The Dudley Group
NHS Foundation Trust

Quality Account 2022-23

Contents

FOREWORD

What is a Quality Report?

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 2022/23. It also sets out the Quality Priorities we have agreed for 2023/24 and how we intend to achieve them.

This report is divided into four parts, the first of which is a statement from the Chief Executive.

Part 2 sets out the quality priorities and goals for 2023/24 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 2022/23.

The annexes include a glossary of the terms used.

The annexes at the end of the report include the comments of our external stakeholders.

PART 1 - INTRODUCTION

1.1 CHIEF EXECUTIVES STATEMENT

The Dudley Group NHS Foundation Trust has a core vision to provide excellent healthcare and improved health for all. through the services it provides. One of our key strategic goals is to provide the right care every time and this enables us to provide safe and effective services for our patients and staff. We also recognise through our strategy that our staff are key to delivering the very best quality care for our patients and we have another goal to be a brilliant place to work and thrive, recognising the intrinsic link between our workforce and quality of services.

This report will take you through just some of the key areas of quality that we monitor across our services and through what has been another challenging year in 2022/23 I am proud of our workforce that continue to provide safe high quality services to our patients. Industrial action this year has impacted on our ability to fully restore planned services and we continue to work with our partners across the Black Country to ensure access to services and waiting times remain as low as possible.

Here we will highlight both areas for improvement and areas of good practice in the quality of services we provide.
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 services by regulators and peer review systems.

We are learning to live with COVID-19, and we may see further peaks, we must continue to deliver our planned and other non-COVID services to our local population.

We continue to deal with high number of emergency patients through our emergency department whilst also continuing 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.

We have worked throughout this year with our partners in the Black Country Provider Collaborative 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. We will continue to do everything possible to maximise the number of patients that we can safely treat, and to 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

Our priority is always to provide high quality, safe care for all patients, and to learn from our mistakes if we fall short of these standards. We are committed to driving improvement and a culture of excellence throughout the organisation.

Our Trust Priorities for 2023/24 have been developed to ensure that we recover as quickly and safely as we can from the pandemic and embed quality improvement into our daily practice whilst adapting to the 'new normal' for the NHS.

We have included as much information as possible in our report 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

PART 2: PRIORITIES FOR IMPROVEMENT

2.1 QUALITY IMPROVEMENT PRIORITIES

Each year, utilising internal intelligence, in consultation with internal and external key stakeholders, and service user groups the Trust commit 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 Trusts Quality and Safety Group/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 2022/23 quality priorities year end position. This year within the NHS the focus has been on restoration and recovery following the impact on our patients post the Covid pandemic. We have seen unprecedented emergency activity which will have negatively impacted on the quality priority outcomes.

It is noted there have been some improvement against the 2022/2023 quality priorities, but the restoration and recovery period has impacted on achieving all. Following consultation, it has been agreed to roll-over all amber and red rated outcomes allowing an opportunity for full compliance during 2023/2024.

Priority 1 for 2022/23: Delivering a great patient experience	
Quality Priority	**How did we do?**
a. <u>Using patient feedback to drive improvements (inpatient survey results)</u> Improve inpatient survey scores related to the following questions: a. Involving patients and their carers in care and treatment decisions (Q23) (target = 72%, current baseline = 68%) b. Leaving hospital - communication around discharge (Q34) (target = 71%, current baseline = 66%) c. Information around conditions and treatment is shared with patients (Q24) (target = 89%, current baseline = 86%)	a. Patient Experience Real-time survey feedback demonstrates that 72% of the 61 patients who answered the survey felt that they were definitely/to some extent involved as much as they wanted to be in decisions about their care and treatment. Patient Reported Experience Measures survey feedback for Q4 shows that 95% of the 812 patients who completed the survey strongly agreed/agreed that they were involved in decisions about their care and treatment. **The target has been achieved for this priority** b. Real-time patient survey feedback for Q4 shows that 23% of the 61 patients who answered the survey were informed about their expected date of discharge (64% stated 'no' to this question). The results for the National Inpatient 2022 have not been published. **The target has not been achieved for this priority.** c. Patient Reported Experience Measures survey feedback for Q4 highlights that 94% of 812 respondents strongly agreed/agreed that they were provided with enough information about their condition and treatment. **The target has been achieved for this priority**

b. <u>Ensure all complaints are responded to in accordance with the Trust complaints and concerns policy*</u> d. Improve complaint closure within 30 days to 50% by April 2023 e. Reduce outstanding backlog by 70% by April 2023 *Trust Governors chose this priority to champion throughout 2022/23	a. For Quarter 4 (2022/23) there were 319 complaints closed and of those 319 complaints, 129 were closed within 30 working days. This is a decrease in the percentage response rate (responding to complaints within 30 working days) from 42.8% in Quarter 3 (2022/23) to 40.5% for Quarter 4. The aim for the end of Quarter 4 was to achieve the target of 50% by April 2023 and this has not been achieved. **The target has not been achieved for this priority** b. At the end of December 2022 (Quarter 3 2022/23) there was a backlog of 46% so there has been a decrease in the percentage backlog by 1.8%. This reflects the challenges faced with the increased number of new complaints received (289 new complaints for Quarter 4). At the end of March 2023, if the reopened complaints and Ombudsman matters are not included in the figures, there were 141 complaints outstanding with 51 complaints in backlog (36%). When compared to Quarter 3 (2022/23) there were 39% in backlog (a difference of 3%). Quality priorities 2e is to reduce the backlog by 70% by April 2023. **The target has not been achieved for this priority**

Priority 2 for 2022/23: Treating patients in the right place, at the right time

Quality Priority	**How did we do?**
c. <u>Capacity and patient flow Same Day Emergency Care (SDEC) pathways</u> a. Providing SDEC services (Surgery, Medicine, and Paediatrics) for 12 hours a day, 7 days per week b. Assessment in 30 minutes from arrival in SDEC, for those patients identified on the 'frailty pathway' c. Increased referral pathways to SDEC, resulting in a decrease in admissions across all relevant specialities d. Improve the quality of referrals direct to SDEC from West Midlands Ambulance Service and primary care	a. Medicine SDEC provides a service that covers 12 hours a day, 7 days a week between 0800 and 2230 with the last referral at 1900. **The target has been achieved for this priority** b. SDEC dashboards are constantly reviewed for improvement and the new report demonstrates that Frailty area achieving assessment within 30 minutes. **Average time of Assessment** **Month / Year** | **Frailty Medicine** Jan 2023 | 13 Feb 2023 | 6 **The target has been achieved for this priority** c. Activity in SDEC continues to improve and there is a steady number of referrals from the clinical hub. d. Referrals from ED and the Dudley Clinical Hub are made via Sunrise. Within the Trust Urgent Treatment Centre and Consultants can telephone through to SDEC to refer patients or seek advice. WMAS call DCH to see if the patient can be supported in the community. e. The SDEC Unit operates a mix of a push and pull model to support ED. During January and February 2023, SDEC admitted 10.49% of patients which sits within the national guidance of 10-15% **The target has been achieved for this priority**

f. Calls to Dudley Clinical Hub in January and February 2023 continues to progress whereby 'Community first and hospital where necessary' is applied. DCH continues to utilise alternative clinical pathways to avoid unnecessary ED conveyances.

