THE ROYAL WOLVERHAMPTON HOSPITALS NHS TRUST

Report to:	Trust Board
Date:	26 March 2012
Subject:	Quality & Safety Report
Report by:	Chief Nursing Officer
Author:	Patient Safety Manager
Purpose of Report	To provide the Board with information regarding performance and progress with Trust quality and safety.

Report

The report relates to January 2012 and includes progress of the Trust's campaign to prevent harm and improve patient safety in addition to an organisational overview of incidents, complaints, inquests, and claims. It also provides information on issues that fall outside of the campaign but contribute to the quality and safety agenda.

Review Committee Approval

This report was presented to the Quality & Safety Committee on the 6 March. Mortality data has since been updated in this report to the Trust Board.

Recommendation(s)

The Committee is asked to note the content of the report

Contents

1) EXECUTIVE SUMMARY

This report on Quality and Safety includes progress on the Campaign for Preventing Harm, Improving Safety. The report refers to the period January 2012.

Section 2 provides an overview of organisational quality and safety.

Section 3 details progress with the Preventing Harm, Improving Safety harm prevention initiatives.

Section 4 reports on the patient experience.

Section 5 includes performance on areas that impact on patient safety and quality.

The areas to note regarding progress are as follows:

- Increase in grade 2 pressure ulcers
- 16 cases of C Diff and 3 MSSA bacteraemias during the month
- 8 DRHABs
- 1 complaint referred to the Ombudsman
- 10 medication administration incidents but none resulting in patient harm

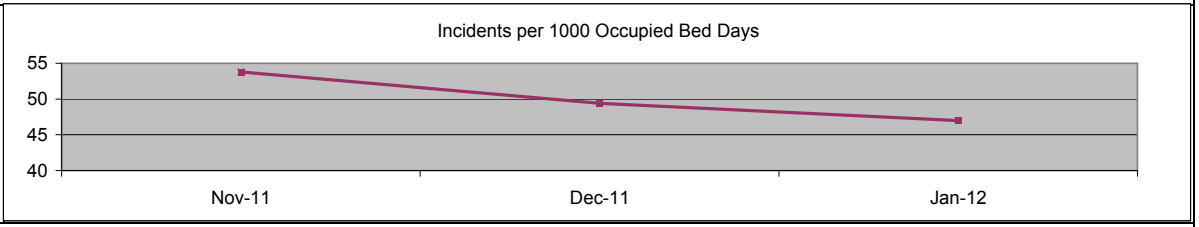
- No serious complaints reported this month
- No safeguarding adult incidents reported this month
- Reduction in the number of radiation incidents compared to previous two months
- HSMR year to date is 90
- Reduction in number of falls resulting in serious injury this month compared to last two months
- Continued reduction in the percentage of late observations
- VTE risk assessments completed in 95.83% patients
- Formal complaints remain below 1% activity at 0.2%
- 100% complaint responses within 25 working days (or agreement to extend)
- No single sex accommodation breaches
- Increase in percentage of nutritional screening documentation

2) TRUST SAFETY & QUALITY OVERVIEW

2.1 Incident Rate

Key to providing high quality care is having good systems in place for staff to report when patients have, or could have been harmed. Organisations with good levels of reporting are able to set safety priorities and direct investment, anticipate problems and reduce costly claims, identify problems and take actions. High reporting of incidents is a mark of high reliability organisations and therefore incident reporting is to be encouraged. It is essential that staff receive feedback, there is a focus on learning, frontline staff are engaged, incident reporting is easy, reporting systems focus on improving safety rather than blaming individuals and appropriate action is taken.

	Nov-11	Dec-11	**Jan-12**
Div 1	399	327	363
Div2	678	741	784
Total	1077	1068	1147
Per 1000obd	53.8	49.4	47



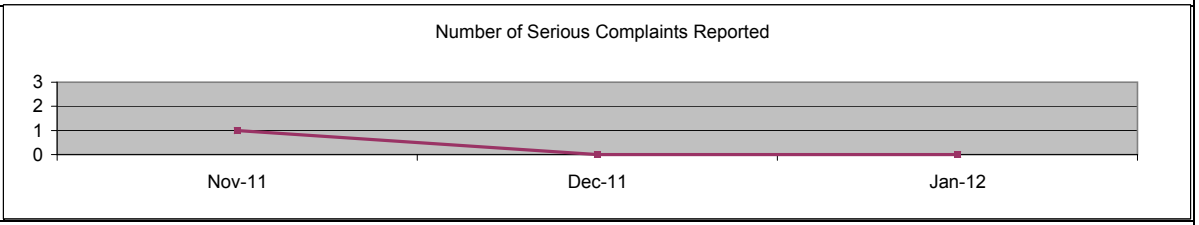
Analysis: The number of incidents reported during January has increased by 7% from the previous month, the incident rate (per 1000 occupied bed days) has however decreased. The majority of incidents are reported by nursing and midwifery staff and the largest category of incidents is patient falls (further information on patient falls in section 3.2).

Actions: The reporting of incidents continues to be encouraged and the use of online reporting of incidents via Datix Web is extending. All directorates are working to achieve a sustained reduction in patients falls.

2.2 Serious Complaints

A serious complaint includes complaints graded amber and red on the Trust's risk matrix. These complaints are reported and monitored by the Quality & Safety Committee on a quarterly basis and the Trust Board receives a summary report of red/amber complaints on a quarterly basis.

	Nov-11	Dec-11	**Jan-12**
Div 1	0	0	0
Div2	1	0	0
Corp	0	0	0
Total	1	0	0



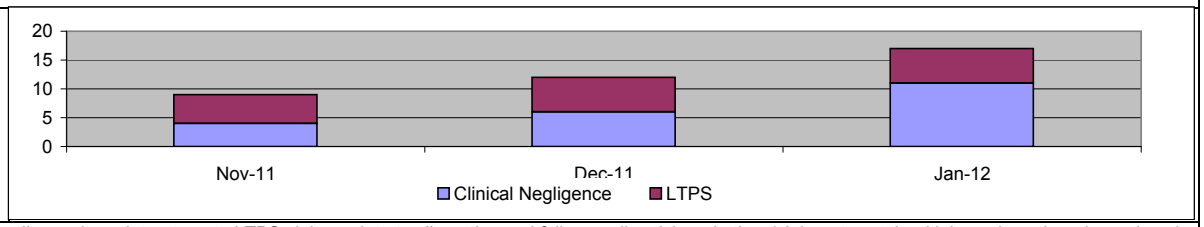
Analysis: There were no serious complaints during January 2012 that were graded as amber or red using the Trust risk matrix.

Actions: No actions to report

2.3 New Litigation

The numbers of new clinical negligence claims and liabilities to third party (LTPS) claims received during the quarter are detailed below. A detailed report is provided in the confidential section of the Trust Board every 6 months.

	Nov-11	Dec-11	**Jan-12**
Clinical Negligence	4	6	11
LTPS	5	6	6
Total New	9	12	17



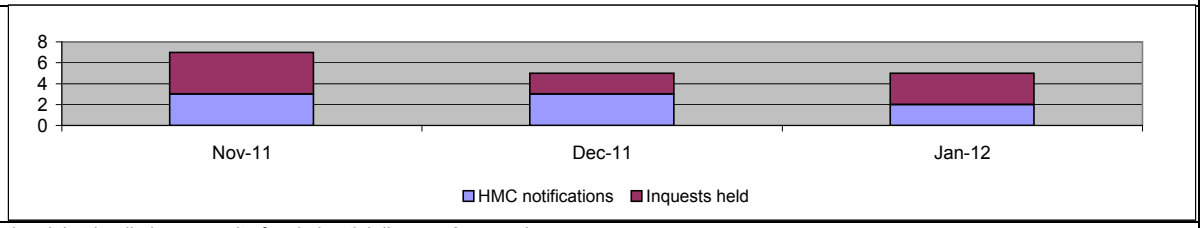
Analysis: During January 2012 clinical negligence claims were received relating to nursing care, diagnosis and treatment. LTPS claims relate to slips, trips and falls, needle stick and other (claimant sustained injury when changing a dressing of an amputee)

Actions: The details of new claims are provided to the divisions in order that they can take the necessary action to assist the risk management process in the prevention of recurrence

2.4 Inquests

The purpose of the inquest is to determine how, when and where the deceased died. Her Majesty's Coroner (HMC) may give a narrative verdict or one of a number of standard verdicts. HMC may also make recommendations on the provision of care/treatment or service provided or, issue a Coroner's Rule 43 which allows him to report the findings to an individual or body who may have the power to prevent a similar death occurring in the future.

