The Dudley Group
NHS Foundation Trust

THE DUDLEY GROUP NHS FOUNDATION TRUST

ANNUAL REPORT AND ACCOUNTS 2025/26

Presented to Parliament pursuant to Schedule 7, paragraph 25 (4) (a) of the National Health Service Act 2006

CARE RESPECT RESPONSIBILITY

The Dudley Group NHS Foundation Trust Annual Report and Accounts 2025/26

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Front Cover captions

One of our corporate services staff members

Newborn baby and mum on our maternity ward

Team members at our Russells Hall Hospital pharmacy

Members of our Virtual Paediatric Ward in the community

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Welcome from the Chairman and Group Chief Executive Officer

Welcome to the annual report for 2025/26. As we reflect on 2025/26, this has been a year defined by both significant challenge and meaningful progress for The Dudley Group NHS Foundation Trust.

Like many organisations across the NHS, we experienced sustained pressure within our Urgent and Emergency Care (UEC) services. Demand remained consistently high, particularly through the winter period, placing considerable strain on our teams and systems. In response, we took the difficult but necessary step of opening additional beds to support patient flow. This brought both financial and workforce challenges, requiring rapid mobilisation of staff and resources in an already constrained environment.

Despite these pressures, I am pleased to report that we ended the year on an upward trajectory of performance. Through focused effort, strong clinical leadership, and the resilience of our staff, we saw improvements in key operational metrics and patient flow, demonstrating our ability to adapt and recover. We have also been able to sustain our high performance in planned care, ensuring that local people are not waiting longer than required for treatment.

During the year, we were pleased to welcome the Minister of State for Care, Stephen Kinnock, to the Trust, providing an opportunity to highlight our progress in digital innovation and our transition from analogue to more modern, integrated digital systems. This transformation is already supporting safer, more efficient care for our patients and better experiences for our staff. We also marked the opening of our new resuscitation (resus) facilities, strengthening our ability to respond to the most critically ill patients. Alongside this, we continued to take healthcare closer to our communities through initiatives such as the Merry Hill health hub, bringing services onto the high street and improving accessibility for local people.

The year was also impacted by industrial action, which added further complexity to service delivery. Throughout this, our staff have continued to demonstrate the Trust's core values of Care, Respect and Responsibility, supporting patients and one another with professionalism and compassion. I would like to place on record my sincere thanks to all colleagues for their continued dedication and commitment.

Group Chief Executive Diane Wake and Chair Sir David Nicholson on the site of our Emergency Department redesign

Our staff survey results highlight both areas of strength and areas where we must do better. We are encouraged by the positive feedback around teamwork and patient care, but we are equally committed to addressing concerns raised. This includes strengthening our culture, improving communication, and ensuring our staff feel valued, supported, and heard.

Financially, we have delivered a strong position. We met our financial plan, significantly reduced our reliance on temporary staffing, and, as a result, had financial measures withdrawn by NHS England. This reflects disciplined management and a collective commitment to using our resources responsibly.

As we look ahead to 2026/27, we do so with ambition and optimism. We have a clear plan to focus on community first, invest in our people and culture, make the best use of our resources, lead with prevention and continue enhancing patient care. Central to this is the opportunity presented by our developing Group model with Sandwell and West Birmingham NHS Trust. By working more closely together, we can unlock efficiencies, share best practice, and deliver broader transformation that benefits our patients and communities.

While challenges remain, we are entering the next year with renewed confidence, a stronger foundation, and a clear sense of direction, grounded in our values and the dedication of our people.

Finally, we would like to extend our sincere thanks to our patients, their families, and carers for the trust they place in us every day. We are deeply grateful to our staff, whose continued commitment makes a difference to the lives of those we serve. We also recognise the importance of the wider population we serve and remain committed to improving health outcomes for all. Our thanks extend to our partners across the NHS, local authorities, and the voluntary and community sector, whose collaboration is essential as we continue to improve services and build a stronger future together.

Thank you

Signed: Sir David Nicholson

Chair

Date: 22nd June 2026

Signed: Diane Wake

Group Chief Executive Officer

Date: 22nd June 2026

Who we are

The Dudley Group NHS Foundation Trust is an integrated provider dedicated to delivering excellent healthcare for the people of Dudley and is the main provider of hospital and adult community services to Dudley, significant parts of the Sandwell borough and smaller, but growing, communities in South Staffordshire and Wyre Forest.

Currently we serve a population of around 450,000 people from three sites at Russells Hall Hospital, Guest Outpatient Centre in Dudley and Corbett Outpatient Centre in Stourbridge, two GP surgeries - as well as in people's homes from our community and primary care teams and at community hubs including the new Merry Hill Health Hub.

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.

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 day care 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 also have enhancing primary care roles such as GP practice-based pharmacists, first contact paramedics, health coaches, social prescribing link workers along with primary care led healthcare to a considerable number of care homes across the borough.

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 provide excellent healthcare for the people of Dudley.

The Dudley Group NHS Foundation Trust's Russells Hall Hospital

A local dance group performed at Russells Hall Hospital for South Asian Heritage Month

The year in review

The year began with a record-breaking achievement, setting a positive tone for the months that followed. Our charity's London Marathon entry not only captured attention but also beat the mythical creature costume world record by 20 minutes. Adam, who completed the 26.2-mile course dressed as a unicorn, raised over £4,000 for our Baby Bereavement Appeal at Russells Hall Hospital. This early success reflected both the dedication of our supporters and the strong community spirit that underpins our work.

Building on this momentum, the Trust continued to focus on innovation and service improvement. In May, we introduced high-intensity theatre weekend sessions as part of the government's Further Faster 20 initiatives, supporting efforts to reduce waiting lists. This approach has since gained national recognition, with 392 surgeries delivered through the initiative so far.

Alongside these operational improvements, significant investment in infrastructure has further strengthened our ability to deliver high-quality care. A major milestone was the opening of our new state-of-the-art resuscitation facilities. Following a successful redevelopment bid in 2020, this enhanced space is transforming care within our emergency department. The development includes a dedicated paediatric area, new isolation rooms to support safe care during potential future outbreaks, and an improved bereavement suite, offering families greater comfort, privacy, and support during challenging times.

This focus on patient safety and experience has also been reflected in our alignment with national priorities. Over the past year, we have driven a Trust-wide focus on the Martha's Rule initiative, reinforcing our commitment to transparency, compassionate care, and early recognition of patient deterioration. By increasing awareness among staff, patients and visitors, and embedding clear escalation pathways, we continue to foster a culture in which speaking up is actively encouraged.

As we moved into the summer months, there were further opportunities to celebrate both patient milestones and staff achievements. The unveiling of the end-of-treatment bell in the urology department at Corbett Outpatient Centre marked an important moment for patients completing their care. At the same time, the Dudley Adult Bladder and Bowel Service was recognised nationally, with the team invited to 10 Downing Street following praise from local MP Sonia Kumar during a House of Commons debate. These moments highlight the growing recognition of the Trust's work at both local and national levels, supported by our continued engagement with MPs through regular briefings, visits, and events.

Corbett Outpatients Centre Urology Clinic with a bell to signify the end of a patients treatment

Innovation in clinical practice has remained a key theme throughout the year. Notably, our Cardiology and Interventional Radiology teams carried out a first-of-its-kind procedure in the West Midlands, successfully implanting a leadless pacemaker in a local hospital setting rather than a specialist centre. This groundbreaking technology, significantly smaller than traditional devices, demonstrates how advancements in care are enabling faster, more efficient, and increasingly personalised treatment for patients. The Trust further transformed access to cardiac care across the region with the introduction of the first SOMATOM Pro.Pulse CT scanner in the UK, bringing specialist cardiac diagnostics closer to patients, reducing waiting times, easing pressure on services and enabling earlier detection and treatment of heart conditions within local settings.

This commitment to innovation was further highlighted during a visit from health minister Steven Kinnock MP to Russells Hall Hospital later in the year. During his visit, he saw the NHS 10 Year Plan in action, including how our stroke team is using artificial intelligence to speed up triage by providing instant access to diagnostic imaging and identifying suspected strokes earlier, even in patients without typical symptoms. He also visited the Paediatric Virtual Ward, which enables children with conditions such as asthma and RSV to receive care at home through digital pathways, reducing unnecessary admissions and supporting earlier discharge.

Alongside these advancements, the Trust has continued to deliver impressive performance across core services. Chapel Street Surgery in Lye received an overall 'Good' rating from the Care Quality Commission, while our Lung Cancer Screening Programme marked its first anniversary with significant impact. Over 65,000 invitations have been issued, leading to more than 31,000 Lung Health Check appointments, over 14,000 CT referrals and 120 lung cancer diagnoses. Importantly, early diagnosis rates have improved dramatically, with 74% of cases now identified at an early stage compared to over 70% previously diagnosed late, improving patient outcomes and treatment options.

Our charitable efforts have also played a vital role in enhancing patient care and experience. The Dudley Group NHS Charity's fifth annual Glitter Ball brought together local businesses in support of the cancer appeal, raising over £20,000 to fund therapies such as reiki and acupuncture. Funding from previous events has already made a difference, including the introduction of Mobii interactive tables within the Forget Me Not dementia unit, helping to stimulate memory, encourage interaction and improve patient wellbeing.

Steven Kinnock MP with a mother and her child on the Paedatric Virtual Ward

At the same time, we have continued to expand care closer to home. In October, services began moving into the new Health Hub at Merry Hill Shopping Centre, marking a significant step forward in improving access to integrated care. Bringing together services such as blood tests, paediatric outpatient clinics and gynaecology in a modern, accessible setting, the hub reflects our commitment to delivering more joined-up, patient-centred care while addressing health inequalities across our communities.

This period also saw a strong focus on staff engagement and wellbeing. Campaigns such as the 'Back to the Flu-ture' flu vaccination programme and the National Staff Survey encouraged participation and feedback, reinforcing the importance of listening to our workforce. Supporting this, the launch of the Listen Act Feedback framework has provided clearer pathways for staff to share their experiences and influence change, ensuring their voices remain central to how we improve as an organisation.

Engagement has extended beyond our workforce to the wider community. Events such as the 'behind the scenes' student visits at Corbett Outpatient Centre and media features highlighting our Frailty Virtual Ward have helped raise awareness of the breadth of services we provide. Similarly, our "Health on the Shelf" initiative over the Christmas period brought together more than 30 organisations to connect with over 400 residents, promoting prevention, education, and access to local support.

We have further increased our local partnership working as our Chief Executive Diane Wake signed the joint Aston University joint Civic Agreement 2030 on behalf of the Trust and also unveiled the new Centre of Excellence for Health Education at Halesowen College.

Further strengthening our clinical offer, the launch of a new vascular "hot clinic" at Russells Hall Hospital has improved access to urgent care. By enabling specialist assessment within 48 hours for patients with time-critical vascular conditions, this service supports faster intervention, reduces hospital admissions, and improves overall patient outcomes.

Equality, Diversity, and Inclusion has remained a central priority throughout the year. Through a wide-ranging programme of events and awareness campaigns, including Black History Month, Pride Month, Disability History Month, and International Women's Day, we have continued to celebrate diversity, promote understanding and encourage inclusive behaviours across the Trust. These activities support our ongoing commitment to fairness, dignity, and respect for all.

The dedication of our staff has also been recognised through numerous awards and achievements at local, regional, and national levels. From HSJ Award short listings to digital innovation accolades and partnership awards, these successes reflect excellence across clinical care, leadership, education, and patient experience. Alongside this, our annual Committed to Excellence Awards and Long Service Awards, celebrating over 4,700 years of NHS service, highlight the exceptional contribution of our workforce.

Chief executive Diane Wake signing the joint Aston University joint Civic Agreement 2030

A collaborative project between Dudley Council and the Trust's ICan programme, alongside an individual learner supported by the council's Adult and Community Learning team, was recognised at this year's WMCA Adult Learning Awards. Supported by the Learning and Work Institute, the awards celebrate outstanding commitment to adult learning, skills and training across the West Midlands, highlighting the achievements of learners, tutors, employers and providers. Receiving the Inclusive and Innovative Recruitment and Career Champion award, it recognised the partnership as the borough's two largest employers to strengthen employment pathways for local residents and position themselves as employers of choice, supported by funding from the Commonwealth Games Legacy Fund.

A combined project between the Dudley Council and our iCan programme and an individual learner using the council's Adult and Community Learning team's services have been recognised in this year's WMCA Adult Learning Awards

In addition, our charity has continued to support meaningful improvements across the Trust, including the creation of new wellbeing rooms, refurbished mortuary waiting areas and the installation of a rainbow sculpture at Russells Hall Hospital, each enhancing the environment for patients, families, and staff alike.

This year laid the foundations for our transition towards a Group model with Sandwell and West Birmingham NHS Trust. Serving overlapping populations and with similar operational, workforce and financial pressures, the plan ensures that deeper collaboration will help us go further and faster on improvement, transformation, and reform. This year saw shadow joint committees form to align objectives and visions as we moved towards the unified Group Board, established as a Joint Committee of both sovereign Trust Boards. These included; Joint Infrastructure Committee, Joint Finance and Productivity Committee, and Joint People Committee.

Finally, our commitment to compassionate, high-quality care has been further demonstrated through clinical excellence, with four wards achieving Gold Standard Framework accreditation for end-of-life care. This reflects the consistent dedication of our teams to delivering personalised, dignified support to patients and their families.

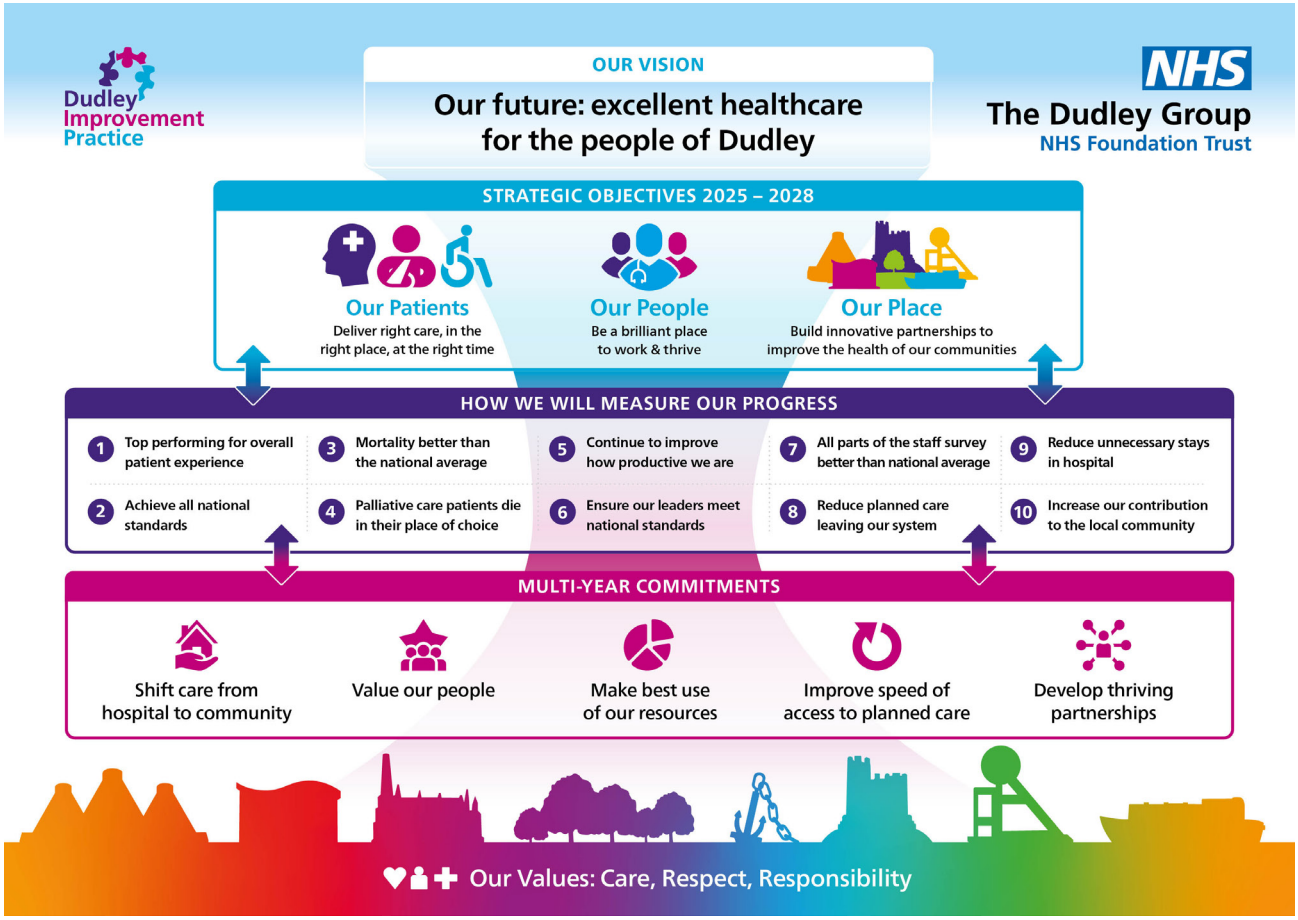
Throughout the year, engagement and collaboration have remained at the heart of our approach. By working closely with partners, stakeholders, and local communities, and by actively listening to the voices of patients, carers, and staff, we continue to shape and improve our services. These collective efforts ensure that we not only respond to current needs but also build strong, trusted relationships that will support the future of care across our communities.

Deputy Lieutenant Stewart Towe, Councillor Peter Lee The Mayor of Dudley and his wife Gloria at the rainbow sculpture unveiling

Overview

Our strategy

Our strategy was refreshed and was formally approved by the Board of Directors in July 2025 following a period of review. The new strategy reflects the changes set out in the government's 10-year Health Plan which was also published in July 2025. Staff and stakeholders across the health and care system were asked for their views in creating this new strategy.



Our vision is: 'Excellent healthcare for the people of Dudley'

Our values remain: **Care**, **Respect** and **Responsibility**.

Some notable achievements in delivering our strategy this past year include:

- Opening the Care Navigation Centre by expanding the capacity and range of services offered as a single point of access for community services. The Centre aims to provide care outside of hospital where possible and reduce pressure on acute hospital services
- Reviewing and transforming pathways for patients admitted to hospital as an emergency to eliminate delays in getting the right care through the learn Adapt Transform programme
- Continued our efforts to transform the way outpatient services are delivered. This has included the introduction of more digital tools and expanding the number of patients offered 'patient-initiated follow-up' giving them greater control over their appointments
- Opened a larger Health Hub within the Merry Hill Centre offering blood tests and several outpatient clinics
- Identification and delivery of cost improvement programmes of £31.4m
- Developed a closer partnership with Sandwell & West Birmingham with the creation several senior leadership roles across both organisations and a review of corporate services to streamline and focus resources on frontline services

With the new joint governance arrangements coming into effect from 1st April 2026, we have been preparing a single strategy across the Group which will describe our priorities for both Trusts.

Risks to delivering our goals

As with any organisation, there are risks to the Trust's ability to deliver its strategy and ensure patient safety. The Trust must 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 2026.

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 orational 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 114 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 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.

Key developments in this area include the training the Trust delivers to staff on incident management and the post incident support offer for staff including restorative supervision.

During 2025/26, the Trust continued to demonstrate a healthy reporting culture, overall reporting has gradual increased 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.

During 2025/26, the Trust has continued to develop and embed the PSIRF framework, implementing proportionate system-based approaches and reducing the number of full Patient Safety Incident Investigations to allow for resource to be directed into improvement work.

Incident responses are centred on engagement and support for those impacted by incidents, patients, families, and staff. We actively seek, monitor and report feedback from those impacted by incidents; feedback has been positive and where suggestions have been made for improvement our process had been strengthened.

Never Events remain a national priority incident when working under the Patient Safety Incident Response Framework.

During 2025/26, there were two Never Events reported; this represents an increase compared to the previous year; there were no trends regarding these incidents. In both cases full Patient Safety Incident Investigations have been commissioned, and immediate learning has been implemented where applicable.

The Trust continues to report both incidents and positive events to the Learning from Patient Safety Events (LFPSE) in line with national requirements and works closely with the Risk Management System supplier to develop our reporting system to support reporting and learning.

How we manage our services

The day-to-day operational management of the Trust's hospitals and services is undertaken by the Executive Director Team, led by the Chief Executive. The Executive Team provides collective leadership and is supported by senior colleagues across corporate and clinical functions, ensuring effective coordination, oversight, and delivery of high-quality, safe, and sustainable services across the organisation.

The Trust's operating model is organised into four clinically led divisions, each supported by corporate services and aligned to deliver integrated, patient-centred care. These divisions are:

- Surgery, Women and Children's Division
- Medicine and Integrated Care Division
- Community and Core Clinical Support Services Division
- Place Division

The divisional structure enables clear lines of accountability while promoting collaboration across pathways and services to support the delivery of seamless care. Each division is led by a triumvirate comprising a Chief of Service, Divisional Director of Operations, and Divisional Chief Nurse. These leadership teams are accountable to the Chief Operating Officer, who in turn is accountable to the Chief Executive.

Corporate services provide the infrastructure, capability, and professional leadership required to enable effective organisational performance and continuous improvement. These functions include:

- Communications
- Estates and Facilities
- Finance
- Governance
- Human Resources
- Information Services
- Organisational Development
- Dudley Improvement Practice (Quality Improvement)
- Research and Development
- Information Technology (IT)

The Trust has established a comprehensive governance framework to support effective stewardship, accountability, and assurance. The Board of Directors retains overall responsibility for setting the strategic direction, ensuring robust systems of internal control, and fostering a culture of openness, learning, and continuous improvement. The Board meets monthly to review organisational performance, risks, and progress against strategic objectives.

Board assurance is supported through a structured committee architecture, providing focused oversight across key domains including quality, finance, workforce, and audit. As part of the development of the Group model with Sandwell and West Birmingham Hospitals NHS Trust, the Trust is progressing arrangements to align and, where appropriate, establish joint committee arrangements operating across both organisations. This

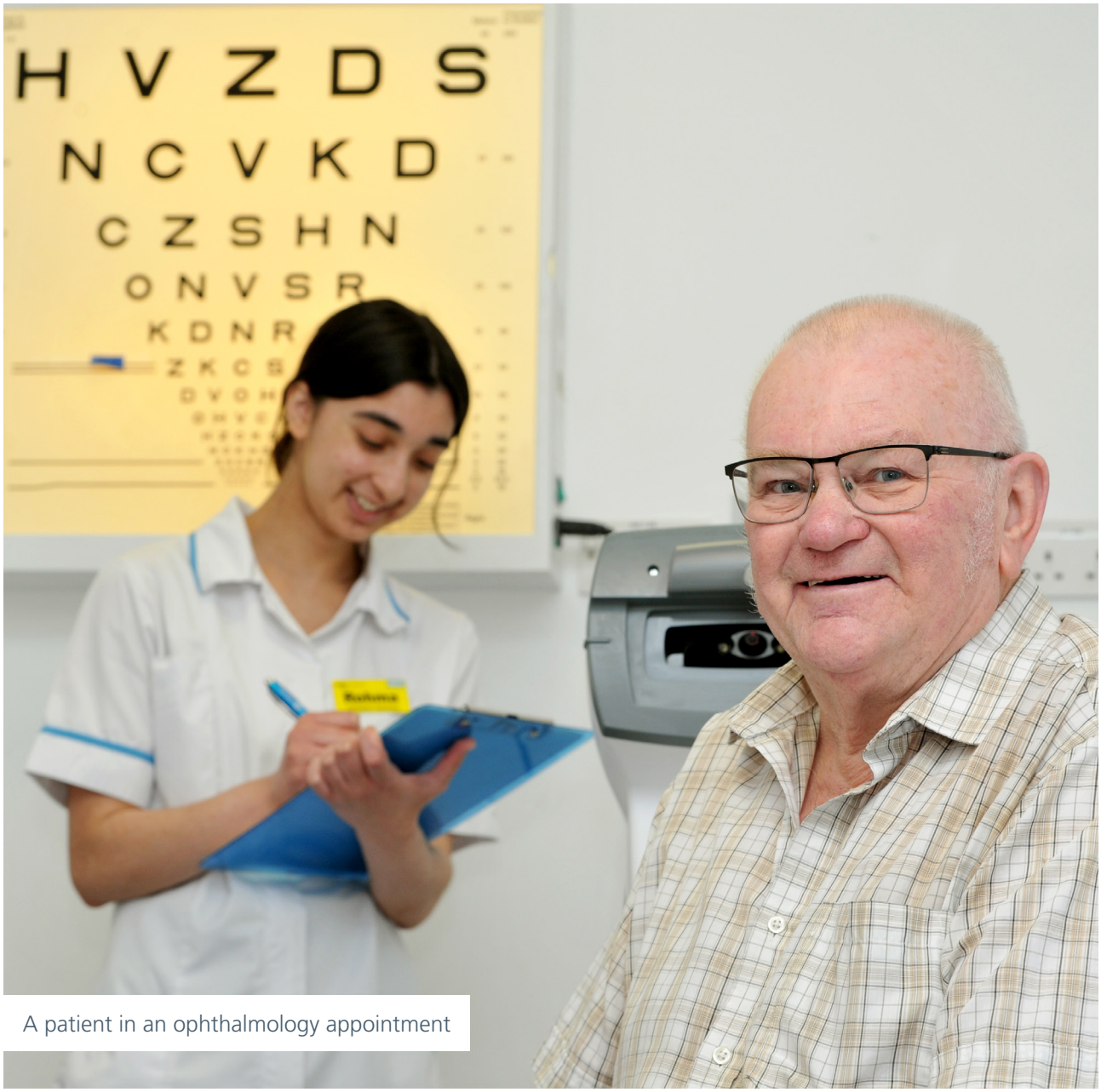
approach is intended to strengthen governance, enhance consistency of oversight, and support effective system leadership and decision-making at Group level.

The principal committees supporting the Board include:

- Finance and Productivity Committee
- Audit Committee
- Quality Committee
- People Committee
- Integration Committee
- Joint Provider Committee
- Infrastructure Committee
- Charity Committee
- Remuneration and Nominations Joint Working 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 near 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.



A patient in an ophthalmology appointment

Performance summary and Emergency Access Standard

Emergency Care - Access Standard Performance

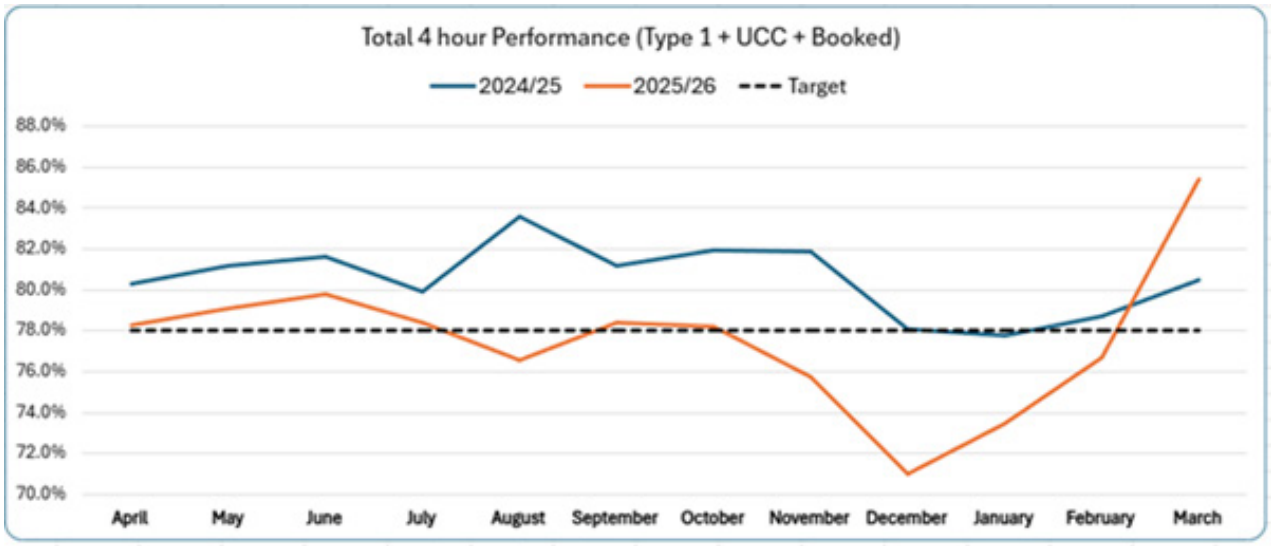
The 2025/26 period has been particularly challenging, marked by rising attendances, increased patient acuity, and sustained pressure at the front door. This has been further compounded by the introduction of the 45-minute ambulance offload standard. Between April 2025 and March 2026, 4-hour performance fluctuated, with several months falling below the national target of 78%, particularly during periods of heightened winter demand, where ongoing constraints in patient flow and bed capacity across the Trust persisted.

March saw a significant improvement, with performance rising to 85%, driven by better utilisation of clinical pathways and the introduction of a new triage process. However, maintaining 4-hour performance continues to be challenging, with timely organisational discharges remaining critical to enabling patient flow from the Emergency Department, alongside the ongoing pressures associated with the 45-minute ambulance offload standard.

To create additional capacity in response to increased patient acuity and walk-in demand at the front door, the Trust activated surge capacity across multiple areas, including the Acute Medical Unit, Discharge Lounge, and Surgical SDEC. These measures were implemented only during periods of heightened demand, when patient flow and capacity were under significant pressure.

Ongoing improvements continue to support performance, including:

1. Strengthened discharge planning in collaboration with the Care Navigation Hub to minimise inpatient bed delays.
2. Prompt transfer of patients from the Emergency Department to appropriate wards.
3. Regular ED huddles, incorporating SDEC teams, to identify patients suitable for alternative care pathways.
4. Increased community in-reach working with partners to stream appropriate patients to community services, helping to reduce and avoid unnecessary admissions.



National Access Standards

This measures compliance against the national access standards set by NHS England for patients waiting for appointments, treatments, and/or surgical procedures.

The Trust continues to perform strongly in elective recovery, having sustained the elimination of long waits over 78 and 65 weeks. The current focus remains eliminating waits over 52 weeks in line with national priorities, while continuing to improve overall waiting times across pathways.

We continue to provide mutual aid in collaboration with system partners across the Black Country to ensure patients are treated as quickly as possible and to support equitable access to care.

Looking ahead, the Trust is focused on continued progress towards delivery of the 18-week Referral to Treatment (RTT) standard, in line with the national trajectory set by NHS England for 2026/27. This will support further reductions in waiting times and ensure more patients receive timely access to care and treatment following the period of significant elective backlog.

Outpatient Transformation

Patient Initiated Follow Up (PIFU)

The Trust continues to actively participate in the Getting it Right First Time (GIRFT) programme with progress against outpatient metrics such as missed appointments and patient-initiated follow-up (PIFU), as well as pre-appointment advice & guidance and remote appointments.

The Trust continues to drive GIRFT improvements in outpatient processes related to:

Pre-Appointment

Currently the Trust delivers between 7,000-9,000 referrals triaged monthly across 54 Specialty area through the Advice & Guidance (A&G) & Referral Assessment Service (RAS) platform.

Our Cinapsis Eye eRS platform supports the triaging of referrals with images from Community Optometrists and the CDC Dermoscopy platform supports Rapid Access Dermoscopy/triaging with images.

Our GP Practices will be a part of the NHSE new electronic-Referral Service (eRS) Pilot from April 26, ahead of the new National eRS A&G Single Point of Access from July 2026 for Elective Referrals.

Missed Appointments/ Did Not Attends (DNA's)

Our missed appointment average performance over a 12-month period sits at 5.9% vs Trust target of 5%.

