NHS

The Dudley Group

NHS Foundation Trust

Quality Account 2023/24








The Dudley Group NHS Foundation Trust
Quality Account 2023/24

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Foreward

All providers of NHS services in England have a statutory duty to produce an annual report to the public about the quality of services they deliver. This is called the Quality Account and includes the requirements of the NHS (Quality Accounts) Regulations 2010 as amended by the NHS (Quality Accounts) Amendments Regulations 2011 and the NHS (Quality Accounts) Amendments Regulations 2012.

The Quality Account (and hence this report) aims to increase public accountability and drive quality improvement within NHS organisations. They do this by ensuring organisations review their performance over the previous year, identify areas for improvement and publish that information, along with a commitment to the public about how those improvements will be made and monitored over the next year.

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

- How safe the care is (patient safety)
- How well the care provided works (clinical effectiveness)
- How patients experience the care they receive (patient experience)

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

Scope and structure of the Quality Report

This report summarises how well The Dudley Group NHS Foundation Trust ('the Trust') did against the quality priorities and goals we set ourselves for 2023/24. It also sets out the Quality Priorities we have agreed for 2024/25 and how we intend to achieve them.

This report is divided into the following four parts:

- Part 1 is a statement from the chief executive.
- Part 2 sets out the quality priorities and goals for 2024/25 and explains how we decided on them, how we intend to meet them and how we will track our progress.
- Part 3 includes statements of assurance relating to the quality of services and describes how we review them, including information and data quality. It includes a description of audits we have undertaken and our research work.
- Part 4 includes performance against national priorities for 2023/24.
- The annexes at the end of the report include the comments of our external stakeholders alongside a glossary of terms used

Part 1 – Introduction

1.1 Chief Executive Statement

Welcome to The Dudley Group NHS Foundation Trust's Quality Account for 2023/24.
I am proud to introduce and share this report that will take you through the key areas of quality that we monitor across our services; highlighting areas of good practice in the quality of services we provide, and areas where there are opportunities for improvement.
2023/24 has been quite the year for The Dudley Group. We continue to recover as quickly and safely as we can from the COVID-19 pandemic and embed quality improvement into our daily practice, whilst adapting to the 'new normal' for the NHS.

Industrial action has impacted on our ability to fully restore planned service but, through collaboration with our partners across the Black Country, I am pleased that we have ensured access to services continues and waiting times remain as low as possible.

In our Emergency Department we continue to deal with a high number of emergency patients, whilst across The Trust we continue to improve our performance for those waiting for planned care. We are proud that The Dudley Group has provided good service to our patients and achieved all the national indicators to reduce long waiters, and we have been able to support partners across the Black Country.

In partnership with the Black Country Provider Collaborative, we have worked hard to review any inequity of access and quality of clinical care in certain pathways and this work will progress in the coming months and years to ensure all patients across our area get the very best services possible.

Our core vision is to provide excellent healthcare and improved health for all through the services we provide, which has been supported over the last year through innovation and the development of our services. These include:

- The launch of the UK's first Complex Nutrition Virtual Ward program, based at Russells Hall Hospital supporting the earlier discharge of patients with known nutritional difficulties.
- Maternity unit and services for children and young people were both inspected by The Care Quality Commission (CQC) with both areas moving from a rating of 'requires improvement' to 'good,' an achievement which is down to the commitment and determination of our staff.
- Participating in the UK's first long distance proctoring surgical procedure which was carried out at Russells Hall Hospital by two consultants who were 170 miles apart.
- New dispensing robots were unveiled in the pharmacy department at Russells Hall Hospital.
- We joined a small number of NHS trusts nationally to have a new state-of-the-art robotic arm in place, which is transforming knee and hip replacement surgeries.

2024 will see the Trust continue to revolutionise care. With our patients and local population at the heart of our work, we will continue to do everything possible to maximise the number of patients that we can safely treat and ensure that patients on our waiting lists are regularly risk assessed and seen according to clinical priority.

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

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

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

We are incredibly proud of all we have achieved this year and I want to end by expressing my sincere thanks to colleagues across every department at The Dudley Group.

The commitment and resilience shown by colleagues drives our priorities and is key to the Trust successfully delivering the very best quality care for our patients whilst being a brilliant place to work and thrive. They should feel proud of their accomplishments as we look forward to the year ahead.

We know there is still a lot of work to do, and we remain fully committed to providing high quality, safe care for all patients and learn from our mistakes if we fall short of these standards. We will continue to drive improvement and to nurture a culture of excellence throughout the organisation.

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

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

1.2 Our vision and values

Our vision

Excellent health care, improved health for all

Our new vision is designed to be simple and memorable. It combines our desire to deliver excellent care for our patients but also recognises the impact that we have on the health of the wider population.

Our values

Our values support our vision and define how the Trust and every member of staff will work to deliver the best care possible. The current values were adopted by the Trust in 2015.

Staff told us that these values helped them during the COVID pandemic, providing a framework for them and what they expected from others.

The values are embedded into our local processes. They form part of the recruitment process and are included in annual appraisals, and this helps to keep them live and relevant.

We, therefore, believe that these values will still be relevant to us as we look ahead over the coming three years.

CARE – we provide safe, quality healthcare for every person – every time

RESPECT – we show respect for our patients, our visitors and each other – at all times

RESPONSIBILITY – we take responsibility for everything we do – every day

Our goals

We have identified five goals, the pursuit of which will guide all that we will do.

Deliver right care every time – our desire to deliver care that is safe and effective. Where mistakes are made, we will learn from these and improve for the future.

To be a brilliant place to work and thrive – we want to be recognised by our staff as the best place to work and to offer them opportunities to grow and develop regardless of who they are.

Drive sustainability – includes financial sustainability in the way in which we use resources and become more productive. Environmental sustainability. Environmental sustainability recognises the responsibility we have in reducing the harmful impact our activities have on the environment.

Build innovative partnerships in Dudley & beyond – includes partnering with other acute trusts in the Black Country, health and social care organisations, the voluntary sector in Dudley, local academic institutions and others who can help us achieve our goals.

Improve health and well-being and reduce inequalities – prioritising investment in areas which are likely to have the biggest impact on health outcomes and reducing health inequalities.

Part 2 – Priorities For Improvement

2.1 Quality improvement priorities

Utilising internal intelligence, in consultation with internal and external key stakeholders and service user groups, the Trust commits to our quality priorities which are our focus for the upcoming financial year.

Agreed key performance indicators related to the quality priorities are monitored on a continuous basis through the Trust's Quality Committee who provide oversight and receive assurance of the clinical care provided.

2.1.1 Looking Back

The table below provides a summary of the 2023/24 quality priorities as at the end of the year. This year has continued to be challenging with demand for acute services and continuing to reduce treatment time waits for our patients.

It is noted there have been some improvement against the 2023/2024 and more details are provided within this Quality Account.

PRIORITY 1 Using patient feedback to drive improvements (inpatient survey results)	
Quality Priority	**Progress against Target**
a) Leaving hospital - communication around discharge target = 71%, current baseline = 23%	During 2023/24 there were 469 patients who completed a real-time inpatient survey. 59% of patients stated 'yes' when asked if they were spoken to about a plan to get them well enough to go home. 57% of patients stated that they were informed of their expected date of discharge. Target not achieved. **Actions:** Home for Lunch remains the primary discharge programme across the Trust and the focus. Clinical Discharge Facilitators (Band 6) have been introduced into the Discharge Team to help with improving the management of complex discharge patients and supporting the admin teams with increased clinical input. Retraining of clinical staff undertaken to ensure discharge checklists are completed routinely with patients as early in the patient journey as possible. Literature is now readily available at all points in the patient journey describing discharge pathways appropriate to the clinical areas. Introduction of Senior staff members to being available at set times daily to answer questions and find out the desired information. Progress is monitored through updates on progress against the workstreams at the Patient Experience Group meeting for assurance of recommendations having been completed and improvements made. In

	addition the documentation audit scores will focus on the discharge checklist completion and repeat real-time survey
b) Improve complaint closure within 30 days to 50% by April 2023 baseline 40.5%	In Q3, 265 complaints were closed with 107 (40.3%) being closed within 30 working days. This is a response rate of 40.3% which is a decrease from Q2, 2023/24 (44.7%) of 4.4%. For Q4, there were 247 complaints closed and of those 247 complaints, 117 (47.4%) were closed within 30 working days. This is an increase of 7.1% from Q3. For the year of 2023/24, there were 1059 complaints closed with 457 closed within 30 working days and a response rate of 43.2%. This is 6.8% short of the target of 50% this indicates that the service is currently not on track and the below actions are being taken to improve this. **Complaints actions:** There is a new formal process in place which includes clear escalation. Accessible online complaints training for staff was launched on 3 June 2024 and is accessible via the complaints intranet hub page for all staff. An online training module allows better accessibility to these training sessions which are already held face to face/over MS Teams. There will be access to training on how to navigate the complaints module in DATIX. Target partially achieved 43.2% target 50%
c) Reduce outstanding backlog by 70% by April 2023 baseline 39%	At the end of Q3, there were 137 total open complaints including reopened complaints and Ombudsman cases. There were 106 open complaints excluding reopened complaints and excluding Ombudsman cases. The backlog excluding reopened complaints and excluding Ombudsman cases was 43. For the end of Q4, there were 145 total open complaints including reopened complaints and Ombudsman cases. There were 101 open complaints excluding reopened complaints and excluding Ombudsman cases. The backlog excluding reopened complaints and excluding Ombudsman cases is 26 (25.7%). Target achieved 74.3% target 70%

Priority 2 for 2022/23: Treating patients in the right place, at the right time PRIORITY 2 Treating patients in the right place, at the right time	
Quality Priority	**Progress against Target**
a) Every inpatient ward will identify one to two patients every day (seven days per week) as part of 'Home for Lunch' initiative.	The Trust has not met the 30% KPI for all inpatient discharges to be achieved before lunch consistently Monday to Sunday. However, it is noted there has been significant improvement in the number of in-patients discharged before 12.00 o'clock, especially Mondays and Weekends. From November'2023, the Trust opened additional capacity beds with the purpose to free acute capacity in response to the demand required by our emergency attendances. The Trust proactively transferred any patients that could go home for lunch and any predicted for discharges for the following day where possible into the discharge lounge. Processes have been strengthened