	Nov-11	Dec-11	**Jan-12**
HMC notifications	3	3	2
Inquests held	4	2	3
HMC Recommendations	0	0	0
% Recommendations per	0	0	0



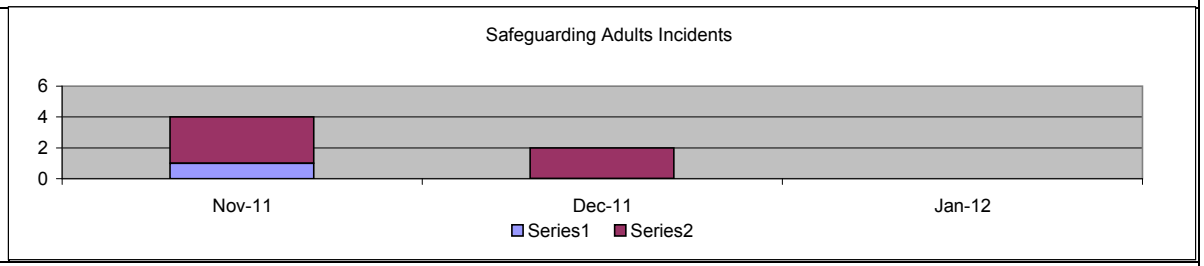
Analysis: During January 2012 three inquests were held. 1 - deceased's death was work related and that he died as a result of an industrial disease. 2- natural causes

Actions: No actions

2.5 Safeguarding Adults Incidents

A vulnerable adult is defined in 'No Secrets' (the Government's Guidance on Adult Abuse) as "a person aged 18 years or over, who is in receipt of or may be in need of community care services by reason of 'mental or other disability, age or illness and who is or may be unable to take care of themselves, or unable to protect themselves against significant harm or exploitation." It is recognised that certain groups of people may be more likely to experience abuse and less able to access services or support to keep themselves safe. The following incidents are those that have been reported under the Wolverhampton Safeguarding Adults policy and procedure 2010.

Safeguarding Adults	Nov-11	Dec-11	**Jan-12**
Div 1	1	0	0
Div2	3	2	0
Total	4	2	0



Analysis: No safeguarding vulnerable adult incidents reported during January 2012.

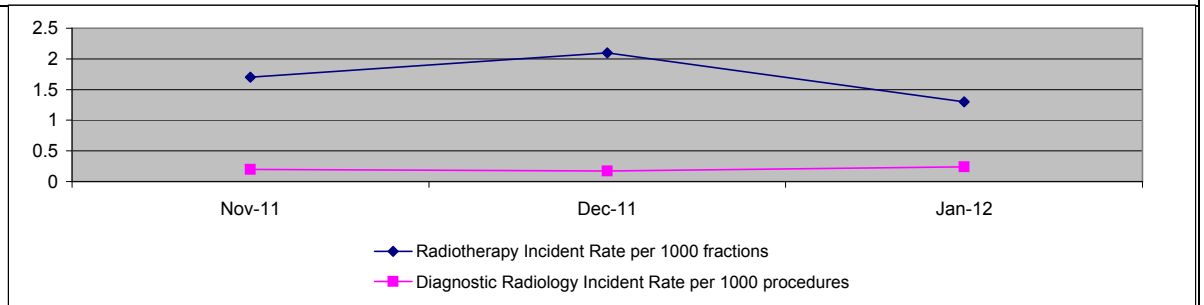
Actions: All internal investigations have been completed for previous safeguarding allegations.

2.7 Radiation Incidents

All incidents involving radiation are reported on the Datix system following the Trusts Policies: HS05 Ionising Radiation Safety Policy and HS06 Laser Safety Policy. There is a legal requirement that incidents involving a greater than intended exposure or exposure of the incorrect patient are reported to the Care Quality Commission under the Ionising Radiation (Medical Exposures) Regulations 2000 and those involving equipment are reportable to the HSE under the Ionising Radiation Regulations 1999. The term 'greater than intended' is defined in HS05. All radiation incidents are reported to and discussed at the Trusts Radiation Safety Committee.

Radiation Incidents	Nov-11	Dec-11	**Jan-12**
Radiotherapy	2	6	4
Diagnostic Radiology	4	3	5
Nuclear Medicine	0	1	1
Laser/Non-ionising	0	0	0

Rates	Nov-11	Dec-11	**Jan-12**
Radiotherapy Incident Rate per 1000 fractions	0.7	2.1	1.3
Diagnostic Radiology Incident Rate per 1000 procedures	0.2	0.17	0.24



Analysis:

▪ Radiotherapy – 2 incidents involved bolus used for patient breast treatment, the effect was clinically insignificant and occurred for 1 fraction of each of the treatment. The other 2 incidents involved incorrect set-up instructions input onto patient treatment sheets after verification images. Incidents to be discussed and highlighted at staff meetings. Approx 3021 fractions of radiotherapy were delivered in total this month. Incident Rate 1.3 incidents per 1000~~#~~. Diagnostic Radiology – 4 incidents involved x-ray requests not been completed correctly. The 5th incident involved the exposure of a pregnant patient who had attended for a chest x-ray. There was no information regarding this on the request form, and it is normal practice not to ask patient LMP status for chest examinations. The incident was reported to the Medical Physics department and advised on dose to foetus. Approx 20,438 radiological examinations were carried out this month. Incident rate 0.24 incidents per 1000 procedures. ▪ Nuclear Medicine – The incident involved radioactive contamination found on a cleaning cloth that had been left in a room during an isolator service. The dose rate was negligible and no contamination was found in the isolator. The company and engineer were informed. The handover procedure is to be reviewed.

Actions:

▪ Incidents to be reviewed by the Radiation Safety Committee Incident Group to see if further actions are required.

3) PREVENTING HARM, IMPROVING SAFETY MEASURES

Introduction:

This section includes progress from the Preventing Harm, Improving Safety Group for the period (month/quarter).

The following initiatives are our priority for 2011-13 and will contribute towards achieving our aim to prevent avoidable harm and avoidable death: Pressure Ulcers, Falls Prevention, Infection Prevention, Venous Thromboembolism, Deteriorating Patient, Nutritional Assessment, Device Related Infections and Clinical Handover.

3.1 Mortality

The Hospital Standardised Mortality Rate (HSMR) is an important indicator of the care provided. Figures shown are the monthly average and are the latest data available by Dr Foster.

	Nov-10	Dec-10	Jan-11	Feb-11	Mar-11	Outturn	Apr-11	May-11	Jun-11	Jul-11	Aug-11	Sep-11	Oct-11	Nov-11	Dec-11	YTD
HSMR	97.5	106.4	103.4	103.4	95	102 [113]	94.2	90	73.7	97.2	89.3	94.7	81.7	84	104.7	91
Observed Death Rate (56 CCS	4.00%	5.10%	4.90%	4.50%	3.90%	4.48%	4.40%	3.50%	2.70%	3.90%	3.20%	3.50%	3.10%	3.10%	4.30%	3.50%
Expected Death Rate (56 CCS	4.10%	4.80%	4.80%	4.30%	4.10%	4.42%	4.70%	3.90%	3.70%	4.00%	3.60%	3.70%	3.80%	3.70%	4.10%	3.90%
No of In Hospital Deaths	126	165	157	128	130	1506	125	100	84	116	95	107	93	92	137	955
Expected Deaths	116.2	141.6	137.6	112.8	125.4	1343	132.7	111.1	114	119.3	106.4	113	113	110	131	1053
Excess Deaths	10	23	19	15	5	163	-7.7	-11.1	-30	-3.3	-11.4	-6	-20	-18	6	-98

Analysis: April- December 2011 is the latest available. The Trust's YTD HSMR based on 9 months data is 91 with a probable rebased value of 100. The rebased figure above will be published in the good hospital guide in November 2012. It is to be noted that HSMR and other high level measures of mortality are subject to in year variation.

The 2011/12 Q1 SHMI figure published on NHS Choices in January 2012 was 109.9 this figure is based on all deaths from Q2, Q3, Q4 of 2010/11 and only Q1 of 2011/12.

Top Diagnostic Groups Contributing to Patient Deaths by Volume

April to December 2011

Diagnosis Group	Spells	Deaths	%	SMR
Pneumonia	647	136	21.50%	104.1
Acute cerebrovascular disease	721	107	17.20%	93.2
Acute myocardial infarction	707	49	7.00%	103
Congestive heart failure, nonhypertensive	358	44	12.50%	90.8
Acute and unspecified renal failure	172	34	20.10%	98.1
Cancer of bronchus, lung	645	35	5.40%	98.1

Alert Status

Analysis: CQC Alert received in August 2011 for Complex Elderly Adults with: Nervous System Primary Diagnosis, Cardiac Primary Diagnosis, Urinary Tract or Male Reproductive System Primary Diagnosis.

Actions: A panel of consultants led by a specialist geriatrician are conducting a detailed case note review. This is being complemented by enhanced level data interrogation of the specified HRGs. The response was signed off by the Trust's Mortality Assurance Review Group (MoRAG) on 21 September 2011. In November 2011 The Trust received confirmation from the CQC that no further enquiries will be necessary with regard to these outlier alerts.

Associated Indicators of Mortality

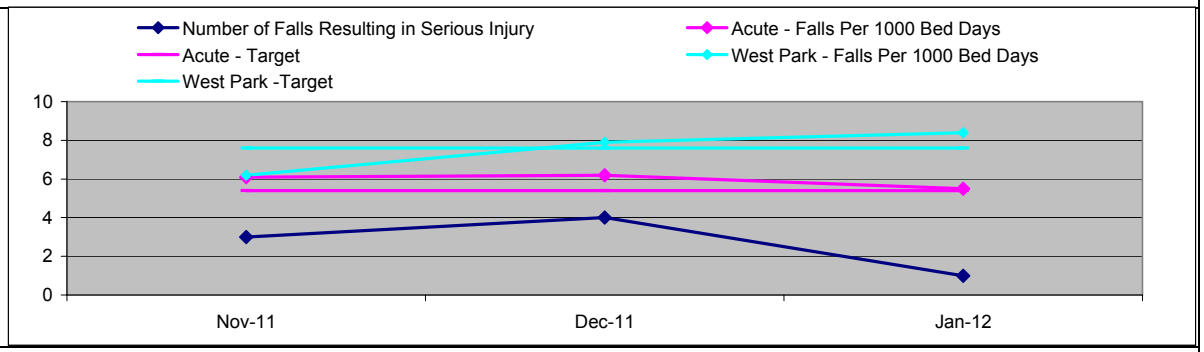
Indicator	Period	Actual	RAG	TREND
Charlson Codes Per Spell (HED)	Apr-Nov 11	**5.56**		➲
Palliative Care Deaths Per 1000 Discharges	Apr-Nov 11	**32**		➲
Expected Death	Apr-Nov 11	**3.90%**		➲

Analysis: The Trust's Specialist Palliative Care team has received a 67% increase in Referrals since 2009. On average 100 referrals to the Specialist Palliative Care Team are received monthly. The number presented in this report is [32] palliative care deaths per 1000 discharges, this should be viewed in the context of over 100 referrals per month to the Trust's Specialist Palliative Care Team

3.2 Inpatient Falls

The proportion of reported patient falls in hospital represents avoidable episodes of harm to patients. Measurements are at a rate of falls per 1000 Occupied Bed Days.