Remote Appointments

We can see that during Q4 we saw an 18-21% monthly average on our virtual performance; this is against a Model Hospital target of only 13-15%. The following data provides a breakdown of our virtual appoints by Division:

- Community with Core Clinical Services: 73% face to face appointments and 27% virtual appointments.
- Medicine and Integrated Care: 74% face to face and 26% virtual appointments
- Surgery, Women's and Children: 86% face to face and 14% virtual appointments

Patient Initiated Follow-Up (PIFU)

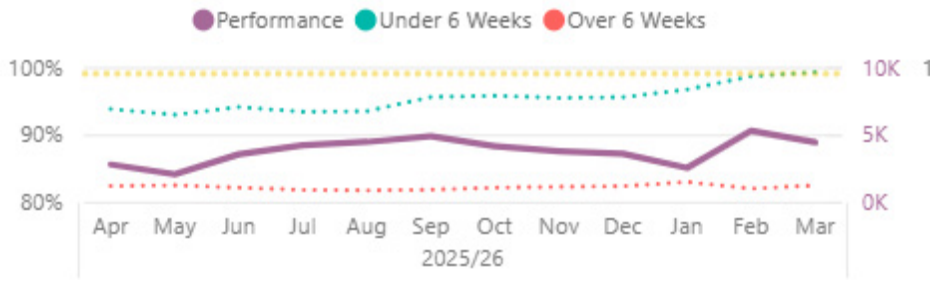
Eleven of our specialty areas achieved or exceeded the National 85th percentile PIFU target with our community monthly PIFU performance reaching 700-900 PIFU pathways. The Trust continues to drive specialty PIFU pathways.

Next Priorities

- Specialty Pathway Reviews in T&O, Gynaecology, Chemical Pathology, ENT together with Primary, Secondary Care & Commissioning teams to identify pathways to be delivered in Community.
- NHSE Funding Bids - ENT Tinnitus App Pilot in Primary Care
- Gastroenterology - GPwER Endoscopy 2 Year training programme.
- (Getting It Right First Time) GIRFT FF Follow Up protocols – To standardised follow ups post op, reduce follow ups, DNA's
- GIRFT National OPD pilot aimed at improving outpatient productivity by maximising clinic estate and slot utilisation.

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. The aim was for 80% of patients to be seen within six weeks by end of March 2026. The Trust's performance for 2025/26 is illustrated below:



DM01 performance shows continuous improvement in the majority of modalities, with the exception of, Dexa, Non-Obstetric Ultrasound, Sleep Studies and Cardiac MRI specialist scans. There are recovery plans in place to deliver improvements in all modalities. A 3-year trajectory has been developed to achieve 99% national target in 2028/29.

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 2025/26 to provide additional diagnostic services. 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.

RTT

The Trust has made strong progress in reducing the number of patients waiting over 52 weeks for treatment. This has been achieved through the optimal use of available resources and a sustained focus on improving productivity across outpatient services and theatre capacity.

Key to this improvement has been the continuation of targeted theatre initiatives, including paediatric 'Super Saturdays.' By dedicating full day-case theatre lists to paediatric activity, the Trust has increased the number of patients treated within a single day, improving both efficiency and access to care.

The Trust has also actively participated in several national 'sprint' initiatives. These have supported comprehensive waiting list validation and enabled the delivery of over 5,000 additional outpatient appointments and surgical procedures. This has not only increased activity but also strengthened the accuracy and management of RTT pathways.

As a result, RTT performance has improved, with a reduction in long waits and more effective patient pathway management.

The Trust's focus now is on sustaining this progress and working towards delivery of the 18-week RTT standard by March 2029. Priorities include further reducing the overall waiting list size, embedding productivity improvements, and continuing to enhance patient flow across pathways.

Cancer services

There are three main standards for cancer services: 1. 80% 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 2025/26 in line with our peers. Coming towards the end of 2025/26 we achieved our targets set by NHS England which were to achieve 80% 28 Day faster diagnosis standard of which we have finished on 84%. We were also asked to achieve 75% for the 62 day referral to treatment, whilst the constitutional standard is set at 85% we achieved 76% in March 2026. 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 2027 is to achieve 80% 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 2026/27 regarding our 62 day backlog, we will continue to monitor locally and as part of the ICB.

Patient Flow

In the last year flow of patients through the organisation has remained challenging, this has been because of reported increasing complexity of patients through our admission portals but also continued difficulties in discharging patients out into the community when the acute phase of their care is completed. Despite these challenges, the Trust has continued to perform well with respect to both 4 hour and 12-hour standards. Ambulance handover has also continued to be a challenge, with a considerable number of patients up until Q4 waiting for longer than an hour to be admitted into our emergency department. Following a significant amount of work into improving our urgent and emergency care pathways that launched in February 2026 the handover performance has improved significantly and is something that the teams will work hard to embed as the new year begins.

The Care Transfer Hub is now embedded into the discharge planning pathway and having a positive impact on ensuring that patients are discharged to the correct destination when they are well enough to leave the organisation. This work now needs to establish an advanced preparation model, and this is where the focus will be as move into the next year.

Equality of Service Delivery

At Dudley Group, we recognise that diversity is a strength and that inclusion is essential to delivering high quality care. We are committed to creating an environment where everyone feels valued, respected, and empowered to contribute. This commitment supports our organisational vision of "Excellent healthcare, improved health for all." By embracing diversity and inclusive practice, we are better able to meet the needs of the diverse communities we serve.

Patients and their families have the right to be treated fairly and to be actively involved in decisions about their treatment and care. All patients should expect to be treated with dignity and respect and will not be discriminated against

on the basis of any protected characteristic, including age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, or sexual orientation.

To support equitable access to services, the Trust provides translation and interpretation services and continues to strengthen communication support for patients through the implementation of the Accessible Information Standard, ensuring that patients with communication needs receive information in formats they can understand.

The Trust has implemented several measures to support equitable service delivery, including:

- Maintaining Disability Confident Leader status, demonstrating our commitment to employing disabled staff and strengthening our ability to meet the needs of disabled patients.
- Providing specialist support through the Learning Disability Team, which works to improve access to hospital services for patients with learning disabilities and their families.
- Collecting and analysing patient equality monitoring data to better understand service access and uptake, including screening services, and to identify potential inequalities.
- Ensuring that all service changes consider health inequalities through the completion of Health Equity Assessments (HEAT).
- Supporting patients' faith, religion, and spiritual needs through the Chaplaincy Service.
- Continuing to implement and strengthen the Equality Delivery System (EDS) to improve services and outcomes for local communities.
- Developing partnerships and collaborative interventions through Dudley Place to better support communities experiencing or at risk of health inequalities.

Patient Experience Indicators

During 2025/26, a total of 53,893 people responded to the Friends and Family Test in comparison to 51,879 in 2024/25. The number of patients rating their overall experience of their care and treatment as 'very good/good' was 81 per cent in 2024/25, a decrease from 2024/25 (83 per cent).

The score for the number of people rating their experience as 'very poor/poor' has increased in 2025/26 at seven per cent in comparison to six per cent in 2024/25. Community services and the Inpatient Department received the highest number of positive scores overall for the year with 87% of patients rating their overall experience of our services as 'very good/good' in 2025/26.

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 business cards with online links/QR codes to improve response rates and to ensure that the Friends and Family Test is accessible to all.

Infection prevention and control

We take infection prevention and control extremely seriously and monitor performance against a range of infections including Clostridioides difficile (CDI), Methicillin Resistant Staphylococcus aureus (MRSA), Methicillin sensitive Staphylococcus aureus (MSSA), pseudomonas aeruginosa and Escherichia coli blood stream infections.

Our end of year figures for 2025/26 are displayed in the tables 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. in the daily huddles. 'You Said, We Have' actions are reported to the patient experience team.

CDI: 72

Month	COHA	HOHA	Total
Apr-25	7	1	8
May-25	5	2	7
Jun-25	3	0	3
Jul-25	4	1	5
Aug-25	6	3	9
Sep-25	4	4	8
Oct-25	2	2	4
Nov-25	2	7	9
Dec-25	2	2	4
Jan-26	3	6	9
Feb-26	3	1	4
Mar-26	3	5	8
Total	**44**	**34**	**78**

E.Coli: 68

Month	COHA	HOHA	Total
Apr-25	1	2	3
May-25	2	4	6
Jun-25	6	2	8
Jul-25	9	4	13
Aug-25	1	4	5
Sep-25	5	2	7
Oct-25	1	4	5
Nov-25	4	3	7
Dec-25	4	5	9
Jan-26	2	4	6
Feb-26	5	3	8
Mar-26	3	3	6
Total	**43**	**40**	**83**

MSSA:

Month	COHA	HOHA	Total
Apr-25	4	2	6
May-25	1	3	4
Jun-25	1	2	3
Jul-25	2	5	7
Aug-25	1	3	4
Sep-25	4	1	5
Oct-25	2	1	3
Nov-25	2	2	4
Dec-25	4	1	5
Jan-26	0	0	0
Feb-26	2	2	4
Mar-26	0	2	2
Total	**23**	**24**	**47**

Klebsiella: 19

Month	COHA	HOHA	Total
Apr-25	1	0	1
May-25	1	1	2
Jun-25	2	1	3
Jul-25	1	0	1
Aug-25	1	0	1
Sep-25	0	0	0
Oct-25	1	0	1
Nov-25	3	2	5
Dec-25	0	0	0
Jan-26	0	2	2
Feb-26	1	2	3
Mar-26	1	0	1
Total	**12**	**8**	**20**

Pseudomonas: 12

Month	COHA	HOHA	Total
Apr-25	1	1	2
May-25	1	1	2
Jun-25	0	0	0
Jul-25	1	2	3
Aug-25	1	0	1
Sep-25	2	1	3
Oct-25	0	0	0
Nov-25	0	0	0
Dec-25	0	0	0
Jan-26	0	2	2
Feb-26	1	2	3
Mar-26	1	1	2
Total	**8**	**10**	**18**

MRSA:

Month	COHA	HOHA	Total
Apr-25	0	0	0
May-25	0	0	0
Jun-25	0	0	0
Jul-25	0	0	0
Aug-25	0	0	0
Sep-25	0	1	1
Oct-25	0	0	0
Nov-25	0	0	0
Dec-25	0	0	0
Jan-26	0	0	0
Feb-26	0	0	0
Mar-26	0	0	0
Total	**0**	**1**	**1**

Quality Priorities

Quality and safety delivery plan 2025/2028

Utilising internal intelligence and engaging with internal and external stakeholders, including service users, the Trust is committed to continuously improving the quality of care delivered to patients. Each year the Trust sets quality priorities that reflect the key areas for improvement for the forthcoming financial year. These priorities are supported by measurable key performance indicators, which are monitored throughout the year by the Trust's Quality Committee, providing oversight and assurance on the quality and safety of clinical care.

In 2025, the Trust committed to delivering 11 overarching quality priorities over a three-year period, each supported by clear objectives to guide progress and achievement. The purpose of this approach was not only to translate actions into practice, but also to ensure sustained improvements over time.

Looking Back

The table below provides a summary of the 2025/26 quality priorities at the end of Year 1 of the Quality and Safety Delivery Plan 2025-2028. This year has continued to be challenging due to high demand for acute services, which has delayed or prevented for improvements to be fully achieved in line with set ambition.

		No. objectives				
		Delivered	Partially Delivered	Not Delivered	Undeliverable/ Obsolete	Total
	Quality Account Summary	31	20	6	4	61
Priority	Area	Delivered	Partially Delivered	Not Delivered	Undeliverable/ Obsolete	Total
1	Improving Partnership Working	3	3	0	0	6
2	Staff Development	1	1	1	0	3
3	Safe management of the deteriorating patient	7	3	2	1	13
4	Develop and implement the updated National Safety Standards for Invasive Procedures 2 (NatSSIPs)	3	1	1	0	5
5	Safe Medicines Management	0	0	2	0	2
6	Care closer to home through refined patient discharge processes	5	1	0	0	6
7	Improving Patient Outcomes	4	3	0	3	10
8	Safer Staffing - inpatient wards, assessment wards, emergency departments	6	0	0	0	6
9	Comprehensive and reliable handover - 7 Day service standards	1	0	0	0	1
10	Reducing the carbon footprint of clinical care	0	6	0	0	6
11	Patient Safety Systems	1	2	0	0	3

In 2025/26 there were 11 priorities, which totalled 61 objectives. Overall, improvements have been demonstrated across all priorities. At year end, the Trust delivered **31 objectives** and partially delivered **20 objectives**, indicating progress has been made but targets have not yet been achieved. There were six objectives which were not delivered and four objectives that were identified as undeliverable/obsolete.

As this represents only the first year of the quality and safety delivery plan, those objectives which have not yet been delivered in 2025/26 are carried over to year two, 2026/27, for delivery.

Priority 1: Improving partnership working

Delivered

Partnership Programme Director, Dudley Health and Care Partnership, Patient Safety Specialist

Year 1 2025/26 Planned Objectives

By the end of September 2025, we will map how the Trust currently hears the patient voice.

By the end of October 2025 we will have supported the development of "Community Voices" - a network of peers who are keen to work with health and wellbeing partners in ensuring that voices of local patients, carers, public and communities are heard by decision makers and acted upon with a minimum of two patient experience Partnership Groups who support the design, commissioning and development of topic specific services.

By the end of March 2026, we will have identified gaps and opportunities in public involvement across the Dudley system.

Patient Safety Partners

Quality and Safety Delivery Plan priority areas will have an identified and active independent member such as a Patient Safety Partner and/or Patient Voice Volunteer.

Work with the Patient Safety Partners to continue to develop patient and family feedback for when they are involved in patient safety incident responses.

To present the Quality and Safety delivery plan to the patient safety partners, to explore which partner has an interest in working alongside a particular priority.

Year 1 2025/26 Where we are now

The Trust captures the patient voice through a range of established channels, including PALS, complaints, Friends and Family Test (FFT), volunteer and staff engagement, and Healthwatch trolley interactions. Feedback from these sources is systematically collated and reported through governance structures such as the Patient Experience Group, Integration Committee, and Equality, Diversity and Inclusion (EDI) forums to inform decision-making.

This work forms part of a wider system approach across Sandwell and West Birmingham NHS Trust (SWB) and The Dudley Group NHS Foundation Trust (DGFT) and remains subject to available funding. The Involvement Team aimed to establish a Patient Voice Panel by June 2026; this has been rescheduled and will continue into the next phase.

A system-wide exercise to map public involvement activity was completed in January. Identified gaps and opportunities will be presented to the Dudley Health and Care Partnership (DHCP) in May (rescheduled due to Good Friday). Delivery of subsequent actions will be owned by the DHCP. This milestone has been achieved.

The Quality and Safety Delivery Plan has been shared with Patient Safety Partners, including exploration of opportunities for independent member participation. This has been delivered. An options appraisal regarding Patient Safety Partner involvement in core groups has been completed and is currently with the Group Chief Nursing Officer (CNO); for consideration to support implementation across the Group, this is partially delivered.

While engagement with Patient Safety Partners is ongoing, planned delivery this quarter has not yet been achieved and will continue into the next phase and will move into Year 2, Quarter 1.

In response to a changing operational landscape, the Trust has adopted a flexible approach to ensure continued progress against objectives.

A key success has been the continued development of the Dudley Engagement Group (DEG), now comprising approximately 230 members from statutory, voluntary, charitable, and third-sector organisations. This network enables broad and inclusive reach across the borough, supporting effective communication, collaborative working, and shared problem-solving. The partnership continues to strengthen, fostering trust, transparency, and accountability through meaningful two-way engagement.

Over the past year, the Trust has engaged with a wide range of communities to understand their experiences, concerns, and aspirations for NHS services. Insights have been fed into governance structures including the Integration Committee, Trust Management Board, and Executive briefings. Engagement has included underrepresented groups such as migrant, refugee and asylum-seeking communities, as well as ethnically diverse populations including Romanian, African Caribbean, and Pakistani communities. Wider groups engaged include stroke support groups, carers, and people with sensory impairments.

The Trust has also delivered targeted initiatives to address health inequalities and improve population health outcomes. These include the "Pressure Drop" event focused on Black African Caribbean communities, and group diabetes education sessions delivered in Urdu.

Looking ahead, the Trust will continue to expand its networks, strengthen community partnerships, and further amplify the voices of local people, including the development of a citizen/patient panel.

Priority 2. Staff Development

Partially delivered

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

Year 1 2025/26 Planned Objectives

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

Year 1 2025/26 Where we are now

The National Leadership and Management Framework and accompanying Self-Assessment remain embargoed, with national launch dates having been rescheduled multiple times. As a result, the joint three-year project plan between Dudley and Sandwell has not yet commenced and will begin once the Framework is formally released. This has not yet been achieved.

An Education Group has been established, bringing together key Education Teams from across the organisation. The group is currently developing its Terms of Reference, with ongoing discussions to determine whether a group-wide model should be adopted. Following this decision, work will progress to define and agree a robust framework, delivery plan, and success measures. This will continue into the next phase of delivery.

Career pathway posters for Nursing, Allied Health Professionals (AHPs), and administrative staff are in place and are actively promoted through the Annual Review process. This action has been delivered.

Priority 3: Safe management of the deteriorating patient

Partially delivered

Clinical Director Patient Safety and Deteriorating Patient Lead

Year 1 2025/26 Planned Objectives

- Provide assurance against latest national guidelines.
- Participate in National Paediatric Early Warning Score Emergency Department Pilot.
- Integrate National Paediatric Early Warning Score triage into Emergency Department escalation processes on sunrise by Q3.
- Martha's Rule (MR) The Dudley Group Foundation Trust pilot site: introduce the patient wellness score to adult, paediatrics and maternity in line with the national launch. Improve accessibility for those who need adjustments to MR processes.
- Develop and implement new national MEWS scoring system into Sunrise by Q3.
- Develop and Implement Newborn Early Warning Trigger and Track 2 scoring system into sunrise by Q4.
- Further develop National Paediatric Early Warning Score sepsis screening processes in line with national steer.
- Develop eObs Task & Finish Group with 4 ward areas across medicine and surgery:
  - Improve eObs by Q1 55-60%/ Q2 60-65%/ Q3 65-70%/ Q4 70-75%
  - Update policies
  - Digital problem and opportunity mapping
- Continued integration of Prevention, Identification, Escalation, Response framework working with Integrated Care Board partners with the deteriorating patient programme, a 3-year quality improvement project focusing on community hospital avoidance using the 'Prevention, Identification, Escalation, Response' (PIER) approach. PIER stands for: prevention: planning ahead of any episode of deterioration to stop what is preventable, considering indicators of risk and patient choice, identification: tools and methods to identify when deterioration is occurring in a standardised way, escalation: timely escalation of care when deterioration has been identified using standardised communication tools, response: timely, appropriate and effective response to escalation of the deteriorating patient/person.
- Continue AQUA pathways work aiming for improvement in composite care scores in particular for Acute Kidney Injury pathway, led by Dr Savage:
  - Further develop the information on Acute Kidney Injury pathways on the Urology HUB page
  - Develop alert within Electronic Patient Record for acknowledgement of Acute Kidney Injury

Year 1 2025/26 Where we are now

Events relating to deteriorating patients in the Emergency Department (ED) continue to represent a significant proportion of all incidents and therefore heavily influence overall Trust performance. Additional areas contributing to the burden include Maternity, C2, assessment areas, and C5/7, which remain key targets for improvement.

Consideration is being given to alternative utilisation of the Deteriorating Patient Team (DPT) to provide more focused support to these high-risk areas. Current capacity pressures mean that central oversight is limited, and this remains an area for improvement.

The pilot of the National Paediatric Early Warning Score (NPEWS) in ED is ongoing, with weekly national meetings attended and local data submitted to NHSE. The ED-specific variant has not been adopted, as the Trust already utilises the full NPEWS system and national guidance indicated that transition would add unnecessary disruption. This action is delivered.

There remains a lack of alignment between triage acuity systems, specifically between Emergency Severity Index (ESI) and NPEWS scoring. Local analysis indicates that ESI assigns a higher proportion of patients to high-acuity categories and is less predictive of admission. Progress in revising the triage model has been slower than planned, and further collaborative work is underway. However, the Acutely Ill Child Group is progressing work to improve compliance with the KPI of completing Early Warning Scores (EWS) within 15 minutes of arrival. Triage processes are gradually evolving to incorporate EWS at the point of triage, with appropriate escalation where required. This remains in progress and will continue into 2026/27.

The Patient Wellness Questionnaire (PWQ) has been implemented, alongside continued staff education on the medical review (MR) process. Translated versions of the PWQ are in development, and multilingual patient information leaflets are now available on the Trust website. An animation for Children and Young People (CYP) continues to be developed in collaboration with Dudley Young Heath Champions (DYHC). This action is delivered.

The Maternity Early Warning Scoring system is expected to be implemented in June 2026, with a newborn trigger system to follow. This action is partially delivered.

Paediatric Early Warning Scoring (EWS) is now fully deployed, with sepsis screening achieving 100% compliance. This action is delivered.

Observation performance (E-obs) met the Quarter 4 target, with 73.4% of observations completed on time against a target range of 70–75%. This action is delivered.

The deteriorating patient policy has been updated. This action is delivered.

A ward leaver icon has been introduced within Sunrise to identify patients temporarily off the ward (e.g. for investigations), ensuring observations are appropriately maintained. This action is delivered.

The Trust continues to engage with the PIER approach (Prevention, Identification, Escalation, Response) to support deteriorating patient management. This action is delivered.

Work on the AQUA pathway to improve composite care scores for the Acute Kidney Injury (AKI) pathway is ongoing. The current composite score is 72.7% against a target of 74.5%. Work is ongoing to allow upload of required information for Urology patients. This will continue into the next phase of delivery.

The development of an electronic AKI alert within Sunrise is now obsolete.

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

Partially delivered

Clinical Director Patient Safety

Year 1 2025/26 Planned Objectives

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

Year 1 2025/26 Where we are now

Policies aligned to National Safety Standards for Invasive Procedures (NatSSIPs) have been developed and implemented. This action is delivered.

Policies covering site marking, consent, retained items, implants, and NatSSIPs have been formally ratified. This action is delivered.

A retained items process has been developed and implemented within Sunrise. This action is delivered.

An implant management register is in place; however, use of the system is currently variable across services. Breast and ophthalmology services are routinely uploading data, while implementation in some other areas, including trauma theatres, is still progressing.

The associated theatres project is currently on hold, and further work is required to fully understand how the Sunrise system can support this process. Although scanning equipment is available, it is not yet being used consistently across all areas. There have also been some challenges relating to access and use of the MDOR system.

This remains an open risk on the organisational risk register and the action is currently ongoing.

A registry of harmonised Local Safety Standards for Invasive Procedures (LocSSIPs) has been established across relevant clinical areas. This action is delivered.

Priority 5: Safe Medicines Management

Not achieved

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

Year 1 2025/26 Planned Objectives

50% improvement on the baseline of administering Parkinson's treatments on time within the Emergency Department and Acute Medical Unit.

Year 1 2025/26 Where we are now

Overall Status: This has not yet been achieved and will continue into the next phase of delivery.

The Levodopa dashboard continues to be updated monthly to monitor performance against agreed KPIs and track any improvement or decline.

Patient awareness of time-critical medications (TCM) is supported through posters displayed in Emergency Department (ED) waiting areas.

The ED TCM Working Group continues to meet on a fortnightly basis. Ongoing efforts are being made to broaden multidisciplinary representation and strengthen engagement.

Sustained improvement has not yet been achieved, and this remains a key focus for the coming year.

Although Quality Improvement (QI) methodology and PDSA cycles were planned, progress has been limited due to the inability to implement changes within the triage process, restricting opportunities to test and evaluate interventions.

Implementation has been delayed, which has limited early identification. This will be progressed in the next phase.

Proposed changes to nurse triage processes could not be implemented, as the current five-level triage system is based on acuity and presenting complaint, limiting the identification of pre-existing TCM conditions.

Proposed enhancements to electronic medical record (EMR) alerts and flagging systems were not approved through Trust digital governance processes.

Progress has been influenced by the need for clearer roles, strengthened communication, and greater alignment across teams.

A meeting is scheduled with senior Emergency Department colleagues to review progress and agree next steps. Year 1 objectives will be carried forward into Year 2.

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

Delivered

Director of Strategy and Partnerships

Year 1 2025/26 Planned Objectives

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

Year 1 2025/26 Where we are now

Overall Status: Delivered

Activity within the Clinical Navigation Centre (CNC) remains high, with 3,829 referrals in January and 3,554 in February. Of these, 2,517 patients in January and 2,306 in February were successfully managed away from the Emergency Department (ED) through alternative pathways, including community services (health and local authority), Same Day Emergency Care (SDEC), both medical and surgical and Urgent Treatment Centres (UTC).

Phase 2 of the CNC, originally planned to open to patients and carers in April 2026, was implemented ahead of schedule. Since go-live in September 2025, the CNC has accepted referrals from patients known to Long-Term Condition (LTC), End-of-Life (EOL) and Rapid Response teams. From 1 February 2026, access was further expanded to include all care agencies across Dudley.

The CNC is also supporting patients residing in Dudley but registered with Sandwell GPs, resulting in a reduction in out-of-area (OOA) patients being declined. A total of 202 referrals for Sandwell patients has been triaged and appropriately signposted.

The continued development of the CNC has driven increased referrals from Primary Care, WMAS, care homes, and other healthcare professionals. This has enabled more patients to be managed within the community and specialist pathways, reducing inappropriate and unplanned ED attendances. As a result, this objective is now embedded as business as usual.

Looking ahead to 2026/27, further pathway development is planned, including work toward a Single Point of Access (SPA) model in the south, in partnership with Sandwell, as part of the wider ICB programme to establish two SPA hubs (north and south).

All patients now have a Target Date for Discharge (TDD) and Estimated Date of Discharge (EDD) recorded within Sunrise. Ongoing work with the Learn, Adapt, Transform (LAT) programme is focusing on strengthening the conditional discharge process. This action is delivered.

Performance relating to No Criteria to Reside (NC2R) continues to improve. However, on average, only 35% of patients requiring support are referred ahead of their Medically Fit for Discharge (MFFD) date. Internal issues within the Care Transfer Hub (CTH) have now been resolved. Increased demand from out-of-area patients, particularly from Sandwell and Worcester, continues to present challenges due to longer discharge planning times. This action is delivered.

Training packages and posters supporting NC2R processes are now embedded as business as usual. Alignment with LAT workstreams and board round outputs continues. This action is delivered.

The target to reduce frailty ward length of stay to below three days has been achieved, with current performance at 2.8 days. This has been supported by strong multidisciplinary team (MDT) attendance at board rounds, close collaboration with the LAT team, and regular improvement-focused discussions. Progress continues toward achieving a 72-hour length of stay on C6 Frailty Ward. Additionally, the appointment of a new substantive Consultant within Elderly Care has strengthened delivery. This action is delivered.

Priority 7: Improving patient outcomes

Partially delivered

Associate Deputy Chief Nurse/Quality Lead/ AHP

Year 1 2025/26 Planned Objectives

Clinical Accreditation:

- Roll out the clinical accreditation process across all inpatient wards ensuring all wards are assessed in this financial year.
- At least 80% of inpatient wards will have received a clinical accreditation visit by end of Q4 2025/26, with a level of accreditation that has been validated by the Clinical Accreditation Board.

Eat Drink Dress Move / PIVOT:

- Scope, pilot and upscale the Eat drink Dress Move initiative across 50% of all in-patient areas by end of Q4 2025/2026.
- Establish key metrics for monitoring and reporting impact.
- Complete PIVOT research project in Trust and consider long term application of findings by year end.

Nutrition and Hydration:

- Define, design and introduce the role of mealtime champions across 70% acute in-patient areas with associated training and resources by end of Q4 2025/2026.
- Establish suite of metrics to monitor impact of Nutrition and Hydration Improvement activity by year end.

Year 1 2025/26 Where we are now

Clinical Accreditation

All 22 inpatient wards have achieved local accreditation in line with NHSE recommendations. Accreditation outcomes have been validated through the Clinical Accreditation Board with the Chief Nursing Officer (CNO). Delivered.

EDDM / PIVOT

A Task and Finish Group has been established, and a three-month pilot across inpatient areas (B4, C7, A4) has been completed. Key action metrics have been defined, and IT support has been secured. The EDDM model has been aligned with DEWI, with established links to the Welsh team. Progress will continue as supporting work is completed around the Sunrise IT interface prior to finalising policy, SOPs, training, and full implementation.

Metrics and impact modelling have been completed, and MDT-driven actions have been mapped. A Sunrise EPR bibliography has been developed and is scheduled for review and approval by the Project Task and Finish Group in May 2026. Delivered.

The final model will be confirmed following Trust-wide consultation as part of the EDDM/DEWI policy

implementation. This will include a Sunrise EPR framework with an embedded actions matrix, automated notifications to responsible clinicians, and time-critical intervention prompts. This will continue into the next phase of delivery.

Nutrition and Hydration

A multidisciplinary project group has been established, bringing together key stakeholders alongside the Improving Together team. An initial meeting is scheduled for May 2026 to agree methodology, outcome measures, and metrics to support improvements in the patient mealtime experience. This will continue into the next phase of delivery.

Metrics to support nutrition and hydration improvement activity have been developed.

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

Delivered

Associate Deputy Chief Nurse – Workforce

Year 1 2025/26 Planned Objectives

- Await directive from National Health Service England for the new Community Nursing Safer Staffing tool, then implement the tool.
- Continue to undertake the acute safer staffing tool.
- Assess inpatient acuity over a given 30-day period, every six months, in January and June, logging data into a central data base for analysis.

By Q4 2025/26:

- 80% of band 6, 7 and 8a staff will have a defined programme of learning aligned to a standard Trust competency set.
- All new graduates take up a place on a preceptorship programme within four weeks of commencing employment and have completed initial competencies within 12 weeks.
- Training needs analysis forms part of service and workforce planning and allocation of Continuing Professional Development funding to meet patient need.
- TNA/NA-RN conversion programme is delivered in line with the agreed plan and allocated financial envelope.
- 80% of final year students choose The Dudley Group Foundation Trust as their organisation of choice.
- 80% of international recruits retained.

Year 1 2025/26 Where we are now

Community services completed their first safer staffing review using the Community Nursing Safer Staffing Tool (CNSST) in September, with the next review scheduled for March 2026. Delivered.

Acute safer staffing reviews have continued, with a focus on challenging areas of poor compliance. Delivered.

Inpatient and Emergency Department safer staffing reviews were completed in January, meeting the biannual safer staffing requirements. Delivered.

80% of Band 6, 7, and 8a staff have undertaken a defined programme of learning aligned to a standardised Trust competency framework. Delivered.

All new graduates are expected to commence a preceptorship programme within four weeks of employment and complete initial competencies within 12 weeks. In practice, due to programme availability, commencement typically occurs within 6–8 weeks. As a result, this objective is no longer considered applicable in its original form. Obsolete.

Training Needs Analysis (TNA) is embedded within service and workforce planning processes and informs the allocation of Continuing Professional Development (CPD) funding to meet patient needs. Delivered.

The TNA / Nursing Associate to Registered Nurse (NA-RN) conversion programme was not delivered due to limited vacancies during the year and therefore was not offered. This objective is now obsolete. Obsolete.

The target for 80% of final-year students selecting the Trust as their organisation of choice was not achieved due to limited vacancy availability. However, this level was achieved in terms of students expressing interest in available roles. This objective is now considered obsolete. Obsolete.

Retention of international recruits has exceeded the target, achieving a rate of 91%. Delivered.