	to support early opportunities for discharge combined with proactive patient care planning and treatment. The Home for Lunch team has provided focused support for the Surgical Division which achieved statistically significant improvement in early discharges, decreased length of stay and overall discharge performance Monday to Sunday across all specialties. Despite the improvement the overall target was not achieved. **Medicine Division** % Home For Lunch Against All Ward Discharges (including those through Discharge Lounge) 	Year	2023												2024		
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Ward	January	February	March	April	May	June	July	August	September	October	November	December	January	February	March
AMU A4	21	14	22	15	12	18	20	27	6	21	18	14	2	15	14
AMU Assessment	10	20	15	22	18	21	16	15	24	15	16	18	15	8	7
AMU1	4	9	8	9	6	18	10	13	18	10	12	14	9	12	7
AMU2	11	16	22	20	16	22	18	15	13	14	13	10	10	7	12
B6 FRAILTY SHORT STAY WARD	22	28	38	37	35	24	25	22	39	26	25	26	28	30	24
CCU	3	12	14	5	9	18	6	6	6	11	8	12	8	7	0
East C1A	33	28	33	21	30	29	32	36	33	22	25	24	25	16	26
EAST C1B	32	27	20	17	26	33	18	23	12	22	18	16	9	25	25
East C3	45	27	30	43	46	37	43	46	28	34	41	28	28	31	50
FMNU	27	33	22	24	18	37	16	37	3	6	19	13	26	34	28
Medical Enhanced Care Unit (MECU)	0	40	0	14	16	14	0	0	0	0	0	6	20	10	7
POST CCU	6	10	6	18	15	13	18	4	4	10	2	7	10	8	10
West C4 - Georgina Unit	16	20	23	10	16	19	9	17	16	12	23	20	15	15	23
West C5A	15	9	29	10	17	20	20	16	11	19	14	13	13	19	10
WEST C5B	9	12	16	10	17	24	24	27	24	21	11	19	11	22	10
West C7	25	26	24	29	22	25	26	26	17	34	18	16	22	24	23
WEST C8 - ASU	14	21	25	33	21	27	23	30	12	13	29	17	38	14	28
West C8 - HASU	20	13	11	20	2	11	9	23	11	9	23	4	11	5	6
WEST C8 - STROKE REHAB	8	25	20	25	24	24	20	25	16	17	18	19	22	13	14 | **Surgical Division** % Home For Lunch Against All Ward Discharges (including those through Discharge Lounge) | Year	2023												2024		
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Ward	January	February	March	April	May	June	July	August	September	October	November	December	January	February	March
East B1	12	14	13	13	13	15	14	10	18	12	17	15	18	14	17
EAST B2 - HIP # SUITE - ST3	13	25	15	20	25	18	45	43	26	42	17	7	16	20	23
EAST B2 - HIP # SUITE - ST4	0	46	30	9	46	20	37	26	15	15	23	17	20	30	28
EAST B2 - TRAUMA - ST2	16	20	26	21	25	22	18	20	25	6	33	30	25	30	21
EAST B2 - TRAUMA - ST1	13	20	11	20	24	21	27	21	33	14	29	25	23	22	30
East B3	16	15	17	15	20	25	19	14	26	12	17	17	18	21	14
EMERGENCY SURGERY HUB AREA 2	15	18	16	12	15	18	10	8	8	11	10	26	18	21	23
EMERGENCY SURGERY HUB AREA 3	11	12	16	13	8	10	14	13	14	16	13	18	15	17	3
West B4A	20	12	17	16	15	20	21	18	23	28	23	24	13	16	23
WEST B4B	16	23	17	8	15	17	17	25	13	29	26	30	23	35	23
West C6	9	16	8	15	21	18	12	13	15	10	12	11	9	6	11	 Target not achieved.
b) Improved use of the discharge lounge, both seated and bedded areas, for all definite discharges target average 30 patients per day	The Discharge lounge has been utilised as an inpatient area from October 2023 – April 2024 to support winter pressures. The key focus now will be to work closely with the Discharge team and to liaise with the site team to ensure patients admitted to the lounge are medically optimised for discharge to de-escalate and return to a fully operational discharge lounge 7 days per week. The main aim is to have 30 patients discharged via the lounge per day when patients are no longer bedded in this area. Prior to the lounge being bedded 25 patients on average were discharged via the lounge across Medicine and Surgery. Target not achieved – Discharge opened to additional capacity since October 2023.

c) All discharge communication with patients, carers and families and third parties are initiated on admission	Admissions document is completed, and patients assigned discharge pathways within 24 hours of admission, indicating what additional support if any maybe required to aid timely discharge. This has now gone live and monitored via Discharge Dashboard and the Complex Discharge Team. Target achieved

PRIORITY 3 Reducing avoidable harm	
Quality Priority	**Progress against Target**
a) The backlog of pressure ulcers has made significant improvements; however, there remains 20 incidents that require review by the scrutiny group.	Target achieved for whole year 2022/23 and there has been no backlog of pressure ulcer incidents that required review. Target achieved.
b) Clear outstanding incident backlog for category 3 and 4 pressure ulcers up until March 2024	Target achieved for whole year 2022/23 and there has been no backlog of pressure ulcer category 3, 4 and unstageable. Target achieved.
c) Develop systems to promote timely investigation and validation of pressure ulcers recorded via the DATIX system.	This year has seen a review of the process to maintain timely oversight of pressure ulcers with weekly pressure ulcer groups to determine if harm has occurred. At the time of this report incidents relating to category 3, 4 and unstageable pressure ulcers undergo a review within 10 days of reporting. Target achieved.
d) Identify and report pressure ulcers earlier in patient pathway anticipating an increase in reported category 1 and 2s correlating to reduction of reported category 3 and 4s.	There has been a rise in category 2 reported incidents. This is indicative that pressure ulcers are potentially being reported earlier in the patient pathway. It is recognised there may be other reasons for this reporting of higher numbers of category 2 pressure ulcers. Target achieved.

2.1.2 Looking Forward

2023/2024 has seen unprecedented demand for emergency services coupled with delayed transfers of care creating a bottle neck within acute services. Despite the challenges facing the Trust, the Trust is committed to driving forward improvements that enhance our patient care and their experience whilst in our care at The Dudley Group of Hospitals NHS Foundation Trust.

Priority 1 Management of diabetes across all service within DGFT
Why we chosen this (rationale)
A monthly cross-divisional Insulin Safety Group has been established to support insulin safety across the Trust, review incidents and provide a monthly and bi-annual thematic review. The Trust noted the high number of incidents but there is no single repository that shows categories of harm at a glance. Availability of hybrid closed loop systems for managing blood glucose levels is insufficient to meet demand as recommended by NICE 2023.
Where do we want to be ?
➢ Development of a power BI report that categorises harm with data collected from Datix. ➢ Shared learning across the organisation with a focus in areas of high numbers of incidents. ➢ Development of a dashboard that captures those patients that a digital solution to the management of their diabetes.
Responsible person/team
Endocrinology Consultant

Priority 2. Improve patient outcomes admitted with a fractured neck of femur
Why have we chose this (rationale)?
The current SHMI for fractured neck of femur is 133. This places the Trust within the top 10 Trusts for poor mortality of this condition.
Where do we want to be ?
➢ The aim is that the trust will be back within the expected range of 100 within 12 months and maintaining this. ➢ Improvement group has been set up to include members of MDT. ➢ The group will use the KPI's set out by the National Hip Fracture database to identify areas where improvement could be made as well as data provided by Informatics. ➢ Early priority area to ensure that admission to a specialised ward/unit within an appropriate time is critical as per national standards. ➢ Reduction of theatre delays.
Responsible person/team
Clinical Director

Priority 3 Improve outcomes for our patients admitted with cerebral vascular accident.

Why have we chosen this (rationale)?

Stroke SHMI is elevated at 135 and there is evidence of reduced Sentinel Stroke National Audit programme (SSNAP) data for recent periods. We have identified lack of access to specialist stroke beds and delays in CT head acquisition.

The latest data shows that we have always achieved SSNAP level C with prioritisation of a thrombolysis bed and rapid vetting of CT head requests has been facilitated. There is still a challenge with swallowing assessments being completed on time, which is being reviewed by the senior AHP team.

Where do we want to be?

- The key ambition is to reach a SSNAP score of 70 (Level B) by Q3.
- Review and implement new stroke guidelines published April 23. Will require us to provide additional therapy input for all stroke patients.
- AI technology will automatically report CT head within minutes of image acquisition to enable early decision for thrombolysis. It will also enable rapid image transfer between secondary and tertiary sites, improving access to mechanical thrombectomy, as well as thrombolysis, for stroke.

Responsible person/team

Clinical Director

Priority 4 to improve our patient survey results in four key areas as identified as main themes from 2022 results received by the Trust October 2023

Why have we chosen this (rationale)?

The Overall Patient Experience Score (OPES) ranged from the lowest score in England of 7.4 to the highest trust score in England of 9.1. The Trust score for 2022 is 7.8 in comparison to 8.0 in 2021 and is performing 'about the same' when compared to all other trusts. The Trust is in the bottom 5 of trusts with the lowest score in comparison to other trusts within the region.

A small number of questions within each section are performing 'somewhat worse than expected/worse than expected' in comparison to the average of Trusts surveyed and these include pain management and hydration & nutrition.

Where do we want to be?

The patient survey results highlight four key themes as detailed below with communication running through each of the themes. The Chief Nurse has agreed Responsible Senior Officer (RSO) to support each work stream.
To improve our patient experience results in the following areas.

- Pain –Divisional Chief Nurse in Surgery
- Nutrition and hydration –Chief AHP
- Discharge –Divisional Chief Nurse in Medicine

Data will be captured each month through our volunteers and audits within AMaT, to monitor improvements and inform interventions. This will allow for triangulation of data with our RSO ensuring the voice of our patients is reflected in future developments.

The RSOs will report through patient experience on progress.

- The aim is to improve our overall scores through providing a better patient experience.

Responsible person/team

Deputy Chief Nurse

Priority 5 Improve care delivered to our patients who have Dementia or Delirium

Why have we chosen this (rationale)

The Dementia and Delirium Team (Formerly Older People's Mental Health Team) are the first point of call for patients with complex vulnerabilities, such as Dementia, Delirium, Korsakoff's and behaviours that challenge and require restrictive interventions, to offer support and advice.

Our Dementia data against find, refer and treat has been inconsistent and below agreed compliance.

Chemical restraint requires further education improving accuracy of data within DATIX.

To understand the high readmission rates for those patients with delirium.

Where do we want to be?

Appoint two Admiral Nurses to support the Delirium agenda.
Monitor DATIX for high numbers of chemical restraint being used to provide focused training and education.
To review high readmission rates and understand the reason for readmission and provide learning for any readmissions for failed discharges.

- Aim to reduce readmissions.
- Evidence of training and education provided to areas with high usage of chemical constraint.
- Reduction of DATIX incidents in Q4 once Admiral Nurses embedded.

Responsible person/team

Deputy Chief Nurse

Priority 6 To improve the service we provide to those patients with learning disabilities

Why have we chosen this (rationale)?

The NHS learning disability standards benchmarking exercise has identified gaps in the current Trust wide provision offered to people with a learning disability.

Where do we want to be?
➢ Compliance of 90% for Oliver McGowan training. ➢ Develop champions in every area to support learning disability agenda. ➢ Embedded learning disability steering group with divisional representation. ➢ Scope and establish mobile resources 'bag of calms' that can be made available for those patients that require them. The Learning Disability Standards action plan will be monitored through Internal Safeguarding Board (ISB) and report into Patient Experience committee.
Responsible person/team
Deputy Chief Nurse

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

The Dudley Group's Russells Hall Hospital site.

Part 3: Statements of Assurance

3.1 Review of services

During 2023/24, The Dudley Group NHSFT provided 59 hospital and community NHS relevant health services. A detailed list is available in the Trust's 'Statement of Purpose' available on our website CQC Registration - Aims and Objectives (dgft.nhs.uk) .

The Dudley Group NHS Foundation Trust has reviewed all the data available on the quality of care in all its services through its permanence management framework and its assurance and governance processes.

The income generated by the relevant health services reviewed in 2023/24 represents 99.6% of the total income generated from the provision of relevant health services in The Dudley Group NHS Foundation Trust.

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

During 2023/24, 46 national clinical audits and 5 national confidential enquiries covered relevant health services that the Trust provides.

During that period, the Trust participated in 97 per cent of the national clinical audits and 100 per cent of the national confidential enquiries of which we were eligible to participate in.

There was one national audit the Trust did not participate in as this was co-ordinated at ICB level during 23/24.

- Fracture Liaison Service Database (FLS-DB)

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

- The national clinical audits and national confidential enquiries that The Dudley Group NHS Foundation Trust was eligible to participate in, and for which data collection was completed during 2023/24.

- The national clinical audits and national confidential enquires that The Dudley Group of Hospitals NHS Foundation Trust participated in, and for which data collection was completed during 2023/24. To include the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of the audit or enquiry.