Q4	Jan 2023	Feb 2023	March 2023
Total Calls to DCH	2128	1653	1755
Patient Sent to SDEC not via ED	24.1% - 514	31.09% - 514	26.5% - 466

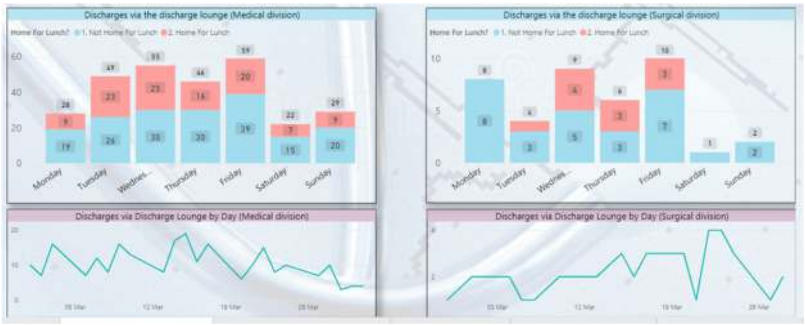
The target has been achieved for this priority

d. <u>Discharge management*</u>

c. Every inpatient ward will identify 1 to 2 patients everyday (7 days per week) as part of 'Home for Lunch' initiative.
d. Improved use of the discharge lounge, both seated and bedded areas, for all definite discharges
e. All discharge communication with patient, carers and families and 3rd parties are initiated on admission

*Trust Governors have chosen this priority to champion throughout 2022/23

a. Home for lunch (HFL) performance:



All ward areas have a morning ward board round (WBR) with a discharge facilitator, occupation therapist, Doctor and a Lead Nurse. They also hold an afternoon WBR at 14:00

The target has not been achieved for this priority

b. The Trust is facilitating an average of 30 discharges over Saturday and Sunday. This has increased since introducing projects such as decision to admit and the introduction of the 'no choice' letter. Last year the Trust was averaging around 15 patients utilising the discharge lounge per day.

c. The Trust operates a 7-day working policy with access to all pathways despite demand. The team follow an escalation process to facilitate as many discharges as possible regardless of the trusts position.

The target has not been achieved for this priority

d. All discharge communication with patients is done on admission: this project only just commenced with a review of discharge on admission paperwork and use of EDD.

e. There is limited evidence to support improvement in communication with patients, careers, families and third parties. 64% of surveyed patients sample stated they were not aware of their discharge date.

The target has not been achieved for this priority

Priority 3 for 2022/23: Reducing avoidable harm

Quality Priority	How did we do?
e. <u>Pressure Ulcers</u> a) Clear outstanding incident backlog for category 3 and 4 pressure ulcers up until March 2022 b) All grade 3 and 4 pressure ulcers will be investigated and closed within 45 working days	a. As of March 2023, there are 20 outstanding Pressure Ulcers to be reviewed by the scrutiny Group. **The target has not been achieved for this priority** b. There have been no breaches in serious incident reports **The target has been achieved for this priority**

c) Develop systems to promote timely investigation and validation of pressure ulcers recorded via the DATIX system d) Identify and report pressure ulcers earlier in patient pathway anticipating an increase in reported category 1 and 2's correlating to reduction of reported category 3 and 4's.	c. A new SIT tool has been devised but requires further ht amendments prior to its launch. There is a user guide to support this tool. Terms of reference have been revised for the Pressure ulcer scrutiny group to include decision tool. New way of monitoring SITs is being set up on Datix **The target has not been achieved for this priority** d. The new SIT tool will allow rapid completion of SIT within 72 hours of identification. Tissue Viability have launched a new referral protocol regarding prioritisation pathway for patients and have regular teaching planned regarding pressure ulcer categorisation and aSSKINg pressure ulcer prevention principles. The team have worked with Patient Safety and informatics to improve data collection. A dashboard has been developed that will provide Divisions to accurate real time data. **The target has not been achieved for this priority.**

2.1.2 Looking Forward

2022/2023 has seen unprecedented demand for emergency services coupled with delayed transfers of care creating a bottle neck within acute services. This was at a time of restoration and recovery within the NHS committing to reducing backlogs formed as a consequence of the pandemic. This has impacted on the Trust's ability to drive forward some of the quality priorities for 2022/2023. For this reason, and the continuing importance of these quality priorities, the Trust has decided to carry forward those priorities that did not achieve the agreed target into 2023/2024.

PRIORITY 1 Using patient feedback to drive improvements (inpatient survey results)
a) Leaving hospital - communication around discharge target = 71%, current baseline = 23% b) Improve complaint closure within 30 days to 50% by April 2023 baseline 40.5% c) Reduce outstanding backlog by 70% by April 2023 baseline 39%
Why we chose this (Rationale)
a) The trust has failed to achieve this target; we recognise that involving our 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 patient's needs. b/c) Resolving complaints within a nationally agreed timeframe reducing the anxiety of the complainant ensuring their concerns have been listened too, resolved and in a timely manner.
How we will monitor and share progress
Monitoring of the Quality priorities will be through a quarterly report to the Quality and Safety Committee who will monitor compliance and assurance and drive progress, aiding in any barriers to progression towards the targets.
Responsible Person/Team
Head of Patient Experience

PRIORITY 2 Treating patients in the right place, at the right time
a) Every inpatient ward will identify 1 to 2 patients everyday (7 days per week) as part of 'Home for Lunch' initiative. b) Improved use of the discharge lounge, both seated and bedded areas, for all definite discharges target average 30 patients per day c) All discharge communication with patient, carers and families and 3rd parties are initiated on admission
Why we chose this (Rationale)
a) Further work to improve the flow of patients to facilitate emergency and planned admissions is required. Embedding the 'Home for Lunch' initiative working with secondary care partners developing further initiatives will assist in enabling planned discharges before lunch. b) Further work is required to consistently increase the use of the discharge lounge to enhance the flow of patients through the Trust and facilitate admissions. c) The trust has failed to achieve this target; we recognise that involving our patient s 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 patient's needs.
How we will monitor and share progress
Monitoring of the Quality priorities will be through a quarterly report to the Quality and Safety Committee who will monitor compliance and assist and assurance whilst aiding in any barriers to progression towards targets.
Responsible Person/Team
Trust Leads for Hospital Discharge

PRIORITY 3 Reducing avoidable harm
a) Clear outstanding incident backlog for category 3 and 4 pressure ulcers up until March 2024 b) Develop systems to promote timely investigation and validation of pressure ulcers recorded via the DATIX system. c) Identify and report pressure ulcers earlier in patient pathway anticipating an increase in reported category 1 and 2's correlating to reduction of reported category 3 and 4's.
Why we chose this (Rationale)
a) The backlog of pressure ulcers has made significant improvements however there remains 20 incidents that require review by the Scrutiny Group. b) The new system developed within Datix is being piloted and requires testing prior to giving assurance the system can deliver.

c) Development of a new DATIX system to monitor INC numbers for duplicate reporting enabling data to be captured per patient rather than per pressure ulcer, if successful this will allow a view of the patients treatment and management of pressure deterioration throughout the patient's pathway.
How we will monitor and share progress
Monitoring of the Quality priorities will be through a quarterly report to the Quality and Safety Committee who will monitor compliance and assist and assurance whilst aiding in any barriers to progression towards targets
Responsible Person
Lead Nurse Tissue Viability

PART 3: STATEMENTS OF ASSURANCE

3.1 REVIEW OF SERVICES

During 2022/23, 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 59 of these relevant health services. This has been achieved through its performance management framework and its assurance and governance processes. This includes patient safety, clinical effectiveness and patient experience.