Priority 9: Comprehensive and reliable handover- 7ds

Delivered

Operational Medical Director/Chiefs of Service

Year 1 2025/26 Planned Objectives

- Structured handover led by competent senior decision maker, documented electronically.
- The Trust will implement an electronic handover process with accompanying SOP detailing roles and responsibilities by April 2026.

Year 1 2025/26 Where we are now

A Trust-wide medical handover takes place twice daily at 09:00 and 21:00. The handover is led by the on-duty Medical Registrar, with support from the on-call Consultant during the morning handover. Attendance includes representation from the Hospital at Night team or the Deteriorating Patient Team, and attendance is formally recorded. The deteriorating patient dashboard is utilised to support structured discussion and prioritisation.

In addition to the Trust-wide process, local handovers are undertaken across several specialty areas, including:

- Obstetrics and Gynaecology
- Critical Care
- General Surgery
- Vascular Surgery

An electronic handover system for medical teams was implemented during 2025/26. Work will continue into 2026/27 to expand this approach and ensure all local handovers transition to electronic systems to improve consistency, accessibility, and governance.

Priority 10: Reducing the carbon footprint of clinical care in line with the Greener NHS sustainability agenda and the DGFT Green Plan

Partially delivered

Sustainability Lead/ Associate Deputy Chief Nurse/ Infection prevention Lead

Year 1 2025/26 Planned Objectives

- Embed 'Bathroom First' principles across 3 pilot wards.
- Relaunch the Glove Aware campaign: an 8% reduction was achieved from 2022 to 23/24; for 2025/26, we will aim for a 10-15% reduction by the end of March 2026.
- Continue to move from intravenous administered medicine to oral medicine when clinically appropriate. (Work on Paracetamol is taking place in theatres, Antibiotics is within the national objectives).
- Increased awareness of the Green Plan and climate impact on health within the workforce. Continue to promote net-zero e-learning and embed within Learning and Development pathways within the Trust. Increase uptake in the Trust's waste training quiz.
- Establish a green plan clinical working group to support delivery, focusing on carbon-intense areas such as critical care, emergency care, diagnostics tests and procedures, and long-term conditions such as diabetes or cardiovascular disease.
- Promote the correct use of couch roll.

Year 1 2025/26 Where we are now

Overall Position

Progress has been made across all areas of the Low Carbon Care programme. The majority of objectives are partially achieved, reflecting the complexity of system-wide change, reliance on pilot activity, and the need for staged implementation.

All partially achieved actions should be carried forward into Year 2, with a strengthened focus on:

- Scaling successful pilots into business-as-usual practice
- Embedding sustainability changes within clinical pathways
- Strengthening governance, performance metrics, and accountability frameworks

Bathroom First / Pulp Reduction

Further clinical engagement will support continued progress to further drive forward the “Bathroom First” initiative. In Year 2, consideration will be given to integrating this work with the Eat, Drink, Dress, Move programme to strengthen alignment.

A 21% reduction in pulp product use has been achieved, indicating a positive shift towards supporting patients to use bathroom facilities rather than bed-based products. This work aligns closely with Eat, Drink, Dress, Move principles, and consideration is being given to formally combining reporting streams.

Data has been rebased to a full-year dataset and refined to include only bathroom-related pulp product usage. This reduction has delivered a financial saving of £13,468 and contributes to reductions in waste, procurement emissions, and overall environmental impact.

Further work is underway to reduce overuse of pulp products, supported by additional communications and engagement materials. Partially Delivered.

Gloves Aware Campaign

The Gloves Aware campaign was relaunched during Year 1 with an ambition to reduce glove use by 10–15%.

Quarter 4 usage totalled 3,226,000 gloves. Over the year, usage reduced by 482,190 gloves (3.5%), delivering a financial saving of £9,644.

Continued implementation is expected to further reduce unnecessary glove use, improve hand hygiene and skin integrity, and deliver additional financial and carbon benefits in support of the Trust's 10–15% reduction target. Partially Delivered.

Medicines Optimisation (IV to Oral Switch)

Work is underway to reduce intravenous medication use where clinically appropriate. A pilot introducing oral paracetamol for day case surgical patients commenced on 8 December 2025, with planned phased expansion to B1 and main theatre day case pathways.

Early learning has identified that oral dosing can be missed where VTE documentation is not completed prior to theatre transfer. This is being addressed in the next phase of implementation. Partially Delivered.

Workforce Awareness and Engagement

Awareness of the Green Plan and wider climate-health agenda is increasing across the workforce.

Student nurses now undertake placements within Clinical Procurement to understand their influence on reducing carbon impact. The Continuous Product Evaluation Group (CPEG) routinely includes sustainability alongside clinical effectiveness and financial considerations in product decisions.

Despite this, uptake of ESR sustainability training remains limited. However, sustainability is increasingly embedded into procurement and clinical decision-making processes. This will continue into the next phase of delivery.

Green Plan Governance and Infrastructure

A Green Plan working group structure is in place. Sustainability training is embedded within the Preceptorship Programme and included in medical induction. Student nurse engagement through Clinical Procurement placements continues to strengthen awareness and capability.

Clinical Green Plan groups are now established within Theatres, Critical Care, and Pharmacy, with plans to expand into additional high-carbon service areas.

The Green Plan hub page is regularly updated, and engagement through the Green Team Microsoft Teams channel continues to grow, with 83 active users and 25 interactive posts in the most recent quarter.

The Annual Committed to Excellence Awards received eight sustainability nominations, with six highlighting impactful clinical transformation work. This will continue into the next phase of delivery.

Couch Roll Reduction Programme

The target to reduce couch roll use by 25% has been supported through approval (February 2026) to remove couch roll from areas without clinical justification. Work is ongoing to finalise exemptions and communications, following which ordering restrictions will be implemented for non-approved areas.

To date, a 10% reduction has been achieved, delivering savings of £6,033 in 2025/26 alongside reduced waste and procurement emissions. This will continue into the next phase of delivery.

New Pilot Projects

Ditch the Caffeine: A pilot to introduce decaffeinated-only hot drink provision in selected areas is underway, supported by Mitie. Initial delays have occurred due to supply chain issues.

Slipper Socks Reduction: Early-stage work is underway to assess opportunities to reduce unnecessary use, with a planned footwear audit in pilot areas to support evidence-based decision-making.

Overall, the programme demonstrates strong progress in embedding sustainability across clinical and operational practice. However, most initiatives remain in partial delivery status due to their reliance on behavioural change, system integration, and staged implementation. Year 2 priorities should focus on scaling proven interventions, formalising governance structures, and embedding sustainability as business as usual across all clinical pathways.

Priority 11: Patient Safety Systems

Partially delivered

Patient Safety Specialist

- All local Patient Safety Incident Response Framework priority areas have detailed supporting plans of improvement which incorporate impact and outcome measures.
- Safety II (good care events) is incorporated into governance reports.
- Increase in good care events awareness and reporting.

Year 1 2025/26 Where we are now

Capacity pressures continue to impact progress in some areas.

All local Patient Safety Incident Response Framework (PSIRF) priority areas continue to develop their oversight reports in collaboration with the Patient Safety Team. There has been notable improvement in the use of thematic analysis within priority areas to identify more meaningful outcome and effectiveness metrics. These reports are being further refined, with ongoing routine monitoring of identified themes. This will continue into the next phase of delivery.

Safety II / Good Care Events

Safety II "good care" events are now embedded within governance reporting structures. Delivered.

Reporting Culture and Sustainability

An initial increase in awareness and reporting of good care events was observed; however, this improvement was not sustained through Quarters 3 and 4. A broader Trust-wide reward and recognition programme is planned for 2026/27, which will include a renewed focus on improving awareness, encouragement, and reporting of good care events.

The front of Russells Hall Hospital

Financial performance

In 25/26 there remained a strong emphasis on collaborative working across the Black Country System. Finance and contractual discussions were undertaken jointly with funding transparently shared across constituent partners. The funding allocations received within the System remained challenging and included a partial clawback of deficits from previous financial years. In 24/25, the System presented a significant opening deficit of £120m which was corroborated by external consultants and resulted in the receipt of national Deficit Support Funding to enable a breakeven plan, of which, Dudley Group received £32.6m. At the start of 25/26, the drive across the System to improve productivity had reduced the opening deficit to £95m and once again, national Deficit Support Funding was made available to ensure a breakeven plan could be submitted. The share of national Deficit Support Funding relating to Dudley Group equated to £21.2m reflecting a reduction of £11.4m.

The impact of the financial environment resulted in the setting of another exceptionally challenging Cost Improvement Programme, equating to £39.0m (6.2% of expenditure plan). Whilst positive progress was achieved against this target, the final delivery of £31.4m resulted in a shortfall of £7.6m. Of the savings achieved, 61% was recurrent.

Throughout 25/26 there remained a key focus on delivering extra elective activity, including first outpatient attendances. This is part of the drive to reduce the backlog of patients waiting for treatment. The contract for elective and first outpatients remained variable with extra activity paid for via set tariffs within the National Payment System alongside one-off funds made available nationally for activity sprints. The Trust made good progress on this, generating additional payments for exceeding plans and delivering sprint activity.

However, non-elective services remained under a block contract for 25/26, placing a significant level of pressure on the Trust due to a rise in patients attending via the emergency portals, particularly within the Black Country and further afield from Worcester. Part of this growth was driven by increased patients from Sandwell following the movement of emergency services to the new Midland Metropolitan Hospital and this was flow was partly recognised in the contract discussions across the System.

A national exercise was undertaken mid-year to understand whether the block funding in contracts correlated to the cost of services being delivered. This demonstrated a significant shortfall for Dudley Group when compared against the recurrent funding in the contract. Going

DGFT Corporate Services

forward, the output from this exercise will be used to influence how payments are adjusted in future years.

Further industrial action was taken by resident doctors during the year over three separate periods. Funding of just under £2m was provided to help manage the additional costs of cover.

Pay budgets included challenging assumptions for reduced substantive (2%), bank (42%) and agency (44%) staff numbers when comparing March 2026 to March 2025. Good progress was made on temporary staff reductions although ultimately this fell some way short of the target. However, agency remains very low at 0.6% of the paybill which is well within the national target. Substantive staff numbers increased over the year. The financial impact of this was fully mitigated by the increased levels of income noted above.

Mid way through 24/25, 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 figures reported below will capture the full year effect of this transaction.

As a result of forecasting to deliver a breakeven position and submitting a compliant plan for 26/27, the Trust was offered the opportunity to receive additional national Deficit Support Funding. This related to resource removed from other Trusts that were failing to achieve their agreed plans. This equated to £3.276m and was awarded on the proviso that the Trust used the funds to improve the financial position from breakeven to a £3.276m surplus. Following receipt of this funding, the Trust has ended the financial year with a surplus of £3.284m, reflecting a position that is £8k better than the revised plan

The numbers presented below relate to The Dudley Group financial performance (including the Trust subsidiary Pharmacy company but excluding the charity).

The numbers presented below relate to The Dudley Group financial performance, not including the charity.

	2025/26			2024/25	
	Plan £000	Actual £000	Variance £000	Plan £000	Actual £000
Income	£636,849	£668,884	£32,035	£599,977	£622,021
Pay	-£421,229	-£429,114	-£7,885	-£385,979	-£401,512
Non-pay	-£194,363	-£231,595	-£37,232	-£178,125	-£183,521
EBITDA	**£21,257**	**£8,175**	**-£13,082**	**£35,873**	**£36,988**
Depreciation and Finance costs*	-£21,018	-£20,446	£572	-£53,401	-£51,283
NET Surplus/(Deficit)	**£239**	**-£12,271**	**-£12,510**	**-£17,528**	**-£14,295**
Technical Adjustments	-£239	£15,555	£15,794	£15,938	£12,752
Final Surplus/(Deficit)	**£0**	**£3,284**	**£3,284**	**-£1,590**	**-£1,543**

*1 Figures include impairment of £2.193m in 24/25 and £15.833m in 25/26 which are removed in the technical adjustments.

*2 Figures include a gain on absorption of £2.503m in 24/25 following the transfer of Dudley Integrated Health and Care NHS Trust. This gain was also removed via the technical adjustments.

Diane Wake

Group Chief Executive Officer

22nd June 2026

Accountability report

Introduction to the 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, Executive Directors and Non-executive Directors (NEDs) all with voting rights, plus other executive directors and associate NEDs who attend board meetings in a non-voting capacity. As of 31st March 2026, there were no executive or non-executive vacancies. The Trust board seeks to reflect the local population it serves, as part of succession planning.

Non-executive Director (NED) appraisals for 2024/25 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. The appraisal findings were considered by the Council of Governors in September 2025.

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 2025/26. 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 2025/26 had no impact on our provision of goods and services for the purposes of the health service in England.

During the year, the Trust was assimilating its developmental self-assessment activity to reflect the refreshed CQC framework. Other self assessment activity across core services in year has been undertaken and has continued to embed any actions arising.

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 2025/26.

Biographies (alphabetical by surname) as of 31st March 2026

Rachel Barlow, Group Chief Development Officer

Rachel is the Group Chief Development Officer at Sandwell and West Birmingham NHS Trust and The Dudley Group NHS Foundation Trust.

Rachel joined Sandwell and West Birmingham NHS Trust in 2011 and oversaw the major transformation programme that opened the Midland Metropolitan University Hospital in 2024, one of England's largest new hospitals, delivering clinical, workforce and digital change and supporting local regeneration.

Rachel started her career in the NHS as a nurse in 1988 working in London, specialising in critical care, vascular surgery, and major trauma. She has worked at Trust Board level since 2011 serving as a Chief Operating Officer for nearly nine years with a responsibility for the delivery of hospital and community-based clinical services. Rachel has Trust Board level responsibilities for delivering the Trust estates strategy, regeneration portfolio, net zero plans and facilities management.

Laura Broster, Group Chief Communications Officer

Laura joined the Trust in June 2025 as Group Director of Communications for Sandwell and West Birmingham NHS Trust and The Dudley Group NHS Foundation Trust.

With over two decades of experience in NHS communications, Laura has established herself as a seasoned leader in strategic communications and stakeholder engagement. She has held previous roles at NHS Black Country Integrated Care Board and NHS Dudley Clinical Commissioning Group.

Laura is dedicated to using insight to drive targeted communications that supports health improvement. Known for her collaborative approach, she brings together NHS staff, service users, and partners to develop coherent, inclusive communication strategies. She is responsible for internal and external communications, ensuring that staff have the information they need to deliver high-quality care, and that patients and local communities feel informed, engaged, and connected with the organisation.

Prof Gary Crowe, Non-Executive Director and Deputy Chair

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 NHS Non-executive Director 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 Trust 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.

Dr James Fleet, Group Chief People Officer

Dr James Fleet is Group Chief People Officer at The Dudley Group NHS Foundation Trust and Sandwell and West Birmingham NHS Trust. He first joined the Trust on an interim basis as Chief People Officer in October 2023, providing executive leadership and support to the people and organisation development directorate and embedding our people plan.

He has previously worked at Lancashire and South Cumbria Integrated Care Board where he was Chief People Officer and Executive lead for transformation and improvement. James was previously Chief People Officer at The Dudley Group NHS Foundation Trust, where he also had executive responsibility for the Dudley Improvement Practice.

James has a professional doctorate in health and care system leadership, as well as a master's degree in employment law and a dual hons degree in Human Resource Management and Business Administration. James is a fellow of the Chartered Institute of Personnel and Development and has extensive Executive and Board experience, including as a national director in Price Waterhouse Cooper's Health Team and as executive leader and co-founder of Four Eyes Insight Clinical Productivity Consulting, where James led major transformation work across a wide range of NHS organisations.

Joanne Hanley, Non-Executive Director (left March 2026)

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.

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.

Catherine Holland, Non-Executive Director

Catherine joined the Trust in September 2018. She 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 is also the Trust's Senior Independent Director.

Julian Hobbs – Medical Director (left July 2025)

Julian joined the Trust in October 2017 from Royal Liverpool. Julian was Deputy Medical Director and leads on Mortality for 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. Julian has had extensive experience in medical management roles for several years. And was Medical Director at The Dudley Group NHS Foundation Trust until July 2025.

Professor Anthony C. Hilton – Associate Non-Executive Director (left October 2025)

Anthony joined the Trust in July 2023 from Aston University where he was 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. And is now Deputy Vice Chancellor (academic) at University of West London. 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.

Paul Hudson, Medical Director

Paul qualified from the University of Birmingham in 1997 and has a long history at the Trust, firstly as a Medical Student, returning as an SHO and taking up his Consultant Anaesthetist post in 2009. Following a range of clinical leadership posts Paul became Deputy Medical Director in 2018 before a further promotion to Operational Medical Director in 2022 and appointment as Medical Director in 2026.

With a strong operational understanding and belief in visible leadership, Paul was instrumental in the Trust's response to the COVID-19 pandemic taking on the Senior Responsible Officer role. Regionally Paul has held several posts including Virtual Ward Clinical Lead and Expert by Experience for Job Planning and has spoken widely on the Trust's Job Planning journey.

Prof Liz Hughes MBE, Non-Executive Director (left March 2026)

The Dudley Group welcomed Liz to its board in December 2019. Liz was Deputy Medical Director for Health Education England and as a Consultant in chemical pathology and metabolic medicine at Sandwell and West Birmingham NHS Trust and is Honorary Professor at the University of Birmingham and University of Aston and Worcester University. She is recognised as a national expert in the treatment of lipid disorders.

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. 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 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 (until March 2026)

Karen joined us as Chief Operating 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.

In her new role, Karen will be leading our Fit for the Future Programme as we enter a significant period of transformation across the The Dudley Group NHS Foundation Trust and Sandwell and West Birmingham NHS Trust.

Mick Laverty, Associate Non-Executive Director

Mick is a chartered accountant and experienced Chief Executive. Mick is currently Chief Executive of the ExtraCare Charitable Trust, a charity that builds and runs the UK's largest retirement villages. Before joining ExtraCare he was Chief Executive of the Student Loans Company, a government-funded 'digital exemplar' organisation that distributes circa £20 billion per annum and has over seven million customers.

Mick has also previously been Chief Executive of Advantage West Midlands, the regional development agency for the West Midlands. Additionally, he has held a number of non-executive director roles in the public, private and charity sectors and is currently a Council Member and was the chair of the Audit Committee at the University of Birmingham and a Non-executive Director of Sandwell and West Birmingham Trust, where he chaired the committee that oversaw the construction and commissioning of the new Midland Metropolitan University Hospital.

Mick was appointed as a Deputy Lieutenant for the West Midlands in 2018.

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. Mohit has held a variety of leadership roles including board-level positions and joined the Trust in June 2024.

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.

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 MBE, Non-Executive Director (left March 2026)

Anne-Maria joined the Trust in June 2024, and her previous roles 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 was 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.

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 KCB CBE, Chair

Sir David Nicholson joined the Trust as Chair on 1st September 2022. He is also currently Chairman of Sandwell and West Birmingham NHS Trust, The Royal Wolverhampton NHS Trust and Walsall Healthcare NHS Trust.

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 was also the chairman of the Metropolitan Group of Hospitals, Nairobi. He is also a visiting Professor of Global Health at the Institute of Global Health Imperial College. 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.

Dr Ita O'Donovan, Associate Non-Executive Director (left May 2025)

Ita 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.

Jonathan Odum, Group Chief Medical Officer

Dr Odum qualified from Birmingham University in 1984, and his postgraduate training was undertaken in the West Midlands and Adelaide, South Australia. He took up post as a Consultant in General Internal Medicine and Nephrology at New Cross Hospital in 1993. His clinical interests include diagnosis and management of hypertension and pathophysiological mechanisms underlying and treatment of glomerular disease.

Dr Odum was elected as a fellow of the Royal College of Physicians (RCP) in 1999 and has been an MRCP PACES examiner from 1999 to the present day. He has a significant interest in service development, and as clinical director for Renal Services (1995-2005), was responsible for the expansion of renal services at Wolverhampton into Walsall and Cannock, and the opening of the satellite Haemodialysis units at Walsall Hospital and Cannock Chase Hospital.

Dr Odum has held several senior medical management positions at The Royal Wolverhampton NHS Trust, including Clinical Director of Medicine and divisional medical director posts, Chief Medical Officer, Responsible Officer, Group Chief Medical Officer. At Integrated Care System (ICS) level, Dr Odum is Chair of the Clinical Leaders Group and is also the Chief Medical Officer for the Black Country Provider Collaborative (BCPC). He joined The Dudley Group in August 2025 as Interim Medical Director before starting his role as Group Chief Medical Officer in February 2026.

Vij Randeniya OBE, Non-Executive Director

Vij is an experienced Non-executive Director within the health service. He was formerly Deputy Chairman of Birmingham Women's and Children's NHS Foundation Trust and sat on the governing body of Aston University.

Vij was 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. He is also commissioner for the South Wales Fire and Rescue. Vij was awarded the OBE in 2006.

Jack Richards, Interim Chief Operating Officer (from March 2026)

Jack joined the Trust in 2020 from University Hospitals Birmingham NHS Foundation Trust. A registered nurse by background, he qualified with a Bachelor of Nursing from the University of Birmingham in 2008 and has since held a range of senior nursing and operational leadership roles across Birmingham and Dudley.

He holds a Master of Business Administration from the University of Wolverhampton (2022), has completed the NHS Leadership Academy Executive Director Pathway, and is a Fellow of the Chartered Management Institute.

Jack was appointed Deputy Chief Operating Officer in 2024 and became Interim Chief Operating Officer in March 2026, joining the Executive Team. He brings a strong track record of operational delivery, transformation, and system leadership.

Mel Roberts, Group Chief Nursing Officer

Mel joined Sandwell and West Birmingham NHS Trust in December 2018, as Director of Operations for Primary Care, Community and Therapy services, before taking on the role of Chief Nurse in January 2021. She was appointed as Group Chief Nursing Officer at The Dudley Group NHS Foundation Trust and Sandwell and West Birmingham NHS Trust in December 2025.

She is an accomplished NHS Senior Leader with a successful track record of delivering and transforming services that provide high quality patient care across acute, community and mental health settings.

Mel previously worked at Worcestershire Health and Care NHS Trust where she served as Deputy Chief Operating Officer/Associate Director Integrated Community Services. Mel is proud to be a nurse and is known for being an inclusive, informative, empowering, kind and compassionate leader.

Kat Rose, Interim Group Chief Partnership 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, Project Management Officer, improvement and planning teams. A role she also performed 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

Adam Thomas, Group Chief Strategy and Digital Officer

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 NHS Foundation Trust 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 master's 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, Group 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 13 years. She joined The Dudley Group NHS Foundation Trust as Chief Executive in April 2017 and became Group Chief Executive in 2025.

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 with 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 a key leader of the Black Country Provider Collaborative driving collaboration and partnership working

Chris Walker, Director of Finance

Chris Walker joined the Trust in 2009 as Deputy Director of Finance and joined the board as Interim Director of Finance in 2024, bringing with him over 30 years of experience working within the NHS.

Chris's first substantive role was with South Birmingham Health Authority and then in 1994, after Trust's 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.

Since joining the Trust, Chris's role has also included 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 Trust in December 2019. He was the 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.

Lowell is a sustainability champion for the Trust, supporting the Trust's Green Working Group.

Board of Directors attendance 2025/26 meetings

Our Board of Directors is the unitary governing body of the Dudley Group NHS foundation Trust and is responsible for setting strategic direction, ensuring quality of care, managing performance, and ensuring financial sustainability. Composed of executive and non-executive members, it holds collective responsibility for delivering safe, effective health services while adhering to regulatory standards and local, as noted in NHS England's role and responsibilities of an NHS Trust Chair.

Role of deputy chair and Senior Independent Director

The Senior Independent Director is non-executive director with additional responsibilities in addition to the duties as a non-executive director and is appointed by the Council of Governors. The duties include serving as an intermediary for other directors when necessary and to lead the annual performance evaluation of the chair taking into account the views of the directors, trust governors and other stakeholders. To provide support and guidance to the council of governors through the Lead Governor, in seeking to resolve concerns or, in the absence of a resolution, in taking formal action.

The Deputy Chairman role is vital to support the shared chair as the local chair by ensuring all board members are fully engaged in developing and determining the trust's visions, values and strategy with the overall objective to deliver organisational purpose and sustainability. They provide visible and inclusive personal leadership to support developing a healthy, open and transparent patient-centred culture for the organisation where trusting and constructive relationships are promoted between elected and appointed members of the council and between the board and the council.

Position	Name	Commencing	End	Attendance out of 9*
Chief Executive Group CEO (from 01/01/25, previously Dudley Group NHS FT CEO)	Diane Wake	03/04/17		9
Director of Finance (interim 1/1/24 – 31/7/25, substantive 01/8/25)	Chris Walker	01/01/24		9
Chief operating officer	Karen Kelly	02/01/18		8
Medical director	Dr Julian Hobbs	02/10/17	31/07/25	2/3

Position	Name	Commencing	End	Attendance out of 9*
Group Chief Medical Officer (01/02/2026)	Jonathan Odum	01/08/25		5/8
(Medical Director (interim) 01/08/25 – 31/01/26)			31/1/26	
Medical Director	Paul Hudson**	01/01/26		3/3
Dudley Deputy Group Chief Nurse appointed 01/1/2026 formerly Chief Nurse - voting	Martina Morris*	03/03/24		6/7
Group Chief People Officer	James Fleet	01/04/25		8
Group Chief Partnership Officer interim from 1/8/25, formerly Chief Integration Officer	Kat Rose**	18/4/22		8
Group Chief Strategy & Digital Officer from 1/4/25, formerly Chief Information Officer	Adam Thomas**	01/09/19		9
Group Chief Development Officer	Rachel Barlow**	01/04/2025		6
Group Chief Nurse	Mel Roberts	01/12/2025		3/3
Director of Communications (formerly Head of Communications)	Liz Abbiss**	01/05/23	31/05/25	1/1
Group Chief Communications Officer	Laura Broster*	01/06/2025		6
Chair	Sir David Nicholson	01/09/22	31/03/27	8
Non-executive Director	Prof Liz Hughes	15/11/19	31/03/26	9
Non-executive Director	Catherine Holland	01/09/18	31/08/27	7
Non-executive Director	Lowell Williams	01/12/19	31/03/28	8
Non-executive Director	Prof Gary Crowe	01/07/19	31/03/2	6
Non-executive Director	Vij Randeniya	20/11/20	31/11/27	9
Non-executive Director	Joanne Hanley	01/06/23	31/03/26	6
Non-executive Director	Anne-Maria Newham	01/06/24	31/03/26	5
Non-executive Director	Peter Featherstone	01/06/24	30/06/27	8
Non-executive Director	Mohit Mandiratta	01/06/24	30/06/27	8
Associate Non-executive Director	Anthony Hilton**	01/07/23	31/10/25	4/4
Associate Non-executive Director	Ita O'Donovan**	01/06/24	31/05/25	0/1
Associate Non-executive Director	Mick Laverty**	01/05/2025	31/08/28	7

**There were three extraordinary meetings held in June and October 2025 and one in February 2026. **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.

Board of directors

As at 31st March 2026

Alphabetical by surname

Group chief executive
Diane Wake

Group chief development officer
Rachel Barlow*

Medical director
Dr Paul Hudson*

Group chief medical director
Jonathan Odum

Interim group chief partnership officer
Kat Rose*

Group chief communications officer
Laura Broster*

Chief officer Fit for the Future
Karen Kelly*

Interim chief operating officer
Jack Richards

Group chief strategy and digital officer
Adam Thomas*

Group chief people officer
Dr James Fleet

Chief nurse and deputy group chief nursing officer
Martina Morris*

Group chief nursing officer
Mel Roberts

Director of finance
Chris Walker

Chairman
Sir David Nicholson KCB CBE

Non-executive director and deputy chair
Prof Gary Crowe

Non-executive director
Catherine Holland**

Non-executive director
Dr Mohit Mandiratta

Non-executive director
Lowell Williams

Non-executive director
Peter Featherstone

Non-executive director
Prof Liz Hughes MBE

Non-executive director
Anne-Maria Newham MBE

Non-executive director
Jo Hanley

Associate non-executive director
Mick Laverty*

Non-executive director
Vij Randeniya OBE

*non voting.
**Senior independent director

Board committee structure

As of 31st March 2026

Council of Governors

- **Experience and Engagement Committee**
- **Appointments and Remuneration Committee**

Board of directors

- **Quality Committee**
- **Audit Committee**
- **People Committee** (shadow joint format, Dec 2025)
- **Finance & Productivity Committee** (shadow joint format, Jan 2026)
- **Integration Committee**
- **Charity Committee**
- **Infrastructure Committee** (shadow joint format, May 2025)
- **Remuneration and Nominations Joint Working Committee** (shadow joint format, Jan 2025)

Patient Experience Indicators

There was an increase in complaints activity during 2025/26 (1354) from 2024/25 (1053) by 28.6%. This is a significant increase in the number of new complaints received. Of notable achievement, the complaints team closed 1336 complaints during the financial year compared to 1118 complaints closed for 2024/25.

The Patient Advice and Liaison Service received 3838 informal concerns and comments and 1900 signposting contacts (in total 5738 cases/activity) in 2025/26, which is an increase from the previous year (2024/25) figures of 5361 in total (3875 informal concerns and comments and 1486 signposting contacts). This is an increase of 377 total cases/activity (7.03%).

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, and bed pressures across the Trust. Concerns continue to be raised regarding nursing care and the discharge process along with staff behaviour. 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. We are also aware with our connections from other local Trust complaints and PALS teams, that they are also seeing a significant increase in concerns being raised.

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 and during the Patient Experience Group.

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

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 2025/26, 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 2025/26.

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

WWe 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.

Stakeholder relations

Dudley Engagement Group (DEG)

Over the past year, we have prioritised meaningful opportunities for community involvement, actively seeking local insight while providing practical health advice and support.

We were proud to host an Armed Forces Day at Himley Hall and deliver Health on the Shelf at Merry Hill Shopping Centre, both of which attracted significant public engagement. Free blood pressure checks proved particularly impactful, with a number of attendees identified with previously undetected hypertension and referred for further clinical support - a clear example of early intervention in action.

Additional outreach activity has included supporting Men's Health Week at Coseley Men's Club; partnership working with the Dudley Stroke Association and Healthwatch Dudley; delivering a diabetes awareness session in Urdu with the DIYYA ladies' group in Lye; and progressing our Digital Front Door programme to improve access to services.

Together, these initiatives demonstrate our commitment to meeting people where they are, reducing health inequalities and strengthening trust within our communities.

We've also held conversations across Dudley, Sandwell and West Birmingham to gather feedback on proposals for elective care services. The proposals included the creation of an elective care hub at Sandwell Hospital for general surgery, gynaecology and orthopaedic procedures for Dudley and Sandwell residents. Over 690 people responded to the conversation with their thoughts on how waiting times could be reduced despite perhaps travelling a little further and how freed up hospital space may be better used.

Involvement Opportunities

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Small Grants Funding

This year marked an important milestone with the launch of a new small grants programme through the Trust's charity. For the first time, up to twelve voluntary and community groups received funding to host local conversations around health, wellbeing, and how people make choices when seeking help and support.

These grassroots discussions are providing rich, authentic feedback that will directly inform how we improve patient experience, accessibility and pathways to care. By investing in our community partners, we are not only amplifying local voices but embedding co-production at the heart of our future planning.

Through sustained partnership, meaningful engagement and a shared ambition to improve outcomes, we continue to build a stronger, more inclusive and more responsive health and care system for Dudley.

Delivering Healthier Futures: progress across the Black Country Integrated Care System

Over the past year, the Black Country Integrated Care System (ICS) has continued to strengthen collaboration across health, care, local government and community partners to deliver the ambitions set out in the **Healthier Futures Integrated Care Strategy**. The strategy provides a shared framework to improve population health, reduce inequalities and create a sustainable, integrated health and care system for the 1.2 million people who live and work across the Black Country.