Table 1

National programme name	Work stream / Topic name	Participation	Data Collection completed	No. and % of cases / questionnaires submitted against number required	Time Period Submitted
BAUS Nephrostomy Audit	N/A	Yes	Yes	100%	Oct to Nov 2023
Breast and Cosmetic Implant Registry	N/A	Yes	Yes	40 (100%)	2017 -2023
British Hernia Society Registry	N/A			Not Applicable to Trust	
Case Mix Programme (CMP)	N/A	Yes	Yes	660 1(00%)	April 2023 to March 2024
Cleft Registry and Audit NEtwork (CRANE) Database	N/A			Not applicable to Trust – procedure not carried out	
Emergency Medicine QIPs	Infection Control	Yes	Yes	318	Oct 22 to Oct 23
Emergency Medicine QIPs	Mental Health	Yes	Yes	318	Mar 23 – Sept 23
Emergency Medicine QIPs	Older People	Yes	Yes	105	April 23 to Sept 23
Epilepsy 12 - National Audit of Seizures and Epilepsies for Children and Young People	Epilepsy12 has separate workstreams/data collection for: Clinical Audit, Organisational Audit	Yes	Yes	Organisation audit - submitted 118 patients	April 2023 to March 2024
Falls and Fragility Fracture Audit Programme (FFFAP)	Fracture Liaison Service Database (FLS-DB)	No	No	No service currently. This is being coordinated at an ICB level during 2024.	N/A

National programme name	Work stream / Topic name	Participation	Data Collection completed	No. and % of cases / questionnaires submitted against number required	Time Period Submitted
Falls and Fragility Fracture Audit Programme (FFFAP)	National Audit of Inpatient Falls	Yes	Yes	7	April 2023 to March 2024
Falls and Fragility Fracture Audit Programme (FFFAP)	National Hip Fracture Database	Yes	Yes	501	Apr 23 to Feb 24
Gastro-intestinal Cancer Audit Programme (GICAP)	National Bowel Cancer Audit	Yes	Yes	63 (100%)	21/22 data in 2023 annual report
Gastro-intestinal Cancer Audit Programme (GICAP)	National Oesophago-Gastric Cancer Audit (NOGCA)	Yes	Yes	75 (100%)	21/22 data in 2023 annual report
Inflammatory Bowel Disease Audit	N/A	Yes	Yes	1526	April 2023 to March 2024
LeDeR - learning from lives and deaths of people with a learning disability and autistic people	Mortality Surveillance	Yes	Yes	14 deaths	April 2023 to March 2024
Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRACE)	Maternal mortality surveillance and confidential enquiry (confidential	Yes	Yes	28	April 2023 to March 2024

National programme name	Work stream / Topic name	Participation	Data Collection completed	No. and % of cases / questionnaires submitted against number required	Time Period Submitted
	enquiry includes morbidity data)				
Mental Health Clinical Outcome Review Programme1				Not applicable to Trust – Mental Health Trusts	
National Adult Diabetes Audit (NDA)	National Diabetes Core Audit1			Not applicable to Trust – Primary Care	
National Adult Diabetes Audit (NDA)	National Diabetes Foot Care Audit	Yes	Yes	100%	April 2023 to March 2024
National Adult Diabetes Audit (NDA)	National Diabetes in Pregnancy Audit	Yes	Yes	42 100%	1st January 2023 to 31st December 2023
National Adult Diabetes Audit (NDA)	National Diabetes Inpatient Safety Audit (NDISA)	Yes	Yes	8 100%	April 2023 to March 2024
National Asthma and COPD Audit Programme (NACAP)	Adult Asthma Secondary Care	Yes	Yes	80 (100%)	April 2023 to March 2024
National Asthma and COPD Audit Programme (NACAP)	Chronic Obstructive Pulmonary Disease Secondary Care	Yes	Yes	336 (100%)	April 2023 to March 2024
National Asthma and COPD Audit Programme (NACAP)	Paediatric Asthma Secondary Care	Yes	Yes	72 (100%)	April 2023 to March 2024
National Asthma and COPD Audit Programme (NACAP)	Pulmonary Rehabilitation Organisational and Clinical Audit	Yes	Yes	229 (100%)	April 2023 to March 2024

National programme name	Work stream / Topic name	Participation	Data Collection completed	No. and % of cases / questionnaires submitted against number required	Time Period Submitted
National Audit of Care at the End of Life (NACEL)	N/A	Yes	Yes	Organisational audit submitted · Case Note Review – 50 submitted · Quality Survey – 33 responses received · Staff Reported Measures – 97 responses received	April 2023
National Audit of Dementia	Care in general hospitals	Yes	Yes	Cases submitted 80 out of 80	April 2023 to March 2024
National Bariatric Surgery Registry				Not applicable to Trust – procedure not carried out	
National Cardiac Arrest Audit (NCAA)	N/A	Yes	Yes	71 (100%)	Jan to Dec 2023
National Cardiac Audit Programme (NCAP)	National Congenital Heart - Disease Audit (NCHDA)			Not applicable to Trust – procedure not carried out	
National Cardiac Audit Programme (NCAP)	The UK Transcatheter Aortic Valve Implantation (TAVI)			Not applicable to Trust – procedure not carried out	
National Cardiac Audit Programme (NCAP)	Myocardial Ischaemia National Audit Project (MINAP)	Yes	Yes	218	April 2023 to March 2024
National Cardiac Audit Programme (NCAP)	National Audit of Cardiac Rehabilitation	Yes	Yes	Unable to determine numbers	April 2023 to March 2024
National Cardiac Audit	National Audit of Cardiac Rhythm	Yes	Yes	Devices/Implants 395/399 = 99%	April 2023 to March 2024

National programme name	Work stream / Topic name	Participation	Data Collection completed	No. and % of cases / questionnaires submitted against number required	Time Period Submitted
Programme (NCAP)	Management (CRM)			Ablation 1/1/ =100%	
National Cardiac Audit Programme (NCAP)	National Audit of Cardiovascular Disease Prevention in Primary Care (CVD Prevent)			Not applicable to Trust – Primary Care	
National Cardiac Audit Programme (NCAP)	National Audit of Mitral Valve Leaflet Repairs (MVLR)			Not applicable to Trust – procedure not carried out	
National Cardiac Audit Programme (NCAP)	National Audit of Percutaneous Coronary Intervention (NAPCI)			Not applicable to Trust – procedure not carried out	
National Cardiac Audit Programme (NCAP)	National Heart Failure Audit	Yes	Yes	699	April 2023 to March 2024
National Child Mortality Database (NCMD)	N/A	Yes	Yes	100%	April 2023 to March 2024
National Clinical Audit of Psychosis (NCAP)				Not applicable to Trust – Mental Health Trusts only	
National Comparative Audit of Blood Transfusion	2023 Bedside Transfusion Audit	Yes	Yes	Audit only started in late March 2024 – not completed yet	Delayed start nationally
National Comparative Audit of Blood Transfusion:	Audit of Blood Transfusion against NICE Quality Standard 138	Yes	Yes	40 (100%)	April 2023

National programme name	Work stream / Topic name	Participation	Data Collection completed	No. and % of cases / questionnaires submitted against number required	Time Period Submitted
National Early Inflammatory Arthritis Audit	N/A	Yes	Yes	41	April 2023 to March 2024
National Emergency Laparotomy Audit (NELA)	N/A	Yes	Yes	142	April to Dec 2023
National Joint Registry	10 workstreams that all report within Annual report: Primary replacement and revision of replacement for • hip • knee • shoulder • elbow • ankle	Yes	Yes	662 (100%)	April 2023 to March 2024 (per NJRcentre website)
National Lung Cancer Audit	N/A	Yes	Yes	179	21/22 data in 2023 annual report
National Maternity and Perinatal Audit (NMPA)	N/A	Yes	Yes	3618	Jan to Dec 2023
National Neonatal Audit Programme (NNAP)	N/A	Yes	Yes	100% cases	Cases automatically gathered from the Badger system
National Ophthalmology Database Audit (NOD)	Adult Cataract Surgery Audit	Yes	Yes	581 (86%)	Jan to Dec 2023
National Paediatric Diabetes Audit	N/A	Yes	Yes	210	April 2023 to March 2024

National programme name	Work stream / Topic name	Participation	Data Collection completed	No. and % of cases / questionnaires submitted against number required	Time Period Submitted
National Perinatal Mortality Review Tool	N/A	Yes	Yes	23 (100%)	April 2023 to March 2024
National Prostate Cancer Audit (NPCA)	N/A	Yes	Yes	925 (100%)	Jan to Dec 2022 – from Somerset Regi
National Vascular Registry	N/A	Yes	Yes	528	April 2023 to March 2024
Paediatric Intensive Care Audit Network				Not Applicable to Trust – no specific Paediatric ICU	
Perioperative Quality Improvement Programme	N/A	Yes	Yes	Patients	
Prescribing Observatory for Mental Health				Not applicable to Trust – Mental Health Trust requirement	
Renal Audits Previously listed under Chronic Kidney Disease Registry and/or UK Renal Registry	National Acute Kidney Injury Audit	Yes	Yes	100% Data submitted directly to Renal Registry	April 2023 to March 2024
Renal Audits Previously listed under Chronic Kidney Disease Registry and/or UK	UK Renal Registry Chronic Kidney Disease Audit	Yes	Yes	100% Data submitted directly to Renal Registry	April 2023 to March 2024

National programme name	Work stream / Topic name	Participation	Data Collection completed	No. and % of cases / questionnaires submitted against number required	Time Period Submitted
Renal Registry					
Respiratory Audits	Smoking Cessation Audit- Maternity and Mental Health Services	Yes	N/A	N/A	Audit abandoned nationally July 2023
Sentinel Stroke National Audit Programme (SSNAP)	N/A	Yes	Yes	515 (90%+)	April 2023 to March 2024
Society for Acute Medicine Benchmarking Audit (SAMBA)	N/A	Yes	Yes	159	
Trauma Audit & Research Network (TARN)	N/A			No national TARN audit in 2023.24 due to data breach at host site	
UK Cystic Fibrosis Registry Cystic Fibrosis Trust	N/A			Not applicable to Trust – condition not routinely managed in Trust	

Table 2 – NCEPOD Studies for April 2023 – March 2024.

Name of Study	Number of cases included	No. and % of cases / questionnaires submitted against number required	No. of case notes submitted	No. of organisation questionnaires submitted
Community acquired pneumonia	8	4/8 (50%)	4	1

Name of Study	Number of cases included	No. and % of cases / questionnaires submitted against number required	No. of case notes submitted	No. of organisation questionnaires submitted
Testicular torsion study	6	4/6 (67%)	4	1
End of Life Care	6	6/6 (100%)	6	1
Endometriosis	6	3/6 (50%)	3	1
Juvenile idiopathic arthritis study	2	½ (50%)	1	1

National Clinical Audit Reports Reviewed by the Provider

The reports of 20 national clinical audits were reviewed by the provider in 2023/24 and The Dudley Group NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided. Below are some examples from across the Trust of actions taken to improve the quality and safety of our services as findings of local clinical audit.

Specialty	Brief description of audit/outcome/improvements	Actions taken/to be taken
Critical Care	ICNARC Case Mix programme discussed at May QPDT meeting. !0 indicators within accepted targets including risk adjusted acute mortality	None required
Diabetes	National Diabetic Foot Audit met all five recommendations in 2022 report.	None required
Anaesthetics	The findings for the NELA project were presented and two recommendations for change were made. 1) Develop a SOP which will ensure an Optimised pathway of care for Emergency Laparotomy Patients 2) Formal assessment of frailty for all patients over 65 years	The SOP is currently under development and Frailty Assessments are now carried out for patients over 65.
Urology	The National Prostate Cancer Audit Report was reviewed and the Trust met the Key Recommendation that 90% of patients with newly diagnosed prostate cancer have TNM staging. The Trust currently has 96% of patients meeting that standard.	No action required
Learning Disabilities	The LeDeR report was discussed at the ISB and no actions were identified for the Trust	No actions required
Maternity	Pregnancy in Diabetes Audit - Areas of improvement identified:	Actions will be agreed when report presented in May 2024

Specialty	Brief description of audit/outcome/improvements	Actions taken/to be taken
	• 5mg folic acid commenced in preconception period. • HbA1c at booking requires improvement. • First contact with diabetes team < 10 weeks' gestation	
Maternity	MBBRACE UK 2023 report has been reviewed however no local recommendations were made.	No actions required
Rheumatology	The report identified 5 recommendations. 4 of which were identified as areas to be taken forward by the specialty.	1) Rheumatology consultant of the week has been introduced to ensure that patients can be triaged as early as possible. 2/3) Additional outpatient department slots to ensure that patients are seen within 3 weeks and started on DMARDS within 6 weeks. 4) Patients are provided with ongoing education.