	Nov-11	Dec-11	**Jan-12**
Acute - Target per occupied bed days	<5.4	<5.4	<5.4
Acute - Number of falls per occupied bed	6.1	6.2	5.5
West Park- Target per occupied bed days	7.6	7.6	7.6
West Park - Number of falls per occupied bed	6.2	7.9	8.4
Number of falls resulting in serious injury	3	4	1



Analysis: Improved rate of falls with serious harm in January. Analysis of beds days number undertaken and confirmed as correct

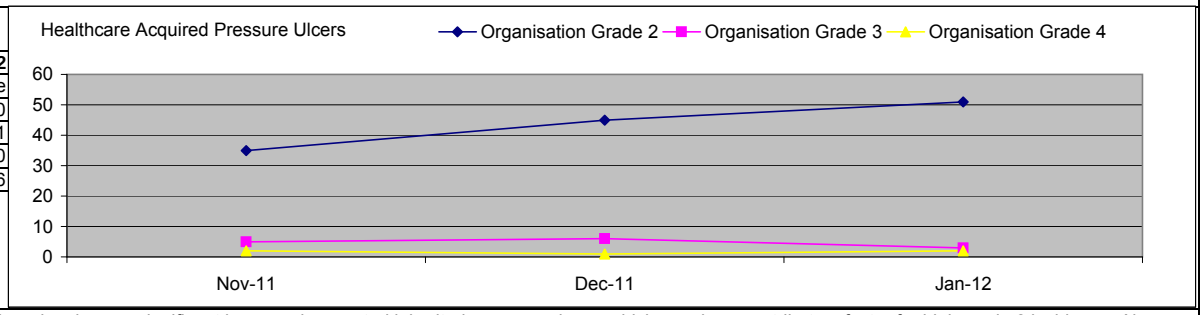
Actions: Continue to embed use of falls prevention care bundle by all professional groups with re audit planned in March 2012. Continue to improve rate of attainment of falls competencies of professional staff

3.3 Pressure Ulcers

Pressure Ulcers are commonly encountered and represent largely avoidable episodes of harm to patients. All healthcare acquired pressure ulcers are reported and the number of pressure ulcers by grades 2,3 & 4 are represented below.

Healthcare acquired pressure ulcers (Grades 2, 3 & 4)

	Nov-11		Dec-11		**Jan-12**	
	Avoidable	Unavoidable	Avoidable	Unavoidable	Avoidable	Unavoidable
Grade 2	12	23	15	31	21	30
Grade 3	1	4	5	0	2	1
Grade 4	1	1	1	0	2	0
Total		42		52		56



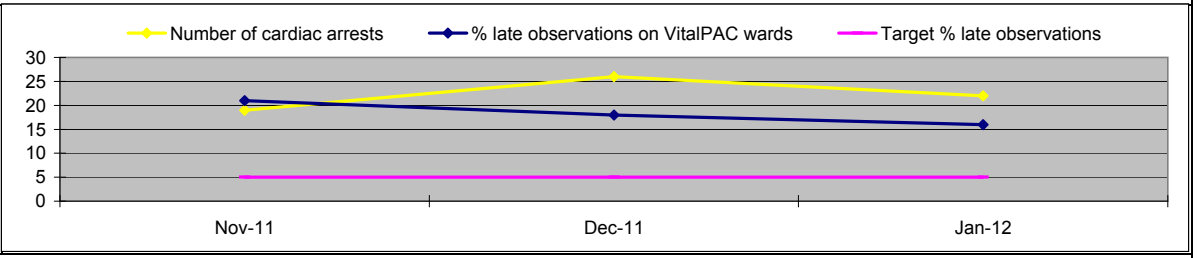
Analysis: Minimal change in reported serious incidents, and an increase in grade 2 reported. There has been a significant increase in reported inherited pressure ulcers, which may be a contributory factor for high grade 2 incidence. Also an increase in reported inherited grade 3 which have then deteriorated to an acquired grade 4.

Actions: Continue to embed zero tolerance to pressure ulcers across the health economy. CQUIN audit in March to check compliance with care package in New Cross. Actions plans from reported serious incidents actioned to provide proactive care to prevent pressure ulcers.

3.4 Recognition of the Deteriorating Patient

The aim is to reduce in-hospital cardiac arrest and mortality rate through earlier recognition and treatment of the deteriorating patient. This involves a review of how physiological observations are recorded and acted upon by staff, ensuring tha staff are trained to undertake these procedures and understand their clinical relevance. In conjunction with this is the review of the use of the Early Warning Score system and communication of the deteriorating acutely ill adult patient. Measures include: Percentage of late patient observation and number of cardiac arrest or crash calls.

	Nov-11	Dec-11	**Jan-12**
Number cardiac arrests	19	26	22
% observations late	21%	18%	16%
Target (late observations)	5%	5%	5%



Analysis: The percentage of late observations continues to reduce.

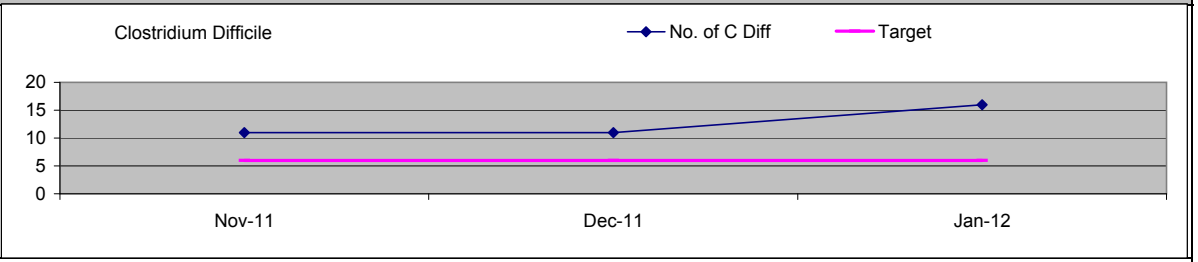
Actions: Ward sisters and Matrons receive weekly compliance reports for actions.

3.5 Healthcare Acquired Infections (HCAIs)

Clostridium difficile (C diff) and Meticillin Sensitive *Staphylococcus aureus* (MSSA) are an important indicator of infection prevention and control.The target for 2011/12, using the RWHT internal definition of attribution of cases, is no more than 6 C diff cases per month (72 or fewer per year) (2010-11 target was <7.5 per month) and 2.5 MSSA bacteraemias per month (30 per year attributable to RWHT).

3.5.1 Clostridium Difficile - hospital acquired for ages >2 years

	Nov-11	Dec-11	**Jan-12**
Number of C Diff	11	11	16
Cum Plan	48	54	60
Cum Actual	95	106	122
Cum Variance	47	52	62

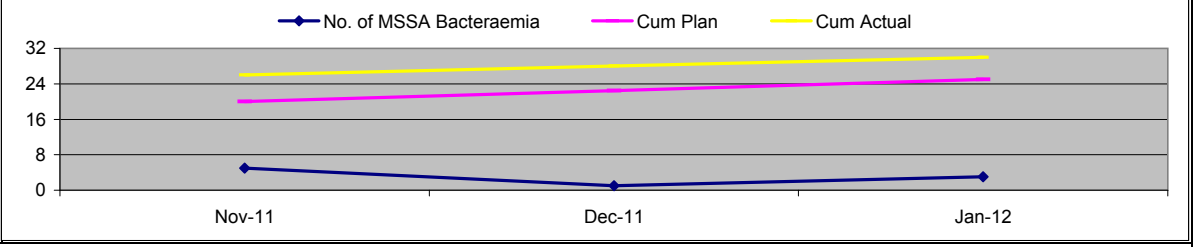


Analysis: 16 cases counting against RWHT using our internal definition of attribution. Against the old external definition of attribution there were 11 cases, but from January we have implemented DH advice and use a clinical assessment of a patients who test positive. Using this new reporting algorithm, there were only 5 cases actually reported against the external target.

Actions: C. difficile ward rounds and same-day visits of all new patients diagnosed continues. Use of hydrogen peroxide environmental decontamination has improved. New guidelines have been issued regarding testing methods and external reporting of C difficile - these changes need to be in place by April 2012, but should result in a decrease in the number of cases.

