77%
61-65	4.78%	5.54%
66-70	0.95%	0.98%
>=71 Years	**0.32%**	**0.33%**

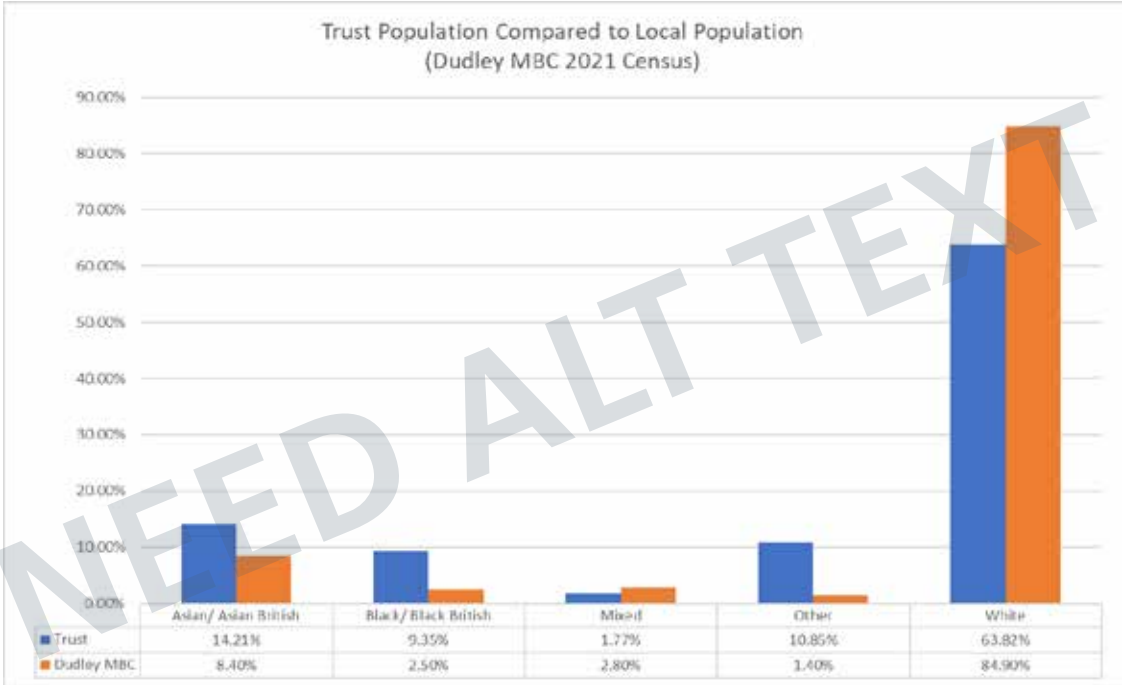
Gender	2024	2025
Female	80.80%	80.33%
Male	19.20%	19.67%

Ethnicity	2024	2025
Bame	27.52%	28.95%
Not Stated / Unknown	8.65%	7.29%
White	63.82%	63.76%

Disability	2024	2025
No	67.03%	67.58%
Not Declared	26.81%	25.81%
Prefer Not To Answer	0.09%	0.26%
Yes	6.06%	6.36%

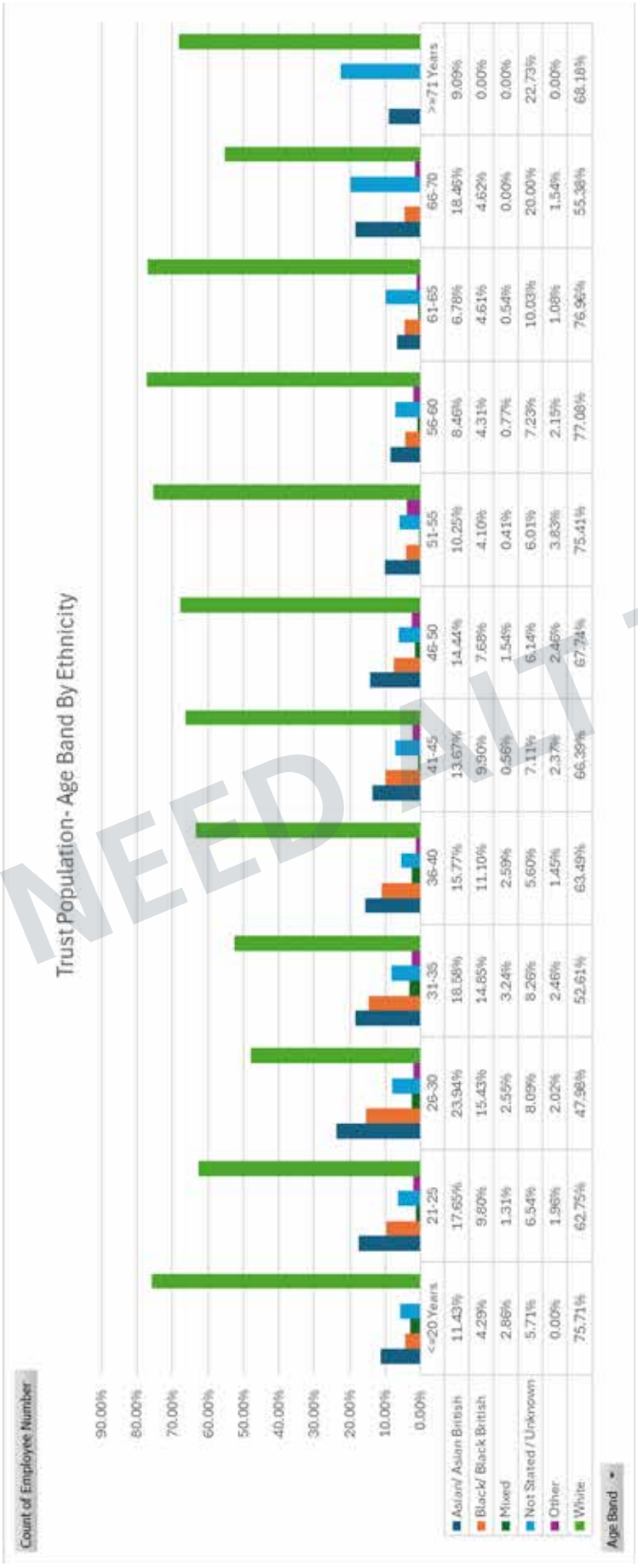
Religious Belief	2024	2025
Atheism	11.46%	11.72%
Buddhism	0.41%	0.42%
Christianity	40.79%	41.35%
Hinduism	2.12%	2.00%
I do not wish to disclose my religion/belief	22.71%	19.67%
Islam	6.10%	6.42%
Jainism	0.09%	0.05%
Judaism	0.06%	0.05%
Other	6.10%	6.11%
Sikhism	1.88%	2.10%
No Response provided	8.29%	10.13%

Sexual Orientation	2024	2025
Bisexual	0.84%	0.93%
Gay or Lesbian	0.98%	1.07%
Heterosexual or Straight	71.17%	72.76%
Not stated (person asked but declined to provide a response)	18.85%	15.17%
Other sexual orientation not listed	0.13%	0.11%
Undecided	0.17%	0.21%
No Response Provided	7.86%	9.75%



Staff numbers

Note 5.3 Average number of employees (WTE basis)	Total Accounts 31 Mar 2025 2024/25 No.	Permanent Accounts 31 Mar 2025 2024/25 No.	Other Accounts 31 Mar 2025 2024/25 No.	Total Accounts 31 Mar 2025 2024/25 No.	Permanent Accounts 31 Mar 2025 2024/25 No.	Other Accounts 31 Mar 2025 2024/25 No.
Medical and dental	899	796	103	873	766	107
Ambulance staff	11	11	0	7	7	
Administration and estates	1,149	1,111	38	1,088	1,031	57
Healthcare assistants and other support staff	1,480	1,260	220	1,504	1,300	204
Nursing, midwifery and health visiting staff	2,107	1,896	212	2,092	1,867	225
Nursing, midwifery and health visiting learners	0			0		
Scientific, therapeutic and technical staff	724	674	49	656	605	51
Healthcare science staff	55	54	1	55	52	3
Social care staff	0			0		
Other	0			**0**		
Total average numbers	**6,425**	**5,802**	**624**	**6,275**	**5,628**	**647**
Of which:						
Number of employees (WTE) engaged on capital projects	44	44	0	11	11	0



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Staff costs

(unaudited)

	Year ended 31 March 2025			Year ended 31 March 2024		
Staff Costs	**Total £'000**	**Permanent £'000**	**Other £'000**	**Total £'000**	**Permanent £'000**	**Other £'000**
Salaries and wages	316,450	314,094	2,356	282,709	279,724	2,985
Social security costs	31,424	31,424	0	29,323	29,323	0
Apprenticeship levy	1,548	1,548	0	1,444	1,444	0
Pension cost - employer contributions to NHS pension scheme	31,344	31,344	0	29,934	29,934	0
Pension cost - employer contributions paid by NHSE on provider's behalf	20,335	20,335	0	12,424	12,424	0
Pension cost - other	68	68	0	64	64	0
Termination benefits	0	0	0	0	0	0
Temporary staff (including agency)	2,799	0	2,799	3071	0	3071
NHS charitable funds staff	174	174	0	136	136	0
Total	**404,142**	**398,987**	**5,155**	**359,105**	**353,049**	**6,056**

Sickness absence data

The detail of staff sickness / absence from work for the year are:

	2024/25	2023/24
Total Days Lost	67,326	59,778
Average FTE for calendar year 2024 and 2023	5,691	5,492
Average Working Days Lost Per FTE	11.8	11

Staff with disabilities

We strive to build an inclusive workplace for everyone to bring their whole self to work.

Disabled people can face discrimination and disadvantage in the workplace, including physical, social, and attitudinal barriers. We want people with disabilities, including long term conditions, neurodiverse and mental health conditions, to feel welcomed, supported and valued.

The Trust is mandated to implement the Workforce Disability Equality Standard (WDES). The WDES is a set of workforce measures that enables the Trust to compare the experiences of disabled and non-disabled staff. The Trust has seen improvements with WDES Indicators on workforce representation, recruitment, engagement and provision of reasonable adjustments.

Workplace adjustments are crucial for improving disability equality, as they enable staff to perform their roles more effectively. In the past year, we have continued to strengthen implementation of reasonable adjustment passport and centralising reasonable adjustment project, including supporting with access to work assessments.

Following are further examples of how the Trust has implemented support to staff with disabilities and long-term conditions:

- Launched a neurodiversity toolkit for staff and managers and training to accompany the toolkit.
- Training and educational webinars on neurodiversity – sharing lived experience.
- Adjustments at interview and during recruitment.

- Maintained Disability Confident Leader Status.
- Developed and launched our anti-discrimination statement, specifically highlighted disability discrimination which has been added to key policies.

The Trust's Disability Staff Network continue to engage with staff, provide peer support and implement several activities to promote inclusive practices, provide education and awareness.

Engaging with our workforce and communities

The Trust is committed to working in partnership with its employees to maximise its potential to deliver against its business objectives, through robust arrangements for joint working which include consultation and negotiation. We appreciate the need for collaborative working on the underpinning aims and values to ensure exemplary practice in the employment and treatment of staff. The Trust recognises the importance of proper representation by recognised trade unions, and we are committed to involving and engaging with Staff Side, trade unions and staff through our Joint Negotiating Committee to ensure that we maintain effective workplace employee relations.

Good communication and engagement across the Trust are a priority to ensure colleagues, patients and the public know what is happening in the Trust. We use many different channels to engage our workforce and community in service development.

The Hub

The Hub is the Trust's intranet and enables us to share news and updates with all our staff. This includes health campaigns, finance information, workforce and recruitment updates. It shares successes such as award wins and innovations, and alerts staff to any operational changes. The Hub is also the central repository for all clinical and non-clinical procedural documents, links and essential information.

In the Know

In the Know is an email bulletin to all staff and our private finance initiative partners and is the go-to source of information in the Trust, allowing us to share key updates quickly.

Team Brief

Led by the chief executive each month, this online event enables staff to receive updates on Trust performance and developments, and to ask questions.

Live Chat

This takes place every month and is led by the chief executive. It is a very popular online forum for staff to put questions and to receive an immediate response from the senior management team. They have the option to do this anonymously. This year has seen several 'themed' live chats with guest expert hosts, such as an opportunity to put questions on vaccines, home working, sustainability and our new Trust strategy.

Healthcare Heroes

Healthcare Heroes is an opportunity to recognise and reward the great work of our teams, individuals and volunteers. Staff and patients submit nominations each month and the winners, chosen by the chief executive, are paid a surprise visit and presented with a certificate and prize.

Patient Safety and Experience Bulletins

We continue to engage clinicians with important patient safety and experience information through weekly email bulletins on specific themes.

Long Service Awards

We feel that 10, 25, 30, 40 and 50 years are big milestones in an NHS career and we recognise this with our Long Service Awards. These events happen annually, and in 2024, we recognised 240 members of staff, including 99 staff members who reached milestones of 25, 30, 40 and 50 years of service. We celebrated a collective total of 4,270 years of service in the NHS.

Social media

We have a strong social media presence and regularly post news about the Trust, events, our services and health advice on Facebook, Twitter and LinkedIn. New for 2024/25 we launched our Trust TikTok channel as a new platform for us to share key health messages and content. We have around 17,996 page followers on Facebook, nearly 7900 followers on Twitter and 1146 followers and 6766 likes on TikTok.

Engagement and Involvement

The year has seen the Trust initiate and collaborate on a number of engagement activities, all aimed at ensuring the voices of our patients, carers, communities and public are at the heart of what we do and helping shape services and drive improvements.

We know that nurturing trust and reciprocity is key in building relationships where people feel valued and supported so teams have also attended a number of events to promote the trust and its services.

Pensioners Fayres in Stourbridge and Netherton

The team attended two local fayres organised by a local MP to help promote services to local people. Over 80 people attended the events and were provided with a warm cuppa and had the opportunity to find out information to support them in living well.

People Panels

Our People Panels are joint spaces for organisations across Dudley to come together and speak with local people and they are hosted collaboratively. From digital panels to NHS 10-year plan panels, we've held conversations with over 100 people to hear their experiences on using digital apps and support in accessing the NHS and wider services and heard views on what the NHS should be focusing on for the next 10 years ahead.

Fibromyalgia workshop

We hosted an online workshop for people living with fibromyalgia with the aim of them helping to shape a self-management programme. We were joined by over 80 attendees who had the opportunity to listen to a range of experts including rheumatologists, pain relief clinicians, dietitians and health coaches on the impacts of the illness. Attendees then had the opportunity to ask questions and discuss their experiences and share advice.

Women's Health Hub

We held an online workshop, The Menopause and Me, to explore developing a local Women's Health Hub and to understand views and experiences on the menopause and heavy menstrual bleeding. We were joined by over 30 ladies who were keen for menopause cafes to be introduced around the borough with tailored support and advice. The menopause café's were introduced in February 2025 and rotate around the family hubs. The first two cafes have been held in Coseley and Brierley Hill with around 37 ladies joining the sessions and have been well received. The ladies hear from a GP with a specialist interest in women's health and have the opportunity for questions and candid conversations.

Brockmoor and Pensnett community event

Partners collaborated to host a community event at the local primary school in Pensnett as part of ongoing work in the area focussing on health inequalities and developing health and community champions. Over 150 people attended the event and took part in activities including sport and CPR. A huge range of teams were available on the day to provide information, signposting and support to attendees from canal and river walks, to family hubs and mental health. Local residents were pleased to be able to attend an event on their doorstep and were impressed with the amount of local activities they could tap into.

Dudley Improvement Practice (DIP)

The Dudley Improvement Practice (DIP) is the Trust's long-term commitment to creating a culture of Continuous Improvement.

The DIP improvement system consists of a range of training, collaborative problem solving and facilitated workshops, which together support teams with a structured approach to their improvement journeys. This is underpinned by developing leadership behaviours that promote an improvement culture, and by a management system that links improvement activities to the Trust's

strategic goals. DIP believes in three essential elements of Continuous Improvement:

- **Engagement** – the power of collaboration is maximised by engaging the people who do the work every day and, therefore, have the most insight about how to improve it.
- **Equality** – harnessing the great diversity in our people by treating everyone as 'thinking equals' drives innovation and creativity.
- **Empowerment** – developing a coaching style of leadership to make our people feel valued and psychologically safe to propose new ways of working, to contribute and to learn together.

Over the last year, members of the DIP team have presented on the NHS IMPACT (national best practice guide to continuous improvement) lunch and learn sessions, and the Improvement Directors Network. In a welcome message from Dr Amar Shah (National Clinical Director for Improvement) for our annual showcase event, he commented that Dudley is one of the leading improvement systems nationwide.

We continue to develop scientific thinking as an improvement mindset using our Kata training which is now double accredited with the Continuous Professional Development Standards Office and Cardiff University through their Kata Competency System. This is one of the few improvement training courses that is accredited to award delegates with improvement coaching certification at two levels of competency. Last year we were visited by Professor Jeffrey Liker from University of Michigan whose articles and books on improvement coaching and scientific thinking have won eleven Shingo Prizes for Research Excellence.

In 2025 the Dudley Improvement Practice team are supporting two strategic programmes of work.

- Shift healthcare closer to home, avoiding unnecessary hospital attendances.
- Reduce length of stay for frail and elderly patients who need to be in hospital for the shortest time possible.

Over the last 12 months, there has been a focus on growing improvement capability amongst staff through the creation of Improvement Champions who will be experts by improvement experience. They are trained and supported by the Dudley Improvement Practice team and are local sources of support for staff undertaking improvements as part of their appraisal objectives.

Corporate resilience

The Corporate Resilience Team (CR Team) ensures the Trust can meet national legislation, guidance and standards pertaining to health and safety, fire safety, emergency planning and business continuity, providing professional input to compliance requirements within the Trust. In addition, the team provides divisions and directorates with the necessary frameworks to ensure that services meet the required standards and comply with statutory legislation.

By ensuring proper and effective oversight is in place, the CR Team is able to provide the Trust Board with assurance that health, safety and fire standards are being maintained, and exceptions are identified and managed and dealt with quickly. The Trust maintains robust health, safety and fire and emergency preparedness resilience and response arrangements, through establishment of a safety management system subject to regular review including testing of the major incident and business continuity plans in relation to incidents (fire, flood etc) as well as industrial action.

The Health Safety and Fire Assurance Group and the Emergency Preparedness Resilience and Response (EPRR) Assurance Group act as the main mechanism for consultation on all Corporate Resilience matters. Both groups meet quarterly with divisional representation to monitor performance against key objectives and gather assurance to evidence to the board that suitable and sufficient arrangements are in place to proactively and reactively respond to safety concerns and threats to business continuity. Both groups convened on four of four occasions as planned with terms of reference updated in line with internal governance requirements. Collectively, Quoracy was achieved in five of eight meetings.

Clear and concise procedural documents are critical to healthcare services to provide staff with clarity and consistency in terms of what they need to do to comply with the law, implement best practice and national standards. Documents including strategy, policy, standard operating procedures (SOPs) and plans have been developed, reviewed, updated and consulted on, during the last financial year. This includes a full review of the:

- Health and Safety Policy

- Fire Lead SOP
- Oxygen Monitoring Device Standard Operating Procedures.

The EPRR team, in line with national core standards have reviewed the EPRR strategy and associated documents:

- Critical incident policy
- Business continuity policy
- Major incident policy
- Adverse weather SOP
- Lockdown and bomb threat SOP
- Evacuation and shelter SOP
- Incident coordination centre (ICC) SOP
- Chemical biological radiological and Nuclear SOP
- VIP management SOP

Suitable and sufficient training, instruction and information are crucial to developing a safe and healthy workforce. The CR Team have continued to provide mandatory and non-mandatory training throughout 2024/25 to underpin the corporate resilience portfolio. As of the end of year mandatory training compliance for Fire Safety reached 91.31% and for Health and Safety, 96.88%. The Fire Team introduced virtual reality fire extinguisher, training over 300 people in the past year. The team implemented a risk-based approach, to support compliance with the Regulatory Reform (Fire Safety Order) 2005 to ensure the Trust has a staff base able to deal with a fire in its immediacy. Additionally, the fire team have provided role specific training to the Site Operations team, Fire Leads, Fire Wardens, and introduced a new Fire Safety for Managers module. Chemical, Biological, Radiological and Nuclear (CBRN) training has continued throughout the year on a monthly basis led by Emergency Department colleagues, supported and monitored by the EPPR team. Non-mandated health and safety training has paused due to depleted capacity within the team and will be reinvigorated when the team is at full compliment.

The Trust uses a range both proactive and reactive measures to manage risk and monitor Corporate Resilience performance. Following the change to HTM 05-03 Part K Guidance on fire risk assessments in complex healthcare premises, a new two-tier process was implemented. Seventy departmental fire risk assessments were completed, now known as Secondary Fire Risk Assessments. A Primary Fire Risk Assessment was also introduced, which reviewed a whole block. Three Primaries were completed, on North Block, East Wing and the Rainbow Unit. This has provided valuable insights into the inter-departmental relationships in the event of an emergency and how we work together to keep our patients safe. The team use the Audit Management and Tracking (AMaT) system for gathering health, safety and fire compliance. During the last 12 months, AMaT has been utilised for all fire risk assessment actions, to provide a more robust review process, and assurance that actions are being taken to improve fire safety. Additional fire safety assurance was gathered via:

- Desktop fire drills were changed from departmental reviews to whole floor participation, providing assurance that we have leads who are fully aware of the fire safety procedures to follow.
- Received two site inspections and two site familiarisation visits from West Midlands Fire Service.
- Supported the establishment of a new dedicated fire safety group with Summit and Mitie, to provide a focus on changing legislation and its applicability to the Trust.

Health and Safety audits have been undertaken to assess the suitability of arrangements for the Control of Substances Hazardous to Health (COSHH). Good practice was identified with substances stored correctly and safely, with recommendations to improve availability and quality of associated risk assessments. A second stress survey has been undertaken with actions feeding into health and wellbeing framework.

As part of the annual NHS England EPRR Core Standards process, the EPRR Team is required to report regularly to senior Trust Committees and the Board of Directors.

NHSE's final assessment for 2024 stated that the Trust was assessed as 'Partially Compliant' at 84% against the EPRR Core Standards; an increase in compliance from 77% when compared with the previous year, 2023.

The Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) 1995 (amended 2013) requires employers to report certain types of injury, some occupational diseases and dangerous occurrences that 'arise out of or in connection with work' to the Health Safety Executive (HSE). The Trust reported 24 RIDDOR incidents over the last 12 months, an increase of four,

compared to the previous year. Predominantly these resulted in 7-days absence from work with contact with moving object, slips trips and falls, and sharps injuries cited as the primary cause.

Moving into the next 12 months, the Corporate Resilience Team will work collaboratively to focus on continuously improving the Trusts safety management, response and resilience arrangements. Key objectives for 2025/26 include:

- Establishment of a multidisciplinary violence prevention and reduction working group to reduce incidence of workplace violence and aggression, implementing NHS England's Violence and Aggression Prevention and Reduction Standards.
- Review of managers and leads health and safety training to ensure there is a significant focus on risk assessment to aid competence and improve quality of assessments undertaken.
- Develop a health and safety self-audit process focussing on compliance with the Trust safety management system.
- Working collaboratively with system partners to share good practice in EPRR and achieving an improved Core Standards rating.
- Developing an Exercise Schedule to strengthen the Trust's resilience and response, based on local risk intelligence.
- Updating EPRR training materials to ensure they reflect best practice, current standards and lessons learnt.
- Continue with the programme of secondary fire risk assessments to ensure high standards of fire safety across all departments, and deliver three primary fire risk assessments on North Block, West Wing and Guest Outpatient Centre.
- Develop a new training needs analysis for all training provided by the team.
- Increase provision of training on fire extinguishers and evacuation equipment, taking a risk-based approach.
- Provide nationally recognised external training to the team to support competency, allowing for a review of the workplan, freeing up time for additional project work and the primary fire risk assessments.

Staff health and wellbeing

At the heart of our Trust's mission to be a 'Brilliant place to work and thrive' is the wellbeing of our workforce, recognising that a supported and healthy team is essential for delivering the best possible patient care. We are committed to ensuring that our staff feel valued, supported, and cared for—especially during challenging times.

We actively role model the importance of self-care, encourage access to support services, and act to continuously improve the ways in which we support our staff. A holistic approach is key to achieving this goal, and we believe in adopting preventative strategies that foster a culture of wellbeing throughout the organisation.

The ongoing delivery of the Trust Wellbeing Journey exemplifies this approach, highlighting our commitment to addressing staff needs proactively.

While we acknowledge that certain challenges are inevitable, we are determined to provide unwavering support during these times, ensuring that our colleagues' wellbeing remains a priority. We recognise that wellbeing is a multifaceted concept and that it is everyone's responsibility, from individual actions to organisational decisions that impact staff health.

Supporting staff wellbeing is an ongoing journey, and we understand that the factors influencing our workforce's health will evolve. Our response will always come from a place of compassion, with staff wellbeing at the core of our approach. By integrating wellbeing into our day-to-day operations, we aim to create a positive work environment where our staff can thrive, benefiting from the support and resources they need to succeed.

Over the past year, we have continued to support our staff, fully recognising the challenging circumstances our workforce continues to face. At the forefront of our efforts has been the reminder that workforce wellbeing is not only essential for the health of our team but also crucial to maintaining the highest standards of patient care.

Wellbeing Key Achievements

We are proud to celebrate the following successes in our ongoing journey to support and prioritise the wellbeing of our workforce:

- We now have over 150 wellbeing champions across the Trust offering supportive wellbeing conversations and onward signposting to professional support offers. We will be strengthening these numbers as we move forward, including the recruitment of champions within our newly established Place division.
- We have successfully run a health check programme over the past 12 months, offering free health checks for all staff to track their health numbers and prioritise healthy lifestyle behaviours.
- The Board of Directors continues to monitor the Trust's activities to promote wellbeing through the Health and Wellbeing Steering Group and the People Committee.
- We have launched a new Team Wellbeing training session, offering support and guidance for managers to embed a positive wellbeing culture locally within teams. We have also continued delivering all of our in-house Trust wellbeing workshops, as well as ad hoc sessions delivered onsite for teams.
- Launched a new Champion Toolkit to enable our wellbeing champions to successfully deliver on the role, including useful templates, signposting, and training opportunities. We have also continued to meet with our wellbeing champions on a bi-monthly basis, offering regular updates and peer support.
- Wellbeing updates and communications are shared regularly, including via our Trust communications email, our wellbeing champions, and our CEO briefing.
- Worked with the Organisational Development team to design and launch a new training session with a focus on resilience, to support our staff who are dealing with challenging circumstances both inside and outside of work.
- All staff can access a variety of support offers which are regularly communicated and shared in relevant policies, including a dedicated employee assistance programme which offers counselling and wider support available to NHS staff, and specific support for areas of wellbeing such as the menopause.
- Monthly webinars and educational wellbeing sessions are offered to staff, promoting national wellbeing days, which are shared regularly via our internal communications and our wellbeing champions.
- Regular engagement offered to teams via the wellbeing business partner, including summarising the wellbeing offer, recruiting champions, and offering suggestions for local implementation of wellbeing initiatives.
- The wider national offer is also available to staff and details of this are accessible via our wellbeing intranet pages and shared with staff, including the 24/7 staff support helpline, and free mental wellbeing apps including Unmind.
- Wellbeing business partner working on key pieces of work to ensure a more joined-up approach to wellbeing, including working with occupational health, health and safety, and human resources on areas such as sickness absence, work-related stress, and wider system work in development.
- Mental health guidance refreshed and shared with key stakeholders across the Trust, including our wellbeing champions, highlighting key learning around mental health and practical steps to take around supporting staff and their mental health.
- Launched sexual safety survey alongside the EDI team, survey data framing the new policy and addressing how concerns are raised and dealt with organisationally.

Occupational Health

Core occupational health services continued to be offered including pre-employment health assessments, immunisations and vaccinations, health surveillance, treatment and follow-up of inoculation injuries/sharps injuries.

Management referrals to the occupational health service are also offered to ensure that staff are cared for and supported when required.

Key areas of focus over the last twelve months:

- Meeting KPIs for both new starters and management referrals received by the service.
- Occupational Health management system upgrade.
- Delivering actions outlined following external audit.
- Development of the team and service overall using SEQOHS standards as a baseline.

Training, Learning and Organisational Development

Being a Brilliant Place to Work and Thrive

This year, we have focussed on our culture work, ensuring we support our people in all the elements of the NHS People Promise, creating a working environment that is a brilliant place to work and where people thrive.

Our People Plans and Delivery Journeys on Culture and Leadership, Recruitment and Retention, Equality, Diversity and Inclusion, Continuous Improvement and Wellbeing have clear goals we're working to deliver.

We established our Being a Brilliant Place to Work group to plan, deliver and review our progress. This includes re-launching 'itchy feet' conversations and 'sorry you're leaving' interviews to understand our strengths and areas for improvement, developing our Careers at Dudley brand and website, and reviewing policies on anti-bullying, anti-discrimination, and sexual safety.

We are always learning

In 2024/25, we delivered a range of training courses and published our updated Prospectus of learning opportunities for staff. This includes programmes like Admin Essentials, Communication Skills, Wellbeing, Flexible Working as well as modules on our leadership programmes. Over 1500 staff participated in these learning activities.

We have reviewed our Leadership Pathway to provide more development opportunities at different stages of leadership, with new programmes launching in 2025/26.

Over 300 people completed our Managers Essentials programme, setting our leadership standard and 60 new leaders completed their induction to leading people at Dudley.

Our Annual Leadership Conference celebrated successes and recognised leaders' work. We also supported leaders who completed development programmes with an alumni event in October 2025 to learn, connect, and refresh their skills.

We delivered our Annual Review programme from April to June, with 92% of staff receiving a progress review and career conversation.

Our careers team supported new and existing staff to access a range of apprenticeships from level 2 up to level 7, including new apprenticeships in digital, podiatry, midwifery and radiography. The national Higher Development Award for Support Workers continued, creating opportunities to learn for clinical staff at the start of their leadership journey.

We have delivered our ICan partnership with Dudley Metropolitan Borough Council (Dudley MBC), offering paid work experience in administration, clinical roles, finance, recruitment and maintenance roles as well as our learning at work programmes for Clinical Support Workers. his programme provided 30 work experience placements and 20 Clinical Support Worker training places, with many candidates finding permanent jobs with The Dudley Group or Dudley MBC.

We work flexibly

This year, we launched training for line managers and reviewed our flexible working options to ensure clarity for staff. We developed a new way to capture this information to measure our flexibility as an employer.

We are a team and we are compassionate and inclusive

Support for teams and leaders continued with the re-launch of our Behaviour Framework and Living the Values training, promoting a positive workplace culture. We delivered this to over 200 team members and 30 teams.

We are safe and healthy

Staff continue to access our Statutory and Mandatory Training programme, which has been reviewed for accessibility, relevance, and effectiveness. We maintained performance above our 90% target throughout 2024/25.

Countering fraud

The Trust has continued to ensure its staff are aware of responsibilities towards fraud and bribery and have both a fraud and corruption policy and an anti-bribery policy to support staff and takes its responsibility for countering these issues very seriously.

We have a Local Counter Fraud Service and one of our key aims is to work together to promote an anti-fraud culture. Newsletters and alerts are published and promoted regularly on the Hub to ensure staff understand that fraud against the NHS will not be tolerated. In addition, a number of training sessions have been facilitated for staff to improve their awareness of cyber fraud and ensuring vigilance.

Equality, diversity and inclusion (EDI)

We are continuing with our ambition to embed equality, diversity, and inclusion as a golden thread into everything that we do. We believe it's the right thing to do and we are passionate about doing it. Our workforce is a rich mix of ethnicities, cultures, religions, faiths, beliefs, ages, genders and identities that come together.

We are committed to creating an inclusive culture where people feel that they belong. We are passionate about this, because it benefits our staff, patients, visitors, service users and the community that we serve. Developing an inclusive environment supports us to comply with our legal and statutory obligations, for example, through the Workforce Race Equality Standard (WRES), Workforce Disability Equality Standard (WDES), Equality Delivery System (EDS), NHSE Improvement plan (High Impact Actions) and the gender pay gap reporting (GPG).

Our equality, diversity and inclusion activity is linked to the NHS People Plan, the Trust's Dudley People Plan and our strategic objectives. We recognise our role and responsibility to provide equal opportunities and advance inclusion, to eliminate discrimination and to foster good relationships as an employer, provider, partner and anchor institution.

The Equality Act 2010 introduced a general equality duty requiring organisations to have due regard in the exercising of their functions. These are to:

Eliminate discrimination, harassment, and victimisation.

Advance equality of opportunity between people who share a protected characteristic and people who do not.

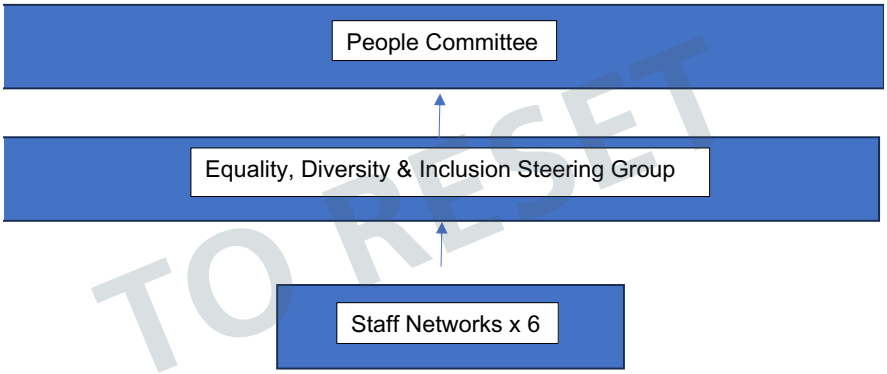
Foster good relations between people who share a protected characteristic and those who do not.

The Protected Characteristics covered by the Equality Act 2010 are:

- Age
- Disability
- Gender Reassignment
- Marriage and Civil partnership
- Pregnancy and Maternity
- Race
- Religion or Belief
- Sex
- Sexual Orientation

Trust Equality, Diversity, and Inclusion (EDI) Governance

Our EDI Governance structure is built on the principle of leadership and inclusion This approach will engage with staff from all communities, professions, and protected characteristics to improve the experience for everyone working at The Dudley Group.



TO RESET

People Committee

The People Committee is a sub-committee of the Trusts' board of directors which overseas workforce and has an overview of equality, diversity and inclusion work plans and receives updates from the EDI Steering Group.

Equality, Diversity, and Inclusion (EDI) Steering Group

The steering group is responsible for the co-ordination and strategic leadership of all aspects of the inclusion agenda and upward reports into the People Committee and to the Trust board.

Membership of the steering group and the committee includes key representatives from each of the departments and divisions.

Equality, Diversity and Inclusion (EDI) Strategic Journey

The Trust's Equality, Diversity and Inclusion (EDI) strategic journey outlines our commitments for the next few years in becoming a more inclusive organisation and ensuring equality, diversity and inclusion are enshrined in our values.

Over the past 12 months the Trust has overhauled and significantly strengthened its work around Equality, Diversity and Inclusion (EDI). As our journey has progressed, we have undertaken various assessments and progressed with our EDI objectives and consolidated action plan.

Staff Networks

It is recognised that staff equality networks are an excellent mechanism through which the general duties of the Equality Act 2010 can be supported in relation to staff from the protected groups and other groups at potential risk of inequality.

The Trust now has six staff networks, namely EmbRACE, LGBTQ+, Disability & Long-term Conditions, Women's, Armed Forces and Carers networks. All our staff networks have an executive sponsor. They provide strategic guidance and support, and this is one of the ways our leaders show visible allyship for diverse staff at Dudley Group.

The networks have focused on growing their membership over the past year to strengthen the voices of colleagues. They work closely together, supporting each other with their priorities and driving improvements alongside the Equalities and Wellbeing Team.

Health Inequalities

The Trust is working with partners in the Dudley Health and Care Partnership including Dudley Council for Voluntary Service and different community groups to better understand the barriers to accessing healthcare and learn how we can ensure our services reach and benefit everyone.

The Trust has an Integration Committee which focuses on the actions the Trust is taking to build partnerships and improve overall health and wellbeing in the population, this includes work to address health inequalities. The committee receives regular updates from preventative services and the actions being taken to address inequalities.

We have further developed our Health Inequalities Core Group which reports to the Integration Committee. This core group has resulted in a better understanding of the available metrics. Relevant reports on health inequalities have been reviewed and recommendations shared with service leads.

EDI Key achievements

- Increased ethnically diverse staff levels to 28%.
- Increased Disability disclosure rates to 6%.
- EDI statements are visible on all external and internal communication channels.
- Implemented Centralised Reasonable Adjustment project.
- Refreshed inclusive recruitment training programme.
- Refreshed the behaviour framework, ensuring a clear stance on unacceptable behaviour towards people with protected characteristics.
- Equality impact assessed recruitment practices and related policies.
- Continued to grow our current staff networks to enhance staff voice and introduced two new networks: a carers network and armed forces network.
- Introduced a standardised anti-discriminatory statement into all relevant workforce policies.
- Continued to monitor culture dashboard and incidents of discrimination and abuse.
- Launched Anti-Racism Statement campaign.
- Developed a prospectus supporting staff from all backgrounds to reach their potential, increasing training and development activities.
- Increased staff engagement through ward rounds and divisional meetings
- Developed SMART EDI objectives for the Chair, Chief Executive and Board members.
- Undertaken career conversations with women from areas where we have a Gender Pay Gap and ethnically diverse nurses to improve career progression.
- Implemented Equality Delivery System domains 1,2 and 3 evaluation and now graded as "achieving".
- Launched Neurodiversity toolkit and training for staff and managers.
- Maintained gold level award from the Employers Network for Equality and Inclusion (enei) in our Talent Inclusion and Diversity evaluation (TIDE)
- Launched Trust wide Anti-racism and Anti-Discrimination statement.
- Launched Cultural Awareness training.
- Launched Transgender Awareness training.
- Launched Allyship training.
- Developing EDI data packs and objectives for divisional teams
- Continued implementation of the RACE Code Kite mark and have a clear set of actions to support our organisation to improve Race equality.
- Reviewed and refreshed Equality Impact Analysis / Health Equality Assessments process and governance.
- Completed the Rainbow Badge Phase II Assessment and developed a set of robust actions to improve equality and inclusion for our LGBTQ+ workforce and patients.

Staff turnover

Our staff turnover for the year was 7.24 per cent. More information on our staff turnover can be found at the **NHS workforce statistics published by NHS Digital**.

Staff survey

The NHS Staff Survey is our annual check in with staff about their experience at work. Conducted between October and November, we encourage all our people to participate. Framed around seven People Promises, feedback highlights areas where we are doing well and those needing improvement. This survey complements our regular engagement activities, including the Quarterly People Pulse and feedback through #makeithappen, where we visit services each quarter to discuss successes, areas for improvement, and organisational initiatives. In the Staff Survey 2024, 49% of our people participated, a 4% increase from 2023, matching the benchmark average for similar organisations (Acute and Community Trusts).

Our Results

Compared to similar organisations, we perform at the benchmark average across all seven People Promises and the themes of 'Staff Engagement and Morale'. Our performance has improved over the last three years, though results have plateaued in the past 12 months. We continue to focus on key areas linked to our People Plan and delivery Journeys to embed the People Promises. Ongoing work includes supporting staff to have a voice, being safe and healthy, both around wellbeing and fostering respectful treatment among colleagues, and effective line management which supports the we are compassionate and inclusive and we are a team promises.

	2024		2023		2022	
People Promise	Trust Result	Benchmark Score	Trust Result	Benchmark Score	Trust Result	Benchmark Score
We are compassionate and inclusive	7.18	7.21	7.23	7.24	7.2	7.2
We are recognised and rewarded	5.81	5.92	5.88	5.94	5.7	5.7
We each have a voice that counts	6.56	6.67	6.65	6.7	6.7	6.6
We are safe and healthy	5.95	6.09	5.97	6.08	5.8	5.9
We are always learning	5.64	5.64	5.69	5.61	5.2	5.4
We work flexibly	6.17	6.24	6.19	6.2	6.0	6.0
We are a team	6.70	6.74	6.72	6.75	6.7	6.6
Staff Engagement	6.71	6.84	6.81	6.91	6.7	6.8
Morale	5.75	5.93	5.8	5.91	5.6	5.7

Each year, we share our results widely across the organisation so that all of our teams and services their performance, identify successes, and pinpoint areas for improvement. We set clear goals for areas of work across the organisation and each division identifies teams or services that may benefit from dedicated action plans if their results are below the benchmark. These teams receive additional support from divisions and corporate support teams, with progress reviewed by our People Committee throughout the year. These are reviewed through our People Committee

Throughout the year, we have focused on flexible working, completing annual reviews, supporting and developing line managers, and delivering our People Plan and five People Journeys. These journeys focus on Equality, Diversity and Inclusion, Wellbeing, Culture, Leadership and Learning, Continuous Improvement, and Recruitment and Retention.

We have also enhanced our approach to anti-bullying and anti-discrimination, launching new training and support at the end of the year. This work will continue into the next year.

Our People Promise manager has supported additional efforts to improve the work experience in 2024, aiming to enhance our Staff Survey results in the long term.