3.3 Local Clinical Audit

The reports of 171 local clinical audits were reviewed by the provider in 2023/24 and The Dudley Group NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided. Below are some examples (one from each division and one from Trust wide) from across the Trust of actions taken to improve the quality and safety of our services as an outcome of local clinical audit.

SPECIALTY	AUDIT TITLE	ACTION PLANNED	IMPROVEMENT
Diabetes	Diabetes Education Programme for Junior Doctors	Pharmacist delivered diabetes training to be held in IT training suite using practical scenarios and case-based discussions at 'Better Training Better Care' sessions.	Ongoing programme now in place
Emergency medicine	The investigation and early management of exacerbation of COPD	Storage cupboard at the front triage area needs to have a stock book/regular checklist etc,	Front triage area salbutamol nebules available for use
Gastroenterology	Use of the 'Decompensated Cirrhosis Discharge Bundle' in RHH patient discharges	Introduce Electronic Liver (decompensated cirrhosis discharge bundle) on Sunrise	Electronic Liver (decompensated cirrhosis discharge bundle) went live on Sunrise on 26.10.23

SPECIALTY	AUDIT TITLE	ACTION PLANNED	IMPROVEMENT
Respiratory	Lung Cancer Pathway Audit – increase in mortality	LIT meeting to be set up between primary and secondary care to review delays leading up to referral to rapid access	LIT meeting in place with clear programme to reduce delays
Stroke	Improving Mortality	A protocol for ICH management will be drafted and circulated for wider consultation before being available on the trust intranet.	A protocol for ICH management has been developed
Critical Care	Targeted Temperature Management (TTM) in critical care for all patients post Return of Spontaneous Circulation (ROSC) following community and in hospital cardiac arrest	New Trust Guidance to be written based on National guidance and current research. Following its publication, critical care can follow a post ROSC care bundle	Guidance has been written and presented to the critical care team. A bedside guide is being made and implemented
General Surgery	Percutaneous Cholecystostomy: an effective intervention to treat biliary sepsis in critically ill and patients not fit for surgery	The decision to perform percutaneous cholecystostomy should be individualised and guided by application of Tokyo severity grading for all patients with acute cholecystitis along with morbidity scoring with ASA and/or P-POSSUM. Patients who are deemed fit for surgery following resolution of the acute episode should be prioritised.	Risk stratification based on Tokyo guidelines and ASA/ P-POSSUM score has been achieved and is ongoing. Registrars and consultants agreed to prioritise patients for surgery who become fit for surgery after the procedure.
Neonates	PERIPrem - Perinatal Excellence to Reduce Injury in Premature Birth	Employ STORK practitioners	2 practitioners now in place and working with mothers.
Vascular Surgery	Assessment of Lower Limb Revascularisation in Patients with CLTI - Are we meeting the CQUIN targets?	Limb salvage ‘hot’ clinics – specialist review, imaging, discuss with radiology, consent. Critical limb consultant of the week	The team on B3 have set up a vascular surgery hot clinic on the ward.

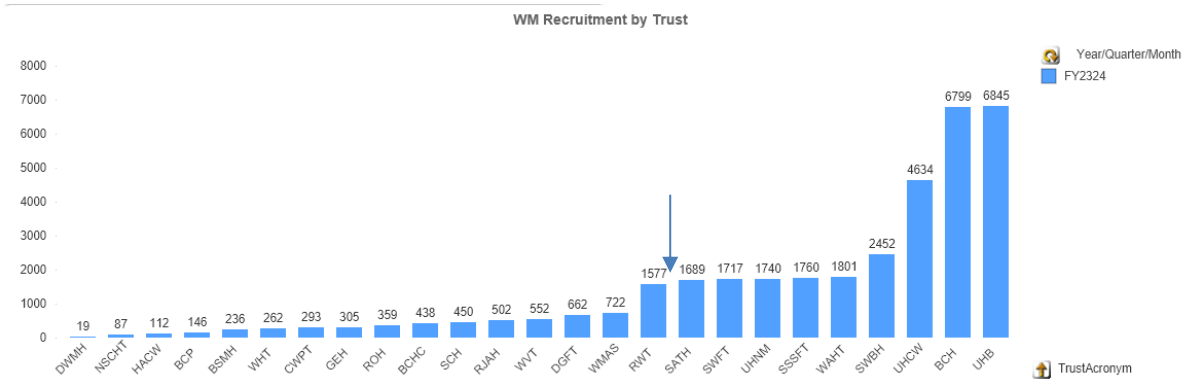
3.4 Research and Innovation (R&I)

The number of participants receiving relevant health services provided or subcontracted by The Dudley Group NHS Foundation Trust that were recruited during 2023/24 period to participate in research.

There were 697 approved by the research ethics committee and 662 went into a NIHR portfolio adopted studies. Table 1 and 35 were carried out as non-portfolio studies). During this period, we have had 96 studies open to recruitment, (16 of which have closed during this year).

These studies consisted of 9 commercial studies (4 have now closed) and 83 non-commercial studies (12 have now closed), with a further 25 studies currently in set-up.

Table 1: 2023-24 Recruitment to studies in the West Midlands



The balance of the portfolio across specialties covers anaesthetics and critical care, cancer, cardiology, chemical pathology, dermatology, diabetes, education gastroenterology, general surgery, geriatrics, haematology, immunology, mental health, neurology, orthopaedics paediatrics, renal, rheumatology, respiratory, reproductive health, stroke, vascular, and urgent public health all continuing to participate or express an interest in research.

Interest in research across non-medical/Allied Health Professions (AHP) staff groups has increased with a number of staff being supported to progress innovation or research ideas.

3.4.1 Innovation

The department has recently taken on the responsibility for all innovation across the Trust, with a formal process now developed and shared on the Trust Hub pages (the Department name has changed to Research and Innovation). The monitoring and reporting of all innovation projects is now also underway. We are working closely with the Health Innovation Network West Midlands and MidTech to develop ideas further. There are currently 15 innovation ideas logged, with 7 of those actively progressing forward.

3.4.2 University Hospital Standards

The Trust is leading work towards the Trust vision of submitting a University Hospital Status application (a joint bid with Sandwell and West Birmingham Hospitals NHS Trust), working with our primary academic collaborator, Aston University. Progress has been made in terms of obtaining statistician support, PhD studentships and an increase in grant applications, although we are yet to be successful in acquiring a competitive NIHR research grant, to support the UHS application requirements.

Across the Trust Research, Innovation and Education have shown many examples of excellence and we are ‘showcasing’ some of these areas through staff videos that will formulate part of the application process for UHS.

The Nurse Consultant in Trauma and Orthopaedics and Director of Research and Innovation for the Trust has been appointed as an Honorary Associate Professor at Aston University. The University grants honorary professorships to people of ‘significant renown within their own discipline’. The position is for five years and allows a strong working relationship between the Trust and the university. It also allows them to share her expert knowledge and contribute to the education of the students so they may reach their full potential.

3.4.3 Training and Infrastructure

The Trust held its second Trust Research and Evidence-based Practice Seminar event on 21st February 2024, which was highly successful with a wide range of speakers and good attendance, including staff from other local Trusts and university staff. We plan to hold further events throughout the year.

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

The department has continued to promote research related training sessions on Good Clinical Practice and Principal Investigator Essentials Masterclasses. We also support staff Research Champions and have regular attendance at the meetings and training sessions. We hold monthly lunchtime drop-in meetings to support any research and innovation ideas, on an ongoing basis.

3.4.4 Celebrating Success

The Trusts Cardiology Research team were nominated for the NIHR Clinical Research Network West Midlands ‘Contribution to Research’ award and subsequently were winners. From technological innovations to amplifying the voices of minority populations - the range of clinical research in the West Midlands was celebrated at Grand Central Wolverhampton, October 2023.

The aim of this event is to celebrate the innovative work that is undertaken, and the commitment demonstrated by health and care colleagues to improve the region’s capacity and capability for research delivery. Trophies and certificates were presented to winners across 10 categories with nominations from across the midlands.

The Paediatric Team and Research Team successfully enrolled the first patient in Europe into a Phase 2 Dose Finding Paediatric Functional Constipation study.

3.4.5 Public engagement

The Trust have held some patient - public involvement focus groups in the community in collaboration with local general practices, to inform a NIHR Research for patient benefit grant application.

We participate in the NIHR National Patient Research Experience Survey (PRES) throughout the year obtaining patients’ views on their experience of taking part in research. The results of the surveys are published annually on the NIHR website.

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

3.4.6 Publications

Trust publications for the calendar year 2023-2024 logged and available on the Library Services Open Repository, including conference posters, stands at 125
https://westmid.openrepository.com/handle/20.500.14200/5

3.5 Commissioning for quality and innovation (CQUIN) payment framework

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

There are 8 incentivised CQUINs, with 12 CQUINs to be undertaken for reporting and quality monitoring. Full payments were included within contractual sums, no clawbacks are anticipated for underperformance, as we continue to provide demonstrable evidence of engagement.

3.6 Care Quality Commission (CQC) registration and reviews

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

The Care Quality Commission has not taken enforcement action against the Trust during 2023/24.

The Dudley Group NHS Foundation Trust has not participated in any special reviews or investigations by the Care Quality Commission during the reporting period.

The Trust was last comprehensively inspected in January/February 2019 and the report was published in July 2019, the result of which was an overall rating of 'Requires Improvement'.

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

Two of the core services, diagnostic imaging, and urgent and emergency care, had domains rated as 'Inadequate' resulting in an overall rating for diagnostic Imaging of 'Inadequate'.

For the period 2023/2024, there have been four inspection visits from the CQC; all four have been published. In addition, there was one report published within this period where the inspection had taken place in the previous 12-month period.

Maternity services were visited as part of the national programme of inspections. The inspection took place in April 2023. An improvement in two of the CQC quality domains, safe and well led, was reported resulting in a rating of GOOD in every domain and an overall GOOD rating for maternity services at the Trust. Link - https://api.cqc.org.uk/public/v1/reports/dbbd0dd3-d2b3-4b86-b1c1-c59e8e8bff42?20230629070517

Paediatric emergency services were inspected in April 2023 as part of a focussed review on safeguarding processes within the service.

An unannounced core service inspection of the Emergency Department was conducted in June 2023. The inspection report was published in October 2023. This resulted in an increase in the ratings for effective and well led domains, however the overall rating for the service remained as REQUIRES IMPROVEMENT. Following the inspection, the Trust provided the CQC with a comprehensive action plan addressing the concerns raised. Link - https://api.cqc.org.uk/public/v1/reports/3e265fac-bbf6-4a4d-92d4-642d95d1dbea?20231122080108

An unannounced core service inspection of the Children and Young People's service was undertaken in June 2023, which resulted in two actions that the services were required to address. The inspection resulted in an uplift of ratings in the responsive and well led domains and resulted in GOOD overall for the service. The report was published in October 2023. Link - https://api.cqc.org.uk/public/v1/reports/3e265fac-bbf6-4a4d-92d4-642d95d1dbea?20231122080108

3.6.1 Improvement plans

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

During March 2024, progress made with the remaining two action plans were presented to the CQC, for assurance. At the time of reporting actions are progressing in line with target dates.

The table below indicates the changes to ratings following the CQC inspections that were rated.