3.5.2 MSSA Bacteraemia

	Nov-11	Dec-11	**Jan-12**
No. of MSSA Bacteraemia	5	1	3
Cum Plan	20	22.5	25
Cum Actual	26	28	30
Cum Variance	4	5.5	5



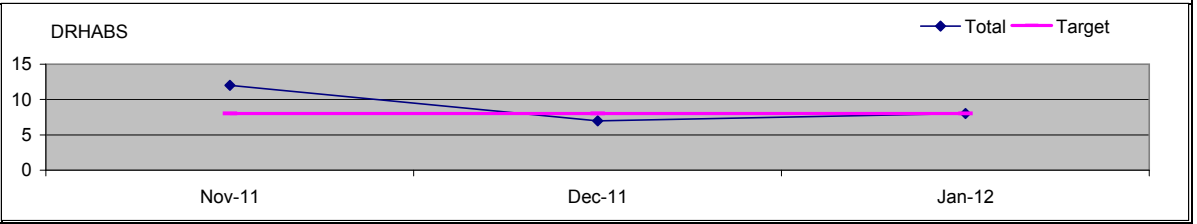
Analysis: 3 RWHT-attributable MSSA bacteraemias. 1 was line-related, 1 was due to a hospital acquired pneumonia (not ventilator-associated) and 1 was secondary to skin and soft tissue infection. Probably only the line-associated case was avoidable.

Actions: Work on a Trust iv team continues. Regular screening of renal patients for MSSA is ongoing.

3.5.3 Device Related Hospital Acquired Bacteraemias

Following a reduction in Device Related Hospital Acquired Bacteraemias (DRHABS) by 25% in 2010/11 the aim of this initiative is to reduce device related hospital acquired bacteraemias by 10% by April 2012. The current internal target is 8 per month.

	Nov-11	Dec-11	**Jan-12**
Target (monthly)	8	8	8
DRHABS	12	7	8



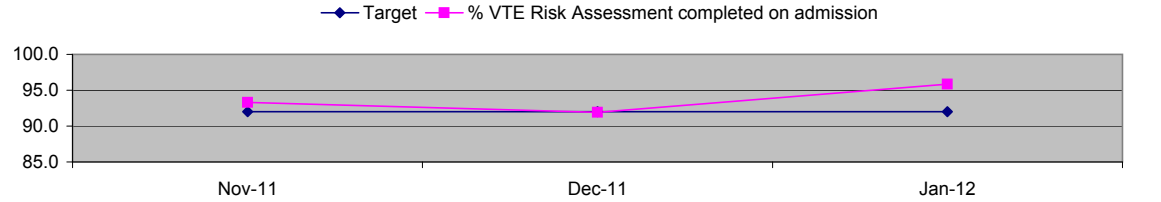
Analysis: Five DRHABS were line related, one to a VAP on ICCU and two were related to urinary catheters; both were long term catheters in situ before the patient was admitted.

Actions: The main in patient areas with line associated DRHABs have been identified as being the high line usage areas, and conjoint work between I P and Patient Safety commenced. Work towards the achievement of a catheter related CQUIN has been commenced. There were no obvious omissions in the preventative care of the patient who developed a VAP on ICCU, but focus on this has been re-emphasised in the formation of a new VAP group.

3.6 Venous Thrombo Embolism

Venous thromboembolism (VTE) is one of the commonest causes of avoidable death in hospitals. There is a national VTE risk assessment and prevention pathway, which has been developed by the Department of Health following NICE Guidance released in January 2010. Compliance with VTE risk assessment is a CQUIN requirement, set at 90%. This is one of 7 key NICE standards for VTE prevention that the Trust is aiming to reach.

	Nov-11	Dec-11	**Jan-12**
% adult patients with completed VTE risk assessment	93.3%	91.9%	95.83%
Number of patients with hospital acquired VTE	5	4	6
Number of patients with community acquired VTE	19	23	23



Analysis: Two of the returned RCAs show patients were fully risk assessed and received full thromboprophylaxis. The third one highlighted issues with foot pumps that were prescribed and not signed for and two doses of clexane missed.

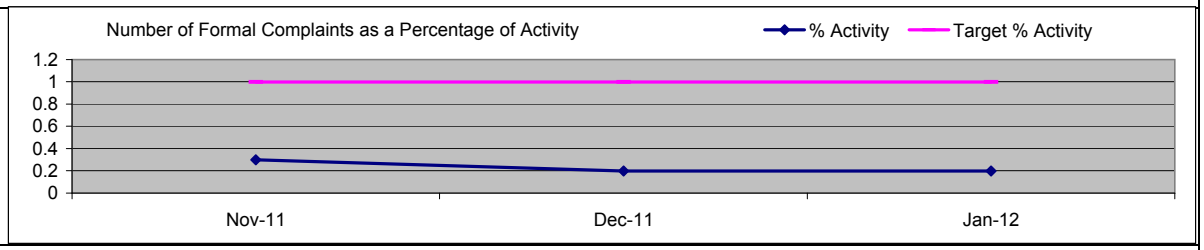
Actions: Ward manager contacted and informed regarding missed clexane. Poor foot pump documentation ongoing issue. Orthopaedics have a local action plan that needs to be implemented and VTE team will monitor. 12 RCA investigations underway and outstanding investigations discussed with governance leads. Trust wide VTE audit commenced on 9th Jan and completed on 1st Feb. Data currently being analysed and report to be completed.

4) PATIENT EXPERIENCE

4.1 Formal complaints

The following numbers are based on the number of formal complaints received during the quarter. There is no national target in relation to the number of complaints received as the Trust welcomes all feedback as this helps us to continually improve the services we provide. However there is an expectation that the number of complaints received is less than 1% of the activity for the Trust. The percentage of complaints based on the number of inpatient spells is shown in the graph below.

Target	Nov-11	Dec-11	**Jan-12**
1.00%	0.3%	0.2%	0.2%



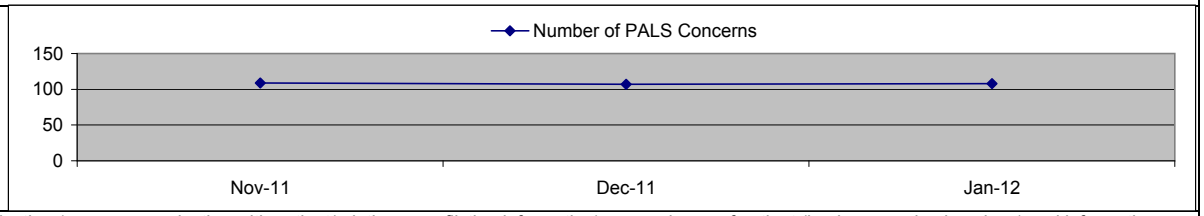
Analysis: 32 complaints were received in January 2012 to 0.2% of Trust activity.

Actions: No action required.

4.2 PALS Concerns

The following numbers are based on the number of informal complaints received during the quarter. There is no national target in relation to the number of complaints received as the Trust welcomes all feedback as this helps us to continually improve the services we provide. The number of informal complaints is shown in the graph below.

Nov-11	Dec-11	**Jan-12**
109	107	108



Analysis: PALS remain consistently busy. The 3 most common themes for PALS are communication (poor communication with patient/relatives, conflicting information), general care of patient (hygiene needs, dressings) and information (patient's/GP's not receiving discharge documentation or patients not receiving the correct clinical information).

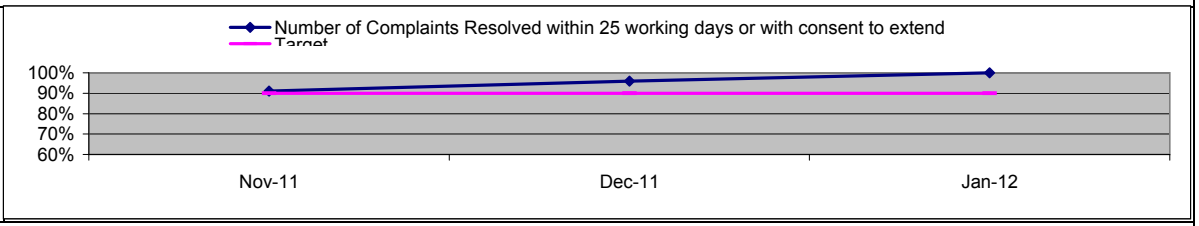
Actions: Continual monitoring of themes via PALS Outreach and Quality Walk Rounds.

4.3 Formal Complaints resolved within 25 days

The Trust aims to provide first class responses to greater than 90% of all complaints within 25 working days and an action plan in place.

Percentage of complaints responded to within 25 working days and with action plan in place

Nov-11	Dec-11	**Jan-12**
91%	96%	100%



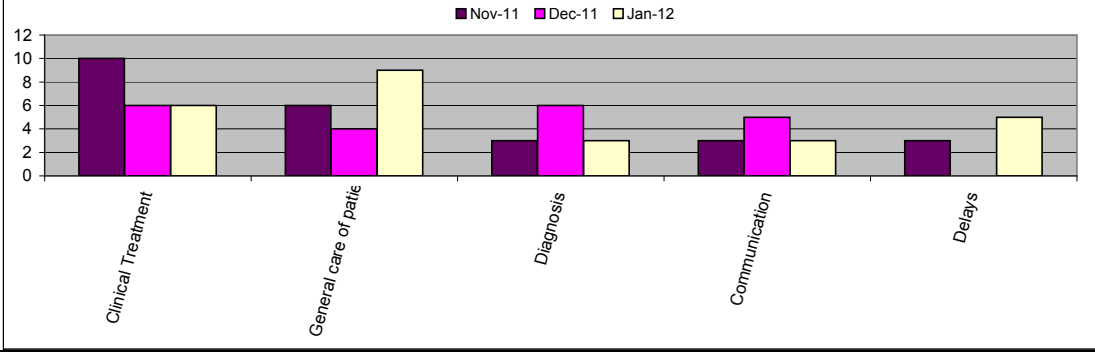
Analysis: The Trust has consistently achieved above its target of 90%.