Established under the Health and Care Act 2022, the ICS brings together NHS organisations, local authorities, the voluntary sector and wider partners to plan joined-up services and improve outcomes. The system operates through two statutory bodies: the NHS Black Country Integrated Care Board (ICB), responsible for NHS planning and resource allocation, and the Integrated Care Partnership (ICP), which brings partners together to oversee delivery of the strategy.

At The Dudley Group NHS Foundation Trust, we are proud to play an active role in this partnership, working collaboratively to improve health outcomes and life chances for the communities we serve.

A shared vision

The Healthier Futures strategy continues to provide the long-term vision for improving outcomes, reducing inequalities and supporting economic prosperity. Recently refreshed alongside the Joint Forward Plan, it strengthens the focus on prevention, population health and the wider determinants of health. Key priorities include:

- improving population health through prevention and early intervention
- reducing health inequalities, particularly for underserved communities
- supporting employment and prosperity as key drivers of health
- strengthening partnership working across organisations
- using data and insight to inform commissioning decisions
- maximising the role of anchor institutions to deliver social value.

These priorities reflect ongoing challenges including deprivation, lower healthy life expectancy and high levels of long-term conditions, reinforcing the importance of prevention, integration and partnership working.

Black Country Integrated Care Partnership

During the year, the ICP continued to provide system leadership, bringing together senior representatives from health, local government, public services and the VCSE sector to support delivery of shared priorities.

Following national policy changes regarding ICP arrangements, partners have begun reviewing future governance arrangements to ensure collaborative working continues. This includes engagement with the West Midlands Combined Authority through the Strategic Health Partnership Board to maintain focus on employment, prevention and health inequalities. Despite these changes, strong partnership working continues to support:

- collaborative action to reduce health inequalities
- delivery of prevention and population health programmes
- alignment of commissioning and population health plans
- the ICB's role as an anchor organisation.

Progress this year includes expanded prevention programmes, improved use of population data to target interventions, and strengthened support for underserved groups including refugees, migrants and people experiencing homelessness. Engagement with VCSE partners has also continued to grow, recognising their vital role in improving community outcomes.

Progress towards an integrated system

Partners have continued to strengthen integration at both system and place level, with place-based partnerships in Dudley, Sandwell, Walsall and Wolverhampton ensuring services reflect local needs. Key areas of progress include:

- **Care closer to home** – expanding community-based models and strengthening collaboration between primary, community and voluntary services.

- **Prevention and inequalities** – increasing focus on early intervention and addressing the wider determinants of health.
- **Children and families** – improving early support and access to services for children and young people.
- **Workforce** – supporting the 60,000 staff across the Black Country through workforce planning, recruitment and retention initiatives.

Working with communities

Partnership with communities remains central to improving health outcomes. Engagement through community forums and voluntary sector partnerships continues to help shape services, improve access and address the wider determinants of health.

Looking ahead

While progress continues, significant challenges remain. The next phase of delivery will focus on strengthening prevention, expanding integrated community services and continuing to address health inequalities. Through strong partnership working, the Black Country ICS remains committed to building a more joined-up, sustainable and equitable health and care system for the future.

Primary Care Development

The Trust has responsibilities for supporting primary care development through a contractual arrangement with the Black Country Integrated Care Board (ICB). This has been achieved via the co-production and delivery of a comprehensive Primary Care Development Plan with primary care partners, including practices and Primary Care Networks (PCNs), focusing on key areas such as modern general practice implementation and integrated care models. The plan has driven significant progress, with extensive engagement through structured practice visits, PCN workshops, development groups, and tailored support instances (over 227 recorded), enabling practices to meet regulatory and operational requirements while fostering resilience and collaboration.

- **Modern General Practice (MGP) Implementation:** Provided hands-on support, practice visits, and targeted guidance so that 100% of Dudley GP practices achieved full Modern General Practice status.
- **Practice Support, Assurance, and Care Quality Commission (CQC) Readiness:** Carried out 34 detailed practice visits, offered practical help with CQC inspections (including mock assessments and action planning), and assisted with ICB contract reviews to ensure practices were well-prepared and supported.
- **General Practice Development Group:** Set up a regular forum bringing practices together to progress shared priorities such as workforce options, safer ways of working, and better use of technology.
- **Digital and Clinical Systems Support:** Created easy-to-use reports to help practices track key performance areas (such as vaccinations, safeguarding, and cancer follow-up), supported PCNs to meet their agreed support framework, and ensured staff had access to necessary digital safety training.
- **Improving Referrals and Primary–Secondary Care Links:** Developed clear local processes for referral forms, introduced a shared inbox for raising and resolving issues between GP practices and hospital services, and set up pilot arrangements to address common concerns more quickly.
- **Workforce and Team Capacity:** Helped practices access extra staff through the Trust's bank system, expanded pharmacy support within GP networks (leading to over 13,000 medication reviews and significant cost savings), and supported training and safer prescribing initiatives.
- **Integrated Neighbourhood Teams (INTs) Development:** Worked with PCNs, care home teams, and system partners to develop more joined-up neighbourhood health teams. This included dedicated support for care homes, workshops to shape future models (covering all ages including children and young people), and piloting tools to better identify and support people at higher risk of needing hospital care.
- **Local Quality Framework and Financial Stability**: Led discussions and detailed

financial analysis with practices and the ICB, securing agreement to continue the local Dudley quality scheme for 2026/27 and protect practice income in the following year.

- **Communication, Engagement, and Wider Support:** Delivered workshops on key topics, ensured practices fully used available winter access funding, improved visibility of local services through digital tools, supported shared health record agreements, and worked with partners on leadership development and better patient communication.

Black Country Provider Collaborative (BCPC)

The four partners of the Black Country Provider Collaborative have continued to work positively together during 2025/26 on the agreed range of priorities best pursued at scale once.

Supported by a small central team and complemented by many executive and clinical leaders from across the system, several programmes of work were agreed for progression with a summary of the positive progress made as follows:

1. Clinical Improvement Programme

Driven by our clinical leads through 14 Clinical Networks the focus of their work has been to improve the quality of care, by *'levelling up'* service standards consistently across all four partners.

There has been a focus on meeting and exceeding best practice standards such as GiRFT, in addition to developing guidelines, patient care pathways, service protocols, and standard operating procedures.

Examples include the implementation of the FIT pathway and development of early rectal cancer management within the colorectal network, in parallel to many guidelines and pathways being developed in critical care, dermatology, gynaecology and ophthalmology clinical networks.

2. Clinical Service Transformation Programme

A parallel programme of work has centred on making best use of our resources (financial, workforce, materials and estate) to develop and establish new models of care which deliver *'better, faster and safer'* care to our local population.

We have made positive strides in establishing a Black Country Elective Hub at Sandwell Health Campus, a new system wide Breast reconstruction service at Dudley, the development of a dual site gynae-oncology service at RWT and SWBH, and the continued pursuit of urology cancer care transformation across the Black Country.

The impact of these service changes should see patients access care in a timelier manner, with significant improvements in both health outcomes and patient experience over the next few years.

3. Corporate Service Transformation Programme

Steady progress has been made across three phases of a corporate service transformation programme which seeks to maximise working at scale through the key benefits of productivity, improvement, resilience and efficiency.

An early phase of work has seen the streamlining of some corporate functions at a Group level, consistent with meeting key national targets. Work has also centred on a small range of sub-functional areas to determine an optimal model for service delivery at scale. These have included Collaborative Bank, Occupational Health Services, Recruitment, and Research & development, with proposed options being reviewed imminently, for subsequent progression.

And finally, the programme has explored with and external partner further opportunities to achieve benefits at scale with a focus in DDaT, Finance, Estates & Facilities, People Services, and Procurement which will be progressed in 2026/27.

Looking ahead and recognising an emerging operating model across a new NHS, the BCPC will continue to work on behalf of its partners, providing key leadership in driving delivery of agreed system wide priorities best pursued at scale, which support our goal of working as *'one hospital across multiple sites providing better, faster, and safer care to our local population and beyond'*.

Dudley Health and Care Partnership (DHCP)

The Dudley Health & Care Partnership brings together local health and care organisations to maximise shared resources and provide strong, system-wide leadership. The Partnership drives the development of an integrated health and care system that aligns planned and urgent care with neighbourhood-based approaches, supporting people to receive the right care, in the right place, at the right time.

Central to the Partnership's work is a commitment to understanding and responding to local need. This is achieved through meaningful community engagement, a strong focus on prevention, addressing health inequalities, and embedding the Joint Strategic Needs Assessment and Health and Wellbeing Board Strategy into decision-making. The Dudley Health & Care Partnership provides strategic oversight of key programmes and workstreams, while supporting workforce development and contributing to local economic growth.

Our Purpose

The Dudley Health & Care Partnership has agreed a shared mission, vision and ambitions that guide Partnership activity:

- **Mission:** *Community where possible; hospital when necessary*
- **Vision:** *Working together, connecting communities, enabling coordinated care so our citizens can live longer, safer, healthier lives*

Our ambitions are to deliver:

- **One Workforce** – working as one Team Dudley, aligned without barriers to improve population outcomes
- **Thriving Communities** – coordinated, preventative care with a strong focus on reducing health inequalities
- **Transforming Services** – responsive, effective services delivered by the right person, at the right time, in the right place
- **The Right Balance** – enabling citizens, families and professionals to work together to achieve better outcomes
- **Environmental Sustainability** – meeting today's needs without compromising future generations
- **Financial Sustainability** – delivering best value health and social care for Dudley residents

The DHCP delivers against its priorities through three core workstreams:

1. Neighbourhood Health and Care (Children and Adults)

This workstream focuses on delivering integrated, preventative and person-centred care through:

- Prevention, promotion and wellbeing
- Navigation and care coordination
- Community Partnership Teams, evolving into Integrated Neighbourhood Teams in line with national guidance

Key achievements this year include:

- **Stronger support for care homes:**
  Closer day-to-day collaboration has strengthened relationships, improved joint working and enabled faster problem-solving. A dedicated Community Partnership Team contributed to a reduction in emergency department admissions for Trust-registered practices, from an average of 81 to 59 per week.
- **Quality and leadership recognised:**
  In March 2026, Dudley Metropolitan Borough Council's adult social care services were rated 'Good' by the Care Quality Commission, recognising strong leadership, a compassionate workforce and effective partnership working.
- **Family Hubs delivering early support:**
  Five Family Hubs and two satellite 'spokes' have been established, bringing together midwifery, health visiting, early years and community services. These hubs offer accessible local entry points for families and directly support the Health and Wellbeing Board priority of ensuring children are ready for school, addressing developmental needs and inequalities linked to deprivation and ethnicity.
- **More flexible intermediate care provision:**
  A Better Care Fund-funded pilot introduced greater flexibility in community bed use, enhanced therapy support and improved patient flow. Joint working with social care has ensured timely assessment and discharge.
- **Improved care coordination for complex patients:**
  Redesigned patient identification and proactive coordination resulted in 279 fewer emergency admissions compared to a matched control group. In 2026/27, teams will further evolve towards a proactive, population health management model, informed by public health intelligence and integrated data.

2. Resilient Communities

This workstream strengthens collaboration with the voluntary and community sector through three complementary programmes:

- **The Dudley Compact:**
  A formal framework for partnership working between statutory organisations and the voluntary and community sector. The Compact Oversight Group met twice to review reported breaches and identify learning, leading to the establishment of a Commissioning Community of Practice, which will be refreshed with new leadership in 2026/27.
- **Trusteeship:**
  Governance across the sector was strengthened through a new trustee recruitment webpage, "Meet the Sector" events, and the recruitment of six new trustees. Dudley CVS also supported organisations to embed good practice in trustee recruitment, induction and retention.
- **Funding:**
  Activity focused on system readiness, including mapping voluntary sector contracts, supporting preparation for Direct Payments with Adult Social Care, and reinvigorating a Maximising Funding Group in October 2025. The group will support a refreshed Funding Code of Practice and the development of system-wide external funding bids.

3. Anchor Institutions

All DHCP partners operate as Anchor Institutions—large, established organisations with a long-term presence and influence in Dudley. Together, they contribute beyond clinical care to support local wellbeing, employment and skills.

Key achievements include:

- **Healthy Futures:**
  Co-creation of Healthy Futures, a framework launched by Windsor Academy Trust in partnership with the NHS and presented in Westminster. The programme strengthens links between education, health and communities, supporting young people into health careers. Twenty young people participated in 2025.
- **I Can Dudley:**
  Expansion of the cross-organisational employment and skills initiative supporting young people with SEND and care leavers. Thirty residents were supported into paid placements, with 50% progressing into permanent employment.

A Clinical Support Worker with a patient at Russells Hall Hospital

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:

Audit areas completed that received partial or minimal assurance included:

- Reasonable Adjustments – partial Assurance
- CQC Self-Assessment – partial Assurance
- Grip and Control Governance Review – partial Assurance
- Job Planning (focused on activity) – minimal Assurance

Other audit areas completed that received reasonable or substantial assurance included: Cost Improvement Programme – reasonable assurance, Key financial Controls (General ledger and selected aspects of budgetary control) – reasonable assurance, Board assurance Framework – Reasonable assurance, Cyber Assessment Framework (independent assessment Risk Rating: High, Confidence rating: High, Key financial controls (creditors) – substantial 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 2025/26 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 2025/26 with attendance as follows:

Audit Committee Membership		
Gary Growe	Non-executive director	1/1
Peter Featherstone	Non-executive director	5
Ita O'Donovan	Associate non-executive director – left Trust end of May 2025	1/1
Rachel Hardy	Non-executive director	1/1
Anne-Maria Newham	Non-executive director – left Trust end of March 2026	2
Joanne Hanley	Non-executive director (Committee Chair) – left Trust end of March 2026	4

In attendance		
Liz Abbiss	Director of communications	1/1
Karen Brogan	Interim chief people officer	2/2
James Fleet	Chief people officer	2/2
Julian Hobbs	Medical director - left Trust July 2025	1/1
Paul Hudson	Deputy medical director	1/1
Karen Kelly	Chief operating officer	1/1
Martina Morris	Chief nurse	2/5
Jonathan Odum	Group medical officer	2/2
Adam Thomas	Chief strategy & digital officer	4
Diane Wake	Group chief executive officer	3
Chris Walker	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 was effective from 1st April 2023 and is based on the principles of the UK Corporate Governance Code.

Diane Wake

Group Chief Executive

22nd June 2026

Remuneration Report

Annual statement on remuneration
(Information not subject to audit)

The Boards of both Sandwell and West Birmingham NHS Trust and The Dudley Group NHS Foundation Trust agreed to establish a Remuneration and Nominations Joint Working Committee with Terms of Reference in place.

Membership comprises the four Non-executive Directors, equally represented by each Trust, the Deputy Chair from each Trust and the shared Chair. 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 Joint Working Committee operates to review and evaluate the both the Group 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 in the case of The Dudley Group NHS Foundation Trust.

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 via the Very Senior Manager (VSM) pay framework.

During the year, the following appointments were made:

- Adam Thomas, Group Chief Strategy and Digital Officer
- James Fleet, Group Chief People Officer
- Rachel Barlow, Group Chief Development Officer
- Kat Rose, Group Chief Partnership Officer (interim)
- Mel Roberts, Group Chief Nurse
- Jonathan Odum, Group Chief Medical Director
- Laura Broster, Group Chief Communications Officer
- Chris Walker, Director of Finance (Dudley)
- Paul Hudson, Medical Director (Dudley)

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 Remuneration and Nominations Joint Working 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.

Remuneration and Nomination Committee *(Information not subject to audit)*

The Remuneration and Nominations Joint Working Committee is a sub-committee of the Board and holds at least one meeting per year. During 2025/26, it held four meetings and attendance at meetings were as below. Executive directors also attend the Remuneration and Nominations Joint Working 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 November 2025 and covers all aspects of the Trust's business.

Remuneration and Nomination Joint Working Committee	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

DGFT District Nursing Staff

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 Operating 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. (Apr- Jul '25) Chief Operating Officer receives 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.
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. Any non-executive directors covering responsibilities in a group role is remunerated at £18,000 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

Fair pay disclosures

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 2025/26 was £195,000 - £200,000 (2024/25 £250,000 - £255,000). This is a change between years of -21.78% (2024/25 4.12%)

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 2025/26 was from £105 to £623,000 (2024/25 £26 to £607,000). 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 3.40% (2024/25 5.4%). The increase incorporates a pay award of 3.6% for agenda for change staff, 4% for consultants and specialist doctors and 4% plus £750 for doctors in training.

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.

2025/26	% change for highest paid director	% change for employees as a whole
Salary and allowances	-21.78	3.40
Performace pay/bonuses	0	0

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

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. 94 employees received remuneration more than the highest paid Director (2024/25, 26).

2025/26	25th Percentile	Median	75th Percentile
	£	£	£
Total Remuneration	£28,266	£40,274	£53,947
Salary component of total remuneration	24,465	35,214	50,299
Pay ratio	**7.0 : 1**	**4.9 : 1**	**3.7 : 1**

2024/25	25th Percentile	Median	75th Percentile
	£	£	£
Total Remuneration	26,401	37,911	52,109
Salary component of total remuneration	22,584	32,559	48,550
Pay ratio	**9.7 : 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 decreased in 25/26 in comparison to 24/25, due to the previously highest paid Director becoming a Group role with their salary split 50:50 with Sandwell.

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

During 2025/26, 19 individuals (2024/25, 21) were executive or non-executive directors for the Trust. Of these, six (2024/25, six) received expenses in the reporting period and the aggregate sum of expenses paid was £3,349.54 (2024/25 £3,510.60). In addition, during 2025/26, 27 individuals (2024/25, 39) were governors for the Trust. Of these, No governor (2024/25, one) received expenses in the reporting period (aggregate sum of expenses 2024/25, £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 2025-26 as high levels of compliance against the code was achieved in each of the 12 months.

	2025/26	2025/26	2024/25	2024/25
	Number	£000	Number	£000
Total non-NHS trade invoices paid in the year	60,318	368,139	52,867	331,556
Total non-NHS trade invoices paid within target	57,047	361,188	50,146	327,546
Percentage of non-NHS trade invoices paid within target	**95%**	**98%**	**95%**	**99%**
Total NHS trade invoices paid in the year	2,237	49,125	2,166	52,020
Total NHS trade invoices paid within target	2,107	47,277	2,070	51,167
Percentage of NHS trade invoices paid within target	**94%**	**96%**	**96%**	**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.

Our Complex Nutrition Virtual Ward who deliver care in the community for patients

Salary and pension entitlements of senior managers (subject to audit)

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

Year Ended 31 March 2026

Name and Title	Note	Salary	* Expense payments (taxable)	Performance pay and bonuses	Long term performance pay and bonuses	# All Pension Related Benefits	Total
		(bands of £5,000)	(to the nearest £100)	(bands of £5,000)	(bands of £5,000)	(bands of £5,000)	(bands of £5,000)
		£	£000	£000	£000	£000	£000
Diane Wake, Chief Executive Group CEO		140-145					140-145
Chris Walker, Director of Finance		140-145				207.5 - 210	350 - 355
Julian Hobbs, Medical Director	I	85-90				35-37.5	120-125
Jonathan Odum, Interim Group Medical Director	J	190-195					190-195
Karen Kelly, Chief Operating Officer		195-200					195-200
Martina Morris, Chief Nurse	K	95-100				87.5-90	185-190
Melanie Roberts, Group Chief Nurse	M	25-30					25-30
James Fleet, Group Chief People Officer	L	90-95					90-95
Sir David Nicholson, Chair	#	25 - 30					25 - 30
Gary Crowe, Non Exec		20-25	400				25-30
Joanne Hanley, Non Exec		15-20					15-20
Anthony Hilton, Non Exec		5-10	400				5-10
Catherine Holland, Non Exec		15-20					15-20
Elizabeth Hughes, Non Exec		15-20					15-20
Vijith Randeniya, Non Exec		15-20	1,100				15-20
Lowell Williams, Non Exec		15-20	800				15-20
Anne-Marie Newham, Non Exec	F	10-15	200				10-15
Peter Featherstone, Non Exec	G	10-15	300				10-15
Mohit Mandiratta, Non Exec	H	10-15					10-15

Salary entitlements of senior managers 2024/25 - Audited

Year Ended 31 March 2025

Name and Title	Note	Salary	* Expense payments (taxable)	Performance pay and bonuses	Long term performance pay and bonuses	# All Pension Related Benefits	Total
		(bands of £5,000)	(to the nearest £100)	(bands of £5,000)	(bands of £5,000)	(bands of £5,000)	(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	A	5 - 10					5 - 10
Karen Brogan, Interim Chief People Officer	E	110 -115					110 -115
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	B	0 - 5	400				0 - 5
Gurjit Bhogal, Non Exec	C	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	D	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		10 - 15	900				10 - 15
Peter Featherstone, Non Exec		10 - 15	300				10 - 15
Mohit Mandiratta, Non Exec		5 - 10					5 - 10

The remuneration for Sir David Nicholson in 2024-25 and 2025-26 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.

**The remuneration figures are representative of Dudley Group's share of Group arrangements with Sandwell & West Birmingham NHS Trust in 2025/26. Diane Wake as Group Chief Executive is split 50:50 with Sandwell.

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 2024/25 and 2025/26.

*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 Alan Duffell started 20 June 2022 and left 31 April 2024
- B Julian Atkins started 4 January 2016 and left 31 May 2024
- C Gurjit Bhogal started 13 October 2022 and left 31 May 2024
- D Anthony Hilton started 1 July 2023 and left 31 July 2024
- E Karen Brogan started 1 May 2024
- F Anne-Maria Newham started 1 June 2024
- G Peter Featherstone started 1 June 2024
- H Mohit Mandiratta started 1 June 2024
- I Julian Hobbs started 2 October 2017 and left 31 July 2025
- J Jonathan Odum started 1 August 2025
- K Martina Morris started 3 March 2024 left 30 November 2025
- L James Fleet started 1 April 2025
- M Melanie Roberts started 1 December 2025

A patient at Corbett Outpatient Centre

b). Pension Benefits -unaudited

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 2026 (bands of £5,000)	Lump sum at pension age related to accrued pension at 31 March 2026 (bands of £5,000)	Cash Equivalent Transfer Value at 1 April 2025	Real Increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 2026	Employer's contribution to stakeholder pension
Chris Walker, Interim Director of Finance*	10.0 - 12.5	22.5 - 25.0	60 - 65	150 -155	1059	212	1306	19,782
Julian Hobbs, Medical Director*	0-2.5	0	80-85	215 - 220	1915	59	2015	9,731
Martina Morris, Chief Nurse	2.5-5	7.5-10	30-35	75-80	843	86	669	13,858

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 paid by Dudley Group and 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 substituated 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 2026 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 2025/26 was £2,500 - £5,000 (2024/25 £2,500 - £5,000)

Diane Wake

Group Chief Executive Officer

22nd June 2026

Staff report

About our employees

As of 31 March 2026, the Trust employs 6,718 substantive staff by headcount. Workforce analysis shows that the demographic profile of our employees broadly reflects that of the local Dudley population. Notably, a higher proportion of colleagues from ethnically diverse backgrounds choose to work at The Dudley Group NHS Foundation Trust compared with the local community. The predominance of female staff is consistent with workforce patterns seen across other combined acute and community trusts, as well as the wider NHS.

Staff in post

Staff Group	Headcount*	FTE**
Add Prof Scientific and Technic	304	271.45335
Additional Clinical Services	1383	1160.01303
Administrative and Clerical	1357	1184.953
Allied Health Professionals	544	468.79785
Estates and Ancillary	7	5.9
Healthcare Scientists	66	57.51013
Medical and Dental	862	801.58392
Nursing and Midwifery Registered	2190	1935.25018
Students	5	5
Grand Total	**6718**	**5890.46146**

* Primary Assignment Only

** Includes Secondary Assignments

Workforce Profile

Age Band	2025	2026
<=20 Years	1.05%	0.64%
21-25	6.90%	6.65%
26-30	14.12%	13.31%
31-35	15.28%	15.42%
36-40	14.48%	14.97%
41-45	10.77%	11.48%
46-50	9.78%	9.91%
51-55	11.00%	10.29%
56-60	9.77%	10.02%
61-65	5.54%	5.95%
66-70	0.98%	1.01%
>=71 Years	0.33%	0.34%

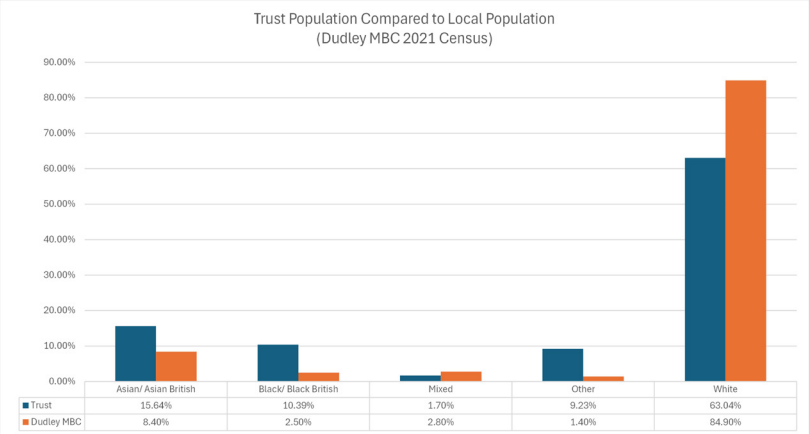
Gender	2025	2026
Female	80.33%	80.26%
Male	19.67%	19.74%

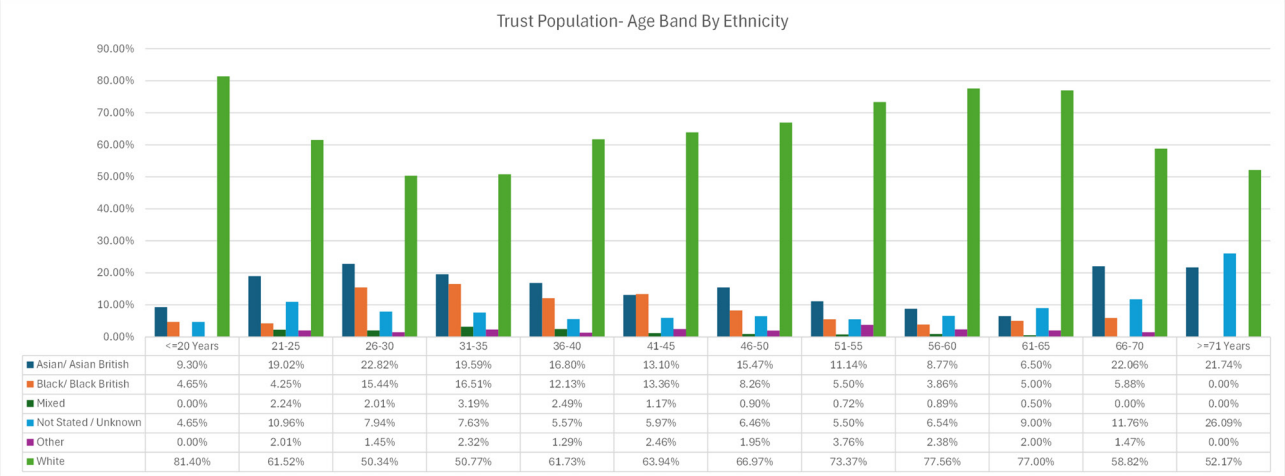
Ethnicity	2025	2026
Bame	28.95%	29.85%
Not Stated / Unknown	7.29%	7.12%
White	63.76%	63.04%

Disability	2025	2026
No	67.58%	69.29%
Not Declared	25.81%	23.52%
Prefer Not to Answer	0.26%	0.45%
Yes	6.36%	6.74%

Religious Belief	2025	2026
Atheism	11.72%	12.10%
Buddhism	0.42%	0.42%
Christianity	41.35%	42.30%
Hinduism	2.00%	2.04%
I do not wish to disclose my religion/belief	19.67%	17.46%
Islam	6.42%	6.31%
Jainism	0.05%	0.04%
Judaism	0.05%	0.03%
Other	6.11%	6.15%
Sikhism	2.10%	2.08%
No Response provided	10.13%	11.06%

Sexual Orientation	2025	2026
Bisexual	0.93%	0.91%
Gay or Lesbian	1.07%	1.04%
Heterosexual or Straight	72.76%	74.37%
Not stated (person asked but declined to provide a response)	15.17%	12.64%
Other sexual orientation not listed	0.11%	0.12%
Undecided	0.21%	0.16%
No Response Provided	9.75%	10.76%





Average Number of Employees Table

Note 5.3 Average number of employees (WTE basis)	Total Accounts 31 Mar 2026 2025/26 No.	Permanent Accounts 31 Mar 2026 2025/26 No.	Other Accounts 31 Mar 2026 2025/26 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	936	853	82	899	796	103
Ambulance staff	12	12	-	11	11	0
Administration and estates	1,133	1,104	29	1,149	1,111	38
Healthcare assistants and other support staff	1,460	1,259	201	1,480	1,260	220
Nursing, midwifery and health visiting staff	2,109	1,925	184	2,107	1,896	212
Nursing, midwifery and health visiting learners	-	-	-	-	-	-
Scientific, therapeutic and technical staff	741	710	31	724	674	49
Healthcare science staff	59	58	1	55	54	1
Social care staff	-	-	-	-	-	-
Other	-	-	-	-	-	-
Total average numbers	**6,449**	**5,921**	**529**	**6,425**	**5,802**	**624**
Of which:						
Number of employees (WTE) engaged on capital projects	17	17	-	44	44	-

Staff costs

	Year Ended 31 March 2026			Year Ended 31 March 2025		
Staff Costs	**Total £'000**	**Permanent £'000**	**Other £'000**	**Total £'000**	**Permanent £'000**	**Other £'000**
Salaries and wages	329,320	326,663	2,657	316,450	314,094	2,356
Social security costs	40,482	40,482	-	31,424	31,424	-
Apprenticeship levy	1,624	1,624	-	1,548	1,548	-
Pension cost - employer contributions to NHS pension scheme	34,036	34,036	-	31,344	31,344	-
Pension cost - employer contributions paid by NHSE on provider's behalf	22,167	22,167	-	20,335	20,335	-
Pension cost - other	35	35	-	68	68	-
Termination benefits	-	-	-	-	-	-
Temporary staff (including agency)	2,532	-	2,532	2,799	-	,799
NHS charitable funds staff	164	164	-	174	174	-
Total	**430,360**	**425,171**	**5,189**	**404,142**	**398,987**	**5,155**

Sickness absence data

During the preparation of the current year's financial statements, an error was identified in the calculation of the staff sickness absence table disclosed in the prior year's annual report. The error resulted in an understatement of reported staff sickness absence for 2024/25. The data has now been revised, and prior year figures restated to correct this error (below). This adjustment affects disclosure only and does not have an impact on the financial position.

Table 5A Staff sickness absence

	2025/26	**2024/25 (Revised)**	**2024/25 (Submitted)**	**Main code**
This table is prepared using data for a financial year	No.	No.	No.	Subcode
Total days lost in financial year	141,130	129,837	67,326	STA0530
Average WTEs for financial year	5921	5802	5,691	STA0540
Average working days lost (per WTE)	**24**	**22**	**12**	**STA0550**

Staff with disabilities

We are committed to creating an inclusive workplace where everyone feels able to bring their whole self to work. We recognise that disabled people can experience discrimination and disadvantage in the workplace, including physical, social and attitudinal barriers. The Trust therefore aims to ensure that staff with disabilities, long-term conditions, neurodiverse profiles and mental health conditions feel welcomed, supported and valued.