Trade Union Facility Time

Trade union representatives and full-time equivalents (FTE)

Trade union representatives: 14

FTE trade union representatives: 1.2

Percentage of working hours spent on facility time

0% of working hours: 0 representatives

1 to 50% of working hours: 13 representatives

51 to 99% of working hours: 0 representatives

100% of working hours: 1 representative

Total pay bill and facility time costs

Total pay bill*: £397,088,100

Total cost of facility time: £69,532

Percentage of pay spent on facility time: 0.02%

Paid trade union activities

Hours spent on paid facility time: 2326

Hours spent on paid trade union activities: 75

Percentage of total paid facility time hours spent on paid trade union activities: 3.22%

* Includes all substantive staff costs, on call payments to substantive staff & overtime paid to substantive staff

Expenditure on consultancy

Details of expenditure on consultancy can be found in our accounts.

Off payroll engagements

There were no off payroll engagements during 2024/25. It is our policy not to use off payroll engagements.

Reporting of other compensation schemes - exit packages 2024/25

Note 6.3 Exit packages: other (non-compulsory) departure payment	Payments agreed Accounts 31 Mar 2025 2024/25 No.	Total value of agreements Accounts 31 Mar 2025 2024/25 £000	Payments agreed Accounts 31 Mar 2024 2023/24 No.	Total value of agreements Accounts 31 Mar 2024 2023/24 £000
Voluntary redundancies including early retirement contractual costs				
Mutually agreed resignations (MARS) contractual costs				
Early retirements in the efficiency of the service contractual costs				
Contractual payments in lieu of notice	15	119	23	100
Exit payments following employment tribunals or court orders				
Non-contractual payments requiring HMT approval (special severance payments)*	1	11		
Total**	**16**	**130**	**23**	**100**

Exit packages - other (non-compulsory) departure payment 2024/25

Note 6.1 Reporting of other compensation schemes - exit packages agreed in 2024/25	Number of compulsory redundancies Accounts 31 Mar 2025 2024/25 No.	Cost of compulsory redundancies Accounts 31 Mar 2025 2024/25 £000	Number of other departures agreed Accounts 31 Mar 2025 2024/25 No.	Cost of other departures agreed Accounts 31 Mar 2025 2024/25 £000	Total number of exit packages Accounts 31 Mar 2025 2024/25 No.	Total cost of exit packages Accounts 31 Mar 2025 2024/25 £000	Number of departures where special payments have been made Accounts 31 Mar 2025 2024/25 No.	Cost of special payment element included in exit packages Accounts 31 Mar 2025 2024/25 £000
<£10,000			10	37	**10**	**37**		
£10,000 - £25,000			6	93	**6**	**93**	**1**	**11**
£25,001 - £50,000					**0**	**0**		
£50,001 - £100,000					**0**	**0**		
£100,001 - £150,000					**0**	**0**		
£150,001 - £200,000					0	0		
>£200,000					0	0		
Total	**0**	**0**	**16**	**130**	**16**	**130**	**1**	**11**

Gender pay gap

Information on the Trust's gender pay gap can be found on the Cabinet Office website at **www.gender-pay-gap.service.gov.uk**.

Hospital volunteer service

Volunteers from the local community give their time on a regular basis to make a real difference to patients, visitors, and staff at the Trust. More than 600 individuals between the ages of 16-83 have volunteered with us in 2024/25. Many of those leaving us have gone on to higher education or employment within the Trust.

We are currently recruiting individuals to support in the following areas:

- Nutrition & hydration
- Wayfinding and outpatients
- Chaplaincy
- Emergency department
- Patient experience
- Pharmacy
- Driving

We welcome individuals of all ages who can either offer a regular weekly shift at one of our sites or those who are willing to join our database to be called upon for ad hoc events. Throughout 2024/25, volunteers have been on hand to support with wayfinding in main reception and other key areas throughout Russells Hall Hospital, Guest Outpatient Centre and Corbett Outpatient Centre and have continued to make drinks and support our patients at mealtimes, providing a friendly chat which can make all the difference. Our chaplaincy volunteers have provided support to patients, visitors and staff from all walks of life. Volunteers have helped the pharmacy team, taking urgent medication to wards, as well as collecting prescriptions and paperwork from wards to free up clinical staff to carry on with their duties. Our patient experience volunteers have assisted with various surveys across the hospital and at our outpatient centres in order to gain feedback to improve the services that we provide.

The new Information Hub in the main reception of Russells Hall Hospital is being utilised effectively by various external organisations and departments in the Trust.

Our new Russells Hall Hospital Information Hub opened in 2024

Approximately 30 volunteers have expressed an interest to support a new research study being undertaken by the therapy department and the University of Southampton. The PIVOT Study – to promote increased physical activity in hospitalised older adults with trained volunteers.

The purpose of this study is to find out if the use of trained volunteers to help promote increased physical activity among older patients in hospital is possible and acceptable. Previous research has shown that physical activity levels of hospitalised older people is generally very low, and this can lead to many negative effects including worsening independence in activities of daily living and poorer health outcomes. A few studies have been carried out to encourage early mobility and improve physical activity levels of older people in hospital and have shown positive results in reducing length of hospital stay and improved physical function and reduced nursing home admissions.

In this study, volunteers will be trained by the therapy team to ensure that they are safe and well-equipped with the skills to promote increased physical activity. Patients who can walk on their own will be encouraged to walk with volunteers and patients who need extra help with walking will be encouraged to do bed or chair-based exercises. This study will be carried out in

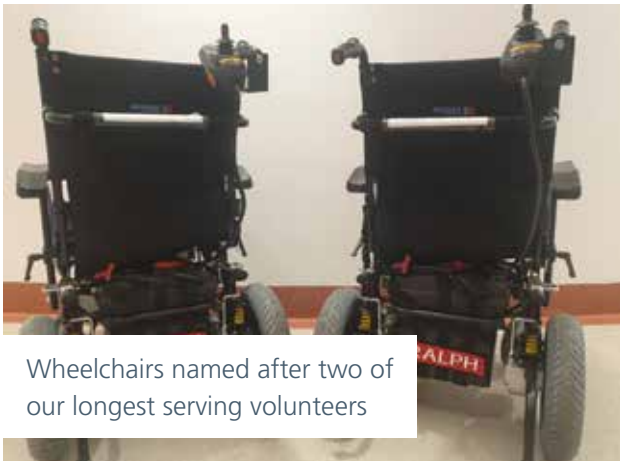
four hospitals on wards in the Medicine for Older People (MOP) department. One hospital will act as a control site where no additional support from volunteers will be provided.

Training has already commenced for this study and the programme is due to start in April 2025.

Two new electric wheelchairs have been purchased to assist volunteers in helping patients throughout the hospital. This purchase was made possible following donations from the families in memory of two wonderful, much missed, volunteers. Ralph Smith and Barry Pilkington. We have named the wheelchairs in their memory.

Our volunteer driver service has continued to help with deliveries of medication, delivery and collection of medical equipment and the return of lost property to its owner. A volunteer 4x4 driver service is also in place to support the Trust in the event of bad weather, bringing staff into work as well as any other reasonable requests. Fortunately, this year we haven't had to use this service but it's better to be prepared!

We continue to support young volunteers wishing to pursue a career in healthcare and are pleased when they rejoin us as staff following their higher education studies. Anyone interested in any of our opportunities should contact the volunteer services team on 01384 456111 ext. 1887. Further information can be found on our webpage on **www.dgft.nhs.uk** or via email: **dgft.volunteering@nhs.net**.



Wheelchairs named after two of our longest serving volunteers

Our volunteers provide essential services to patients in the community

Our volunteers receive recognition through our Healthcare Heroes awards

Volunteers are essential to clinical teams right across the Trust

Volunteers are vital in transporting medical documents between departments

Our Ophthalmology team provide an invaluable service to patients in the community at the Corbett Outpatient Centre

Sustainability and the environment

Momentum has really grown over the years with the Trust's Green Plan with more staff becoming engaged and joining the Green Team to develop their own sustainable projects. We've had some great examples such as Greener Pharmacy, who won a Committed to Excellence Award in 2024 for their medicine return project.

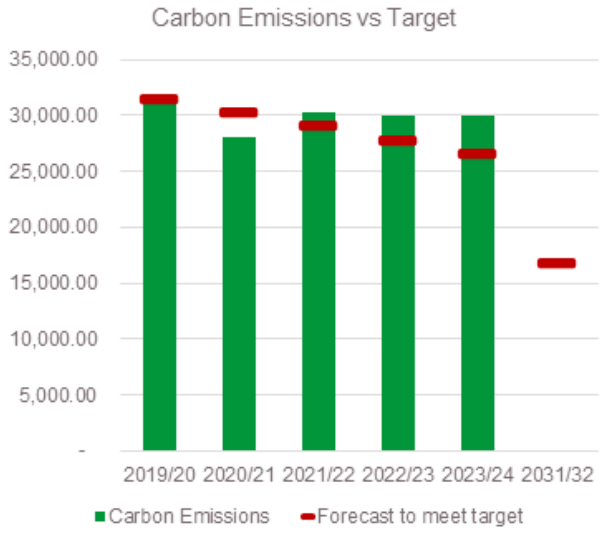
The 2023/24 carbon report showed that our emissions have reduced by 7% since the baseline year (2019/20). For us to meet the net zero target we need to reduce emissions by a further 5.4% each year, or 2,148 tCO2e. We're working with the PFI partners within the Energy and Estates Sub-Group to progress action and meet net-zero. LED lighting and ventilation setbacks are just some of the projects that are building momentum as we head into 2025/26.

The Green Plan Working Group have delivered many Green Week campaigns, engaging with hundreds of staff, organised feedback sessions and toured the hospital to raise awareness and gathered feedback from those on the shopfloor for their sustainable improvement ideas.

The Trust has partnered with travel providers to deliver travel offers for staff and patients, resulting in a modal shift and reducing the cost of travel.

Carbon Report 23/24 Overview

- The 2023/24 carbon report showed Trust emissions have reduced by 7% since the baseline year. For us to meet the net zero target we need to reduce emissions by a further 5.4% each year, or 2,148 tCO2e
- While the overall carbon trajectory needs to improve, the Trust has made notable reductions in:
  - **Patient travel** (-15%, saving 2,467.9 tCO2e)
  - **Medical gases** (-15%, saving 213 tCO2e)
  - **Waste** (-55%, saving 293.2 tCO2e)
  - **Water usage** (-64%, saving 115.8 tCO2e)



- Since the last year's carbon report, emissions have increased by 1.5% or 600tCO2e. The average annual change in emissions is -0.3% or -710tCO2e, totalling a reduction of 7% and 2,836tCO2e from the baseline year. For the Trust to meet the Net Zero target set by NHSE and embedded within the legislation, we need to bring emissions down to 22,553 tCO2e, requiring the removal of 17,183 tCO2e from this year's carbon footprint. This equates to an annual reduction of 2,148 tCO2e or -5.4% over the next eight years.

Green Plan Working Group:

The Green Plan Working Group meet and reports to Finance and Productivity Committee every quarter.

Here are some of the highlights from 2023/24:

- Green Weeks
  - There were a number of Green Weeks for staff groups such as AHP, Nurses and Midwives. To raise awareness we organised competitions for green ideas and completed the online training. We received a number of donations for the prizes including a Ninja Air Fryer and EcoEgg Laundry Eggs.
- The Make it Happen Tour was focused on the Green Plan in July, the GPWG and Governors

and other staff members went on a ward walk arounds to ask staff for feedback and ideas for our green plan.

- Our annual staff awards "Committed to Excellence" had its first Sustainability Award the winning nomination was Medicine Return to Pharmacy Project, which has so far saved £63,308 and reduced pharmaceutical waste by 3.8 tonnes, with an estimated 8.1 tCO2e emissions avoided. Other nominees included staff travel group and the sustainable theatres group.
- In July we sent out our annual staff travel survey;
  - Staff provided feedback on Park and Ride
  - Travel Survey had a 12%, an increase of 4.8% from last year
  - Free bus travel offers – 2% increase in bus users
  - Launch a new cycle-to-work scheme in January 2025
- **We're working with Transport for West Midlands (TFWM) to offer staff free bus travel:**
  - Total Staff using codes - **298**
  - New Starters – **149 (Journeys -6,250)**
  - Existing staff – **149 (Journeys -3,409)**
  - Total Journey Count – **9,659**, saving an estimated 3.8 tCO2e from switching the car to the bus.

Green Team Projects

We have over 100 Green Team members who help us embed sustainable changes in their areas, here are some examples of their work.

Spring Bulb planting took place in early January after receiving a donation from Farmer Gracy. Members of the Green Team planted the raised beds at the South Block entrance and the beds near the maternity entrance.

Staff member Heather Jones from our intensive care unit (ICU) has been embedding sustainability throughout the department, projects include reducing blood tests and increasing recycling.

- Recycling of feed bottles
- Recycling the IV Fluid bags
- Reducing medicine wastage
- Reducing Blood testing and blood gas sampling
- Tackling glove use and improving hand hygiene
- Teaching staff about recycling and correct waste segregation
- Quarterly newsletter featuring sustainability

To reduce wastage, Heather transitioned ICU from 50ml syringes to 100ml bottles of propofol. The result of this work has led to a reduction in syringe use as well as saving staff time:

- 125 hours – one month nurse time
- 10,950 needles and syringes
- £3,858 saved!

Heather initiated a project to reduce the daily testing of blood glucose. Between May 2023 to June 2024, ITU sent 8,000 blood samples for glucose testing. This equates to, 56 pints of blood, six peoples circulating volume, is more blood than any person can donate in a lifetime! This project has saved staff time and plastic waste! Savings:

- £560 on glucose bottles costs
- £240 on lab processing
- Saved **8,000 plastic bottles**, £800 and 1.1tCO2e from the plastic alone
- Totalling £1,600 savings

The medicine returns project is a major win—saving £63,308 and reducing pharmaceutical waste by 3.8 tonnes, with an estimated 8.1 tCO2e emissions avoided.

Review of DRAS Inhaler reuse:

	Total	Cost	Average monthly per-order	Carbon tCO2e
Post project	233	£640.75	13	0.87
Pre project	514	£1,413.50	43	1.93
Saved	**281**	**£772.75**		**1.05**

Review of Medicine Returns:

	Cost saving	No of Drugs returned	Carbon saved tCO2e
Jan 2023 to Oct 2024	£63,308.79	2,300	8.10
April 2023 to Oct 2024	£57,035.54	2,130	7.30

Comparing wastage weights from medicines for pre-returns and the duration of the return project, the overall pharmaceutical waste has been reduced by 3.8 tonnes, reducing waste costs by £3,725.

Green Plan

The Green Plan is currently under review, and we hope to launch the new plan in early 25/26.

Food waste recycling was introduced, which reduces carbon emissions by recycling the methane from decomposing food waste.

Plans for next year:

- Launch the refreshed green plan
- Mitie to establish feasibility for boiler replacement and to transition to low-temperature heat generation
- Heat decarbonisation plan to be developed with the Midlands Net-Zero Hub
- Install Solar Panels on North Block at Russells Hall Hospital
  - 500 panels
  - Complete by April 2026
  - Annual saving £34,705
  - Annual carbon saved 38 tCO2e
  - Pay back within 6.5 years

Code of governance

Foundation Trust Membership

The membership of the Trust comprises local people and staff who are directly employed by us or our partner organisations. Our minimum age for membership is 14 years; there is no upper age limit. Full details of who is eligible to register as a member of the Trust can be found in the Trust Constitution, which is available on our website **https://www.dgft.nhs.uk/wp-content/uploads/2025/03/Trust-Constitution-2024-25_V1.0.pdf**. Any public members wishing to come forward as a governor when vacancies arise or to vote in governor elections must reside in one of the Trust's constituencies. Staff are automatically included as members within staff group constituencies unless they choose to opt out.

During 2024/25, we continued to maintain a public membership of more than 13,000. As of 31st March 2025, the Trust had a total of 13,286 public members.

More information about the Trust and the latest news can be found on our website at **www.dgft.nhs.uk**. The members' area of the website also contains information about being a member and the contribution members make to the ongoing success of the organisation.

Members can:

- Be involved in shaping the future of healthcare in Dudley by sharing their views.
- Vote in governor elections.

- Stand for election to represent their constituency (candidates must be minimum of 16 years old).
- Attend behind the scenes tours and member events.
- Participate in public meetings, public and patient involvement panels and focus groups.
- Fundraise for The Dudley Group NHS Charity.

Public membership

31st March 2023	13,334
31st March 2024	13,275
31st March 2025	13,286

Membership constituency breakdown report as of 31st March 2025

Public Constituencies	Number of Members
Brierley Hill	1678
Central Dudley	2376
Halesowen	1068
North Dudley	1255
Rest of England	2249
Out of Trust area	77
South Staffordshire and Wyre Forest	1035
Stourbridge	1603
Tipton and Rowley Regis	1945

Public membership breakdown by age, gender and ethnicity		Number of Members
Age	0-16 years	21
	17-21 years	397
	22+ years	12248
	Not stated	620
Gender	Male	4136
	Female	8814
	Unspecified/not stated	336
Ethnicity	White	10209
	Mixed	383
	Asian or Asian British	1280
	Black or Black British	421
	Other	69
	Not stated	924

Staff constituencies

Staff Constituencies	Number of Members
Allied Health Professionals, Pharmacy and Healthcare Scientists	1198
Medical and Dental	789
Nursing and Midwifery	3254
Non-Clinical	1376
Partner Organisations	702

Council of Governors

The Council of Governors was formed on 1st October 2008 and is responsible for holding the non-executive directors to account for the performance of the Board of Directors. The majority of the Trust's governors are elected through the public membership to make up the Council of Governors which consists of 25 governors in total:

- Public elected: 13 governors.
- Staff elected: eight governors.
- Appointed from key stakeholders: four governors.

Tables summarising the Council of Governors and the constituencies they represent can be found on page 128.

The Board of Directors continues to work closely with the Council of Governors through regular attendance at both full Council of Governor meetings and the committees of the council. Both non-executive and executive directors are assigned as nominated attendees at the Council of Governors' sub-committees. This provides opportunities for detailed discussion and debate on strategy, performance, quality and patient experience and enables governors to see non-executive directors function. Governors regularly attend public Board of Directors' meetings and are invited to observe meetings of the committees of the board and encouraged to contribute by the respective chairs.

The Board of Directors is accountable to the Council of Governors, ensuring it meets its Terms of Authorisation. A Register of Interests confirming individual declarations for each governor is available on the Trust's website or is available on request by calling 01384 321124 or emailing **dgft.foundationmembers@nhs.net**.

All of the Trust's governors comply with the 'fit and proper' persons test as described in the Trust's provider licence. The conditions are incorporated into the Foundation Trust Constitution.

A process is available to apply should any governor or group of governors behave or acts in a way that may be incompatible with the values and behaviours of the NHS foundation trust.

The Council of Governors has the following key responsibilities:

- Appointing and/or removing the chair, including appraisal and performance management.
- Appointing and/or removing the non-executive directors.
- Appointing the external auditors.
- Advising the Board of Directors on the views of members and the wider community.
- Ensuring the Board of Directors complies with its Terms of Authorisation and operates within that licence.
- Recruiting and engaging with members.
- Advising on strategic direction.
- Receiving the Annual Accounts, any report of the auditor on them, and the Annual Report at the Annual Members' Meeting.
- Approving significant transactions which exceed 25 percent by value of Trust assets, Trust income, or increase/reduction to capital value.
- Approving any structural change to the organisation worth more than 10 per cent of the organisation's assets, revenue, or capital by way of merger, acquisition, separation or dissolution.
- Deciding whether the level of private patient income would significantly interfere with the Trust's principal purpose of providing NHS services.
- Approving amendments to the Trust's Constitution.

Where an item is reserved for both Council of Governors and Board of Directors approval, for example, a change to the Trust's Constitution, then this change would not be made if either party did not approve the recommendation put before them. In practice, a constructive and close working arrangement is maintained between the Council of Governors and the board through the chair and lead governor.

In the event of a dispute or disagreement between the Council of Governors and the Board of Directors, the chair would endeavour to resolve this in the first instance. Should a resolution not be reached, the chair may ask the board secretary, senior independent director and/or the deputy chair to review the matter further. In the event a resolution is not reached, the matter would be referred back to the chair for a final decision.

If a dispute arose which involved the chair, the dispute would be referred to the senior independent director, who would use all reasonable efforts to resolve the matter.

The Trust continues to work closely with the Council of Governors to further develop the governor role to reflect the requirements of the Health and Social Care Act and other best practice and guidance. This includes adopting and adapting to the changes set out in the Health and Social Care Act 2022 that has been reflected in the Addendum to Statutory Duties.

The Trust provides ongoing training and development, allowing experts from within and outside the Trust to work with the Council of Governors to identify key aspects of their role. This includes how they influence strategy within the Trust and how they will engage with members and the wider community so that their views and opinions can be heard.

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If a dispute arose which involved the Chair, the dispute would be referred to the Senior Independent Director, who would use all reasonable efforts to resolve the matter.

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The Trust provides ongoing training and development, allowing experts from within and outside the Trust to work with the Council of Governors to identify key aspects of their role. This includes how they influence strategy within the Trust and how they will engage with members and the wider community so that their views and opinions can be heard.

Council of Governors committees

The Council of Governors reviewed its committees and their terms of reference and operates the following:

- Remuneration and Appointments Committee (chair Sir David Nicholson)
- Experience and Engagement Committee (committee chair Mushtaq Hussain)

The Remuneration and Appointments Committee meets at least once a year and comprises a membership where the majority is made up of governor members. It is responsible for ensuring a formal, rigorous and transparent procedure for the appointment, appraisal, reappointment and removal of the chair, deputy chair and non-executive directors, reviewing their number, specific skill mix and remuneration as set out in the relevant aspects of the Code of Governance and in line with the Trust's Constitution.

The committee, chaired by the Trust's chair, oversees the recruitment process through the use of interview and stakeholder assessment panels. The Remuneration and Appointments Committee submits its recommendations for appointments, outcomes of appraisals, reappointments and removals to the full Council of Governors.

The table on page xxx provides a summary of the non-executive members' length of appointment.

Council of Governors membership and meeting 2024/25

Figures show the number of meetings attended that were held during the term of office.

Public Governors

Name	Constituency	
Julius Adams (Elected December 2024)	Halesowen	2/2
Emily Butler (Resigned December 2024)	Halesowen	1/3
Lewis Callary	Rest of England	4/4
Alex Giles (Re-elected December 2024)	Stourbridge	4/4
Sandra Harris	Central Dudley	3/4
Mike Heaton (Term ended December 2024)	Brierley Hill	0/3
Vicky Homer (Re-elected June 2024)	South Staffordshire and Wyre Forest	3/4
Mushtaq Hussain	Central Dudley	4/4
Maria Lodge-Smith	Stourbridge	1/4
Elizabeth Naylor (Re-elected June 2024)	North Dudley	0/4
Craig Nevin (Resigned March 2025)	Tipton & Rowley Regis	3/3
Angelika Pachowicz (Elected December 2024)	Brierley Hill	1/2
Yvonne Peers	North Dudley	3/4
Phil Tonks (Elected December 2024)	Brierley Hill	2/2
Joanne Williams	Halesowen	2/4
Barrie Wright (Resigned December 2024)	Brierley Hill	0/3

Staff Governors

Name	Constituency	
Kerry Cope (Term ended December 2024)	Nursing & Midwifery	1/3
Jill Faulkner	Non-clinical	1/4
Syed Gilani (Term ended June 2024)	AHP, Pharmacy &HCS	1/1
Clare Inglis	AHP, Pharmacy &HCS	4/4
Yunzheng Jiao (Elected June 2024)	AHP, Pharmacy & HCS	4/4
Catherine Lane (Resigned December 2024)	Nursing & Midwifery	0/3
Anand Letha (Elected December 2024)	Nursing & Midwifery	1/2
Atef Michael	Medical and Dental	0/4
Lyndsay Millington (Elected December 2024)	Nursing & Midwifery	2/2
Khadeejat Ogunwolu	Nursing & Midwifery	2/4
Jonathan Woolley	Partner Organisations	1/4
Angelika Pachowicz (Elected December 2024)	Brierley Hill	1/2
Yvonne Peers	North Dudley	3/4
Phil Tonks (Elected December 2024)	Brierley Hill	2/2
Joanne Williams	Halesowen	2/4
Barrie Wright (Resigned December 2024)	Brierley Hill	0/3

Appointed Governors

Name	Constituency	
Natalia Hill	Institute of Health – University of Wolverhampton	4/4
Mohit Mandiratta (Resigned June 2024)	Primary Care Representative	0/1
Alan Taylor	Dudley Metropolitan Borough Council	3/4
Mary Turner	Dudley CVS & Trust volunteers	3/4

The Council of Governors maintains an attendance policy and monitors attendance at full council meetings and committee meetings as agreed under the governors' Code of Conduct. In all instances above where governors have maintained less than the required attendance, the Council of Governors is satisfied that there was reasonable cause for non-attendance.

Full Council of Governors meetings are regularly attended by key clinicians and senior staff from across the Trust, providing presentations and question and answer sessions to help governors understand how the organisation works.

Governor elections and reappointments

During 2024/25, elections were held for vacancies in the following constituencies:

- Public:
  - Halesowen, North Dudley, South Staffordshire and Wyre Forest and Stourbridge – one vacancy in each.
  - Brierley Hill – two vacancies.
- Staff:
  - Allied Health Professionals, Pharmacy and Health Care Scientists – one vacancy.
  - Nursing & Midwifery – two vacancies.

In accordance with the Trust's Constitution, we use the method of single transferable voting for all elections. This system allows voters to rank candidates in order of preference and, after candidates have either been elected or eliminated, unused votes are transferred according to the voter's next stated preference.

During the year, a total of 19 members put themselves forward as nominees for the vacancies arising with percentage of returning votes in contested elections: Allied Health Professionals, Pharmacy and Health Care Scientists – 15.4%, Brierley Hill – 10.6%, Stourbridge – 9.8% and Halesowen – 7.7%. Civica Election Services was appointed to oversee the election process, returning the following governors for a three-year term:

- **Public:** Brierley Hill, Angelika Pachowicz and Phil Tonks
- **Public:** North Dudley, Elizabeth Naylor
- **Public:** South Staffordshire and Wyre Forest, Vicky Homer
- **Public:** Stourbridge, Alex Giles
- **Staff:** Allied Health Professionals, Pharmacy and Health Care Scientists, Yunzheng Jiao
- **Staff:** Nursing & Midwifery, Anand Letha and Lyndsay Millington

The appointed governor position for Primary Care Representative is currently vacant.

Governors reaching end of term of office or resigning during 2024/25

June 2024

Vicky Homer, Public elected: Staffordshire and Wyre Forest (end of term of office)

Elizabeth Naylor, Public elected: North Dudley (end of term of office)

Syed Gilani, Staff elected: Allied Health Professionals, Pharmacy and Health Care Scientists (end of term of office)

December 2024

Emily Butler, Public elected: Halesowen (resigned)

Kerry Cope, Staff: Nursing & Midwifery (end of term of office)

Alex Giles, Public elected: Stourbridge (end of term of office)

Mike Heaton, Public elected: Brierley Hill (end of term of office)

Catherine Lane, Staff: Nursing & Midwifery (resigned)

Barrie Wright, Public elected: Brierley Hill (resigned)

Council of Governors review 2024/25

The Council of Governors remains committed to fulfilling its statutory duties effectively and continues to undertake regular reviews to assess its performance. The next formal review of the Council's effectiveness is scheduled for summer 2025, and the outcomes will be reported at the following full Council of Governors meeting.

The Council of Governors meetings and training events for the coming year will continue to be a mix of face-to-face and hybrid meetings. This will help the Trust ensure good governor participation at meetings throughout the year.

Governor development remains a key priority. The governor training programme follows a modular structure and is delivered across a minimum of six sessions in a year. These modules are specifically designed to support newly appointed and elected governors while also serving as a refresher for existing council members.

These modules were delivered for the newly elected governors from the elections in quarters one and three, and as refreshers for those returned for a further term of office and new governors. One-to-one support is offered to all new governors, and a buddying system is encouraged, enabling experienced governors to share knowledge and support new council members in their roles.

To strengthen collaboration across the region, the Trust continues to work in partnership with Black Country Healthcare NHS Foundation Trust by delivering two joint governor training sessions each year. These sessions provide an opportunity for governors from both trusts to meet, share experiences and explore areas of joint working. At the most recent session, held in January 2025, governors from both trusts led a session on membership engagement. The focus was on sharing best practices and methods for community engagement. The session was positively received. The Trust plans to develop further workshop-based training sessions, building on this success.

Governors have actively participated in a range of trust and governor-led activities throughout the year. These included attendance at patient participation panels and community engagement events, such as the Freshers Fayre at Dudley College. This event was particularly successful in engaging with younger people and encouraging membership sign-ups. Feedback from these activities has been shared through the Council of Governors, its sub-committees and the Board of Directors, helping to shape ongoing engagement efforts.

The Council of Governors has continued to maintain good attendance at the Annual Members Meeting, quarterly council meetings and at a series of development events to supplement their training.

Council members have also maintained attendance at Board of Directors meetings, board committees and working groups.

The Annual Members Meeting was held in person for the first time since the COVID-19 pandemic. The event featured presentations from staff on the Trust's virtual wards initiative, as well as a review of the 2023/24 year from the executive team, external auditors, and the lead governor. The meeting was well attended by local stakeholders, Trust members, and members of the public, who were invited to submit questions relating to the Annual Report and Accounts.

Governor engagement

The Trust remains committed to supporting governors in their roles as representatives of their constituencies and in promoting awareness of the Trust's work among both the public and staff. The 'Out There' initiative continues to support governors to undertake their role in finding out what people think about the Trust and feedback their views to the Board of Directors.

We circulate regular update emails to our foundation trust members and a Trust Newsletter that contains an invitation to attend the Council of Governors and Board of Directors meetings. Members are also encouraged to submit questions in advance, supporting transparent and inclusive engagement.

Throughout the year, governors have continued to participate in a variety of Trust activities that seek to assure and improve standards of quality and patient experience and have joined various sessions hosted by the Trust and other health economy stakeholders, including the People's Network, Healthier Futures and Healthwatch. The Board of Directors have provided opportunities for governors to share their views in the development of the Annual Plan and the proposals to refresh Trust Strategy for 2025-28.

Lead governor

The lead governor role is designed to assist the Council of Governors where it may be considered inappropriate for the chair, or deputy chair, to deal with a particular matter. The lead governor will also provide an independent link between the Council of Governors and the Board of Directors.

Alex Giles, public elected governor for Stourbridge, has been re-elected as lead governor at the last full Council of Governor's meeting held in March 2025.

How to contact a governor or director

There are several ways Trust members or members of the public can contact either their governor or a member of the Board of Directors:

- at Council of Governors meetings (public session).
- at Board of Directors meetings (public session).
- at the Annual Members' Meeting.
- at members events; and
- via the Foundation Trust office on email, freepost, or by phone.

For dates and times of these meetings and other members' events, please visit the members section on the Trust website at **www.dgft.nhs.uk** or contact the Foundation Trust office:

Email **dgft.foundationmembers@nhs.net**

Telephone (01384) 321124

Write Freepost RSEH-CUZB-SJEG, 2nd Floor, South Block, Russells Hall Hospital, Pensnett Road, Dudley, DY1 2HQ

NHS Foundation Trust Code of Governance Disclosures

- The Trust's Council of Governors, see page 128.
- The Trust's Board of Directors, see page 64.
- Nominations and Remuneration Committee, see page 85.
- Audit Committee, see page 81.
- The Foundation Trust's Membership, see page 124.

NHS Oversight Framework

NHS England's NHS Oversight Framework (NoF) provides the framework for overseeing systems including providers and identifying potential support needs.

NHS organisations are allocated to one of four 'segments'.

A segmentation decision indicates the scale and general nature of support needs, from no specific support needs (segment 1) to a requirement for mandated intensive support (segment 4). A segment does not determine specific support requirements. By default, all NHS organisations are allocated to segment 2 unless the criteria for moving into another segment are met. These criteria have two components:

a. objective and measurable eligibility criteria based on performance against the six oversight themes using the relevant oversight metrics (the themes are: quality of care, access and outcomes; people; preventing ill-health and reducing inequalities; leadership and capability; finance and use of resources; local strategic priorities)

b. additional considerations focused on the assessment of system leadership and behaviours, and improvement capability and capacity. An NHS foundation trust will be in segment 3 or 4 only where it has been found to be in breach or suspected breach of its licence conditions.

Segmentation

The Trust has been assigned a segmentation rating of 3 as of 31st March 2025. Segmentation of 3 or 4 would indicate a trust is, or is likely to be, in breach of its licence. For more information on how the Trust reviews its governance, risk management and systems of internal control see the Annual Governance Statement at pages xxx to xxx.

This segmentation information is the Trust's position as at 31st March 2025. Current segmentation information for NHS trusts and foundation trusts is published on the

NHS England website: **NHS England » NHS oversight framework segmentation**

Statement of the chief executive's responsibilities as the accounting officer of The Dudley Group NHS Foundation Trust

The NHS Act 2006 states that the chief executive is the accounting officer of the NHS foundation trust. The relevant responsibilities of the accounting officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the NHS Foundation Trust Accounting Officer Memorandum issued by NHS England.

NHS England has given Accounts Directions which require The Dudley Group NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis required by those Directions. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of

The Dudley Group NHS Foundation Trust and of its income and expenditure, other items of comprehensive income and cash flows for the financial year.

In preparing the accounts and overseeing the use of public funds, the Accounting

Officer is required to comply with the requirements of the Department of Health and Social Care Group Accounting Manual and in particular to:

- observe the Accounts Direction issued by NHS England, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis
- make judgements and estimates on a reasonable basis
- state whether applicable accounting standards as set out in the NHS

Foundation Trust Annual Reporting Manual (and the Department of Health and Social Care Group Accounting Manual) have been followed, and disclose and explain any material departures in the financial statements

- ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance
- confirm that the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the NHS foundation trust's performance, business model and strategy and
- prepare the financial statements on a going concern basis and disclose any material uncertainties over going concern.

The accounting officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the The Dudley Group NHS Foundation Trust and to enable them to ensure that the accounts comply with requirements outlined in the above mentioned Act. The Accounting Officer is also responsible for safeguarding the assets of the NHS foundation trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

As far as I am aware, there is no relevant audit information of which the foundation trust's auditors are unaware, and I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that the entity's auditors are aware of that information.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in the NHS Foundation Trust Accounting Officer Memorandum.

Diane Wake

Chief Executive Officer

… July 2025

Our Long Service Awards celebrate colleagues who have served 10, 25, 30, 40 and 50 years in the NHS with families coming together to celebrate their achievements

Annual Governance Statement

Scope of responsibility

As Accounting Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS foundation trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the NHS foundation trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the ***NHS Foundation Trust Accounting Officer Memorandum***.

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of The Dudley Group NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in The Dudley Group NHS Foundation Trust for the year ended 31 March 2025 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

The Board of Directors has established committees of the board that oversee the corporate level risks to gain assurance of their effective management and mitigations.

The Risk and Assurance Group is a critical oversight forum for risk management providing a platform for supportive challenge on risk mitigation plans whilst ensuring the effective operation of Trust Risk Registers. The group meets monthly and reports to the Quality Committee. Each division of the Trust, through their divisional governance framework, reports to the Risk and Assurance Group on the management of significant Divisional level risks. The group also reviews corporate level risk registers to ensure operational and corporate level leads can share risk information, ensuring corporate risks are fully informed on the scope of operational risks.

The Trust has a comprehensive induction and training programme, supplemented by electronic training packages and additional learning opportunities for staff. Collectively, these cover a wide range of governance and risk management topics for both clinical and non-clinical staff in all disciplines and at all levels in the organisation.

Enhanced or additional training is available from the governance team on aspects of the wider risk management and governance agenda.

The risk and control framework

The Foundation Trust is fully compliant with the registration requirements of the CQC.

The Board of Directors provides leadership on the management of risks, determining the risk appetite for the organisation and ensuring that the approach to risk management is applied consistently. On an annual basis, the board determines the risk appetite the Trust is prepared to accept in the delivery of its strategic objectives.

The Board Assurance Framework (BAF) provides the platform for defining the key risks aligned to each Strategic Objective. The board takes its assurance from its committees in the management of these risks. The BAF incorporates the controls in place to manage the identified risks to their determined target score and the monitoring of any required actions where the risk exceeds the board's appetite for risk in that area. Regular scheduled reports are received at the Board of Directors meetings detailing the risks to the achievement of Trust objectives and their link to the aligned Corporate Risk Register.

To ensure a consistent approach, the Trust's Risk Management Framework was refreshed during the year and provides guidance on the process of risk management inclusive of risk identification, evaluated, transfer, escalation and gaining assurance on control measures in place.

Risk registers provide a tool for risk owners to document and monitor individual risks but also facilitate the collation and review of risks impacting at different levels of the organisation. At each level of management, including

board, reviews are undertaken of the risks for which it is responsible and importantly assurance level is ascertained on the strength of controls in place.

Risk identification is, in the main, operationally and clinically driven with divisions undertaking continuous risk reviews to maintain their risk registers and to implement mitigation plans. Risks are assessed by using a 5x5 scoring risk matrix where the score is an indicator to likelihood of risk materialising and the severity of the impact.

The Trust uses a dedicated electronic Risk Management system. The system provides a platform for the documentation and monitoring for all risks across the organisation. The system also incorporates an archive of risks that have been closed when fully mitigated. The system is accessible to risk owners and facilitates access of key information for reporting risk registers to the various governance forums where risk is a standing agenda item.

The Trust faced the following major risks during the course of the year:

- Delays in patient discharges coupled with increased demand for emergency department services and inpatient admissions may result in patients not accessing appropriate and timely interventions impacting on patient outcomes and experience and breaches in national key performance metrics.
- Failure to creating a culture and environment where staff feel safe to speak up on sexual safety. Limited education, support, training leading to staff not being appropriately supported, cases of sexual safety being under reported and inability to provide psychological safety and safe working environments.
- As detaining Authority, the Trust had no agreement in place to provide Responsible Clinician (consultant psychiatrist) and Mental Health Act Administrator responsibilities to patients who were detained under the Mental Health Act, leading to the possibility of unlawful detention of patients under the Mental Health Act, and potential litigation and reputational damage.
- Financial performance risks.
- Failure of the IT infrastructure/cyber incident causing widespread operational capability issues.

The reporting framework requires risks to be identified, on both board and committee front summary sheets that accompany all reports submitted, providing an ongoing record of emerging issues which allow the link back to the Board Assurance Framework and the Corporate Risk Register.

The foundation trust has published on its website regular updates of the register of interests, including gifts and hospitality, for decision-making staff (as defined by the trust with reference to the guidance) within the past twelve months, as required by the 'Managing Conflicts of Interest in the NHS' guidance.

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments into the Scheme are in accordance with the Scheme rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations.

Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with.

The Trust has undertaken risk assessments on the effects of climate change and severe weather and has developed a Green Plan following the guidance of the Greener NHS programme. The Trust ensures that its obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

The Trust adopts a robust approach to data quality and governance with more information available on page xxx.

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 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.

Board assurance is provided by the Caldicott and Information Governance Group (CIGG); with the Data Protection Officer (DPO), Senior Information Risk Owner (SIRO), Chief Information Officer (CIO) and the Caldicott Guardian being core members of this Group.

The Trust also has well established arrangements to monitor the quality of services delivered and the associated governance arrangements. An integral part of this is a programme of internal supportive Core Services Reviews (formerly Quality and Safety reviews) led by the Compliance Team. The team utilise the CQC key lines of enquiry and more recently quality statements to gain assurance around the quality of service delivery, incorporating a focus on staff wellbeing and workforce culture. The Compliance team work collaboratively with the service under review and wider divisional leads to formulate improvement plans. The review findings and subsequent improvement monitoring is overseen by the Quality and Safety Group which reports to Quality Committee.

Review and monitoring of Nursing Care Indicators and the robust monitoring against local and national targets for quality measures including healthcare associated infections (HCAI), pressure ulcers and falls are also undertaken. The outcomes are reported to the Quality Committee.

The Trust has strengthened its integrated performance reporting and uses Statistical Process Control (SPC) reporting which informs the effectiveness of our business improvement processes. A consistent base set of data is used to report to each of the relevant board committees – people, finance and productivity, and quality committee, as well as operationally to the divisions and the executive. Quality dashboards are also provided for each ward giving visual feedback on quality metric delivery for staff and patients.

Regular reports on the progress against key quality priorities provide assurance that these are actively managed and progressed at an operational level. Internal audit involves external stakeholder partners and provides an independent opinion on the adequacy of the arrangements for ensuring compliance with the Care Quality Commission Regulatory Standards.

The Trust is registered with the Information Commissioner's Office registration number Z8909702. During the year, integration with the Dudley Integrated Health and Care NHS Trust included the operation of Chapel Street Surgery registration number Z2401384.

Non-executive directors chair all committees of the board. The board has established committees each with clear terms of reference which are reviewed annually to ensure they remain appropriate and effective to support the board.

Committee effectiveness reviews were undertaken by each committee during quarter four 2024/2025 and amendments to workplans and terms of reference were made as a result. There are no outstanding actions arising from these reviews.