Russells Hall Hospital Current and New for U&E Services and Children and Young People

	Safe		Effective		Caring		Responsive		Well-led		Overall	
	Old rating	Draft Rating	Old rating	Draft Rating	Old rating	Draft Rating	Old rating	Draft Rating	Old rating	Draft Rating	Old rating	Draft Rating
Urgent and emergency services	Requires Improvement (April 2021)	Requires Improvement ⇔	Requires Improvement (May 2019)	Good ↑	Good (May 2019)	Good ⇔	Requires Improvement (April 2021)	Requires Improvement ⇔	Requires Improvement (April 2021)	Good ↑	Requires Improvement (April 2021)	Requires Improvement ⇔
Medical care (including older people's care)	Good (April 2018)		Good (April 2018)		Good (April 2018)		Good (April 2018)		Good (April 2018)		Good (April 2018)	
Surgery	Requires Improvement (May 2019)		Good (May 2019)		Outstanding (May 20019)		Good (May 2019)		Good (May 2019)		Good (May 2019)	
Critical care	Good (May 2019)		Good (May 2019)		Good (May 2019)		Requires Improvement (May 2019)		Good (May 2019)		Good (May 2019)	
Maternity	Requires Improvement (May 2019)	Good 2023	Good (May 2019)		Good (May 2019)		Good (May 2019)		Requires Improvement (May 2019)	Good 2023	Requires Improvement (May 2019)	Good 2023
Services for children and young people	Requires Improvement (May 2019)	Requires Improvement ⇔	Good (May 2019)	Good ⇔	Good (May 2019)	Good ⇔	Requires Improvement (May 2019)	Good ↑	Requires Improvement (May 2019)	Good ↑	Requires Improvement (May 2019)	Good ↑
End of Life care	Good (May 2019)		Good (May 2019)		Good (May 2019)		Good (May 2019)		Good (May 2019)		Good (May 2019)	
Outpatients	Requires Improvement (May 2019)		N/A		Good (May 2019)		Good (May 2019)		Requires Improvement (May 2019)		Requires Improvement (May 2019)	
Diagnostic imaging	Inadequate (May 2019)		N/A		Requires Improvement (May 2019)		Requires Improvement (May 2019)		Inadequate (May 2019)		Inadequate (May 2019)	

CQC rating tables for Corbett Hospital and community services:

Ratings for Corbett Outpatients Centre

	Safe	Effective	Caring	Responsive	Well-led	Overall
Surgery	Requires improvement May 2019	Good May 2019	Good May 2019	Good May 2019	Good May 2019	Good May 2019
Outpatients	Requires improvement May 2019	N/A	Good May 2019	Good May 2019	Requires improvement May 2019	Requires improvement May 2019
Diagnostic imaging	Inadequate May 2019	N/A	Good May 2019	Good May 2019	Inadequate May 2019	Inadequate May 2019
Overall*	Inadequate May 2019	Good May 2019	Good May 2019	Good May 2019	Inadequate May 2019	Inadequate May 2019

*Overall ratings for this hospital are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Ratings for community health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community health services for adults	Good Apr 2018	Good Apr 2018	Good Apr 2018	Requires improvement Apr 2018	Good Apr 2018	Good Apr 2018
Community end of life care	Good May 2019	Good May 2019	Outstanding May 2019	Good May 2019	Good May 2019	Good May 2019
Overall*	Good →← May 2019	Good →← May 2019	Outstanding ↑ May 2019	Requires improvement →← May 2019	Good →← May 2019	Good →← May 2019

*Overall ratings for community health services are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

3.7 Quality of Data

3.7.1 Hospital Episode Statistics

The Dudley Group NHS Foundation Trust submitted records during 2023/24 to the Secondary Uses Service (SUS) for inclusion in the Hospital Episode Statistics (HES) which are included in the latest published data.

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

	The Dudley Group	National average
Admitted Patient Care	99.8%	99.6%
Outpatient Care	99.9%	99.8%
Accident and Emergency Care	99.7%	98.9%

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

	The Dudley Group	National average
Admitted Patient Care	100%	99.8%
Outpatient Care	99.9%	99.5%
Accident and Emergency Care	100%	99.5%

Latest available figures from NHS England CDS DQ Dashboard:
Provider View (for APC and OPA) and ECDS Current View for April 2023 to February 2024

3.7.2 Information Governance

The Dudley Group NHS Foundation Trust Information Governance Assessment Report overall score for 2022- 2023 was 'Standards Met' for data submitted to the Data Security & Protection Toolkit.

The date for the submission of the 2023-24 toolkit is 30th June 2024 and, therefore, the results are not available at the time this report was written.

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

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

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

3.7.3 Clinical Coding Error Rate

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

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

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

	Level of attainment mandatory	Level of attainment advisory	Trust Percentage Correct 2023/2024
Primary diagnosis	>= 90.0%	>= 95.0%	99%
Secondary diagnosis	>= 80.0%	>= 90.0%	98%
Primary procedure	>= 90.0%	>= 95.0%	98%
Secondary procedure	>= 80.0%	>= 90.0%	95%

Standards were exceeded in each category.

The overall HRG error rate for this audit was twelve episodes which is 6% of the total number of episodes. The value of the HRG changes was £8,884 gross, £8,428 net which is a change of 3.2% absolute and 3.1% net.

The Dudley Group NHS Foundation Trust will be taking the following action to improve data quality.

Outcomes / Recommendations	Action
The coders are reliant on accurate documentation recorded in Sunrise by clinical teams. This includes the patient's conditions, co-morbidities and medical history for the current admission. In addition, for the clinical teams to make a judgement if previously reported conditions have any bearing on the current episode for coding purposes. Dialogue will continue with clinical teams.	Raised awareness roll out and continuous re-iteration and discussion with clinical staff the need to document all comorbidities clearly and to ensure the primary diagnosis is documented clearly to enable the clinical coding staff to accurately record the necessary information

3.8 Learning from deaths

During 2023, 1686 of The Dudley Group NHS Foundation Trust patients died. This comprised of the following number of deaths which occurred in each quarter of that reporting period. Refer to the chart below.

By 31st December 2023, 224 case records reviews and 34 investigations have been carried out in relation to the 1686 deaths.

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

3.8.1 Harm

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

- 1 representing 2.2% for the first quarter.
- 2 representing 4.5% for the second quarter.
- 1 representing 2.3% for the third quarter.
- 0 representing 0% for the fourth quarter.

1682 deaths representing 99.8% of the 1686 patient deaths during 2023 are judged to be more likely **not** to have been due to problems in the care provided to the patient.

These numbers have been estimated using a) The Trust's mortality review process which includes a medical examiner scrutiny and a Level 1 peer review of all deaths by the department concerned using a standard questionnaire.

This may lead to a Level 2 review performed by a mortality panel using a structured case note review data collection as recommended by the National Mortality Case Record Review Programme, b) Coroner Rule 28 cases when making recommendations about future care and c) root cause analysis reports following investigations if a death is reported as a serious incident if that is clinically appropriate (e.g., death potentially avoidable).

Dudley Group NHS FT	Reporting Period 2023				
	Q1	Q2	Q3	Q4	Comments
Number of patients who died	497	418	339	432	
Number of deaths subjected to a case note review	74	45	44	60	
Number of deaths subjected to an investigation	9	9	5	11	
Number of deaths subject to a case note review and investigation	9	9	9	11	
Number and representing percentage of quarterly total judged more than likely **NOT** to be due to problems in care	71 95.9%	42 93.3%	43 99%	59 99%	
Number and representing percentage of quarterly total judged more than **likely** to be due to problems in care	3 4.1%	3 1.07%	1 1%	1 1%	
Estimate of the number of deaths thought to be more likely than not due to problems in the care provided	1	2	1	0	All cases were part of the DATIX process and referred for SJR by Governance

3.8.2 Learning

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

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

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

- Ongoing implementation of the Gold Standards Framework (GSF).
- The Medical Examiner system is now reviewing 100% of hospital deaths.
- Cases with learning are highlighted to the specialty and discussed at the Joint Mortality Meetings within the ICS.
- Positive assurance related to quality of care includes, SJRs output, falling HSMR with no weekend effect and no regulation 28 notices in 5 years.
- The Trust is being supported by the Advancing Quality Alliance (AQuA) to look at several deteriorating patient pathways. The first condition groups to undertake this work were AKI, sepsis and alcohol related liver disease. Work stream plans have been generated and are in the process of being fully implemented in association with the specific teams and audit department.
- Implementation of RESPECT document both within the Trust and the community setting.
- Validation of case notes for Acute Cerebrovascular Disease and Fracture Neck of Femur.

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

- Sepsis mortality continues to be reduced.
- ME scrutiny to be used as the primary review of death to allow a more robust approach to structured Judgement Reviews and Alerts.
- Fracture Neck of Femur Improvement Group to identify and action improvements in patient care, aligned with the National Hip Fracture Database.
- Continuing decline in the SHMI for Fracture Neck of Femur and Acute Cerebrovascular Disease.

3.9 Seven Day Hospital Services (7DS)

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

The Trust now reports via an internal board report and a deep dive into compliance was submitted to Quality Committee in March 2024. This provided assurance that services are in place to meet the required 10 standards and detailed a specific review of Respiratory and Endocrinology due to the services not having evidenced 7-day service compliance in the 22/23 Job Planning Round.

Priority Standards

Standard	Assurance
Standard 2: All emergency admissions must be seen and have a thorough clinical assessment by a suitable Consultant as soon as possible but at the latest within 14 hours from the time of admission to hospital.	The Trust has a strong assurance in relation to the 14 hour review standard due to the continual review model in Acute Medicine. In addition, acute physicians work within the Emergency Department daily. This was evidenced in job plans from the last planning round. 7 day consultant cover was documented in the majority of consultant plans (see standard 8). **Next steps: Job planning consistency panels for 24/25 plans and Trust wide audit.**
Standard 5: Hospital inpatients must have scheduled 7 day access to diagnostic services, typically ultrasound, computerised tomography (CT), magnetic resonance imaging (MRI), echocardiography, endoscopy, and microbiology. Consultant-directed diagnostic tests and completed reporting will be available 7 days a week.	There is emergency and urgent access to CT, MRI and Ultrasound based on the critical (1 hr) and urgent (12 hr) TAT. A full compliance is detailed at Appendix 2. Whilst overall compliance has been achieved for Standard 5, further work is required for compliance against all modalities specifically CT and MRI as significant challenges remain. Due to staffing and skill mix MRI scans are not available overnight with an SLA in place with UHB for transfer of patients requiring emergency neurological imaging. A 7 day Consultant on-call service is provided by endoscopy procedures and is evident in gastroenterology Consultant job plans. Consultant Microbiology workforce provide 24/7; 365 service via a duty microbiologist rota which is available via switchboard and directly accesses a consultant at any time. This service also delivers the Health and Social Care Act requirement to have 24/7; 365 infection control advice as the IPC nursing team currently work only within the core working week; all other advice provided out of hours and weekends is provided by the Microbiology Consultant workforce.
Standard 6: Hospital inpatients must have timely 24 hour access, 7 days a week, to key Consultant-directed interventions that meet the relevant specialty	The Trust has a Critical Care Unit supported by Critical Care outreach 24/7. There is emergency and urgent access to interventional radiology and CT for thrombolysis. A Consultant on-call model is in operation for Urgent Endoscopy requests 7 days per week. A Consultant on-call model is in operation for General and Vascular services.

<table>
<tr><th>Standard</th><th>Assurance</th></tr>
<tr><td>guidelines, either on-site or through formally agreed networked arrangements with clear written protocols. These interventions would typically be: • Critical care • Interventional radiology • Interventional endoscopy • Emergency general surgery • Emergency renal replacement therapy • Urgent radiotherapy • Stroke thrombolysis and thrombectomy• Percutaneous Coronary Intervention • Cardiac pacing (either temporary via internal wire or permanent).</td><td>Dudley Consultants work on a shared rota with Royal Wolverhampton to provide coronary interventions.</td></tr>
<tr><td>Standard 8: All patients with high dependency needs should be seen and reviewed by a consultant TWICE DAILY (including all acutely ill patients directly transferred and others who deteriorate). Once a clear pathway of care has been established, patients should be reviewed by a consultant at least ONCE EVERY 24 HOURS, 7 days a week, unless it</td><td>Over 90% of Consultants had a signed off job plan in 2022/23 with speciality level consistency panels held during summer 2023. A key criteria for the panel was 7 day service compliance. Respiratory and Endocrinology had previously been highlighted as partially compliant.