Actions: No action needed.

4.4 Formal Complaints trends

Analysis of complaint themes during the quarter is detailed in the graph below.

	Nov-11	Dec-11	**Jan-12**
Number of formal complaints	33	26	32



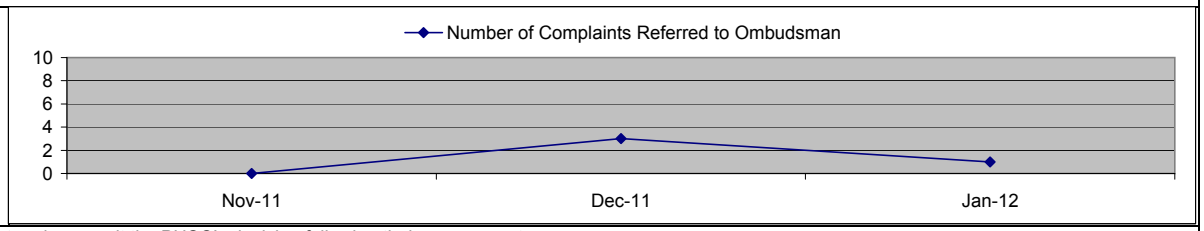
Analysis: The top three themes raised in formal complaints during January were clinical treatment, general care of patient and delays.

Actions: The revised complaints policy has now been ratified and the new complaints process will be in place from 20 February 2012.

4.5 Ombudsman

The role of the Parliamentary & Health Service Ombudsman is to consider complaints that government departments, a range of other public bodies in the UK, and the NHS in England, have not acted properly or fairly or have provided a poor service. The Ombudsman will normally only take on a complaint after the complainant has first tried to resolve the complaint with the organisation involved and has received a response from them. The number of complaints referred to the PHSO by complainants is detailed below.

	Nov-11	Dec-11	**Jan-12**
Number of complaints referred to the PHSO	0	3	1

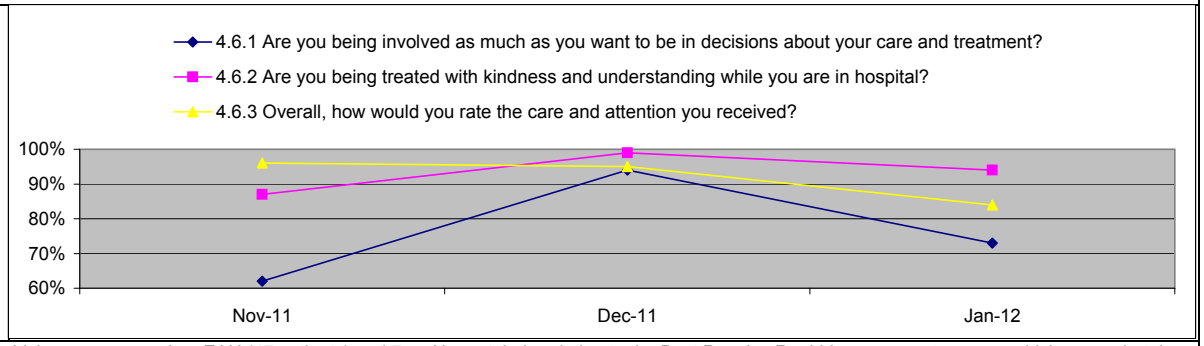


Analysis: One complaint was referred to the PHSO in January. Papers were requested and sent and we await the PHSO's decision following their assessment.

Actions: CSM to undertake responsibility for all final responses with a view to providing a more robust and detailed response.

4.6 Patient Experience Tracker

	Nov-11	Dec-11	**Jan-12**
4.6.1 People that said yes definitely to: Are you being involved as much as you want to be in decisions about your care and treatment?	62%	94%	73%
4.6.2 People that answered yes all of the time to :Are you being treated with kindness and understanding while you are in hospital?	87%	99%	94%
4.6.3 People that answered 'excellent or good' to :Overall, how would you rate the care and attention you received?	96%	95%	84%



Analysis: 426 patients were surveyed in January, these figures include the additional patients which were surveyed on EAU (47 patients) and 7 on Neonatal. In relation to the Best Practice Rapid Improvement surveys which are undertaken 46 patients were surveyed on ward D18, 44 patients on ward D19 and 46 patients on ward D20.

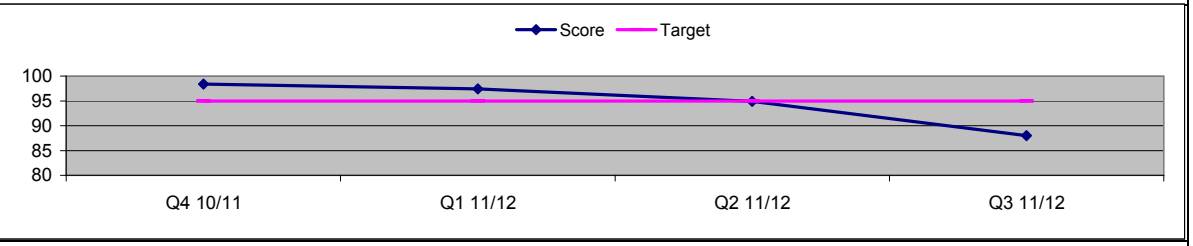
Actions: It has been agreed that all volunteers will bring any concerns highlighted to them whilst undertaking the tracker surveys to the attention of the ward manager with the patients consent. Patient Experience Lead to review the tracker questions to ensure that the feedback gained is more qualitative and informative.

5) PATIENT SAFETY AND QUALITY

5.1 Hand Hygiene Practice

Consistent hand hygiene is key to high quality infection prevention practice. Quarterly audits measure compliance with hand hygiene standards. The Trust has set a target of 95%.

	2010/11		2011/12	
Target	Q4	Q1	Q2	**Q3**
95%	98.4%	97.4%	94.90%	88%



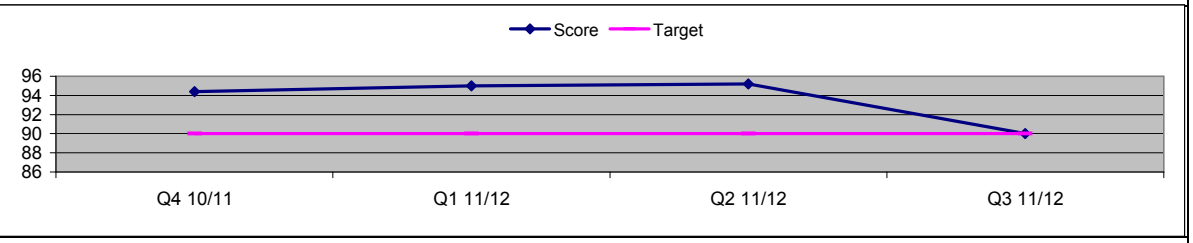
Analysis:
Quarterly report - due May 2012

Actions:

5.2 Environmental standards

Cleanliness and tidiness of the environment is an important quality marker and valued highly by patients and the public. Quarterly audits measure compliance with stringent environmental standards. The Trust has set a target of 90%.

	2010/11		2011/12	
Target	Q4	Q1	Q2	**Q3**
90%	94.4%	95.0%	95.20%	90.00%



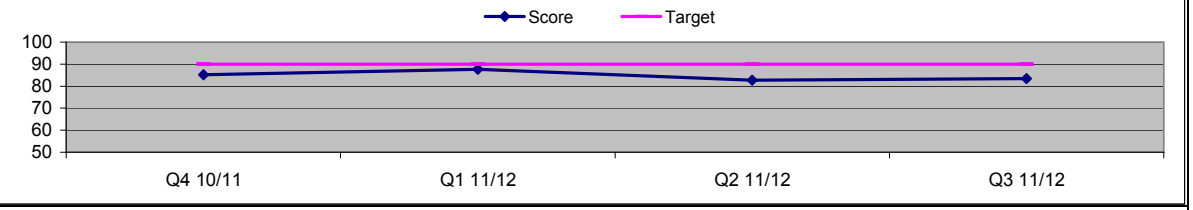
Analysis:
Quarterly report - due May 2012

Actions:

5.3 Essence of Care standards

Essence of Care audits are conducted quarterly to measure compliance against a small number of key standards embracing privacy & dignity, communication, nutrition, personal hygiene, mental health and continence. The Trust has set a target of 90%.