Each committee chair provides a formal summary of key issues arising from the committee to the Board of Directors meeting. This summary report provides information on the assurance received at the committee which supports the Trust's assurance framework and performance reporting ultimately received by the board.

The Trust informs and engages with its key stakeholders in relation to risk through a number of forums. This includes regular review meetings with the Trust's regulators and commissioners and the sharing of performance reports with the Trust's Council of Governors. Key stakeholders include local and national politicians, Integrated Care Board, our PFI partner Summit Healthcare (Dudley) Ltd, the Council of Governors, the Foundation Trust (FT) members, patient groups, patients, the local community and the Dudley Health and Wellbeing Board on Health and Adult Social Care.

The Trust has also adopted additional forms of assurance outside of its formal decision-making structures. For example, there are regular meetings of non-executive directors and the chief executive, which are minuted and ensure that key operational matters are given additional scrutiny.

Non-executive directors are assigned additional roles and also engage in a variety of programmed activities to allow them to triangulate information received though formal meetings. This includes participating in Trust-wide Team Briefs, joining divisional team meetings, shadowing and volunteering sessions and contributing to a number of improvement forums. The Trust assigns champion roles to its non-executive directors in line with the NHS England Review of Enhancing Board Oversight – a new approach to non-executive director champion roles.

All directors have completed in-year appraisals that have continued to feed into a structured Board Development Programme. This will provide an additional evidence base for the board to identify and focus on the key challenges

over the next 12 months.

During 2024/25, the work of the internal auditors and the board review of the Board Assurance Framework and supporting governance processes had identified some recommendations. Other reviews undertaken within the internal audit plan, identified some gaps in control which resulted in specific action plans being drawn up with their progress reported to, and any follow up audit work monitored by, the Audit Committee.

The head of internal audit opinion includes an assessment of the Trust's Risk Management processes and control framework.

The Audit Committee

Greater detail on the role of the Audit Committee is set out elsewhere in the Annual Report, however the Audit Committee, comprised of non-executive directors, is established to provide assurance to the board that there is an effective system of integrated governance, risk management and internal control across the whole of the Trust's activities (both clinical and non-clinical), that supports the achievement of the Trust's objectives and that this system is established and maintained.

After each of its meetings during the year, the Audit Committee provides a written report to the Trust Board that details the matters discussed, key issues identified and any items requiring referral to Trust board.

Further, as part of discharging its main functions, the Audit Committee prepares an annual report for the Trust board and the chief executive as accounting officer of the Trust and expresses its considered opinion on key aspects of governance based upon the evidence and assurances it has received.

Workforce safeguards

The Trust regularly reviews progress and delivery against its People Plan (Dudley People Plan) which is aligned to the NHS People Plan 2020/2021 and the Trust's strategic objective for the Trust to be 'a brilliant place to work and thrive', including key workforce development, transformation and wellbeing initiatives. The board approved the revised Dudley People Plan 2023-2026 which is an overarching framework to enable us to deliver the Trust's Shaping #OurFuture strategy. The plan outlines our overall direction for our services which support our people and our ambition for Dudley to be a brilliant place to work and thrive.

The Dudley People Plan 2023-2026 sets the overall direction for our people agenda by creating understanding of the context we work within, including national, regional, and local drivers. Ensuring we have an understanding of our Trust, including its demographics, its culture, and the community it serves by providing us with clear objectives to achieve and identifying how we will measure our progress and demonstrate our success.

The Dudley People Plan is underpinned by the development of five journeys as key people priorities:

- Recruitment and retention
- Organisational development
- Health and wellbeing
- Equality, diversity, and inclusion
- Continuous Improvement

The main areas of workforce performance including absence rates, vacancy rates, staff turnover, agency spend, appraisal and mandatory training compliance are reported within the specific Workforce Key Performance Indicator (KPI) Report, which is also reported to the Board of Directors.

The implementation of the plan is overseen by the People Committee, supported by an Equality, Diversity and Inclusion Steering Group and also a Health and Wellbeing Steering Group which is chaired by the Trust's Wellbeing Guardian who is a non-executive director of the Trust.

The Trust collates and reviews data every month for a range of workforce metrics, quality and outcomes indicators and productivity measures. This enables the Trust to undertake safe workforce planning and delivery against its ambitious People Plan priorities, including improvements in staff satisfaction and inclusivity.

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments into the scheme are in accordance with the scheme rules, and that member pension scheme records are accurately updated in accordance with the timescales detailed in the regulations.

Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with.

Further information on staff matters is available in the staff section of the Annual Report.

Failure to remain financially sustainable in 2024/25 and beyond

For 2024/25 the main source of income for the Trust was contracts with commissioners for health care services. Funding envelopes were set at an Integrated Care System (ICS) level. Most of the Trust's income is earned from NHS commissioners in the form of fixed payments to fund an agreed level of activity. In 2024/25 contracts contained both a fixed and variable element. The variable element related to elective recovery funding providing additional funding to Integrated Care Boards to fund the commissioning of elective services within their systems.

Additional resources have been channelled through the Black Country Integrated Care System (ICS) and all constituent organisations have agreed a formal risk share arrangement to manage any additional pressures arising in individual organisations. A combination of non-recurrent measures and a share of non-recurrent income has enabled the Trust to achieve its financial plan after technical adjustments.

The Black Country ICS has received its funding allocation for 2025/26 and significant work has been done to agree allocations to constituent organisations. The Trust has planned to receive non-recurrent funding again in 2025/26 through System allocations and along with a challenging cost improvement programme has approved a breakeven plan. Work continues to refine plans at a System and Trust level to reduce the underling deficit as much as possible. The Trust's sustainability going forward is heavily reliant on two main factors; the ability to reduce costs and equally improve efficiency and the Systems approach to designing a sustainable clinical model.

Work continues with the Black Country ICS and NHS England to ensure all resource issues are addressed. The Trust continues to support medium term planning objectives to secure a recurrently financial balanced position. Oversight continues to be provided by the board and the Finance and Productivity Committee. While a break-even plan has been approved in 2025/26 all efforts need to be put into making the Trust sustainable over the next five years without the need for non-recurrent funding.

Never Events

There were no Never Events reported during 2024/25; this represents a reduction in reporting compared to the previous period (1 reported). The Trust continues to work to the Patient Safety Incident Response Framework (PSIRF) in which Never Events are a national priority for investigation response. All incidents where there is significant harm indicated or there is an opportunity for substantial learning are reviewed at the Trust's Incident Decision and Learning Group (formerly the Weekly Meeting of Harm). This group, chaired by the Medical Director and Chief Nurse, deploys a collaborative approach to initial incident reviews where a multi-disciplinary forum determines the most appropriate response in line with our PSIRF. Importantly our response processes are centred on engagement and support for those impacted by incidents, patients, families and staff. All investigation response reports are reviewed at the Risk and Assurance Group for wider consideration and to share learning.

Green Plan

The Trust's Green Plan was approved by the board in December 2020. Following the formal adoption of the strategic plan in September 2021, the director-level responsibility of this agenda sits with the director of finance. Aligned with NHS England, it ensures that its compliance with the Climate Change Act and the Adaptation Reporting requirements are complied with. To view the full Green Plan or for further information visit **www.dgft.nhs.uk/about-us/environmental-sustainability/**

The Green Plan is under review and will be published in 2025. Additionally, we have established a Climate Change Adaptation Plan and Travel Plan for Russells Hall Hospital.

Delivery of the Green Plan is overseen by the Green Plan Working Group reporting quarterly to the Finance and Productivity Committee. Other groups include the Waste Review Group and the Estates and Energy Sub-Group. Waste pre-acceptance audits take place annually by an external auditor, actions are coordinated by the Waste Preview Group to ensure compliance with waste legislation and regulations.

The Green Plan not only relates to the Climate Change Act 2008 and the Environment Act 2021 but also the Health and Care Act 2022, as the NHS became the first health system to embed net zero carbon targets into legislation.

Care Quality Commission (CQC)

The Trust's overall CQC rating has remained as Requires Improvement. There have been no new CQC inspections throughout the year and our current CQC ratings are found here: **The Dudley Group NHS Foundation Trust - Overview - Care Quality Commission**

In October 2024, the Trust's registration was updated to include the primary care services that transitioned to Trust from the former Dudley Integrated Health and Care NHS Trust. These services are yet to be inspected and rated by the CQC. 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. During this period, the Trust has undertaken a comprehensive self-assessment of each core service based upon the CQC assessment framework. This has enabled the identification strengths, the sharing of best practice and strengthened our understanding of areas for improvement. This process in conjunction with our internal Core Service Reviews are integral to our assurance and improvement work overseen by the Quality Committee

Review of economy, efficiency and effectiveness of the use of resources

In 2024/25 the profile of the use of resources has been high during a financially challenging year. The Trust continues to benchmark its spend with available metrics including the Use of Resources framework and Model Hospital. Throughout 2024/25 the Trust has continued to review Patient Level Information and Costing System (PLICS) data locally to provide assurance that the costing data was robust and to identify specific clinical pathways where the Trust appeared to be an outlier. These were cross referenced to Getting It Right First-Time metrics where available and are being used to identify where resources can be used more effectively. This has been discussed at the Financial Improvement Group that has continued to meet monthly.

The Trust has worked with both the Black Country ICS and the Acute Collaboration to refine its long-term financial model. This has been updated with the 2025/26 income allocations and our cost improvement programme to address the current underlying deficit. Getting the Trust to a sustainable financial position in the medium, term is our high priority.

The form of the operational planning process continued as it was from the previous financial year with funding envelopes being set at an Integrated Care System (ICS) level with block allocations and a concentration on elective recovery. The Board of Directors, supported by the Finance and Productivity Committee, were kept informed of the changes in the planning and financial regime at the beginning of the year and the Committee reviewed the financial plan on several occasions before recommending it to the Trust Board for approval.

The in-year resource utilisation is monitored by the board and its committees via a series of detailed reports covering finance, activity, capacity, human resource management and risk. Clinical and quality risk assessments are conducted on individual savings proposals that may impact on the provision or delivery of clinical services. The 2025/26 financial framework and subsequent funding means the Trust has set a breakeven plan with non-recurrent funding however an underlying financial challenge remains. This is being addressed at a System level through the Acute Collaboration and at a Trust level through the Finance Improvement Group and enhanced 'Grip and Control' measures.

Performance review meetings assess each division's performance across a full range of financial and quality matrices which, in turn, form the basis of the monthly integrated performance report to the Finance and Productivity Committee. The Trust has been assigned a segmentation rating of 3 as of 31st March 2025 with regard to the NHS National Oversight Framework.

The key processes embedded within the Trust to ensure that resources are used economically, efficiently and effectively, centre around a robust budget setting and control system which includes activity related budgets and periodic reviews during the year which are considered by executive directors and the Board of Directors. The budgetary control system is complemented by Standing Financial Instructions, a Scheme of Delegation and Financial Approval Limits. This process enables regular review of financial performance by highlighting areas of

concern via variance analysis. The Finance and Productivity Committee also receives a monthly report showing the Trust's performance against the block contract and the elective recovery fund. The external auditors also give comment upon this aspect of the Trust business.

As Accounting Officer, I have overall accountability for delivery of the Annual Plan and I am supported by the executive directors with delegated accountability and responsibility for delivery of specific targets and performance objectives. These are formally reviewed and monitored monthly by the Board of Directors and its committees. Independent assurance on the use of resources is provided through the Trust's internal audit programme, Audit Committee and external agencies such as NHS England, External Audit and the CQC.

Information governance

The General Data Protection Regulation (GDPR), as implemented by the UK Data Protection Act 2018, came into UK law on 25th May 2018. It introduced a duty on all organisations to report certain types of personal data breach to the relevant supervisory authority. The Security of Network and Information Systems Directive ("NIS Directive") also requires reporting of relevant incidents to the Department of Health and Social Care (DHSC) as the competent authority from 10th May 2018.

An organisation must notify a qualifying breach of personal data within 72 hours. If the breach is likely to result in a high risk to the rights and freedoms of individuals, organisations must also inform those individuals without undue delay. Those breaches that also fulfil the criteria of a NIS notifiable incident will be forwarded to the DHSC where the Secretary of State is the competent authority for the implementation of the NIS directive in the health and social care sector. The Information Commissioner remains the national regulatory authority for the NIS directive.

The Trust has self-reported to the Information Commissioner on five occasions during 2024/25.

Governance and leadership

The executive and non-executive directors have a collective responsibility as a board to ensure that the governance arrangements supporting the Quality Accounts and Report provide adequate and appropriate information and assurances relating to the Trust's quality objectives. Board sponsors are nominated for all Quality Priorities providing visible board leadership of specific quality initiatives.

Whilst the chief executive has overall responsibility for the quality of care provided to patients, the implementation and co-ordination of the quality framework is delegated to both the chief nurse and medical director. They have joint responsibility for reporting to the Board of Directors on the development and progress of the quality and safety priorities and ensuring that the Quality and Safety Delivery Plan is implemented and evaluated effectively.

The Black Country acute providers (The Dudley Group NHS Foundation Trust, Sandwell and West Birmingham Hospitals NHS Trust, The Royal Wolverhampton NHS Trust, and Walsall Healthcare NHS Trust) have formed the Black Country Provider Collaborative (BCPC).

The collaborative works together in formal agreement for the benefit of all. The boards jointly agreed a shared workplan and priorities with the associated delegations within the scope of service improvement and transformation and some joint exercising of agreed Partner Trust responsibilities related to clinical transformation programme, financial recovery plan and supporting integrated system working. The governance and oversight remaining the direct responsibility of each board. The boards receive regular reports to ensure effective monitoring and accountability..

For more information on the Black Country Provider Collaborative please see page XX

Policies

High quality organisational procedural documents are essential tools for effective governance which in turn supports the Trust to achieve its strategic objectives, operational requirements and bring consistency to daily practice. Trust procedural documents are developed using a common agreed format and all documents are subject to a robust review, consultation and ratification process, overseen by the corporate governance team. Trust process facilitate consistent and safe practice and processes, reinforces corporate identity and helps to ensure that policies and procedures in use are up to date. All procedural documents are accessible to all staff supporting the delivery of safe and effective patient care.

Development and reporting of quality indicators and the Quality Account

The systems and processes which support the development of quality indicators and the Quality Account, include engagement activities with a variety of stakeholders and a triangulated review of quality, safety and wider indicators to determine our priorities.

During 2024/25, the Trust continued to progress and monitor the agreed quality priorities, which included management of diabetes across all services, improving outcomes for the patients admitted with a fractured neck of femur and cerebral vascular incident, improvement in patient survey results, focus on dementia and delirium and learning disabilities. There is an established governance process to report on progress against the quality priorities, which includes quarterly reporting to the Quality Committee and bi-annual reporting to the Board of Governors. Overall, good progress has been made against last year's priorities with more details enclosed within the Quality Account. This also outlines the quality priorities for 2025/26.

In terms of quality indicators, monitoring and reporting is ensured via the Integrated Performance Report, which is shared with the Quality Committee and Trust Board. During 2024/25, a Chief Nurse Quality dashboard has been developed to facilitate a triangulated review and oversight of quality pertaining to individual clinical areas.

Electronic Staff Record programme (ESR)

ISE 402 service auditor report covering the period of 1st April 2022 to 31st March 2023, which identified potential control deficiencies impacting (in the 3rd party national ESR solution). The Dudley Group NHS Foundation Trust is happy that mitigating controls are in place and that this does not present a risk to the Trust.

People and skills

In addition to the leadership provided by the Board of Directors, clinical divisional management teams (led by clinical directors and co-ordinated by general managers) are accountable for, and ensure that, a quality service is provided within their respective divisions and areas of authority. They are required to implement the Quality Improvement Strategy, providing safe, effective and personal care and ensure that patients have a positive experience and are treated with courtesy, respect and kindness.

Training opportunities are available for clinical and non-clinical staff and competency is monitored as part of the Trust's appraisal system. The Board of Directors ensures that quality improvement is central to all activities. This is achieved by routine monitoring, participation in national improvement campaigns, celebrating success with our staff awards and proactively seeking patient views on our services.

The Dudley People Plan sets out our approach to people and skills, it recognises the contribution made by every member of staff and the important role they play, each and every day, in delivering safe, effective, high quality patient care, whilst role modelling our values. Our plan recognises that our people are our most important asset, who through dedication and commitment, provide excellent care for our patients.

The Dudley People Plan should be read in conjunction with the organisational strategy Shaping #OurFuture and the five key people journeys as they reflect what matters to our people in its delivery. It is recognised that not all of our people provide direct patient care but that we all have a key role in the patient journey. All of our people should feel supported and valued in their development to ensure they are able to progress as far as possible in their careers. The plan covers a three-year period from 2023-2026 and summarises what our people can expect embedded in our five People Journeys.

To develop our journeys, we have used the employee lifecycle to illustrate and plan for each stage of our peoples' interactions with our Trust; providing us with the insight necessary to develop our journeys by providing a framework for engagement and development allowing us to maximise the value of our workforce, their talent, and their contribution.

Equality, inclusion and diversity

The Equality, Diversity & Inclusion Journey identifies six core workforce priorities with key actions anchored in the employee life cycle, whilst reflecting on national and regional workforce equality and inclusion strategies and priorities, including The Race Equality Code. The EDI Journey is aligned to compliance requirements under the Public Sector Equality Duty (PSED) under the Equality Act 2010, taking into account national compliance drivers.

Culture, Leadership and Learning

Our Culture, Leadership and Learning Journey describes our ambition to support those who choose to work with us. It helps our people to understand what is on offer for them and creates a clear picture of where we are and where we want to be in three years' time.

Wellbeing

Our Trust vision statement is 'Excellent healthcare, improved health for all' and the Wellbeing Journey complements that vision to better support and influence the wellbeing of our workforce. The Wellbeing Journey provides a framework to support delivery of this vision, to include establishing a comprehensive and diverse health and wellbeing journey for all our people which sits at the heart of the Trust's strategic goal of being a brilliant place to work and thrive.

Recruitment and retention

This recruitment and retention journey starts us along the road to changing the way we do things and to being more people centred in our approach and to become more progressive, modern, flexible, and adaptable and tailor our approaches to the diverse needs of our people.

Continuous Improvement

The Dudley Improvement Practice is a Continuous Improvement system supporting the application and delivery of the values, behaviours, culture, and leadership aspirations stated throughout this document. It is accessible to every employee through their everyday work, and it leverages all three enablers: digital, communication and engagement.

The Dudley Improvement Practice (DIP) is the Trust's long-term commitment to creating a culture of Continuous Improvement. Aligned with the national approach to improvement (NHS IMPACT), the DIP method consists of a range of training, tools, facilitated workshops and reporting styles which together support teams with a structured approach to their improvement journeys. This is underpinned by changes in leadership behaviours to promote an improvement culture and by a management system that links improvement activities to the Trust's strategic goals. DIP believes in three essential elements of Continuous Improvement.

1. **Engagement** – the power of collaboration is maximised by engaging the people who do the work every day and therefore have the most insight about how to improve it.
2. **Equality** - harnessing the great diversity in our people by treating everyone as thinking equals drives innovation and creativity.
3. **Empowerment** – developing a coaching style of leadership to make our people feel valued and psychologically safe to propose new ways of working, to contribute and to learn together.

All the improvement training courses are accredited with the Continuous Professional Development Standard Organisation and the Improvement Mindset training is double accredited with the Kata Competency System through Cardiff University.

Dudley Improvement Practice (DIP) training in improvement fundamentals is now an integral part of the two in-house leadership training programmes: Managers' Essentials and Developing Leaders. The training and post-training improvement coaching provides our people with the skills and support needed to complete an improvement project as part of their development portfolio and achieve DGFT Managers Accreditation. To further support the improvement capability of the Trust, all line managers are encouraged to include DIP training and an improvement project as an objective in appraisals held April to June.

Data quality and governance

Data Quality (DQ) Assurance over the various elements of quality, finance and performance is of key importance to management and the board. Reviews of the Trust's system of internal control in respect of data quality are undertaken in each year through the internal audit work plan.

The Dudley Group NHS Foundation Trust continues to develop digital and data services heightening the reliance upon good data quality. Data quality is pivotal to the Trust's innovation plans. High levels of data quality are required for modern analytic techniques and artificial intelligence (AI). When new digital services are introduced,

high data quality must be assured from the outset. We do this by providing real-time data support tools to allow operational teams to see the impact of their interventions and interrogate the quality data entry. This is underpinned by open and transparent engagement with data generators to aid progression of quality standards. The Trust operates a 'data quality kite-mark policy' that provides a 360 view of assurance on the data being used to aid decision making.

The Data Quality and Standards Group provides assurance oversight, knowledge sharing and escalate decision points by direct engagement with information asset owners, operational teams and executive directors.

The Trust has maintained a Data Quality Maturity Index (DQMI) score above 94.3 throughout the year. This is significantly higher than the national average score of 75.1.

The Trust's IT Department (Terafirma) maintains ISO27001 accreditation, holds Cyber Essentials (CE) certification and has achieved 100 per cent compliance with regards to the NHSD Data Security Protection (DSP) Toolkit and Data Guardian Standards. Our approach to delivering data security is defined in the Trust board approved Cyber Security Strategy which identifies the key data security and protection risks including but not limited to; supply chain compromise (SCC), business email compromise (BEC) and the Internet of Things (IoT).

The Trust has implemented sophisticated technology solutions and controls including data leak protection (DLP), Microsoft Endpoint Defender (MDE), proactive threat monitoring and automated security validation, geo-referencing and secure domain firewalling to address key data security risks and continues to invest in new technologies and solutions to provide further assurance. In the constantly evolving technology and cyber workspace, the Trust maintains its commitment to provide robust assurances and delivery plans to further enhance our controls and ensuring alignment with the Network and Security Systems (NIS) Directive and the NHS England Cyber Security Programme.

As the Trust continues to increase the deployment of digital workflows to support clinical and operational activities, the technology solutions which have been implemented continue to provide significant assurance; however, workforce remains a risk in terms of an access point for a major cyber-attack. This is due to several factors including human response which may, for example, increase susceptibility to attempted phishing attacks. There is emphasis to ensure that the Trusts system of internal control to mitigate any control weaknesses is closely monitored. Staff cyber awareness remains a key focus.

The Dudley Group NHS Foundation Trust's head of IT operations currently chairs the Black Country Integrated Care System cybersecurity sub-group. In this role, the Trust has developed and influenced a collaborative knowledge sharing network between local experts to meet the challenges of modern healthcare IT delivery and the amplified cyberthreat landscape.

Review of effectiveness

As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the NHS Foundation Trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on performance information available to me. My review is also informed by comments made by the external auditors in their ISA 260 report and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the board, the Audit Committee, Risk and Governance Group and Quality Committee, and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The Board Assurance Framework and the Trust's risk management arrangements provide me with evidence that the controls to manage the risks to the Trust achieving its principal objectives have been reviewed and are effective. My review is also informed by the work of external and independent assessors and advisors including the Care Quality Commission.

During 2024/2025, the work of the internal auditors and the board review of the Board Assurance Framework and supporting governance processes had identified some recommendations. Other reviews undertaken within the internal audit plan, identified some gaps in control which resulted in specific action plans being drawn up with their progress reported to, and any follow up audit work monitored by, the Audit Committee. Specifically, whilst not significant issues in themselves, Internal Audit

identified some internal control weaknesses and judged them relevant for consideration as part of the annual governance statement in regard to audits in the areas of:

- Patient monies and properties
- Bank and Agency (medics)

None of the gaps had impacted on the final delivery of the Trust's stated objectives.

The Trust complies with the NHS Foundation Trust Code of Governance with the aim to deliver effective corporate governance, contribute to better organisational performance and ultimately discharge our duties in the best interests of patients.

Counter fraud provisions are in place in line with the NHS Counter Fraud Authority (NHSCFA) Standards. The Trust complies with its responsibilities to fully implement a Code of Conduct that includes reference to fraud, bribery and corruption and the requirements of the Bribery Act 2010. The effectiveness of the implementation of the process and staff awareness of the requirements of the code is regularly tested. RSM are also the providers of our local counter fraud service.

The Head of Internal Audit opinion stated that the Trust has an 'adequate and effective framework for risk management, governance and internal control. However, our work has identified further enhancements to the framework of risk management, governance and internal control to ensure that it remains adequate and effective.'

However, none of the identified weaknesses were deemed to be significant in terms of the overall systems of internal control of the Trust.

Operational Performance Elective and Recovery Update

The 2024/25 year presented challenges particularly around industrial action involving the medical workforce. With respect to elective care shortages of Anaesthetic cover was particularly difficult to maintain leading to large scale cancellations of routine elective activity. Despite this the Trust continued to perform well achieving the NHS set recovery targets throughout the year.

The operational management team has worked closely with clinicians to balance the prioritisation of patients between long waits and clinical urgency. This balancing has meant that at Dudley we have been able to not only continue with treating our own local patients but also to provide a degree of mutual aid both in and out of the Black Country, reducing variation in waits for treatment times for patients in a much wider area. This has required flexibility and commitment of our workforce and this should be commended across the teams.

We have striven to ensure that our cancer patients are seen and treated in accordance with both national standards and individual need. The Trust achieved all of the national cancer standards, 62 day backlog reduction, the 70% 62 day standard and the 28 day faster diagnostic standard.

From an Urgent and Emergency Care perspective the Trust has faced challenges with maintaining timely offload of ambulances at the front door, exacerbated by difficulty in obtaining support for patients who require support in the community or an alternative care setting when they no longer require care in the acute trust. There has been executive level work undertaken between the Trust and the local authority and this is ongoing at present. The Trust continues to perform well against the four-hour target and achieved the 70% expectation of NHS England.

In order to support the goal of the Trust of 'Community First, Hospital when necessary' a significant amount of work and investment has been placed in launching the Acute Medical Virtual Ward. This has increased the number of adult virtual wards to five, incorporating Respiratory, Frailty, Heart Failure, Complex Nutrition and Acute Medicine. There also remains one Paediatric virtual ward. A focus on stepping up rather than only stepping down to the virtual ward has been put in place and work remains ongoing to form partnerships with the virtual ward space in other local organisations to enable Dudley to step down to the Sandwell virtual ward and vice versa for patients who live within that location but have been admitted to another Trust.

The Finance and Productivity Committee and the Board of Directors have continued to oversee operational performance and resilience in line with key national standards and elective restoration and recovery targets.

Conclusion

My review of the effectiveness of the risk management and internal control has confirmed that:

- The Trust has a generally sound system of internal control designed to meet the organisation's objectives and that controls are generally being applied consistently.
- Based on the work undertaken by a range of assurance providers, there were no significant control issues identified during 2024/25.
- I confirm that the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the NHS Foundation Trust's performance, business model and strategy.
- We prepare the financial statements on a 'going concern' basis.
- Where improvements had been recommended, we have acted on them and tracked their implementation at both management and board/committee level.

I, therefore, believe that the Annual Governance Statement is a balanced reflection of the actual control position in place within the year.

Diane Wake

Chief Executive Officer

… June 2025

Our AMU Rainbow Unit has been one of the Dudley Group's flagship developments in recent years

Statement of directors' responsibilities in respect of the accounts

The directors are required under the National Health Service Act 2006 to prepare accounts for each financial year. The Secretary of State, with the approval of the Treasury, directs that these accounts give a true and fair view of the state of affairs of the Trust and of the income and expenditure, recognised gains and losses and cash flows for the year. In preparing those accounts, directors are required to:

- apply on a consistent basis accounting policies laid down by the Secretary of State with the approval of the Treasury,
- make judgements and estimates which are reasonable and prudent, and
- state whether applicable accounting standards have been followed, subject to any material departures disclosed and explained in the accounts.

The directors are responsible for keeping proper accounting records which disclose the position of the Trust and to enable them to ensure that the accounts comply with requirements outlined in the above mentioned direction of the Secretary of State. They are also responsible for safeguarding the assets of the Trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities. The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the accounts.

By order of the board

Diane Wake

Chief Executive Officer

… June 2025

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Interim Director of Finance

… June 2025

Our annual Committed to Excellence Awards allow us to showcase the brilliant work that takes place across the Trust

Independent auditor's report to the Council of Governors of The Dudley Group NHS Foundation Trust

Report on the audit of the financial statements

Opinion on financial statements

We have audited the financial statements of The Dudley Group NHS Foundation Trust (the 'Trust') and its subsidiaries (the 'group') for the year ended 31 March 2025, which comprise the consolidated and foundation trust statements of comprehensive income, the consolidated and foundation trust statements of financial position, the consolidated and foundation trust statements of changes in taxpayers' and others' equity, the consolidated and foundation trust statements of cash flows and notes to the financial statements, including material accounting policy information. The financial reporting framework that has been applied in their preparation is applicable law and international accounting standards in conformity with the requirements of the Accounts Directions issued under Schedule 7 of the National Health Service Act 2006, as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2024-25.

In our opinion, the financial statements:

- give a true and fair view of the financial position of the group and of the Trust as at 31 March 2025 and of the group's expenditure and income and the Trust's expenditure and income for the year then ended; and
- have been properly prepared in accordance with international accounting standards as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2024-25; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law, as required by the Code of Audit Practice (2024) ("the Code of Audit Practice") approved by the Comptroller and Auditor General. Our responsibilities under those standards are further described in the 'Auditor's responsibilities for the audit of the financial statements' section of our report. We are independent of the group and the Trust in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the FRC's Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Conclusions relating to going concern

We are responsible for concluding on the appropriateness of the Accounting Officer's use of the going concern basis of accounting and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast significant doubt on the group's and the Trust's ability to continue as a going concern. If we conclude that a material uncertainty exists, we are required to draw attention in our report to the related disclosures in the financial statements or, if such disclosures are inadequate, to modify the auditor's opinion. Our conclusions are based on the audit evidence obtained up to the date of our report. However, future events or conditions may cause the group or the Trust to cease to continue as a going concern.

In our evaluation of the Accounting Officer's conclusions, and in accordance with the expectation set out within the Department of Health and Social Care Group Accounting Manual 2024-25 that the group's and the Trust's financial statements shall be prepared on a going concern basis, we considered the inherent risks associated with the continuation of services provided by the group and the Trust. In doing so we had regard to the guidance provided in Practice Note 10 Audit of financial statements and regularity of public sector bodies in the United Kingdom (Revised 2024) on the application of ISA (UK) 570 Going Concern to public sector entities. We assessed the reasonableness of the basis of preparation used by the group and the Trust and the group's and the Trust's disclosures over the going concern period.

In auditing the financial statements, we have concluded that the Accounting Officer's use of the going concern basis of accounting in the preparation of the financial statements is appropriate.

Based on the work we have performed, we have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on the group's and the Trust's ability to continue as a going concern for a period of at least twelve months from when the financial statements are authorised for issue.

Our responsibilities and the responsibilities of the Accounting Officer with respect to going concern are described in the relevant sections of this report.

Other information

The other information comprises the information included in the annual report and accounts, other than the financial statements and our auditor's report thereon. The Accounting Officer is responsible for the other information contained within the annual report and accounts. Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in our report, we do not express any form of assurance conclusion thereon.

Our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the audit or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements themselves. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact.

We have nothing to report in this regard.

Other information we are required to report on by exception under the Code of Audit Practice

Under the Code of Audit Practice published by the National Audit Office in November 2024 on behalf of the Comptroller and Auditor General (the Code of Audit Practice) we are required to consider whether the Annual Governance Statement does not comply with the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual 2024/25 or is misleading or inconsistent with the information of which we are aware from our audit. We are not required to consider whether the Annual Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls.

We have nothing to report in this regard.

Opinion on other matters required by the Code of Audit Practice

In our opinion:

- the parts of the Remuneration Report and the Staff Report to be audited have been properly prepared in accordance with the requirements of the NHS Foundation Trust Annual Reporting Manual 2024/25; and
- based on the work undertaken in the course of the audit of the financial statements, the other information published together with the financial statements in the annual report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we are required to report by exception

Under the Code of Audit Practice, we are required to report to you if:

- we issue a report in the public interest under Schedule 10 (3) of the National Health Service Act 2006 in the course of, or at the conclusion of the audit; or
- we refer a matter to the regulator under Schedule 10 (6) of the National Health Service Act 2006 because we have reason to believe that the Trust, or an officer of the Trust, is about to make, or has made, a decision which involves or would involve the incurring of unlawful expenditure, or is about to take, or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency.

We have nothing to report in respect of the above matters.

Responsibilities of the Accounting Officer

As explained more fully in the Statement of the Chief Executive's responsibilities as the accounting officer, the Chief Executive, as Accounting Officer, is responsible for the preparation of the financial statements in the form and on the basis set out in the Accounts Directions included in the NHS Foundation Trust Annual Reporting Manual 2024/25, for being satisfied that they give a true and fair view, and for such internal control as the Accounting Officer determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the Accounting Officer is responsible for assessing the group's and the Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless the Accounting Officer has been informed by the relevant national body of the intention to dissolve the Trust and the group without the transfer of their services to another public sector entity.

Auditor's responsibilities for the audit of the financial statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists.

Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

Irregularities, including fraud, are instances of non-compliance with laws and regulations. The extent to which our procedures are capable of detecting irregularities, including fraud is detailed below:

- We obtained an understanding of the legal and regulatory frameworks that are applicable to the group and the Trust and determined that the most significant which are directly relevant to specific assertions in the financial statements are those related to the reporting frameworks (international accounting standards and the National Health Service Act 2006, as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2024-25).
- We enquired of management and the audit committee, concerning the group's and the Trust's policies and procedures relating to:
  - the identification, evaluation and compliance with laws and regulations;
  - the detection and response to the risks of fraud; and
  - the establishment of internal controls to mitigate risks related to fraud or non-compliance with laws and regulations.
- We enquired of management, internal audit and the audit committee, whether they were aware of any instances of non-compliance with laws and regulations or whether they had any knowledge of actual, suspected or alleged fraud.
- We assessed the susceptibility of the group's and the Trust's financial statements to material misstatement, including how fraud might occur, evaluating management's incentives and opportunities for manipulation of the financial statements. This included the evaluation of the risk of management override of controls and the presumed risk of fraud in non-block contract revenue recognition (specific to occurrence) and a related risk regarding existence of receivables. We determined that the principal risks were in relation to:
  - Journal entries that altered the Trust's financial performance for the year.
- Our audit procedures involved:
  - evaluation of the design effectiveness of controls that management has in place to prevent and detect fraud;
  - journal entry testing, with a focus on significant journals at the end of the financial year which impacted on the Trust's financial performance;

- challenging assumptions and judgements made by management in its significant accounting estimates in respect of land and building valuations; and
- assessing the extent of compliance with the relevant laws and regulations as part of our procedures on the related financial statement item.

- These audit procedures were designed to provide reasonable assurance that the financial statements were free from fraud or error. The risk of not detecting a material misstatement due to fraud is higher than the risk of not detecting one resulting from error and detecting irregularities that result from fraud is inherently more difficult than detecting those that result from error, as fraud may involve collusion, deliberate concealment, forgery or intentional misrepresentations. Also, the further removed non-compliance with laws and regulations is from events and transactions reflected in the financial statements, the less likely we would become aware of it.
- We communicated relevant laws and regulations and potential fraud risks to all engagement team members. We remained alert to any indications of non-compliance with laws and regulations, including fraud, throughout the audit.
- The engagement partner's assessment of the appropriateness of the collective competence and capabilities of the group and Trust audit team members included consideration of their:
  - understanding of, and practical experience with audit engagements of a similar nature and complexity through appropriate training and participation
  - knowledge of the health sector and economy in which the group and the Trust operates
  - understanding of the legal and regulatory requirements specific to the group and the Trust including:
  - the provisions of the applicable legislation
  - NHS England's rules and related guidance
  - the applicable statutory provisions.
- In assessing the potential risks of material misstatement, we obtained an understanding of:
  - The group's and the Trust's operations, including the nature of its income and expenditure and its services and of its objectives and strategies to understand the classes of transactions, account balances, financial statement consolidation process, expected financial statement disclosures and business risks that may result in risks of material misstatement.
  - The group's and the Trust's control environment, including the policies and procedures implemented by the group and the Trust to ensure compliance with the requirements of the financial reporting framework.

A further description of our responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website at: www.frc.org.uk/auditorsresponsibilities. This description forms part of our auditor's report.

Report on other legal and regulatory requirements – the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

Matter on which we are required to report by exception – the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

Under the Code of Audit Practice, we are required to report to you if, in our opinion, we have not been able to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2025.

We have nothing to report in respect of the above matter.

Responsibilities of the Accounting Officer

The Chief Executive, as Accounting Officer, is responsible for putting in place proper arrangements for securing economy, efficiency and effectiveness in the use of the Trust's resources.

Auditor's responsibilities for the review of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

We are required under paragraph 1 of Schedule 10 of the National Health Service Act 2006 to be satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance issued by the Comptroller and Auditor General in November 2024. This guidance sets out the arrangements that fall within the scope of 'proper arrangements'. When reporting on these arrangements, the Code of Audit Practice requires auditors to structure their commentary on arrangements under three specified reporting criteria:

- **Financial sustainability:** how the Trust plans and manages its resources to ensure it can continue to deliver its services;
- **Governance:** how the Trust ensures that it makes informed decisions and properly manages its risks; and
- **Improving economy, efficiency and effectiveness:** how the Trust uses information about its costs and performance to improve the way it manages and delivers its services.

We have documented our understanding of the arrangements the Trust has in place for each of these three specified reporting criteria, gathering sufficient evidence to support our risk assessment and commentary in our Auditor's Annual Report. In undertaking our work, we have considered whether there is evidence to suggest that there are significant weaknesses in arrangements.

Report on other legal and regulatory requirements – Delay in certification of completion of the audit

We cannot formally conclude the audit and issue an audit certificate for The Dudley Group NHS Foundation Trust for the year ended 31 March 2025 in accordance with the requirements of Chapter 10 of the National Health Service Act 2006 and the Code of Audit Practice until we have completed the work necessary in relation to the Trust's consolidation schedules, and we have received confirmation from the National Audit Office that the audit of the NHS group consolidation is complete for the year ended 31 March 2025. We are satisfied that this work does not have a material effect on the financial statements for the year ended 31 March 2025.

Use of our report

This report is made solely to the Council of Governors of the Trust, as a body, in accordance with Schedule 10 of the National Health Service Act 2006. Our audit work has been undertaken so that we might state to the Trust's Council of Governors those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Trust and the Trust's Council of Governors as a body, for our audit work, for this report, or for the opinions we have formed.

M C Stocks

Mark Stocks, Key Audit Partner for and on behalf of Grant Thornton UK LLP, Local Auditor

Birmingham, 23 June 2025

Our incredible nursing staff are celebrated annually on Nurses Day but we are thankful for their work all year round

Foreword to the Accounts

These accounts for the period 1st April 2022 to 31st March 2023 have been prepared by The Dudley Group NHS Foundation Trust in accordance with paragraphs 24 and 25 of Schedule 7 to the NHS Act 2006 and are presented to Parliament pursuant to Schedule 7, paragraph 25 (4) (a) of the National Health Service Act 2006.

Diane Wake

Chief Executive Officer

… July 2025

Consolidated and Foundation Trust Statements of Comprehensive Income

For the Year Ended 31 March 2025

	Note	Group		Foundation Trust	
		Year Ended 31 March 2025	Year Ended 31 March 2024	Year Ended 31 March 2025	Year Ended 31 March 2024
		£'000	£'000	£'000	£'000
Operating Income from patient care activities	3	**588,787**	**550,056**	**588,787**	**550,056**
Other Operating Income	4	33,685	29,321	33,599	29,267
Total Operating Income from continuing operations		**622,472**	**579,377**	**622,386**	**579,323**
Operating Expenses from continuing operations	5	(606,065)	(570,161)	(606,101)	(570,146)
Operating Surplus / (Deficit)		**16,407**	**9,216**	**16,285**	**9,177**
Finance Costs					
Finance income	9	1,473	2,125	1,345	2014
Finance expense - financial liabilities	10	(36,353)	(41,765)	(36,353)	(41,765)
Net Finance Costs		**(34,880)**	**(39,640)**	**(35,008)**	**(39,751)**
Gain/(loss) of disposal of assets	13	31	69	31	69
Gains/(losses) from transfers by absorption		2,503	0	2,503	0
Corporation tax expense	11	(91)	(65)	0	0
Surplus/(Deficit) for the year from continuing operations		**(16,030)**	**(30,420)**	**(16,189)**	**(30,505)**
SURPLUS/(DEFICIT) FOR THE YEAR		**(16,030)**	**(30,420)**	**(16,189)**	**(30,505)**
Other comprehensive income/(expense) Will not be reclassified to income and expenditure:					
Impairments	13	0	(55,627)	0	(55,627)
Revaluations	13	357	263	357	263
Fair value gains/(losses) on equity instruments designated at FV through OCI	14	(20)	(2)	0	0
Other reserve movements		0	3	0	3
TOTAL COMPREHENSIVE INCOME / (EXPENSE) FOR THE YEAR		**(15,693)**	**(85,783)**	**(15,832)**	**(85,866)**

The notes on pages 6 to 53 form part of these accounts.

All income and expenditure are derived from continuing operations.

There are no Non-Controlling Interests in the Group, therefore the deficit for the year of £16,030,000 (2023/24 deficit of £30,420,000) and the Total Comprehensive Expense of £15,693,000 (2023/24 Total Comprehensive Income of £85,783,000) is wholly attributable to the Trust.