Endocrinology was again partially compliant, with reliance on the current Consultant body undertaking additional sessions to provide the required cover. A business case has been approved for additional resource, but recruitment remains a challenge.

Respiratory are partially compliant and were able to demonstrate job planned ward rounds at weekends as detailed below.

<table>
<tr><th>Team</th><th>Surname</th><th>Monday</th><th>Tuesday</th><th>Wednesday</th><th>Thursday</th><th>Friday</th><th>Saturday</th><th>Sunday</th><th>No Fixed Day</th><th>Grand Total</th></tr>
<tr><td>Respiratory Medicine</td><td>Ward Round - Medical HDU</td><td>1.75</td><td>0.48</td><td>0.48</td><td>1.67</td><td>1.67</td><td></td><td></td><td>2.82</td><td>8.87</td></tr>
<tr><td></td><td>Ward Round - Routine</td><td>2.76</td><td>1.69</td><td></td><td>1.67</td><td>3.10</td><td></td><td></td><td></td><td>9.22</td></tr>
<tr><td></td><td>Ward Round - Weekend</td><td></td><td></td><td></td><td></td><td></td><td>1.48</td><td>1.48</td><td></td><td>2.96</td></tr>
<tr><td>Respiratory Medicine Total</td><td></td><td>4.51</td><td>2.17</td><td>0.48</td><td>3.34</td><td>4.77</td><td>1.48</td><td>1.48</td><td>2.82</td><td>21.05</td></tr>
</table>

Discussions have been held to move to a Consultant of the week model, however this would require investment and an increase in consultant numbers to prevent clinic displacement and other core services such as the lung cancer pathway.</td></tr>
</table>

Standard	Assurance
has been determined that this would not affect the patient's care pathway.	A Deep Dive into Respiratory and Endocrinology following non compliance in 2022/23 has been completed with the support of the Clinical Effectiveness team which highlights : • 95% of patients were seen within the recommended time frames set out by NHS England. • 100% had a management plan in place and documented discussions with the patient, relative or carers. • 100% had a Consultant review on admission. **Next steps: Job Planning Consistency Panels for 24/25 plans**

A Trust wide audit has been planned for 2024/25 to assess all standards. This will complement existing work underway to improve the quality of handover in the Trust.

3.10 Raising Concerns

The Trust is committed to giving every member of staff the opportunity to speak up if there is something they do not feel is right and when they do, they have the support they need. The Freedom to Speak up (FTSU) service aims to provide all staff (including non-substantive) with a safe route to raise concerns in the workplace. Concerns can be raised confidentially with the FTSU team who will listen and offer support and signpost as well as escalate appropriately as/when necessary. The service is represented as follows:

Diane Wake - CEO and executive lead for Freedom to Speak up.
Julian Atkins – non-executive lead for Freedom to Speak up.
April Burrows – Lead Freedom to Speak up Guardian.
Philippa Brazier – Freedom to Speak up Guardian.

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

3.10.1 Governance arrangements

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

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

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

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

3.10.2 Champions

To maximise the accessibility of the FTSU service, we have a network of 19 champions across the Trust in various roles including administrative, nursing and AHP. Their role is a combined FTSU, and patient safety role and the team are there primarily to listen and signpost; champions do not usually handle concerns themselves.
Proactive efforts have been undertaken to ensure there are champions based in as many key areas as possible: this includes a new champion in the Bereavement Office, two further champions are in the process of being trained.

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

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

3.10.3 Next steps being taken by the Trust.

1. All three FTSU training modules have now been released by the National Guardian's Office. They are not mandated at present but are recommended for the following staff groups:
    - Speak up – for all staff.
    - Listen up – for all managers.
    - Follow up – for senior leaders.
2. The National Guardian's Office 'Freedom to Speak up – a reflection and planning tool' has been completed by senior leaders. The data is being collated and will be shared once completed.
3. The Freedom to Speak up Policy has been updated in July2023. Which is in line with the National Guardian's Office recommendations.

3.10.4 Recent activities

Drop-in sessions planned across all locations, including early morning and evening sessions.

Collaborative staff well-being event to be held at Corbet Hospital and Dudley Guest in April 2024.

3.11 Junior Doctor Rota Gaps And The Plan For Improvement

In 2016 contractual rules were introduced to ensure rotas are designed and managed in a way that allows doctors to meet their training needs, avoid fatigue and overwork and maintain work-life balance, while allowing employers to deliver the service. These were reviewed and updated in 2019.

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

- A medical training initiative (MTI) - a two-year training programme has been established. These doctors help to cover any ongoing Deanery and Trust vacancies

at registrar and SHO level. They also help backfill any shifts unfilled by the increasing number of LTFT (less than full time) trainees we are assigned by the Deanery.

- Increased physician associate roles in several areas to support medical teams with appropriate supervision. This has been particularly successful in the Acute Medical Unit and has been extended to other areas in the Trust.
- The use of recruitment agencies for particularly hard to fill, senior level vacancies within specialist areas.
- Increasing our internal bank coverage so that, for example, when junior staff leave due to their rotation elsewhere to undertake research, we are arranging for those staff to remain on our internal staff bank.
- More effective rostering using the Medirota system for junior doctors has been implemented across all divisions within the Trust. The General Internal on call rota is fully implemented and solely used and managed via Medirota.
- Funding of rota co-ordinators in specific departments to co-ordinate rotas and provide a single point of contact for doctors.

Theatre staff and Ophthalmology staff.

Part 4: National Core Set Of Quality Indicators

4.1 Preventing People From Dying Prematurely

4.1.1 Mortality

The summary hospital level mortality indicator (SHMI) is a mortality measure that takes account of several factors, including patient's comorbidities. It includes patients who have died whilst having treatment in hospital or within 30 days of being discharged from hospital.

The SHMI score is measured against the NHS average which is 1.00. A score below 1.00 denotes a lower-than-average mortality rate and therefore indicates good, safe care.

Summary hospital-level mortality indicator

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

Data source: HED Benchmarking Tool

The Dudley Group NHS Foundation Trust considers that this data is as described for the following reasons:
Data is taken from Secondary Users Service (SUS) Hospital Episode Statistics (HES) data which is audited on an annual basis by external auditors.

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

- Ongoing implementation of the Gold Standards Framework (GSF).
- The Medical Examiner system is fully implemented and reviews 100% of hospital deaths.
- Increased usage of the priorities of care documentation across the Trust.
- Cases with learning are highlighted to the specialty and discussed at the Joint Mortality Meetings within the ICS.
- The Trust is supported by the Advancing Quality Alliance (AQuA) to look at several deteriorating patient pathways. The condition groups currently been undertaken AKI, sepsis, community acquired pneumonia and decompensated liver disease. Work stream plans have been generated and are in the process of being fully implemented in association with the specific teams and audit department. Significant improvements

have been noted in DLD. The Trust also has developed an electronic Deteriorating Patient Pathway to highlight patients at risk of deterioration, which is being embedded across the whole Trust resulting fewer medical emergency team (MET) calls and cardiac arrests.

- Implementation of RESPECT document.
- Improving the way alerts are allocated to the relevant speciality for QI work.

4.2 Helping People To Recover From Episodes Of Ill Health Or Following Injury

4.2.1 Patient reported outcome measures

Patient Reported Outcome Measures (PROMs) assess the quality of care delivered to NHS patients from the patient perspective. They calculate the health gains after surgery using pre and post operative survey questionnaires. This currently covers two clinical procedures, hip replacements and knee replacements.

The following table provides an overview of The Dudley Group NHS Foundation Trusts participation rates for 2023 – 2024.

Month	Total Scanned Hip	Total Scanned Knee	Monthly Hip HES	Monthly Knee HES	HIP Participation Rate %	Knee Participation Rate %
April 2023	0	0	33	42	0	0
May 2023	10	16	33	42	30	38
June 2023	19	30	33	42	58	71
July 2023	25	37	33	42	76	88
Aug 2023	23	23	33	42	70	55
Sept 2023	37	39	33	42	112	93
Oct 2023	47	63	24	25	196	252
Nov 2023	29	41	24	25	121	164
Dec 2023	12	16	24	25	50	64
Jan 2024	44	38	24	25	183	152
Feb 2024	29	47	24	25	121	188
March 2024	29	47	24	25	121	188

4.2.2 Readmissions to Hospital within 30 Days of Discharge

	2022/23			2023/24		
	0 – 15 years	16 & over	Total	0 – 15 years	16 & over	Total
Discharges*	11378	112155	123533	11505	134389	145894
Readmissions within 30 days (number)	292	12015	12307	384	14441	14825
Percentage %	2.6%	10.7%	10.0%	3.3%	10.7%	10.2%

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

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

The Dudley Group NHS Foundation Trust considers that this data is as described for the following reasons:
Data is taken from Secondary Users Service (SUS) Hospital Episode Statistics (HES) data which is audited on an annual basis by external auditors.

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

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

4.3 Ensuring People Have A Positive Experience Of Care

4.3.1 Responsiveness to the Personal Needs of Patients

Following the merger of NHS Digital and NHS England on 1st February 2023, the future presentation of the NHS Outcomes Framework indicators are being reviewed. As part of this review, the annual publication which was due to be released in March 2023 has been delayed.

4.3.2 National Patient Experience Surveys

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

National Inpatient Survey
The CQC National Adult Inpatient Survey 2023 will not be publishing its results until August 2024. To note the following scores and actions relate to the latest published National Adult Inpatient Survey 2022.

The Inpatient Survey is part of a national survey programme and collects feedback on the experiences of inpatients using NHS services across the country. The feedback from the Inpatient Survey provides invaluable feedback which we use to drive improvement and to improve patient experience. All patients from the age of 16 and who have spent a night in the hospital are eligible to take part in the survey which is split into eight categories: ED, waiting list and planned admissions, the hospital and ward, doctors, nurses, care and treatment, operations and procedures, leaving hospital.

The results from *the* ***National Adult Inpatient Survey 2022*** (published September 2023) shows that the Trust is performing ‘about the same’ when compared to all other trusts. The Trust top three results for the Trust were for patients being asked about their experience of the care received, for the quality of the food and cleanliness of the ward.

The table below details questions from the national Inpatient Survey 2022 where there was a decline in score in comparison to the previous year's survey and the national average.

Question/Quality Priority	Trust Score 2022	Trust Score 2021	National Average	Expected Range
Pain Management				
Do you think staff did everything the could to help control your pain?	8.2	8.4	8.8	**Much worse than expected**
Nutrition and Hydration				
Did you get enough help from staff to eat your meals?	6.4	6.9	7.4	**Worse than expected**
During your time in hospital did you get enough to drink?	9.1	9.1	9.4	**Somewhat worse than expected**
Discharge				
To what extent did staff involve you in decisions about leaving hospital?	6.2	6.7	6.9	**Worse than expected**
To what extent did hospital staff involve your family or carers in discussions about you leaving hospital?	4.9	-	5.6	**Somewhat worse than expected**
Were you given enough notice about when you were going to leave hospital?	6.1	6.7	6.8	**Worse than expected**
Before you left hospital, were you given any information about what you should or should not do after leaving hospital?	7.1	7.8	7.9	**Worse than expected**
To what extent did you understand the information you were given about what you should or should not do after leaving hospital?	8.5	8.9	8.9	**Worse than expected**
Before you left hospital, did you know what would happen next with your care	6.0	6.2	6.6	**Somewhat worse than expected**

Note: Trust scores for 2023 will not be published until August 2024

The key themes included preparation for discharge, not feeling involved in decisions, being given notice of when they were due to be discharged and being given information on what to do or not to do after leaving hospital. Management of pain, food and nutrition with communication running through as a golden thread.