	2010/11		2011/12	
Target	Q4	Q1	Q2	**Q3**
90%	85.2%	87.6%	82.70%	83.40%



Analysis:
Quarterly report - due May 2012

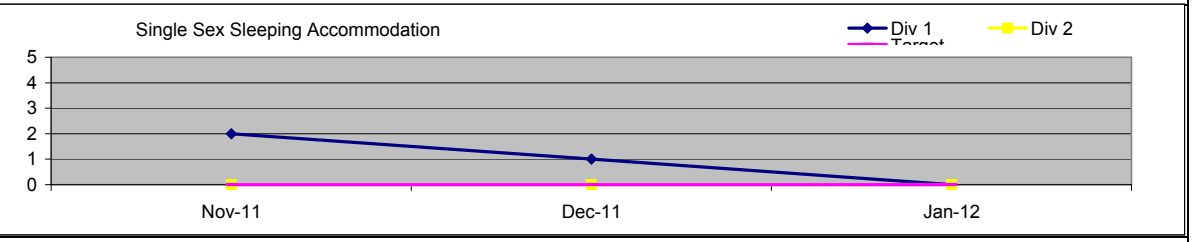
Actions:

5.4 Single sex accommodation

Patients want care delivered in single sex accommodation. All of our clinical areas have declared themselves compliant against Department of Health standards for single sex accommodation. Our main challenges continue within ICCU, whilst making every attempt to segregate men and women, will be unable to achieve this consistently for clinical reasons. We will measure incidents of mixed sex sleeping accommodation for all in-patient areas, and for ICCU, when the patient becomes suitable for transfer to a ward, but is cared for in a mixed sex area because of no available ward bed.

Number of incidents	Nov-11	Dec-11	**Jan-12**
Division 1	2	1	0
Division 2	0	0	0
Target	0	0	0

Definition of Single sex incident: A patient located in a bay with patients of the opposite sex is defined as one incident (e.g in a six bedded bay, 1 incident not 6 incidents)



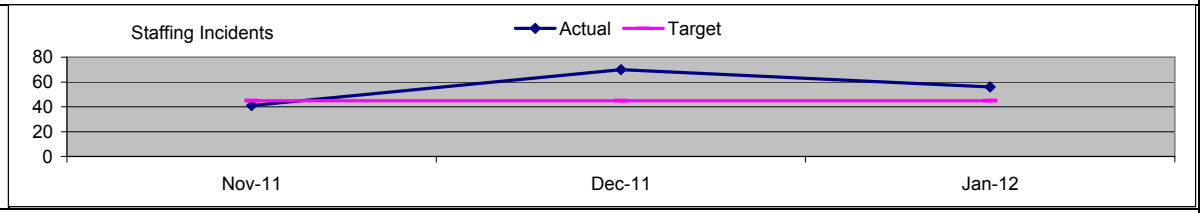
Analysis: No single sex breaches reported.

Actions: No actions required.

5.5 Nursing & Midwifery staffing levels

Nursing staffing levels impact on the safety and quality of patient care. The wards and departments within the Trust have agreed normal staffing levels. Deviations from normal staffing levels that impact on the safety or quality of patient care are reported as incidents. The target is 45 incidents per month based on an average number of 50 incidents per month in 08/09.

	Nov-11	Dec-11	**Jan-12**
Division 1	15	24	25
Division 2	26	46	31
Total	41	70	56
Target	45	45	45



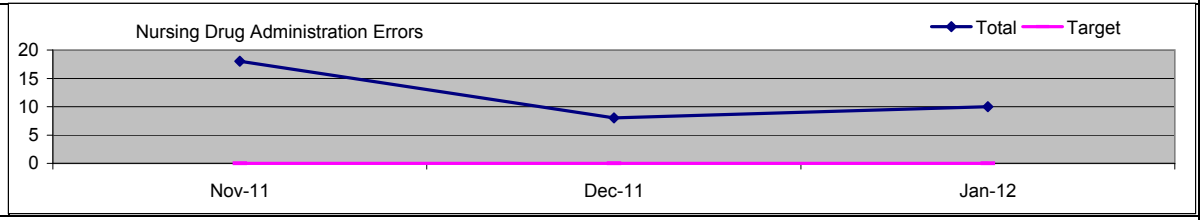
Analysis: Div 1 - one incident graded as amber. No incidents resulted in actual patient harm. Division 2 - of the 31 incidents - 9 were graded amber, no direct patient harm occurred as a result but there was delay in undertaking patient observations.

Actions: Staffing situation is monitored by the Matron and if possible additional staff found

5.6 Medication administration incidents

Medication incidents cover a wide range of events involving the prescription, administration and provision of medicines to take home. These incidents have the potential to harm patients and therefore all reported incidents are investigated. The indicator set for medication incidents is concentrating on nursing administration errors resulting in low, moderate & high levels of harm or causing death.

	Nov-11	Dec-11	**Jan-12**
Division 1	3	1	2
Division 2	15	7	8
Total	18	8	10
Target	0	0	0



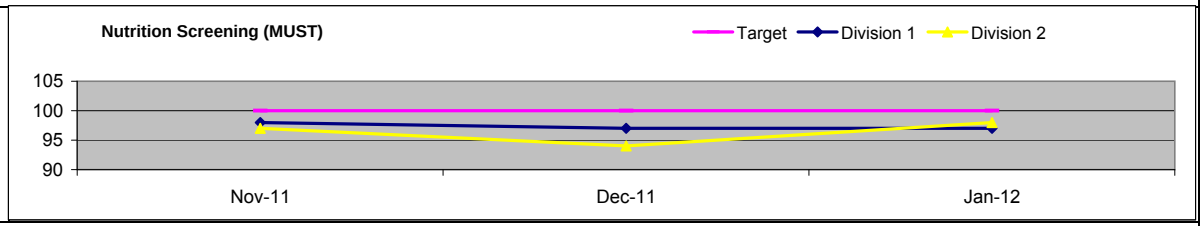
Analysis: Div 1 - both incidents yellow, neither incident resulted in patient harm. Div 2 - no incident resulted in patient harm

Actions: All staff managed in accordance with Trust policy

5.7 Nutrition

MUST is a nutritional screening tool. All adult patients should undergo nutrition risk screening and those identified as high risk should have a full nutritional assessment.

% adult inpatients with completed MUST	Nov-11	Dec-11	**Jan-12**
Division 1	98%	97%	97%
Division 2	97%	94%	98%
Target	100%	100%	100%



Analysis: High level attainment maintained.

Actions: Continue to monitor.

Surgical Division - Quality & Safety Scorecard - February 2012 data

Patient Experience	This Month	Last Month	Trend
Patient Complaints as a percentage of activity	A	G	↓
Number of complaints accepted for investigation by Ombudsmen	R	R	↔
Number of serious complaints received	G	G	↔
Percentage of complaints responded to within 25 working days (or with consent to breach)	A	G	↓
% of people responding "yes" to the question - Are you being involved as much as you want to be in decisions about your care and treatment?	R	R	↔
Percentage of patients who rated overall satisfaction good/excellent			
Percentage of patients who answered "yes" to being treated with care and compassion	R	R	↔
Number of cancelled/rescheduled outpatient appointments	G	G	↔
Cancelled operations as a percentage of elective admissions	R	R	↔
Overall Rating	R		↔

Patient Safety	This Month	Last Month	Trend
Number of red incidents	G	G	↔
Number of healthcare/inpatient falls	R	R	↔
Number of healthcare/inpatient falls - resulting in serious injury	G	G	↔
Number of healthcare acquired avoidable pressure ulcers acquired/deteriorated	A	G	↓
Percentage of inpatient MUST assessments completed within 24 hours of admission	A	G	↓
MSSA Bacteraemia	G	G	↔
Clostridium Difficile - hospital acquired for ages >2 years	A	G	↓
Device related bacteraemias	G	G	↔
Percentage of VitalPAC VTE risk assessments on admitting ward	G	A	↑
Percentage of late observations (VitalPAC wards only)	R	R	↔
Overall Rating	A		↔

Patient Outcomes	This Month	Last Month	Trend
Length of stay (elective)	G	G	↔
Length of stay (non-elective)	A	A	↔
Percentage of emergency re-admissions within 30 days	G	G	↔
Delayed discharges	G	G	↔
18 week RTT - admitted	G	G	↔
18 week RTT - non-admitted	G	G	↔
Clinical correspondence turnaround within 48 hours	R	R	↔
Overall Rating	A		↔

Resources	This Month	Last Month	Trend
Sickness absence	A	R	↑
Percentage of staff who have undergone an annual appraisal	A	A	↔
Percentage of trained nursing vacancies per funded establishment	G	G	↔
Percentage of medical training grade vacancies per funded establishment	G	G	↔
Pay budget (ward pay budget only)	R	R	↔
WTE budgeted against actual (ward WTE only)	G	A	↑
Overall Rating	A		↔

Trust Dashboard: February 2012

Surgical Division

Directorates with any indicator that is red on 3 occasions during any 3 month rolling period is required to submit an exception report on the third occasion.