The income generated by the relevant health services reviewed in 2022/23 represents (Waiting end of year data) per cent of the total income generated from the provision of relevant health services in The Dudley Group NHS Foundation Trust for 2022 /23.

3.2 PARTICIPATION IN NATIONAL CLINICAL AUDITS, NATIONAL CONFIDENTIAL ENQUIRIES, AND LOCAL CLINICAL AUDIT

During 2022/23, 51 national clinical audits and 7 national confidential enquiries covered relevant health services that the Trust provides.

During that period, the Trust Dudley Group NHS Foundation Trust participated in 97 per cent of the national clinical audits and 100 per cent of the national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

There had been 3 National confidential enquiries and one national audit (Smoking Cessation Audit-Maternity and Mental Health Services) that were not commenced nationally. In addition, the Trust did not participate in two of the national clinical audits.

- Fracture Liaison Service Database (FLS-DB) – the Trust is not currently running this service
- UK Parkinson's Audit

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 2022/23.

- 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 2022/23. Alongside 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
Breast and Cosmetic Implant Registry	N/A	Yes	Yes	40 100%	2017 -2022
Case Mix Programme (CMP)	N/A	Yes	Yes	90%+ case ascertainment Cases are continually submitted	01/04/2022 to 31/03/23
Elective Surgery (National PROMs Programme)	N/A	Yes	Yes	302 (hips and knees)	01/01/2022 to 31/12/22
Emergency Medicine QIPs	Consultant sign off	Yes	Yes	130	01/10/2022 to 31/10/22
Emergency Medicine QIPs	Infection Prevention and Control	Yes	Yes	260	01/10/2022 to 31/10/23
Emergency Medicine QIPs	Mental Health self harm	Yes	Yes	Ongoing data collection	01/10/2022 to 31/10/23
Emergency Medicine QIPs	Assessing for cognitive impairment in older people	Yes	No	The RCEM audit start date is 01/04/23	No data submission details
Emergency Medicine QIPs	Pain in Children	Yes	Yes	260	01/10/2021 to 31/10/22
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 332 patients	01/04/2022 to 10/03/23
Falls and Fragility Fracture Audit Programme (FFFAP)	National Audit of Inpatient Falls	Yes	Yes	14 submissions that were falls within the Trust.	2022 -2023
Falls and Fragility Fracture Audit Programme (FFFAP)	National Hip Fracture Database	Yes	Yes	562	Averaged over 12 months to end of Jan 2023 (as per NHFD website)
Falls and Fragility Fracture Audit Programme (FFFAP)	Fracture Liaison Service Database (FLS-DB)	No	No	No service currently	N/A
Gastro-intestinal Cancer Audit Programme (GICAP)	National Bowel Cancer Audit	Yes	Yes	274	01/04/2022 to 31/3/2023
Gastro-intestinal Cancer Audit Programme (GICAP)	National Oesophago-Gastric Cancer Audit (NOGCA)	Yes	Yes	67	01/04/2022 to 31/3/2023
Inflammatory Bowel Disease Audit	N/A	Yes	Yes	>500 self-consenting forms sent to pts	01/04/2022 to 31/3/2023

National programme name	Work stream / Topic name	Participation	Data Collection completed	No. and % of cases / questionnaires submitted against number required	Time Period Submitted
LeDeR - learning from lives and deaths of people with a learning disability and autistic people	Mortality Surveillance	Yes	Yes	19 deaths	01/04/2022 to 31/3/2023
Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRACE)	Maternal mortality surveillance and confidential enquiry (confidential enquiry includes morbidity data)	Yes	Yes	23 100%	01/04/2022 to 31/3/2023
Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRACE)	Perinatal confidential enquiries	Yes	Yes	23 100%	01/04/2022 to date
Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRACE)	Perinatal mortality surveillance	Yes	Yes	23 100%	01.04.2022 to date
National Adult Diabetes Audit (NDA)	National Diabetes Foot Care Audit	Yes	Yes	20	01/04/2022 to 31/3/2023
National Adult Diabetes Audit (NDA)	National Diabetes Inpatient Safety Audit (NDISA) (Previously NaDIA-Harms)	Yes	Yes	9	Jan 2022 - Jan 2023
National Adult Diabetes Audit (NDA)	National Diabetes in Pregnancy Audit	Yes	Yes	48 100%	01/01/2022 to 31/12/2023
National Asthma and COPD Audit Programme (NACAP)	Adult Asthma Secondary Care	Yes	Yes	42	01/04/2022 – 30/09/2022
National Asthma and COPD Audit Programme (NACAP)	Chronic Obstructive Pulmonary Disease Secondary Care	Yes	Yes	202 pts admitted between 1.4.22 & 8.3.23 203 pts discharged between 1.4.22 & 8.3.23	01/04/2022 – 30/09/2022
National Asthma and COPD Audit Programme (NACAP)	Paediatric Asthma Secondary Care	Yes	Yes	27	01/04/2022 – 30/09/2022
National Asthma and COPD Audit Programme (NACAP)	Pulmonary Rehabilitation Organisational and Clinical Audit	Yes	Yes	196	01/03/2022 – 30/09/2022
National Audit of Breast Cancer in Older Patients (NABCOP)	N/A	Yes	Yes	237	01/04/2022 to 31/03/2023
National Audit of Care at the End of Life (NACEL)	N/A	Yes	Yes	Fourth round of the audit (2022/23) states - Organisational Level Audit submitted & a Case Note Review of 50 deaths	25 consecutive deaths between 01/04/22 - 14/04/22 and 25 consecutive deaths between

National programme name	Work stream / Topic name	Participation	Data Collection completed	No. and % of cases / questionnaires submitted against number required	Time Period Submitted
					09/05/22-22/05/22
National Audit of Dementia	Care in general hospitals	Yes	Yes	Cases submitted 69 out of 80/ carers feedback 13 (10 required)/ patient feedback 47 (10 required)	01/04/2022 to 31/03/2023
National Cardiac Arrest Audit (NCAA)	N/A	Yes	Yes	71	Q1 and Q2 only for 01.04.2022 - 31.03.2023
National Cardiac Audit Programme (NCAP)	Myocardial Ischaemia National Audit Project (MINAP)	Yes	Yes	160	01/04/2022 to 20/03/2023
National Cardiac Audit Programme (NCAP)	National Audit of Cardiac Rhythm Management (CRM)	Yes	Yes	Devices/Implants 395/399 = 99% Ablation 1/1/ =100%	01/04/2022 to 31/03/2023
National Cardiac Audit Programme (NCAP)	National Heart Failure Audit	Yes	Yes	338	01-04-22 - 20-03-23
National Early Inflammatory Arthritis Audit	N/A	Yes	Yes	34	01/04/2022 to present
National Emergency Laparotomy Audit (NELA)	N/A	Yes	Yes	190	01/04/2022 to 08/03/2023
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	764	01/04/2023 to 08/03/2023 (per NJRcentre website)
National Maternity and Perinatal Audit (NMPA)	N/A	Yes	Yes	3618	01/08/2022 to 31/07/2022
National Neonatal Audit Programme (NNAP)	N/A	Yes	Yes	100% cases	Cases automatically gathered from the Badger system
National Obesity Audit	N/A	Yes	N/A	N/A	01/04/2022 to 31/0320/23
National Ophthalmology Database Audit (NOD)	Adult Cataract Surgery Audit	Yes	Yes	between 500-1499	2022-2023 not submitted as yet