Consolidated and Foundation Trust Statements of Financial Position

As at 31 March 2025

	Note	Group		Foundation Trust	
		31 March 2025 £'000	31 March 2024 (Restated) £'000	31 March 2025 £'000	31 March 2024 (Restated) £'000
Non-current assets					
Intangible assets	12	9,847	9,126	9,847	9,126
Property, plant and equipment	13	195,804	186,771	195,804	186,771
Right of Use Assets	8	17,535	18,179	17,535	18,179
Other Investments/financial assets	14	1,382	202	0	0
Receivables	16	19,167	18,649	19,167	18,649
Total non-current assets		243,735	232,927	242,353	232,725
Current assets					
Inventories	15	4,668	5,228	4,458	5,058
Receivables	16	12,844	12,362	12,613	12,139
Cash and cash equivalents	17	33,311	22,119	30,611	18,404
Total current assets		50,823	39,709	47,682	35,601
Current liabilities					
Trade and other payables	18	(39,512)	(35,741)	(39,299)	-35,602
Borrowings	19	(13,155)	(13,168)	(13,155)	-13,168
Provisions	20	(225)	(176)	(225)	-176
Other liabilities	21	(2,139)	(3,366)	(2,139)	-3,366
Total current liabilities		(55,031)	(52,451)	(54,818)	(52,312)
Total assets less current liabilities		**239,527**	**220,185**	**235,217**	**216,014**
Non-current liabilities					
Borrowings	19	(290,108)	(277,464)	(290,108)	(277,464)
Provisions	20	(567)	(554)	(567)	(554)
Total non-current liabilities		(290,675)	(278,018)	(290,675)	(278,018)
Total assets employed		**(51,148)**	**(57,833)**	**(55,458)**	**(62,004)**
Financed by Taxpayers' equity					
Public Dividend Capital		96,672	71,801	96,672	71,801
Revaluation reserve		7,521	7,154	7,521	7,154
Income and expenditure reserve		(157,767)	(139,348)	(159,651)	(140,959)
Others' equity					
Charitable Fund reserves		2,426	2,560		0
Total Taxpayers' and Others' equity		**(51,148)**	**(57,833)**	**(55,458)**	**(62,004)**

The notes on pages 6 to 53 form part of these accounts.

The financial statements on pages 3 to 53 were approved by the Board of Directors and authorised for issue on their behalf by:

Diane Wake

Chief Executive Officer

… July 2025

Consolidated and Foundation Trust Statements of Changes in Taxpayers' and Others' Equity

for the Year Ended 31 March 2025

	Group Taxpayers' Equity					Foundation Trust Taxpayers' Equity			
	Public Dividend Capital £'000	Restated Revaluation Reserve* £'000	Income and Expenditure Reserve £'000	Charitable Fund Reserves £'000	Total Taxpayers' and Others' Equity £'000	Public Dividend Capital £'000	Restated Revaluation Reserve * £'000	Income and Expenditure Reserve £'000	Total Taxpayers' Equity £'000
Taxpayers' and Others' Equity at 1 April 2024	**71,801**	**7,154**	**(139,348)**	**2,560**	**(57,833)**	**71,801**	**7,154**	**(140,959)**	**(62,004)**
Surplus / (Deficit) for the year	0	0	(15,973)	(57)	(16,030)	0	0	(16,189)	**(16,189)**
Transfers by absorption: transfers between reserves	2,493	10	(2,503)	0	0	2,493	10	(2,503)	0
Net Impairments		0			0	0	0	0	0
Revaluations - property, plant and equipment	0	357	0	0	357	0	357	0	357
Fair value gains/(losses) on equity instruments designated at FV through OCI	0	0	0	(20)	**(20)**	**0**	**0**	**0**	**0**
Public Dividend Capital Received	26,253	0	0	0	26,253	26,253	0	0	26,253
Public Dividend Capital Repaid	(3,875)	0	0	0	(3,875)	(3,875)	0	0	(3,875)
Consolidation adjustment	0	0	57	(57)	0	0	0	0	0
Taxpayers' and Others' Equity at 31 March 2025	**96,672**	**7,521**	**(157,767)**	**2,426**	**(51,148)**	**96,672**	**7,521**	**(159,651)**	**(55,458)**
Taxpayers' and Others' Equity at 1 April 2023	**65,045**	**62,516**	**26,175**	**2,671**	**156,407**	**65,045**	**62,516**	**24,758**	**152,319**
Prior period adjustment	0	0	8,987	0	8,987		0	8,987	8,987
Application of IFRS16 measurement principles to PFI liability on 1 April 2023	0	0	(144,200)	0	(144,200)	0	0	(144,200)	(144,200)
Surplus / (Deficit) for the year	0	0	(30,365)	(55)	(30,420)	0	0	(30,505)	(30,505)
Transfers between reserves	0	0	0	0	0	0	0	0	0
Net Impairments	0	(55,627)	0	0	(55,627)	0	(55,627)	0	(55,627)
Revaluations - property, plant and equipment	0	263	0	0	263	0	263	0	263
Fair value gains/(losses) on equity instruments designated at FV through OCI	0	0	0	(2)	(2)	0	0	0	0
Public Dividend Capital Received	6,756	0	0	0	6,756	6,756	0	0	6,756
Other reserve movements	0	2	1	0	3	0	2	1	3
Consolidation adjustment	0	0	54	(54)	0	0	0	0	0
Taxpayers' and Others' Equity at 31 March 2024	**71,801**	**7,154**	**(139,348)**	**2,560**	**(57,833)**	**71,801**	**7,154**	**(140,959)**	**(62,004)**

The notes on pages 6 to 53 form part of these accounts.

Consolidated and Foundation Trust Statements of Changes in Taxpayers' and Others' Equity

Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. Additional PDC may also be issued to trusts by the Department of Health and Social Care. A charge, reflecting the cost of capital utilised by the trust, is payable to the Department of Health as the public dividend capital dividend.

Revaluation reserve

Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse impairments previously recognised in operating expenses, in which case they are recognised in operating income. Subsequent downward movements in asset valuations are charged to the revaluation reserve to the extent that a previous gain was recognised unless the downward movement represents a clear consumption of economic benefit or a reduction in service potential.

Income and expenditure reserve

The balance of this reserve is the accumulated surpluses and deficits of the trust.

Charitable funds reserve

This reserve comprises the ring-fenced funds held by the Dudley Group NHS Foundation Trust Charity consolidated within these financial statements.

These reserves comprise Unrestricted Funds £2,139,000 (2023/24 £2,355,000) of which £1,506,000 (2023/24 £2,083,000) have been designated for specific purposes, Restricted Funds £287,000 (2023/24 £205,000) and Endowment Funds £nil (2023/24 £nil). Unrestricted Funds comprise those funds that the Trustee is free to use for any purpose in furtherance of the Charity objectives, Restricted Funds are specific appeals for funds or donations where legal restrictions have been imposed by the Donor, and Endowment Funds are held as capital by the Charity to generate income for charitable purposes but cannot themselves be spent.

Consolidated and Foundation Trust Statements of Cash Flows

For the Year Ended 31 March 2025

	Group		Foundation Trust	
	31 March 2025 £'000	31 March 2024 £'000	(Restated) 31 March 2025 £'000	31 March 2024 £'000
Cash flows from operating activities				
Operating surplus/(deficit) from continuing operations	16,407	9,216	16,285	9,177
Operating surplus/(deficit)	**16,407**	**9,216**	**16,285**	**9,177**
Non-cash income and expense:				
Depreciation and amortisation	18,181	16,225	18,181	16,225
Impairments and Reversals	2,193	15,032	2,193	15,032
Income recognised in respect of capital donations (cash and non-cash)	(128)	(146)	(128)	(146)
(Increase)/Decrease in trade and other receivables	(173)	6,412	(240)	6,437
(Increase)/Decrease in inventories	560	(245)	600	(279)
Increase/(Decrease) in trade and other payables	609	(8,103)	540	(8,362)
Increase/(Decrease) in other liabilities	(1,434)	(123)	(1,434)	(123)
Increase/(Decrease) in provisions	62	(32)	62	(32)
Movements in charitable fund working capital	(1,235)	1,200	0	0
Corporation Tax (paid) / received	(91)	(65)	0	0
NET CASH GENERATED FROM/ (USED IN) OPERATIONS	34,951	39,371	36,059	37,929
Cash flows from investing activities				
Interest received	1,395	1,982	1,395	1,982
Purchase of intangible assets	(2,758)	(2,298)	(2,758)	(2,298)
Purchase of Property, Plant and Equipment	(21,480)	(12,173)	(21,480)	(12,173)
Proceeds from sales of Property, Plant and Equipment	42	163	42	162
NHS Charitable funds - cash flows from investing activities	93	110	0	0
Net cash generated from/ (used in) investing activities	(22,708)	(12,216)	(22,801)	(12,327)
Cash flows from financing activities				
Public dividend capital received	26,253	6,756	26,253	6,756
Public dividend repaid	(3,875)	0	(3,875)	0
Capital element of PFI Obligations	(10,914)	(10,866)	(10,914)	(10,866)
Capital element of lease liability repayments	(2,453)	(2,268)	(2,453)	(2,268)
Interest element of PFI Obligations	(11,696)	(11,160)	(11,696)	(11,160)
Interest element of lease liability repayments	(185)	(173)	(185)	(173)
PDC Dividend paid	0	(1,103)	0	(1,103)
Net cash generated from/ (used in) financing activities	**(2,870)**	**(18,814)**	**(2,870)**	**(18,814)**
Increase/(decrease) in cash and cash equivalents	**9,373**	**8,341**	**10,388**	**6,788**
Cash and Cash equivalents at 1 April	**22,119**	**13,778**	**18,404**	**11,616**
Cash and cash equivalents transferred by absorption	1,819	0	1,819	0
Cash and Cash equivalents at 31 March	**33,311**	**22,119**	**30,611**	**18,404**

The notes on pages 6 to 53 form part of these accounts.

1. Accounting Policies and Other Information

NHS England has directed that the financial statements of NHS foundation Trusts shall meet the accounting requirements of the Department of Health and Social Care (DHSC) Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2024/25, issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the NHS Foundation Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts.

Going Concern

The Foundation Trust's annual report and accounts have been prepared on a going concern basis.

International Accounting Standard 1 requires the Board to assess, as part of the account's preparation process, the Group and Trust's ability to continue as a going concern. Non-trading entities in the public sector are assumed to be going concerns where the continued provision of service in the future is anticipated, as evidenced by inclusion of financial provision for that service in published documents.

The financial statements should be prepared on a going concern basis unless there are plans for, or no realistic alternative other than, the dissolution of the Group and Trust without the transfer of its services to another entity within the public sector. In preparing the financial statements, the Board of Directors has considered the Group's and Trust's overall financial position against the requirements of IAS1. After making enquiries, the directors have a reasonable expectation that the services provided by the NHS foundation Trust will continue to be provided by the public sector for the foreseeable future. For this reason, the directors have adopted the going concern basis in preparing the accounts, following the definition of going concern in the public sector adopted by HM Treasury's Financial Reporting Manual.

Accounting Convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

1.1 Consolidation

The Group financial statements consolidate the financial statements of the Trust, and all of its subsidiary undertakings made up to 31st March 2025. The income, expenses, assets, liabilities, equity and reserves of the subsidiaries have been consolidated into the Trust's financial statements and group financial statements have been prepared.

Subsidiaries

Subsidiary entities are those which the Foundation Trust is exposed to, or has rights to, variable returns from its involvement with the entity and has the ability to affect those returns through its power over the entity. The income, expenses, assets, liabilities, equity and reserves of subsidiaries are consolidated in full into the appropriate financial statement lines. The capital and revenue attributable to minority interests are included as a separate item in the Statement of Financial Position. The amounts consolidated are drawn from the published financial statements of the subsidiaries for the year. Where subsidiaries' accounting policies are not aligned with those of the Foundation Trust

then amounts are adjusted during consolidation where the differences are material. Inter-entity balances, transactions and gains/losses are eliminated in full on consolidation. Dudley Clinical Services Limited is a subsidiary of the Trust.

NHS Charitable Fund

The NHS Foundation Trust is the corporate trustee to The Dudley Group NHS Charity. The Foundation Trust has assessed its relationship to the charitable fund and determined it to be a subsidiary because the Foundation Trust is exposed to, or has rights to, variable returns and other benefits for itself, patients and staff from its involvement with the charitable fund and has the ability to affect those returns and other benefits through its power over the fund.

The charitable fund's statutory accounts are prepared to 31st March in accordance with the UK Charities Statement of Recommended Practice (SORP) which is based on UK Financial Reporting Standard (FRS) 102. On consolidation, necessary adjustments are made to the charity's assets, liabilities and transactions to:

- recognise and measure them in accordance with the Foundation Trust's accounting policies; and
- eliminate intra-group transactions, balances, gains and losses.

1.2 Revenue

In the application of IFRS 15 a number of practical expedients offered in the Standard have been employed.

These are as follows:

- As per paragraph 121 of the Standard the Foundation Trust will not disclose information regarding performance. Obligations part of a contract that has an original expected duration of one year or less.
- The Foundation Trust is to similarly not disclose information where the revenue is recognised in line with the practical expedient offered in paragraph B16 of the Standard where the right to consideration corresponds directly with the value of the performance completed to date.
- The FReM has mandated the exercise of the practical expedient offered in C7 (a) of the Standard that requires the Foundation Trust to reflect the aggregate effect of all contracts modified before the date of initial application.

Where income is derived from contracts with customers, it is accounted for under IFRS 15. The GAM expands the definition of a contract to include legislation and regulations which enables an entity to receive cash or another financial asset that is not classified as a tax by the Office of National Statistics (ONS).

Revenue in respect of goods/services provided is recognised when (or as) performance obligations are satisfied by transferring promised goods/services to the customer and is measured at the amount of the transaction price allocated to those performance obligations. At the year end, the Trust accrues income relating to performance obligations satisfied in that year. Where the Trust's entitlement to consideration for those goods or services is unconditional a contract receivable will be recognised. Where entitlement to consideration is conditional on a further factor other than the passage of time, a contract asset will be recognised. Where consideration received or receivable relates to a performance obligation that is to be satisfied in a future period, the income is deferred and recognised as a contract liability.

The main source of income for the Trust is contracts with commissioners for healthcare services. Funding envelopes are set at an Integrated Care System (ICS) level. The majority of the Trust's NHS income is earned from NHS commissioners under the NHS Payment Scheme (NHSPS). The NHSPS sets out rules to establish the amount payable to Trusts for NHS-funded secondary healthcare

Aligned payment and incentive contracts form the main payment mechanism under the NHSPS. In 2024/25 API contracts contain both a fixed and variable element. Under the variable element, providers earn income for elective

activity (both ordinary and day case), out-patient procedures, out-patient first attendances, diagnostic imaging and nuclear medicine, and chemotherapy delivery activity. The precise definition of these activities is given in the NHSPS. Income is earned at NHSPS prices based on actual activity. The fixed element includes income for all other services covered by the NHSPS assuming an agreed level of activity with 'fixed' in this context meaning not varying based on units of activity. Elements within this are accounted for as variable consideration under IFRS 15 as explained below.

High costs drugs and devices are excluded from the calculation of national process are reimbursed by NHS England based on actual usage or at a fixed baseline in addition to the price of the related services.

In 2024/25 fixed payments were set at a level assuming the achievement of elective activity targets within 'aligned payment and incentive' contracts. These payments are accompanied by a variable element to adjust income for actual activity delivered on elective services and advice and guidance services. Where actual elective activity delivered differed from the agreed level set in the fixed payments, the variable element either increased or reduced the income earned by the Trust at a rate of 100% of the tariff price.

The Trust also receives income from commissioners under Commissioning for Quality Innovation (CQUIN) and Best Practice Tariff (BPT) schemes. Delivery under these schemes is part of how care is provided to patients. As such CQUIN and BPT payments are not considered distinct performance obligations in their own right; instead, they form part of the transaction price for performance obligations under the overall contract with the commissioner and are accounted for as variable consideration under IFRS 15. Payment for CQUIN and BTP on non-elective services is included in the fixed element of API contracts with adjustments for actual achievement being made at the end of the year. BPT earned on elective activity is included in the variable element of API contracts and paid in line with the actual activity performed.

Where the relationship with a particular integrated care board is expected to be a low volume of activity (annual value below £0.5m), an annual fixed payment is received by the provider as determined in the NHSPS documentation. Such income is classified as 'other clinical income' in these accounts.

Revenue from research contracts

Where research contracts fall under IFRS 15, revenue is recognised as and when performance obligations are satisfied. For some contracts, it is assessed that the revenue project constitutes one performance obligation over the course of the multi-year contract. In these cases, it is assessed that the Trust's interim performance does not create an asset with alternative use for the Trust, and the Trust has an enforceable right to payment for the performance completed to date. It is therefore considered that the performance obligation is satisfied over time, and the Trust recognises revenue each year over the course of the contract. Some research income alternatively falls within the provisions of IAS 20 for government grants.

NHS injury cost recovery scheme

The Foundation Trust receives income under the NHS Cost Recovery Scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation have subsequently been paid, for instance by an insurer. The Foundation Trust recognises the income when it receives notification from the Department of Work and Pension's Compensation Recovery Unit has completed the NHS2 form and confirmed there are no discrepancies with the treatment. The income is measured at the agreed tariff for the treatments provided to the injured individual, less a provision for unsuccessful compensation claims and doubtful debts in line with IFRS 9 requirements of measuring expected credit losses over the lifetime of the asset.

Other forms of income

Grants and donations

Government grants are grants from government bodies other than income from commissioners or trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure. Where the grant is used to fund capital expenditure, it is credited to the Statement of Comprehensive Income once conditions attached to the grant have been met. Donations are treated in the same way as government grants.

Apprenticeship service income

The value of the benefit received when accessing funds from the Government's apprenticeship service is recognised as income at the point of receipt of the training service. Where these funds are paid directly to an accredited training provider from the Trust's apprenticeship service account held by the Department for Education, the corresponding notional expense is also recognised at the point of recognition for the benefit.

Education and Training

The Trust receives income from NHS England for education and training of medical and non-medical trainees. Revenue is in respect of training provided and is recognised when performance obligations are satisfied when training has been performed. All performance obligations are undertaken within the financial year and is agreed and invoiced to NHS England.

1.3 Expenditure on Employee Benefits

Short-term Employee Benefits

Salaries, wages and employment-related payments, including payments arising from the apprenticeship levy, are recognised in the period in which the service is received from employees including non-consolidated performance pay earned but not yet paid. Employees are not permitted to carry forward leave into the following period. Therefore, the Trust does not recognise any untaken leave in the financial statements.

Pension costs

NHS Pension Scheme

Past and present employees are covered by the provisions of the NHS Pension Schemes. Details of the benefits payable and rules of the schemes can be found on the NHS Pensions website at **www.nhsbsa.nhs.uk/pensions**. Both the 1995/2008 and 2015 schemes are accounted for, and the scheme liability valued, as a single combined scheme. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

Pension costs

NHS Pension Scheme

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2025, is based on valuation data as at 31 March 2023, updated to 31 March 2025 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the Statement by the Actuary, which forms part of the annual NHS Pension Scheme Annual Report and Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full actual (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (considering recent demographic experience), and to recommend the contribution rate payable by employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2020. The results of this valuation set the employer contribution rate payable from April 2024 to 23.7% of pensionable pay. The core cost cap cost of the scheme was calculated to be outside of the 3% cost cap corridor as at 31 March 2020. However, when the wider economic situation was taken into account through the economic cost cap cost of the scheme, the cost cap corridor was not similarly breached. As a result, there was no impact on the member benefit structure or contribution rates.

The 2024 actuarial valuation is currently being prepared and will be published before new contribution rates are implemented from April 2027.

1.4 Expenditure on Other Goods and Services

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

1.5 Property, Plant and Equipment

Recognition

Property, Plant and Equipment is capitalised where:

- it is held for use in delivering services or for administrative purposes;
- it is probable that future economic benefits will flow to, or service potential be provided to, the Foundation Trust;
- it is expected to be used for more than one financial year; and
- the cost of the item can be measured reliably and

- has an individual cost of at least £5,000; or
- the items form a group of assets which collectively have a cost of at least £5,000, and individually have a cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under the same managerial control; or
- form part of the initial equipping and setting up cost of a new building or refurbishment of a ward or unit, and the items collectively have a cost of at least £5,000.

Where a large asset, for example a building, includes a number of components with significantly different asset lives e.g. plant and equipment, then these components are treated as separate assets and depreciated over their own useful economic lives.

Valuation

All Property, Plant and Equipment assets are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

For property assets the frequency of revaluations will be at least every five years.

The fair value of land and buildings are determined by valuations carried out by professionally qualified valuers in accordance with the Royal Institution of Chartered Surveyors (RICS) Appraisal and Valuation Manual. The valuations are carried out primarily on the basis of depreciated replacement cost, modern equivalent asset basis for specialised operational property and existing use value for non-specialised operational property. Assets held at depreciated replacement cost have been valued on a Modern Equivalent Asset Optimised alternative site basis where this would meet the location requirements of the service being provided. For the Trust's PFI buildings the valuation does not include any VAT liability as VAT is recoverable on the unitary payments made by the Trust and any re-provision of the buildings would be carried out via a further PFI agreement. The value of land for existing use purposes is assessed at existing use value. For non-operational properties including surplus land, the valuations are carried out at open market value.

Assets under construction are valued at cost and are subsequently revalued by professional valuers when they are brought into use if factors indicate that the value of the asset differs materially from its carrying value. Otherwise, the asset should only be revalued on the next occasion when all assets of that class are revalued.

An item of property, plant and equipment which is surplus with no plan to bring it back into use is valued at fair value under IFRS 13, if it does not meet the requirements of IAS 40 or IFRS 5.

Subsequent expenditure

Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the enterprise and the cost of the item can be determined reliably. Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance is charged to the Statement of Comprehensive Income in the period in which it is incurred.

Depreciation

Items of Property, Plant and Equipment are depreciated over their remaining useful economic lives in a manner consistent with the consumption of economic or service delivery benefits.

The Trust depreciates its non-current assets on a straight-line basis over the expected life of the assets after allowing for the residual value. Useful lives are determined on a case-by-case basis. The typical lives for the following assets are:

Asset Category	Useful Life (years)
Buildings	2 - 79
Engineering Plant & Equipment	1 - 15
Medical Equipment	1 - 15
Transport Equipment	7 - 10
Information Technology	3 - 15
Furniture & Fittings	3 - 10

Freehold land is considered to have an infinite life and is not depreciated.

Property, Plant and Equipment which has been reclassified as 'Held for Sale' ceases to be depreciated upon reclassification.

Assets in the course of construction and residual interests in off-Statement of Financial Position PFI contract assets are not depreciated until the asset is brought into use or reverts to the Trust, respectively.

Revaluation gains and losses

Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating expenditure.

Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned and thereafter are charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'.

Impairments

In accordance with the FT ARM, impairments that arise from a clear consumption of economic benefits or of service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

An impairment that arises from a clear consumption of economic benefit or of service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss are reversed.

An impairment that arises from a clear consumption of economic benefit or of service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss are reversed. Reversals are recognised in operating income to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.

Other impairments are treated as revaluation losses. Reversals of other impairments are treated as revaluation gains.

De-recognition

Assets intended for disposal are reclassified as 'Held for Sale' once the following criteria are met. The sale must be highly probable and the asset available for immediate sale in its present condition.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged, and the assets are not revalued, except where the 'fair value less costs to sell' falls below the carrying amount. Assets are de-recognised when all material sale contract conditions have been met. Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as 'Held for Sale' and instead is retained as an operational asset and the asset's economic life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

Donated, Government Grant and other grant funded assets

Donated and grant funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation/grant is credited to income at the same time, unless the donor has imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation/grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met. The donated and grant funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

Private Finance Initiative (PFI) transactions

PFI transactions which meet the IFRIC 12 definition of a service concession, as interpreted in HM Treasury's FReM, are accounted for as 'on-Statement of Financial Position' by the Trust. Annual contract payments to the operator (the unitary charge) are apportioned between the repayment of the liability including the finance cost, the charges for services and lifecycle replacement of components of the asset.

In accordance with HM Treasury's FReM, the underlying assets are recognised as property, plant and equipment, together with an equivalent liability. Initial measurement of the asset and liability are in accordance with the initial measurement principles of IFRS 16 (see leases accounting policy).

Assets are subsequently accounted for as property, plant and equipment and/or intangible assets as appropriate.

The liability is subsequently reduced by the portion of the unitary charge allocated as payment for the asset and increased by the annual finance cost. The finance cost is calculated by applying the implicit interest rate to the opening liability and is charged to finance costs in the Statement of Comprehensive Income. The element of the unitary charge allocated as payment for the asset is split between payment of the finance cost and repayment of the net liability.

Where there are changes in future payments for the asset resulting from indexation of the unitary charge, the Trust remeasures the PFI liability by determining the revised payments for the remainder of the contract once the change in cash flows takes effect. The remeasurement adjustment is charged to finance costs in the Statement of Comprehensive Income.

The service charge is recognised in operating expenses in the Statement of Comprehensive Income.

The lifecycle element is established on the lifecycle plan contained within the financial model. Components of the asset replaced by the operator during the contract ('lifecycle replacement') are capitalised where they meet the Trust's criteria for capital expenditure. They are capitalised at the time they are provided by the operator and are

measured initially at their fair value. The element of the annual unitary payment allocated to lifecycle replacement is pre-determined for each year of the contract from the operator's planned programme of lifecycle replacement. Where the lifecycle component is provided earlier or later than expected, a short-term finance lease liability or prepayment is recognised respectively. Where the fair value of the lifecycle component is less than the amount determined in the contract, the difference is recognised as an expense when the replacement is provided. If the fair value is greater than the amount determined in the contract, the difference is treated as a 'free' asset and a deferred income balance is recognised. The deferred income is released to the operating income over the shorter of the remaining contract period or the useful economic life of the replacement component.

Initial application of IFRS 16 liability measurement principles to PFI liability in 2023/24

IFRS 16 liability measurement principles were applied to PFI, LIFT and other service concession arrangement liabilities in these financial statements from 1 April 2023. The change in measurement basis was applied using a modified retrospective approach with the cumulative impact of remeasuring the liability on 1 April 2023 recognised in the income and expenditure reserve.

1.6 Intangible Assets

Intangible assets are non-monetary assets without physical substance controlled by the Trust. They are capable of being sold separately from the rest of the Trust's business or arise from contractual or other legal rights. Intangible assets are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the Trust and where the cost of the asset can be measured reliably. Where internally generated assets are held for service potential, this involves a direct contribution to the delivery of services to the public.

Internally generated goodwill, brands, mastheads, publishing titles, customer lists and similar items are not capitalised as intangible assets. Expenditure on research is not capitalised. Expenditure on development is capitalised only where all of the following can be demonstrated:

- the project is technically feasible to the point of completion and will result in an intangible asset for sale or use.
- the Trust intends to complete the asset and sell or use it.
- the Trust has the ability to sell or use the asset.
- how the intangible asset will generate probable future economic or service delivery benefits e.g. the presence of a market for it or its output, or where it is to be used for internal use, the usefulness of the asset.
- adequate financial, technical and other resources are available to the Trust to complete the development and sell or use the asset; and
- the Trust can measure reliably the expenses attributable to the asset during development.

Software

Software which is integral to the operation of hardware e.g. an operating system is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware e.g. application software, is capitalised as an intangible asset where it meets recognition criteria.

Purchased computer software licences are capitalised as intangible non-current assets where expenditure of at least £5,000 is incurred and amortised over the shorter of the term of the license and their useful lives.

Measurement

Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management. Subsequently intangible assets are measured at current value in existing use. Where no active market exists, intangible assets are valued at the lower of depreciated replacement cost and the value in use where the asset is income generating. Revaluations gains and losses and impairments are treated in the same manner as for property, plant and equipment. An intangible asset which is surplus with no plan to bring it back into use is valued at fair value where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investments properties or assets held for sale.

Amortisation and impairment

Intangible assets are amortised over their expected useful economic lives in a manner consistent with the consumption of economic or service delivery benefits. The carrying value of intangible assets is reviewed for impairment at the end of the first full year following acquisition and in other periods if events or changes in circumstances indicate the carrying value may not be recoverable.

Asset Category	Useful Life (years)
Software Licences	2 - 15

1.7 Government Grants

Government grants are grants from Government bodies other than income from Integrated Care Boards or NHS Trusts for the provision of services. Grants from the Department of Health, are accounted for as Government grants as are grants from the Big Lottery Fund. Where the Government grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure. Where the grant is used to fund capital expenditure the grant is credited to income at the same time, unless the grant has imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the grant, in which case, the grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.

1.8 Inventories

Inventories are valued at the lower of cost and net realisable value. The cost of inventories is measured using the First In, First Out (FIFO) method.

Between 2020/21 and 2023/24, the Trust received inventories including personal protective equipment from the Department of Health and Social Care at nil cost. In line with the GAM and applying the principles of the IFRS Conceptual Framework, the Trust has accounted for the receipt of these inventories at a deemed cost, reflecting the best available approximation of an imputed market value for the transaction based on the cost of acquisition by the Department. Distribution of inventories by the Department ceased in March 2024.

1.9 Cash and Cash Equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value. In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the Foundation Trust's cash management. Cash, bank and overdraft balances are recorded at current values.

1.10 Financial Instruments and Financial Liabilities

Financial assets

Financial assets are recognised when the Foundation Trust becomes party to the contractual provision of the financial instrument or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are derecognised when the contractual rights have expired or when the asset has been transferred and the Foundation Trust has transferred substantially all of the risks and rewards of ownership or has not retained control of the asset.

Financial assets are initially recognised at fair value plus or minus directly attributable transaction costs for financial assets not measured at fair value through profit or loss. Fair value is taken as the transaction price, or otherwise determined by reference to quoted market prices, where possible, or by valuation techniques.

Financial assets are classified into the following categories: financial assets at amortised cost, financial assets at fair value through other comprehensive income, and financial assets at fair value through profit and loss. The classification is determined by the cash flow and business model characteristics of the financial assets, as set out in IFRS 9, and is determined at the time of initial recognition. All of the financial assets held by the Group are held at amortised cost with the exception of the investment held by Dudley Group NHS Charity which is held at fair value through profit and loss.

Financial assets at amortised cost

Financial assets measured at amortised cost are those held within a business model whose objective is to hold financial assets in order to collect contractual cash flows and where the cash flows are solely payments of principal and interest. This includes most trade receivables, loans receivable, and other simple debt instruments.

After initial recognition, these financial assets are measured at amortised cost using the effective interest method, less any impairment. The effective interest rate is the rate that exactly discounts estimated future cash receipts through the life of the financial asset to the gross carrying amount of the financial asset.

Financial assets at fair value through other comprehensive income

Financial assets measured at fair value through other comprehensive income are those held within a business model whose objective is achieved by both collecting contractual cash flows and selling financial assets and where cash flows are solely payments of principal and interest. This category also includes investments in equity instruments where the Group has opted to classify them here.

Financial assets at fair value through profit and loss

Financial assets measured at fair value through profit or loss are those that are not otherwise measured at amortised cost or fair value through other comprehensive income. This includes derivatives and financial assets acquired principally for the purpose of selling in the short term.

Impairment

For all financial assets measured at amortised cost or at fair value through other comprehensive income (except equity instruments designated at fair value through other comprehensive income), lease receivables and contract assets, the Foundation Trust recognises a loss allowance representing expected credit losses on the financial instrument.

The Foundation Trust adopts the simplified approach to impairment, in accordance with IFRS 9, and measures the loss allowance for trade receivables, contract assets and lease receivables at an amount equal to lifetime expected

credit losses. For other financial assets, the loss allowance is measured at an amount equal to lifetime expected credit losses if the credit risk on the financial instrument has increased significantly since initial recognition (stage 2), and otherwise at an amount equal to 12-month expected credit losses (stage 1).

HM Treasury has ruled that central government bodies may not recognise stage 1 or stage 2 impairments against other government departments, their executive agencies, the Bank of England, Exchequer Funds, and Exchequer Funds' assets where repayment is ensured by primary legislation. The Foundation Trust therefore does not recognise loss allowances for stage 1 or stage 2 impairments against these bodies. Additionally, the Department of Health and Social Care provides a guarantee of last resort against the debts of its arm's length bodies and NHS bodies (excluding NHS charities), and the Foundation Trust does not recognise loss allowances for stage 1 or stage 2 impairments against these bodies.

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of the estimated future cash flows discounted at the financial asset's original effective interest rate. Any adjustment is recognised in profit or loss as an impairment gain or loss.

Financial liabilities

Financial liabilities are recognised when the Foundation Trust becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are de-recognised when the liability has been extinguished – that is, the obligation has been discharged or cancelled or has expired.

Financial liabilities at fair value through profit and loss

Derivatives that are liabilities are subsequently measured at fair value through profit or loss, Embedded derivatives that are not part of a hybrid contract containing a host that is an asset within the scope of IFRS 9 are separately accounted for as derivatives only if their economic characteristics and risks are not closely related to those of their host contracts, a separate instrument with the same terms would meet the definition of a derivative, and the hybrid contract is not itself measured at fair value through profit or loss.

Other Financial liabilities

After initial recognition, all other financial liabilities are measured at amortised cost using the effective interest method. The effective interest rate is the rate that exactly discounts estimated future cash payments through the life of the asset, to the amortised cost of the financial liability. In the case of DHSC loans that would be the nominal rate charged on the loan.

1.11 Leases

A lease is a contract or part of a contract that conveys the right to use an asset for a period of time in exchange for consideration. An adaptation of the relevant accounting standard by HM Treasury for the public sector means that for NHS bodies, this includes lease-like arrangements with other public sector entities that do not take the legal form of a contract. It also includes peppercorn leases where consideration paid is nil or nominal (significantly below market value) but in all other respects meet the definition of a lease. The trust does not apply lease accounting to new contracts for the use of intangible assets.

The Trust determines the term of the lease term with reference to the non-cancellable period and any options to extend or terminate the lease which the Trust is reasonably certain to exercise.

The Trust as lessee

Initial recognition and measurement

At the commencement date of the lease, being when the asset is made available for use, the Trust recognises a right of use asset and a lease liability.

The right of use asset is recognised at cost comprising the lease liability, any lease payments made before or at commencement, any direct costs incurred by the lessee, less any cash lease incentives received. It also includes any estimate of costs to be incurred restoring the site or underlying asset on completion of the lease term.

The lease liability is initially measured at the present value of future lease payments discounted at the interest rate implicit in the lease. Lease payments include fixed lease payments, variable lease payments dependent on an index or rate and amounts payable under residual value guarantees. It also includes amounts payable for purchase options and termination penalties where these options are reasonably certain to be exercised.

Where an implicit rate cannot be readily determined, the Trust's incremental borrowing rate is applied. This rate is determined by HM Treasury annually for each calendar year. A nominal rate of 4.72% applied to new leases commencing in 2024 and 4.81% to new leases commencing in 2025.

The Trust does not apply the above recognition requirements to leases with a term of 12 months or less or to leases where the value of the underlying asset is below £5,000, excluding any irrecoverable VAT. Lease payments associated with these leases are expensed on a straight-line basis over the lease term or other systematic basis. Irrecoverable VAT on lease payments is expensed as it falls due.

Subsequent measurement

As required by a HM Treasury interpretation of the accounting standard for the public sector, the Trust employs a revaluation model for subsequent measurement of right of use assets, unless the cost model is considered to be an appropriate proxy for current value in existing use or fair value, in line with the accounting policy for owned assets. Where consideration exchanged is identified as significantly below market value, the cost model is not considered to be an appropriate proxy for the value of the right of use asset.

The Trust subsequently measures the lease liability by increasing the carrying amount for interest arising which is also charged to expenditure as a finance cost and reducing the carrying amount for lease payments made. The liability is also remeasured for changes in assessments impacting the lease term, lease modifications or to reflect actual changes in lease payments. Such remeasurements are also reflected in the cost of the right of use asset. Where there is a change in the lease term or option to purchase the underlying asset, an updated discount rate is applied to the remaining lease payments.

The Trust as lessor

The Trust assesses each of its leases and classifies them as either a finance lease or an operating lease. Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

Where the Trust is an intermediate lessor, classification of the sublease is determined with reference to the right of use asset arising from the headlease.

Finance leases

Amounts due from lessees under finance leases are recorded as receivables at the amount of the Trust's net investment in the leases. Finance lease income is allocated to accounting periods to reflect a constant periodic rate of return on the Trust's net investment outstanding in respect of the leases.

Operating leases

Income from operating leases is recognised on a straight-line basis or another systematic basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised as an expense on a straight-line basis over the lease term.

1.12 Provisions

The NHS Foundation Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using HM Treasury's discount rates effective for 31 March 2025.

		Asset Category	Useful Life (years)
Short-term	Up to 5 years	4.03%	4.26%
Medium-term	After 5 years up to 10 years	4.07%	4.03%
Long-term	After 10 years up to 40 years	4.81%	4.72%
Very long-term	Exceeding 40 years	4.55%	4.40%

HM Treasury provides discount rates for general provisions on a nominal rate basis. Expected future cash flows are therefore adjusted for the impact of inflation before discounting using nominal rates. The following inflation rates are set by HM Treasury, effective 31 March 2025:

	Inflation rate	Prior Year rate
Year 1	2.60%	3.60%
Year 2	2.30%	1.80%
Into perpetuity	2.00%	2.00%

Early retirement provisions and injury benefit provisions both use the HM Treasury's post-employment benefits discount rate of 2.40% (2023-24 2.45%) in real terms.

Clinical negligence costs

NHS Resolution (the trading name of the NHS Litigation Authority NHSLA) operates a risk pooling scheme under which the NHS Foundation Trust pays an annual contribution to the NHS Resolution, which, in return, settles all clinical negligence claims. The contribution is charged to expenditure. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the NHS Foundation Trust. The total value of clinical negligence provisions carried by the NHS Resolution on behalf of the NHS Foundation Trust is disclosed at note 20 but is not recognised in the Trust accounts.

Non-clinical risk pooling

The NHS Foundation Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the Trust pays an annual contribution to NHS Resolution and in return receives assistance with the costs of claims arising. The annual membership contributions, and any 'excesses' payable in respect of particular claims are charged to operating expenses when the liability arises.

1.13 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets but are disclosed in note 24 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in note 24, unless the probability of a transfer of economic benefits is remote. Contingent liabilities are defined as:

- possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or
- present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

1.14 Public Dividend Capital

Public dividend capital is a type of public sector equity finance, which represents the Department of Health and Social Care's investment in the trust. HM Treasury has determined that, being issued under statutory authority rather than under contract, PDC is not a financial instrument within the meaning of IAS 32.

At any time, the Secretary of State can issue new PDC to, and require repayments of PDC from the trust. PDC is recorded at the value received.

A charge, reflecting the cost of capital utilised by the Trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the Trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, with certain additions and deductions as defined in the PDC dividend policy issued by the Department of Health and Social Care. This policy is available at **https://www.gov.uk/government/publications/guidance-on-financing-avaliable-to-nhs-trusts-and-foundation-trusts**.

1.15 Value Added Tax

Most of the activities of the NHS Foundation Trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.16 Foreign Exchange

The functional and presentational currencies of the Trust are sterling.

A transaction which is denominated in a foreign currency is translated into the functional currency at the spot exchange rate on the date of the transaction. Where the Trust has assets or liabilities denominated in a foreign currency at the Statement of Financial Position date:

- monetary items (other than financial instruments measured at 'fair value through income and expenditure') are translated at the spot exchange rate on 31 March:
- non-monetary assets and liabilities measured at historical cost are translated using the spot exchange rate at the date of the transaction; and
- non-monetary assets and liabilities measured at fair value are translated using the spot exchange rate at the date the fair value was determined.

Exchange gains or losses on monetary items (arising on settlement of the transaction or on re-translation at the Statement of Financial Position date) are recognised in income or expenditure in the period in which they arise. Exchange gains or losses on non-monetary assets and liabilities are recognised in the same manner as other gains and losses on these items.

1.17 Third Party Assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the NHS Foundation Trust has no beneficial interest in them. However, they are disclosed in note 28 to the accounts in accordance with the requirements of HM Treasury's Financial Reporting Manual.

1.18 Corporation Tax

The Trust is a Health Service Body within the meaning of S519A ICTA 1988 and accordingly is exempt from taxation in respect of income and capital gains within categories covered by this. There is a power for the Treasury to remove the exemption in relation to specified activities of a Foundation Trust (s519A (3) to (8) ICTA 1988). Accordingly, the Trust is potentially within the future scope of income tax in respect of activities where income is received from a non-public sector source. The Charity is also exempt from corporation tax.

The tax expense on the Statement of Comprehensive Income comprises current and deferred tax due to the Trust's trading commercial subsidiary. Current tax is the expected tax payable for the year, using tax rates enacted or substantively enacted at the Statement of Financial Position date, and any adjustment to tax payable in respect of previous years.

Deferred tax is provided using the Statement of Financial Position liability method, providing for temporary differences between the carrying amounts of the assets and liabilities for financial reporting purposes and the amounts used for taxation purposes. Deferred tax is not recognised on taxable temporary differences arising on the initial recognition of goodwill or for temporary differences arising from the initial recognition of assets and liabilities in a transaction that is not a business combination and that affects neither accounting nor taxable profit.