N/A=data not available, hash box=not reportable

Trends:
→ No change
↑ Improvement on previous month
↓ Deterioration on previous month

Patient Experience	Target	Tolerance	Data Source	Diagnostics Service Group			Theatres/ ICCU Service Group			Cardio- thoracic/ Cardiology Service Group			General Surgery/ Urology			Orthopaedics			Obstetrics & Gynaecology			Ophthalmology/ Head & Neck Services Group		
				This Month	Last Month	Trend	This Month	Last Month	Trend	This Month	Last Month	Trend	This Month	Last Month	Trend	This Month	Last Month	Trend	This Month	Last Month	Trend	This Month	Last Month	Trend
Patient complaints as a percentage of activity	<0.5%	<0.5 = Green, 0.5+ = Red	Nina Dunmore	0.1%	0.1%	→	0.1%	0%	↓	0	0.1%	↑	0.5%	0.1%	↓	0.3%	0.2%	↓	0.6%	0.5%	↓	0.1%	0%	↓
Number of complaints accepted for investigation by the Ombudsman	0	0 = Green, else Red	Nina Dunmore	0	0	→	0	0	→	0	0	→	0	0	→	0	0	→	1	1	→	1	0	↓
Number of serious complaints received	0	0 = Green, else Red	Nina Dunmore	0	0	→	0	0	→	0	0	→	0	0	→	0	0	→	0	0	→	0	0	→
Percentage of complaints responded to within 25 working days (or with consent to breach)	90%	>/= 90% = Green, else Red	Nina Dunmore	100%	100%	→	100%	N/A		0	100%		67%	100%	↓	100%	100%	→	86%	100%	↓	100%	N/A	
% of people responding "yes" to the question - Are you being involved a much as you want to be in decisions about your care and treatment?	95%	>95% = Green, 85-95% = Amber, <85% = Red	Nina Dunmore	N/A	N/A		N/A	N/A		100%	77%	↑	76%	72%	↑	82%	81%	↑	83%	84%	↓	77%	50%	↑
Percentage patients who rated overall satisfaction good/excellent	95%	>95% = Green, 85-95% = Amber, <85% = Red	Nina Dunmore	N/A	N/A		N/A	N/A		N/A	N/A		N/A	N/A		N/A	N/A		N/A	N/A		N/A	N/A	
Percentage of patients who answered "yes" to being treated with care and compassion	95%	>95% = Green, 85-95% = Amber, <85% = Red	Nina Dunmore	N/A	N/A		N/A	N/A		100%	71%	↑	90%	46%	↑	88%	48%	↑	100%	58%	↑	100%	45%	↑
Number of cancelled/rescheduled outpatient appointments	–	Reduction of 40% in year	Lesley Taff							11	110	↑	102	216	↑	183	104	↓	53	111	↑	763	570	↓
Cancelled operations as a percentage of elective admissions	0.8%	< 0.8% = Green, else Red	Lesley Taff							4.5%	5.7%	↑	2.2%	0.9%	↓	0.9%	0.2%	↓	2.9%	1.25%	↓	0%	0.32%	↑
Patient Safety																								
Number of red incidents	0	0 = Green, else Red	Sukhy Khunkhuna	0	0	→	0	0	→	0	0	→	0	0	→	0	0	→	0	0	→	0	0	→
Number of healthcare/inpatient falls *RAG= tolerance multiplied by the number of inpatient wards	0	Ward specific	Sukhy Khunkhuna	0	0	→	0	2	↑	5	4	↓	11	9	↓	5	6	↑	3	0	↓	5	4	↓
Number of healthcare/inpatient falls - resulting in serious injury *RAG= tolerance multiplied by the number of inpatient wards	0	*Green = 0, Amber = 1-4, Red = 4+	Sukhy Khunkhuna	0	0	→	0	0	→	0	0	→	0	0	→	0	0	→	0	0	→	0	0	→
Number of healthcare acquired avoidable pressure ulcers acquired/deteriorated (Grade 2, 3 & 4)		Basline to be agreed	Sukhy Khunkhuna	0	0	→	0	0	→	0	1	↑	1	1	→	6	2	↓	0	0	→	1	0	↓
Percentage inpatient MUST assessments completed within 6 hours of admission	100%	100% = Green, 75-99% = Amber, <75% Red	Rose Baker Zena Young				100%	100%	→	100%	100%	→	99%	100%	↓	88%	84%	↑	100%	100%	→	100%	100%	→
MSSA bacteraemia	–	<2 = Green, 2-3 = Amber, >3 = Red	Mike Cooper	0	0	→	0	0	→	0	0	→	0	0	→	0	0	→	0	0	→	0	0	→
Clostridium Difficile - hospital acquired for ages >2 years	–	Green = 0,Amber = 1-2, Red = >2	Mike Cooper	0	0	→	0	1	↑	2	0	↓	1	0	↓	0	0	→	0	0	→	0	0	→
Device related bacteraemias	–	Green = 0,Amber = 1,Red = >1	Mike Cooper	0	0	→				0	0	→	0	0	→	0	0	→	0	0	→	0	0	→
Device related bacteraemias (Haem/Onc, ICCU, Renal, Neonates)	–	Green = 0,Amber = 1- 2 Red = >2	Mike Cooper				0	1	↓															
Percentage VitalPAC VTE risk assessments assessed on admitting ward (VitalPAC wards only represented by Directorate, excludes maternity & low risk cohorts)	90%	90% = Green, 70-89% = Amber, <70% = Red	Jayne Lawrence	100.0%	100.0%	→	95.56%	96.88%	↓	92.35%	90.35%	↑	76.5%	83.60%	↓	91.3%	86.21%	↑	90.9%	91.35%	↓	97.17%	98.48%	↓
Percentage of late observations (VitalPAC wards only)	5%	<5% = Green, 5-10% = Amber, >10% = Red	Mandy Gibbs				5.5%	3.7%	↓	14.7%	14.3%	↓	11.7%	13.0%	↑	22.0%	24.8%	↑	12.0%	10.0%	↓	7.9%	23.0%	↑
Patient Outcomes																								
Length of stay (elective)	specific	Specific	Lesley Taff							4.16	4.18	↑	2.24	2.58	↑	3.0	3.0	→	2.6	2.6	→	1.9	1.8	↓
Length of stay (non elective)	specific	Specific	Lesley Taff							6.53	6.53	→	3.5	3.29	↓	5.5	5.6	↑	1.1	1.1	→	2.44	2.39	↓
Percentage of emergency readmissions within 30 days	4.19%	<4.19% = Green, 4.2-5% = Amber, >5%= Red	Lesley Taff							0.83%	1.79%	↑	0.81%	1.57%	↑	0.22%	0.64%	↑	0.49%	2.08%	↑	0.72%	0.16%	↓
Delayed discharges			Lesley Taff	0.0%	0.0%	→	0.0%	0.0%	→	0.5%	0.50%	→	0.5%	1.0%	↑	0.1%	0.12%	↓	0.0%	0.2%	↑	0.1%	0.1%	→
18 week RTT - admitted	90%	90% = Green, else Red	Lesley Taff							99.53%	96.93%	↑	92.35%	91.97%	↑	90.24%	90.31%	↓	90.29%	91.9%	↓	93.71%	94.29%	↓
18 week RTT - non-admitted	95%	95% = Green, else Red	Lesley Taff							95.66%	95.36%	↑	95.72%	95.24%	↑	95.10%	95.14%	↓	95.35%	95.04%	↑	98.07%	97.68%	↑
Clinical correspondence turnaround within 48 hours	100%	100% = Green, 75-99% = Amber, else Red	Lesley Taff	88.8%	82.9%	↑				56.5%	46.8%	↑	47.7%	59.0%	↓	63.5%	52.6%	↑	68.7%	59.8%	↑	70.7%	62.1%	↑
Support Services																								
Sickness absence	<4%	<4% = Green, 4.1-5.9% = Amber, >6% = Red	Lesley Taff	4.01%	3.74%	↓	5.21%	6.55%	↑	4.09%	4.00%	↓	4.89%	5.53%	↑	8.32%	7.76%	↓	4.01%	6.08%	↑	4.24%	5.20%	↑
Percentage of staff who have undergone annual appraisal	80%	>/=80% = Green, 70-79% = Amber, <70% = Red	Lesley Taff	84.3%	79.5%	↑	82.4%	81.9%	↑	77.3%	79.7%	↓	81.9%	82.9%	↓	69.1%	70.4%	↓	83.4%	85.5%	↓	46.0%	57.6%	↓
Percentage of trained nursing vacancies per funded establishment	2%	</=2% funded est = G, 2% 5% = A, else Red	Lesley Taff	0.00%	0.00%	→	0.00%	0.23%	↑	-0.32%	-0.35%	↑	-0.92%	-1.55%	↑	1.62%	1.55%	↓	4.33%	0.61%	↓	-0.21%	1.22%	↑
Percentage of medical training grades vacancies per funded establishment	2%	</=2% funded est = G, 2% 5% = A, else Red	Lesley Taff	0.00%	0.00%	→	0.00%	0.42%	↑	0.00%	0.00%	→	0.00%	0.00%	→	0.00%	0.00%	→	0.00%	0.58%	↑	0.55%	0.00%	↓
Pay budget (ward pay budget only)	In balance	Yes = Green, Agreed = Amber, No = Red	Alison Reynolds							£(248) k	£(212) k	↓	£(208) k	£(181) k	↓	£(90) k	£(82) k	↓	£(65) k	£(55) k	↓	£(55) k	£(55) k	→
WTE budgeted against actual (ward WTE only)	In balance	variance < 5% = Green variance 5-10% = Amber variance >10% = Red	Alison Reynolds							(2.44) %	1.98 %	↓	0.37 %	3.38 %	↓	(4.60) %	0.12%	↓	(1.21) %	(1.64)%	↓	(13.36) %	(3.68)%	↓

The Royal Wolverhampton Hospitals NHS Trust

The completion of this report is prompted by the existence of red alerts in the Quality & Safety Dashboard indicators on 3 occasions in any rolling 3 month period and is submitted by the Directorate/Group Management to the Trust Board.