Communication relating to discharge has been a recurring theme from previous surveys and is a quality focus for the Trust for 2024/2025. We recognise that involving patients in planning their discharge earlier in the patient's pathway facilitates the patient to be involved in decision making and an improvement in discharge planning centred around our patients' needs.
A Discharge Improvement Group (DIG) has been established and is a standing item on the Patient Experience Group (PEG) agenda. Progress is monitored through updates against the workstreams at the Patient Experience Group for assurance of recommendations having been completed and improvements made.

National Cancer Patient Experience Survey (CPES) 2022 (Published July 2023)
The survey shows a number of questions that are below the expected range of what Trusts of the same size and demographics are expected to perform. The results have seen a decline overall since the 2021 survey.

The main themes for improvement and where scores fell below or within the lower expected range were for communication (around patients being given a point of contact, advice about a second opinion before making decisions, being able to discuss worries and fears, being given information about therapies, managing the impact of long-term side effects of medication, and offering enough information and support between final treatment and follow-up appointment).

Scores were below average and within the lower expected range for waiting times for diagnostic tests and length of waiting time at clinic and day unit for cancer treatment. These scores were lower than the national average score.

Patients scored positive for being informed that they could have a family member, carer or friend with them when told their diagnosis was above the expected range.

To improve these scores the lead cancer nurse along with cancer management, cancer Clinical Nurse specialists and the wider clinical teams continue to work on the action plan to improve the National Cancer Patient Experience Survey results. The cancer management team are working with the clinical teams and divisions to improve pathways/waiting times and implement the best practice timed pathways for each tumour group. At the end of 23/24 we achieved the targets set by NHSE at the start of 23/24: To achieve 70% against combined 62-day RTT Standard – Achieved 71.5%.

We now have cancer navigators embedded in all sites, they have nearly completed their competencies and have improved the Holistic Needs Assessment, care plan and treatment summary rates for all tumour sites as part of the personalised care agenda (NHS Long Term Plan). They also track and help patients through the pathway and help out at health and wellbeing events.

National Maternity Survey 2023 (Published February 2024)
The survey shows that the Trust has been identified as an outlier as ‘worse than expected’ overall across all scored questions relating to experience of care during labour and birth, and on the ward after the birth (in comparison to ‘much worse than expected’ in 2022).

The top five results for the Trust that are highest compared with the average of all Trusts included the cleanliness of the hospital room, women receiving help and advice from a midwife or health visitor about feeding their baby, being able to get a member of staff to help when they needed it while in hospital and for discharge experience.

Urgent and Emergency Care (UEC) 2022 (Published July 2023)
The Trust is performing ‘about the same’ when compared to all other trusts. The Overall Patient Experience Score (OPES) for the Trust has seen a decline since the previous survey in 2020 however, this score is in the top five of Trusts in the region and a top five highest score for the Trust compared with the national average.

Areas for improvement focus on waiting times to be seen and examined, being able to speak to a member of staff when needed, cleanliness and support after leaving the A&E Department.

To improve the scores from the national survey a new approach is being trialled for seeing and treating minors' patients. From the hours of 10-22 an Advanced Care Practitioner will now be based in A&E. This will allow for more patients to be streamed to minors if appropriate. The benefits from this will be a reduction in crowding in the main waiting room as patients will be directed to minors. This will aid flow and decrease length of stay. The department also streams all GP referrals from Urgent Care to avoid them coming to the Emergency Department. This will include all patients sent from their GP to be reviewed by either Same Day Emergency Care , Emergency Surgical Hub and Paediatric Assessment Unit. The figures demonstrate that this this is approximately 20 – 30 patients a day.

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

4.3.3 Patient Recommendation to Family and Friends

The Friends and Family Test scores remain a national focus, provides valuable benchmarking information and drive improvement to the patient experience. The NHS Friends and Family Test (FFT) is firmly embedded within the Trust with all patients given the opportunity to complete the survey during or after each episode of care and treatment in all areas of the organisation.

Feedback is captured through a variety of methods (SMS, tablet, paper, online). The FFT is presented as the percentage of respondents that rate their experience very good/good and the percentage of respondents that rate their experience poor/very poor.

Dudley Group NHS FT	2021/22	2022/23	2023/2024
% Very Good/Good	**80%**	**83%**	**83%**
National Benchmarking	**90%**	**90%**	**91%**
% Very Poor/Poor	**7%**	**6%**	**6%**
National Benchmarking	**5%**	**6%**	**4%**

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

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

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

- FFT percentage very good/good scores are monitored through the divisional updates at the Patient Experience Group for assurance and to highlight action taken to improve scores at ward/department level were required.
- Patients' responses and feedback are shared with teams for earning and service improvement, comments and scores are sent to all members of staff and discussed in the daily huddles and You Said We Have actions are reported to the Patient Experience Team.
- We have distributed posters throughout the hospital displaying the links to the FFT and we have seen an increase in the number of patients completing the survey online.
- We produced FFT stickers with online links/QR codes for the Maternity Department to put on patients' maternity antenatal and postnatal notes and ensure that the FFT is accessible to all, as SMS text messaging was not available within the service. Posters and paper surveys are to be updated in the Antenatal Department as these are currently out of date.
- We have implemented the Patient Experience Champions role within the Trust and each ward and service have identified a Patient Experience Champion for their area. The champions will promote patient experience within their areas to help drive Trust-wide improvements, share good practice, and provide the best patient experience and care.
- We have hosted a number of patient panels and supported several departments and teams to deliver 'Listening into Action' events throughout the year to capture people's views and experiences on what we did well and what we could improve to help us shape future service.

4.3.4 Staff Recommendation to Family and Friends

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

	2023/24			
	Q1	**Q2**	**Q3**	**Q4**
Dudley Group NHS FT	**53.8%**	**56.3%**	**58%**	**53%**
National average for combined acute/community Trust	Data not available	Data not available	**63%**	Data not available
Highest combined acute/community Trust	Data not available	Data not available	**89%**	Data not available
Lowest combined acute/community Trust	Data not available	Data not available	**44%**	Data not available

Data source

Quarter 1, 2 and 4 – National Quarterly People Pulse.
Score is a % score based on positive answer (Strongly Agree and Agree) to Would you recommend as a place to receive care. Response rate for People Pulse varies across each quarter. Average <10% response rate.
Quarter 3 – National Staff Survey – Delivered across two months in Q3. Response rate higher than People Pulse. For Q3 2023/24, response rate 45%.

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

- Continuing workforce pressures have resulted in staff unable to deliver the care they aspire to
- National results are reflective of a similar trend to Dudley and, therefore, provides a picture of similar experience across all healthcare workers
- Response rates for the Quarterly Survey remain low (<20%). Data in these months are lower than for the national staff survey. Performance in the national Staff Survey has remained static.

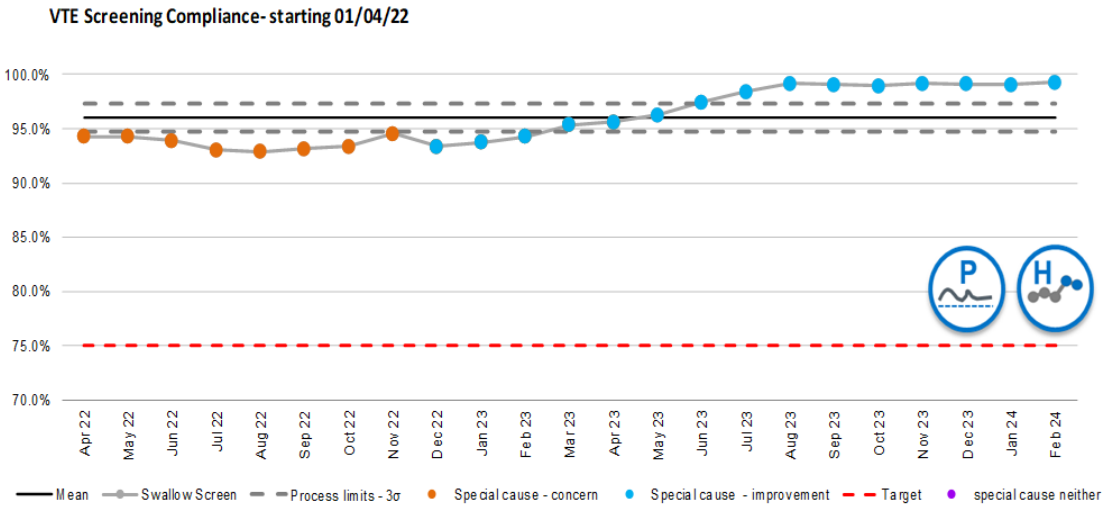
The Dudley Group NHS Foundation Trust has taken the following actions to improve these percentages, and so the quality of its services, by:

- Increasing response rates to People Pulse to ensure data is comparable across each quarter
- Using quarterly pulse data to capture areas where staff identify improvements can be made in this area
- Continuing to increase the Staff Survey response rate
- Focusing on workforce recruitment and retention activity through the Trust People Plan and Recruitment and Retention Journey. This includes a focus on flexible working, development support and ongoing recruitment which will improve staff experience in the long term.
- Developing local action plans and additional engagement and support for areas within the organisation that are outliers (comparatively poorer scores when compared with the organisation's benchmark). This activity includes additional focus on leadership and management development, wellbeing actions and team support.

4.4 Venous Thromboembolism

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

The Trust provides updates via the Integrated Performance Report to Trust Board on a regular basis. Compliance has been above the 95% target since May 2023 as shown below.



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

- All incidents of Hospital associated thrombosis reported on DATIX.
- Where issues identified reported back to responsible team to investigate further and action.
- Patient safety team contacted and asked to review whether requires discussion at WMOH.
- Concerns raised at Thrombosis Group meeting at how incidents in DATIX are graded.

4.5 Infection Control – Clostridiodes Difficile (C.DIFF)

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

	2020/21	2021/22	2022/23	2023/24
Trust apportioned cases (Lapses in care)	11	18	3	*
Trust bed days	242,400	242,400	242,400	*
Rate per 100,000 bed days	25.66372145	43.9281982040303	26.3075971956101	*
National average	46.60237797	25.1971091564799	27.55607775882	*
Best performing trust	2.254715173	0	0	*
Worst performing trust	140.5415535	138.379575174704	133.644082989716	*

*= data not available until October 2024

Data source: CDI annual data table 2022/2023

Changes to the CDI reporting have been made to align the UK definitions with international descriptions of disease. These changes will mean that additional patients will be included in the group of patients that the hospital must investigate. The patients who will be included are categorised in the following groups:

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

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

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

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

- The process for reviewing CDI cases in line with the new national framework is now embedded.
- All HOHA CDI cases are reviewed both internally and with our external partners where the cases are reviewed and assigned.
- COHA cases requests are made to the GP for information
- The well-functioning antimicrobial guidelines continue to be updated to reflect national objectives including reductions in carbapenem usage and increased prescribing from within the access list of antibiotics which the Trust is.

4.6 Patient Safety Incidents

Dudley Group NHS FT Total reported incidents	Previous reporting period Apr 2021 – Mar 2022	Previous reporting period Apr 2022 – Mar 2023	Latest reporting period Apr 2023 – Mar 2024
Total reported incidents	9159	15053	14159
Rate per 1000 bed days	37.3	76.7	52.65
National average (acute non-specialist)	57.5	No data available	No data available
Highest reporting rate (acute non-specialist)	205.5 (11,903)	No data available	No data available

Dudley Group NHS FT Incidents causing severe harm or death	Previous reporting period Apr 2021 – Mar 2022	Previous reporting period Apr 2022 – Mar 2023	Latest reporting period Apr 2023-Mar 2024
Incidents causing severe harm or death	26	35	23
% of incidents causing severe harm or death	0.28	0.23	0.16
National average (acute non-specialist)	0.152	No data available	No data available
Highest reporting rate	0.901 (48)	No data available	No data available
Lowest reporting date	0.004 (1)	No data available	No data available

During the reporting period 2023/24, the number of patient safety incidents reported has fallen slightly compared to 2022/23 However, it was noted that during 22/23 there was a retrospective upload of pressure ulcers present on admission from the previous year in line with national guidance.