Deferred taxation is calculated using rates that are expected to apply when the related deferred asset is realised, or the deferred taxation liability is settled. Deferred tax assets are recognised only to the extent that it is probable that future taxable profits will be available against which the assets can be utilised.

1.19 Critical accounting judgements and key sources of estimation and uncertainty

In the application of the Trust's accounting policies, management is required to make judgements, estimates and assumptions

about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates and the estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period or in the period of the revision and future periods if the revision affects both current and future periods.

Critical judgements in applying accounting policies

The following are the critical judgements, apart from those involving estimations (see below) that management has made in the process of applying the Trust's accounting policies and that have the most significant effect on the amounts recognised in the financial statements.

- Accounting for PFI
- Application of IFRS 16 Determining whether an Arrangement contains a Lease
- Application of IFRIC 12 Service Concession Arrangements

Russells Hall Hospital, Guest Ambulatory Centre and Corbett Ambulatory Centre are owned by Summit Healthcare (Dudley) Limited and provided to the trust under a Private Finance Initiative (PFI) contract. The accounting judgement is around the classification of the transaction under IFRS 16 and IFRIC 12.

Management have reviewed the service concession of the PFI scheme and has confirmed it is within the scope of IFRIC 12. The PFI scheme is 'on-balance sheet' meaning that the buildings and equipment are recognised in the Trust's balance sheet along with a finance lease creditor for the amount owed by the Trust over the PFI contract term.

Key sources of estimation uncertainty

The following are assumptions about the future and other major sources of estimation uncertainty, at the end of the reporting period, that have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities within the next financial year.

Valuation of Non-Current Assets

Modern equivalent asset valuation of property

As detailed in accountancy policy note 1.5 'Property, plant and equipment' the Trust's Valuer provided the Trust with a valuation of the land and building assets (estimated fair value and remaining useful life). The significant estimation being the specialised building - depreciation replacement value, using modern equivalent asset optimised alternative site methodology, of the hospital sites (Russell's Hall, Corbett and Guest). The result of this valuation, based on estimates provided by a suitably qualified professional in accordance with HM Treasury guidance, is disclosed in note 13 to the financial statements on page 32. Future revaluations of the Trust's property may result in further material changes to the carrying value of non-current assets.

The impact of using modern equivalent asset valuation is shown in note 13.7 on page 35.

A further valuation has been undertaken as at 31 March 2025 to update the costs assumptions within the valuation. The total valuation of land and buildings was £140.083m. This valuation considers several factors including BCIS index, location factors, functional obsolescence and fees. Should any of these factors change this could lead to a

material change in the valuation of the buildings (a change of 2.6% would impact on the value by £3.6m).

1.20 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2024/25.

1.21 Standards, amendments and interpretations in issue but not yet effective or adopted

The DHSC GAM does not require the following IFRS Standards and Interpretations to be applied in 2024/25.

IFRS 17 Insurance Contracts – The Standard is effective for accounting periods beginning on or after 1 January 2023. IFRS 17 has been adopted by the FReM from the 1 April 2025. Adoption of the Standard for NHS bodies will therefore be in 2025/26. The standard revises the accounting for insurance contracts for the issuers of insurance. Application of this standard from 2025/26 is not expected to impact on the financial statements.

IFRS 18 Presentation and Disclosure in Financial Statements - The Standard is effective for accounting periods beginning on or after 1 January 2027. The Standard is not yet UK endorsed and not yet adopted by the FReM. Early adoption is not permitted. The expected impact of applying the standard in future periods has not yet been assessed.

IFRS 19 Subsidiaries without Public Accountability: The Standard is effective for accounting periods beginning on or after 1 January 2027. The Standard is not yet UK endorsed and not yet adopted by the FReM. Early adoption is not permitted. The expected impact of applying the standard in future periods has not yet been assessed.

Changes to non-investment asset valuation – Following a thematic review of non-current asset valuations for financial reporting in the public sector, HM Treasury has made a number of changes to valuation frequency, valuation methodology and classification which are effective in the public sector from 1 April 2025 with a 5 year transition period. NHS bodies are adopting these changes to an alternative timeline.

Changes to subsequent measurement of intangible assets and PPE classification/terminology to be implemented for NHS bodies from 1 April 2025:

- Withdrawal of the revaluation model for intangible assets. Carrying values of existing intangible assets measured under a previous revaluation will be taken forward as deemed historic cost.
- Removal of the distinction between specialised and non-specialised assets held for their service potential. Assets will be classified according to whether they are held for their operational capacity. The expected impact of applying the standard in future periods has not yet been assessed.

Changes to valuation cycles and methodology to be implemented for NHS bodies in later periods:

- A mandated quinquennial revaluation frequency (or rolling programme) supplemented by annual indexation in the intervening years.
- Removal of the alternative site assumption for buildings valued at depreciated replacement cost on a modern equivalent asset basis. The approach for land has not yet been finalised by HM Treasury. The expected impact of applying the standard in future periods has not yet been assessed.

1.22 Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis.

The losses and special payments note is compiled directly from the losses and compensations register which reports on an accruals basis with the exception of provisions for future losses.

1.23 Transfers of functions to/from other NHS/Local Government Bodies

For functions that have been transferred to the Trust from another NHS Body, the transaction is accounted for as a transfer by absorption. The assets and liabilities transferred are recognised in the accounts using the book value as at the date of transfer. The assets and liabilities are not adjusted to fair value prior to recognition. The net gain/loss corresponding to the net assets/liabilities transferred is recognised within income/expenses, but not within operating activities.

For property plant and equipment assets and intangible assets, the cost and accumulated depreciation/amortisation balances from the transferring entity's accounts are preserved on recognition in the Trust's accounts. Where the transferring body recognised revaluation reserve balances attributable to the assets, the Trust makes a transfer from its income and expenditure reserve to its revaluation reserve to maintain transparency within public sector accounts.

For functions that the Trust has transferred to another NHS body, the assets and liabilities transferred are de-recognised from the accounts as at the date of transfer. The net loss/gain corresponding to the net assets/liabilities transferred is recognised within income/expenses, but not within operating activities. Any revaluation reserve balances attributable to assets de-recognised are transferred to the income and expenditure reserve.

There was one transfer from other NHS bodies during 2024-25. This related to the transfer of services from Dudley Integrated Healthcare NHS Trust which took place on 1st October 2024.

2 Segmental Analysis

The analysis by business segment is presented in accordance with IFRS 8 Operating Segments, on the basis of those segments whose operating results are regularly reviewed by the Board (the Chief Operating Decision Maker as defined by IFRS 8) as follows:

Healthcare Services

The Board as 'Chief Operating Decision Maker' has determined that the Trust operates in the provision of healthcare services. The segmental reporting format reflects the Trust's management and internal reporting structure.

The Trust has identified segments in line with the thresholds in IFRS 8, applying the requirement of the DH GAM to consider expenditure instead of income, as income is not analysed between segments in our monthly finance report to the Trust Board. Following a significance test of the expenditure segments the Trust found that there were three significant operating segments subject to the external reporting requirements of IFRS 8. Applying the aggregation criteria to the Trust's three significant operating segments found that in all cases the segments had similar economic characteristics, the nature of the services are similar, the nature of the production process are similar, the type or class of customer for the services are similar, the methods used to provide the services are similar and the nature of the regulatory environment is similar.

The Trust's significant operating segments satisfy all of the criteria listed for an aggregation to be deemed appropriate. The three significant operating segments of the Trust are all active in the same business – the provision of healthcare, and all operate within the same economic environment – the United Kingdom. Given that the purpose of disclosing segmental information is to enable users of the financial statements to evaluate the nature and financial effects of business activities and economic environments, reporting a single segment of "Healthcare" would be consistent with the core principle of IFRS 8, as it would show the singular nature of both the business activity and the economic environment of the Trust.

Income from activities (medical treatment of patients) is analysed by customer type in note 3 to the accounts on page 22. Other operating income is analysed in note 4 to the accounts on page 24 and materially consists of revenues from healthcare, research and development, medical education, and the provision of services to other NHS bodies. Total income by individual customers within the whole of HM Government and considered material, is disclosed in the related parties' transactions note 25 to the accounts on page 43.

Dudley Clinical Services Limited

The company is a wholly owned subsidiary of the Trust and provides an Outpatient Dispensing service. As a trading company, subject to an additional legal and regulatory regime (over and above that of the Trust), this activity is considered to be a separate business segment whose individual operating results are reviewed by the Trust Board (the Chief Operating Decision Maker).

A significant proportion of the company's revenue is inter segment trading with the Trust which is eliminated upon the consolidation of these group financial statements. The quarterly performance report to the Chief Operating Decision Maker reports financial summary information in the format of the table on page 20.

Dudley Group NHS Charity

The Trust Board is corporate trustee for Dudley Group NHS Charity. Following Treasury's agreement to apply IFRS 10 to NHS Charities from 1st April 2013, the Trust has established that as the Trust is the corporate trustee of the linked NHS Charity, it effectively has the power to exercise control so as to obtain economic benefits. The Charity is therefore treated as a group entity and is consolidated. The consolidation is for reporting purposes only and does not affect the charities' legal and regulatory independence and day to day operations. Some of the charity's expenditure is inter segment trading with the Trust which is eliminated upon the consolidation of these group financial statements. The quarterly performance report to the Chief Operating Decision Maker reports financial summary information in the format of the table on page 20.

2 Segmental Analysis (continued)

Year ended 31 March 2025	Healthcare Services £000	Dudley Clinical Services Limited £000	Dudley Group NHS Charity £000	Inter Group Eliminations £000	Total £000
Total segment revenue	622,386	5,692	508	(6,114)	622,472
Total segment expenditure	(606,101)	(5,363)	(715)	6,114	(606,065)
Operating Surplus/(Deficit)	16,285	329	(207)	0	16,407
Net Financing	(35,008)	35	93	0	(34,880)
Taxation	0	(91)	0	0	(91)
Retained surplus/(deficit) - before non-recurring items	(18,723)	273	(114)	0	(18,564)
Non-recurring items	2,534	0	0	0	2,534
Retained surplus/(deficit)	(16,189)	273	(114)	0	(16,030)
Reportable Segment assets	290,035	2,478	2,461	0	294,974
Eliminations	0	0	0	(416)	(416)
Total assets	290,035	2,478	2,461	(416)	294,558
Reportable Segment liabilities	(345,493)	(594)	(35)	0	(346,122)
Eliminations	0	0	0	416	416
Total liabilities	(345,493)	(594)	(35)	416	(345,706)
Net assets/liabilities	(55,458)	1,884	2,426	0	(51,148)

Restated for Prior Period Adjustment

Year ended 31 March 2024	Healthcare Services £000	Dudley Clinical Services Limited £000	Dudley Group NHS Charity £000	Inter Group Eliminations £000	Total £000
Total segment revenue	579,323	5,191	455	(5,592)	579,377
Total segment expenditure	(570,146)	(4,933)	(674)	5,592	(570,161)
Operating Surplus/(Deficit)	9,177	258	(219)	0	9,216
Net Financing	(39,751)	1	110	0	(39,640)
Taxation	0	(65)	0	0	(65)
Retained surplus/(deficit) - before non-recurring items	(30,574)	194	(109)	0	(30,489)
Non-recurring items	69	0	0	0	69
Retained surplus/(deficit)	(30,505)	194	(109)	0	(30,420)
Reportable Segment assets	268,326	2,161	2,590	0	273,077
Eliminations	0	0	0	(441)	(441)
Total assets	268,326	2,161	2,590	(441)	272,636
Reportable Segment liabilities	(330,330)	(550)	(30)	0	(330,910)
Eliminations	0	0	0	441	441
Total liabilities	(330,330)	(550)	(30)	441	(330,469)
Net assets/liabilities	(62,004)	1,611	2,560	0	(57,833)

3 Operating income from patient care activities (Group and Foundation Trust)

3.1 By Source

	Year Ended 31 March 2025 £'000	Year Ended 31 March 2024 £'000
NHS England	53,869	72,996
Integrated Care Boards	530,929	474,480
NHS Foundation Trusts	134	70
NHS Trusts	371	370
Local Authorities	23	1,385
Non-NHS: Private patients	3	5
Non-NHS: Overseas patients (chargeable to patient)	373	66
NHS injury scheme (was RTA)	940	635
Non-NHS: Other	2,145	49
Total income from activities	**588,787**	**550,056**

3.2 By Nature

	Year Ended 31 March 2025 £'000	Year Ended 31 March 2024 £'000
Acute Services		
Aligned payment & incentive (API) income - Variable (based on activity) *	144,710	120,373
Aligned payment & incentive (API) income - Fixed (not based on activity)	338,440	345,984
High-cost drugs income from Commissioners	46,937	40,527
Other NHS clinical income	5,483	5,014
Community Services		
Aligned payment & incentive (API) income *	27,725	23,959
Income from other sources (e.g. local authorities)	0	342
Private Patients	3	5
Elective recovery fund #	0	0
Pay award central funding ***	1,191	222
Additional pension contribution central funding **	20,335	12,424
Other clinical income	3,963	1,206
Total income from activities	**588,787**	**550,056**

*Aligned payment and incentive contracts are the main form of contracting between NHS providers and their commissioners. More information can be found in the 2023/25 NHS Payment Scheme documentation. **https://www.england.nhs.uk/pay-syst/nhs-payment-scheme/**

**Increases to the employer contribution rate for NHS pensions since 1 April 2019 have been funded by NHS England. NHS providers continue to pay at the former rate of 14.3% with the additional amount being paid over by NHS England on providers' behalf. The full cost of employer contributions (23.7%, 2023/24: 20.6%) and related NHS England funding (9.4%, 2023/24: 6.3%) have been recognised in these accounts.

***Additional funding was made available directly to providers by NHS England in 2024/25 and 2023/24 for implementing the backdated element of pay awards where government offers were finalised after the end of the financial year. NHS Payment Scheme prices and API contracts are updated for the weighted uplift in in-year pay costs when awards are finalised.

This is now categorised within Acute Services Aligned payment & incentive (API) income - variable. The value for 2024/25 was £18,052,000 (2023/24 £4,817,000).

3.3 Income from Commissioner Requested Services and Non-Commissioner Requested Services

Under the terms of its Provider Licence, the Trust is required to analyse the level of income from activities that has arisen from commissioner requested and non-commissioner requested services. Commissioner requested services are defined in the provider licence and are services that commissioners believe would need to be protected in the event of provider failure. This information is provided in the table below:

	Year Ended 31 March 2025 £'000	Year Ended 31 March 2024 £'000
Income from Commissioner Requested Services	535,570	511,898
Income from Non-Commissioner Requested Services	27,725	24,301
Income from Activities	563,295	536,199
Other Clinical Income	3,966	1,211
Elective Recovery Fund *	0	0
Pay award central funding	1,191	222
Additional pension contribution central funding	20,335	12,424
Total Income	588,787	550,056
Total income from activities	**588,787**	**550,056**

Other NHS Clinical Income comprises the following services pathology; rehabilitation; community support services; radiology; renal services; patient transport services; and appliances.

3.4 Additional information on contract revenue (IFRS 15) recognised in the period

	2024/25 £'000	2023/24 £'000
Revenue recognised in the reporting period that was included within contract liabilities at the previous period end	2,139	3,366
Revenue recognised from performance obligations satisfied (or partially satisfied) in previous periods	0	0

3.5 Overseas Visitors

	Year Ended 31 March 2025 £'000	Year Ended 31 March 2024 £'000
Income recognised this year	373	66
Cash payments received in-year	63	24
Amounts added to provision for impairment of receivables	373	66
Amounts written off in-year	18	0

4 Other Operating Income (Group)

	Year Ended 31 March 2025 £'000	Year Ended 31 March 2024 £'000
Recognised in IFRS15:		
Research and development	1,120	1,163
Education and training	19,721	17,148
Non-patient care services to other bodies	1,916	1,738
Income in respect of employee benefits accounted for on a gross basis	6,645	5,173
Other *	1,994	1,770
Recognised in accordance with other standards:		
Education and training - apprenticeship fund	1,204	1,150
Charitable asset donations	128	146
Contributions to expenditure - consumables (inventory) donated from DHSC group bodies for COVID response	0	126
Operating leases - variable lease receipts	449	452
NHS Charitable Funds incoming resources excluding investment income	508	455
Total other operating income	**33,685**	**29,321**

* Other income is derived from Pharmacy Drugs £629,000 (2023/24 £530,000); and numerous other small amounts.

4.1 Operating lease income and future receipts

	Year Ended 31 March 2025 £'000	Year Ended 31 March 2024 £'000
Total in-year operating lease income	449	452
Of which:		
Income generated from owned assets	449	452
Future minimum lease receipts due:		
- not later than one year	456	449
- later than one year and not later than two years	7	7
- later than two years and not later than three years	6	6
- later than three years and not later than four years	7	7
- later than four years and not later than five years	6	6
- later than five years	0	7
Total	**482**	**482**

5 Operating Expenses of continuing operations (Group)

5.1 Operating Expenses

	Year Ended 31 March 2025 £'000	Year Ended 31 March 2024 £'000
Purchase of healthcare from NHS and DHSC bodies	1,759	1,291
Purchase of healthcare from non-NHS and non-DHSC bodies	1,642	1,805
Staff and executive directors' costs	400,331	358,017
Non-executive directors	229	205
Supplies and services - clinical (excluding drug costs)	60,967	55,990
Supplies and services – clinical: utilisation of consumables donated from DHSC group bodies for COVID response	0	226
Supplies and services - general	2,327	2,018
Drug costs (inventory consumed and purchase of non-inventory drugs)	50,575	47,263
Drugs Inventories written down	0	87
Consultancy costs	0	174
Establishment	3,206	3,018
Premises - Business Rates	1,787	1,666
Premises - Other	8,292	9,344
Transport - Business Travel	641	601
Transport - Other	164	332
Depreciation on property, plant and equipment and right of use assets	16,144	14,539
Amortisation on intangible assets	2,037	1,686
Impairments net of (reversals)	2,193	15,032
Movement in credit loss allowance: contract receivables/assets	390	46
Audit fees payable to the external auditor:		
• Audit services	141	134
• Other Auditor Remuneration	9	9
• NHS Charitable Fund Accounts	13	13
Internal audit	172	171
Clinical negligence	14,421	15,593
Legal Fees	325	492
Insurance	172	158
Research and development - staff costs	1,355	1,310
Research and development - non staff	150	151
Education and training - non staff	1,445	1,473
Education and training - apprenticeship fund	1,204	1,150
Lease expenditure - short term leases (<= 12 months)	8	39
Lease expenditure - low value assets (<£5k, excluding short term leases)	28	19
Lease expenditure - irrecoverable VAT (map to premises costs in accounts)	9	36
Charges to operating expenditure for on-SOFP IFRIC 12 schemes e.g. PFI	33,249	35,310
Car Parking and security	12	8
Hospitality	68	70
Other losses and special payments	26	6
Other NHS Charitable funds resources expended	471	471
Other	103	208
TOTAL	**606,065**	**570,161**

Other expenditure includes numerous small amounts.

Audit fees are shown inclusive of vat where this is not recoverable.

5.2 The Late Payment of Commercial Debts (interest) Act 1998

During the year 2024/25 the Trust paid £nil (2023/24 £nil) for interest for the late payment of commercial debts.

	Year Ended 31 March 2025			Year Ended 31 March 2024		
	Total	Permanent	Other	Total	Permanent	Other
	£'000	£'000	£'000	£'000	£'000	£'000
Salaries and wages	316,450	314,094	2,356	284,045	281,191	2,854
Social security costs	31,424	31,424	0	29,323	29,323	0
Apprenticeship Levy	1,548	1,548	0	1,444	1,444	0
Employer's contributions to NHS Pensions	31,344	31,344	0	29,934	29,934	0
Pension cost - employer contributions paid by NHSE on provider's behalf (2024/25: 9.4%, 2023/24: 6.3%)	20,335	20,335	0	12,424	12,424	0
Pension Cost - other	68	68	0	64	64	0
Temporary Staff (including agency)	2,799	0	2,799	3,071	0	3,071
NHS Charitable funds staff	174	174	0	136	136	0
Total Staff costs	404,142	398,987	5,155	360,441	354,516	5,925
Costs capitalised as part of assets	2,456	2,456	0	1,114	1,114	0
Total staff costs excluding capitalised costs	401,686	396,531	5,155	359,327	353,402	5,925

6.2 Average Number of Persons Employed

This information can now be found in the staff report section of the accountability report within the annual report and accounts.

6.3 Employee Benefits

Employees benefits include payment of salaries/wages and pension contributions. There were no other employee benefits paid in 2024/25 (2023/24 £ nil).

6.4 Retirements due to Ill-health

During the year 2024/25 there 1 early retirements from the Trust on the grounds of ill-health (in 2023/24 there were 6)

The estimated additional pension liability of this ill-health retirement will be £10,229 (2023/24: £565,906).

The cost of these ill-health retirements is borne by the NHS Business Services Authority - Pensions Division, and therefore there is no liability or provision in the Trust annual report and accounts.

6.5 Other Compensation Schemes and Exit Packages

This information can now be found in the staff report section of the annual report and accounts.

7 Directors' Remuneration and other benefits (Group)

	Year Ended 31 March 2025 £'000	Year Ended 31 March 2024 £'000
Salary	1,726	1,325
Taxable Benefits	0	0
Performance Related Bonuses	0	0
Employer contributions to a pension scheme	148	71
Total	**1,874**	**1,396**

Further details of directors' remuneration can be found in the remuneration report.

8 Right of Use Assets (Group and Foundation Trust)

8.1 Right of use assets 2024/25

The Trust's lease contracts comprise leases of operational buildings, medical equipment and motor vehicles. Most are individually insignificant. Two elements, however, are significant in their own right:

1. The Trusts most significant lease relates to its community services operated from Community Health Partnership premises. This lease is currently undocumented, and the Trust has used a 10-year lease term to account for the lease transaction. The 10-year term has taken into consideration the Trust and System business plans as well as the terms of other property leases the Trust currently has. The value of the asset at 31st March 2025 was £13.460m. The Trust has measured the right-of-use asset applying a cost model. The Trust has applied the cost model given that the lease is property but are simply rooms within a much larger building and the agreement has a relatively short economic life. The lease was also subject to a re-measurement in 2024/25 due to an inflation increase.
2. The Trust also has a lease relating to further community services operated from NHS Property Services Limited premises. This lease is currently undocumented, and the Trust has used a 10-year lease term to account for the lease transaction. The 10-year term has taken into consideration the Trust and System business plans as well as the terms of other property leases the Trust currently has. The value of the asset at 31st March 2025 was £2.446m. The Trust has measured the right-of-use asset applying a cost model. The Trust has applied the cost model given that the lease is property but are simply rooms within a much larger building and the agreement has a relatively short economic life. The lease was also subject to a re-measurement in 2024/25 due to an inflation increase.

2024/25	Total £'000	Land & Buildings £'000	Plant & Machinery £'000	Transport £'000
Valuation/gross cost 1 April 2024	22,827	22,625	175	27
Transfers by absorption	477	477	0	0
Additions - lease liability	669	0	669	0
Remeasurements of lease liability	796	796	0	0
Gross value 31 March 2025	24,769	23,898	844	27
Accumulated depreciation at 1 April 2024	4,648	4,490	132	26
Transfers by absorption	31	31	0	0
Provided during the year - right of use asset	2,522	2,388	133	1
Provided during the year - peppercorn leased asset	33	33	0	0
Accumulated depreciation 31 March 2025	7,234	6,942	265	27
Net book value 31 March 2025	17,535	16,956	579	0
Net book value of right of use assets leased from other DHSC group bodies	15,906	15,906	0	0

There are no right of use assets with other NHS providers.

2023/24	Total £'000	Land & Buildings £'000	Plant & Machinery £'000	Transport £'000
Valuation/gross cost 1 April 2023	22,167	21,965	175	27
Remeasurements of lease liability	660	660	0	0
Gross cost value 31 March 2024	22,827	22,625	175	27
Accumulated depreciation 1 April 2023	2,305	2,205	83	17
Provided during the year	2,343	2,285	49	9
Accumulated depreciation at 31 March 2024	4,648	4,490	132	26
Net book Value 31 March 2024	18,179	18,135	43	1
Net book value of right of use assets leased from other DHSC group bodies	17,382	17,382	0	0
There are no right of use assets with other NHS providers.				

8.2 Reconciliation of the carrying value of lease liabilities

Lease liabilities are included within borrowings in the statement of financial position. A breakdown of borrowings is disclosed in note 19.

2024/25	Total £'000	Leased from other DHSC bodies £000	Lease from bodies external to government £000
Carrying value at 1 April 2024	18,347	17,541	806
Lease additions	669	0	669
Transfers by absorption	61	0	61
Lease remeasurement	796	796	0
Interest charge arising in year	185	152	33
Lease payments (cash outflows)	(2,638)	(2,368)	(270)
	17,420	16,121	1,299

2023/24	Total £'000	Leased from other DHSC bodies £000	Lease from bodies external to government £000
Carrying value at 1 April 2023	19,955	18,982	973
Lease additions	0	0	0
Lease remeasurement	660	660	0
Interest charge arising in year	173	165	8
Lease payments (cash outflows)	(2,441)	(2,266)	(175)
Carrying value at 31 March 2024	18,347	17,541	806

Lease payments for short term leases, leases of low value underlying assets and variable lease payments not dependent on an index or rate are recognised in operating expenditure.

These payments are disclosed in note 5.1. Cash outflows in respect of leases recognised on-SOFP are disclosed in the reconciliation above.

8.3 Lease liabilities maturity analysis

2024/25	Total £'000	Leased from other DHSC bodies £000	Lease from bodies external to government £000
Undiscounted future lease payments payable in:			
- not later than one year;	2,669	2,369	300
- later than one year and not later than five years;	10,394	9,475	919
- later than five years.	4,880	4,738	142
Total gross future lease payments	17,943	16,582	1,361
Finance charges allocated to future periods	(523)	(461)	(62)
Net lease liabilities	17,420	16,121	1,299

2023/24	Total £'000	Leased from other DHSC bodies £000	Lease from bodies external to government £000
Undiscounted future lease payments payable in:			
- not later than one year;	2,405	2,266	139
- later than one year and not later than five years;	9,407	8,861	546
- later than five years.	7,143	7,000	143
Total gross future lease payments	18,955	18,127	828
Finance charges allocated to future periods	(608)	(586)	(22)
Net lease liabilities	18,347	17,541	806

9 Finance Income (Group)

	Year Ended 31 March 2025 £'000	Year Ended 31 March 2024 £'000
Interest on bank accounts	1,380	2,015
NHS Charitable funds: investment income	93	110
Performance Related Bonuses	1,473	2,125

10 Finance Expense - Financial Liabilities (Group and Foundation Trust)

	Year Ended 31 March 2025 £'000	Year Ended 31 March 2024 £'000
Interest Expense		
Other interest:		
Interest on lease obligations	185	173
Finance Costs in PFI obligations:		
Main Finance Costs	11,695	11,161
Remeasurement of PFI/other service concession liability resulting from a change index or rate	24,473	30,431
	36,353	41,765

11 Corporation tax expense (Group)

The activities of the subsidiary company Dudley Clinical Services Limited have given rise to a corporation tax liability recognised in the Statement of Comprehensive Income of £91,000 (2023/24 £65,000). The activities of the Trust and the Charity do not incur corporation tax.

UK Corporation Tax Expense

	Year Ended 31 March 2025 £'000	Year Ended 31 March 2024 £'000
Current tax expense		
Current year	91	65
Total income tax expense in Statement of Comprehensive Income	91	65

Reconciliation of effective tax rate

	Year Ended 31 March 2025 £'000	Year Ended 31 March 2024 £'000
Effective tax charge percentage	25.00%	25.00%
Tax if effective tax rate charged on surpluses before tax	0	0
Effect of:		
(Surpluses)/losses not subject to tax	91	65
Total income tax charge for the year	91	65

12 Intangible Assets

2024/25	Group and Foundation Trust	
	Computer Software £'000	Total £'000
Gross Cost as at 1 April 2024	19,035	19,035
Additions Purchased	2,758	2,758
Disposals	0	0
Gross Cost as at 31 March 2025	21,793	21,793
Accumulated Amortisation as at 1 April 2024	9,909	9,909
Provided during the Year	2,037	2,037
Disposals	0	0
Accumulated Amortisation as at 31 March 2025	11,946	11,946
Net Book Value		
Purchased at 31 March 2024	9,124	9,124
Donated at 31 March 2024	2	2
Total at 31 March 2024	9,126	9,126
Net Book Value		
Purchased at 31 March 2025	9,847	9,847
Donated at 31 March 2025	0	0
Total at 31 March 2025	9,847	9,847

2023/24	Group and Foundation Trust	
	Computer Software £'000	Total £'000
Gross Cost as at 1 April 2023	16,886	16,886
Additions Purchased	2,298	2,298
Disposals	(149)	(149)
Gross Cost as at 31 March 2024	19,035	19,035
Accumulated Amortisation as at 1 April 2023	8,372	8,372
Provided during the Year	1,686	1,686
Disposals	(149)	(149)
Accumulated Amortisation as at 31 March 2024	9,909	9,909
Net Book Value		
Purchased at 31 March 2023	8,510	8,510
Donated at 31 March 2023	4	4
Total at 31 March 2023	8,514	8,514
Net Book Value		
Purchased at 31 March 2024	9,124	9,124
Donated at 31 March 2024	2	2
Total at 31 March 2024	9,126	9,126

A separate schedule for the Trust intangible assets has not been produced as the NHS Charity intangible assets represent £nil (31 March 2024 £nil) of the net book value held by the Group and the subsidiary does not have any intangible assets.

The valuation of intangible assets is on the basis described in the accounting policy in note 1.6 on page 11. No revaluation has taken place, and historic cost is considered to be the appropriate valuation basis.

13 Property, Plant and Equipment

13.1 2024/25

Group and Foundation Trust

	Total £'000	Land £'000	Buildings excluding dwellings £'000	Dwellings £'000	Assets under Construction & POA £'000	Plant & Machinery £'000	Transport Equipment £'000	Information Technology £'000	Furniture & Fittings £'000
Cost at 1 April 2024	213,156	5,180	136,973	0	963	52,194	512	16,158	1,176
Transfers by absorption	640	0	0	0	0	2	0	577	61
Additions - purchased	24,048	0	6,716	0	8,092	6,486	0	2,754	0
Additions - donated	128	0	0	0	0	104	0	0	24
Impairments charged to operating expenses	(7,669)	0	(7,669)	0	0	0	0	0	0
Impairments charged to the revaluation reserve	0	0	0	0	0	0	0	0	0
Revaluations	(975)	0	(975)	0	0	0	0	0	0
Disposals	(3,008)	0	0	0	0	(3,008)	0	0	0
Cost at 31 March 2025	226,319	5,180	135,045	0	9,055	55,777	512	19,489	1,261
Accumulated depreciation at 1 April 2024	26,385	0	93	0	0	17,463	181	7,659	989
Transfers by absorption	347	0	0	0	0	2	0	313	32
Provided during the year	13,589	0	6,875	0	0	4,700	47	1,892	75
Impairments charged to operating expenses	(5,476)	0	(5,476)	0	0	0	0	0	0
Impairments charged to the revaluation reserve	0	0	0	0	0	0	0	0	0
Revaluations	(1,332)	0	(1,332)	0	0	0	0	0	0
Disposals	(2,999)	0	0	0	0	(2,999)	0	0	0???
Accumulated depreciation at 31 March 2025	30,514	0	160	0	0	19,166	228	9,864	1,096
Net book value 31 March 2024									
Owned - purchased	63,546	5,180	29,216	0	0	20,166	331	8,490	163
On SOFP PFI contracts and other service concession arrangements	122,612	0	107,664	0	963	13,985	0	0	0
Owned - donated / granted	613	0	0	0	0	580	0	9	24
NBV total at 31 March 2024	186,771	5,180	136,880	0	963	34,731	331	8,499	187
Net book value 31 March 2025									
Owned - purchased	68,071	5,180	29,405	0	585	22,899	284	9,598	120
On SOFP PFI contracts and other service concession arrangements	126,787	0	105,150	0	8,470	13,167	0	0	0
Owned - donated / granted	946	0	330	0	0	544	0	27	45
NBV total at 31 March 2025	195,804	5,180	134,885	0	9,055	36,610	284	9,625	165

A separate schedule for the Trust tangible assets has not been produced as neither the NHS Charity nor the subsidiary Dudley Clinical Services Limited have any tangible assets.

13 Property, Plant and Equipment

13.2 2023/24

Group and Foundation Trust

	Total £'000	Land £'000	Buildings excluding dwellings £'000	Assets under Construction & POA £'000	Plant & Machinery £'000	Transport Equipment £'000	Information Technology £'000	Furniture & Fittings £'000
Cost at 1 April 2023	280,360	12,925	203,027	0	45,622	512	17,056	1,218
Prior period adjustment	3,992	0	0	0	3,992	0	0	0
Additions - purchased	11,478	0	2,327	963	6,999	0	1,189	0
Additions - donated	146	0	0	0	146	0	0	0
Impairments charged to operating expenses	(15,032)	(478)	(13,951)	0	(603)	0	0	0
Impairments charged to the revaluation reserve	(61,696)	(7,267)	(54,429)	0	0	0	0	0
Revaluations	(1)	0	(1)	0	0	0	0	0
Disposals	(6,091)	0	0	0	(3,962)	0	(2,087)	(42)
Cost at 31 March 2024	213,156	5,180	136,973	963	52,194	512	16,158	1,176
Accumulated depreciation at 1 April 2023	31,516	0	30	0	22,333	132	8,062	959
Prior period adjustment	(4,995)	0	0	0	(4,995)	0	0	0
Provided during the year	12,196	0	6,396	0	3,995	49	1,684	72
Impairments charged to the revaluation reserve	(6,069)	0	(6,069)	0	0	0	0	0
Revaluations	(264)	0	(264)	0	0	0	0	0
Disposals	(5,999)	0	0	0	(3,870)	0	(2,087)	(42)
Accumulated depreciation at 31 March 2024	26,385	0	93	0	17,463	181	7,659	989
Net book value 31 March 2023								
Owned - purchased	68,843	12,925	30,514	0	15,814	380	8,978	232
On SOFP PFI contracts and other service concession arrangements	178,767	0	172,483	0	6,284	0	0	0
Owned - donated / granted	146	0	0	0	103	0	16	27
Owned - equipment donated from DHSC and NHSE for COVID response	1,088	0	0	0	1,088	0	0	0
NBV total at 31 March 2023	248,844	12,925	202,997	0	23,289	380	8,994	259
Net book value 31 March 2024								
Owned - purchased	63,546	5,180	29,216	0	20,166	331	8,490	163
On SOFP PFI contracts and other service concession arrangements	122,612	0	107,664	963	13,985	0	0	0
Owned - donated / granted	613	0	0	0	580	0	9	24
NBV total at 31 March 2024	186,771	5,180	136,880	963	34,731	331	8,499	187

A separate schedule for the Trust tangible assets has not been produced as neither the NHS Charity nor the subsidiary Dudley Clinical Services Limited have any tangible assets.

13 Property, Plant and Equipment (continued)

Group and Foundation Trust

13.3 Financing of Property, Plant and Equipment

	Total £'000	Land £'000	Buildings excluding dwellings £'000	Assets under Construction £'000	Plant & Machinery £'000	Transport Equipment £'000	Information Technology £'000	Furniture & Fittings £'000
Net Book Value at 31 March 2024								
Owned - purchased	63,546	5,180	29,216	0	20,166	331	8,490	163
On SOFP PFI contracts and other service concession arrangements	122,612	0	107,664	963	13,985	0	0	0
Off-SOFP PFI residual interests	0	0	0	0	0	0	0	0
Owned - donated / granted	613	0	0	0	580	0	9	24
	186,771	5,180	136,880	963	34,731	331	8,499	187
Net Book Value at 31 March 2025								
Owned - purchased	68,071	5,180	29,405	585	22,899	284	9,598	120
On SOFP PFI contracts and other service concession arrangements	126,787	0	105,150	8,470	13,167	0	0	0
Off-SOFP PFI residual interests	0	0	0	0	0	0	0	0
Owned - donated / granted	946	0	330	0	544	0	27	45
	195,804	5,180	134,885	9,055	36,610	284	9,625	165

A separate schedule for the Trust tangible assets has not been produced as neither the NHS Charity or the subsidiary Dudley Clinical Services Limited have any tangible assets.

13.4 Analysis of Property, Plant and Equipment

Group and Foundation Trust

	Total £'000	Land £'000	Buildings excluding dwellings £'000	Assets under Construction £'000	Plant & Machinery £'000	Transport Equipment £'000	Information Technology £'000	Furniture & Fittings £'000
Net Book Value at 31 March 2024								
Commissioner Requested Assets	134,581	5,180	129,401	0	0	0	0	0
Non Commissioner Requested Assets	52,190	0	7,479	963	34,731	331	8,499	187
	186,771	5,180	136,880	963	34,731	331	8,499	187
Net Book Value at 31 March 2025								
Commissioner Requested Assets	132,471	5,180	127,291	0	0	0	0	0
Non Commissioner Requested Assets	63,333	0	7,594	9,055	36,610	284	9,625	165
	195,804	5,180	134,885	9,055	36,610	284	9,625	165

Commissioner Requested assets are land and buildings owned or leased by the Foundation Trust, the disposal of which may affect the Trust's ability to provide these requested goods and services.

Commissioner requested assets are land and buildings owned or leased by the Foundation Trust, the disposal of which may affect the Trust's ability to provide these requested goods and services.

* The Trust has included a prior period adjustment in the financial statements relating to the valuation of imaging equipment contained in the Trust's PFI contract. In 2023/24 the Trust was required to transition to the IFRS16 accounting standard for the PFI contract, but this did not allow for the valuation of equipment in PFI schemes. The Trust has therefore reviewed the valuation of the equipment in 2024/25 and restated the 2023/24 financial statements to value the equipment in line with the lease cost methodology used in IFRS16.

** The prior year has been restated to align with note 13.3.

	Total £'000	Land £'000	Buildings excluding dwellings £'000	Assets under Construction £'000	Plant & Machinery £'000	Transport Equipment £'000	Information Technology £'000	Furniture & Fittings £'000
Final Position								
Net Book Value at 31 March 2024								
Commissioner Requested Assets	134,581	5,180	129,401	0	0	0	0	0
Non-Commissioner Requested Assets	52,190	0	7,479	963	34,731	331	8,499	187
	186,771	5,180	136,880	963	34,731	331	8,499	187
Restatement *								
Net Book Value at 31 March 2024								
Commissioner Requested Assets	0	0	0	0	0	0	0	0
Non-Commissioner Requested Assets	8,987	0	0	0	8,987	0	0	0
	8,987	0	0	0	8,987	0	0	0
Net Book Value at 31 March 2024								
Commissioner Requested Assets	134,581	5,180	129,401	0	0	0	0	0
Non-Commissioner Requested Assets	43,203	0	7,479	963	25,744	331	8,499	187
Restatement **								
Net Book Value at 31 March 2024								
Commissioner Requested Assets	(73,862)	(7,745)	(66,117)	0	0	0	0	0
Non-Commissioner Requested Assets	963	0	0	963	0	0	0	0
	(72,899)	(7,745)	(66,117)	963	0	0	0	0
As per 23/24 published accounts								
Net Book Value at 31 March 2024								
Commissioner Requested Assets	208,443	12,925	195,518	0	0	0	0	0
Non-Commissioner Requested Assets	42,240	0	7,479	0	25,744	331	8,499	187
	250,683	12,925	202,997	0	25,744	331	8,499	187

13 Property, Plant and Equipment (continued)

13.5 Economic Life of Assets

The estimated useful economic lives of the Group's intangible and tangible assets are as follows with each asset being depreciated over this year, as described in accounting policy notes 1.5 and 1.6.

	Minimum Life Years	Maximum Life Years
Intangible		
Software Licences	2	15
Tangible		
Buildings excluding dwellings	2	79
Plant & Machinery	1	15
Transport Equipment	7	10
Information Technology	3	15
Furniture & Fittings	3	10

In January 2019, The Royal Institution of Chartered Surveyors issued guidance clarifying that where a large asset includes a number of components with significantly different asset lives, then these components must be treated as separate assets and depreciated over their own useful lives. The Trust's asset valuation, undertaken as at 31 March 2025, took account of this clarification.

13.6 Impairment Losses

The Trust carried out an impairment review of its non-current assets in March 2025. For land and buildings, the Trust received a valuation report from Cushman & Wakefield prepared on a Modern Equivalent Asset (MEA) basis. The valuation report was prepared in accordance with the terms of the Royal Institution of Chartered Surveyors' Valuation Standards, 6th Edition, insofar as the terms are consistent with the requirements of HM Treasury, the National Health Service and NHSI. The valuation also included a review of functional obsolescence. On application there was a decrease in value of land and buildings (£1.826m) compared to the carrying value following the March 2024 valuation. In line with IFRS the Trust took the decrease in value of the buildings directly to the revaluation reserve. The valuation for Russells Hall Hospital buildings (£1.621m) and a new CT building at Guest (£0.572m) resulted in an impairment of £2.193m which the Trust has taken to the income and expenditure account.