The Trust is mandated to implement the Workforce Disability Equality Standard (WDES), which provides a set of workforce measures enabling comparison of the experiences of disabled and non-disabled staff. Recent WDES data shows continued improvement across several indicators, including workforce representation, recruitment, staff engagement and the provision of reasonable adjustments.

Workplace adjustments remain a key priority in improving disability equality, as they enable staff to perform their

roles effectively and sustain employment. Over the past year, the Trust has strengthened its approach to reasonable adjustments through the continued rollout of the Reasonable Adjustment Passport and the development of a centralised reasonable adjustments project. This includes improved coordination of support for Access to Work assessments and implementation of recommended adjustments.

Further initiatives implemented to support staff with disabilities and long-term conditions include:

- Launch of a Neurodiversity Toolkit for staff and managers, supported by accompanying training.
- Delivery of training sessions and educational webinars on neurodiversity, including sharing lived experience.
- Ensuring adjustments are offered and implemented during recruitment and interview processes.
- Maintaining Disability Confident Leader status.
- Development and launch of the Trust's Anti-Discrimination Statement, which explicitly addresses disability discrimination and has been incorporated into key organisational policies.

The Disability Staff Network continues to play an important role in engaging with staff, providing peer support and delivering activities that promote inclusive practices, raise awareness and support education on disability inclusion across the organisation.

Engaging with Our Workforce & Communities

The Trust is committed to working collaboratively with staff to ensure delivery against objectives, through robust arrangements for join working which includes 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 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 updates.

The Hub

The Hub is the Trust's intranet on which we share news and updated with all of our staff. This includes health campaigns, finance information, workforce and recruitment updates. These updates include successes such as important service updates and operational changes. The Hub is also the central repository for all clinical and non-clinical procedural documents, links and essential information.

In the Know

Our weekly newsletter, In the Know, is emailed to all staff, our private finance initiative partners, non-executive directors and neighbouring Trust communication teams. This is our go-to source of information for the Trust, which allows us to share key updates effectively.

Team Brief

Hosted by the Group Chief Executive each month on Teams, this event enables staff who join the call to receive updates on the Trust performance, upcoming events, recent developments and to ask questions directly.

Live Chat

Live Chat is a very popular online forum for staff to put questions to the Group Chief Executive and to receive an immediate response from the senior management team. Staff have the option to do this anonymously.

Coffee and Chat

Held quarterly, our coffee and chat session provide an opportunity for staff to speak in-person with our Group Chief Executive about their concerns and ideas and provide feedback.

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 Group Chief Executive, are paid a surprise visit and presented with a certificate and prize.

Patient Safety 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, 35, 40 and 50 years are big milestones in an NHS career, and we recognise this annually in our Long Service Awards. In 2025, we recognised 240 members of staff, and 126 staff members celebrated 25, 30 and 40 years. We celebrated a collective 4,784 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, key messages and health advice on Facebook, X, LinkedIn and TikTok. We have around 20,000 followers on Facebook, 2,500 on TikTok, 8,000 on LinkedIn and 7,700 on X.

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.

Dying Matters Workshop reflected on the end-of-life journey

On 8th May 2025, we hosted a free online End of Life Journey Workshop during Dying Matters Week Mary Stevens Hospice. The event brought together healthcare professionals, hospice staff, funeral directors, and bereavement specialists to explain the dying process and the support available to patients and families.

Participants found the workshop informative and comforting, highlighting the value of hearing from different professionals. The event aimed to encourage open conversations about death and help people feel more prepared to discuss end-of-life wishes.

Merry Hill Health Hub – Improving Access to Outpatient Services

Our new Merry Hill Heath Hub opened earlier in the year, and we were keen to work with local community groups and organisations to look at the accessibility of the venue. We worked with Healthwatch Dudley, Access in Dudley, Centre for Inclusive Living, Dudley Voices for Choice, Beacon Centre, Queens Cross and Headway to provide solutions including an easy read patient leaflet, audio and visual routes from the bus station to the hub.

Health and Wellbeing Carnival Marquee Shines at Armed Forces Day at Himley Hall and Park

We hosted a Health and Wellbeing Carnival Marquee on 29th June 2025 at Himley Hall and Park as part of Armed Forces Day. The family-friendly event attracted thousands of visitors and featured 17 local partners offering health advice, screenings, and wellbeing activities. Many residents accessed free services and on-the-spot referrals, while partners connected with the community on important health topics. The event successfully combined entertainment with health education, helping raise awareness and support efforts to reduce health inequalities.

Neighbourhood hub workshop

As the host of the Dudley Health and Care Partnership, we were pleased to be part of the facilitation of the Neighbourhood Hub Workshop in July 2025. Over 100 participants joined us at Brierley Hill Civic Hall. The event introduced the NHS 10 Year Health Plan for England and gathered community ideas on how neighbourhood hubs could support local health and wellbeing.

Through discussions and interactive activities, participants highlighted the need for accessible, inclusive community spaces, joined-up services, stronger mental health support,

and hubs that reflect local identity. Key barriers identified included transport issues, digital access, financial pressures, and limited awareness of services.

Overall, attendees envisioned community-led, one-stop neighbourhood hubs located in familiar places like schools, libraries, and local shops, offering health advice, wellbeing services, and connections to support. These ideas support the NHS plan's focus on community care, digital services, and prevention.

Picnic in the Park: Celebrating Health and Learning Disability Support

The Picnic in the Park event at Mary Stevens Park on 17th September 2025 promoted health and community wellbeing in a relaxed outdoor setting. The Communications Team from The Dudley Group NHS Foundation Trust showcased the Learning Disability Liaison Team's work at Russells Hall Hospital, highlighting support such as accessible information, Health Passports, digital flags, and communication aids. Visitors joined interactive activities exploring communication challenges and learned about inclusive, patient-centred healthcare.

Putting Patients in the Driving Seat: Dudley's Digital Front Door and PIFU

We introduced a Patient-Initiated Follow-Up (PIFU) system, allowing patients to book appointments only when they feel they need them, helping reduce waiting times and unnecessary visits. Feedback collected with Healthwatch Dudley showed benefits such as more flexibility and patient control but also highlighted digital access and communication challenges. The Trust plans to improve inclusion by supporting digital access, reusing devices, and exploring tools like a patient passport to better record care preferences.

Health on the Shelf

Our Health on the Shelf event brought together NHS teams, council services, charities, and voluntary groups to support community health and wellbeing at the Merry Hill Shopping Centre.

More than 400 people attended, exploring 30+ stalls and receiving over 200 free blood pressure checks, with 33 people advised seeking follow-up care. Feedback was highly positive, with all respondents saying they would attend similar events again. The event successfully raised awareness of local services and will be expanded in future.

Sweet Enough: Living Well With (or Without) Diabetes

A community workshop, "Sweet Enough – Living Well With (or Without) Diabetes," was held at Lye Community Centre in partnership with DIYYA, attracting over 70 local women. Delivered in Urdu with support from Chapel Street Surgery and public health colleagues, the two-hour session included education, myth-busting activities, gentle exercise and health checks. Lead clinician Sarah Baig helped facilitate a supportive space to improve confidence and awareness around diabetes.

Shaping the Future of Local Health Services Workshop

Over 50 people joined our online and face to face workshops to explore how a joint clinical strategy could be shaped to work across Dudley, Sandwell and West Birmingham, helping local health services grow and change. There were conversations highlighting some frustrations and challenges and also some positive experiences. Participants were supportive of care closer to home and emphasised that success would depend on strong partnerships.

Glow and Grow - Celebrating International Women's Day

The Glow and Grow International Women's Day Event, held on 9th March 2026 at Merry Hill Shopping Centre, successfully brought together 21 health, voluntary, and community organisations to promote women's health and wellbeing. The event generated over 700 interactions, offering health advice, support services, and blood pressure checks. Feedback was highly positive, with 97% of attendees willing to attend future events. Attendees valued learning about local services, community connections, and women's health support, while key priorities identified included mental health, access to care, and menopause support. Overall, the event effectively raised awareness of local services and strengthened community engagement.

Improving Together (formerly Dudley Improvement Practice)

Improving Together is the Trust's long-term commitment to creating a culture of Continuous Improvement.

In 2025, the improvement teams from both Dudley and Sandwell & West Birmingham joined forces to create Improving Together; one team with one improvement approach supporting two organisations.

The Improving Together system supports teams and services with a structured approach to achieving their improvement goals and projects. The approach includes training, collaborative problem solving and facilitated workshops.

Improving Together is part of the Office of Strategic Management (OSM) along with strategy, data, digital and technology, and the programme management. This ensures that the Trust strategy is designed, deployed and delivered using a continuous improvement approach.

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. The Improving Together team 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, Dudley has drawn attention nationally for our improvement approach particularly in improvement leadership and the use of the new national best practice guide to continuous improvement (NHS IMPACT).

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.

NHS England recognises that only Trusts that have well-embedded improvement approaches achieve 'outstanding' in the Care Quality Commission well-led domain.

Working with the Organisational Development team, Improving Together have designed an improvement leadership programme which includes skills development in coaching, psychological safety and intelligent failure. We have been asked to present our learning on leadership development at two national improvement groups; the Improvement Directors' Network and the NHS England IMPACT Lunch and Learn session.

Throughout 2025, the Improving Together team supported strategic pieces of work - Community First and Frailty - bringing together system partners across health, care, and the voluntary sector to co-design future models of care. From this work, new ways of working were trialled and developed, including a 24-hour escalation pathway for care homes, using community services and Trust GP practices to reduce hospital admissions and keep residents in their normal place of care wherever possible. Teams from across acute frailty relocated their Frailty Assessment Unit to ED, with improved processes and an increased number of patients being transferred there for the most appropriate care. The two workstreams also combined to pilot a Community Frailty Intervention Team, completing Comprehensive Geriatric Assessments in the community to proactively identify and support those at risk of frailty. This saw a reduction in prescribed medication and an increase in onward referrals to specialist teams for the targeted cohort.

There will continue to be a focus on growing improvement capability amongst staff across the Trust, through the development of the Community of Improvement Practice. Currently made up of 30 Improvement Champions, this network of 'experts by experience' are trained and supported by the Improving Together team to be local sources of improvement support in their department for staff undertaking improvements as part of their appraisal objectives.

In 2026, Improving Together is developing a Quality Management System (QMS) which is designed to ensure that staff throughout the organisation are focused and involved in delivering trust priorities defined in the new joint single strategic planning framework. Goals flow down from Trust Board through to front line teams, and performance data flows up. The management system consists of management routines such as performance

huddles and review meetings which ensure data is used so that the right staff are focus on solving the right problems to progress towards agreed goals.

Fire Safety

The Fire Safety Team, now operating within the Estates and Compliance Directorate, is responsible for ensuring the Trust meets all relevant national fire safety legislation and guidance. The team provides the organisational framework required to deliver safe and effective care within a fire-safe environment. Assurance is provided to the Board through the Trust's Fire Safety Management System, which enables systematic review of policy, the delivery of training, and completion of fire risk assessments across all departments and buildings.

Clear and robust fire safety procedures are essential in supporting staff to prevent fire incidents and to respond effectively should one occur, ensuring the ongoing safety of patients, visitors, and colleagues. During the reporting year, three key procedural documents were reviewed and updated:

- Departmental Response to Fire and Fire Alarms
- Fire Response Team Procedure – Russells Hall Hospital
- Use of Evacuation Aids

These updated procedures provide staff with detailed, step-by-step actions to follow in the event of a fire or alarm activation, and similar procedural reviews for community sites are currently underway. To test awareness and application of these procedures, the Fire Safety Team delivered seven site-wide desktop fire drills involving a range of stakeholders, reinforcing joint working and effective evacuation planning.

Assessment of fire risk remains a statutory requirement. Building on the introduction of primary fire risk assessments in 2024/25, the Fire Safety Team completed two primary assessments during the year, for North Block and the Corbett Outpatient Centre. This enhanced approach provides a comprehensive review of passive and active fire protection measures, as well as the inter-departmental dependencies that would be critical during an incident. In addition, 63 secondary fire risk assessments were completed. Any issues identified through either assessment type are logged and monitored through the AMaT system until resolution, providing a robust mechanism for improvement.

Training continues to form a core component of the team's work. The Trust delivers a varied programme comprising mandatory fire safety training for all staff and bespoke, role-specific modules where needed. At year end, mandatory fire safety training compliance stood at 97.5%. A total of 377 staff completed virtual reality fire extinguisher training, representing a 46% increase from the previous year, and 124 staff completed evacuation mat training. Additionally, 47 managers successfully completed the Fire Safety for Managers programme.

The Health, Safety and Fire Assurance Group remains the principal forum for consultation, oversight, and review of fire safety matters. The group meets quarterly with divisional representatives to monitor performance against key objectives and to provide assurance that appropriate and sufficient arrangements are in place across the organisation. The tri-party Fire Safety Group has continued to meet monthly, allowing for a detailed and focused approach to fire safety matters on site.

Looking ahead, key objectives for 2026/27 include continued delivery of primary and secondary fire risk assessments, a comprehensive review and refresh of fire safety training programme, and an evaluation of fire safety support arrangements between The Dudley Group and Sandwell and West Birmingham NHS Trusts, with the aim of sharing best practice and strengthening collaborative working

Corporate Resilience

The Corporate Resilience Team (CR Team) ensures the Trust can meet national legislation, guidance and standards pertaining to health, safety, and 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 and safety standards are being maintained, and exceptions are identified and managed and dealt with quickly. The Trust maintains robust health, safety 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. Combined, these groups convened on 7 of a possible 8 occasions as planned with terms of reference updated in line with internal governance requirements. Collectively, Quoracy was achieved in all 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, procedures and plans have been developed, reviewed, updated and consulted on, during the last financial year. This includes a full review of the:

- The EPRR Policy
- Business Continuity Policy
- Working at Height Policy
- Slips/ trips/ falls policy
- RIDDOR Policy
- Health and Safety Risk Assessment Policy

The EPRR team, in line with national core standards have reviewed and developed all associated plans:

- Incident Response plan (combining both Critical and Major incident plans)
- Adverse weather plan
- Lockdown and bomb threat plan
- Evacuation and shelter plan
- Incident coordination centre plan
- Chemical Biological Radiological and Nuclear plan
- VIP management plan
- Emergency Communication plan
- New and Emerging Infectious Disease and Pandemic plan (inc. High Consequence Infectious Disease)
- Mortuary Major Incident plan

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 2025/26 to underpin the corporate resilience portfolio. As of the end of year mandatory training compliance for Health and Safety, ended at 98%. 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 for managers and leads training was established in October 2025 and continues to be facilitated monthly. Further training packs have been developed to deliver the following training:

- Display Screen Equipment for Assessors
- COSHH for Assessors,
- Sharps Safety Awareness,
- EPRR and Business Continuity Awareness
- Business Continuity Leads Training

The Trust uses a range both proactive and reactive measures to manage risk and monitor Corporate Resilience performance. The team use the Audit Management and Tracking (AMaT) system for gathering health, safety and business continuity assurance. Performance against key indicators is fed back through divisional Corporate Resilience reports quarterly and assurance provided via divisional reports into both the EPRR and Health, Safety and Fire Assurance Groups. An annual health and safety system compliance audit is planned to go live in quarter 1 2026/27 with an EPPR peer audit being facilitated at year end in March 2026 with colleagues from Sandwell and West Birmingham NHS Trust

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 2025 stated that the Trust was assessed as 'Substantially Compliant' at 94% against the EPRR Core Standards; an increase in compliance from 'Partial' (84%) when compared with the previous year, 2024.

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 11 RIDDOR incidents over the last 12 months. 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 2026/27 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.

Developing local team/ service-based exercise package to test the efficacy of service level planning arrangements.

Rolling out newly devised EPRR and Health and Safety non-mandated training modules.

Utilising AMaT data to drive future objective-setting to plan exercises, and specialist-led audit.

Staff Health & Wellbeing

At the heart of our ambition to remain a brilliant place to work and thrive is our ongoing commitment to the health and wellbeing of our workforce. We recognise that a supported, healthy, and engaged team is fundamental to delivering safe, high quality patient care. This year, we have continued to embed a culture where staff feel valued, listened to, and cared for, particularly during periods of operational pressure and change.

Across 2025/26, we have strengthened our focus on prevention, early support, and the creation of a compassionate working environment. We continue to role model the importance of self-care, actively encourage colleagues to access wellbeing resources, and take meaningful action to enhance the range and effectiveness of the support available. Our approach remains holistic, recognising that wellbeing is shaped by personal, professional, organisational, and environmental factors.

The ongoing delivery and development of the Trust Wellbeing Journey remains central to this work. This programme has supported us to proactively identify emerging themes, respond to staff needs more quickly, and ensure our wellbeing provision evolves in line with the challenges our workforce faces. Through regular engagement, feedback mechanisms, and partnership with teams across the organisation, we are continually refining how we enable colleagues to look after their physical, psychological, social, and financial wellbeing.

We acknowledge that many of the pressures experienced by NHS staff nationally continue to be felt locally. Despite this, we remain committed to providing consistent, visible, and responsive support. Wellbeing is a shared responsibility, and we continue to embed this principle, from individual actions that promote self-care to organisational decisions that shape healthy, supportive working environments.

Supporting staff wellbeing is not a standalone initiative; it is an integral part of how we operate as a Trust. Over the past year, we have continued to build wellbeing considerations into everyday practice, leadership behaviours, and workforce planning. This ensures that our colleagues have the resources, conditions, and culture they need to thrive both now and in the future.

As we move forward, we remain steadfast in placing staff wellbeing at the centre of our approach. We will continue to listen, learn, and adapt, ensuring that every colleague feels supported to deliver their best for our patients and for one another.

Wellbeing Key Achievements

Throughout 2025/26, we have continued to build a compassionate and proactive wellbeing culture across The Dudley Group NHS Foundation Trust. We are proud to highlight the following achievements that reflect our ongoing commitment to supporting the health and wellbeing of our workforce:

- **Launched a new Employee Assistance Programme (EAP) in partnership with Spectrum Life**, providing all staff with enhanced 24/7 confidential support, including counselling, wellbeing resources, and specialist guidance to promote better emotional, financial, and psychological wellbeing.

- **Strengthened our Wellbeing Champion Network**, now comprising 200 trained champions across the Trust who provide supportive wellbeing conversations and signpost colleagues to professional services. We will continue targeted recruitment within divisions to enhance local support further.
- **Expanded access to physical health suppor**t through the year-long promotion of our free staff health check programme, enabling colleagues to monitor key health indicators and prioritise healthier lifestyle choices.
- **Maintained strong leadership oversight**, with the Board of Directors continuing to monitor wellbeing activity via the Health and Wellbeing Steering Group and the People Committee.
- **Embedded wellbeing training for staff and managers**, equipping teams with the knowledge and confidence to foster positive wellbeing cultures within their own services.
- **Introduced a refreshed Wellbeing Action Plan template**, supporting managers to hold structured, meaningful wellbeing conversations with their teams.
- **Held bi-monthly engagement meetings with our Wellbeing Champions**, providing regular updates, shared learning, and peer support opportunities.
- **Enhanced communications and visibility of wellbeing support**, sharing regular updates through Trust-wide communications, wellbeing champions, and CEO briefings.
- **Ensured all staff have access to a wide range of wellbeing offers**, including our employee assistance programme, counselling services, and specialist support, such as resources for colleagues experiencing menopause.
- **Delivered monthly wellbeing webinars and educational sessions**, aligned to national awareness days and promoted through internal communications and our wellbeing champion network.
- **Strengthened local engagement**, with the wellbeing business partner offering direct team support, champion recruitment, and tailored guidance on implementing wellbeing initiatives.
- **Promoted national NHS wellbeing offers**, including the 24/7 staff support helpline and access to free mental wellbeing apps such as Unmind, with information regularly updated on our wellbeing intranet pages.
- **Co-designed and launched a new Menstrual and Menopause Wellbeing Policy**, developed collaboratively with the equalities and wellbeing team, the women's staff network, and the menopause working group. This policy supports colleagues by providing practical guidance and improving understanding of menstrual and menopausal health.
- **Introduced a new Sexual Safety Policy and training**, developed with the EDI team, supporting staff and managers to understand, recognise, and safely report incidents.

Occupational Health

Core Occupational Health (OH) services have continued to be delivered to support the health, safety and wellbeing of staff across the organisation. These services include pre-employment health assessments, immunisations and vaccinations, health surveillance, and the treatment and follow-up of inoculation and sharps injuries. Management referrals to the Occupational Health service also remain a key component of the provision, ensuring that staff who require support related to health, attendance, or workplace adjustments receive timely clinical advice and appropriate interventions.

Over the last twelve months, a number of targeted actions have been undertaken to strengthen and modernise the Occupational Health service and improve both efficiency and quality of provision. Key areas of focus have included:

Improving service responsiveness and performance against KPIs, ensuring that pre-employment clearances for new starters and management referrals are processed within agreed timeframes to support safe recruitment and effective workforce management.

Upgrading the Occupational Health management system, enhancing digital record management, reporting capability and overall service efficiency.

Improving referral pathways into the service, including the introduction of a revised management referral form and supporting guidance for managers, to ensure referrals are more consistent, contain the appropriate information and enable Occupational Health clinicians to provide timely and more effective advice.

Implementing actions identified through an external audit, strengthening governance, compliance and quality assurance processes within the service.

Strengthening internal collaboration with HR, Infection Prevention and Control, and Health and Safety teams, enabling a more coordinated approach to workforce health risks, case management and preventative interventions.

Training Learning and Organisational Development

Being a Brilliant Place to Work and Thrive

This year, we have continued to prioritise our culture work, ensuring we support our people across every element of the NHS People Promise. Our aim remains to create a workplace where colleagues feel valued, supported, and able to thrive.

Our People Plans and Delivery Journeys, covering Culture and Leadership, Recruitment and Retention, Equality, Diversity and Inclusion, Continuous Improvement, and Wellbeing, set clear goals that guide our actions and progress.

The Being a Brilliant Place to Work group continues to drive, coordinate, and review this work. Recent activity includes ongoing 'itchy feet' conversations and 'sorry you're leaving' interviews, updating our leavers questionnaire, all helping us better understand what we do well and where we can improve. We have also continued to strengthen our Careers at Dudley brand and website, and implemented key policies on anti-bullying, anti-discrimination, Menopause & Menstrual Health, and sexual safety.

Also, we have developed our first Listen, Act and Feedback framework, which shows a clear way for staff to share feedback and how the Trust will act on it and share progress.

We are always learning

In 2025/26, we delivered a range of training courses, supported by our Prospectus of learning opportunities for staff. This includes continuing programmes such as Admin Essentials, Communication Skills, Wellbeing, and Recruitment, as well as modules on our leadership programmes. More than 1,200 staff members participated in these learning activities.

After reviewing our Leadership pathway, we developed new programmes for our people, including Resilience, Resolving Conflict, Organisational Awareness & Report Writing and Workforce Planning. With the anticipated launch of the national Leadership and Management Framework in 2026/27, we will continue to review our programmes to ensure they align with the national standard programmes. We will work with our neighbouring Trust, Sandwell and West Birmingham NHS Trust to create join leadership programmes, replacing our existing Developing Leaders programme in 2026.

Over 250 people completed our Managers Essentials programme, bringing the total to 1,300 leaders having completed the Managers Essentials programme since its launch in 2019.

We delivered our Annual Review programme from April to June, with 92% of staff receiving a progress review and career conversation.

The Trust continued to deliver a broad apprenticeship offer across Levels 2 to 7, supporting workforce development in both clinical and non-clinical areas. New enrolments were achieved in Pharmacy, Business Administration, ODP, and Radiography, while leadership capability was further strengthened through continued Level 5 and Level 6 provision.

Following the national decision to end levy funding for the Level 7 Senior Leader Master's Apprenticeship from January 2026, the Trust secured places for 36 staff on the final cohorts to ensure continued access to advanced leadership development.

The year also marked the launch of the Digital and Data apprenticeship pathway, with over 40 staff joining new Level 3 and Level 4 programmes. In maternity services, the Trust continued to build its workforce pipeline with the second cohort of Midwifery Degree Apprentices starting in September and a further cohort of Maternity Support Workers commencing their Level 3 apprenticeship.

Overall, this year's apprenticeship activity demonstrates the Trust's sustained commitment to developing a skilled and future-ready workforce.

We have continued to develop our ICan partnership with Dudley Metropolitan Borough Council (Dudley MBC). Together we are supporting 25 young people with significant barriers to work to gain employment in Dudley, alongside delivering another paid work experience programme for 18–21-year-olds not in employment, education and training, partnering for the first time with our PFI partner Mitie and Dudley Zoo and Castle to offer a broader range of opportunities.

We work flexibly

Over the past 12 months, we have strengthened and promoted our flexible working offer across the organisation. We launched a new online flexible working application form, improving the way requests are submitted, considered, and monitored.

We have also enhanced how we measure flexibility as an employer by using our annual review window to collect flexible working data for all staff. As a result, we now hold accurate flexible working information in ESR for more than 75% of our workforce.

To ensure the fair and consistent application of our new Flexible Working People Policy, we continue to provide regular flexible working training for managers.

We are a team, and we are compassionate and inclusive

We have provided support for individuals, teams, and leaders, embedded our Behaviour Framework, facilitated meaningful career and coaching conversations and trained teams via the Living the Values training programme.

Alongside this, we've hosted further targeted support on coping with change, accountability and personal effectiveness to over 150 team members across various departments.

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 2025/26.

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 and shared with line managers directly 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)

The Trust continues to embed equality, diversity and inclusion as a golden thread through everything we do. We are committed to fostering an environment where every colleague feels they belong, are valued, and can thrive. Our workforce reflects a rich diversity of ethnicities, cultures, religions, beliefs, ages, genders and identities, and we recognise this diversity as one of our greatest strengths.

Creating an inclusive culture is central to delivering high quality care and positive experiences for our staff, patients, service users, visitors and the wider community. Our commitment to EDI also supports compliance with our statutory and regulatory obligations, including the Workforce Race Equality Standard (WRES), Workforce Disability Equality Standard (WDES), Equality Delivery System (EDS), the NHS Improvement High Impact Actions, and gender pay gap reporting.

EDI is embedded within the NHS People Plan, the Trust's Dudley People Plan and our wider strategic objectives. As an employer, provider, partner and anchor institution, we recognise our responsibility to promote equality of opportunity, advance inclusion, eliminate discrimination and build strong relationships across our diverse communities.

Under the Equality Act 2010, we are required to demonstrate due regard to the general equality duty in all aspects of our work. This includes:

- Eliminating discrimination, harassment and victimisation
- Advancing equality of opportunity between

people who share a protected characteristic and those who do not

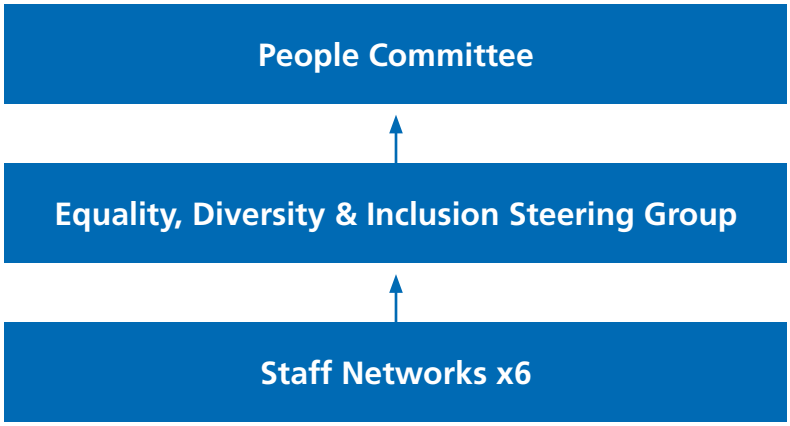
- Fostering good relations between people who share a protected characteristic and those who do not

The protected characteristics defined within the Act 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

The Trust has a robust governance framework to ensure accountability and oversight of all Equality, Diversity, and Inclusion (EDI) activities. This framework comprises the following committees and groups:



People Committee

The People Committee is a sub-committee of the Trust 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 group provides strategic leadership, oversight and assurance on all matters relating to equality, diversity and inclusion (EDI), ensuring that these principles are embedded across all aspects of the Trust's work.

The steering group upward reports into the People Committee and to the Trust board. Membership of the steering group includes key representatives from across the Trust, i.e. clinical and non-clinical services, staff networks, Human Resources, Patient Experience and Trade Unions.

Equality, Diversity and Inclusion (EDI) Strategic Journey

The Trust's Equality, Diversity and Inclusion (EDI) strategic journey sets out our ambitions and commitments for the coming years to become a more inclusive organisation. It provides a clear framework to ensure that equality, diversity and inclusion are embedded within our values, leadership behaviours and everyday practice across the Trust.

Over the past 12 months, the Trust has undertaken significant work to strengthen its approach to EDI. This has included reviewing existing arrangements, undertaking a range of organisational assessments and listening to

the experiences of our workforce. As a result, we have refined our priorities and developed a more focused and consolidated EDI action plan. This work has helped to ensure that our objectives are aligned with organisational priorities, enabling us to take a more structured and impactful approach to improving equality and inclusion across the Trust.

Staff Networks

It is recognised that staff equality networks are an important mechanism through which the general duties of the Equality Act 2010 can be supported, particularly in amplifying the voices and experiences of staff from protected groups and those at risk of inequality.

The Trust has six staff networks: EmbRACE, LGBTQ+, Disability & Long-term Conditions, Women's, Armed Forces, and Carers. Each network is supported by an Executive Sponsor, providing strategic guidance, advocacy and visibility at senior leadership level. This sponsorship helps ensure that the perspectives of diverse staff are represented in decision making and demonstrates visible allyship from leaders across the Dudley Group.

Over the last twelve months, the networks have continued to strengthen their role within the organisation. Membership across several networks has grown, enabling broader representation and stronger engagement with colleagues. Through regular meetings, awareness events and collaboration with the Equalities and Wellbeing Team, the networks have contributed to a number of positive developments. These include raising awareness of key equality issues, shaping inclusive policies and guidance, supporting cultural awareness initiatives, and providing safe spaces for staff to share experiences and influence organisational improvement.

The networks have also worked increasingly collaboratively, supporting one another's priorities and co-hosting events linked to national awareness days and campaigns. This collective approach has helped embed a more inclusive culture across the Trust, while ensuring that the lived experiences of staff continue to inform the Trust's equality, diversity and wellbeing priorities.

Health Inequalities

The Trust continues to strengthen its approach to tackling health inequalities through improved governance, stronger partnerships and enhanced staff awareness. The Health Inequalities Core Group has expanded and now provides clearer oversight of data, service planning and performance, reporting regularly to the Integration Committee. Working with local partners, including the Dudley Health and Care Partnership, community groups and the voluntary sector, is helping us better understand barriers to care and shape more inclusive services.

Key progress includes improving data quality, particularly ethnicity coding, expanding staff education through Trust-wide training and resources, and enhancing accessibility via improved translations, web tools and staff support for the Accessible Information Standard. The Trust has also completed NHS Rainbow Badge accreditation, strengthening inclusive practice for LGBTQ+ patients. Audits have driven improvements in recording and delivering reasonable adjustments, especially in maternity services, with new workflows and staff training underway.

The Trust is a national pilot site for Martha's Rule, embedding equitable escalation processes and community engagement. Tools such as the Health Equity Assessment Tool continue to shape service redesign, including new maternity clinics at Merry Hill. A gap analysis is also underway to align with the NHS Patient Safety Healthcare Inequalities Framework launched in 2025.