National programme name	Work stream / Topic name	Participation	Data Collection completed	No. and % of cases / questionnaires submitted against number required	Time Period Submitted
National Paediatric Diabetes Audit	N/A	Yes	Yes	210	01/04/2022 to 08/03/2023
National Perinatal Mortality Review Tool	N/A	Yes	Yes	23 100%	01/04/2022 - to date
National Prostate Cancer Audit (NPCA)	N/A	Yes	Yes	294	To be submitted Q4 22/23
National Vascular Registry	N/A	Yes	Yes	528	01/01/2022 to 06/03/2023
Renal Audits Previously listed under Chronic Kidney Disease Registry and/or UK Renal Registry	National Acute Kidney Injury Audit	Yes	Yes	Data submitted directly to Renal Registry	01/04/2022 to 31/03/2023
Renal Audits Previously listed under Chronic Kidney Disease Registry and/or UK Renal Registry	UK Renal Registry Chronic Kidney Disease Audit	Yes	Yes	Data submitted directly to Renal Registry	01/04/2022 to 31/03/2023
Respiratory Audits	Smoking Cessation Audit- Maternity and Mental Health Services	Yes	N/A	N/A	Audit start delayed beyond 01/03/2023
Sentinel Stroke National Audit Programme (SSNAP)	N/A	Yes	Yes	448 (90%+)	2022 -2023 Q3
Serious Hazards of Transfusion (SHOT): UK National haemovigilance scheme	N/A	Yes	Yes	28	01/04/2022 to 31/03/2023
Society for Acute Medicine Benchmarking Audit (SAMBA)	N/A	Yes	Yes	Undetermined	23/6/22
Trauma Audit & Research Network (TARN)	N/A	Yes	Yes	570 (89%)	01/04/2022 to 31/03/2023
UK Parkinson's Audit	N/A	Yes	no	No submissions due to responsible lead off sick	2022-2023

Table 2

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	3/8 (38%)	6	1
Crohn's disease	6	1/6 (17%)	5	1
End of Life Care	Not Started nationally	Not Started nationally	Not Started nationally	Not Started nationally
Endometriosis	Not Started nationally	Not Started nationally	Not Started nationally	Not Started nationally
Epilepsy Study	Not Started nationally	Not Started nationally	Not Started nationally	Not Started nationally

National Clinical Audit Reports Reviewed by the Provider

The reports of 24 national clinical audits were reviewed by the provider in 2022/23 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 a result of local clinical audit.

Specialty	Brief description of audit/outcome/improvements	Actions taken/to be taken
Stroke	SSNAP - SSNAP (Sentinel Stroke National audit Programme) The latest figures show that the Trust overall audit compliance band is A with a score of 97.2%. This is the top quartile of the national audit results.	The Trust now has a Direct line for WMAS to access the stroke nurse 24/7 to reduce delays in referrals. Nurses are being trained to carry a stroke bleep to reduce the risk of the services being suspended due to absence. Thrombolysis sop
LeDeR	There have been 19 deaths of people with a learning disability within Trust this financial year to date. • Development of pathways with Community learning disability health services to ensure patient care is transferred from and to each team working with the patient. • Support needed for autistic people when they come into hospital, there is no alert flag available for autistic patients to enable staff to identify that they may need reasonable adjustments when coming into hospital.	Action Taken. Raised awareness and training. There is now evidence of • The Mental Capacity Act being documented in decision making for capacity to make decisions with regards to serious medical treatments. • Reasonable adjustments being made which include family and carers to be able to remain at bedside to support their loved ones (outside of visiting hours)
ICNARC	All KPIs were in the 95% target and 99.8% predicted ranges with the exception of 2 indicators that the Trust have action plans.	Critical Care continue to escalate appropriately with 2 x daily capacity reports, presence at capacity meetings, use of internal escalation levels and reporting of Mixed Sex Breaches and delays > 48 hours – escalation to division when capacity is very tight. Added to the Corporate Risk Register
Children and Young people Asthma	3/5 indicators have been met. 1 cannot be met as there is no smoking cessation service in the Trust.	Access to diagnostic tools: spirometry and fractional exhaled nitric oxide (FeNO) (Improvement priority). This is a national priority.
COPD Secondary Care Audit (National Asthma and COPD Audit Programme)	All data submitted 1/6 KPI's achieved.	Investigation into the 5 not achieved KPIs identified that some investigations like spirometry on the ward stopped during Covid as the service could not meet the demand of any but the acutely ill patients.

Specialty	Brief description of audit/outcome/improvements	Actions taken/to be taken
Inflammatory Bowel Disease Audit (IBD Registry	The national audit updated the requirement for the patient to consent by post. The Trust sent over 500+ consent forms but no data was submitted to the registry.	N/A
NACEL	5 KPI's assessed	No actions required. To continue to maintain implementation of GSF and monitor via regular, ongoing local clinical audit.
Paediatrics	National Neonatal Audit Programme - Neonatal Intensive and special Care (NNAP)	All KPI's achieved
General Surgery	National Bowel cancer Audit	Adoption of robotic surgery for colorectal cancer resections Surgeons to ensure they meet the minimum practical rectal cancer resections each year to meet the threshold defined by NICE. – Improved completion and accuracy of new genomics data items for all patients
Diabetes & Endocrinology	National Diabetes Footcare Audit (The National Diabetes Audit (NDA))	The NDFA has found that the proportion of referrals seen by a specialist foot care team within 13 days has increased from 43% in 2014-15 to 46% in 2020-21 . We have also seen a linked reduction in the proportion of ulcers that are severe at first expert assessment (FEA) and the subsequent decrease in the proportion of ulcers still active (not healed) at 12 weeks . This suggests that the NDFA focus on prompt referral to the specialist team has been effective.
Diabetes & Endocrinology	National Diabetes Inpatient Safety Audit (previously NaDIA Harms) (The National Diabetes Audit (NDA))	Improved reporting of diabetic incidents
Anaesthetics	National Emergency Laparotomy Audit (NELA)	All KPI's achieved better than national average
Trauma & orthopaedics	National Hip Fracture Database (NHFD) There were 7/9 KPI's met	Work to be done to ensure patients are admitted to orthopaedic ward in 4 hours and mobilised the day after surgery.
Trauma & Orthopaedics	National Joint Registry (NJR)	Excellent results need to focus on patient consent.
Obstetrics	MBRRACE (Maternal, Newborn and Infant Clinical Outcome Review Programme)	A monthly PMRT Board is held and the MDT review cases and identify learning: • mprovements have been made to ensure that the "Golden Hour is achieved when babies are transferred to the NNU. • The intrauterine transfer SOP has been updated to include the need to discuss 22-to-24-week gestation babies with the transport team. • Less Invasive Surfactant Administration (LISA) has been fully implemented on the NNU, and staff training had been undertaken prior to this. • The implementation of staff allocation form in ED for resuscitation. When a SUDIC case was reviewed in August 2022 it was clear that these improvements had been implemented and that staff were appropriately allocated and a member of staff supported the family through out. • Review of the process for pregnant woman who are outliers on other wards in the hospital. This is now documented on the Delivery Suite and Maternity Triage handover board. • The process for OOA bookings from SWB to be reviewed to ensure that all women have booking completed by RHH midwives.