In addition the Trust undertook an impairment review of equipment and intangible assets; the carrying value of these was deemed to fairly reflect the value of the assets. Unforeseen obsolescence in 2023/24 relates to equipment donated to the Trust during COVID which was deemed not suitable for use within the Trust (£0.603m).

	31 March 2025 £'000	31 March 2024 £'000
Impairment of Assets		
Unforeseen obsolescence	0	603
Changes in market price	2,193	14,429
Total impairments charged to operating surplus/deficit	2,193	15,032
Total net impairments charged to the revaluation reserve	0	55,627
Total Impairments	2,193	70,659

13.7 Asset Valuations

A Modern Equivalent Asset Optimised Alternative Site valuation was undertaken as at 1st April 2018 by the District Valuer. The underlying principle is that the valuation of land and buildings should reflect a modern configuration of the estate required for the provision of the same services as already provided by the existing estate. With service delivery requirements evolving, this requires the Trust to consider whether the existing buildings and sites are optimal in terms of number and size. If the Trust were starting with a 'clean sheet', the Modern Equivalent Asset aligned to service delivery would be very different to the current layout in terms of building configuration and the size of the land. The net book value of the Trust's land and buildings decreased by £52,412,000 between 31 March 2018 and 31 March 2019, of which £41,768,000 was the result of using an optimised alternative site valuation.

13.8 Non-Current Assets Held for Sale and assets in disposal groups

There are no Non-Current Assets held for sale in 2024/25.

13.9 Capital Commitments

Commitments under capital expenditure contracts at the end of the year, not otherwise included in the annual report and accounts were £7,752,000 (2023/24 £2,021,000). The amount relating to property, plant and equipment is £7,752,000 (2023/24 £2,021,000) and intangible assets £nil (2023/24 £nil).

13.10 Gains/losses on disposal /derecognition of assets

	31 March 2025 £'000	31 March 2024 £'000
Gains on disposal/derecognition of other property, plant and equipment	41	90
Losses on disposal/derecognition of other property, plant and equipment	(10)	(21)
	31	69

14 Other Investments / financial assets

14.1 Investments

	Group	
	2024/25 £'000	2023/24 £'000
Non-Current		
NHS Charitable funds: investments/financial assets	1,382	202
Total	1,382	202

There are no current investments (2023/24 £Nil).

Non-current funds are investments in stocks and shares which are only held by The Dudley Group NHS Foundation Trust Charity.

Movements in Non-current Investments

	2024/25 £'000	2023/24 £'000
Carrying Value at 1 April	202	1,433
Fair value movements taken to OCI (for equity instruments designated as FV through OCI)	(20)	(2)
Additions	1,200	0
Disposals	0	(1,229)
Carrying Value at 31 March	1,382	202

A separate schedule for the Trust investments or financial assets has not been produced as the Trust does not have any investments or financial assets (2023/24 £nil).

14.2 Subsidiaries

The Trust wholly owns the subsidiary company Dudley Clinical Services Limited with a share of £1. Dudley Clinical Services Limited, was registered in the UK company number 8245934, and commenced trading on 9 October 2012.

The registered address for the Trust, Charity and Subsidiary is Russells Hall Hospital, Dudley, DY1 2HQ.

15 Inventories

	Group		Foundation Trust	
	31 March 2025 £'000	31 March 2024 £'000	31 March 2025 £'000	31 March 2024 £'000
Drugs	2,186	2,714	1,976	2,544
Consumables	2,289	2,322	2,289	2,322
Consumables donated from DHSC group bodies	26	26	26	26
Energy	30	44	30	44
Other	137	122	137	122
TOTAL Inventories	**4,668**	**5,228**	**4,458**	**5,058**

The Group expensed inventories during the year of £52,891,000 (2023/24 £50,255,000), of which £49,278,000 (2023/24 £45,792,000) related to the Trust.

The Trust charged £nil to operating expenses in the year due to write-downs of obsolete inventories (2023/24 £87,000). This 23/24 expense occurred due to the expiry of stock which was unable to be used. There were no other write-offs of inventories within the Group.

16 Receivables

16.1 Trade and Other Receivables

	Group		Foundation Trust	
Current	**31 March 2025**	**31 March 2024**	**31 March 2025**	**31 March 2024**
	£'000	**£'000**	**£'000**	**£'000**
Contract receivables (IFRS15): invoiced	6,838	6,193	6,838	6,193
Contract receivables (IFRS15): not yet invoiced/non-invoiced	0	267	0	267
Contract assets (IFRS15)	0	0	0	0
Allowance for impaired contract receivables/assets	(1,107)	(780)	(1,107)	(780)
Allowance for impaired other receivables	0	0	0	0
Deposits and Advances	10	1	10	1
Prepayments(revenue) non PFI	5,205	4,887	5,199	4,880
Interest Receivable	138	153	138	153
PDC dividend receivable	0	0	0	0
VAT Receivable	1,660	1,588	1,506	1,403
Corporation and other taxes receivable	0	0	0	0
Clinician pension tax provision reimbursement funding from NHSE	29	22	29	22
Other receivables	0	0	0	0
NHS Charitable funds: receivables	71	31	0	0
TOTAL CURRENT RECEIVABLES	**12,844**	**12,362**	**12,613**	**12,139**

	Group		Foundation Trust	
Non-Current	**31 March 2025**	**31 March 2024**	**31 March 2025**	**31 March 2024**
	£'000	**£'000**	**£'000**	**£'000**
Contract receivables (IFRS15): not yet invoiced/non-invoiced	1,433	1,390	1,433	1,390
Allowance for impaired contract receivables/assets	(350)	(321)	(350)	(321)
Prepayments(revenue) non PFI	1,303	1,391	1,303	1,391
PFI Lifecycle prepayments (revenue)	16,339	15,760	16,339	15,760
Clinician pension tax provision reimbursement funding from NHSE	442	429	442	429
Other Receivables	0	0	0	0
NHS Charitable funds: receivables	0	0	0	0
TOTAL NON-CURRENT RECEIVABLES	**19,167**	**18,649**	**19,167**	**18,649**
Of which receivable from NHS and DHSC group bodies:				
Current	4,131	4,407	4,131	4,407
Non-current	442	429	442	429

Current and non-current contract assets include the NHS Injury Scheme (was RTA).

Included within trade and other receivables of both Group and Trust are balances with a carrying amount of £5,731,000 (31 March 2024 £5,815,000) which are past due at the reporting date but for which no specific provision has been made as they are considered to be recoverable based on previous trading history.

16 Receivables (continued)

16.2 Allowances for credit losses (doubtful debts)

	Group and Foundation Trust		
	Total £'000	Contract Receivables/ Contract Assets £'000	All Other Receivables £'000
Allowances at 1 April 2024	1,101	1,101	0
Changes in the calculation of existing allowances	822	822	0
Reversals of allowances (where receivable is collected in year)	(432)	(432)	0
Utilisation of allowances (where allowance is written off)	(34)	(34)	0
Allowances as at 31 March 2025	1,457	1,457	0
Loss/(gain) recognised in expenditure note 5.	390		0

	Group and Foundation Trust		
	Total £'000	Contract Receivables/ Contract Assets £'000	All Other Receivables £'000
Allowances at 1 April 2023	1058	1058	0
New allowances arising	391	391	0
Reversals of allowances (where receivable is collected in year)	(345)	(345)	0
Utilisation of allowances (where allowance is written off)	(3)	(3)	0
Allowances as at 31 March 2024	1,101	1,101	0
Loss/(gain) recognised in expenditure note 5.	46		0

Separate schedules for the Trust analysis of receivables have not been produced as the NHS Charity receivables are without credit loss assessment and represent just £71,000 (31 March 2024 £31,000) of the value shown by the Group in the 0-30 days category and the subsidiary did not have any receivables outstanding.

Credit loss impairments are not recognised against NHS receivables, in accordance with the DHSC Group Accounting Manual.

17 Cash and Cash Equivalents

	Group		Foundation Trust	
	31 March 2025 £'000	31 March 2024 £'000	31 March 2025 £'000	31 March 2024 £'000
At 1 April	22,119	13,778	18,404	11,616
Transfers By Absorption	1,819	0	1,819	0
Net change in year	9,373	8,341	10,388	6,788
At 31 March	33,311	22,119	30,611	18,404
Analysed as follows:				
Cash at commercial banks and in hand	1,693	1,359	1	1
Cash with the Government Banking Service	31,618	20,760	30,610	18,403
Other current investments	0	0	0	0
Cash and cash equivalents as in Statement of Financial Position	**33,311**	**22,119**	**30,611**	**18,404**
Cash and cash equivalents as in Statement of Cash Flows	**33,311**	**22,119**	**30,611**	**18,404**

18 Trade and Other Payables

	Group		Foundation Trust	
	31 March 2025 £'000	31 March 2024 £'000	31 March 2025 £'000	31 March 2024 £'000
Current				
Trade payables	2,344	2,352	2,344	2,181
Capital payables	5,171	2,603	5,171	2,603
Accruals	4,859	6,546	4,774	6,675
Annual leave accrual	0	0	0	0
Vat payable	54	40	54	40
Taxes payable	8,922	8,088	8,829	8,021
PDC dividend payable	0	0	0	0
Pension contributions payable	4,521	3,767	4,521	3,767
Other payables	13,606	12,315	13,606	12,315
NHS Charitable Funds trade and other payables	35	30	0	0
TOTAL CURRENT TRADE & OTHER PAYABLES	39,512	35,741	39,299	35,602
Non-Current				
Trade payables	0	0	0	0
TOTAL NON-CURRENT TRADE & OTHER PAYABLES	0	0	0	0
Of which payables from NHS and DHSC group bodies:				
Current:	4,023	2,787	4,023	2,787
Non-current:	0	0	0	0

Taxes payable consists of employment taxation only (Pay as You Earn and National Insurance contributions), owed to HM Revenue and Customs at the year end, and Corporation Tax payable by the subsidiary Dudley Clinical Services Limited.

Other payables include superannuation owed to NHS Pensions.

19 Borrowings

	Group and Foundation Trust	
	As at 31 March 2025 £'000	As at 31 March 2024 £'000
Current		
Lease liabilities	2,510	2254
Obligations under Private Finance Initiative contracts (excl lifecycle)	10,645	10,914
Total Current borrowings	13,155	13,168
Non-Current		
Lease liabilities	14,910	16,093
Obligations under Private Finance Initiative contracts	275,198	261,371
Total Other Non-Current Liabilities	290,108	277,464
Current:	4,023	2,787
Non-current:	0	0

A separate schedule for the Trust borrowings has not been produced as neither the NHS Charity nor the subsidiary Dudley Clinical Services Limited have any borrowings.

Reconciliation of liabilities arising from financing activities

	Total £'000	Lease Liabilities £'000	PFI and other service concessions £'000
Carrying value 1 April 2024	290,632	18,347	272,285
Cash movements:			
Financing cash flows - principle	(13,367)	(2,453)	(10,914)
Financing cash flows - interest	(11,881)	(185)	(11,696)
Non-cash movements:			
Transfers by absorption	61	61	0
Additions	669	669	0
Lease liability remeasurements	796	796	0
Remeasurement of PFI/other service concession resulting from change in index or rate	24,473	0	24473
Interest charge arising in year	11,880	185	11,695
Carrying value 31 March 2025	303,263	17,420	285,843
Carrying value 1 April 2023	128,475	19955	108520
Cash movements:			
Financing cash flows - principle	(13,134)	(2,268)	(10,866)
Financing cash flows - interest	(11,334)	(173)	(11,161)
Non-cash movements:			
Application of IFRS16 measurement principles to PFI liability on 1 April 2023	144,200	0	144200
Lease liability remeasurements	660	660	0
Remeasurement of PFI/other service concession resulting from change in index or rate	30,431	0	30,431
Interest charge arising in year	11,334	173	11,161
Carrying value 31 March 2024	290,632	18,347	272,285

19 Borrowings

	Group and Foundation Trust	
	As at 31 March 2025 £'000	As at 31 March 2024 £'000
Current		
Other legal claims	196	154
2019/20 Clinician's pension tax reimbursement	29	22
Total	225	176
Non-Current		
Other legal claims	125	125
2019/20 Clinician's pension tax reimbursement	442	429
Total	567	554

	Total £'000	Other legal claims £'000	Clinical pension tax reimbursement £'000	Lease dilapidations £'000
At 1 April 2024	730	154	451	125
Change in discount rate	(4)	0	(4)	0
Arising during the year	260	251	9	0
Utilised during the year	(136)	(128)	(8)	0
Reversed unused	(81)	(81)	0	0
Unwinding of discount	23	0	23	0
At 31 March 2025	792	196	471	125
Expected timing of cashflows:				
- not later than one year;	225	196	29	0
- later than one year and not later than five years;	185	0	60	125
- later than five years.	382	0	382	0
TOTAL	792	196	471	125

Other Legal Claims include claims under Employers' and Public Liability.

Clinicians pension tax reimbursement relates to costs associated with the pension tax scheme. Clinicians who are members of the NHS Pension Scheme and who, as a result of work undertaken in this tax year (2019/20) face a tax charge in respect of the growth of their NHS pension benefits above their pension savings annual allowance threshold will be able to have this charge paid by the NHS Pension Scheme. Individual Trusts have been instructed to reflect this future estimated liability within the provisions note and include a corresponding amount as owing from NHS England within the receivables note.

The NHS Litigation Authority has included in its provisions at 31 March 2025: £239,109,728 (2023/24: £215,932,000) in respect of clinical negligence liabilities for the Trust.

21 Other Liabilities

	Group		Foundation Trust	
	31 March 2025 £'000	31 March 2024 £'000	31 March 2025 £'000	31 March 2024 £'000
Current				
Deferred Income	2,139	3,366	2,139	3,366
TOTAL OTHER CURRENT LIABILITIES	2,139	3,366	2,139	3,366

Where income has been received for a specific activity which is to be delivered in the following financial year, that income is deferred.

22 Deferred Tax (Group)

Liability for corporation tax only arises from the activity of the commercial subsidiary, the activities of the Trust do not incur corporation tax, see accounting policy note 1.18 for detailed explanation.

The subsidiary did not have any deferred tax in 2024/25 (2023/24 £nil).

23 Events after the reporting year (Group and Foundation Trust)

There are no events after the reporting year.

24 Contingencies (Group and Foundation Trust)

Neither the Group nor the Trust have any contingent assets or liabilities in 2024/25 (2023/24 £nil).

25 Related Party Transactions (Group and Foundation Trust)

During the year none of the Department of Health Ministers, Trust Board Members or members of the key management staff, or parties related to any of them, have undertaken material transactions with The Dudley Group NHS Foundation Trust.

The Department of Health and Social Care is the parent department to the Trust and is considered to be a related party.

During 2024/25 the Trust has had a significant number of transactions over £300k with the Department, and with other entities for which the Department is regarded as the parent Department. These entities are:

- Black Country Healthcare NHS Foundation Trust
- NHS Birmingham and Solihull ICB
- NHS Black Country ICB
- NHS England
- NHS Herefordshire and Worcestershire ICB
- NHS Resolution

- NHS Shropshire, Telford and Wrekin ICB
- NHS Staffordshire and Stoke-on-Trent ICB
- Sandwell And West Birmingham Hospitals NHS Trust
- The Royal Wolverhampton NHS Trust
- Walsall Healthcare NHS Trust
- Worcestershire Acute Hospitals NHS Trust
- University Hospitals Birmingham NHS Foundation Trust

In addition, the Trust has had a number of material transactions with other Government Departments and Local Government Bodies. These related parties are summarised below by Government Department.

- Care Quality Commission
- Community Health Partnerships
- Dudley Metropolitan Borough Council
- HMRC
- NHS Blood & Transplant
- NHS Pensions
- NHS Property Services

Key management personnel, namely the Trust Board Directors, are those persons having authority and responsibility for planning, directing and controlling the activities of the Trust. During the year none of the key management personnel have parties related to them that have undertaken any material transactions with The Dudley Group NHS Foundation Trust.

The following members of the Trust Board hold positions in the organisations stated below.

	Trust position	Other Body	Position held
Sir David Nicholson	Chairperson	Sandwell & West Birmingham Hospitals NHS Trust; Walsall Healthcare NHS Trust; The Royal Wolverhampton NHS Trust	Chairperson
Diane Wake	Group Chief Executive	Sandwell & West Birmingham Hospitals NHS Trust	Chief Executive Officer
		Black Country ICB	CEO member on Board
Chris Walker	Interim Director of Finance	Dudley Clinical Services Ltd	Director
Elizabeth Abbiss	Director of Communications	The Royal Wolverhampton NHS Trust; Walsall Healthcare NHS Trust	Group Chief People Officer
Adam Thomas	Chief Strategy and Digital Officer	Dudley Clinical Services Ltd	Director
		Sandwell & West Birmingham NHS Trust and The Dudley Group NHS Foundation Trust	Group Chief Strategy and Digital Officer
Gary Crowe	Non Executive Director	University Hospital of North Midlands NHS Trust	Non Executive Director
		The Human Tissue Authority	Independent Member
Elizabeth Hughes	Non Executive Director	NHS England (formerly Health Education England)	Medical Director
		Birmingham and Solihull ICB	Non Executive Director/ Chair of Quality Committee
		Sandwell & West Birmingham NHS Trust	Research Director
Peter Featherstone	Non Executive Director	Shropshire Community Health NHS Trust	Non Executive Director
Lowell Williams	Non Executive Director	Dudley Clinical Services Ltd	Director
Vijith Randeniya	Vice Chair	Birmingham Women's and Children's Foundation Trust	Vice Chairman
		Dudley Clinical Services Ltd	Director

The annual report and accounts of the parent (the Trust) are presented together with the consolidated annual report and accounts and any transactions or balances between Group entities have been eliminated on consolidation. Dudley Group NHS Charity has a Corporate Trustee who are the Board members of the Trust. The Board members of Dudley Clinical Services Limited include from the Trust, Executive Directors Chris Walker and Adam Thomas, and Non-Executive Directors Lowell Williams as Chairman and Vijith Randeniya as a Director.

The Trust received revenue payments from Dudley Group NHS Charity for finance administration services totalling £57,000 (2023/24 £54,000). Dudley Clinical Services Limited received income of £5,692,000 (2023/24 £5,191,000) and incurred expenditure of £365,000 (2023/24 £347,000) with the Trust.

Dudley Group NHS Charity and Dudley Clinical Services Limited and do not have any transactions with any NHS or Government entity except those with its parent, the Trust and HMRC.

26 Private Finance Initiatives (Group and Foundation Trust)

26.1 PFI schemes on the Statement of Financial Position

The Dudley PFI project provided for the refurbishment and new building of major inpatient facilities at Russells Hall Hospital, the building of new facilities at Guest Hospital and Corbett Hospital. The Capital value of the scheme was £160,200,000.

The Project agreement runs for 40 years from May 2001. The Dudley PFI is a combination of buildings (including hard

Facilities Managed (FM) services) and a significant range of allied and clinical support services.

The standard Unitary Payment changes periodically as a consequence of:

- Inflation (based on RPI and reviewed annually)
- Deductions for poor performance (Deficiency points and financial penalties for poor performance or non-compliant incidents).
- Variations to the Project Agreement (PA) (agreed under Variations procedure in the PA)
- 50% of market testing or refinancing impact
- Energy tariff adjuster (the difference between actual energy tariff changes and the uplift that comes through RPI)
- Volume adjuster (computed by comparing actual in patient days against that in the schedule, with a tolerance of plus, or minus 3%)

The Trust has the rights to use the specified assets for the length of the Project Agreement and has the rights to expect provision of the range of allied and clinical support services. At the end of the Project Agreement the assets will transfer back to the Trust's ownership.

The PFI transaction meets the IFRIC 12 definition of a service concession, as interpreted in the Group Accounting Manual GAM) issued by Monitor, and therefore the Trust is required to account for the PFI scheme 'on-balance sheet'. In accordance with HM Treasury's FReM, the underlying assets are recognised as property, plant and equipment, together with an equivalent liability. Initial measurement of the asset and liability are in accordance with the initial measurement principles of IFRS 16. Where there are changes in future payments for the asset resulting from indexation of the unitary charge, the Trust remeasures the PFI liability by determining the revised payments for the remainder of the contract once the change in cash flows takes effect. The remeasurement adjustment is charged to finance costs in the Statement of Comprehensive Income.

The following obligations in respect of the PFI arrangement are recognised in the statement of financial position.

	As at 31 March 2025 £'000	As at 31 March 2024 £'000
Gross PFI Liabilities	401,378	395,585
of which liabilities are due		
- not later than one year;	22,302	22,609
- later than one year and not later than five years;	84,733	86,169
- later than five years.	294,343	286,807
Finance charges allocated to future periods	(115,535)	(123,300)
Net PFI liabilities	**285,843**	**272,285**
- not later than one year;	10,645	10,914
- later than one year and not later than five years;	42,580	43,656
- later than five years.	232,618	217,715

Total future commitments for on-SOFP schemes are as follows:

	31 March 2025 £'000	31 March 2024 £'000
- not later than one year;	57,682	55,741
- later than one year and not later than five years;	230,728	222,965
- later than five years.	639,166	668,894
Total	**927,576**	**947,600**

Analysis of amounts payable to the service concession operator:

	31 March 2025 £'000	31 March 2024 £'000
Unitary payment payable to the concession operator	**55,741**	**51,144**
Consisting of:		
- Interest charge	11,695	11,161
- Repayment of finance lease liability	10,914	10,866
- Service element	28,105	25,787
- Capital lifecycle maintenance	4,275	1,253
- Contingent rent Addition to lifecycle	0	0
- Prepayment	752	2,077
Total amount paid to concession operator	**55,741**	**51,144**
Other amounts paid to the service concession operator but not part of the unitary payment		
Amounts charges to revenue	5,144	9,523
Amounts capitalised	0	0
Total amount paid to the service concession operator	**60,885**	**60,667**

27 Net Gain/Loss on Transfer by Absorption

On 1 October 2024, there was a transfer of services from Dudley Integrated Healthcare NHS Trust to The Dudley Group NHS Foundation Trust. The assets and liabilities related to the transfer are shown below.

	Transfer 2024/25 £'000
PPE	
Cost/valuation: Plant & Machinery	2
Cost/valuation: Information technology	577
Cost/valuation: Furniture and fittings	61
Accumulated depreciation: Plant & Machinery	(2)
Accumulated depreciation: Information technology	(313)
Accumulated depreciation: Furniture and fittings	(32)
Net book value of PPE transferring	**293**
Right of use Assets	
RoU assets - leased from other DHSC group bodies	
Cost/valuation: Property	362
Accumulated depreciation: Property	(23)
Net book value of RoU assets - leased from other DHSC group bodies	**339**
RoU assets - leased from Local Authorities	
Cost/valuation: Property	69
Accumulated depreciation: Property	(4)
Net book value of RoU assets - leased from other Local Authorities	**65**
RoU assets - leased from bodies external to Government	
Cost/valuation: Property	46
Accumulated depreciation: Property	(4)
Net book value of RoU assets - leased from bodies external to Government	**42**
Total net book value of RoU assets transferring	**446**
Receivables	
Current: all other receivables	802
Total receivables transferring	**802**
Cash and cash equivalents	**1,819**
Trade and other payables	
Current: Annual leave accrual	(92)
Current: All other trade and other payables	(497)
Total trade and other payables transferring	**(589)**
Other liabilities	
Current: Other liabilities	(207)
Total other liabilities transferring	**(207)**
Borrowings	
Non-current: Lease liabilities with bodies external to government	(49)
Current: Lease liabilities with bodies external to government	(12)
Total borrowings transferring	**(61)**
Net gain/(loss) on absorption transfers	**2,503**
Revaluation reserve	
Revaluation reserve: RoU assets - leased from other DHSC group bodies	6
Revaluation reserve: RoU assets - leased from Local Authorities	2
Revaluation reserve: RoU assets - leased from ext to Gov bodies	2
Total revaluation reserve reinstated/eliminated	**10**

Impact of the transfer

	Group Including Transfer	Group Excluding Transfer
	31 March 2025 £'000	31 March 2025 £'000
Operating Income from patient care activities	588,787	588,787
Other Operating Income	33,685	33,685
Total Operating Income from continuing operations	**622,472**	**622,472**
Operating Expenses from continuing operations	(604,444)	(604,444)
Operating Surplus / (Deficit)	**18,028**	**18,028**
Finance Costs		
Finance income	1,473	1,473
Finance expense - financial liabilities	(36,353)	(36,353)
Net Finance Costs	**(34,880)**	**(34,880)**
Gain/(loss) of disposal of assets	31	31
Gains/(losses) from transfers by absorption	2,503	-
Corporation tax expense	(91)	(91)
Surplus/(Deficit) for the year from continuing operations	**(14,409)**	**(16,912)**
SURPLUS/(DEFICIT) FOR THE YEAR	**(14,409)**	**(16,912)**

28 Prior Period Adjustment

The Trust has included a prior period adjustment in the financial statements relating to the valuation of imaging equipment contained in the Trust's PFI contract. In 2023/24 the Trust was required to transition to the IFRS16 accounting standard for the PFI contract, but this did not allow for the valuation of equipment in PFI schemes. The Trust has therefore reviewed the valuation of the equipment in 2024/25 and restated the 2023/24 financial statements to value the equipment in line with the lease cost methodology used in IFRS16.

The PPA has resulted in a £8.987m increase in Property, plant and equipment offset by an equivalent increase in the Income and Expenditure reserve.

As these amounts related to prior years they have been treated as a prior period adjustment and reflected over the years affected. These prior period adjustments have been accounted for as follows:

	Group	Foundation Trust
	31 March 2025 £'000	31 March 2024 £'000
Balance Sheet		
Non-current assets		
Property, plant and equipment		
As previously reported	177,784	177,784
Prior period adjustment	8,987	8,987
Restated balance	186,771	186,771
Taxpayers' equity		
Income and expenditure reserve		
As previously reported	(148,335)	(149,946)
Prior period adjustment	8,987	8,987
Restated balance	(139,348)	(140,959)
Statements of Changes in Taxpayers' and Others' Equity		
Income and expenditure reserve		
Taxpayers' and Others' Equity at 1 April 2023	26,175	24,758
Prior period adjustment	8,987	8,987
In year movements	(174,510)	(174,705)
Restated taxpayers' and Others' Equity at 31 March 2024	(139,348)	(140,960)

In addition to the statements listed above, other notes affected by this prior period adjustment is Note 13 - Property, plant and equipment.

29 Financial Instruments and Related Disclosures

A financial instrument is a contract that gives rise to a financial asset in one entity and a financial liability or equity instrument in another entity. The nature of the Group's activities means that exposure to risk, although not eliminated, is substantially reduced.

The key risks that the Group have identified are as follows:

29.1 Financial Risk

Because of the continuing service provider relationship that the Trust has with Integrated Care Boards (ICB's) and the way those ICB's are financed, and the relationship that the subsidiary company and charity have with the Trust, the Group is not exposed to the degree of financial risk faced by business entities. Financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The Group has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the Trust in undertaking its activities.

The Group's treasury management operations are carried out by the finance department, within parameters defined formally within the standing financial instructions and policies agreed by the Board of Directors. Group treasury activity is subject to review by the Finance and Performance Committee.

29.2 Currency Risk

The Group are principally domestic organisations with the great majority of transactions, assets and liabilities being in the UK and Sterling based. The Group have no overseas operations. The Group therefore have low exposure to currency rate fluctuations.

29.3 Market (Interest Rate) Risk

All of the Group financial assets and all of its financial liabilities carry nil or fixed rates of interest. The Group is not therefore, exposed to significant interest rate risk.

29.4 Credit Risk

The majority of the Group's income comes from contracts with other public sector bodies, resulting in low exposure to credit risk. The maximum exposures as at 31 March 2025 are in receivables from customers, as disclosed in note 17 to the annual report and accounts. The Group mitigates its exposure to credit risk through regular review of debtor balances and by calculating a credit loss allowance at the end of the year.

29.5 Liquidity Risk

The Group's net operating costs are incurred under annual service agreements with Integrated Care Boards and NHS England, which are financed from resources voted annually by Parliament. This is regulated by the Trust's compliance with the 'Financial Sustainability Risk Rating' system created by Monitor, the Independent Regulator of NHS Foundation Trusts. In addition, should the Group identify a shortfall on cash, the Trust has the ability to borrow from NHS England. The Group ensures that it has sufficient cash to meet all its commitments when they fall due. The Board continues to monitor monthly and future cash positions and has governance arrangements in place to manage cash requirements throughout the year. The Group is not, therefore, exposed to significant liquidity risks.

29.6 Fair Values

All of the financial assets and all of the financial liabilities of the Group are measured at fair value on recognition and subsequently amortised cost, with the exception of the investment of the Charity which is measured at fair value through other comprehensive income.

The following tables show by category the financial assets and financial liabilities at 31 March 2025. The values are shown at amortised cost which is representative of the carrying value.

	Group			Foundation Trust	
	Total £'000	Valued at amortised cost £'000	Investments in equity instruments designated at fair value through OCI £'000	Total £'000	Valued at amortised cost £'000
Financial Assets as at 31 March 2025					
Receivables (excluding non-financial assets) with NHS and DH bodies	4,168	4,168	0	4,168	4,168
Receivables (excluding non-financial assets) with other bodies	2,695	2,695	0	2,624	2,624
Cash and cash equivalents	33,311	33,311	0	30,611	30,611
Other Investments/financial assets	1,382		1,382	0	0
	41,556	40,174	1,382	37,403	37,403

	Group		Foundation Trust	
	Total £'000	Valued at amortised cost £'000	Total £'000	Valued at amortised cost £'000
Financial Liabilities as at 31 March 2025				
Obligations under leases	17,420	17,420	17,420	17,420
Obligations under Private Finance Initiative contracts	285,843	285,843	285,843	285,843
Trade and other payables (excluding non-financial liabilities) with NHS and DH bodies	3,097	3,097	3,097	3,097
Trade and other payables (excluding non-financial liabilities) with other bodies	22,918	22,918	22,670	22,670
Other Investments/financial assets	792	792	792	792
	330,070	330,070	329,822	329,822

The following tables show by category the financial assets and financial liabilities at 31 March 2024. The values are shown at amortised cost which is representative of the carrying value.

	Group			Foundation Trust	
	Total £'000	Valued at amortised cost £'000	Investments in equity instruments designated at fair value through OCI £'000	Total £'000	Valued at amortised cost £'000
Financial Assets as at 31 March 2024					
Receivables (excluding non-financial assets) with NHS and DH bodies	4,384	4,384	0	4,384	4,384
Receivables (excluding non-financial assets) with other bodies	2,518	2,518	0	2,518	2,518
Cash and cash equivalents	19,762	19,762	0	18,404	18,404
Consolidated NHS Charitable fund financial assets	2,590	2,388	202	0	0
	29,254	29,052	202	25,306	25,306

A financial asset is measured at fair value through other comprehensive income where business model objectives are met by both collecting contractual cash flows and selling financial assets and where the cash flows are solely payments of principal and interest. Movements in the fair value of financial assets in this category are recognised as gains or losses in other comprehensive income except for impairment losses. On derecognition, cumulative gains and losses previously recognised in other comprehensive income are reclassified from equity to income and expenditure, except where the Trust elected to measure an equity instrument in this category on initial recognition. The Trust has irrevocably elected to measure the charity equity instruments at fair value through other comprehensive income.

	Group		Foundation Trust	
	Total £'000	Valued at amortised cost £'000	Total £'000	Valued at amortised cost £'000
Financial Liabilities as at 31 March 2024				
Obligations under leases	18,347	18,347	18,347	18,347
Obligations under Private Finance Initiative contracts	272,285	272,285	272,285	272,285
Trade and other payables (excluding non-financial liabilities) with NHS and DH bodies	2,639	2,639	2,639	2,639
Trade and other payables (excluding non-financial liabilities) with other bodies	21,177	21,177	20,694	20,694
IAS 37 provisions which are financial liabilities	730	730	730	730
Consolidated NHS Charitable Fund financial liabilities	30	30	0	0
	315,208	**315,208**	**314,695**	**314,695**

Note 29.7 Maturity of Financial Liabilities

	Group		Foundation Trust	
	As at 31 March 2025 £'000	As at 31 March 2024 £'000	As at 31 March 2025 £'000	As at 31 March 2024 £'000
In One Year or Less	51,211	49,036	51,211	49,036
In more than one year but not more than five years	95,312	95,742	95,312	95,742
In more than five years	299,605	294,338	299,605	294,338
Total	446,128	439,116	446,128	439,116

30 Third Party Assets (Group and Foundation Trust)

The Trust held £4,000 as cash at bank or in hand at 31 March 2025 (31 March 2024 £10,000) which related to monies held by the Trust on behalf of patients. These balances are excluded from cash at bank and in hand figures reported in the annual report and accounts note 17 on page 39.

31 Losses and Special Payments (Group and Foundation Trust)

NHS Foundation Trusts are required to record payments and other adjustments that arise as a result of losses and special payments on an accruals basis, excluding provisions for future losses.

	2024/25		2023/24	
	Number	Value £000	Number	Value £000
Loss of Cash	3	8	0	0
Bad debts and claims abandoned	29	23	11	4
Damage to Buildings, property etc. due to:				
Theft	0	0	1	2
Stores losses	7	304	7	187
Total Losses	**39**	**335**	**19**	**193**
Ex gratia payments	42	73	37	73
Overtime Corrective Payments *	0	0	0	0
Total Special Payments	42	73	37	73
Total Losses and Special Payments	**81**	**408**	**56**	**266**

* The overtime corrective payments are considered as special payments for which HMT approval was sought nationally by NHS England on local employers' behalf.

There were no (2023/24 £nil) clinical negligence, fraud, personal injury, compensation under legal obligations or fruitless payment cases where the net payment for the individual case exceeded £300,000

32 Auditors' Liability (Group and Foundation Trust)

In accordance with the Companies (Disclosure of Auditor Remuneration and Liability Limitation Agreements) Regulations 2008, the liability of the Trust Auditor, Grant Thornton UK LLP is restricted to £1,000,000 in respect of liability to pay damages for losses arising as a direct result of breach of contract or negligence in respect of services provided in connection with or arising from their letter of engagement dated 6th May 2021.

Further information about the Trust

Our Russells Hall Hospital Stroke Ward engaging their patients with gifts and festive carols at Christmas time

Dudley Group NHS Foundation Trust

???

dgft.nh.net

Find out more

@DudleyGroupNHS DudleyGroupNHS

Trust Strategy
2025 – 2028

NHS
The Dudley Group
NHS Foundation Trust

Our Patients Our People Our Place

Contents

Welcome from chairman and chief executive 2

Introduction 3

The Dudley Group NHS Foundation Trust 4

About Dudley and the Black Country 6

Our context continues to change 7

Our context

Our system 8

Our place 9

Our strategy

Strategic framework 10

Our assurance metrics 14

Our multi-year commitments 15

Our underpinning plans 17

Implementing our strategy 19

References 19

Our Patients

Our People

Our Place

Welcome

Welcome to this strategy of The Dudley Group NHS Foundation Trust.

When our previous strategy was written in 2021, we were still managing the COVID-19 pandemic but despite this, our talented, committed and dedicated staff have made some remarkable achievements across our Trust.

We have seen major investments in our acute assessment units with the opening of a modular building at Russells Hall and more diagnostic services available in the community which are proving very popular. Recent inspections of some of our services by the Care Quality Commission have demonstrated the improvements we have been able make.

We know that as a result of the disruption caused by the pandemic, our waiting times have not recovered to where they were, and too many patients wait too long for investigations and treatment. We are committed to working together to meet the constitutional targets set by the government for the NHS and to do this equitably across the different communities we serve.

With the forthcoming 10-year health plan, we know that much more will be expected of us over the coming years. This strategy demonstrates what we intend to do to meet these new expectations on the NHS and how we will work together with our partners in Dudley and across the Black Country to achieve this. We will remain rooted in Dudley, but as part of an emerging group model with Sandwell & West Birmingham Trust, we will develop this partnership to deliver benefits for our patients.

Our actions will continue to be driven by our values – **care, respect and responsibility**.

We are excited by the opportunities for The Dudley Group NHS Foundation Trust – we invite you to join us on this next stage of our journey so that the people of Dudley may benefit from excellent healthcare

Introduction

When our previous strategy was published in September 2021, the world was still dealing with the immediate aftereffects of the global pandemic. Nearly four years on, the effects are still being felt across global health systems. Within the NHS, waiting times increased and have struggled to return to pre-COVID levels and many have questioned why increased funding has not always led to corresponding increases in activity levels. The foundations for greater collaboration which were being laid in 2021, have resulted in new organisational structures and ways of working. As predicted, the Trust is now working much more closely with neighbouring trusts in the Black Country and with partners such as primary care, Dudley Council and voluntary organisations in Dudley.

This Trust strategy 2025 – 2028 re-visits what we set out to do in 2021 and celebrates what we have been able to achieve, whilst looking ahead to what is yet to be done. We have deliberately chosen to set the time frame of this strategy to align with the current parliament.

This strategy sets out our vision, values and objectives and embeds how we ensure that we are an inclusive organisation, for staff, patients, families and local communities. It recognises the significant role that The Dudley Group can play as an anchor institution, and the benefits this can bring to the local economy and, in turn, to local people.

This strategy gives us a framework for how we will shape our future as an organisation, and best serve our patients, staff and communities..

About The Dudley Group NHS Foundation Trust

The Dudley Group NHS Foundation Trust (DGFT) provides acute and community services to the population of Dudley and to other parts of the Black Country, west Birmingham, south Staffordshire and north Worcestershire. Since October 2024, we have taken on responsibility for two GP practices and the provision of support to primary care across Dudley covering the work of GP practices and the six primary care networks. We provide some commissioning functions on behalf of the Integrated Care Board. We provide a range of specialist services, some of which are accessed by patients from across the UK. These include vascular surgery, endoscopic procedures, stem cell transplants and specialist genitourinary reconstruction. Our staff are our greatest asset. We have a workforce of over 6,000 whole time equivalent (WTE) staff making us the second largest employer in Dudley. Russells Hall Hospital has more than 650 beds, including intensive care beds and neonatal cots. The hospital provides secondary and tertiary services such as maternity, critical care and outpatients, an Emergency Department and a new modular building which opened in November 2021 housing the acute medical unit. The Guest Outpatient Centre in Dudley and Corbett Outpatient Centre in Stourbridge provide a range of outpatient and day case services. We have expanded the number and range of diagnostics tests carried out as a result of becoming a community diagnostic centre. We currently provide a full range of community services including adult community nursing, end of life care, podiatry, therapies and outpatient services in people's homes and from a range of community venues across the borough.

We are a designated teaching hospital of the universities of Birmingham, Aston, Worcester and St Georges, Grenada with up to nearly 200 undergraduate medical students undertaking placements with us each year. We provide placements for nurses, midwives, allied health professionals and technicians from local universities. We have an active research team.

The Trust has not had its overall rating updated by the Care Quality Commission since an inspection was carried out in February 2019. Three services were re-inspected in 2024, leading to significant improvements. Both maternity and services for children and young people have been rated as 'good', a testament to our continuous efforts. However, urgent and emergency services remain 'requires improvement' but did show improvements in two domains. Overall, the Trust remains 'requires improvement' with a rating of 'good' for effectiveness and caring and 'inadequate' for safety. Given the hard work our staff have done to improve services since the last trust inspection, the Trust is actively working towards a re-inspection soon to improve the overall ratings our above inspections provided.

Patient feedback is reviewed regularly. The latest national inpatient survey 2023 showed that the Trust was performing 'worse' than average for 4 questions in comparison to 14 in 2022. The overall patient experience score for the Trust improved from 7.8 in 2022 to 8.1 in 2023. There has been an improvement in overall performance banding with all section scores sitting within the expected range in 2023 in comparison to the 2022 survey where a number of sections were performing 'worse' or 'somewhat worse' in comparison to other trusts nationally.

The National Cancer Patient Experience survey 2023 demonstrates an improved picture in comparison to the previous survey. Questions in the 'Hospital Care' and 'Your Treatment' section have seen the biggest improvement since the 2022 survey around communication and controlling pain. There has been a decrease in the number of scores that fall below the expected range from 25 in 2022 to 12 in 2023.

We received 77,476 pieces of feedback in 2024/25 with 3,985 compliments. The proportion of patients rating their overall experience of care and treatment for the Trust overall as 'very good/good' was 83%.

The Dudley Group is a combined acute and community trust and is classified by NHS England as a medium acute trust. Income comes mainly from our commissioners (local Integrated Care Boards and NHS England for certain specialised services) but the Trust also earns income from the training of healthcare professionals and from research.

Following the decision by NHS England to dissolve Dudley Integrated Health and Care (DIHC) NHS Trust, many of the services provided by them have been transferred to The Dudley Group meaning that we are now responsible for two local GP practices (Chapel Street and High Oak with a combined list size of 6,800), the provision of support services to primary care and some commissioning functions on behalf of the Integrated Care Board.

In 2024/25, the trust spent £638.3m of which £39.4m related directly to primary care and community services.

Since 1st September 2022 we have shared a chair with Sandwell & West Birmingham Trust and since 1st January 2025 we now share a chief executive officer. Since then, other senior leadership roles have been filled that cover both whilst retaining their separate organisational identities.