Widening Participation and Community Impact

The ICAN Dudley programme has continued to deliver strong outcomes for local residents facing barriers to employment. In 2025, 70 participants secured substantive employment, with high participation from disabled people, care experienced individuals and those from deprived areas. The programme has received regional and Trust recognition for its impact on inclusion and economic wellbeing.

Key Equality and Diversity Achievements

- Retained Disability Confident Leader (Level 3) status, reaffirming our commitment to supporting colleagues with disabilities and long-term conditions.
- Increased representation of Black and Minority Ethnic (BME) staff across the Trust, reflecting progress towards a workforce that mirrors our local communities.
- Re-launch of Anti-Discrimination & Anti-Bullying Harassment policy and launched

Sexual Misconduct Policy, supported by comprehensive manager toolkits and training.

- The Trust has also embedded the NHS Sexual Safety Charter, introducing new reporting mechanisms, sexual safety guardians, strengthened policies and Trust-wide training to reinforce a zero-tolerance approach to sexual misconduct
- In 2025/26, the Trust achieved an EDS score of 22.5, "Achieving", representing a notable improvement from the previous year's "Developing" rating. This reflects the meaningful progress made in embedding equality and inclusion across services, workforce practices and leadership
- Expansion of six active Staff Networks (EmbRACE, LGBTQ+, Disability & Long-Term Conditions, Women's, Armed Forces, and Carers), enhancing staff voice and engagement.
- Implementation of the Reasonable Adjustment Project, improving access to workplace support, equipment and adaptations for staff with additional needs.
- Launch of the Neurodiversity Toolkit and manager training, helping teams create inclusive environments for neurodivergent colleagues.
- Enhanced flexible working policy and digital request system, supporting work–life balance and improving retention, particularly for carers.
- Ongoing progress with the RACE Code Kitemark, reinforcing the Trust's commitment to tackling race inequality.
- Positive trends in WRES data, including a reduction in staff reporting bullying, harassment or discrimination from colleagues.
- Increased confidence in Freedom to Speak Up reporting, indicating improved organisational culture and psychological safety.

Staff turnover

Our staff turnover for the year was 6.15 per cent. More information on our staff turnover can be found at the **NHS workforce statistics published by NHS Digital**.

DGFT staff at training

NHS Staff Survey

The NHS Staff Survey remains a key source of insight into how our colleagues experience working at the Trust. Conducted each autumn, it reflects the voices of thousands of staff and helps us understand where we continue to excel and where improvement is required. The survey is structured around the seven People Promise elements and compliments our regular engagement activity, including the Quarterly People Pulse, Make it Happen feedback sessions and our People Promise newsletter.

This year, 38% of our workforce participated in the survey and while this represents an 11% decline in engagement compared with last year and sees us fall below the benchmark average, the reduction reflects a trend seen across the wider NHS.

Our Results

When compared with similar organisations, our performance has dropped below the benchmark average across all seven People Promise themes, as well as the broader themes of Staff Engagement and Morale, although not statistically significantly lower for all themes.

Over the past four years, our overall People Promise scores remained broadly stable in 2022 and 2023, with small declines seen in some themes in 2024 before further declines in 2025. This reflects the wider operational and financial pressures facing the NHS this year and aligns with feedback shared across national staff experience platforms.

	2025		2024		2023		2022	
People Promise	**Trust Result**	**Benchmark**	**Trust Result**	**Benchmark**	**Trust Result**	**Benchmark**	**Trust Result**	**Benchmark Score**
We are compassionate and inclusive	7.12	7.28	7.18	7.21	7.23	7.24	7.2	7.2
We are recognised and rewarded	5.63	5.87	5.81	5.92	5.88	5.94	5.7	5.7
We each have a voice that counts	6.41	6.60	6.56	6.67	6.65	6.7	6.7	6.6
We are safe and healthy	5.88	6.07	5.95	6.09	5.97	6.08	5.8	5.9
We are always learning	5.40	5.57	5.64	5.64	5.69	5.61	5.2	5.4
We work flexibly	6.14	6.22	6.17	6.24	6.19	6.2	6.0	6.0
We are a team	6.55	6.75	6.70	6.74	6.72	6.75	6.7	6.6
Staff Engagement	6.46	6.74	6.71	6.84	6.81	6.91	6.7	6.8
Morale	5.54	5.84	5.75	5.93	5.8	5.91	5.6	5.7

Our action plan will prioritise three People Promise areas where improvement is most needed:

- We Are Always Learning - Colleagues told us they want clearer development pathways, higher quality appraisal conversations and better access to training.
- We Are Recognised & Rewarded - Staff reported wanting more meaningful recognition and to feel that their contribution is understood and valued.
- We Are Safe & Healthy - Workload pressures, burnout indicators and wellbeing support were recurring themes, and this remains a core focus area for 2026.

Our Priorities for 2026

Guided by our People Plan and the themes raised in the survey results, our priorities for 2026 will focus on strengthening culture, improving wellbeing and ensuring staff feel heard and supported.

To provide a clearer structure, our priorities are grouped into two areas: culture & leadership and health, wellbeing & safety.

Culture & Leadership

Strengthening opportunities for staff voice and involvement across all areas of the organisation.

Fostering a culture of respect, collaboration, and positive team relationships.

Supporting effective and compassionate line management through ongoing development and guidance.

Embedding flexible working practices more consistently through improved processes and local support.

Health, Wellbeing & Safety

Continuing the implementation and promotion of our antibullying and antidiscrimination policy, supported by targeted training and awareness sessions.

Enhancing workforce wellbeing to ensure colleagues feel safe, healthy, and supported at work.

Strengthening mechanisms that empower staff to raise concerns safely and see visible action in response.

Using Our Results to Drive Improvement

Each year, we share our survey results widely to help teams understand their feedback, recognise areas of strength, and identify opportunities for improvement. This approach continues in 2026, with an enhanced focus on ensuring that every team has the right information and support to take meaningful action.

New for 2026, we are introducing team level reports, giving individual services more granular insight into their results. This will support more localised action planning, ensuring every team has access to meaningful data that they can use to shape improvements in their working environment.

Building on this strengthened approach, divisions will identify teams/areas requiring targeted action, particularly where results fall below benchmark or organisational averages. These teams will receive additional support from divisional and corporate colleagues, with progress reviewed regularly through our Group People Committee.

Our aim is to ensure that every colleague sees – and feels – the impact of their feedback, with improvements co-created as close to the point of care as possible.

Our colleagues' voices remain central to shaping our culture and improvement work. The 2025 staff survey results give us a clear mandate to act, and we are committed to working in partnership with teams across the organisation to create a positive, supportive and inclusive working environment.

A staff member interacting with a patient at Chapel Street Surgery

Trade Union Facility Time

Trade union representatives and full-time equivalents (FTE)

Trade union representatives: 14

FTE trade union representatives: 1.20

Percentage of working hours spent on facility time

0% of working hours: representatives 0

1 to 50% of working hours: representatives 13

51 to 99% of working hours: representatives 0

100% of working hours: representative 1

Total pay bill and facility time costs

Total pay bill*: £424,985,900

Total cost of facility time: £72,035

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.

Reporting High Paid Off Payroll Arrangements

There were no off payroll engagements during 2025/26. It is our policy not to use off payroll engagements.

Reporting Of Compensation Schemes Table

Note 6.3 Exit packages: other (non-compulsory) departure payment	Payments agreed Accounts 31 Mar 2026 2025/26 No.	Total value of agreements Accounts 31 Mar 2026 2025/26 £000	Payments agreed Accounts 31 Mar 2025 2024/25 No.	Total value of agreements Accounts 31 Mar 2025 2024/25 £000
Voluntary redundancies including early retirement contractual costs				
Mutually agreed resignations (MARS) contractual costs	4	119		
Early retirements in the efficiency of the service contractual costs				
Contractual payments in lieu of notice	15	59	15	119
Exit payments following employment tribunals or court orders				
Non-contractual payments requiring HMT / DHSC approval (special severance payments)*			1	11
Total	**19**	**178**	**16**	**130**

Gender pay gap

Information of the Trust's gender pay gap can be found on the Cabinet Office website **www.gender-pay-gap.service.gov.uk**.

Hospital Volunteer Service – Living Our Values

The Hospital Volunteer Service continues to play a vital role across The Dudley Group NHS Foundation Trust, reflecting our commitment to Care, Respect and Responsibility in everything we do. Volunteers from our local communities give their time, skills and compassion to enhance the experience of patients, visitors and staff across all Trust sites.

During 2025/26, more than 640 volunteers aged between 16 and 83 supported services across the Trust. Many individuals who completed their volunteering journey went on to higher education or secured employment within the Trust, demonstrating volunteering as both a valued contribution to patient care and a pathway into healthcare careers.

Care – Improving Patient Experience Every Day

Volunteers supported patients across Russells Hall Hospital, Guest Outpatient Centre and Corbett Outpatient Centre, offering practical help, reassurance and companionship. This included wayfinding in main reception and key hospital areas, supporting nutrition and hydration at mealtimes, and providing friendly conversation that can make a meaningful difference to patients' wellbeing.

Chaplaincy volunteers continued to provide compassionate support to patients, visitors and staff from all backgrounds and belief systems. Pharmacy volunteers assisted with the delivery of urgent medication and collection of prescriptions and paperwork from wards, enabling clinical teams to focus on direct patient care. Patient experience volunteers supported survey activity across hospital and outpatient settings, helping the Trust to learn from feedback and improve services.

Respect – Valuing People and Contributions

We welcome volunteers of all ages and backgrounds, whether committing to a regular weekly shift or supporting services on an ad hoc basis. Volunteers currently support a wide range of areas including nutrition and hydration, wayfinding and outpatient services, chaplaincy, the Emergency Department, patient experience, pharmacy and volunteer driving.

In summer 2025, the Trust introduced Long Service Awards to recognise volunteers who reached milestones of 5, 10, 15, 25, 30 and 35 years of service. Awards were presented during Volunteers' Week in June, celebrating the dedication of our volunteers and recognising the many members of Trust staff who began their careers as volunteers.

The Trust continues to support young volunteers aspiring to careers in healthcare and is proud when they return to the organisation as members of staff following their studies.

Responsibility – Supporting Innovation, Safety and Flow

Volunteers played an important role in supporting service efficiency and innovation. Approximately 30 volunteers supported the PIVOT research study, delivered in partnership with the Therapy Department and the University of Southampton, which explores a volunteer-led approach to increasing physical activity across hospitals of varying size and geography. Volunteers received specialist training and made a valued contribution to the project, which was recognised through praise in the PIVOT volunteer newsletter. The Trust's Frailty Team received the Research Impact Award for their work on the study, highlighting the positive impact on allied health professionals, patients and communities.

Work continues to enhance ward volunteer roles through additional training to support a more therapeutic and activity-based approach to care, including the introduction of befriending volunteers.

The Volunteer Driver Service supported deliveries of medication and medical equipment and the return of lost property. The Trust also invested in a six-seater automatic Ford Torneo, coordinated by the Capacity Hub, to support safe and timely inpatient discharge. Volunteers will work in pairs, focusing on both driving safety and patient comfort. Fourteen volunteers are currently in recruitment and training, supported by volunteer driving experts, including retired driving instructors and a current driving examiner.

In January 2026, volunteers with 4x4 vehicles supported approximately 250 NHS staff and patients during severe snowfall, ensuring access to essential healthcare services during extreme weather conditions.

Community Partnership and Reducing Inequalities

Through funding secured via Volunteering for Health, the Trust is supporting the Community Bridge Project, a nationally backed initiative aimed at improving health outcomes, reducing inequalities and strengthening community connections. Working with partners across the Black Country, volunteers will support patients during the discharge process by identifying concerns, linking with Trust Care Coordinators and Social Prescribing Link Workers, and ensuring patients receive the right support in the community. Post discharge follow-up will help reduce readmissions, promote independence and ease pressure on hospital beds.

Colleagues engaging with a training session in our Clinical Education Centre

Sustainability and the environment

This year marks a defining moment in our sustainability journey. With the approval of our new Green Plan in October 2025, The Dudley Group NHS Foundation Trust has renewed its commitment to reducing environmental impacts, health equity, and responsible resource use. The year has been one of collaboration, innovation, and tangible progress, built on the shared efforts of our staff, partners, and community.

As climate change continues to influence the health outcomes of the populations we serve, our actions today shape the wellbeing of future generations. This report celebrates the achievements of 2025–26 and sets the foundation for the next phase of our Net Zero ambitions.

The Launch of the New Green Plan and Strategic Process

The highlight of the year was the **sign-off of the Trust's refreshed Green Plan (October 2025)**, a comprehensive roadmap aligned with NHS England's Green Plan Guidance and Net Zero strategy. The new plan sets out clear priorities across estates, travel, procurement, waste, and clinical pathways, ensuring sustainability becomes a core enabler of high-quality care.

To support delivery, a **new Group governance structure** was established across The Dudley Group NHS Foundation Trust and Sandwell and West Birmingham NHS Trust, with oversight led by the Group Chief Development Officer at Board level.

Carbon and Energy Performance

Despite ongoing operational pressures, the Trust continued to demonstrate meaningful reductions in emissions and improved resource efficiency. The Trust worked with the Midlands Net-Zero Hub to generate a Heat Decarbonisation Plan.

Carbon Emissions

- **8% reduction** in carbon emissions from building Energy from the 2018/19 baseline to 2024/25.
- **Full Carbon Report** pending finalisation.

Energy Consumption

- Overall energy consumption decreased by 2%.
- **Electricity use down 39%** and **oil use down 55%**, showcasing the impact of energy efficiency measures and system optimisation.
- **Gas use increased by 13%**, reflecting increased heating demand and ongoing reliance on fossil fuel systems.

Energy Optimisation Projects

Theatre Setbacks – automating ventilation shutdowns across theatres to deliver an estimated 136tCO2e saving per year

LED lighting upgrades – Mitie are upgrading the lighting across the estate and adding automation, estimated savings of 407tCO2e

Boiler replacement – 70% efficiency to 90% efficiency, estimated savings of 1,051 tCO2e

There is still more work to be done to fully decarbonise our estate and to achieve our net-zero target.

Clinical & Operational Sustainability

Waste Reduction

Overall emissions from waste have reduced by 65% from 2020-21 to 2024-25, 524.38tCO2e down to 181.96 tonnes.

The Trust is on target to meet the **NHS Clinical Waste Target** of 20:20:60; achieving 7:28:65

Theatre Waste Yard Tour and Video developed to improve staff engagement and training.

Food Waste Audit conducted, recording detailed measurements of canteen food waste in kilograms, providing essential baseline data to guide future reductions within a commercial food waste setting.

The **Medicine Returns** Project that runs internally on wards and pharmacy, so far this has saved £150k and 25tCO2e.

Continuing to pilot and practice sustainable clinical behaviours such as the Bathroom First pilot, Decaf Drinks, as well as good practice for glove and couch roll use.

Nitrous Oxide Reduction

A particularly significant achievement was the **full decommissioning of nitrous oxide manifolds**:

- Russells Hall Hospital: **July 2025**
- Corbett Hospital: **November 2025**

This change is estimated to save 414 tonnes of carbon per year and reduces long term exposure to Nitrous Oxide. Now that this has concluded, we look to focus on reducing waste from Entonox, otherwise known as Gas and Air in Maternity. So far, improving the practice of removing demand valves has greatly reduced leaks at the point of delivery and risk to staff working in these areas. More work is underway to view the practicalities of moving to a portable cylinder system so that the manifold can be decommissioned, as we have done so for Nitrous Oxide.

Logistics and Portering Manager, Jeremy Pugh won sustainability award at 2025 Committed to Excellence awards

Engagement, Education & Culture

Nurturing a culture of sustainability remained a major focus this year, with initiatives that connected staff, students, and community partners.

Staff & Community Engagement

- **Cycle Solutions** delivered in-person site events and online webinars, with free bike repairs and safety checks.
- **Wellbeing** and **biodiversity walk** to promote nature connection.
- **BioBlitz events**, though lightly attended, provided valuable ecological data and opportunities for community involvement.
- Sustainability celebrated in the **Committed to Excellence Awards**, with recognition for Jeremy Pugh's contribution to reducing emissions from Waste.

Education & Workforce Development

- Green Plan Training and Awareness Session held regularly throughout the year and embedded within the Preceptorship Programme.
- Multiple **student placements** delivered both within the Trust and across the Black Country.
- **Visiting lecture at the University of Birmingham.**
- **Doctors' Handbook updated** to include sustainability principles.
- Regular In the Know posts, Hub Stories and Your Trust articles to promote the Green Plan and sustainable action across the Trust. Updated Intranet pages, making it easier to share resources, creating an interactive internal Swop Shop to help rehome unwanted items and equipment.

Foundation Trust Membership

(Updated with the new membership figures)

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 – **click here**. 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.

As of 31 March 2026, the Trust had a total of 10,744 public members. Membership remained above 13,000 until the second quarter of 2025/26. In Quarter Three, a membership cleanse was conducted alongside the governor elections, managed by our election provider, Civica Election Services. All public members in constituencies holding elections who did not have an email address were asked to confirm their wish to remain on the register. Members who did not respond by the deadline were removed from the membership database in accordance with GDPR requirements.

As a result of this process, membership numbers fell below 13,000; however, they remain above the minimum required by the Trust Constitution. The Trust will continue to carry out phased membership cleanses alongside future elections until all public constituencies have been reviewed.

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.

DGFT Intermediate Care Team

Public membership

31st March 2024	13,275
31st March 2025	13,286
31st March 2026	10,744

Membership constituency breakdown report as of 31st March 2026

Public Constituencies	Number of Members
Brierley Hill	1665
Central Dudley	730
Halesowen	1061
North Dudley	406
Rest of England	417
Out of Trust area	1916
South Staffordshire and Wyre Forest	1023
Stourbridge	1598
Tipton and Rowley Regis	1928

Public membership breakdown by age, gender and ethnicity		Number of Members
Age	0-16 years	10
	17-21 years	315
	22+ years	9918
	Not stated	501
Gender	Male	3332
	Female	7119
	Unspecified/not stated	293
Ethnicity	White	8251
	Mixed	315
	Asian or Asian British	1017
	Black or Black British	337
	Other	55
	Not stated	769

Staff constituencies

Staff Constituencies	Number of Members
Allied Health Professionals, Pharmacy and Healthcare Scientists	1214
Medical and Dental	857
Nursing and Midwifery	3266
Non-Clinical	1360
Partner Organisations	682

NHS Foundation Trust Code of Governance Disclosure

- The Trust's Council of Governors, see page 105.
- The Trust's Board of Directors, see page 54.
- Nominations and Remuneration Committee, see page 68.
- Audit Committee, see page 65.
- The Foundation Trust's Membership, see page 102.

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:** thirteen 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 107.

The Board of Directors continues to work closely with the Council of Governors through regular attendance at both full Council of Governors 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 the non-executive directors' function. Governors regularly attend Board of Directors' meetings – public sessions 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 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.

Responsibilities of the Council of Governors

- 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 per cent 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.

Alongside these statutory responsibilities, the Council also considers how its role continues to evolve in response to national policy and wider changes across the NHS.

NHS 10-Year Plan and the Future Role of Governors

The NHS 10-Year Plan sets out a long-term vision for how health services will develop to meet the challenging needs of the population. It seeks to address challenges such as waiting times, access to appointments and increasing demand on services. The plan focuses on three key shifts: delivering more care into local communities, making greater use of digital technology, and placing stronger emphasis on preventing illness.

Although the wider NHS landscape continues to change, the statutory responsibilities of governors remain the same. Governors continue to represent the voice of members, staff and the wider community, ensuring that local perspectives are considered as services evolve and new ways of working are introduced.

As care becomes increasingly community-based and digitally enabled, maintaining strong connections with the communities we serve is more important than ever. Governors play a key role in supporting transparency, public confidence and local engagement. Central to this is their responsibility to hold the non-executive directors to account and to provide constructive challenge and assurance as the Trust responds to national priorities while continuing to meet local needs.

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 interviews 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 53 provides a summary of the non-executive members' length of appointment.

Council of Governors membership and meeting 2025/26

Figures show the number of meetings attended that were held during the term of office.

Public Governors

Name	Constituency	
Julius Adams	Halesowen	3/4
Lewis Callary	Rest of England	2/4
Alex Giles	Stourbridge	4/4
Sandra Harris	Central Dudley	4/4
Vicky Homer	South Staffordshire and Wyre Forest	1/4
Mushtaq Hussain (Re-elected December 2025)	Central Dudley	3/4
Maria Lodge-Smith	Stourbridge	1/4
Elizabeth Naylor (Resigned December 2025)	North Dudley	0/2
Angelika Pachowicz	Brierley Hill	3/4
Hasmukh S Patel (Elected December 2025)	North Dudley	1/2
Yvonne Peers (Term ended June 2025)	North Dudley	1/1
Arinderpal Sikham (Elected June 2025 and resigned March 2026)	Tipton and Rowley Regis	1/3
Phil Tonks	Brierley Hill	4/4
Joanne Williams	Halesowen	0/4

Staff Governors

Name	Constituency	
Jill Faulkner	Non-clinical	2/4
Syed Gilani (Re-elected December 2025)	AHP, Pharmacy andHCS	1/2
Clare Inglis (Term ended December 2025)	AHP, Pharmacy and HCS	2/3
Yunzheng Jiao	AHP, Pharmacy and HCS	0/4
Anand Letha	Nursing and Midwifery	0/4
Atef Michael (Term ended June 2025)	Medical and Dental	0/1
Lyndsay Millington	Nursing and Midwifery	2/4
Khadeejat Ogunwolu	Nursing and Midwifery	2/4
Rinesh Parmar (Elected June 2025)	Medical and Dental	1/4
Jonathan Woolley	Partner Organisations	3/4

Appointed Governors

Name	Constituency	
Natalia Hill	Institute of Health – University of Wolverhampton	2/4
Alan Taylor	Dudley Metropolitan Borough Council	4/4
Mary Turner	Dudley CVS and Trust volunteers	3/4

As of the 31st March the following constituencies were vacant:

- North Dudley
- Tipton and Rowley Regis
- Primary Care Representative

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 2025/26, elections were held for vacancies in the following constituencies:

Public:

- Central Dudley, and Tipton and Rowley Regis – one vacancy in each.
- North Dudley – two vacancies.

Staff:

- Allied Health Professionals, Pharmacy and Healthcare Scientists and Medical and Dental – one vacancy in each.

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 9 members put themselves forward as nominees for the vacancies arising with percentage of returning votes in contested elections: Allied Health Professionals, Pharmacy and Healthcare Scientists – 14.4%, and Medical and Dental – 15.9%.

Civica Election Services was appointed to oversee the election process, returning the following governors for a three-year term:

- **Public:** Central Dudley, Mushtaq Hussain
- **Public:** North Dudley, Hasmukh S Patel
- Public: Tipton and Rowley Regis, Arinderpal Sikham
- **Staff:** Allied Health Professionals, Pharmacy and Healthcare Scientists, Syed Gilani
- **Staff:** Medical and Dental, Rinesh Parmar

Cllr Alan Taylor was re-appointed for a three-year term representing Dudley Metropolitan Borough Council. The appointed governor position for Primary Care Representative remains vacant.

Governors reaching end of term of office or resigning during 2025/26

June 2025

- Atef Michael, Staff elected: Medical and Dental (end of term of office)
- Yvonne Peers, Public elected: North Dudley (end of term of office)
- Alan Taylor, Appointed governor: Dudley Metropolitan Borough Council (end of term of office)

December 2025

- Mushtaq Hussain, Public elected: Central Dudley (end of term of office)
- Clare Inglis, Staff elected: Allied Health Professionals, Pharmacy and Healthcare Scientists (end of term of office)
- Elizabeth Naylor, Public elected: North Dudley (resigned)

March 2026

- Arinderpal Sikham, Public elected: Tipton and Rowley Regis (resigned)

Council of Governors review 2025/26

The Council of Governors remains committed to fulfilling its statutory duties effectively and continues to undertake regular reviews to assess its performance. The most recent formal review of the Council's effectiveness was completed on 31 October 2025, and the resulting actions will be followed up by the Council of Governors Experience and Engagement Committee.

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.

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.

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 opportunities for joint working.

At the most recent session, held in June 2025, the Learning and Organisational Development team led an interactive workshop on The Power of Questions in Your Role as a Governor, focusing on the sharing of best practice.

The Trust will continue to develop further workshop-based training sessions to provide governors with additional opportunities to meet and build relationships with governors from other trusts.

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 Futures Fair at Halesowen College and the Health and Well Being Carnival for Armed Forces Day at Himley Hall. 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 on 16 October 2025. The event featured presentations from staff on Moving care from hospital to community, as well as a review of the 2024/25 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 in seeking the views of members, patients and the wider community, and in sharing this feedback with the Board of Directors.

Regular update emails are circulated to our foundation trust members alongside the Trust Newsletter, which includes invitations to attend meetings of the Council of Governors and the Board of Directors. Members are also encouraged to submit questions in advance, supporting transparent and inclusive engagement.

During the year, governors have participated in a range of Trust activities aimed at providing assurance on, and supporting improvements to, the quality of services and patient experience. Governors have also attended sessions hosted by the Trust and wider system partners, including the Black Country Provider Collaborative, Place Division and Healthwatch.

The Board of Directors has provided opportunities for governors to contribute to the development of the Trust's Medium-Term Plan. They were actively involved in a workshop on the Medium-Term Plan in October 2025 and the feedback received from governors has been incorporated into the plan.

Throughout the year, Governors have received ad hoc briefings as part of their involvement in, and contribution to, the journey towards establishing a Group Board, reflecting increased collaborative working with Sandwell and West Birmingham NHS Trust. Progress updates have been provided through Council of Governors meetings and dedicated briefing sessions, ensuring Governors were kept informed and had regular opportunities to ask questions and provide feedback throughout the process.

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 in March 2025 and was endorsed as part of the annual review process at the last full Council of Governors meeting held in March 2026

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.u**k 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 Oversight Framework

NHS England's NHS Oversight Framework (NOF) provides the framework for overseeing systems including providers and identifying potential support needs. A revised framework was introduced where NHS organisations are allocated to one of five 'segments' (was four).

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 and 5). 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.

As part of the NHS Oversight and Assessment Framework (NOF), NHS England assesses NHS trusts' capability, using this alongside providers' NOF segments to judge what actions or support are appropriate at each trust. Launched in August 2025, the Self-Assessment Process is an annual requirement by NHS England for all NHS trusts.

The process involves evaluating organisational capability across six domains: strategy, leadership and planning; quality of care; people and culture; access and delivery of services; productivity and value for money; and financial performance and oversight.

In October 2025, the Trust Board determined that there were appropriate levels of assurance and was satisfied to propose that a confirmed status was submitted in response to the statements aligned to all of the 6 domains. Following a review by the NHSE regional team, the Trust was advised in February 2026 that an overall single overall capability rating of Amber – Green for 2025/26 would be assigned.

Segmentation

The Trust has been assigned a National Oversight Framework rating segmentation rating of 3 as of 31st March 2026.

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 114- 126.

This segmentation information is the Trust's position as of 31st March 2026. Current segmentation information for NHS trusts and foundation trusts is published on the NHS England website: **NHS England » NHS oversight framework segmentation**

Statement of chief executive's responsibilities

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 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*.

Signed

Diane Wake
Group Chief Executive Officer
22nd June 2026

An optometrist in front of a Snellen chart

Annual Governance Statement

Scope of responsibility

As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS 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 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 Trust Accountable 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 NHS 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 NHS Trust NHS Trust for the year ended 31 March 2026 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 and development 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 Care Quality Commission.

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 2024/25 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 ED 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 achieve staff reduction targets in line with national requirements and subsequent impact on staff, capacity and wellbeing
- Financial performance risks with the potential for regulatory action
- 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 124.

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)/ Cyber Assurance Framework (CAF). 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), Group Senior Information Risk Owner (SIRO), Group 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 regularly 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, integration, infrastructure 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. in October 2024, the Trust integrated with the Dudley Integrated Health and Care NHS Trust which included the operation of Chapel Street Surgery, their Information Commissioners Office 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 at least annually to ensure they remain appropriate and effective to support the board.

Committee effectiveness reviews were undertaken by each committee during the year 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/s, 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 2025/2026, 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 (the Dudley People Plan), which remains aligned to the NHS People Plan and the Trust's strategic objective to be a brilliant place to work and thrive. During 2025/26, delivery continued against the Dudley People Plan 2023–2026, which provides the overarching framework to support the Trust's Shaping #OurFuture strategy and to enable sustainable workforce development, transformation and staff wellbeing. The Dudley People Plan 2023–2026 sets the overall direction for the Trust's people agenda, reflecting the national, regional and local context in which the Trust operates. The plan is informed by an understanding of the Trust's workforce demographics, organisational culture and the diverse communities it serves. It establishes clear objectives, identifies priority actions, and defines how progress and impact will be measured and reported. The Dudley People Plan continues to be underpinned by five key workforce priority journeys:

- Recruitment and retention
- Organisational development
- Health and wellbeing
- Equality, diversity, and inclusion
- Continuous Improvement

Performance against key workforce indicators, including absence rates, vacancy rates, staff turnover, agency expenditure, appraisal completion and mandatory training compliance, is monitored through the Workforce Key Performance Indicator (KPI) Report. This report is reviewed regularly and formally reported to the Board of Directors, providing assurance on workforce sustainability and risk.

Delivery and oversight of the People Plan are provided through the People Committee, supported by the Equality, Diversity and Inclusion Steering Group and the Health and Wellbeing Steering Group. The Health and Wellbeing Steering Group continues to be chaired by the Trust's Wellbeing Guardian, a Non-Executive Director, ensuring Board-level leadership and visibility of staff wellbeing priorities.

The Trust collates and reviews workforce data on a monthly basis across a range of metrics, quality indicators and productivity measures. This supports effective workforce planning, safe staffing and informed decision-making, while enabling the Trust to track progress against People Plan ambitions, including improvements in staff experience, engagement, equality and inclusion.

Safe staffing reviews for nursing and midwifery are undertaken in line with national process, using validated tools. Resultant reports are presented to the Executive group, Quality Committee and People Committee, prior to presenting at Trust Board. In terms of the Allied Health Professional workforce, the Trust has undertaken a detailed review despite no national tools being available, which was reported via the same governance process as the nursing and midwifery workforce reviews. A review of the Clinical Nurse Specialist workforce was also undertaken during 2025. The Trust has undertaken two Developing Workforce Safeguards self-assessments in the last two years and submitted them to NHS England – Midlands, predominantly declaring compliance with a small number

of areas which continue to be subject to ongoing oversight as they continue to be embedded.

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.

Appropriate control measures are also in place to ensure the Trust meets its statutory obligations under equality, diversity and human rights legislation, supporting fair treatment, inclusion and equity across the workforce.

Further information on staff matters is included within the Staff Report section of the Annual Report.

Failure to remain financially sustainable in 2025/2026 and beyond

For 2025/2026 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 2025/2026 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 NHS financial framework for 2026/27 and beyond has moved away from a System based framework to individual provider accountability. Funding is provided through individual contracts with providers rebasing previous block contracts, so they are more in line with the actual activity being provided. National deficit funding is being phased out over the medium-term planning period with the Trust still receiving non-recurrent funding again in 2026/2027 through a national allocation. Alongside the local and national funding allocations the Trust has a challenging cost improvement programme and has approved a breakeven plan. The Trust's sustainability going forward is heavily reliant on two main factors; the ability to reduce costs and equally improve efficiency and its approach to designing a sustainable clinical model.

Work continues in the Trust 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 2026/2027 all efforts need to be put into making the Trust sustainable over the next three years without the need for non-recurrent funding.