Specialty	Brief description of audit/outcome/improvements	Actions taken/to be taken
		• To review the need to undertake colour flow Doppler in a coronal section to demonstrate the renal arteries as a routine in consultant performed detailed fetal scans. • To undertake a full review of the pathway in relation to poor pregnancy outcome.
Deteriorating Patient Team (Corporate)	National Cardiac Arrest Audit (NCAA)	Refocus of all senior reviewers to make a robust treatment and escalation plan for each individual. The requirement for a TERP for every patient within 24hrs of admission was put in place in the medical charter for the trust RADAR also focused education at the medical workforce for completing treatment and escalation plans. Standardised MET & CA documentation was introduced in November too with prompts for further escalation decisions.

3.3 LOCAL CLINICAL AUDIT

The reports of 116 local clinical audits were reviewed by the provider in 2022/23 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 a result of local clinical audit

SPECIALTY	AUDIT TITLE	IMPROVEMENT	ACTION PLANNED
Cardiology	Assessment of stroke and bleeding risk in patients with AF	Compliance in all areas, template for referral completed and teaching sessions.	Re-audit registered Nov 2022
Cardiology	Assessing inter-operator variability when calculating left ventricular ejection fraction (LVEF) on Trans-Thoracic Echocardiography (TTE) using the Simpson's biplane method	Routine AQ activity in echo review meetings, 2D biplane training sessions conducted by a BSE accredited echocardiographer implemented. 3d biplane training requested.	Re-audit not required
Gastroenterology	To Assess the Quality of Gastroenterology Inpatient referrals	Modifications made to online referral form	Re-audit 02/04/2023
Stroke	Effectiveness of Intermittent Pneumatic Compression (IPC) in acute stroke patient's within the 28days of event	100% compliance rate was achieved with NICE Guidance specific to IPC and acute stroke	Completed Re-audit not required
General Surgery	Discharge Information - RE-AUDIT	Significant improvement in the information provided in discharge summaries, specifically about pain relief, wound care, follow up precautions/general activities, and the contact info. The one key information that was missing was the discharge information leaflet. It was provided to 87% of patients, but not documented in the discharge summary.	Re-audit not required Raised awareness for medical staff to record discharge leaflet given on discharge.
General Surgery	Outcome of colonic stenting at Russell's Hall	Outcomes of colonic stenting in RHH is comparable to published evidence.	No Action Plan - The audit is a review of

SPECIALTY	AUDIT TITLE	IMPROVEMENT	ACTION PLANNED
		Its advantage as a palliative tool is employed in RHH	outcomes which has been concluded.
Urology	Evaluation of the current CTKUB Pathway Re-audit	Following recommendations from the 1st cycle of the audit: •Capacity increased to 2 slots •Quicker scans but not fulfilling recommendation for scan within 24 hours •Some improvement in follow ups •Increased usage of US for young patients •No young patient with –ve dip had CT. •Improved access of ESH to CT KUB pathway with wait time now almost halved.	No imminent change in the pathway is expected considering that there is no change in the workforce numbers is anticipated, which will required to create nurse-led clinics
Urology	Indications, incidence, and Outcomes of emergency ureteroscopy (EURTS) at RHH	EURTS is a beneficial procedure and it helps to reduce the load of ureteric stones patients on elective lists. It is a quick way to deal with patients coming in emergency with ureteric stones related complications and hence reduces morbidity.	No actions required as pathway working well
Obstetrics	Care of women with complex pregnancies	New SOP on Hub and reinforcement of information via clinical leads and clinical director	Re – audit 01/06/22
Paediatrics	Audit of use of Sedation for day case procedures on children's ward	Fully compliant against NICE Guidance CG112	No action plan, scheduled re-audit 01/08/2023
Acute Medicine	Speciality Referrals	Audit met all criteria within 10% no cause for concern,	The second cycle of the audit shows full compliance with the documentation of the post take ward round times and the morning ward round times
Rheumatology	A service evaluation project to evaluate the impact of vertebral fracture assessment on DEXA recommendations	Extend criteria for VFA scanning by adding primary hyperparathyroidism as an indication. and adding additional time for radiographers to perform VFA scans.	As per previous column
Anaesthetics	Analgesic efficacy of spinal diamorphine versus fentanyl for elective caesarean section in the first 72 post-operative hours at Russells Hall Hospital	100% of all women undergoing elective caesarean surgery were prescribed ibuprofen, paracetamol and oral morphine.	No further action
Ophthalmology	Anterior Chamber Intraocular lens outcomes	100% compliance	No further action
Vascular	Assessing the outcomes of ruptured AAA in terms of mortality and morbidity in our trust	Second consultant surgeon available on rota for leaking AAA emergencies.	Re audit scheduled 01/07/2027
Elderly Care	Falls audit at Netherton Green Step Down	All criteria were met except one which we improved drastically to 86% (just one patient failed) however we cannot implement any changes because the unit is closed.	No further action
Gynaecology	Management of women with postmenopausal bleeding	The project has fully achieved the standards or criteria being audited against	Clinical guideline developed re audit scheduled 01/03/2024
Obstetrics	Post C-Section wound infection rate	Development of a pathway for patients with wound infections.	Re audit scheduled 01/09/2023

SPECIALTY	AUDIT TITLE	IMPROVEMENT	ACTION PLANNED
Rheumatology	Rheumatology New Patient Casemix Audit	Re-allocation of new patient slots to increase the number of suspected inflammatory arthritis slots to ensure a better service for newly presenting inflammatory arthritis	Re audit scheduled 02/01/2025
Safeguarding	Staff knowledge of staff of female genital mutilation	Training has been improved to help staff identify FGM better and understand it.	Re audit scheduled 31/01/2024
Gastroenterology	AQ Pathway Decompensated Liver Disease (DLD)	The trust has introduced an Alcohol Care Team (ACT) alongside the Dudley integrated liver service to ensure that the trust have alcohol liaison nurses on site, as a result over 66% of patients are now referred to ACT. •Continued good performance with bleeds •Ascitic tap improved again in June to 87% •Electronic systems appear to be having positive effect e.g. with regards to alcohol assessment	Increase Pabrinex prescription
Renal	AQ Pathway Acute Kidney Injury (AKI)	The development of a digital flowsheet to document the urine dipstick ACE and ARB's are stopped within 24 hours in 100% of the patients all the time Bedside portable scanners to improve ultrasound scanning	•Improve documentation of patient leaflet given. •Improved support from the Renal Consultants/PA
Respiratory	AQ Pathway Community Acquired Pneumonia (CAP)	Oxygen assessment within 4 hours of admission Improvement in antibiotics administered within 4 hours of admission	New process being implemented for chest x-ray within 4 hours New process to achieve compliance for CURB 65 Recruitment of a pneumonia nurse
Deteriorating Patient Team	AQ pathway Sepsis	Achieved all the KPI indicators	New Trust DPP dashboard has increased the accuracy of the documentation for the senior clinical reviews and early identification / treatment for sepsis (removing need to screen every patient who only triggered a screen from a single trigger of 3 in NEWS2
Learning Disabilities team	Learning Disabilities Mortality Review	There is 100% compliance with the causes of death	No action needed

3.4 RESEARCH AND DEVELOPMENT (R&D)

The number of participants receiving health services provided or sub-contracted by the Trust in 2022-23 (to date 21.03.23) that were recruited during that period to participate in research approved by a research ethics committee was 689. We currently have 44 studies open to recruitment, which

consist of 8 commercial studies and 35 non-commercial studies, with a further 20 studies being set-up

The balance of the portfolio across specialties covers Anaesthetics & Critical Care, Cancer, Cardiology, Chemical Pathology, Dermatology, Diabetes, Gastroenterology, Haematology, Neurology, Paediatrics, Renal, Trauma & Orthopaedics, Rheumatology, Stroke, Vascular, General Surgery, Education and Palliative Care all continuing to participate or express an interest in research. Interest in research across non-medical/AHP staff groups has increased with a number of staff being supported to progress innovation or research ideas.