The proportion of incidents reported to have resulted in severe harm or death has decreased across the three-year period. Together this is indicative of a positive reporting culture.

In September 2023, the Trust transitioned from reporting to the National Reporting and Learning System (NRLS) to the Learning from Patient Safety Events System (LFPSE) in line with national directive. As part of the Trust's work to transition and embed this change in reporting, a refreshed training programme has been designed and is in the process of being rolled out to further promote reporting across the organisation. Furthermore, incident reporter feedback has been strengthened and incorporated into the reporting system.

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

Dudley Group NHS FT	Trust 2022/23	Target 2023/24	National 2023/24	Trust 2023/24
Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate – patients on an incomplete pathway	57.8%	92%	N/A	56.6%
A&E: maximum waiting time of 4 hours from arrival to admission, transfer, discharge	76.53%	76%	N/A	73.17%
All cancers: 62 day wait for first treatment from urgent GP referral for suspected cancer	60.0%	85%	N/A	55.26%
All cancers: 62 day wait for first treatment from NHS Cancer Screening Service referral	82.7%	90%	N/A	72.47%
Diagnostic 5 week wait performance	99.00%	85.00%	72.76%	90.6%
Venous Thrombolism (VTE) Risk Assessment	93.6%	95%	N/A	98.34%

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

Surgery colleagues

Glossary of terms:

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

Annex

Comment from the Trust's Council of Governors – 2023/24

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

The Council of Governors is invited to review the draft report and prepare a comment. The process adopted in preparing the governor's comment on the Quality Account 2023/2024 saw a copy of the draft report circulated to all governors for their review and response. Governors were then supported to collate responses and formulate the comment for inclusion as given below:

The Council of Governors has diligently reviewed the Quality Account for 2023/2024 and commends the Trust for its steadfast commitment to maintaining high standards of care despite significant financial challenges. They are reassured that patient care remains a top priority due to the robust quality of the agenda being pursued despite the existing financial constraints and they intend to closely monitor this balance.

The Council has continued to review the performance data over the last year and compare it to the quality indicators and constitutional performance standards. They would like the Trust to continue focussing on discharging patients on time. They understand the challenges faced with achieving this goal due to the macro environment the hospital operates within so they are pleased with the progress made in ensuring that patients receive timely and clear discharge communication and with the effective embedding of this process.

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

The Council of Governors is dedicated to supporting Priority 5 and Priority 6 for the upcoming year, focusing on patients with dementia and learning disabilities as they feel it is vital for these groups of patients to receive the compassionate and comprehensive care they deserve.

The Council commended the Trust on embedding cancer navigators across all sites as this initiative represents a substantial step forward in providing personalised and comprehensive care for cancer patients.

The Council of Governors were proud of the recent success of the Trust's Cardiology Research Team who won the National Institute for Health and Care Research (NIHR) Clinical Research Network West Midlands 'Contribution to Research' award. This recognition highlights the team's dedication and excellence in research, contributing to the advancement of cardiology care.

Additionally, the Council is pleased with the Trust's efforts to achieve University Hospital Status in collaboration with Aston University. They feel this achievement will not only enhance the reputation

of the Trust but will also foster a stronger partnership with the academic community, promoting research and innovation in healthcare.

The Council of Governors will continue to monitor the alignment of quality targets with financial realities and provide oversight and support to ensure that high standards of care are maintained. They celebrate the Trust's successes and remain dedicated to supporting its goals for continuous improvement and excellence in patient care.

Comment from the Black County Integrated Care Board

The Dudley Group NHS Foundation Trust - Quality Report 2023/2024

The Black Country Integrated Care Board (ICB) welcome the opportunity to review and comment on The Dudley Group NHS Foundation Trust Quality Account for 2023/2024. This was a transparent, honest and a comprehensive account of the last year. We would like to take the opportunity to thank the Trust and the staff for their dedication, commitment, and hard work throughout the last year. The ICB notes the progress made by the Trust against the 2023/2024 priorities, with reducing avoidable harm and improving the response rate to patient complaints.

We note that the quality priorities for 2023/2024 were only partially achieved and acknowledge the ongoing commitment to improving data quality within the clinical areas, embedding quality improvement initiatives, enabling the ongoing improvements to meet the priorities of reducing avoidable harm and improving complaint response times.

With consideration of the 2023/2024 patient safety quality priorities, the BICB notes the commitment to the successful implementation of the Patient Safety Incidence Response Framework (PSIRF) across the Trust. The new Patient Safety Incident Response Framework is a significant change to the way the NHS understands and learns from incidents. The focus is upon improving patient safety with an emphasis on how incidents happen and the factors that contribute to incidents. The strong links with the Dudley Quality Improvement Team within the Trust has led to real and sustainable changes in practices. We know that the voice and experience of patients and staff is integral to driving real change in reducing unwanted variation of outcomes as well as achieving sustainable and accelerated improvements and we are pleased the Trust has empowered patients to becomes partners in patient safety.

For the period 2023/2024, there have been four inspection visits from the Care Quality Commission (CQC); all four have been published on the CQC website. In addition, there was one report published within this period where the inspection had taken place in the previous 12-month period.

We particularly want to highlight the improving work across maternity services. Following recent Quality Peer Review visits to the neonatal unit, it is noted that there have been focused improvements in this area, including strengthening of the nursing and medical leadership, and review of workforce model. The ICB support the de-escalation of monitoring by NHSE specialised commissioning and the ODN and will continue to work closely in oversight and support.

Maternity services were also visited as part of the national programme of inspections. The inspection took place in April 2023. An improvement in two of the CQC quality domains, safe and well led, was reported resulting in a rating of good in every domain and an overall good rating for maternity services at the Trust.

Paediatric emergency services were inspected in April 2023 as part of a focussed review on safeguarding processes within the service.

An unannounced core service inspection of the Emergency Department was conducted in June 2023. The inspection report was published in October 2023, this resulted in an increase in the ratings for effective and well led domains. However, the overall rating for the service remained as requires improvement. Following the inspection, the Trust provided the CQC with a comprehensive action plan addressing the concerns raised and the ICB has reviewed and supported this action plan through Care Quality Review Meetings with the trust.
An unannounced core service inspection of the Children and Young People's service was also undertaken in June 2023, which resulted in two actions that the services were required to address. The inspection resulted in an uplift of ratings in the responsive and well led domains and resulted in good overall for the service. The report was published in October 2023.

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

The section 'Clinical Audit' provides evidence of the Trust's performance. It is positive to see the number of clinical audits undertaken during 2023/2024. It is also encouraging to see that the Trust continues to be a strong advocate for research, development, learning, improvement, and innovation. It is evident from the Trust's quality account that The Dudley Group NHS Foundation Trust are doing great work to progressing research, improvement, and innovation across the various departments within the Trust.

Throughout this Quality Account, the Trust demonstrates their commitment and aspirations to improve safety and quality of care of services delivered, and the ICB would welcome a continued focus on reducing avoidable harms, including pressure injuries and falls within and across the Trust. Opportunities for revised arrangements in out of hospital will support assuring arrangements to treat patients in the right place at the right time, ensuring seamless transfer of care pathways. The recent focus on those patients with a learning disability and the opportunity to support these patients in collaboration with the Mental Health LDA Lead Provider are welcomed.

Heading into 2024/2025, the ICB are committed to collaboratively working with the Trust to improve the quality and safety of services available for the population of Dudley place to improve patient safety, care, outcomes, and experience.

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

Comment from Healthwatch Dudley

Healthwatch Dudley – Quality Account Statement 2023/24

The Dudley Group NHS Foundation Trust

As the independent champion for people who use health and social care services in the Dudley borough, Healthwatch Dudley welcomes The Dudley Group NHS Foundation Trust's commitment to improving patient care and experiences.

We are pleased with the Trust's proactive approach in evaluating progress for 2023/24. The involvement of patient-public focus groups with local general practices demonstrates a strong commitment to integrating patient feedback into research and service improvement. Additionally, the Trust's participation in the NIHR National Patient Research Experience Survey and the inclusion of a patient representative in key decision-making groups further highlight this dedication to enhancing the patient experience.

Another noteworthy initiative is the implementation of the Patient Experience Champion role across the Trust. We hope the appointed champions will be well-positioned to provide valuable insights into service users' experiences and contribute to future improvements. The existing methods to collect patient feedback are varied and have led to service improvements. For instance, feedback regarding communication issues between healthcare providers and patients led to the implementation of communication training programs for staff, improving patient-provider interactions.

The Friends and Family Test has been widely promoted, and scores show a positive trend. This commitment to collecting feedback is admirable. Additionally, the implementation of Patient Experience Champions within each ward and service is a commendable step for continuous improvement in patient care. However, the recent National Adult Inpatient Survey results indicate areas needing improvement, particularly in discharge communication. In addition, while the Urgent and Emergency Care survey results show that the Trust is performing 'about the same' as others, there are still areas for enhancement, particularly in waiting times and post-discharge support.

Considering this, we support the Trust's new approach to managing minor injuries and streaming GP referrals to avoid unnecessary congestion in the Emergency Department. It is also reassuring that the Trust has established a Discharge Improvement Group (DIG) and is focusing on core areas to address these concerns.

We hope that the DGNHSFT continues to monitor patient feedback and use the valuable insights provided to improve their service. We look forward to seeing future developments and are open to working collaboratively with the DGNHSFT to enhance services based on feedback from our community.

Healthwatch Dudley Team

May 2024

Comment from the Health and Adult Social Care Scrutiny Group

Members are pleased to have had the opportunity to provide scrutiny to the 2023-4 DGFT Quality Accounts, recognising that the full year's data was incomplete at the time of draft submission to Committee.

Half of the Trust's ten targets for the year had been achieved. Complaints within 30 days was almost met, and there was a move away from formal written responses to encouraging face to face dialogue with members of the clinical team who had been involved in providing care. Treating patients in the right place and at the right time had been particularly challenging across the healthcare sector. Amongst the Trust's successes for the year were reducing avoidable harm, particularly tissue viability, and the introduction of "virtual wards" that enabled appropriately selected patients to be looked after at home rather than in hospital. The Trust had the opportunity to showcase how they implemented the Gold Standards Framework for caring for patients in the final year of life to a visiting team of clinicians from Singapore.

New priorities for the coming year included improvements for patients with diabetes, fractured neck of femur, stroke, dementia and learning disabilities; plus a focus on addressing the main themes that had emerged from patient surveys. Members sought assurance that patient participation would be encouraged when addressing these new priorities. Members sought assurance about how the Trust was addressing readmission rates and heard about the support available in the community and at home after discharge, including introduction of technological solutions.

Whilst not all priorities had been achieved, the organisation is striving to make improvements in challenging circumstances and the Committee looks forward to working constructively with DGFT in the future.

Statement of Directors' Responsibilities in Respect of the Quality Report 2023/2024

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

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

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

The content of the Quality Report meets the requirements set out in the *NHS foundation Trust annual reporting manual 2018/19* and supporting guidance *Detailed requirements for quality reports 2023/2024* and;

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

- Board minutes and papers for the period April 2023 to March 2024
- Papers relating to quality reported to the board over the period April 2023 to March 2024
- Feedback from Integrated Care Board June 2023
- Feedback from governors June 2024
- Feedback from Healthwatch May 2024
- Feedback from Overview and Scrutiny Committee Dudley Metropolitan Borough Council Health and Adult Social Care Scrutiny Committee May 2023
- The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009,
- The latest national inpatient survey March 2024
- The latest national staff survey, dated March 2024
- CQC inspection report dated 12th July 2019
- The Quality Report presents a balanced picture of the NHS foundation Trust's performance over the period covered.
- The performance information reported in the Quality Report is reliable and accurate.
- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice.
- The data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review.

The Quality Report has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report.

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

By order of the board

Signed: Sir David Nicholson
Chair
Date: June 2024

Signed: Diane Wake
Chief Executive
Date: June 2024