Never Events

There were two Never Events reported during 2025/26; Patient Safety Incident Investigations (PSIIs) have been commissioned for both in line with the Trust's current Patient Safety Incident Response Plan (PSIRP). This represents an increase in reporting compared to the previous period where there were no Never Events reported.

One of the Never Events relates to a near-miss (i.e. no actual harm) involving entrapment of a child in bed rails in a non-compliant bed on a ward, and the other relates to an incorrect lesion being biopsied at a Dermatology outpatient clinic which resulted in moderate harm.

At the time of reporting both cases remain under investigation and await approval however the immediate learning identified has resulted in a number of actions being completed to mitigate future incidents. These include the procurement of new paediatric beds, associated training provision and revised policies and risk assessments as well as the implementation of a new app to manage the upload of skin lesion images, additional devices for image capture and associated training of staff.

The Trust continues to manage incidents in line with the Patient Safety Incident Response Framework. Never Events are a national priority incident for investigations however during 2025/26, a national review of the Never Events Framework has been initiated and whilst this continues organisations have been advised to utilise proportionate approaches to their review; PSII is no longer mandated.

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. 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 PSIRP.

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 Incident Response Sign Off Meeting a sub-group of the Trust's Risk and Assurance meeting.

Green Plan

The Trust's Green Plan was updated and approved by the board in October 2025. The refreshed plan aligns with NHS England guidance and ensures continued compliance with the Climate Change Act, the Environment Act, Health and Social Care Act requirements. In addition, the Trust has developed a Climate Change Adaptation Plan and Travel Plan for Russells Hall Hospital.

To view the full Green Plan or for further information, visit **www.dgft.nhs.uk/about-us/environmental-sustainability/**

Delivery of the Green Plan is overseen by the newly established Group Green Plan Working Group, which reports into the Group Infrastructure Committee. As part of the new Group governance structure, four cross-organisational workstreams have been established across DGFT and SWBT to support the delivery of Green Plan actions. These workstreams cover:

- Digital Transformation
- Travel & Transport, Clean Air, Wellbeing and Biodiversity
- Energy, Estates, Waste & Recycling, Food & Nutrition
- Clinical Transformation, Medicines and Supply Chain

A set of Group actions and KPIs has been agreed to monitor progress and ensure delivery of the Green Plan across the Group.

The Trust has a dedicated Sustainability Lead who provides operational and strategic coordination of the Green Plan, ensuring statutory compliance and alignment with national Greener NHS requirements. Executive leadership is provided through the Group governance structure led by the Group Chief Development Officer. This provides the Board with assurance that environmental responsibilities, legal duties and net-zero commitments are being effectively managed.

Annual waste pre-acceptance audits are undertaken by an external auditor, with actions coordinated by the Waste Preview Group to maintain compliance with waste legislation and relevant regulations.

The Trust submits quarterly data returns to the Greener NHS team to monitor delivery and compliance with national Green Plan requirements.

Care Quality Commission (CQC)

The Trust's overall CQC rating has remained as Requires Improvement. 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 have been inspected by CQC resulting in both GP surgeries achieving GOOD ratings overall, with GOOD ratings across all five domains within the practices. Learning from inspection has been collated into a single improvement plan and is being used by primary care teams to further develop and improve services.

During this period, the Trust has continued with a programme of 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 informs our internal quality reviews which 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 2025/26 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 2025/26 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 twice a month.

The Trust has submitted a medium term 3 year financial model to NHS England as part of the 2026/27 planning round. This has included the 2026/27 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 changed from 2025/26 with a move away from System allocations to defined contracts between ICB's and providers. In 2026/27 and the medium term there is a transition from a block contract approach to each individual contract being activity based. 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 2026/27 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 through the 3-year medium terms planning process 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 2026 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's Office (ICO) on four occasions during 2025/26. The ICO have responded and confirmed that they were not considering any further action against the Trust for two of these cases, with the other two remaining open at this time having only been reported towards the end of March 2025.

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 61.

During the 2025/2026, the strategic context and case for change to work in a collaboration with Sandwell and West Birmingham NHS Trust was finalised recognising that both trusts serve a largely shared population, face similar operational and financial pressures, and hold aligned ambitions for quality, equity and sustainability. The current collaboration has demonstrated the benefits of working together; however, to go further and faster on improvement and reform, a more formal and coherent Group Model was proposed. Key strategic drivers included:

- Improving access to safe, high-quality care – reducing variation in outcomes, access and experience across sites.
- Delivering better outcomes and reducing unwarranted variation – using shared standards, pathways and data.
- Maintaining strong local executive leadership and accountability – preserving clear site-level responsibility while strengthening Group-level oversight.
- Supporting and developing the workforce – creating a larger, more flexible talent pool and consistent leadership expectations.
- Acting together as anchor institutions – maximising impact on local communities, employment and inequalities.
- Standardising governance and minimising duplication – reducing unnecessary repetition in committees, reporting and assurance.
- Being sensitive to local needs and identities – retaining place-based leadership and sovereign Boards.
- Planning and delivering change jointly where it adds value – prioritising Group-level action where scale, consistency or risk justify it.

The Group model is designed as "one Board, two sovereign organisations": a shared strategic leadership and governance framework, underpinned by two statutory bodies with clear local responsibilities.

In January 2025, Diane Wake was appointed as Chief Executive at both trusts followed by a number of key board level group appointments as the year progressed. There has been a key focus on developing robust governance to support the creation of a single Group Board effective from 1st April 2026. More details about the move to group working can be found in the main body of the report.

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 processes 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 that support the development of quality indicators and the Quality Account include the effective use of internal intelligence and active engagement with both internal and external stakeholders, including service users. The Trust continues to be committed to the continuous improvement of the quality of care delivered to patients. Each year, the Trust sets out quality priorities that reflect the key areas for improvement for the forthcoming financial year. These priorities are underpinned by measurable key performance indicators, which are monitored throughout the year by the Trust's Quality Committee, providing oversight and assurance regarding the quality and safety of clinical care.

In 2025, the Trust committed to delivering 11 overarching quality priorities over a three-year period, each supported by clear objectives to guide progress and achievement. This approach was designed not only to translate actions into practice but also to ensure that improvements are sustained over time.

A robust governance framework is in place to monitor and report progress against these quality priorities. This includes quarterly reporting to the Quality Committee, and bi-annual reporting to the Board of Governors. Overall, good progress has been made against the 2025/26 quality priorities, with further detail provided within the Quality Account. The Quality Account also sets out the quality priorities objectives for 2026/27.

Monitoring and reporting of quality indicators are further supported through the Integrated Quality Performance Report, which is shared monthly with the Quality Committee and the Trust Board bimonthly.

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 and development opportunities are available to both clinical and non-clinical staff, with competence monitored through the Trust's appraisal and performance review processes. The Board of Directors ensures that quality improvement is embedded across all Trust activities through routine performance monitoring, participation in national improvement initiatives, celebrating success through staff awards, and proactively seeking and responding to patient feedback.

The Dudley People Plan sets out the Trust's approach to people and skills development. It recognises the contribution made by every member of staff and the vital role they play each day in delivering safe, effective and high-quality patient care, while role-modelling the Trust's values. The plan reinforces that the Trust's people are its most important asset and that their dedication and commitment underpin excellent patient care.

The Dudley People Plan should be read in conjunction with the Trust's organisational strategy, Shaping #OurFuture, and its five People Journeys, which reflect what matters most to staff in the delivery of the strategy. While not all staff provide direct patient care, every role contributes to the overall patient journey. The Trust is committed

to ensuring that all staff feel supported and valued in their development, enabling them to progress as far as possible in their careers. The plan covers a three-year period from 2023 to 2026 and sets out what staff can expect to be embedded across the five People Journeys.

The development of the People Journeys has been informed by the employee lifecycle, enabling the Trust to consider and plan for each stage of an individual's employment. This approach provides a structured framework for engagement and development, supporting the effective use of workforce talent and maximising individual and organisational 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

The Culture, Leadership and Learning Journey sets out the Trust's ambition to support and develop its workforce. It provides clarity on what staff can expect and articulates where the Trust currently is and where it aims to be over the three-year life of the People Plan.

Wellbeing

The Trust's vision is Excellent healthcare, improved health for all, and the Wellbeing Journey supports this ambition by promoting and enhancing workforce wellbeing. It provides a framework for a comprehensive and inclusive approach to staff health and wellbeing, aligned to the Trust's strategic objective of being a brilliant place to work and thrive.

Recruitment and retention

The Recruitment and Retention Journey focuses on transforming the Trust's approach to workforce attraction and retention, adopting more people-centred, flexible and modern practices. It aims to tailor approaches to meet the diverse needs of the workforce and support long-term workforce sustainability.

Continuous Improvement

Improving Together 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.

Improving Together (IT) is the Trust's long-term commitment to creating a culture of Continuous Improvement. Aligned with the national approach to improvement (NHS IMPACT), the ITmethod 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. Improving Together believe 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.

Improving Together 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 IT 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 provide 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 of 95.8 throughout the year. This is significantly higher than the national average score of 71.1. The Trust has maintained its position in the face of national deterioration.

The Trust's IT Department (Terafirma) maintains ISO27001 accreditation, holds Cyber Essentials (CE) certification and has achieved 'Approaching Standards' status in terms of the CAF aligned NHSD Data Security Protection (DSP) Toolkit and Data Guardian Standards for 2024/25 with an approved Action Plan in place to achieve Standards Met .

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 Associate Director 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 trust who have responsibility for the development and maintenance of the internal control framework comprising 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 the information provided in this annual report and other 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 2025/26, 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 topics internal control weaknesses and judged them relevant for consideration as part of the annual governance statement in regard to audits in the areas of:

- Reasonable Adjustments – Partial Assurance
- CQC Self-Assessment – Partial Assurance
- Grip and Control Governance Review – Partial Assurance
- Job Planning (focused on activity) – Minimal Assurance

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 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. 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 2025/26.
- 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

Group Chief Executive Officer

22nd June 2026

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 policy 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

Group Chief Executive Officer

22nd June 2026

Chris Walker

Interim Director of Finance

22nd June 2026

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 2026, 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 2025-26.

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 2026 and of the group's expenditure and income and the Trust's expenditure and income for the year then ended;
- 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 2025-26; 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 2025-26 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 2025/26 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 2025/26; 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 2025/26, 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 2025-26).
- 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 fraud in income and expenditure recognition. We determined that the principal risks were in relation to:
  - journal entries that altered the Trust's financial performance for the year;
  - management's approach to key accounting estimates and judgments, in particular, the valuation of land and buildings;

- the presumed risk of fraud in non-block contract revenue recognition (specific to accuracy) and a related risk regarding accuracy of receivables; and
- fraud in the recognition of operating expenses excluding staff and directors' costs, depreciation, amortisation, impairments, credit loss allowances and audit fees, (specific to completeness at year-end) and a related risk regarding the completeness of accruals at year-end.

- 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 and unusual 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;
  - evaluating the Trust's accounting policy for income recognition, updating our understanding of the Trust's system for accounting for income and testing substantively by agreeing a sample of income and receivables to supporting documentation to confirm correct accounting treatment;
  - evaluating the Trust's accounting policy for expenditure recognition, updating our understanding of the Trust's system for accounting for expenditure and testing substantively by agreeing a sample of post year-end payments made and invoices received to supporting documentation to confirm correct accounting treatment; 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 2026.

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 March 2026. 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 2026 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 2026. We are satisfied that this work does not have a material effect on the financial statements for the year ended 31 March 2026.

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

22 June 2026

Foreword to the Accounts

These accounts for the period 1st April 2025 to 31st March 2026 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

Group Chief Executive Officer

22nd June 2026

Consolidated and Foundation Trust Statements of Comprehensive Income

For the Year Ended 31 March 2026

	Note	Group		Foundation Trust	
		Year Ended 31 March 2026 £'000	Year Ended 31 March 2025 £'000	Year Ended 31 March 2026 £'000	Year Ended 31 March 2025 £'000
Operating Income from patient care activities	3	**631,906**	**588,787**	**631,906**	**588,787**
Other Operating Income	4	37,400	33,685	37,365	33,599
Total Operating Income from continuing operations		**669,306**	**622,472**	**669,271**	**622,386**
Operating Expenses from continuing operations	5	(661,507)	(606,065)	(661,407)	(606,101)
Operating Surplus / (Deficit)		**7,799**	**16,407**	**7,864**	**16,285**
Finance Costs					
Finance income	9	1,582	1,473	1,479	1,345
Finance expense - financial liabilities	10	(21,899)	(36,353)	(21,899)	(36,353)
Net Finance Costs		**(20,317)**	**(34,880)**	**(20,420)**	**(35,008)**
Gain/(loss) of disposal of assets	13	29	31	29	31
Gains/(losses) from transfers by absorption		0	2,503	0	2,503
Corporation tax expense	11	(85)	(91)	0	0
Surplus/(Deficit) for the year from continuing operations		**(12,574)**	**(16,030)**	**(12,527)**	**(16,189)**
SURPLUS/(DEFICIT) FOR THE YEAR		**(12,574)**	**(16,030)**	**(12,527)**	**(16,189)**
Other comprehensive income/(expense) Will not be reclassified to income and expenditure:					
Impairments	13	0	0	0	0
Revaluations	13	425	357	425	357
Fair value gains/(losses) on equity instruments designated at FV through OCI	14	144	(20)	0	0
Other reserve movements		0	(54)	0	0
TOTAL COMPREHENSIVE INCOME / (EXPENSE) FOR THE YEAR		**(12,005)**	**(15,747)**	**(12,102)**	**(15,832)**

The notes on pages 6 to 52 form part of these accounts.

All income and expenditure is derived from continuing operations.

There are no Non-Controlling Interests in the Group, therefore the deficit for the year of £12,574,000 (2024/25 deficit of £16,030,000) and the Total Comprehensive Expense of £12,005,000 (2024/25 Total Comprehensive Expense of £15,747,000) is wholly attributable to the Trust.

Consolidated and Foundation Trust Statements of Financial Position

As at 31 March 2026

	Note	Group		Foundation Trust	
		31 March 2026 £'000	31 March 2025 (Restated) £'000	31 March 2026 £'000	31 March 2025 (Restated) £'000
Non-current assets					
Intangible assets	12	9,995	9,847	9,995	9,847
Property, plant and equipment	13	182,835	195,804	182,835	195,804
Right of Use Assets	8	16,880	17,535	16,880	17,535
Other Investments/financial assets	14	1,727	1,382	0	0
Receivables	16	19,724	19,167	19,724	19,167
Total non-current assets		231,161	243,735	229,434	242,353
Current assets					
Inventories	15	6,131	4,668	5,909	4,458
Receivables	16	29,734	12,844	29,441	12,613
Cash and cash equivalents	17	20,565	33,311	18,402	30,611
Total current assets		56,430	50,823	53,752	47,682
Current liabilities					
Trade and other payables	18	(35,245)	(39,566)	(35,193)	(39,299)
Borrowings	19	(14,757)	(13,155)	(14,757)	(13,155)
Provisions	20	(234)	(225)	(234)	(225)
Other liabilities	21	(3,152)	(2,139)	(3,152)	(2,139)
Total current liabilities		(53,388)	(55,085)	(53,336)	(54,818)
Total assets less current liabilities		**234,203**	**239,473**	**229,850**	**235,217**
Non-current liabilities					
Borrowings	19	(287,388)	(290,108)	(287,388)	(290,108)
Provisions	20	(545)	(567)	(545)	(567)
Total non-current liabilities		(287,933)	(290,675)	(287,933)	(290,675)
Total assets employed		**(53,730)**	**(51,202)**	**(58,083)**	**(55,458)**
Financed by Taxpayers' equity					
Public Dividend Capital		106,149	96,672	106,149	96,672
Revaluation reserve		7,946	7,521	7,946	7,521
Income and expenditure reserve		(170,038)	(157,767)	(172,178)	(159,651)
Others' equity					
Charitable Fund reserves		2,213	2,372	0	0
Total Taxpayers' and Others' equity		**(53,730)**	**(51,202)**	**(58,083)**	**(55,458)**

The notes on pages 6 to 52 form part of these accounts.

The financial statements on pages 6 to 52 were approved by the Board of Directors and authorised for issue on their behalf by:

Diane Wake

Group Chief Executive Officer

22nd June 2026

Consolidated and Foundation Trust Statements of Changes in Taxpayers' and Others' Equity

for the Year Ended 31 March 2026

	Group					Foundation Trust			
	Taxpayers' Equity					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 2025	**96,672**	**7,521**	**(157,767)**	**2,372**	**(51,202)**	**96,672**	**7,521**	**(159,651)**	**(55,458)**
Surplus / (Deficit) for the year	0	0	(12,331)	(243)	(12,574)	0	0	(12,527)	**(12,527)**
Revaluations - property, plant and equipment	0	425	0	0	425	0	425	0	**425**
Fair value gains/(losses) on equity instruments designated at FV through OCI	0	0	0	144	144	0	0	0	**0**
Public Dividend Capital Received	9,477	0	0	0	9,477	9,477	0	0	**9,477**
Other reserve movements	0	0	60	(60)	0				
Taxpayers' and Others' Equity at 31 March 2026	**106,149**	**7,946**	**(170,038)**	**2,213**	**(53,730)**	**106,149**	**7,946**	**(172,178)**	**(58,083)**
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 between reserves	2,493	10	(2,503)	0	0	2,493	10	(2,503)	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)
Other reserve movements	0	0	57	(111)	(54)	0	0	0	0
Taxpayers' and Others' Equity at 31 March 2025	**96,672**	**7,521**	**(157,767)**	**2,372**	**(51,202)**	**96,672**	**7,521**	**(159,651)**	**(55,458)**

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 are classified as restricted or unrestricted. These reserves comprise Unrestricted Funds £2,021,000 (2024/25 £2,139,000) of which £1,528,000 (2024/25 £1,506,000) have been designated for specific purposes, Restricted Funds £192,000 (2024/25 £233,000) and Endowment Funds £nil (2024/25 £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 2026

	Group		Foundation Trust	
	31 March 2026	31 March 2025	31 March 2026	31 March 2025
	£'000	£'000	£'000	£'000
Cash flows from operating activities				
Operating surplus/(deficit) from continuing operations	7,799	16,407	7,864	16,285
Operating surplus/(deficit)	**7,799**	**16,407**	**7,864**	**16,285**
Non-cash income and expense:				
Depreciation and amortisation	20,223	18,181	20,223	18,181
Impairments and Reversals	15,833	2,193	15,833	2,193
Income recognised in respect of capital donations (cash and non-cash)	(194)	(128)	(194)	(128)
(Increase)/Decrease in trade and other receivables	(17,519)	(173)	(17,420)	(240)
(Increase)/Decrease in inventories	(1,463)	560	(1,451)	600
Increase/(Decrease) in trade and other payables	(805)	609	(646)	540
Increase/(Decrease) in other liabilities	1,013	(1,434)	1,013	(1,434)
Increase/(Decrease) in provisions	(13)	62	9	62
Movements in charitable fund working capital	(198)	(1,235)	0	0
Corporation Tax (paid) / received	(85)	(91)	0	0
NET CASH GENERATED FROM/ (USED IN) OPERATIONS	24,591	34,951	25,231	36,059
Cash flows from investing activities				
Interest received	1,544	1,395	1,514	1,395
Purchase of intangible assets	(2,239)	(2,758)	(2,239)	(2,758)
Purchase of Property, Plant and Equipment	(21,182)	(21,480)	(21,182)	(21,480)
Proceeds from sales of Property, Plant and Equipment	61	42	61	42
NHS Charitable funds - cash flows from investing activities	73	93	0	0
Net cash generated from/ (used in) investing activities	(21,743)	(22,708)	(21,846)	(22,801)
Cash flows from financing activities				
Public dividend capital received	9,477	26,253	9,477	26,253
Public dividend repaid	0	(3,875)	0	(3,875)
Capital element of PFI Obligations	(10,645)	(10,914)	(10,645)	(10,914)
Capital element of lease liability repayments	(2,527)	(2,453)	(2,527)	(2,453)
Interest element of PFI Obligations	(11,657)	(11,696)	(11,657)	(11,696)
Interest element of lease liability repayments	(242)	(185)	(242)	(185)
PDC Dividend paid	0	0	0	0
Net cash generated from/ (used in) financing activities	**(15,594)**	**(2,870)**	**(15,594)**	**(2,870)**
Increase/(decrease) in cash and cash equivalents	**(12,746)**	**9,373**	**(12,209)**	**10,388**
Cash and Cash equivalents at 1 April	**33,311**	**22,119**	**30,611**	**18,404**
Cash and cash equivalents transferred by absorption	0	1,819		1,819
Cash and Cash equivalents at 31 March	**20,565**	**33,311**	**18,402**	**30,611**

The notes on pages 6 to 52 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 2025/26, 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 accounts 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 2026. 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 a patient care spell is incomplete at the year end, revenue relating to the partially complete spell is accrued in the same manner as other revenue. 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 2025/26 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 2025/26 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 the Best Practice Tariff (BPT) scheme. Delivery under this scheme is part of how care is provided to patients. As such 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 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 Injury Cost Recovery Scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has 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. Both schemes are unfunded, defined benefit schemes that cover NHS employer, general practices and other bodies, allowed under the direction of Secretary of State for Health and Social Care in England and Wales. The scheme is not designed in a way that would enable employers to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as though it is a defined contribution scheme: the cost to the trust is taken as equal to the employer's pension contributions payable to the scheme for the accounting period. The contributions are charged to operating expenses as they become due.

Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill-health. The full amount of the liability for the additional costs is charged to the operating expenses at the time the Trust commits itself to the retirement, regardless of the method of payment.

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 2026, is based on valuation data as 31 March 2023, updated to 31 March 2026 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	15-90
Engineering	2-18
Medical Equipment	2-18
Transport Equipment	7-10
Information Technology	2-10
Furniture & Fittings	2-10
PFI Equipment	18

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.

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. From 1 April 2025, subsequent measurement of intangible assets is at cost less amortisation.

Prior to 1 April 2025, intangible assets were held under a revaluation approach reflecting current value in existing use. Revaluation gains and losses and impairments were treated in the same manner as for property, plant and equipment. On 1 April 2025, the carrying value of these assets was carried forward as 'deemed cost' and any related revaluation surpluses in the revaluation reserve were transferred to the I&E reserve.

Intangible assets held for sale are measured at the lower of their carrying amount or fair value less costs to sell.

Impairments

Where indicators of impairment exist, the recoverable amount is assessed as the higher of its fair value and the cost to replace the service capacity. Where this is lower than the carrying value an impairment is recognised in expenditure. The recoverable amount of intangible assets under construction is assessed annually, irrespective of indicators of impairment.

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.

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 4.81% applied to new leases commencing in 2025 and 5.32% to new leases commencing in 2026.

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 2026.

		Nominal rate	Prior Year rate
Short-term	Up to 5 years	3.64%	4.03%
Medium-term	After 5 years up to 10 years	4.22%	4.07%
Long-term	After 10 years up to 40 years	5.32%	4.81%
Very long-term	Exceeding 40 years	5.07%	4.55%

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 2026:

	Nominal rate	Prior Year rate
Year 1	2.50%	2.60%
Year 2	2.00%	2.30%
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 2.95% (2024-25 2.40%) 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**.

In accordance with the requirements laid down by the Department of Health and Social Care (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the "pre-audit" version of the annual accounts. The dividend calculated is not revised should any adjustment to net assets occur as a result of the audit of the annual accounts. The PDC dividend calculation is based upon the trust's group accounts (i.e. including subsidiaries) but excluding consolidated charitable funds.

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 31 to the accounts in accordance with the requirements of HM Treasury's Financial Reporting Manual.

1.18 Corporation Tax

TThe 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 30. 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 34.

A further valuation has been undertaken as at 31 March 2026 to update the costs assumptions within the valuation. The total valuation of land and buildings was £139.780m. 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 £3.634m).

1.20 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2025/26.

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 2025/26.

IFRS 14 Regulatory Deferral Accounts – The Standard applies to first time adopters of IFRS after 1 January 2016 and is not UK endorsed. Therefore not applicable to DHSC group bodies.

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.

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 were no transfers from other NHS bodies during 2025/26. There was one transfer from other NHS bodies during 2024-25. This related to the transfer of services from Dudley Integrated Health and care 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 Healthcare Services operate in an operating segment, which is 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 23 and materially consists of revenues from healthcare, research and development, medical education, and the provision of services to other NHS bodies. Note 25 for related party transactions on page 41 discloses the individual customers within the whole of HM Government.

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 21.

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 21.

2 Segmental Analysis (continued)

Year ended 31 March 2026	Healthcare Services £000	Dudley Clinical Services Limited £000	Dudley Group NHS Charity £000	Inter Group Eliminations £000	Total £000
Total segment revenue	669,271	6,098	482	(6,545)	669,306
Total segment expenditure	(661,407)	(5,787)	(858)	6,545	(661,507)
Operating Surplus/(Deficit)	7,864	311	(376)	0	7,799
Net Financing	(20,420)	30	73	0	(20,317)
Taxation	0	(85)	0	0	(85)
Retained surplus/(deficit) - before non-recurring items	(12,556)	256	(303)	0	(12,603)
Non-recurring items	29	0	0	0	29
Retained surplus/(deficit)	(12,527)	256	(303)	0	(12,574)
Reportable Segment assets	283,186	2,715	2,268	0	288,169
Eliminations	0	0	0	(578)	(578)
Total assets	283,186	2,715	2,268	(578)	287,591
Reportable Segment liabilities	(341,269)	(575)	(55)	0	(341,899)
Eliminations	0	0	0	578	578
Total liabilities	(341,269)	(575)	(55)	578	(341,321)
Net assets/liabilities	(58,083)	2,140	2,213	0	(53,730)

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)	(89)	0	(346,176)
Eliminations	0	0	0	416	416
Total liabilities	(345,493)	(594)	(89)	416	(345,760)
Net assets/liabilities	(55,458)	1,884	2,372	0	(51,202)

3 Operating income from patient care activities (Group and Foundation Trust)

3.1 By Source

	Year Ended 31 March 2026 £'000	Year Ended 31 March 2025 £'000
NHS England	57,364	53,869
Integrated Care Boards	566,890	530,929
NHS Foundation Trusts	103	134
NHS Trusts	2,021	371
Local Authorities	39	23
Non-NHS: Private patients	1	3
Non-NHS: Overseas patients (chargeable to patient)	221	373
NHS injury scheme (was RTA)	1,038	940
Non-NHS: Other	4,229	2,145
Total income from activities	**631,906**	**588,787**

3.2 By Nature

	Year Ended 31 March 2026 £'000	Year Ended 31 March 2025 £'000
Acute Services		
Aligned payment & incentive (API) income - Variable (based on activity) *	140,723	144,710
Aligned payment & incentive (API) income - Fixed (not based on activity)	362,542	338,440
High-cost drugs income from Commissioners	51,516	46,937
Other NHS clinical income	8,747	5,483
Community Services		
Aligned payment & incentive (API) income *	38,597	27,725
Income from other sources (e.g. local authorities)	0	0
Private Patients		
Elective recovery fund #	1	3
Pay award central funding ***	0	1,191
Additional pension contribution central funding **	22,167	20,335
Other clinical income	7,613	3,963
Total income from activities	**631,906**	**588,787**

*Aligned payment and incentive contracts are the main form of contracting between NHS providers and their commissioners. More information can be found in the 2025/26 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 14.38% with the additional amount being paid over by NHS England on providers' behalf. The full cost of employer contributions (23.7%) and related NHS England funding (9.4%) have been recognised in these accounts.

***Additional funding was made available directly to providers by NHS England in 2024/25 for implementing the backdated element of pay awards where government offers were finalised after the end of the 2023/24 financial year. NHS Payment Scheme prices and API contracts are updated for the weighted uplift in in-year pay costs when awards are finalised.

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 2026 £'000	Year Ended 31 March 2025 £'000
Income from Commissioner Requested Services	563,528	535,570
Income from Non-Commissioner Requested Services	38,597	27,725
Income from Activities	602,125	563,295
Other Clinical Income		
Elective Recovery Fund *	7,614	3,966
Pay award central funding	0	1,191
Additional pension contribution central funding	22,167	20,335
Total income	**631,906**	**588,787**

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

	2025/26 £'000	2024/25 £'000
Revenue recognised in the reporting period that was included within contract liabilities at the previous period end	3,152	2,139
Revenue recognised from performance obligations satisfied (or partially satisfied) in previous periods	0	0

3.5 Overseas Visitors

	Year Ended 31 March 2026 £'000	Year Ended 31 March 2025 £'000
Income recognised this year	221	373
Cash payments received in-year	74	63
Amounts added to provision for impairment of receivables	387	373
Amounts written off in-year	238	18

4 Other Operating Income (Group)

	Year Ended 31 March 2026 £'000	Year Ended 31 March 2025 £'000
Recognised in IFRS15:		
Research and development	1,435	1,120
Education and training	20,391	19,721
Non-patient care services to other bodies	2,876	1,916
Income in respect of employee benefits accounted for on a gross basis	8,654	6,645
Other *	1,641	1,994
Recognised in accordance with other standards:		
Education and training - apprenticeship fund	1,197	1,204
Charitable asset donations	194	128
Contributions to expenditure - consumables (inventory) donated from DHSC group bodies for COVID response	0	0
Operating leases - variable lease receipts	530	449
NHS Charitable Funds incoming resources excluding investment income	482	508
Total other operating income	**37,400**	**33,685**

*Other income is derived from Pharmacy Drugs £712,000 (2024/25 £629,000); and numerous other small amounts.

4.1 Operating lease income and future receipts

	Year Ended 31 March 2026 £'000	Year Ended 31 March 2025 £'000
Total in-year operating lease income	530	449
Of which:		
Income generated from owned assets	530	449
Future minimum lease receipts due:		
- not later than one year	530	456
- later than one year and not later than two years	9	7
- later than two years and not later than three years	9	6
- later than three years and not later than four years	9	7
- later than four years and not later than five years	10	6
- later than five years	0	0
Total	**567**	**482**

5 Operating Expenses of continuing operations (Group)

5.1 Operating Expenses

	Year Ended 31 March 2026 £'000	Year Ended 31 March 2025 £'000
Purchase of healthcare from NHS and DHSC bodies	1,260	1,759
Purchase of healthcare from non-NHS and non-DHSC bodies	2,634	1,642
Staff and executive directors' costs	427,403	400,331
Non-executive directors	228	229
Supplies and services - clinical (excluding drug costs)	66,507	60,967
Supplies and services – clinical: utilisation of consumables donated from DHSC group bodies for COVID response	0	0
Supplies and services - general	2,332	2,327
Drug costs (inventory consumed and purchase of non-inventory drugs)	53,207	50,575
Drugs Inventories written down	0	0
Consultancy costs	195	0
Establishment	3,226	3,206
Premises - Business Rates	1,820	1,787
Premises - Other	8,886	8,292
Transport - Business Travel	576	641
Transport - Other	342	164
Depreciation on property, plant and equipment and right of use assets	18,119	16,144
Amortisation on intangible assets	2,104	2,037
Impairments net of (reversals)	15,833	2,193
Movement in credit loss allowance: contract receivables/assets	214	390
Increase/(decrease) in other provisions	126	0
Audit fees payable to the external auditor:		
• Audit services	228	141
• Other Auditor Remuneration	12	9
• NHS Charitable Fund Accounts	17	13
Internal audit	198	172
Clinical negligence	13,527	14,421
Legal Fees	192	325
Insurance	161	172
Research and development - staff costs	1,529	1,355
Research and development - non staff	207	150
Education and training - non staff	992	1,445
Education and training - apprenticeship fund	1,197	1,204
Lease expenditure - short term leases (<= 12 months)	17	8
Lease expenditure - low value assets (<£5k, excluding short term leases)	7	28
Lease expenditure - irrecoverable VAT (map to premises costs in accounts)	-21	9
Redundancy	346	0
Charges to operating expenditure for on-SOFP IFRIC 12 schemes e.g. PFI	37,143	33,249
Car Parking and security	12	12
Hospitality	24	68
Other losses and special payments	6	26
Other NHS Charitable funds resources expended	617	471
Other	84	103
TOTAL	**661,507**	**606,065**

Other expenditure includes numerous small amounts. Audit fees are shown inclusive of vat where this is not recoverable.