Studies that were on hold due to the COVID pandemic, have now all re-opened, whilst we are continuing to support COVID-related research studies. We were extremely successful with recruiting participants to these urgent public health studies, and we were a top recruiters for a number of these.

Research into practice
We recruited 21 participants to the FAST-FORWARD study (Principal Investigator Dr G Kuriakose) investigating a shorter radiotherapy treatment benefits women with early-stage breast cancer. Breast cancer patients in the UK can now receive fewer radiotherapy sessions following surgery after this trial confirmed that a one-week course was as safe and effective as the standard three-week course. The new treatment schedule is now being adopted internationally.

Training and infrastructure
We held our first Trust Research Training event on 10th February 2023, which was highly successful with a wide range of speakers and good attendance, with attendance from other local Trusts and University staff. We will hold further events throughout the year.

We continue to support Student Nurse's 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.

Public engagement
We had held a second Listening into Action (LIA) event in October 2022; with an action plan in place and a follow-up event early 2023, to advise the patient group how actions have been implemented.
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, that attend our Research, Education and Innovation Group, attends LIA events, Research Training sessions held in February 2023 and is a member of our Research Protocol Review Panel, for any 'home grown' studies.

Publications
Trust publications for the calendar year 2022, including conference posters, stands at 115.

3.5 COMMISSIONING FOR QUALITY AND INNOVATION (CQUIN) PAYMENT FRAMEWORK

The Trust's income in 2022/23 was conditional on achieving quality improvement and innovation goals through the Commissioning for Quality and Innovation payment framework, there were 8 incentivised CQUINs, with 12 CQUINs mandated to be undertaken for reporting and quality monitoring, the Trust appear on target to achieve 7 of the incentivised CQUINs, and under the caveat of the CQUIN, income may not be clawed back as a penalty, but reinvested for further

service development, the final position of performance is yet to be fully confirmed. The contracts that were subject to these achievements include Black Country ICB, Specialised Services and Hereford and Worcester

3.6 CARE QUALITY COMMISSION (CQC) REGISTRATION AND REVIEWS

The Dudley Group NHS Foundation Trust is required to register with the Care Quality Commission (CQC) and its current registration status is registered without conditions. The Care Quality Commission has not taken enforcement action against The Dudley Group NHS Foundation Trust during 2022/23.

The Trust was last inspected in January/February 2019 and the report was published in July 2019, the result of which was an overall rating of 'Requires Improvement'. In arriving at this overall assessment, the CQC assessed 56 elements within nine areas. Of the 56 elements, 32 were rated as 'Good', which meant that for Surgery, Critical Care, End of Life Care (hospital) and End of Life Care (community services) the Trust was in fact rated as 'Good'. In addition, Surgery at Russell's Hall Hospital and End of Life Care (community) services were both given an 'Outstanding' rating for 'Caring'. Two of the core services, Diagnostic Imaging, and Urgent and Emergency Care, had two and one element respectively rated as 'Inadequate' resulting in an overall rating for Diagnostic Imaging of 'Inadequate'.

The CQC undertook an unannounced focus inspection of the Emergency Department in February 2021 as part of their 'Resilience 5 Plus' process. The previous rating of an overall 'Requires Improvement' remained as this was not a full inspection. What was reviewed fully was the 'Safe' domain which was found to have met the requirements of previous enforcement action and was rated as 'Requires Improvement' rather than 'Inadequate' from the previous inspection.

The CQC undertook an unannounced focussed inspection of the Paediatric Emergency Department in February 2023, due to concerns about the safeguarding of children and young people attending the department. Following the inspection, the Trust provided the CQC with a comprehensive action plan with evidence addressing how the Trust was responding or had responded to the concerns raised. The inspection report had not been published at the time of writing this report.

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

Ratings for Russells Hall Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement ↑ Feb 2021	Requires improvement →← May 2019	Good ↑ May 2019	Requires improvement →← May 2019	Requires improvement ↑ May 2019	Requires improvement ↑ May 2019
Medical care (including older people's care)	Good →← Apr 2018	Good →← Apr 2018	Good →← Apr 2018	Good →← Apr 2018	Good →← Apr 2018	Good →← Apr 2018
Surgery	Requires improvement ↓ May 2019	Good →← May 2019	Outstanding ↑ May 2019	Good →← May 2019	Good →← May 2019	Good →← May 2019
Critical care	Good ↑ May 2019	Good ↑ May 2019	Good →← May 2019	Requires improvement →← May 2019	Good ↑ May 2019	Good ↑ May 2019
Maternity	Requires improvement ↓ May 2019	Good ↑ May 2019	Good →← May 2019	Good →← May 2019	Requires improvement ↓ May 2019	Requires improvement ↓ May 2019
Services for children and young people	Requires improvement →← May 2019	Good ↑ May 2019	Good →← May 2019	Requires improvement →← May 2019	Requires improvement →← May 2019	Requires improvement →← May 2019
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
Overall	Inadequate ↓ May 2019	Good ↑ May 2019	Good →← May 2019	Requires improvement →← May 2019	Requires improvement →← May 2019	Requires improvement →← May 2019

Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Inadequate ↓ May 2019	Good ↑ May 2019	Good →← May 2019	Requires improvement →← May 2019	Requires improvement →← May 2019	Requires improvement →← May 2019

The rating for well-led is based on our inspection at trust level, taking into account what we found in individual services. Ratings for other key questions are from combining ratings for services and using our professional judgement.

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 Trust submitted records during 2022/23 to the Secondary Uses Service (SUS) for inclusion in the Hospital Episode Statistics (HES) latest published data.

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

	The Dudley Group	National average
Admitted Patient Care	99.9%	99.6%
Outpatient Care	99.9%	99.8%
Accident and Emergency Care	99.7%	98.7%

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	99.6%	99.6%
Outpatient Care	99.8%	99.8%
Accident and Emergency Care	98.7%	98.7%

Latest available figures from NHS England CDS DQ Dashboard:
Provider View (for APC and OPA) and ECDS Current View for April 2022 to February 2023

3.7.2 Information Governance

The Dudley Group NHS Foundation submitted the Data Security & Protection Toolkit for 2021/22 in June 2022 with 'Standards Met'.

The date for the submission of the 2022-23 toolkit is 30th June 2023 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 2022/2023
Primary diagnosis	>= 90.0%	>= 95.0%	98%
Secondary diagnosis	>= 80.0%	>= 90.0%	98%
Primary procedure	>= 90.0%	>= 95.0%	97%
Secondary procedure	>= 80.0%	>= 90.0%	87%

Standards were exceeded in primary and secondary diagnosis plus primary procedures with the standards being met in secondary procedures.

The overall Healthcare Resource Group (HRG) error rate was eight episodes which is 4% of the total number of episodes. The value of the HRG changes was £11,588 gross, £584 net which is a change of 2.1% absolute and just 0.1% net.