Our context

The care that we provide and the way that we provide it will continue to be shaped by the national, regional and local factors that impact on us. We know that circumstances are going to change and the expectations on us will be different from what they are today. The following section describes the main things that, to the best of our knowledge, will influence the Trust over the next three to four years.

> ***"The proportion of patients rating their overall experience of care and treatment for the Trust overall as 'very good/good' was 83%."***

About Dudley and the Black Country

It is important that we understand the diverse needs and expectations of the local population. Using intelligence from Dudley Metropolitan Borough Council and other published data, we have been able to summarise the health status of the communities we serve and how this is predicted to change.

We have used tools which provide us with in-depth demographic, health and socio-economic profile of the communities living in Dudley Borough. This has helped us better understand the people we serve and the wide variation in our communities.

About Dudley:

- **The population of the Dudley borough was estimated to be 323,000 (in 2023), with 66,000 people aged over 65 years.**[1]
- **Life expectancy for men in the most deprived areas of Dudley is 9.2 years lower than in the least deprived areas, 8.6 years lower for women.**[2] **Life expectancy and healthy life expectancy have been decreasing in recent years.**
- **Almost a third (28.6%) of the Dudley population live in areas amongst the 20 per cent most deprived in England.**[3]
- **Those living in Dudley in bad or very bad health (6.0%) are higher in proportion compared to the England average (5.2%).**[4]
- **84.8% of Dudley's population are white**[5] **and the age structure is similar to England, but older compared to other parts of the West Midlands.**[6]
- **The rate of current smokers is similar to England and slightly lower than the West Midlands.**[7]
- **At 79.7% the employment rate is the highest in the Black Country with the top three employment sectors being health, retail and education.**[8]
- **95.6% of the Dudley population aged 3 and over have English as their first or preferred language. The next most prevalent preferred languages are Urdu with 0.8% of the population, Panjabi with 0.7% and Polish with 0.5%**[9]

How is this expected to change?

The number of elderly people will continue to rise. The number of people aged 75 and over in Dudley is expected to increase by over 4,000 (13%) by 2032. Births are expected to show a decreasing trend.[10]

There will be more people living with multiple, complex and long-term health conditions.[11]

Local people tell us that they are particularly concerned about access to GP services[12]. Growing up in Dudley[13] tell us that families and young people with special educational needs experience loneliness and isolation and do not know where to find information. Many struggle with mental health needs.

Whilst many of the people we serve are digitally literate, we know that there are parts of the population that struggle to access on-line services through lack of access to suitable technology.

It is clear that there are significant inequalities faced by the people of Dudley, both between Dudley and the rest of England and within the borough. As a major employer and provider of health care services, we recognise the major role we must play to address these inequalities.

Our context continues to change

Following the general election in July 2024, the new government commissioned Lord Darzi to conduct an independent investigation of the NHS in England. Published in September 2024, the report concluded that the NHS is in critical condition but with vital signs that are strong. The report identified the major themes for the forthcoming 10-year health plan which is expected to be published in 2025:

- **Re-engage staff and re-empower patients**
- **Lock in the shift of care closer to home by hardwiring financial flows**
- **Simplify and innovate care delivery for a neighbourhood NHS**
- **Drive productivity in hospitals**
- **Tilt towards technology**
- **Contribute to the nation's prosperity**
- **Reform to make the structure deliver**

The plan will be developed with a focus on three major shifts in the way healthcare is delivered:

- **Hospital to community: plans for neighbourhood health services with care closer to home**
- **Analogue to digital: greater use of the NHS App and sharing data more easily**
- **Sickness to prevention: patients with long-term conditions better able to manage their own health including through the use of wearable technology**

The 10-year health plan is expected to build on the direction set out in the NHS Long Term Plan (NHS England 2019) with its aim of boosting 'out of hospital' care and integrating primary and community services and reducing pressure on emergency hospital services.

Following the Health and Care Act 2022, integrated care boards have been established as the local 'headquarters' of the NHS across England supported by integrated care partnerships involving a wider range of stakeholders including local councils, education providers and the voluntary sector. When the last strategy was written, these components of system working were only just emerging. Three years on, they are established and starting to deliver.

We remain an NHS Foundation Trust, delivering services for the people of Dudley and surrounding area and remaining accountable to them through our governors and members. We are still responsible for the quality of services and the way in which we use our resources. But we have an important role in integrating services in our 'place' (Dudley) and our 'system' (The Black Country) and take responsibility for ensuring that services across organisations are sustainable and of the highest quality.

An NHS Long Term Workforce Plan was published in June 2023 which set out a path for increasing the size of the NHS workforce to meet increasing demand. This will be updated following publication of the 10-year health plan.

Our system

The Trust is now a key partner within the Black Country Integrated Care System and our activities need to support the delivery of both the Black Country Integrated Care Strategy and the Joint Forward Plan published by Black Country Integrated Care Board. Like many other systems, The Black Country Integrated Care System faces significant challenges including the need for services to be financially sustainable. The system has developed an operating model which sets out how the different parts of the system will work in order to bring about the purposes of the ICS:

- **improve outcomes in population health and healthcare**
- **tackle inequalities in outcomes, experience and access**
- **enhance productivity and value for money**
- **help the NHS support broader social and economic development.**

This will include delegation of authority to provider collaboratives and place-based partnerships who will over time become responsible for the commissioning and delivery of services.

The Trust is part of the Black Country Provider Collaborative, where we join with colleagues from Sandwell & West Birmingham Trust, The Royal Wolverhampton Trust and Walsall Healthcare Trust to '*provide better, faster and safer care to the population of the Black Country*'. Through our collective efforts, we have been able to establish specialist skin cancer surgery (Mohs) within the Black Country and introduce robotic surgery to both Russells Hall Hospital and Sandwell health campus in addition to New Cross Hospital. This is expected to lead to the relocation and consolidation of specialist urology services across The Black Country making the best use of precious resources and improving outcomes for patients. The collaborative supports clinical networks which are standardising care and reducing variation where it cannot be clinically justified.

The collaborative not only focuses on clinical improvements. There is opportunity to look at our 'back office' functions to ensure that these are delivered in as efficient a way as possible. The collaborative is currently working on the creation of a single payroll function and standardising mandatory training with plans for other projects in development.

One of the most significant changes to hospital services locally has been the opening of the Midland Metropolitan University Hospital (MMUH), managed by Sandwell & West Birmingham NHS Trust in October 2024. The facility replaces many of the inpatient services previously located at Sandwell General and City Hospitals. We will work closely with Sandwell & West Birmingham Trust and the ICB to monitor the impact of this change, particularly for emergency care following the closure of the Emergency Department at Sandwell General Hospital.

To meet the challenges being faced by primary care both locally and within the Black Country, the ICB has published a draft strategy on the future of primary care.[14] This emphasises the need for primary care to focus more on the prevention of ill health with improved access to unplanned care in general practice making better use of community pharmacy. The future direction of primary care development will obviously impact the two practices that have now transferred to the Trust.

> ***"...we have been able to establish specialist skin cancer surgery (Mohs) within the Black Country and introduce robotic surgery to both Russells Hall Hospital and Sandwell health campus in addition to New Cross Hospital."***

Our place

All organisations are expected to work towards better integration of services: integrating primary health care and hospital services, physical and mental health, health and social care. Within Dudley, we play our part in the Dudley Health & Care Partnership – one of four place-based partnerships in the Black Country.

The Partnership has continued to build trust and relationships within Dudley. Community Partnership Teams have been established in all primary care networks consisting of professionals from different organisations working together to support people with long-term conditions. Pathways have been redesigned to make the mission of '***community where possible, hospital when necessary***' a reality[15]. Recent achievements include increased use of the falls pickup service which has supported more people to remain in the community and encouraging results from the Community Partnership teams which shows a reduction in the average number of GP attendances and hospital admissions for those supported by the teams.

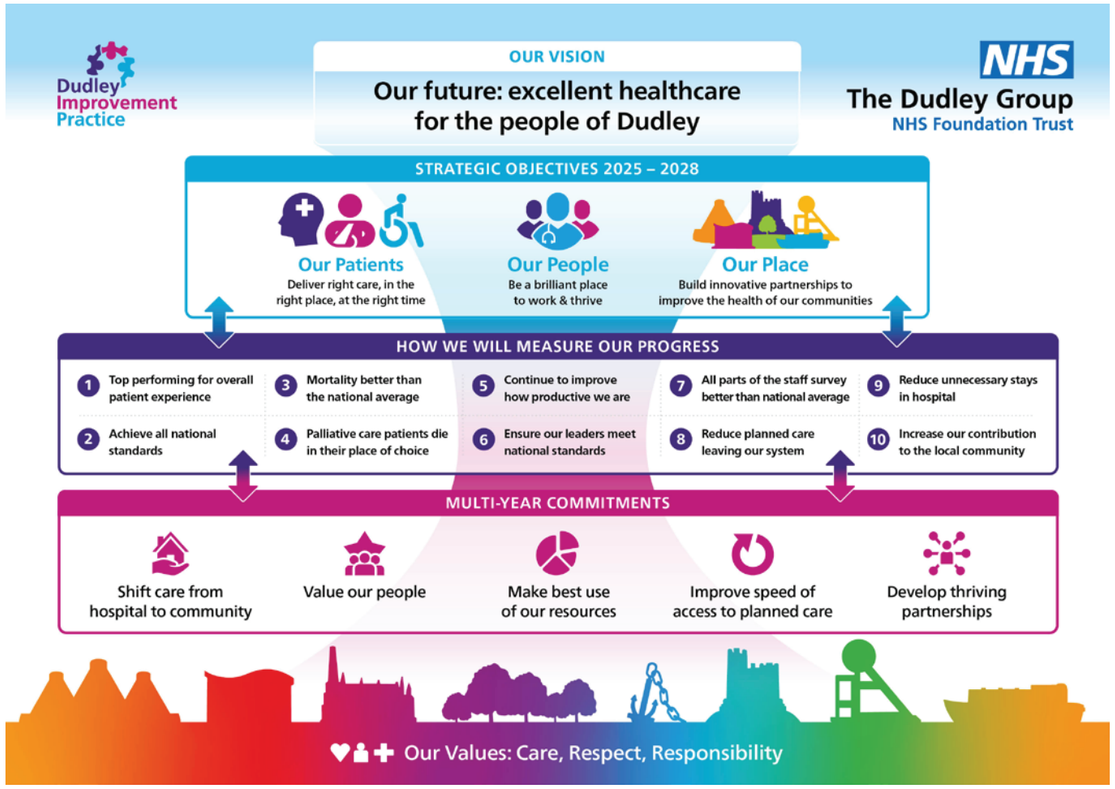
The Dudley Health & Wellbeing Board provides leadership for Dudley's health and care system. Using local evidence, it works to identify the needs of local residents, promote high quality, safe and joined-up services and tackle health inequalities across the borough. The Health and Wellbeing Strategy (2023 – 2028) is about how to make Dudley a place where everyone can live 'longer, safer and healthier lives'. The strategy is focussing on three goals:

1. **Children are ready to learn and ready for school**
2. **Fewer people die from circulatory disease**
3. **More women are screened for breast cancer**

We clearly have a role to play in achieving these goals and the steps we plan to take are set out later in this document.

Partners are committed to working together to take on responsibility for commissioning of some services across Dudley as part of the operating model of the ICS.

Strategic framework



Our vision

Our new vision is designed to be simple. It combines our desire to deliver excellent care recognising that this is primarily for the people of Dudley.

Our strategic objectives

We have identified three strategic objectives, the pursuit of which will guide all that we do. For each of these, we have summarised the key achievements since the last strategy was introduced and what we want to achieve by 2028.

Our values

Our values support our vision and define how the Trust and every member of staff will work to deliver the best care possible. We adopted our current values in 2015 and since then have been increasingly embedded into our local processes. They form part of the recruitment process, are included in annual reviews and underpin our approach to improvement through the Dudley Improvement Practice. We believe that these values remain relevant to us in this next phase of our journey.

Care - we provide safe, quality healthcare for every person – every time

Respect - we show respect for our patients, our visitors and each other – at all times

Responsibility - we take responsibility for everything we do – every day

Deliver right care, in the right place, at the right time

What we have done since 2021

- Received a CQC rating of 'good' for maternity and childrens services
- Implemented the Patient Safety Incident & Reporting Framework
- Introduced robotic surgery to improve outcomes for patients
- Opened a hybrid theatre to improve the quality of care provided to vascular patients
- Opened the Rainbow Unit housing the acute medical unit and expanded the space for Same Day Emergency Care and the range of services available
- Implemented the Community Diagnostic Centre with more services available in community locations
- Provided community midwifery services in the Family Hubs alongside health visiting and local authority services

What we want to do by 2028

- Achieve a rating of at least 'good' for all of the services inspected by CQC
- Develop an elective hub away from Russells Hall Hospital for the majority of our inpatient elective surgery
- Expand our provision of virtual wards, reducing the need for admission to hospital
- Provide as many outpatient services as possible in suitable community locations preventing the need to come to hospital
- Develop a new model for the care of older, frail people with more services available in people's homes

Case Study

Family Hubs

Our model of family hubs demonstrates innovation in neighbourhood health and care services. Specialist skills are pooled together in calm safe spaces in the community that provide one-stop access for families.

In 2022 Dudley borough was allocated £3.7 million of Family Hub/Start for Life national funding to provide a coordinated and accessible "front door" for families. One element of the Dudley offer was the recruitment of 15 Family Hub Practitioners, 5 each from maternity, health visiting and children's services.

By the trust offering midwife antenatal and postnatal appointments at the Hubs, families were not only able to access services closer to home, but they were also introduced to the wide range of multiagency and voluntary sector support, at a time proven to be when parents are most likely to make behaviour changes. This supports our system wide priority to give Dudley's infants the best start in life.

Family feedback shows that the offer of universal services has changed public opinion of the Hubs to a family friendly space offering a one-stop shop for their needs. In future the trust will host 3 Family Hub Practitioners, supported by a specialist midwife to target their support to infants under 2 to achieve the health and wellbeing goal for children to be ready to learn.

> *"Family feedback shows that the offer of universal services has changed public opinion of the Hubs to a family friendly space offering a one-stop shop for their needs."*

Be a brilliant place to work

What we have done since 2021

- Reduced the vacancy rate from 13% to less than 7%
- Increased the response rate for the staff survey and achieved results that are now similar to the England average
- Reviewed nursing allocations to ensure safe staffing levels
- Increased the staff wellbeing offer and established a network of wellbeing champions across the organisation
- To the end of 2024, trained 5,500 staff in improvement methodologies, started a community of improvement practice and asked all staff to identify an improvement project as part of their objectives
- Improved appraisal process and increased completion rate from 68% in 2022 to 90% in 2024

What we want to do by 2028

- Be the local employer of choice – supporting people to get into work, develop and progress
- Continue to expand the wellbeing offer to staff with more people accessing support for mental health and physiotherapy for musculo-skeletal problems. This is expected to reduce sickness absence
- Expand the number and range of wellbeing champions with at least one active champion for each service
- Sustain and expand membership of individual diversity networks
- Ensure that the behaviour framework and Trust values translate into staff lived experiences
- Ensure that staff have a voice that counts and feel empowered to speak up about any concerns that that might have and feel confident that action will be taken
- Raise the profile of the anti-discrimination agenda through our policies and practices
- Embed the community of improvement practice to provide an in-house improvement consultancy
- Improvement co-designed with people with lived experience
- Standardised management systems embedded across the organisation and partner trusts in the Black Country

Case Study

In May 2022, the trust launched a programme to recruit wellbeing champions. Starting with 40 this has now grown to approximately 140 across the organisation. Champions are often already in roles that lend themselves to being supportive to staff, and the champion role helps to develop this further by ensuring the champions are up to date with the support offer and how best to approach conversations with staff. The champions are networked through regular meetings and a teams channel where they can share ideas. As a result of introducing the champion role:

- **Wellbeing boards have been set up in departments where information and resources can be shared**
- **Local drop-in sessions covering topics such as fitness, team building, financial wellbeing**
- **Staff now have a 'go to' person they can have a conversation with about their wellbeing**
- **Training in mental health first aid has been provided**

We have seen a positive increase in our wellbeing results as measured in the annual staff survey. As the champion role continues to embed across the organisation, we expect this to continue.

Build innovative partnerships to improve the health of our communities

What we have done since 2021

- Agreed principles of working together with the other acute and community trusts in the Black Country through the Black Country Provider Collaborative. As an example, this has established a service for specialist skin cancer surgery (Mohs) by working with Royal Wolverhampton and Walsall trusts
- Agreed 'principles for collaboration and partnership' between primary and secondary care and played a key role in Community Partnership Teams (CPTs) supporting people with long-term conditions
- Became the host of the Dudley health & care partnership
- Started alcohol and tobacco teams to support patients with alcohol and tobacco dependency
- Supported the 'Kickstart' employment programme and started a local pre-employment programme with Dudley Council to support people into work (ICan)
- Forged closer link with local schools and offered regular 'Behind the scenes' tours for local secondary students to promote the range of careers available in the NHS
- Joined the lung cancer screening programme to detect lung cancer earlier and improve chances of recovery

What we want to do by 2028

- Provide specialist vascular services to the whole population of the Black Country
- Further develop the Community Partnership Teams (CPTs) into the neighbourhood teams envisaged in the 10-year health plan by identifying those most at risk and preventing illness
- Work with partners in Dudley including Dudley College and University of Worcester to make Health Innovation Dudley, the new health and care campus, a resounding success
- Support the development of primary care in Dudley as part of the primary care transformation in the Black Country
- Front-line clinical staff to have more time and capacity to support patients by 'Making every contact count' to prevent illness and address health inequalities
- Develop a care navigation centre for Dudley health and care services
- Support the earlier detection of cancer through provision of responsive and culturally-appropriate screening services for breast, lung and colorectal cancers
- Work with partners to make the Family Hubs in Dudley sustainable by co-locating appropriate womens and childrens services alongside preventive health and local authority services
- Develop a much closer partnership with Sandwell & West Birmingham Trust, working together to harness the strengths of both trusts whilst retaining individual organisational identities
- Realise the benefits to our organisation of having university trust status, developing closer relationships with Aston University and increasing the amount of research conducted within the trust

Case Study

ICan is an employment partnership with a difference. Forged as a way of working differently, we have been working with Dudley Council to deliver access to employment, changes to make our recruitment practices more inclusive and developing ways of working in partnership that help us learn and deliver good employment for those furthest from jobs.

What we've done: Working together with some additional external funding (Combined Authority, Commonwealth Games Legacy), we have provided supported paid work experience placements to give candidates genuine work experience - improving their chances of work in the future and changing their thoughts about what it is like to work for Dudley Group or the Council. Many of our work experience candidates have gone on to get jobs with the Trust. We also created a direct entry training route into clinical support worker jobs.

The key elements of the programme were working together to build how we support people into work, their first steps on the programme and routes into permanent roles. We work and learn together - so our programme has developed over time (and continues to do so). We've managed to create opportunities for local residents to get into work, address barriers for people with disabilities and support people with care experience to get ahead.

Our assurance metrics

We will monitor our progress against delivering the strategic objectives in this strategy through a small number of measures. In designing these measures, we have adopted the approach used by the Dudley Improvement Practice, namely that our measures should reflect four domains: **delivery, quality, cost and morale**.

Delivery

- Achieve all national standards
- Reduce planned care leaving our system
- Reduce unnecessary stays in hospital

Quality

- Overall experience score
- Mortality (SHMI/ HSMR)
- People die in their preferred place

Cost

- Continue to improve how productive we are

Morale

- Staff survey results
- Leaders meet national competency framework
- Increase our contribution to the local community

Our multi-year commitments

To realise our strategic objectives, we are making five multi-year commitments. Over the period of our strategy, these commitments will lead to objectives that we need to deliver each year which will help us to deliver our strategy and drive the change we wish to see.

Shift care from hospital to community

We will shift care closer to home, so that only those who need to be in hospital are seen there, providing the best experience of care.

Our commitment is to shift the focus of care from hospital settings to community-based services, promoting a holistic approach to health, wellbeing and earlier intervention. Through our continued work in our local health and care partnerships and by investing in community health initiatives, we aim to provide proactive, integrated care that supports patients in, or as close as possible, to their own home. Our goal is to enhance health outcomes, reduce hospital admissions, and foster a healthier, more resilient community.

A key dependency of this is the interconnected improvement work to reduce waiting lists and the backlogs the pandemic created, ensuring people are treated promptly and get back to a state of wellbeing.

In practice, our divisions will be developing new pathways and models of care to focus on the following areas:

- Frailty and nursing homes
- Development of the clinical hub
- Moving outpatient services out of hospital

Value our people

We will create an environment which allows everyone to be their best self and provide opportunities for personal growth, to recruit and retain the best talent.

We are committed to creating an environment where everyone can thrive by listening to staff and acting on their concerns. Building on our work in health, wellbeing, and development, we will expand opportunities for growth and retention. Our integration with primary care and collaboration with Sandwell & West Birmingham Trust opens new career pathways, while partnerships with Aston University and others enhance access to research and education.

We will promote shared roles, flexibility, and inclusivity, foster a culture free from bullying and discrimination, and empower every individual to feel valued, engaged, and supported in delivering outstanding patient care.

In practice this could mean:

- More shared roles and flexibility for staff to work across organisations
- More staff from all disciplines engaged in research

Make best use of our resources

We will become more efficient by streamlining our processes, optimising our facilities and harnessing technology and artificial intelligence, to demonstrate best value

Our commitment is to get the best possible value for the taxpayer by eliminating duplication. Many of our assets such as imaging equipment and operating theatres are expensive to run and need to be used in the most efficient way possible. Greater use of digital technologies will support us to do this and release precious clinical time to focus on patient care.

Our corporate services are included within this, where we will work with others to deliver quality services at a reduced cost.

In practice, our teams will be:

- Looking at how to make best use of our estate
- Making data from primary and secondary care available to each other
- Piloting the use of AI and scaling up if benefits can be demonstrated

Our multi-year commitments

Improve speed of access to planned care

We will reduce waiting times for investigations and treatments, to provide personalised care at the right time and be the preferred choice for patients.

Our commitment is to return to the constitutional target of 92% patients being treated within 18 weeks of a referral by the end of this strategy. We will do this by focusing effort on better communication between primary and secondary care, making the best use of the resources available to us and adopting best practice from across the NHS.

In practice, our teams will :

- **Offer more advice and guidance to primary care so that only patients requiring secondary care are put on to a waiting list**
- **Ensure that waiting lists are always well-managed**
- **Where appropriate, deliver as much surgery as possible in a day case or outpatient setting and when patients need to be admitted, ensure their length of stay is as short as possible**
- **Provide planned surgery in a protected facility called an elective hub in conjunction with Sandwell & West Birmingham Trust**

Develop thriving partnerships

We will work with partners on innovation, transformation and sustainability to achieve the best outcomes for our communities.

We aim to lead a cultural shift from a treatment-centred model to one that prioritises prevention and early intervention. We recognise that some of the most powerful health interventions occur well before hospital and community care is needed, namely that a safe home, education and employment upon leaving school are fundamental determinants of health. As a large public service, major employer and anchor institution within the borough, we can influence and support these early fundamentals through close working with our partners.

In practice, our early prevention schemes will focus on the following areas:

- **Working with the local authority on planning**
- **Education, safeguarding and physical activity in local schools**
- **Clear access points for local employment into all roles**

In addition, by implementing comprehensive public health programs, expanding access to health education, and encouraging healthy lifestyles, we will empower our patients and communities to take charge of their own health. Through proactive measures and innovative prevention strategies, we aim to reduce the incidence of chronic diseases and improve overall health outcomes for future generations.

In practice our health interventions will focus upon:

- **Targeted screening to detected disease such as cancers earlier**
- **Public health campaigns and vaccination**
- **Research into genomics and personalised healthcare**

Our underpinning plans

The Trust's single strategy is underpinned by several cross-linked delivery plans, that set out the key milestones, projects and programmes of work that delivery our vision and strategic objectives. Dudley Improvement Practice is our design and delivery improvement methodology. This is a matured, well adopted home grown quality improvement mindset, supported by a growing network of improvement champions to sustain the approach. Our plans will assure delivery through a range of mechanisms embedded with our corporate governance approach, aggregated in a Board Assurance Framework (BAF) addressing our strategic risks.

The Dudley People Plan

The Dudley People Plan (our workforce strategy) covers a three-year period from 2023 -2026 and summarises what our people can expect around support for them whilst they work with us. This is outlined in each of our five People Journeys:

- **Equality, inclusion and diversity**
- **Culture, Leadership and Learning**
- **Wellbeing**
- **Recruit and retain**
- **Continuous improvement**

The plan describes our ambition to support our people - and to attract people to come and work with us. Implementation will need to incorporate the implications of the NHS Long Term Workforce Plan which aims to increase workforce capacity across the NHS over the next fifteen years.

Quality and Safety

A 3-year Quality and Safety Delivery Plan is being developed to outline how the trust will deliver high quality and safe care to its patient population for the period 2025 - 2028. It will align to the Trust strategy and be supported by the Trust vision, values, and strategic objectives. The enabling plan will support the Trust to deliver on overarching priorities with clear yearly objectives to demonstrate proactive thinking and action, whilst ensuring there are sustainable outcomes for patients and staff.

The proposed overarching priorities include:

- **Improving partnership working**
- **Staff development**
- **Safe management of the deteriorating patient**
- **Improving patient outcomes**
- **Development and implementation of National safety standards for invasive procedures (NatSSIPS)**
- **Safe medicines management**
- **Care closer to home**
- **Improving patient outcomes**
- **Improving patient experience**
- **Right workforce**
- **Digital infrastructure to support quality and safety**

Our underpinning plans

Estates and facilities

The Trust's Estates Strategy 2022 – 2027 was reviewed and updated in November 2022. In recent years the Trust has successfully bid for capital to expand the endoscopy suite and the number of minor procedure rooms at Russells Hall Hospital. The Rainbow Unit (a modular build) was opened to services in November 2021. The trust has received capital to expand the resuscitation area within the Emergency Department and work is due to be completed by winter 2025.

Following the development of an estates strategy across the integrated care system decisions about significant capital funding will be made with partners across the ICS.

Digital, data and technology plan

Based on our progress to date highlighted by our digital maturity assessment scoring, The Dudley Group is one of the leading digital trusts in the midlands. We have become a provider that does not need a 'digital strategy', as technology has and will continue to be adopted as a mechanism for innovation to deliver the core Trust Strategy. Our plan is to build on the 'brilliant basics' we have put in place such as our electronic patient record that by March 2025 will meet almost all of the national standards set out in the digital capability framework (DCF) which is mandated by 2027.

To further align to our patient needs and the wider national and regional requirements, our new digital plan will focus in 3 key areas: digitise, connect, and transform.

Using our Dudley Improvement Practice methods, we will therefore:

- **digitise services**
- **connect them to support integration, and through these foundations**
- **transform services to improve quality and safety.**

Green plan

The Green Plan is due to refreshed in 2025. Since the plan was introduced in December 2020, we have been able to raise awareness amongst staff and implemented schemes to reduce waste, improve recycling and make it easier for staff to use alternative methods of transport. The NHS aims to be world's first net zero carbon health system by 2040 (2045 for wider emissions in the supply chain) so there is much more that we need to do. We need to work with our PFI partners in order to decarbonise the estate we occupy, so we will focus our efforts over the coming years on issues within our direct control.

Research, development and innovation

A revised strategy 2022 – 2027 to promote research, development and innovation across all departments and disciplines was adopted by the Trust in September 2022. The Trust has a vision to become the organisation known for providing an environment where research, innovation and the adoption of new technology flourish: supporting staff to identify challenges to the delivery of high quality care, then working with them to seek, support, implement and evaluate solutions.

Key to this will be working with local academic institutions, industry and Health Innovation West Midlands to identify opportunities for research and the adoption of new technologies and processes. We aim to embed a culture where research will be integrated into routine clinical care to benefit our patients, by creating a supportive environment that optimises the best outcomes for our staff, patients and the wider population.

Our ambition is that as a result of these actions we will achieve university trust status.

Implementing our strategy

This strategy sets out our goals and what we are going to do from 2024 to 2027 at a high level. We believe delivery of ambitious strategic goals can only be achieved by taking a continuous improvement approach to learning, responding and implementing change, to benefit our patients, staff and Dudley people.

In 2018, we made a long-term commitment to building a system for continuous improvement and were selected by NHS England to be part of the first national cohort in the Vital Signs programme. Supported by NHS England, eight trusts co-produced an approach to developing a culture of continuous improvement which is founded on supporting and empowering staff to improve the services they are passionate about. Using NHS IMPACT, the NHSE best practice guide for continuous improvement, we continue to evolve the Dudley Improvement Practice (DIP).

All improvement activity supported by the Dudley Improvement Practice team is aligned to the Trust's vision and goals which we continually strive towards. Each division, department and team will use the vision and goals to guide their improvement efforts by defining objectives specific to their work area. Using a variety of methods appropriate to the work, and a ward to board reporting information cascade of virtual or physical improvement boards and team huddles, every member of staff will know how their work is contributing to the strategy.

Alongside the adoption of this new strategy, the Trust has also reviewed the strategic risks that will prevent our goals from being delivered; this was undertaken in line with the Trust's Risk Management Framework and agreed risk appetite. The Board Assurance Framework will document the Board's strategic risks alongside its appetite for risk in the achievement of strategic objectives. The Board Assurance Framework is reviewed throughout the year at the board and its committees to monitor the management of identified risks in line with its agreed risk appetite. Corrective action is taken to mitigate these risks and to the attain the target score.

References

1. Dudley Borough in Numbers April 2023 (allaboutdudley.info)
2. Dudley Borough in Numbers April 2023 (allaboutdudley.info)
3. Dudley Borough in Numbers April 2023 (allaboutdudley.info)
4. Census Area Profile - Dudley Local Authority compared to England (allaboutdudley.info)
5. Census Area Profile - Dudley Local Authority compared to England (allaboutdudley.info)
6. Understanding Dudley Population - All About Dudley Boroug (allaboutdudley.info)
7. Adult smoking habits in the UK - Office for National Statistics (ons.gov.uk)
8. Dudley Borough in Numbers April 2024 (allaboutdudley.info)
9. Language, England and Wales - Office for National Statistics (ons.gov.uk)
10. Joint Strategic Needs Assessment - All About Dudley Borough (allaboutdudley.info)
11. Health in 2040: projected patterns of illness in England - The Health Foundation (health.org.uk)
12. Exploring access to GP services in Dudley borough - Healthwatch Dudley (healthwatchdudley.co.uk)
13. Growing Up in Dudley-Report (allaboutDudley.info)
14. Future of Primary Care in the Black Country - Black Country ICB (blackcountry.icb.nhs.uk)
15. Dudley Care Partnership Annual Report (dgft.nhs.uk)

NHS
The Dudley Group
NHS Foundation Trust

dgft.nhs.uk

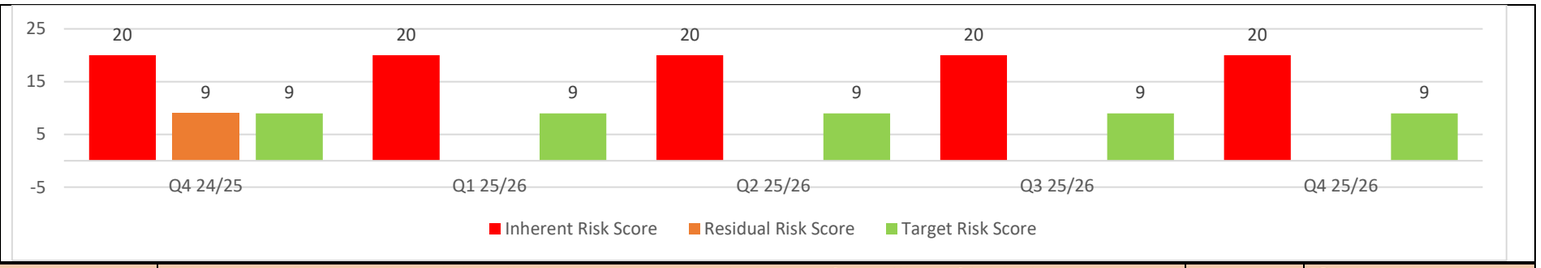
DudleyGroupNHS DudleyGroupNHS
the-dudley-group-nhs-foundation-trust dudley-group-nhs

Excellent healthcare for the people of Dudley

Principle Risk	**BAF Risk 1** Failure to deliver the right care, in the right place at the right time resulting in poor clinical outcomes and patient experience
Linked strategic measures:	Top performing for overall patient experience: Mortality better that the national average: Palliative care patients die in their place of choice: Reduce unnecessary stays in hospital

Strategic Goal:	**Lead Executives**	**Lead Committee with oversight**	**Rationale for current risk score: 9** *Consequence x Likelihood (3x3)* Following discussions at Committee and Board in March 2025, it was agreed that based on current strength of controls, the current score would be reduced from 12 to 9. The reduction was endorsed at the May 2025 meeting of the Board of Directors.	**Rationale for target score: 9** *Consequence x Likelihood (3x3)* Having very recently reduced the score to 9, the focus for the year will be to sustain this score. Every attempt will be made to further reduce it, however given complexities associated with quality and safety, this may be too ambitious to achieve.	**Risk Appetite and Tolerance limit score** Cautious 9	**Committee Assurance Rating** May 2025 Positive
Our Patients Our People Our Place	Martina Morris Julian Hobbs Karen Kelly Karen Brogan/ James Fleet	Quality Committee				

	24/25 Q4	**25/26 Q1**	**Q2**	**Q3**	**Q4**
Inherent Risk	20	**20**	**20**	**20**	**20**
Current Residual Risk Score	9				
Target Risk Score*	9	9	9	9	9



Key Controls	**Gaps in Key Controls**	**Mitigation Actions** *linked directly to gaps in key controls, use formatting of table (merge function) to line up with associated gap*	**Exec Lead**	**Status /due**
The breadth of patient safety data – a comprehensive suite of information, utilised to monitor quality and safety and inform interventions including: • Live data and sitreps for all emergency portals • Trust capacity related reporting (multiple times each day) • Model Hospital provides some peer data • Martha's rule data • Patient experience and complaints data • Patient Advice Liaison Service (PALS) concerns • Friends and Family Test (FTT) results • National patient survey results • Accreditation reviews and their outcomes • Psychological harm captured and considered in incident reporting • Equality Diversity Inclusion Working Group and associated data • Inequalities Working Group and associated data • Service level incident and risk reports • Patient safety Incident Response Framework (PSIRF) response and oversight reports • Thematic reviews • CQC self-assessment • Quality/safety reviews • Ward to Board feedback • External visits feedback and reports	• Gaps in the breadth of data collection and analysis across the entire patient journey, not just related to patient admission • Although there are reasonable numbers of excellence reports submitted, there is limited evidence of these being further explored utilising responses such as Appreciative Inquiry to explore and learn from good and innovative practice • Accessibility to real time data through triangulated service level dashboards • Clinical accreditation is in the early stages of implementation • Place services are relatively new to the Trust and therefore the Trust is in the early phases of capturing and understanding intelligence data • Limited assurance that live dashboards to monitor Deteriorating Patient Pathway (DPP) are used locally	1. Further embed the positive learning from GREATix and ensure it is reported on and utilised to drive clinical excellence. 2. Develop a programme of work for the NatSIPPS Group. 3. Implement and embed the clinical accreditation programme. 4. Review and strengthen the nursing and midwifery audits, including their utilisation to drive improvements. 5. Explore opportunities with development of Place Division to review and oversee safety across care settings locally. 6. On going surveillance, using Healthcare Evaluation Data (HED) data sets and Hospital Episode Statistic (HES) clinical indicators, to respond to all outliers or those conditions where observed deaths are greater than expected. 7. Morbidity surveillance via directorate Morbidity and Mortality (M&M) meetings with reporting to Quality committee via divisional governance. 8. Deteriorating patient dashboard oversight to be formally established at ward and directorate level.	MM/JH	1.December 2025 2.September 2025 3.May 2025 **completed** 4.June 2025 **completed, with ongoing embedding and refinement as required** 5.September 2025 6.April 2026 7.December 2025 8.December 2025

The accuracy of key patient safety measures – accurate and timely measures to positively inform patient outcomes • Deteriorating Patient Pathway (DPP) in place to identify • Hospital at Night team have commenced process of monitoring the DPP list at 3 hourly intervals out • Martha's Rule operational in the Trust • There are a series of system groups (Mortality, CQRM, LMNS) however data remains organisationally focused currently • Clinical Governance and risk management process • Governance Framework to enable key information flow and escalation to ensure support and shared risk as necessary • Capacity meetings throughout the day to monitor ambulance 45-minute hand over and those patients seated in our waiting area • Monitoring of Referral to Treatment (RTT) performance • Harm reviews and associated data	• Structured Judgement Review (SJR) process not fully inclusive of the whole episode of care • Harm review process not standardised across the Trust • Recurrent incident and complaint themes • Limited evidence that data and intelligence is used systematically and robustly to translate into improvements in patient care and outcomes • Staff capacity and resource to meaningfully engage in processes	1. Structured Judgement Review (SJR) process to review whole episode of care (access to EMIS available via Medical Examiner (ME) service and GP already supports SJR process). 2. Commence work with public health colleagues in relation to mortality focusing on futile treatment, and a left shift to secondary and primary prevention. 3. Standardise the harm review process, including associated governance. 4. Review and strengthen the role of the Patient Safety Partners and Patient Safety Champions. 5. Ensure nursing and medical input into the Health Inequalities group to further develop its focus. 6. Develop and deliver an improvement plan to address patient observations not being completed and recorded on time. 7. Undertake a thematic review of incidents and discuss it at the Incident Decision and Learning Group, including agreement on the next steps.	JH/MM	1.September 2025 2.June 2025 **in progress** 3.September 2025 4.September 2025 5.May 2025 **in place.** 6.May 2025 **completed and being progressed** 7.May 2025 **review completed and next steps to be agreed**
A workforce plan for the NHS and social care system – the right people, with the right skills, are in the right place and the right time • A variety of development programmes is in place to support leadership development • Annual reviews/appraisals • Safer staffing processes – dynamic risk assessments and mitigations and reviews in line with national guidance • Focussed leadership and cultural interventions in specific areas of concern • Strengthened oversight with regards to recruitment (VAR panels), bank and agency controls	• Mixed culture and strength of leadership across the organisation with negative impact on quality	Working with the Chief People Officer: 1. Foster a culture of positive learning with clear measurement and improvements as reflected with the AQUA tool and the use of learning from excellence. This includes the use of positive cultural interventions embedded in the quality strategy. 2. Further strengthen workforce oversight, rostering and Bank use controls, ensuring the set plan for 2025/26 is fully achieved. 3. Participate in the national Enhanced Therapeutic Observation and agree improvement actions, with their full realisation by the end of financial year.	MM/JH	1.March 2026 2.March 2026 **developed and biweekly meetings in place** 3.March 2026 **commenced and Trust participating in national group**
Integrated Care Systems to play a central role in monitoring patient safety • A variety of Integrated Care Board (ICB) interface meetings in place, with staff representation from across the Trust (for example, Clinical Quality Review meetings (CQRM), Executive level oversight meetings, Trust DMD co-chairs a system mortality group)	• Variability in the current approach. • Impact of the NHS reform announcement in March 2025 and the lack of clarity on future arrangements.	1. Continue to fully engage in system quality and safety workstreams. 2. Work collaboratively with ICB colleagues to support transition and influence development of the new NHS landscape.	MM/JH	1.April 2026 **in progress** 2.April 2026 **in progress**
Progress in the safety of maternity services – accelerated work to improve and sustain quality and safety • Our maternity and neonatal improvement work is a strong example of how sustainable improvements can be achieved • 3-year delivery plan	• Working relationships and culture continue to be inconsistent and strained amongst certain staff groups	1. Ensure that the Trust's perinatal service continue to focus on cultural improvement work and strengthening interprofessional working. 2. Achieve a further positive progress and embeddedness of the actions associated with the 3-year improvement plan. 3. Achieve full Maternity Incentive Scheme (MIS) year 7 compliance.	MM/JH MM/JH MM/JH	1.April 2026 **in progress** 2.April 2026 3.April 2026 4.July 2026

• Maternity Incentive Scheme (MIS) compliance • A variety of working and oversight group in place with Executive and Non-Executive Director involvement • Wider system working via the Local Maternity and Neonatal System (LMNS)		4. Working collaboratively with SWBH and the wider system, agree key interventions to achieve improvements associated with neonatal congenital disease.		
Significant financial controls in place – robust oversight and QIA processes in pace to mitigate risks • Quality impact assessments (QIA) identifying potential risks and mitigations with an Executive Director level approval and final sign off	• Inconsistent application of QIA process, although this has improved since 2024/25) with staff not considering all instances when it is required.	1. Undertake a survey and audit of the QIA process application across the Trust. 2. Ensure that the findings and learning from the QIA audit are shared via the Trust's governance process and Divisions. 3. Continue to maintain the strengthened oversight and sign off process of the QIAs.	MM/JH	1.July 2025 **in progress** 2.September 2025 3.April 2026
Elective care pathways - comprehensive processes to support delivery of quality safe care • A variety of data sets to monitor performance and the quality of care • Surveillance of waiting times and associated mitigations	• Inconsistent understanding of responsibilities across MDT teams pertaining to patient experience	1. Improvement plans to be developed for all patient experience surveys, ensuring a holistic approach to improvements required, including how positive feedback can be further maximised. 2. Improvement plans fully delivered, with demonstrable improvements in patient experience evidenced in future survey results/other pertinent data. 3. Deliver joint leadership development at directorate, division and corporate level to role model appropriate behaviours and culture.	MM/JH/ KK	1.May 2025 **in place including further developments planned** 2.March 2026 3.March 2026
Non-elective pathways - comprehensive processes to support delivery of quality safe care • A variety of data sets to monitor performance and the quality of care	• Inconsistent processes for discharge management • Variable engagement and cultural challenges • Inconsistent and variable leadership	1. High impact action pertaining to patient discharges fully delivered (in line with improvement plan) with demonstrable improvement in discharge processes and outcomes. 2. Patient experience Urgent and Emergency Care (UEC) survey improvement plan to be developed, ensuring a holistic approach to improvements required, including how positive feedback can be further maximised. Oversight of the plan to be ensured via the established Divisional governance process and Patient Experience Group. 3. Patient experience UEC survey improvement plan fully delivered, with demonstrable improvement in patient experience evidenced in future survey results/other pertinent data. 4. Implement forward assurance in external accreditation and real time use of dashboards to monitor DP and care bundle delivery.	MM/JH/ KK/KB	1.September 2025 2.May 2025 **developed and further refinements to take place and oversight ensured via PEG** 3.March 2026 4.September 2025

Assurances		**Gaps in Assurance**	**Link to Risk Register (operational risks):**
Level 1 Assurance *Provided by those responsible for delivering specific objective/operation. Generally provided by those that own and manage risk, by its nature this can be subjective, but its value is that it comes from those who know the business, culture, and day to day challenges*	**Date of assurance**	Limited engagement from services in reviewing and actioning incident themes Patient flow and discharge improvement work All Core Services yet to be reviewed utilising the Quality and safety Review process. CQC self-assessment is a new and developing form of assurance – strengthening of the process is underway. Last CQC inspection took place in May/June 2023 – Trust actively prompting review of Imaging services.	**(Red risks – updated 05/2025)** **COR2368:** Delays in patient discharges coupled with increased demand for ED services and inpatient admissions may result in patients not accessing appropriate and timely interventions resulting in poor patient outcomes and experience and breaches in national key performance metrics. **DS2309** There is an inability to maintain surgical emergency patient flow due to insufficient ward and theatre capacity to manage increasing emergency demand, which may lead to delays in care and treatment or care not being delivered in the relevant specialist area. This may result in poorer patient outcomes and patient experience
Core service CQC self-assessment (cycle 1) – positive assurance	24/25		
Ockenden self-assessment – in progress	May 2025		
Level 2 Assurance *Functions that oversee risk. Associated with oversight of activity separate from those responsible for delivery. Provides valuable management insight. More objective than the level 1*	**Date of assurance**		
Core Service Review – Surgery – limited assurance	November 2024		
Core Service Review – Critical Care – partial assurance	January 2025		
Core Service Review- CYP – partial assurance	March 2025		
Local clinical accreditation programme across inpatient wards	2025/26		
Ward to Board Visits	March 2025 (next planned date June		

	2025)
Level 3 Assurance *Functions that provide independent assurance. Generally, includes internal audit, regulators, external bodies. Independent of the 1st and 2nd level, providing a higher level of assurance*	**Date of assurance**
ICB contract visit High Oak Surgery – positive	October 2024
ICB Urgent Care Response Team Quality Assurance Visit – partial assurance	January 2025
ED/Urgent care NHSE visit	March 2025
ICB Visit – PSIRF Engagement - positive	March 2025
Trauma Peer Review - Midlands Clinical Networks – positive assurance with 2 serious but not immediate concerns	March 2025
Midland Kidney Network visit – positive assurance (awaiting formal report)	April 2025
LMNS Visit – positive with areas for consideration (awaiting formal report)	April 2025
JAG accreditation awarded (GI endoscopy)	May 2025
MIS year 6 – positive assurance	February 2025

UC2112 Overall combined paediatric nursing numbers have reduced resulting in patient: nurse ratio falling below acceptable and safe nursing numbers, also inadequate skill mix and senior oversight of the area, which could result in patient harm

PA2492: Following the development of services at Guest and Corbett Outpatient sites, there is insufficient emergency response provision in place to provide consistent cover for all patients in the event of a medical emergency out of core working hours. This could lead to significant delays in patients receiving required urgent treatment and potential poorer patient outcomes.