*Audit services include £3,000 which relates to the Eye Department Audit performed by the Royal College of Ophthalmologists.

5.2 The Late Payment of Commercial Debts (interest) Act 1998

During the year 2025/26 the Trust paid £nil (2024/25 £nil) for interest for the late payment of commercial debts.

5.3 Income from activities arising from Commissioner requested services

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:

	2025/26 £'000	2024/25 £'000
Income from services designated as commissioner requested services	666,008	620,105
Income from services not designated as commissioner requested services	3,358	2,516
Total	**669,366**	**622,621**

6 Employee Expenses and Numbers

6.1 Employee Benefits

	Year Ended 31 March 2026			Year Ended 31 March 2025		
	Total £'000	Permanent £'000	Other £'000	Total £'000	Permanent £'000	Other £'000
Salaries and wages	329,320	326,663	2,657	316,450	314,094	2,356
Social security costs	40,482	40,482	0	31,424	31,424	0
Apprenticeship Levy	1,624	1,624	0	1,548	1,548	0
Employer's contributions to NHS Pensions	34,036	34,036	0	31,344	31,344	0
Pension cost - employer contributions paid by NHSE on provider's behalf (2024/25: 9.4%, 2023/24: 6.3%)	22,167	22,167	0	20,335	20,335	0
Pension Cost - other	35	35	0	68	68	0
Temporary Staff (including agency)	2,532	0	2,532	2,799	0	2,799
NHS Charitable funds staff	164	164	0	174	174	0
Total Staff costs	430,360	425,171	5,189	404,142	398,987	5,155
Costs capitalised as part of assets	1,082	1,082	0	2,456	2,456	0
Total staff costs excluding capitalised costs	429,278	424,089	5,189	401,686	396,531	5,155

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 2025/26 (2024/25 £ nil).

6.4 Retirements due to Ill-health

During the year 2025/26 there were 8 early retirements from the Trust on the grounds of ill-health (in 2024/25 there was 1)

The estimated additional pension liability of this ill-health retirement will be £578,007 (2024/25: £10,229).

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.

This information can now be found in the staff report section of the annual report and accounts.

7 Directors' Remuneration and other benefits

	Year Ended 31 March 2026 £'000	Year Ended 31 March 2025 £'000
Salary	1,159	1,726
Taxable Benefits	0	0
Performance Related Bonuses	0	0
Employer contributions to a pension scheme	43	148
Total	**1,202**	**1,874**

Further details of directors' remuneration can be found in the remuneration report.

8 Right of Use Assets

8.1 Right of use assets 2025/26

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 2026 was £13.275m. 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 2025/26 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 2026 was £2.142m. 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.

2025/26	Total £'000	Land & Buildings £'000	Plant & Machinery £'000	Transport £'000
Valuation/gross cost 1 April 2025	24,769	23,898	844	27
Transfers by absorption	0	0	0	0
Additions - lease liability	1,566	1,511	0	55
Remeasurements of lease liability	519	519	0	0
Disposals/derecognition - lease termination	(119)	(98)	0	(21)
Gross value 31 March 2026	26,735	25,830	844	61
Accumulated depreciation at 1 April 2025	~	6,942	265	27
Transfers by absorption	0	0	0	0
Provided during the year - right of use asset	2,644	2,481	155	8
Provided during the year - peppercorn leased asset	65	65	0	0
Disposals/derecognition - lease termination	(88)	(67)	0	(21)
Accumulated depreciation 31 March 2026	9,855	9,421	420	14
Net book value 31 March 2026	16,880	16,409	424	47
Net book value of right of use assets leased from other DHSC group bodies	15,671	15,671	0	0

There are no right of use assets with other NHS providers.

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.

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.

2025/26	Total £'000	Leased from other DHSC bodies £000	Lease from bodies external to government £000
Carrying value at 1 April 2025	17,420	16,121	1,299
Lease additions	1,566	1,353	213
Transfers by absorption	0	0	0
Lease remeasurement	519	519	0
Interest charge arising in year	242	206	36
Early terminations	(31)	0	(31)
Lease payments (cash outflows)	(2,769)	(2,461)	(308)
Carrying value at 31 March 2026	16,947	15,738	1,209

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)
Carrying value at 31 March 2025	17,420	16,121	1,299

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

2025/26	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;	3,243	2,944	299
- later than one year and not later than five years;	11,605	10,761	844
- later than five years.	2,584	2,446	138
Total gross future lease payments	17,432	16,151	1,281
Finance charges allocated to future periods	(485)	(413)	(72)
Net lease liabilities	16,947	15,738	1,209

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

9 Finance Income (Group)

	Year Ended 31 March 2026 £'000	Year Ended 31 March 2025 £'000
Interest on bank accounts	1,509	1,380
NHS Charitable funds: investment income	73	93
Performance Related Bonuses	1,582	1,473

10 Finance Expense - Financial Liabilities (Group and Foundation Trust)

	Year Ended 31 March 2026 £'000	Year Ended 31 March 2025 £'000
Interest Expense		
Other interest:		
Interest on lease obligations	242	185
Finance Costs in PFI obligations:		
Main Finance Costs	11,657	11,695
Remeasurement of PFI/other service concession liability resulting from a change index or rate	10,000	24,473
	21,899	36,353

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 £85,000 (2024/25 £91,000). The activities of the Trust and the Charity do not incur corporation tax.

UK Corporation Tax Expense

	Year Ended 31 March 2026 £'000	Year Ended 31 March 2025 £'000
Current tax expense		
Current year	(85)	(91)
Total income tax expense in Statement of Comprehensive Income	(85)	(91)

Reconciliation of effective tax rate

	Year Ended 31 March 2026 £'000	Year Ended 31 March 2025 £'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	85	91
Total income tax charge for the year	85	91

For 2025/26 all companies with profits over £250k paid at a rate of 25% for corporation tax.

12 Intangible Assets

2025/26	Group and Foundation Trust	
	Computer Software £'000	Total £'000
Gross Cost as at 1 April 2025	21,793	21,793
Additions Purchased	2,239	2,239
Additions Donated	13	13
Disposals	0	0
Gross Cost as at 31 March 2026	24,045	24,045
Accumulated Amortisation as at 1 April 2025	11,946	11,946
Provided during the Year	2,104	2,104
Disposals	0	0
Accumulated Amortisation as at 31 March 2026	14,050	14,050
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
Net Book Value		
Purchased at 31 March 2026	9,982	9,982
Donated at 31 March 2026	13	13
Total at 31 March 2026	9,995	9,995

2024/25	Group and Foundation Trust	
	Computer Software	Total
	£'000	£'000
Gross Cost as at 1 April 2024	19,035	19,035
Additions Purchased	2,758	2,758
Additions Donated	0	0
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

A separate schedule for the Trust intangible assets has not been produced as the NHS Charity intangible assets represent just £nil (31 March 2025 £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 12. Measurement of intangible assets is at cost less amortisation.

13 Property, Plant and Equipment

13.1 2025/26

	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 2025	226,319	5,180	135,045	0	9,055	55,777	512	19,489	1,261
Additions - purchased	17,700	0	6,572	0	7,567	2,841	4	592	124
Additions - donated	181	0	0	0	0	0	0	181	0
Impairments charged to operating expenses	(21,873)	0	(21,873)	0	0	0	0	0	0
Impairments charged to the revaluation reserve	(676)	0	(676)	0	0	0	0	0	0
Revaluations	(63)	0	16,665	0	(16,622)	713	0	(819)	0
Disposals	(1,104)	0	0	0	0	(1,104)	0	0	0
Cost at 31 March 2026	220,484	5,180	135,733	0	0	58,227	516	19,443	1,385
Accumulated depreciation at 1 April 2025	30,514	0	160	0	0	19,166	228	9,864	1,096
Provided during the year	15,410	0	7,222	0	0	5,662	49	2,385	92
Impairments charged to operating expenses	(6,040)	0	(6,040)	0	0	0	0	0	0
Impairments charged to the revaluation reserve	(1,101)	0	(1,101)	0	0	0	0	0	0
Revaluations	(63)	0	(13)	0	0	(56)	0	6	0
Disposals	(1,072)	0	0	0	0	(1,072)	0	0	0
Accumulated depreciation at 31 March 2026	37,648	0	228	0	0	23,700	277	12,255	1,188
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
Net book value 31 March 2026									
Owned - purchased	64,435	5,180	30,009	0	0	21,708	239	7,158	141
On SOFP PFI contracts and other service concession arrangements	117,428	0	105,080	0	0	12,348	0	0	0
Owned - donated / granted	972	0	416	0	0	470	0	30	56
NBV total at 31 March 2026	182,835	5,180	135,505	0	0	34,526	239	7,188	197

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 Property, Plant and Equipment

13.2 2024/25

	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 (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 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
Net Book Value at 31 March 2026								
Owned - purchased	64,435	5,180	30,009	0	21,708	239	7,158	141
On SOFP PFI contracts and other service concession arrangements	117,428	0	105,080	0	12,348	0	0	0
Off-SOFP PFI residual interests	0	0	0	0	0	0	0	0
Owned - donated / granted	972	0	416	0	470	0	30	56
	182,835	5,180	135,505	0	34,526	239	7,188	197

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 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
Net Book Value at 31 March 2026								
Commissioner Requested Assets	132,984	5,180	127,804	0	0	0	0	0
Non Commissioner Requested Assets	49,851	0	7,701	0	34,526	239	7,188	197
	182,835	5,180	135,505	0	34,526	239	7,188	197

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 reviewed the valuation of the equipment in 2024/25 to value the equipment in line with the lease cost methodology used in IFRS16.

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	1	15
Tangible		
Buildings excluding dwellings	15	90
Plant & Machinery	2	18
Transport Equipment	7	10
Information Technology	2	10
Furniture & Fittings	2	10
PFI Equipment		18

Land does not depreciate.

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 2026, took account of this clarification.

13.6 Impairment Losses

The Trust carried out an impairment review of its non-current assets in March 2026 . 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 net decrease in value of land and buildings (£15.407m) compared to the carrying value following the March 2026 valuation. In line with IFRS the Trust took the net increase in value of the buildings that had a revaluation reserve balance directly to the revaluation reserve (£0.426m). The remaining decrease in valuation related to Russells Hall Hospital buildings that had no revaluation reserve balance and resulted in an impairment of £15.833m 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.

	31 March 2026 £'000	31 March 2025 £'000
Impairment of Assets		
Unforeseen obsolescence	0	0
Other	15,833	0
Changes in market price	0	2,193
Total impairments charged to operating surplus/deficit	15,833	2,193
Total net impairments charged to the revaluation reserve	0	0
Total Impairments	15,833	2,193

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 £118,000 (2024/25 £7,752,000). The amount relating to property, plant and equipment is £118,000 (2024/25 £7,752,000) and intangible assets £nil (2023/24 £nil).

13.10 Gains/losses on disposal /derecognition of assets

	31 March 2026 £'000	31 March 2025 £'000
Gains on disposal/derecognition of other property, plant and equipment	31	41
Losses on disposal/derecognition of other property, plant and equipment	(2)	(10)
	29	31

14 Other Investments / financial assets

14.1 Investments

	Group	
	2025/26 £'000	2024/25 £'000
Non-Current		
NHS Charitable funds: investments/financial assets	1,727	1,382
Total	1,727	1,382

There are no current investments (2024/25 £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

	2025/26 £'000	2024/25 £'000
Carrying Value at 1 April	1,382	202
Fair value movements taken to OCI (for equity instruments designated as FV through OCI)	144	(20)
Additions	201	1,200
Disposals	0	0
Carrying Value at 31 March	1,727	1,382

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 (2024/25 £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 2026 £'000	31 March 2025 £'000	31 March 2026 £'000	31 March 2025 £'000
Drugs	2,431	2,186	2,209	1,976
Consumables	3,391	2,289	3,391	2,289
Consumables donated from DHSC group bodies	26	26	26	26
Energy	35	30	35	30
Other	248	137	248	137
TOTAL Inventories	**6,131**	**4,668**	**5,909**	**4,458**

The Group expensed inventories during the year of £58,593,000 (2024/25 £52,891,000), of which £53,344,000 (2024/25 £49,278,000) related to the Trust.

The Trust charged £nil to operating expenses in the year due to write-downs of obsolete inventories (2024/25 £nil). This 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 2026**	**31 March 2025**	**31 March 2026**	**31 March 2025**
	£'000	**£'000**	**£'000**	**£'000**
Contract receivables (IFRS15): invoiced	13,630	6,838	13,630	6,838
Contract receivables (IFRS15): not yet invoiced/non-invoiced	8,041	0	8,041	0
Contract assets (IFRS15)	0	0	0	0
Allowance for impaired contract receivables/assets	(961)	(1,107)	(961)	(1,107)
Allowance for impaired other receivables	0	0	0	0
Deposits and Advances	16	10	16	10
Prepayments(revenue) non PFI	6,923	5,205	6,918	5,199
Interest Receivable	103	138	103	138
PDC dividend receivable	0	0	0	0
VAT Receivable	1,935	1,660	1,681	1,506
Corporation and other taxes receivable	0	0	0	0
Clinician pension tax provision reimbursement funding from NHSE	13	29	13	29
Other receivables	0	0	0	0
NHS Charitable funds: receivables	34	71	0	0
TOTAL CURRENT RECEIVABLES	**29,734**	**12,844**	**29,441**	**12,613**

	Group		Foundation Trust	
Non-Current	**31 March 2026**	**31 March 2025**	**31 March 2026**	**31 March 2025**
	£'000	**£'000**	**£'000**	**£'000**
Contract receivables (IFRS15): not yet invoiced/non-invoiced	1,588	1,433	1,588	1,433
Allowance for impaired contract receivables/assets	(391)	(350)	(391)	(350)
Prepayments(revenue) non PFI	1,216	1,303	1,216	1,303
PFI Lifecycle prepayments (revenue)	16,891	16,339	16,891	16,339
Clinician pension tax provision reimbursement funding from NHSE	420	442	420	442
Other Receivables	0	0	0	0
NHS Charitable funds: receivables	0	0	0	0
TOTAL NON-CURRENT RECEIVABLES	**19,724**	**19,167**	**19,724**	**19,167**
Of which receivable from NHS and DHSC group bodies:				
Current	17,430	4,131	17,430	4,131
Non-current	420	442	420	442

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 £12,669,000 (31 March 2025 £5,731,0000) 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 2025	1,457	1,457	0
Changes in the calculation of existing allowances	775	775	0
Reversals of allowances (where receivable is collected in year)	(561)	(561)	0
Utilisation of allowances (where allowance is written off)	(319)	(319)	0
Allowances as at 31 March 2026	1,352	1,352	0
Loss/(gain) recognised in expenditure note 5.	214		

	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
New allowances arising	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		

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 £34,000 (31 March 2025 £71,000) 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 2026 £'000	31 March 2025 £'000	31 March 2026 £'000	31 March 2025 £'000
At 1 April	33,311	22,119	30,611	18,404
Transfers By Absorption	0	1,819	0	1,819
Net change in year	(12,746)	9,373	(12,209)	10,388
At 31 March	20,565	33,311	18,402	30,611
Analysed as follows:				
Cash at commercial banks and in hand	2,163	1,693	1	1
Cash with the Government Banking Service	18,402	31,618	18,401	30,610
Other current investments	0	0	0	0
Cash and cash equivalents as in Statement of Financial Position	**20,565**	**33,311**	**18,402**	**30,611**
Bank overdraft	**0**	**0**	**0**	**0**
Cash and cash equivalents as in Statement of Cash Flows	**20,565**	**33,311**	**18,402**	**30,611**

18 Trade and Other Payables

	Group		Foundation Trust	
	31 March 2026 £'000	31 March 2025 £'000	31 March 2026 £'000	31 March 2025 £'000
Current				
Trade payables	4,915	2,344	4,697	2,344
Capital payables	1,689	5,171	1,689	5,171
Accruals	5,895	4,859	6,204	4,774
Annual leave accrual	0	0	0	0
Vat payable	95	54	95	54
Taxes payable	9,585	8,922	9,497	8,829
PDC dividend payable	0	0	0	0
Pension contributions payable	4,672	4,521	4,672	4,521
Other payables	8,339	13,606	8,339	13,606
NHS Charitable Funds trade and other payables	55	89	0	0
TOTAL CURRENT TRADE & OTHER PAYABLES	35,245	39,566	35,193	39,299
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:	4,922	4,023	4,922	4,023
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 includes superannuation owed to NHS Pensions.

19 Borrowings

	Group and Foundation Trust	
	As at 31 March 2026 £'000	As at 31 March 2025 £'000
Current		
Lease liabilities	3,055	2,510
Obligations under Private Finance Initiative contracts (excl lifecycle)	11,702	10,645
Total Current borrowings	14,757	13,155
Non-Current		
Lease liabilities	13,892	14,910
Obligations under Private Finance Initiative contracts	273,496	275,198
Total Other Non-Current Liabilities	287,388	290,108

A separate schedule for the Trust borrowings has not been produced as neither the NHS Charity or 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 2025	303,263	17,420	285,843
Cash movements:			
Financing cash flows - principle	(13,172)	(2,527)	(10,645)
Financing cash flows - interest	(11,899)	(242)	(11,657)
Non-cash movements:			
Transfers by absorption	0	0	0
Additions	1,566	1566	0
Lease liability remeasurements	519	519	0
Remeasurement of PFI/other service concession resulting from change in index or rate	10,000	0	10,000
Interest charge arising in year	11,899	242	11,657
Early Terminations	(31)	(31)	0
Carrying value 31 March 2026	302,145	16,947	285,198
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:			
Application of IFRS16 measurement principles to PFI liability on 1 April 2023	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	24,473
Interest charge arising in year	11,880	185	11,695
Carrying value 31 March 2025	303,263	17,420	285,843

20 Provisions

	Group and Foundation Trust Current		Group and Foundation Trust Non Current	
	As at 31 March 2026 £'000	As at 31 March 2025 £'000	As at 31 March 2026 £'000	As at 31 March 2025 £'000
Other legal claims	221	196	0	0
2019/20 Clinician's pension tax reimbursement	13	29	420	442
Lease Dilapidations	0	0	125	125
Total	234	225	545	567

	Total £'000	Other legal claims £'000	Clinical pension tax reimbursement £'000	Lease dilapidations £'000
At 1 April 2025	792	196	471	125
Change in discount rate	(33)	0	(33)	0
Arising during the year	196	196	0	0
Utilised during the year	(114)	(101)	(13)	0
Reversed unused	(90)	(70)	(20)	0
Unwinding of discount	28	0	28	0
At 31 March 2026	779	221	433	125
Expected timing of cashflows:				
- not later than one year;	234	221	13	0
- later than one year and not later than five years;	91	0	91	0
- later than five years.	454	0	329	125
TOTAL	779	221	433	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 2026 £227,948,658 (2024/25 £239,109,728) in respect of clinical negligence liabilities for the Trust.

21 Other Liabilities

	Group		Foundation Trust	
	31 March 2026 £'000	31 March 2025 £'000	31 March 2026 £'000	31 March 2025 £'000
Current				
Deferred Income	3,152	2,139	3,152	2,139
TOTAL OTHER CURRENT LIABILITIES	3,152	2,139	3,152	2,139

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 2025/26 (2024/25 £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 2025/26 (2024/25 £nil).

25 Related Party Transactions

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 2025/26 the Trust has had a significant number of material transactions 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	Group Chair
Diane Wake	Group Chief Executive	Sandwell & West Birmingham Hospitals NHS Trust	Group Chief Executive
		Black Country Integrated Care Board (up to 30/11/2025)	CEO Member on Board
Chris Walker	Director of Finance	Dudley Clinical Service Lt	Director
Adam Thomas	Chief Strategy and Digital Officer	Sandwell & West Birmingham NHS Trust and The Dudley Group NHS Foundation Trust	Group Chief Strategy and Digital Officer
		Dudley Clinical Services Ltd	Director for DCSL
Gary Crowe	Non Executive Director	University Hospital of North Midlands NHS Trust (up to 31/08/2025)	Non Executive Director
		The Human Tissue Authority (up to 31/08/2025)	Independent Member
		GAD (as of 01/08/2025)	Non Executive Director
Elizabeth Hughes	Non Executive Director	NHS England (formerly Health Education England)	Medical Director
		Birmingham and Solihull ICB (up to 16/12/2025)	Non Executive Director/ Chair of Quality Committee
		Sandwell & West Birmingham NHS Trust	Research Director
Peter Featherstone	Non Executive Director	Shropshire Community Health NHS Trust (up to 01/11/2025)	Non Executive Director
		Dudley Integrated Health and Care NHS Trust (up to 1/10/2024)	Non Executive Director
Lowell Williams	Non Executive Director	Dudley Clinical Services Ltd	Director
		Transformational Technologies Partnership Ltd (Up to 22/06/2025)	Non Executive Director
Mohit Mandiratta	Non Executive Director	Futureproof Health Ltd	Practice Based Shareholding
		Black Country Healthcare NHS FT - Work well	Chairman
Vijith Randeniya	Vice Chair	Birmingham Women's and Children's Foundation Trust Facilities Management company, Vital Services,	Vice Chairman
		Dudley Clinical Services Ltd	Director
		DEFRA Trent Regional Flood and Coastal Committee	Non Executive Director

	Trust position	Other Body	Position held
Joanne Hanley	Non Executive Director	Derbyshire Healthcare NHS Foundation Trust	Non Executive Director
		Post Office Limited	Non Executive Director
Martina Morris	Chief Nurse, Deputy Group Chief Nursing Officer	National Chief Nursing Officer Strategic Advisory Group	Member
		Care Quality Commission	Executive Reviewer - NHS Trusts
Anne-Maria Newham	Non Executive Director	St Andrews HealthCare	Non Executive Director
		Nuture Care Ltd (up to 31/05/2025)	Chair
Mel Roberts	Group Chief Nurse	Sandwell & West Birmingham Hospitals NHS Trust	Group Chief Nurse
		Your City an Metropolitan Hospital Charity	Group Chief Nurse
Jonathan Odum	Interim Medical Director	Walsall Healthcare NHS Trust & Royal Wolverhampton NHS Trust - (Paused July 2025.)	Walsall Healthcare NHS Trust & Royal Wolverhampton NHS Trust - (Paused July 2025.)
		Nuffield Health	Clinician
		Black Country and Wet Birmingham ICS Clinical Leaders Group	Chair
		The Royal College of Physicians of London	Fellow
James Fleet	Group Chief People Officer	Sandwell & West Birmingham Hospitals NHS Trust	Group Chief People Officer
Catherine Holland	Senior Independent Director	Sandwell & West Birmingham Hospitals NHS Trust	Non Executive Director
		Eponawise Limited	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 £60,000 (2024/25 £57,000). Dudley Clinical Services Limited received income of £6,096,000 (2024/25 £5,692,000) and incurred expenditure of £387,000 (2024/25 £365,000) with the Trust.

Dudley Group NHS Charity and Dudley Clinical Services Limited 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 2026 £'000	As at 31 March 2025 £'000
Gross PFI Liabilities	393,470	401,378
of which liabilities are due		
- not later than one year;	23,407	22,302
- later than one year and not later than five years;	88,695	84,733
- later than five years.	281,368	294,343
Finance charges allocated to future periods	(108,272)	(115,535)
Net PFI liabilities	**285,198**	**285,843**
- not later than one year;	11,702	10,645
- later than one year and not later than five years;	46,808	42,580
- later than five years.	226,688	232,618

Total future commitments for on-SOFP schemes are as follows:

	31 March 2026 £'000	31 March 2025 £'000
- not later than one year;	60,070	57,682
- later than one year and not later than five years;	240,281	230,728
- later than five years.	600,703	639,166
Total	**901,054**	**927,576**

Analysis of amounts payable to the service concession operator:

	31 March 2026 £'000	31 March 2025 £'000
Unitary payment payable to the concession operator	**57,682**	**55,741**
Consisting of:		
- Interest charge	11,657	11,695
- Repayment of finance lease liability	10,645	10,914
- Service element	29,083	28,105
- Capital lifecycle maintenance	5,585	4,275
- Contingent rent Addition to lifecycle	0	0
- Prepayment	712	752
Total amount paid to concession operator	**57,682**	**55,741**
Other amounts paid to the service concession operator but not part of the unitary payment		
Amounts charges to revenue	8,060	5,144
Amounts capitalised	0	0
Total amount paid to the service concession operator	**65,742**	**60,885**

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 2025/26 £'000	Transfer 2024/25 £'000
PPE		
Cost/valuation: Plant & Machinery	0	2
Cost/valuation: Information technology	0	577
Cost/valuation: Furniture and fittings	0	61
Accumulated depreciation: Plant & Machinery	0	(2)
Accumulated depreciation: Information technology	0	(313)
Accumulated depreciation: Furniture and fittings	0	(32)
Net book value of PPE transferring	**0**	**293**
Right of use Assets		
RoU assets - leased from other DHSC group bodies		
Cost/valuation: Property	0	362
Accumulated depreciation: Property	0	(23)
Net book value of RoU assets - leased from other DHSC group bodies	**0**	**339**
RoU assets - leased from Local Authorities		
Cost/valuation: Property	0	362
Accumulated depreciation: Property	0	(23)
Net book value of RoU assets - leased from other Local Authorities	**0**	**339**
RoU assets - leased from bodies external to Government		
Cost/valuation: Property	0	46
Accumulated depreciation: Property	0	(4)
Net book value of RoU assets - leased from bodies external to Government	**0**	**42**
Total net book value of RoU assets transferring	**0**	**446**
Receivables		
Current: all other receivables	0	802
Total receivables transferring	**0**	**802**
Cash and cash equivalents	**0**	**1,819**
Trade and other payables		
Current: Annual leave accrual	0	(92)
Current: All other trade and other payables	0	(497)
Total trade and other payables transferring	**0**	**(589)**
Other liabilities		
Current: Other liabilities	0	(207)
Total other liabilities transferring	**0**	**(207)**
Borrowings		
Non-current: Lease liabilities with bodies external to government	0	(49)
Current: Lease liabilities with bodies external to government	0	(12)
Total borrowings transferring	**0**	**(61)**
Net gain/(loss) on absorption transfers	**0**	**2,503**
Revaluation reserve		
Revaluation reserve: RoU assets - leased from other DHSC group bodies	0	6
Revaluation reserve: RoU assets - leased from Local Authorities	0	2
Revaluation reserve: RoU assets - leased from ext to Gov bodies	0	2
Total revaluation reserve reinstated/eliminated	**0**	**10**

	Group Including Transfer	Group Excluding Transfer	Group Including Transfer	Group Excluding Transfer
	31 March 2026	31 March 2026	31 March 2025	31 March 2025
	£'000	£'000	£'000	£'000
Operating Income from patient care activities	0	0	588,787	588,787
Other Operating Income	0	0	33,685	33,685
Total Operating Income from continuing operations	**0**	**0**	**622,472**	**622,472**
Operating Expenses from continuing operations	0	0	(604,444)	(604,444)
Operating Surplus / (Deficit)	**0**	**0**	**18,028**	**18,028**
Finance Costs				
Finance income	0	0	1,473	1,473
Finance expense - financial liabilities	0	0	(36,353)	(36,353)
Net Finance Costs	**0**	**0**	**(34,880)**	**(34,880)**
Gain/(loss) of disposal of assets	0	0	31	31
Gains/(losses) from transfers by absorption	0	0	2,503	0
Corporation tax expense	0	0	(91)	(91)
Surplus/(Deficit) for the year from continuing operations	**0**	**0**	**(14,409)**	**(16,912)**
SURPLUS/(DEFICIT) FOR THE YEAR	**0**	**0**	**(14,409)**	**(16,912)**

28 Prior Period Adjustment

The Trust has included a prior period adjustment in the financial statements relating to an Income Accrual in our Charity Accounts. In 2024/25 the trust had made an accrual in regards to an outstanding invoice raised by the trust to be paid. This accrual was prior to Charity Accounts completion and Charity Accounts audit. During the audit of Charity Accounts it was recommended the £54,000 accrual to be reversed from the Charity Accounts. This note therefore discloses the prior period adjustment of £54,000.

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 2026 are in receivables from customers, as disclosed in note 16 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.

29.7 Financial Assets and Liabilities By Category

The following tables show by category the financial assets and financial liabilities at 31 March 2026. 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 2026					
Receivables (excluding non-financial assets) with NHS and DH bodies	17,379	17,379	0	17,345	17,345
Receivables (excluding non-financial assets) with other bodies	4,665	4,665	0	4,665	4,665
Other investments and Financial Assets	0	0	0	0	0
Cash and cash equivalents	20,565	20,565	0	18,402	18,402
Consolidated NHS Charitable fund financial assets	1,727	0	1,727	0	0
	44,336	42,609	1,727	40,412	40,412

	Group		Foundation Trust	
	Total £'000	Valued at amortised cost £'000	Total £'000	Valued at amortised cost £'000
Financial Liabilities as at 31 March 2026				
Obligations under leases	16,947	16,947	16,947	16,947
Obligations under Private Finance Initiative contracts	285,198	285,198	285,198	285,198
Trade and other payables (excluding non-financial liabilities) with NHS and DH bodies	4,922	4,922	4,922	4,922
Trade and other payables (excluding non-financial liabilities) with other bodies	15,971	15,971	16,007	16,007
IAS 37 provisions which are financial liabilities	779	779	779	779
	323,817	**323,817**	**323,853**	**323,853**

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 and Financial Assets	1,382		1,382	0	0
	41,556	40,174	1,382	37,403	37,403

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 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
IAS 37 provisions which are financial liabilities	792	792	792	792
	330,070	**330,070**	**329,822**	**329,822**

Note 30 Maturity of Financial Liabilities

	Group		Foundation Trust	
	As at 31 March 2026 £'000	As at 31 March 2025 £'000	As at 31 March 2026 £'000	As at 31 March 2025 £'000
In One Year or Less	47,777	51,211	47,855	51,211
In more than one year but not more than five years	100,391	95,312	100,391	95,312
In more than five years	284,406	299,605	284,406	299,605
Total	432,574	446,128	432,652	446,128

31 Third Party Assets (Group and Foundation Trust

The Trust held £7,000 as cash at bank or in hand at 31 March 2026 (31 March 2025 £4,000) 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 37.

32 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.

	2025/26		2024/25	
	Number	Value £000	Number	Value £000
Loss of Cash	1	0	3	8
Bad debts and claims abandoned	9	300	29	23
Stores losses	12	174	7	304
Total Losses	**22**	**474**	**39**	**335**
Ex gratia payments	32	17	42	73
Special severance payments	0	0	0	0
Total Special Payments	32	17	42	73
Total Losses and Special Payments	**54**	**491**	**81**	**408**

There were no (2024/25 £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

33 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 £2,000, in respect of liability to pay damages for losses arising as a direct result of breach of contract, tort, breach of statatory duty or negligence in respect of services provided in connection with or arising from their engagement start date 1st April 2025.

The Dudley Group NHS Foundation Trust

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Find out more

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