Recommendation	Action
Programme of training to be developed to address gaps in knowledge and skill	Review undertaken of the gaps in knowledge and skills to determine the content of the training programme It was determined it needed to include. • Z11.5 has not required coding since 1st April 2021 • DCS.IX.10: Heart failure (I50) • DCS.XI.7: Rectal haemorrhage and per rectal haemorrhage (K62.5 and K92.2) • DCS.XI.8: Alcoholic liver disease and alcoholic pancreatitis (K70, K85.2 and K86.0) • DChS.XVIII.1: Signs, symptoms and abnormal laboratory findings • PGCS10: Coding endoscopic procedures • PCSU1: Diagnostic imaging procedures (U01–U21 and U34–U37) • PCSU2: Radiological contrast and body areas (Y97-Y98) Training programme developed and delivered to all coders on the 10th May 2022
Ensure all staff are aware of the need to check that all conditions or comorbidities highlighted by the MHS have been documented in the current patient episode (if not they must not be coded)	
To review the use of the coding tool Medical History Assurance (MHA) which highlights chronic co-morbidities to the coder as this allow the selection of comorbidities that are not in the current care documentation	The Trust has ceased using MHA in October 2022

3.8 LEARNING FROM DEATHS

During 2022, 1927 of The Dudley Group NHS Foundation Trust patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period. Refer to the chart below.

By 31st December 2022, 188 case records reviews and 18 investigations have been carried out in relation to the 1927 deaths.

In 18 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

2 deaths representing 0.10% of the patient deaths during the reporting period are judged to be more likely than **not** to have been due to problems in the care provided to the patient. In relation to each quarter, this consisted of:

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

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 2022**				
	Q1	**Q2**	**Q3**	**Q4**	**Comments**
Number of patients who died	457	458	546	466	
Number of deaths subjected to a case note review	54	46	38	50	
Number of deaths subjected to an investigation	0	3	5	11	
Number of deaths subject to a case note review and investigation	0	3	5	11	
Number and representing percentage of quarterly total judged more than likely **NOT** to be due to problems in care	54 100%	45 97.8%	38 100%	49 98%	
Number and representing percentage of quarterly total judged more than **likely** to be due to problems in care	0	1 2.2%	0	1 2%	
Estimate of the number of deaths thought to be more likely than not due to problems in the care provided	0	0	1	1	2 cases were related to insulin. All cases have been investigated via Datix

1925 representing 99.9% of the patient deaths during 2022 are judged to be more likely **not** to have been due to problems in the care provided to the patient.

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. A gap in updating GSF for patients when patients begin to deteriorate. Overall end of life care is good within the trust. Delays in implementation of best supportive care may occur when decisions are awaited from tertiary centres. Such delays may prevent a	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.

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.	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 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. 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. End of Life Care is now a statutory part of staff training.	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. Continuing validation of notes in patients with fluid and electrolyte disorders. Implementation of RESPECT document

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. Reduction in investigation requests from the coroner.	Decreased number of serious incidents. Reduction in Fluid and Electrolyte disorder mortality.

3.9 SEVEN-DAY HOSPITAL SERVICES (7DS)

The 7-day service standards were first introduced in 2013 by NHS Improvement, four of which were identified as clinical priorities in 2016 based on their potential to positively affect patient outcomes. The 7DS programmes aim is to provide a standard of consultant led care to all patients presenting urgently or as an emergency such that their outcomes are optimised and there is equity of access nationwide. The outcomes are not dependent on the time of day or day of the week patients present. It should be noted that national reporting was suspended due to COVID-19 pressures and has not resumed.

Priority Standard 2 (time to first Consultant review) and Standard 8 (ongoing daily review)

The last reported audit achieved 92% for standard 2 and for standard 8 94% for once daily review and 87% for twice daily reviews. Assurance of continued compliance of these standards now forms part of the annual job planning cycle for all departments overseen by the Medical Job Planning Consistency Committee. 100% of ward round documents are being initiated on sunrise.

Priority Standard 5 (access to diagnostics) and 6 (Access to Consultant led interventions)

Significant progress has been made since the launch of the 7DS standards and following previous audit work performance against standard 5 is reported and monitored in real time.

A reaudit of the standards is due to commence in 2023/24.

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 this to assure, 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 escalating 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.
Rebekah Plant – Lead Freedom to Speak up Guardian.
Philippa Brazier – Freedom to Speak up Guardian.

The team operate 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 office (NGO)'s 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 ICS Guardians have monthly meetings to provide peer support and develop joint working where appropriate. At present regular attendees (along with ourselves) are DIHC, RWT and WMAS.

3.10.2 Champions

In order to maximise the accessibility of the FTSU service we have a network of 20 champions across the Trust in various roles including administrative, medical, 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 two new champions in Maternity (acute and community), a new champion in ED and a new champion in Phlebotomy. Expressions of interest have been invited from paediatrics.

A core group of experienced champions remain in place throughout the acute and community sites including: Imaging, Pharmacy and BHSCC.
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 BAME, LGBTQ+ and Disability staff groups.

3.10.3 Next steps being taken by the Trust

1. All three FTSU training modules have now been released by the National Guardian 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 Guardians Office has recently published 'Freedom to Speak up – a reflection and planning tool' and advised that this should be completed at least every two years.
3. The National Guardian Office has recently released their national policy with the recommendation that it should be adapted, for use, in individual organisations by 2024.

3.10.4 Recent activities

For 'Speak up' month 2022 a green raffle was held: staff could take a (free) ticket and win a green item. Feedback from this activity was very positive.

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 SHO level activity. This has been particularly successful in the Acute Medical Unit and is being 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 Oncqc 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.

PART 4: NATIONAL CORE SET OF QUALITY INDICATORS

4.1 PREVENTING PEOPLE FROM DYING PREMATURELY

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	November 2020 – October 2021	November 2021 – October 2022
Trust	1.12 (Band 1)	1.13 (Band 1)
National Average	1.01	1.02
Lowest	0.75	0.67
Highest	1.21	1.27
Trust	19.5%	20.9%
National Average	36.8%	37.9%
Lowest	9.1%	5.9%
National	80.2%	82.1%

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 now reviewing 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 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

4.2 HELPING PEOPLE TO RECOVER FROM EPISODES OF ILL HEALTH OR FOLLOWING INJURY

4.2.1 Patient reported outcome measures

NHS digital published in 2021 that significant changes had been made to the processing of Hospital Episode Statistics (HES) data and its associated data fields which are used to link the PROMs-HES data. Redevelopment of an updated linkage process between these data are still outstanding nationally with no definitive date for completion at this present time. This has unfortunately resulted in a pause in the current publication reporting series for PROMs at this time

4.2.2 Readmissions to Hospital within 30 Days of Discharge

	2021/22			2022/23		
	0 – 15 years	16 & over	Total	0 – 15 years	16 & over	Total
Discharges*	10939	94123	105062	11378	112155	123533
Readmissions within 30 days (number)	242	10011	10253	292	12015	12307
Percentage %	2.2%	10.6%	9.8%	2.6%	10.7%	10.0%

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 Ramsey 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

Our score is for the five questions in the national patient survey relating to responsiveness and personal care.