WC2429: The Neonatal unit is not fit for purpose which is impacting on the quality of care provided and compliance with national standards. This could lead to compromised patient care and poor parental experience

CSS1956: Delay in specialist imaging reporting due to shortage of Consultant Radiologists, which could result in the delay of diagnosis and treatment of patients.

ASM2449: British Thoracic Society recommendation for commencement of treatment with Non Invasive Ventilation (NIV) for patients presenting with hypercapnic respiratory failure within two hours is not currently being met which could result in a longer stay in hospital and potentially death**.**

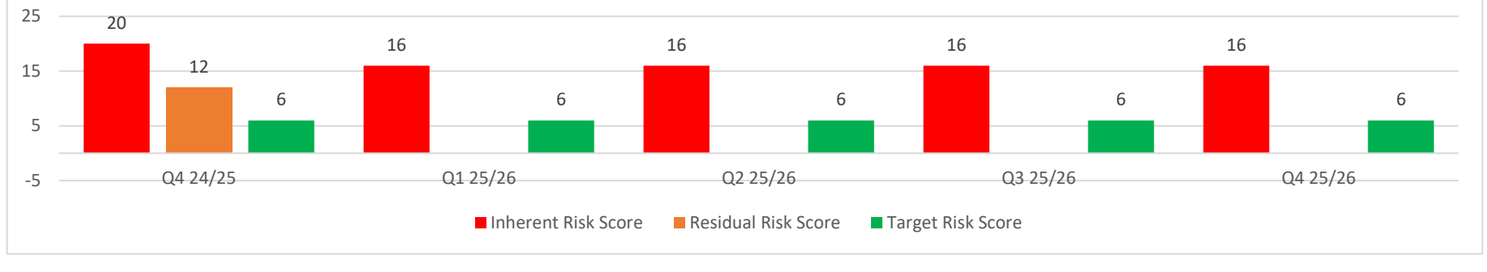
ASM2485: Due to a reduction in staffing capacity and increase in referrals, waiting times for routine lung function tests are increasing leading to delays in diagnosis and patient management.

ASM2496: Due to pressures in Trust capacity, additional areas are sourced to bed patients on a temporary basis. This could potentially lead to the use of the C5 treatment room as extra bedded capacity in times of surge and potential for patient harm due to lack of available facilities, depending on where patient is placed (i.e. visualisation, access to oxygen and suction).

SUV1849: Due to a significant increase in demand within (ESH) Emergency Surgical Hub, there is an increased occurrence of overcrowding within waiting areas, delays in patients being triaged and assessed. This is impacting on patient safety and delays in providing care and/or treatments which may lead to poorer patient outcomes.

Principle Risk	BAF Risk 2 Description: Inability to attract, retain, and develop a skilled and engaged workforce may compromise the delivery of safe, high-quality care, reduce staff morale, and risk non-compliance with regulatory standards.						
Strategic Goal:	**Strategic Measure:**	**Lead Executive/s**	**Lead Committee with oversight**	**Rationale for current risk score:** *Likelihood x Consequence*	**Rationale for target score:** *Likelihood x Consequence*	**Risk Appetite and score**	**Committee Assurance Rating**
To be a brilliant place to work and thrive.	Improvement in staff engagement, retention, and diversity metrics.	James Fleet	People Committee	3 x 4 Possible x Major Reflects ongoing challenges in workforce retention, system optimisation, and cultural transformation.	2 x 3 Unlikely x Moderate Achievable through full implementation of the People Plan, improved data systems, and strengthened leadership development.	Seek	

	24/25 Q4	**25/26 Q1**	**Q2**	**Q3**	**Q4**
erent Risk	**20**	**16**	**16**	**16**	**16**
Current Residual Risk Score	**12**				
Target Risk Score*	**6**				



Key Controls	Gaps in Key Controls	Mitigation Actions *linked directly to gaps in key controls, use formatting of table (merge function) to line up with associated gap*	Lead	Status /due
The People Plan A strategic roadmap that outlines how the organisation will attract, develop, support, and retain its workforce. It actively aligns workforce priorities with organisational goals, ensuring staff are empowered, engaged, and equipped to deliver high-quality services. **EDI Journey & Steering Group** An ongoing programme led by a dedicated steering group to embed **Equality, Diversity, and Inclusion** across the organisation. This includes setting measurable goals, reviewing policies, and championing inclusive practices to ensure all staff feel valued and respected. **Organisational Development Journey** A structured approach to enhancing organisational culture, capability, and performance. This journey includes leadership development, team effectiveness initiatives, and change management strategies to build a resilient and agile workforce. **Wellbeing Journey & Steering Group** A proactive programme supported by a steering group that drives initiatives to support physical, mental, and emotional wellbeing. This includes access to mental health resources, flexible working options, and wellbeing champions across departments.	ESR & Rostering Optimisation Failure to fully optimise ESR (Electronic Staff Record) for workforce management and the implementation of local systems that do not interface with each other have been developed and used in silos	Implement establishment control in ESR (Electronic Staff Record), to enable the analysis of vacancy, turnover and retention data	HW	30/09/2025 in progress (3 of 5 divisions complete)
		Go live with Manager Self-Service so all Managers/Supervisors can manage their teams and associated pay affecting changes using ESR (Electronic Staff Record)	HW	31/01/2026 (in progress project scoping still underway)
		Update all User Responsibility Profiles from limited access to full access	HW	31/01/2026 on track
		Fully implement medical Rostering (Medi-rota)	HW	31/12/2026 - project plan developed. E-leave implemented
		Undertake an establishment review of medical workforce	HW	30/09/2025 - in progress
	Policies Policy Framework is not up to date	Develop rectification plan for 25/26 to ensure all policies are in date and reviewed.	HW	31/05/2025
	Absence Management Effective management of short-term absence (including non-sickness absence) which will impact on the ability to safely manage our services due to poor leadership and management at a range of levels	Re-launch wellbeing conversations	PS	31/05/2025
		Review processes and recording of absence for Medical Staff and establish a process for confirm and challenge on a regular basis – including the development for the medical workforce in recording, monitoring, and taking appropriate action to improve short-term absence.	HW	30/06/2025

Recruitment & Retention Journey A targeted strategy to attract top talent and retain skilled staff. This includes employer branding, streamlined recruitment processes, onboarding improvements, and career development pathways to reduce turnover and fill critical roles. **Being a Brilliant Place to Thrive Steering Group** A cross-functional group focused on creating a positive, inclusive, and high-performing workplace culture. They lead initiatives that celebrate success, encourage innovation, and ensure staff feel heard, supported, and motivated. **25/26 Workforce Plan** A forward-looking plan that projects workforce needs for the 2025/26 period. It includes workforce modelling, succession planning, and skills gap analysis to ensure the organisation is future-ready and sustainably staffed. **Trust Values and Behavioural Framework** A clearly defined set of core values and expected behaviours that guide how staff interact with each other and service users. This framework is embedded in appraisals, recruitment, and daily practice to foster a respectful and compassionate culture. **Leadership & Development Programmes** Structured programmes that build leadership capability at all levels. These include coaching, mentoring, and formal training to develop confident, inclusive, and effective leaders who can drive transformation and inspire teams. **Staff Inclusion Networks** Employee-led groups that provide safe spaces for underrepresented staff communities. These networks influence policy, raise awareness, and promote a culture of belonging through events, advocacy, and peer support. **Robust People Policies** A comprehensive suite of HR policies that ensure fairness, consistency, and legal compliance. These policies cover areas such as grievance, disciplinary, flexible working, and leave, and are regularly reviewed to reflect best practice. **People Systems (ESR, Rostering, Case Management, TRAC)** Integrated digital systems that support workforce management. These tools enable efficient rostering, recruitment tracking, case handling, and employee record management, ensuring data-driven decision-making and operational efficiency. **Safer Staffing** A framework that ensures the right number of staff with the right skills are in place at all times. This includes real-time staffing dashboards, acuity tools, and escalation protocols to maintain safe and effective care delivery. **Robust Workforce Data**	Data Development Robust analysis and action planning on leaver predictions including capturing exit data	Redesign of the Exit Survey and Exit survey process – to also include internal movements	RA	31/05/2025
		Implement Exit survey quarterly reporting to People Committee with a KPI (Key Performance Indicator) around % compliance of termination forms	RA	31/05/2025
		Continuous promotion and embedding of the Trust's 'Stay' process - reviewed each quarter	RA	30/06/2025
	Fragile services and sustainable recruitment and retention of staff	Develop a framework and metrics to identify fragile services and use this to map/identify services (high absence, unavailability, recruitment challenges, poor retention, high turnover)	HW	31/07/2025
		Develop a workforce development and recruitment/retention plan for use/adaptation to fragile services once identified	HW	31/07/2025
		Ensure a robust support, engagement and development plan is in place for internationally educated and recruited staff	RA	31/07/2025
		Develop and deliver a plan to support effective utilization of bank staff and to improve engagement and morale	HW	30/06/2025
		Deliver phase 1 improvements identified from the AHP Workforce review – including tailored recruitment and development plans and flexible working profiles	RA	30/06/2025
		Develop Phase 2 delivery plan for ICan programme and deliver against plan – Paid Work Experience to support improved local reputation and pipeline into roles: CSW Novice Programme creating a sustainable pipeline of work ready CSWs and pathways into Health Records and Phlebotomy	RA	Develop plan 31/05/2025 Delivery 31/3/2026
	Bank & Agency Usage	Review of Medical Locum payrates both internally and across the system	HW	30/06/2025
		Implement Medical Temporary work claim system	HW	30/06/2025
		Undertake analysis - rates paid vs published for SAS and Consultants	HW	01/06/2025
		Scope definitions and agreement of 'bank' versus other extra contractual	HW	01/06/2025
		Formalise principles for bank and WLI/ECW	HW	31/05/2025
		Develop Proposal for bank and WLI/ECW rates for SAS and Consultants	HW	30/06/2025
		Develop robust principles and controls for bank usage	HW	31/05/2025
	Staff Health and Wellbeing service recovery and resilience to meet unplanned demand (e.g. measles outbreak)	Ensure policies, procedures and SOPs are in place for all clinical and administrative functions within the departments	PS	31/05/2025
		Strengthen pathways into supporting services including EAP (Employee Assistance Programme) and Staff Physio as well as explore fast track options for staff on NHS waiting lists	PS	30/06/2025
		Implement a rolling programme of health surveillance is in place via the Trust's Occupational Health Service (SHAW)	PS	30/06/2025
	Staff awareness and utilisation of development opportunities and decreasing role satisfaction/fulfilment	Develop and launch dedicated career and development portal (accessible via intranet and external web page)	RA	30/06/2025
		Develop and deliver a clear approach to succession planning for service critical posts including competencies, development framework and SOP for annual review of succession plans	RA	30/09/2025
	Poor culture around flexible working	Develop data capture and reporting to support improved impact and satisfaction around flexible working options and experience of staff	RA	30/06/2025
	Lack of triangulation around raising concerns and decreasing confidence around raising concerns	Delivery of FTSU (Freedom to Speak Up) Strategy and Year 1 Actions in conjunction with FTSU (Freedom to Speak Up) Guardian. Strategy in development – Year 1 Actions to be reviewed at end of 25/26.	RA	31/03/2026
		Undertake an initial review of data regarding employee experience (to include FTSU, Datix, Complaints, HR concerns/grievances, Staff Survey) to establish baseline. Develop a regular review of this data to inform listening and engagement strategy, bespoke team support and deliver of People Plan and associated Journeys	RA	31/05/2025
		Develop pilot of a balanced scorecard to reflect engagement and morale measures alongside workforce, performance, and patient experience	RA	30/09/2025
	Lack of diversity in senior leadership roles	Develop and launch dedicated career and development portal (accessible via intranet and external web page) Review and design underway with task and finish group. Aligned to wider website redesign	RA	30/09/2025

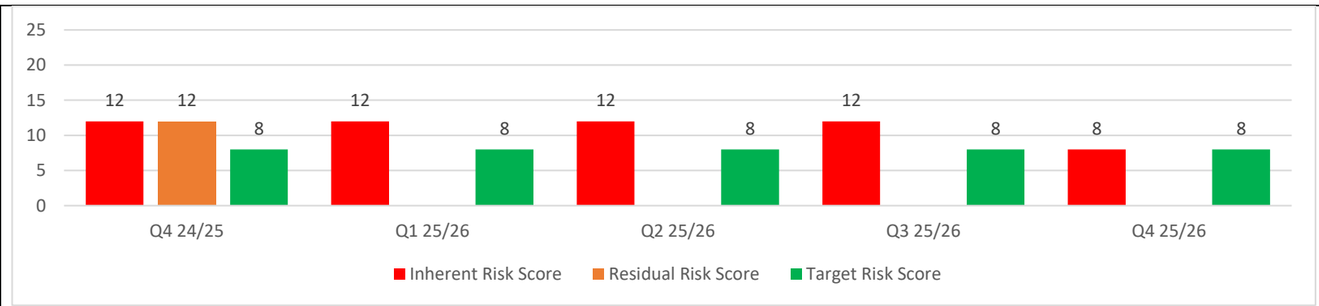
Accurate, timely, and comprehensive workforce analytics that inform strategic decisions. This includes data on turnover, sickness, diversity, and training compliance, enabling targeted interventions and performance monitoring. **Grip and Control (Vacancy, Bank, and Agency)** A set of controls to manage workforce supply and cost. This includes vacancy tracking, bank staff optimisation, and agency usage monitoring to ensure financial sustainability and continuity of care. **Anti-Bullying and Discrimination Policy and Campaign** A zero-tolerance policy supported by awareness campaigns and reporting mechanisms. This initiative promotes a respectful workplace, encourages speaking up, and ensures swift action against inappropriate behaviour.		Deliver Executive and Divisional Leadership development programme to support succession planning as above. Development during 2025/26.	RA	31/03/2026
	Staff engagement and effective communication with staff at all levels	Launch and embed Listen, Act and Feedback approach including additional promotion of formal information gathering and informal routes (line manager responsibility). Deliver Make it Happen during 2025/26 with a view to sustain and embed through Divisions	RA	Launch 30/6/2025 Make it Happen 31/12/2025
	Reported experiences of incivility, lack of respect and bullying and discrimination	Delivery of awareness campaign linked to re-launch of Anti-bulling and anti-discrimination policies and training uptake.	RA/HW	31/03/2026
	Challenges in leadership effectiveness at all levels	Ongoing delivery of Managers Essentials and Leadership Development programmes with increased participation from target areas including Directorate Leaders to meet goal of all managers being trained in minimum standards.	RA	31/3/2026
		Roll-out of national leadership framework once approved (expected Sept 2025)	RA	31/3/2026

Assurances		**Gaps in Assurance**	**Link to Risk Register (operational risks):**
Level 1 Assurance *Provided by those responsible for delivering specific objective/operation. Generally provided by those that own and manage risk, by its nature this can be subjective, but its value is that it comes from those who know the business, culture, and day to day challenges*	**Date of assurance**	Infrastructure for delivery (systems, resource) is limited and likely to be impacted by in-year workforce reductions and corporate service transformation which may restrict ability to deliver	**(Red risks – score of 20 or above) updated Month/year)** None
People Plan Delivery Workstreams	Monthly	Financial restrictions sustained increased operational pressures and external environment (cost of living, unstable socio-economic factors) have an impact on engagement and morale that is difficult to control.	
Key Performance Indicators	Monthly	Unknown impact of NHSE and ICB changes on policy and implementation of People practices and national policy direction.	
Safer Staffing Reports	Bi-annual	Inability to reduce the Gender Pay Gap, address diversity in senior leadership and impact on bullying and harassment experienced as reported through the WRES and WDES indicators which impact on the ability to meet public sector equality duties and standards	
Staff Survey Action Plans	Bi-Annual		
Level 2 Assurance *Functions that oversee risk. Associated with oversight of activity separate from those responsible for delivery. Provides valuable management insight. More objective than the level 1*	**Date of assurance**		
People Committee	Monthly		
BAF	Quarterly		
Workforce Plan	Monthly		
Make it Happen	Bi-annual		
Board to ward	Monthly		
Freedom to Speak Up	Monthly		
Level 3 Assurance *Functions that provide independent assurance. Generally, includes internal audit, regulators, external bodies. Independent of the 1st and 2nd level, providing a higher level of assurance*	**Date of assurance**		
Pulse Survey	Quarterly		
Staff Survey	Annually		
WRES & WDES	Annually		
Gender Pay Gap reporting	Annually		

Principle Risk	**BAF Risk 3 If** the Trust fails to build innovative partnerships, there is a risk that the Trust will be unable to transform the way services are delivered which will impact on the Trust's ability to improve the health of our communities
Linked strategic measures:	Achieve all constitutional standards (access & finance) - People die in their preferred place when receiving palliative care - Reduce unnecessary bed days - Increase our contribution to the local community

Strategic Goal:	**Lead Executive/s**	**Lead Committee with oversight**	**Rationale for current risk score:** *Likelihood x Consequence*	**Rationale for target score:** *Likelihood x Consequence*	**Risk Appetite and score**	**Committee Assurance Rating**
Our Place	Chief Integration Officer	Integration Committee	The current risk score is 12 (3x4). This is based on a possible and major impact assessment. The impact is assessed as major as the health outcomes of our population will not improve without us working in partnership to deliver transformation. There will also be an impact on our reputation.	The target score is 8 (2x4). The Trust should be making appropriate plans to ensure that this is 'unlikely', whilst the impact would remain 'major'.	**Significant 20**	**Positive April 25**

	24/25 Q4	**25/26 Q1**	**Q2**	**Q3**	**Q4**
Inherent Risk	**12**	**12**	**12**	**12**	**8**
Current Residual Risk Score	**12**				
Target Risk Score*	**8**	**8**	**8**	**8**	**8**



Key Controls	**Gaps in Key Controls**	**Mitigation Actions** *linked directly to gaps in key controls, use formatting of table (merge function) to line up with associated gap*	**Exec Lead**	**Status /due**
DGFT is an active member of Dudley Health and Care Partnership Board. The Dudley Health and Care Partnership Board has identified Dudley Group NHS Foundation Trust (DGFT) as its host body, responsible for the governance and operation of the partnership and employment of its core partnership staff. DGFT has also been identified as its Lead Provider Designate.	Some Trust relationships with partners in Dudley Health and Care Partnerships are not as strong as others.	Dudley Stakeholder map and management plan to be updated and refreshed regularly.	Group Director of Communications	October 2025
Dudley Health and Care Partnership Agreement in place and approved by Trust Board.	Sustainability of Partners due to changes in government policy and lack of finances.	Continue to build strong individual relationships and open dialogue between partners.	Chief Integration Officer	March 2026
Dudley Health and Care Partnership Primary, Community and Secondary Care 'Our Principles for collaboration and partnership' has been developed and published. Fortnightly meetings in place with Senior Trust and Primary Care representation.		Establish partnership risk tracking and refresh governance arrangements for Dudley Health and Care Partnership	Chief Integration Officer	October 2025
Integration Board Committee in place to provide the Board with assurance concerning the delivery plans for the Trusts strategic objective to 'Build innovative partnerships to improve the health of our communities.'	Lack of Community EPR	Community Portal been developed for role out in 2025 and development of business case for a Community EPR to be a strategic task and finish project work. Identified as a priority with the Trust and Black Country ICB digital three-year strategy.	Chief Integration Officer.	March 2026
Dudley Health and Care Partnership Board have agreed a vision, priority outcomes and a 5 year plan. They have also agreed 16 KPI's and a set of outcomes they are working on. With regular performance monitoring of KPI through the Partnership Board.	Lack of Black Country wide data sharing agreement with partners involved in health and care service delivery to enable population health management and risk stratification tool.	Work with partners in Black country ICB to confirm timescales for delivery,	Chief Integration Officer.	March 2026
Dudley Primary Care Development plan developed in line with the Black Country Primary Care Transformation Programme and agreed with Dudley Primary Care Collaborative.	New national initiatives drive conversations around establishing new structures and organizations that take capacity away from delivering change with partners.	Partnership Programme Director and Deputy Director of Integration to remain focused on delivering changes that have been agreed through partnership. Chief Integration Officer and ICB Managing Director to lead on developing any new structures with strategic leads from partners to try and limit the impact.	Chief Integration Officer.	March 2026
Joint Provider Committee directly into Trust Board.				

Joint Provider Committee and Black Country Provider Executive Group established with DGFT CEO acting as SRO. Black Country Collaboration Agreement approved by all four Acute and Community Trust in the Black Country.	Group model with Sandwell offers opportunities to collaborate on a wider scale, however each place and Trust is starting from a different baseline and have slightly differing local priorities.	Group clinical services plan to be developed which maximises the opportunities for collaboration across NHS services and with partners	Chief Integration Officer and Group Chief Strategy and Digital Officer	March 2026

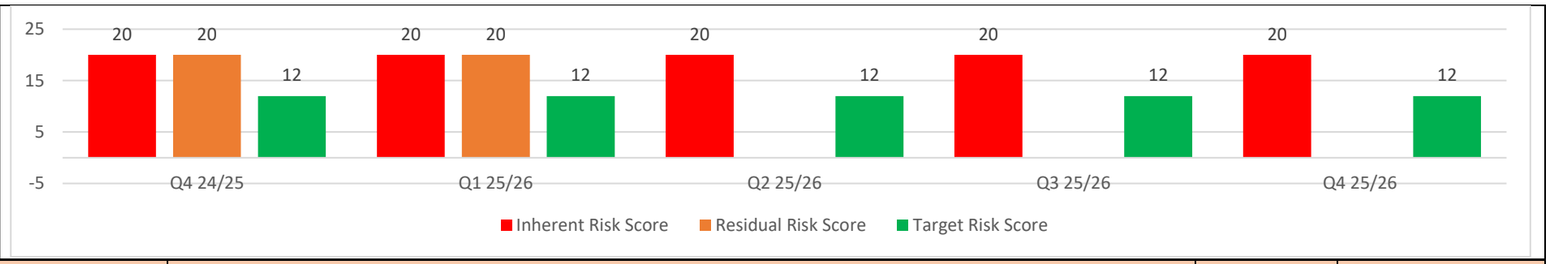
Assurances		**Gaps in Assurance**	**Link to Risk Register (operational risks):**
Level 1 Assurance *Provided by those responsible for delivering specific objective/operation. Generally provided by those that own and manage risk, by its nature this can be subjective, but its value is that it comes from those who know the business, culture, and day to day challenges*	**Date of assurance**	Lack of clarity around assurance required from ICB from Provider collaborative and Place.	**(Red risks – score of 20 or above) updated Month/year)**
Dudley Health and Care Partnership Programme Director regular progress report to Trust Integration Committee.	March 2025	Impact of Dudley Metropolitan Borough Council financial challenges and management restructure on opportunities for partnership working.	
		Lack of clarity around what the ICB will delegate to Provider Collaboratives and Place	
Level 2 Assurance *Functions that oversee risk. Associated with oversight of activity separate from those responsible for delivery. Provides valuable management insight. More objective than the level 1*	**Date of assurance**		
Dudley Health and Care Partnership Agreement in place and approved by Trust Board.	June 2023		
Black Country Collaboration Agreement approved by all four Acute and Community Trust in the Black Country. This will be subject to periodic review.	July 2023		
Level 3 Assurance *Functions that provide independent assurance. Generally, includes internal audit, regulators, external bodies. Independent of the 1st and 2nd level, providing a higher level of assurance*	**Date of assurance**		

The Dudley Group NHS Foundation Trust

Principle Risk	**BAF Risk 4:** Failure of the Trust to achieve its financial plan in 2025/26 may result in NHS England taking regulatory action
Linked strategic measures:	Continue to improve how productive we are | reduce planned care leaving our System | reduce unnecessary stays in hospital.

Strategic Goal:	**Lead Executive**	**Lead Committee with oversight**	**Rationale for current risk score:**	**Rationale for target score:**	**Risk Appetite and score**	**Committee Assurance Rating**
Our Patients Our People Our Place	Director of Finance	Finance & Productivity Committee	The current risk score is 20 (5x4) based on an almost certain and major impact assessment. The Trust had set a breakeven plan which includes £26.95m of deficit funding and a distribution of the Integrated Care Board surplus. To achieve this plan the Trust is required to deliver a Cost Improvement Programme of £38.976m. At plan submission £8.9m of the Cost Improvement Programme was unidentified with most of the remainder at either 'Opportunity' or 'Plans in Progress' status.	The target risk score is 12 (4x3). This is based on a reduction in likelihood (from 4 to 3) and a reduction in consequence (from 5 to 4). This will be reviewed throughout the year and will reflect the Trust having a robust forecast to deliver the 2025/26 financial plan, a fully identified Cost Improvement Programme for 2025/26 that is delivering and recurrent cost savings maintaining the Trusts underlying financial position against the financial recovery plan.	OPEN 12	Positive April '25

	24/25 Q4	**25/26 Q1**	**Q2**	**Q3**	**Q4**
Inherent Risk	20	20	20	20	20
Current Residual Risk Score	20	20			
Target Risk Score*	12	12	12	12	12



Key Controls	**Gaps in Key Controls**	**Mitigation Actions** *linked directly to gaps in key controls, use formatting of table (merge function) to line up with associated gap*	**Exec Lead**	**Status /due**
• Financial plan approved by Trust Board and risks to delivery fully understood and articulated with clear assurance reporting throughout the year.	• There needs to be enhanced monitoring of performance to ensure recovery plans can be immediately put in place should actual delivery start to deteriorate from plans.	1. Monthly reporting to Finance & Productivity Committee to include overall financial performance against plan and recovery plans if applicable. 2. Monthly 'Challenge' meetings with Divisions led by Chief Executive to hold to account delivery against agreed financial plans.	Chris Walker Diane Wake/Chris Walker	1. Complete 2. Complete
• Budgets owned and signed off by budget managers with clear accountability as set out in the Budget Management Policy.	• All budgets are accepted and signed off by Budget Holders for 2025/26 financial year. • Up to date and Budget Management Policy with relevant content to the current financial regime we are working in.	1. Confirmation and evidence that all budgets were signed off by budget managers prior to the commencement of the 2025/26 financial year. **Majority complete** 2. Budget Management Policy is in date and has been updated to include all relevant financial grip and control measures required to manage budgets. **awaiting completion of equality impact assessment**	Richard Price Richard Price	1. ~~30/04/2025~~ 30/06/2025 2. ~~31/05/2025~~ 30/06/2025
• Grip and Control measures continued from 2024/25 to provide enhanced financial control.	• Formal groups are set up and working through on-going pay and non-pay controls and reporting.	1. Enhanced bank controls to be established for both nursing and medical bank to ensure grip and control is in place. 2. Non-Pay group to expand oversight and ensure Trust wide communication and controls are in place to improve effectiveness.	James Fleet Chris Walker	1. 30/06/2025 2. 30/06/2025
• Cost Improvement Programme delivery and reporting fully embedded in organisations and adequately resourced at both operational delivery level and reporting.	• At plan stage the Trust does not have a fully identified cost improvement programme to fully achieve the required savings identified in the approved plan submitted to NHS England.	1. Monthly reporting of CIP progress to Finance & Productivity Committee clearly articulating any risk to the financial position of unidentified or non-delivering CIP. **Complete** 2. 2025/26 CIP plans finalised, fully identified and approved through appropriate governance route. 3. All CIP is recurrent as we exit the 2025/26 financial year. 4. Corporate back-office reductions have a clear and robust plan in place to deliver the required savings as per the CIP plan.	Matt Gamage Matt Gamage Matt Gamage Chris Walker	1. 31/05/2025 **Complete** 2. 30/06/2025 3. 31/12/2025 4. 30/06/2025

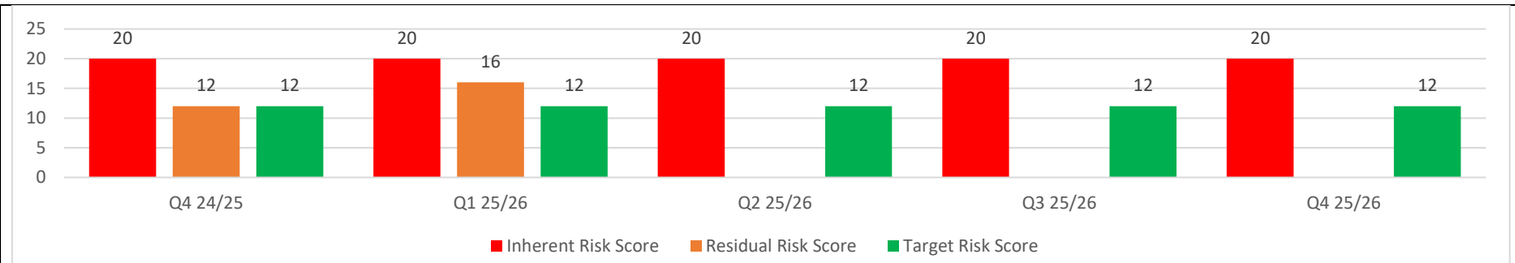
Assurances		Gaps in Assurance	Link to Risk Register (operational risks):
Level 1 Assurance *Provided by those responsible for delivering specific objective/operation. Generally provided by those that own and manage risk, by its nature this can be subjective, but its value is that it comes from those who know the business, culture, and day to day challenges*	**Date of assurance**	The Cost Improvement Programme plan is not fully identified or fully recurrent.	**(Red risks – score of 20 or above) updated Month/year)** *To be updated*
Financial Improvement Group		The Cost Improvement Programme must have the right level of resource, including capability and capacity to deliver the productivity schemes.	
Confirm & Challenge meeting with operational divisions and corporate directorates to review financial performance.		The Trust does not have non-recurrent CIP schemes worked up to mitigate any short falls or under delivery on current CIP schemes.	
		Un-funded surge bed areas remain open which will impact on the delivery of the financial plan.	
Level 2 Assurance *Functions that oversee risk. Associated with oversight of activity separate from those responsible for delivery. Provides valuable management insight. More objective than the level 1*	**Date of assurance**		
Monitoring of financial plan delivery via financial indices and key metrics by Finance & Productivity sub-committee of Board			
Level 3 Assurance *Functions that provide independent assurance. Generally, includes internal audit, regulators, external bodies. Independent of the 1st and 2nd level, providing a higher level of assurance*	**Date of assurance**		
Integrated Care Board review of plan.			
NHS England review and acceptance of plan			
External Audit Value for Money Audit Opinion			
NHS England fortnightly review of Cost Improvement Programme progress			
NHS England monthly financial performance submission and review			

The Dudley Group NHS Foundation Trust

Principle Risk	BAF Risk 5 Failure to achieve operational performance requirements and deliver strategic goals
Linked strategic measures:	Achieve all national standards | Continue to improve how productive we are | Reduce unnecessary stays in hospital | Reduce planned care leaving our System

Strategic Goal:	Lead Executives	Lead Committee with oversight	Rationale for current risk score: *Consequence x Likelihood*	Rationale for target score: *Consequence x Likelihood .*	Risk Appetite and score	Committee Assurance Rating
Our Patients	Chief Operating Officer (COO)	Finance and Productivity	The current risk score is 16 (4x4). This is on the basis that the current likelihood is "likely". The impact of this risk, should it be realised for the Trust's services, is 'major'.	The target risk score is 12 (3 x 4). The impact of this risk should it be realised would remain as major, but the likelihood for the Trust should be reduced to possible.	Open	

	24/25 Q4	25/26 Q1	Q2	Q3	Q4
Inherent Risk	20	20	**20**	**20**	**20**
Current Residual Risk Score	12	16			
Target Risk Score*	12	12	12	12	12



Key Controls	Gaps in Key Controls	Mitigation Actions *linked directly to gaps in key controls, use formatting of table (merge function) to line up with associated gap*	Exec Lead	Status /due
• **Performance Management Framework** There is a regular review of adherence to the national operational performance requirements. This is completed through the integrated performance report and deep dive presentations to the Finance and Performance Committee then upwards to Board. • **Escalation Policies** Clear escalation process in place with linked action cards to Escalation Level. • **Site management and system control** Five site meetings per day to review current site position and twice daily calls with the Black Country Trusts to assess overall capacity and to arrange support if needed, chaired by the Integrated Care Board. • **Elective Recovery Plan** Close monitoring of the Referral to Treatment time recovery and adherence to the national recovery plan. Regular Elective recovery meetings shared across the Black Country to ensure mutual aid is provided if required. • **Outpatient Transformation Workstream** Focusing on key specialities on key areas, in particular Validation, Triage, Reducing DNA	• **Capacity and Demand modelling** Capacity and demand modelling has not been repeated in light of the changing patient demographic and the change in geography. • **Reduced Majors Cubicles in ED** Cubicle space reduced as a result of the Resuscitation building work. • **Lack of real time capacity information** The Trust does not have an electronic bed management system resulting in inability to see real time information • **Delays in social care provision** The delay in provision of care on all pathways, particularly pathway 3 results in extended length of stay for patients who do not meet the criteria to reside. • **Full seven day provision has not been realised** There are not full 7 day face to face ward rounds and variability in discharge performance at weekends and	• Capacity and demand modelling is being undertaken in multiple specialities for both elective and urgent and emergency care workstreams. This is focused on both space and workforce to meet the current demand. • Focus on movement of patients out of the department as soon as plan is place for ongoing care. This is reliant on improvement in management of discharge out of the organisation and utilisation of alternative pathways to manage patients in the community. • Electronic bed state currently under development and to enter to the testing phase. Work then to continue to enable the ability for this to provide discharge information. • Trust representation now on the Better Care Fund Executive Committee. Trust has commissioned How to Find a Care Home to provide bridging care for Pathway 1 patients with a confirmed care start date that is not today. Care transfer hub is to be created and to be opened in June 2025. • A review of the expectations of on call teams for patient review to be carried out within the divisions. Job planning exercise to be completed to ensure adequate time in place for weekend activity for medical staff. Therapy provision in key areas and diagnostic availability also to be reviewed.	COO COO DCOO/CIO/CNIO DCOO/DOPS/DCN MD/COO/CN	Dec 2025 Ongoing Sep 2025 Jun 2025 Sep 2025

rate and use of Patient Initiated Follow Up. This is in line with the Getting It Right First Time (GIRFT) Further Faster 20 (FF20) programme. • **Data availability to look retrospectively at performance** Strong informatics resource to look at previous performance and to identify key themes for improvement. • **Lead SRO and CEO within Dudley Group for the Elective and Diagnostic Recovery Board** This ensures influence with performance not only within the Trust but within the system • **Cancer Oversight Meeting** Chaired by the Cancer Team overseeing the adherence to Diagnostic and Treatment targets. Enabling early intervention for challenged specialities.	public holidays. • **Insufficient theatre capacity to meet elective demand** Demand outweighs the availability of theatre space.	• Mutual aid arrangement in place to use vacant theatre capacity at Sandell and West Birmingham Trust pending the development of the South Elective Hub. Maximisation of high volume and high intensity theatre lists to utilise available theatre time effectively. Team job planning to ensure that lists are not dropped during periods of leave.	DOPS	Jul 2025

Assurances		**Gaps in Assurance**	**Link to Risk Register (operational risks):**
Level 1 Assurance *Provided by those responsible for delivering specific objective/operation. Generally provided by those that own and manage risk, by its nature this can be subjective, but its value is that it comes from those who know the business, culture, and day to day challenges*	**Date of assurance**	• Working in collaboration to achieve system performance metrics may impact on individual organisation trajectories • Ability to flex finances to support additional waiting list initiatives to improve performance • Workforce reduction strategy may impact ability to validate patient pathways • Strategic change may impact on current service delivery	**(Red risks – score of 20 or above) updated Month/year)** • COR2368 Delays in patient discharges coupled with increased demand for ED services and inpatient admissions may result in patients not accessing appropriate and timely interventions resulting in poor patient outcomes and experience and breaches in national key performance metrics (May 2025)
Trust Management Team meeting with an opportunity to review performance and mitigations	Monthly		
Level 2 Assurance *Functions that oversee risk. Associated with oversight of activity separate from those responsible for delivery. Provides valuable management insight. More objective than the level 1*	**Date of assurance**		
Finance and Productivity Committee receive IPR and other operational performance updates	Monthly		
Quality Committee received regular performance reports	Monthly		
Executives meeting	Weekly		
Level 3 Assurance *Functions that provide independent assurance. Generally, includes internal audit, regulators, external bodies. Independent of the 1st and 2nd level, providing a higher level of assurance*	**Date of assurance**		
NHSE monitoring and escalation returns/sitreps	Regular Returns		
Elective & Diagnostic ICS Board	Monthly		
ICS Cancer Board overseeing delivery against strategy in line with NHS goals	Monthly		
Screening Quality Assurance Services (NHSE)	Monthly		
Dudley Council Health Scrutiny Committee	As needed/required		
Tiering Calls	Weekly		
Regional Access Board	Monthly		
Peer Benchmarking through GIRFT	Monthly		