	2021/22	2022/23
Dudley Group NHS FT	**71.7**	Waiting end of year data not yet published
National average	**67.9**	Waiting end of year data not yet published
Highest	**84.1**	Waiting end of year data not yet published
Lowest	**54.4**	Waiting end of year data not yet published

NHS Outcomes Framework (NHS OF) digital.nhs.uk

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

Awaiting publication of national end of year data sets

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

Awaiting publication of national end of year data sets

4.3.2 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 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
% Very Good/Good	80%	83%
National Benchmarking	90%	90%
% Very Poor/Poor	7%	6%
National Benchmarking	5%	6%

Unify - community - Patient experience survey reporting
https://www.england.nhs.uk/publication/friends-and-family-test-data)

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.
- Patient's responses and feedback are shared with teams for earning and service improvement, comments are 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 patient's 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 planning and development.
- A Patient Voice Volunteer (PVV) is a non-trust employee who supports the hospital in improving patient experience. PVV's bring an independent perspective and are involved, as an equal partner, in a wide range of activities and programmes to improve the patient experience. We have recruited seven PVVs who all bring lots of experience of using Trust services or caring for someone who has been a patient.

4.3.3 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 gather in the National Staff Survey (Quarter 3); and in the National Quarterly People Pulse (Quarter 1, 2 and 4)

Dudley Group NHS FT	2022/23			
	Q1	Q2	Q3	Q4
National average for combined acute/community trust	Awaiting data	Awaiting data	Awaiting data	Awaiting data
Highest combined acute/community trust	Awaiting data	Awaiting data	Awaiting data	Awaiting data
Lowest combined acute/community trust	Awaiting data	Awaiting data	Awaiting data	Awaiting data

Data source

The Dudley Group NHS Foundation Trust considers that this data is as described for the following reason:
Awaiting publication of national end of year data sets

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

Awaiting publication of national end of year data sets

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.

	2021/22	2022/23
Dudley Group NHS FT	**93.2%**	**93.6%**
National average	**No data available**	**No data available**
Best performing Trust	**No data available**	**No data available**
Worst performing Trust	**No data available**	**No data available**

Data source EPMA VTE and Bleeding Assessment - Power BI Report Server (wmids.nhs.uk)

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

Due to the Covid-19 pandemic, the national collection of data related to this metric was paused. The Trust has continued to provide updates via the Integrated Performance Report to Trust Board on a regular basis.

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

- Following a deep dive into the completion of VTE assessments in January 2022 key areas of non-completion of the assessment and paper records were identified. A discrepancy between the electronic reporting and paper records was identified.
- The Trust asked internal audit to review the data quality relating to VTE and a report providing reasonable assurance was received in November 2022. The audit identified a number of actions that are now being worked through.
- A redesign of sunrise to add an additional function that will not allow staff to bypass the assessment is underway and expected to significantly increase the KPI compliance.
- For further assurance outcome and readmission data were reviewed in relation to VTE. The Trust is in the lower quartile for readmissions relating to VTE and outcome data shows continual improvement.

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
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**	**24.80**
National average	**46.60237797**	**25.1971091564799**	*
Best performing trust	**2.254715173**	**0**	*
Worst performing trust	**140.5415535**	**138.379575174704**	*

*= data not available

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 2 or more days after admission.
2. Community Onset Healthcare Associated (**COHA**): cases that occur in the community or within 2 days of hospital admission when the patient has been an inpatient in the Trust reporting the case, within the previous 4 weeks.

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

- The Trust continues to perform well against national data. This is especially pleasing in a climate where nationally numbers of cases are increasing.

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

- 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
- 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 achieving.
- Treatment protocols continue to be updated to ensure they reflect evidence-based practice and follow National guidelines
- An annual Clostridiodes difficile improvement plan has been developed and is presented to the Infection Prevention and Control Group on a bi-monthly basis.

4.6 PATIENT SAFETY INCIDENTS

Dudley Group NHS FT **Total reported incidents**	Previous reporting period Apr 2020 – Mar 2021	Previous reporting period Apr 2021 – Mar 2022	Latest reporting period Apr 2022 – Mar 2023
Total reported incidents	6191	9159	15053
Rate per 1000 bed days	29.1	37.3	76.7
National average (acute non-specialist)	58.4	57.5	No data available
Highest reporting rate (acute non-specialist)	118.7 (32,917)	205.5 (11,903)	No data available

Dudley Group NHS FT Incidents causing severe harm or death	Previous reporting period Apr 2020 – Mar 2021	Previous reporting period Apr 2021 – Mar 2022	Latest reporting period Apr 2022 – Mar 2023
Incidents causing severe harm or death	24	26	35
% of incidents causing severe harm or death	0.38	0.28	0.23
National average (acute non-specialist)	0.225	0.152	No data available
Highest reporting rate	1.835 (107)	0.901 (48)	No data available
Lowest reporting date	0.014 (1)	0.004 (1)	No data available

NHS Outcomes Framework Indicators March 2022 release

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

During the reporting period 2022-23, there has been a significant increase in the number of incidents reported the NRLS; it should be noted however that during this period there was a retrospective up-load of pressure ulcers from the previous year when it was identified that pressure ulcers present on admission incidents had not been reported in line with national guidance (Stop the Pressure). Although this retrospective up-load accounts for the majority of the increase in reporting seen, there has been an overall increase in reporting in year.

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

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

As part of the Trust's work to transition to the Learn from Patient Safety Events (LFPSE) service, a communications and engagement campaign is planned to help further promote reporting across the organisation. Furthermore, work to improve incident reporter feedback is be incorporated in this workstream.

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 2021/22	Target 2022/23	National 2022/23	Trust 2022/23
Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate – patients on an incomplete pathway	73.6%	92%	58%	57.8%
A&E: maximum waiting time of 4 hours from arrival to admission, transfer, discharge	79.75%	95%	N/A	76.53%
All cancers: 62 day wait for first treatment from urgent GP referral for suspected cancer	60.0%	85%	N/A	Data not available
All cancers: 62 day wait for first treatment from NHS Cancer Screening Service referral	82.7%	90%	N/A	Data not available
Maximum 6 week wait for diagnostic procedures	81.20%	99.00%	70.26%	77.77%

Dudley Group NHS FT	Trust 2021/22	Target 2022/23	National 2022/23	Trust 2022/23
Venous Thrombolism (VTE) Risk Assessment	93.2%	95%	N/A	93.6%

Trust data from DM01 Diagnostic Waiting Times submissions to NHSD
*2022/23 Trust performance shows year to date i.e., April 2022 to December 2022
**2022/23 National performance taken from NHSE website of “Trust” provider DM01 submissions

Glossary of terms

A&E	Accident and Emergency (also known as ED)	HQIP	Healthcare Quality Improvement Partnership
AAA	Abdominal Aortic Aneurysm	ICB	Integrated Care Board
AKI	Acute Kidney Disease	ICNARC	Intensive Care National Audit & Research Centre
Bed Days	Unit used to calculate the availability and use of beds over time	ICP	Integrated Community Provider
C. diff	Clostridiodes difficile	IPC	Infection Prevention and Control
CMP	Case Mix Programme	KPI	Key Performance Indicator
CPR	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

To be added after Quality and Safety Committee

Comment from the Integrated Care Board

To be added after Quality and Safety Committee

Comment from Healthwatch

To be added after Quality and Safety Committee

Comment from the Health and Adult Social Care Scrutiny Group

To be added after Quality and Safety Committee

Statement of directors' responsibilities in respect of the Quality Report 2022/2023

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 2022/2023* 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 2022 to May 2023
- Papers relating to quality reported to the board over the period April 2022 to May 2023
- Feedback from commissioners Integrated Care Board May 2023
- Feedback from governors May 2023
- Feedback from Healthwatch May 2023
- 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, May 2023
- The latest national inpatient survey March 2023
- The latest national staff survey, dated March 2023
- 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: Date:

Chairman

Signed: Date:

Chief Executive