HIGH LEVEL INDICATOR EXCEPTION REPORT TO TRUST BOARD (26 March 2012)

Report from: Directorate/Group	Theatres/ICCU Services Group
Report prepared by: Name, Job Title	Marion Washer, Group Manager and Beverley Morgan, Senior Matron

Description of indicator:	Number of healthcare/inpatient falls
Indicator tolerance:	Target 0, Tolerance – ward specific
Period of alert: (i.e. Jun, Jul, Aug 2011)	Nov, Dec 2011 & Jan 2012
Actions: Please identify where completed or a timescale for completion and who by	**Appleby** 2 patients had a fall as a result of suffering an epileptic fit. Both patients were seen in A & E, neither had sustained an injury. In both cases the elective surgery was cancelled and rescheduled. No patients who with known epilepsy are allocated a space in the lounge, all patients are allocated a chair/bed in one of the three bays. **ICCU** 1 x member of staff fell in a bed space – no reason determined for the fall. (RIDDOR reported) 1 x visitor became lightheaded and fell hitting head on drip stand. Sent to A & E no injuries sustained **Beynon Short Stay** 2 patient falls, no injury sustained – protocol followed 1 patient sustained no jury but fainted following lumbar puncture. Nurse re-trained in the care of post lumbar puncture patients.
Assurance/Monitoring: Please identify monitoring arrangements in place to sustain improvements	**Appleby** Epilepsy and general risk of falls is determined at pre-assessment **ICCU** In order to prepare visitors for this challenging environment, they are briefed by the nurse caring for the patient when they first visit the Unit **Beynon Short Stay** Team have shared the learning from this incident procedure reiterated regarding care of post lumbar puncture.

The Royal Wolverhampton Hospitals NHS Trust

The completion of this report is prompted by the existence of red alerts in the Quality & Safety Dashboard indicators on 3 occasions in any rolling 3 month period and is submitted by the Directorate/Group Management to the Trust Board.

HIGH LEVEL INDICATOR EXCEPTION REPORT TO TRUST BOARD (26 March 2012)

Report from: Directorate/Group	Cardiology/Cardiothoracic Service Group
Report prepared by: Name, Job Title	Kate Middlemiss, Directorate Manager

Description of indicator:	Cancelled operations as a % elective admissions	% Late observations (VitalPAC wards only)	Clinical correspondence turnaround within 48 hrs	Length of Stay (non elective)	Ward pay budget
Indicator tolerance:	Target = 0.8% Red = >0.8%	Target = 5% Red = >10%	Target = 100% Red = < 75%	Target & Tolerance = specific	Target = in balance Red = not in balance
Period of alert: (i.e. Jun, Jul, Aug 2011)	Nov, Dec 2011 & Jan 2012	Nov, Dec 2011 & Jan 2012	Nov, Dec 2011 & Jan 2012	Nov, Dec 2011 & Jan 2012	Nov, Dec 2011 & Jan 2012
Actions: Please identify where completed or a timescale for completion and who by	Any potential cancellations are discussed with CD, Matron and/or DM. All cancellations are minimised by looking at utilising beds in other areas or transferring staff wherever possible (if staffing issues), extending the working day, reviewing all options in order to avoid cancellation. Ongoing.	Ward manager/ Shift co-ordinator to monitor daily. Staff to be challenged individually and also to be discussed at Band 6/5 ward meeting. Problems with VitalPAC indentified and reported to Patient safety improvement co-ordinator Monthly report via KPI Ongoing	Dedicated 'typing time' was created for the team of secretaries by putting all calls through to another office and these were dealt with by the Band 2's in the department. This enabled a rapid reduction in outstanding correspondence and is a practice the department is routinely going to introduce. Ongoing.	Continue to monitor	Continued overspend due to incremental increases (not funded at budget setting) and newly created posts being funded at bottom of scale. Both areas also changed staffing skill mix at weekends to ensure more senior cover was visible which has created budget pressures. Bank spend and all other pay spend is closely monitored and minimised. Due to ongoing opening of the cath lab day ward overnight for capacity pressures, bank spend will continue to be high and pay spend out of balance.

Assurance/Monitoring: Please identify monitoring arrangements in place to sustain improvements	Responsibility of management team to ensure all cancellations are minimised and this is constantly monitored.	Responsibility of Matron and Ward managers to ensure reduction in late observations	Practice manager monitors typing correspondence and turnaround on a daily basis, reallocating jobs where necessary and proactively managing workloads to ensure equitable.	Monitored by DM and Divisional team with monthly reporting arrangements in place to Divisional Manager.	Ongoing monitoring by ward manager, Matron and DM during budget meetings. All bank spend has to be approved and signed off by Matron and/or Divisional Head Nurse.

The Royal Wolverhampton Hospitals NHS Trust

The completion of this report is prompted by the existence of red alerts in the Quality & Safety Dashboard indicators on 3 occasions in any rolling 3 month period and is submitted by the Directorate/Group Management to the Trust Board.

HIGH LEVEL INDICATOR EXCEPTION REPORT TO TRUST BOARD
(26 March 2012)

Report from: Directorate/Group	General Surgery & Urology Group
Report prepared by: Name, Job Title	Ruth Horton, Group Manager & Kerry Anelli, Matron

Description of indicator:	% people responding yes to: 'Are you being involved as much as you want to be in decisions about your care & treatment?'	Cancelled operations as a % of elective admissions	% Late observations (VitalPAC wards only)	Clinical correspondence turnaround within 48 hrs	Ward pay budget
Indicator tolerance:	Target = 95% Red = <85%	Target = 0.8% Red = >0.8%	Target = 5% Red = >10%	Target = 100% Red = < 75%	Target = in balance Red = not in balance
Period of alert: (i.e. Jun, Jul, Aug 2011)	Nov, Dec 2011 & Jan 2012	Nov, Dec 2011 & Jan 2012	Nov, Dec 2011 & Jan 2012	Nov, Dec 2011 & Jan 2012	Nov, Dec 2011 & Jan 2012
Actions: Please identify where completed or a timescale for completion and who by	1. Ward managers to do daily walk around with patients to discuss ongoing plans with patients and their families. 2. Documentation in notes to certify discussions are made. 3. Re trial communication aides on surgical wards. 4. Pals to be asked to attend sr meetings to highlight patients stories regarding poor communication.	Recruiting to fifth consultant urologist.	1) Matron and Ward Managers to undertake review of system to identify trends and address specific issues 2) Ward Receptionist to undertake daily review to identify and where possible remove any extraneous factors which could affect reported compliance	The biggest issues relates to Urology. The Department is operating with 5 Consultants – one of whom is a locum and as such has no funding attributed to him or funding for support. Non-pay monies are being used to fund outsourcing to Dict8 to mitigate the impact. 5th substantive Consultant approved with associated funding for support. Awaiting College Approval of JD before pursuing advertisement.	Weekly review by Matron of bank usage planned. This ensures safe staffing levels and ensures account is taken of the 20% staffing uplift already within the budget. Significant staffing pressures associated with higher than usual maternity leave levels and high percentage of sickness associated with surgical procedures,
Assurance/Monitoring: Please identify monitoring arrangements in place to sustain improvements	Notes review and feedback at sr meetings monthly. Monthly review of action plans at sr meetings and to be standing item on interim governance agenda to promote this action.	Weekly reporting via Chief Operating Officers report	Monthly Matron KPI Standing agenda item for Ward managers Meeting and Directorate Meetings Reviewed at individual Ward Manager 121 meetings with Matron	Weekly reports to Group Manager and standing agenda item at Directorate Meetings Weekly reporting via Chief Operating Officers report	Maternity leave pressures are highlighted on Directorate and Divisional Risk Register Budget review meetings held monthly with all Ward/Departmental

	Review at individual ward meetings				Managers. Monthly Finance and Performance Meetings chaired by deputy Chief Operating Officer in conjunction with Clinical Finance Manager

The Royal Wolverhampton Hospitals NHS Trust

The completion of this report is prompted by the existence of red alerts in the Quality & Safety Dashboard indicators on 3 occasions in any rolling 3 month period and is submitted by the Directorate/Group Management to the Trust Board.

HIGH LEVEL INDICATOR EXCEPTION REPORT TO TRUST BOARD (26 March 2012)

Report from: Directorate/Group	Orthopaedics
Report prepared by: Name, Job Title	Helen Read, Directorate Manager

Description of indicator:	% people responding yes to: 'Are you being involved as much as you want to be in decisions about your care & treatment?'	% Late observations (VitalPAC wards only)	Clinical correspondence turnaround within 48 hrs	Ward pay budget
Indicator tolerance:	Target = 95% Red = <85%	Target = 5% Red = >10%	Target = 100% Red = < 75%	Target = in balance Red = not in balance
Period of alert: (i.e. Jun, Jul, Aug 2011)	Nov, Dec 2011 & Jan 2012	Nov, Dec 2011 & Jan 2012	Nov, Dec 2011 & Jan 2012	Nov, Dec 2011 & Jan 2012
Actions: Please identify where completed or a timescale for completion and who by	Mr Simons speaking with consultants about the importance of involving patients in care plans. Ward staff to be made aware by Matron.	Matron monitoring closely. Matron to discuss with Matron Boyce how the best practice wards achieved improved compliance and implement best practice	Additional secretarial hours have been funded to tackle the backlog which has arisen from the large number of additional clinics over and above those timetabled and planned.	Sickness absence being actively managed. Matron agreeing additional bank shifts requested.
Assurance/Monitoring: Please identify monitoring arrangements in place to sustain improvements	Conduct survey of patient in 6 months to see if this has improved.	Regular monitoring by Matron.	Regular monitoring by Team Leader.	Monthly finance meetings with budget holder.

The Royal Wolverhampton Hospitals NHS Trust

The completion of this report is prompted by the existence of red alerts in the Quality & Safety Dashboard indicators on 3 occasions in any rolling 3 month period and is submitted by the Directorate/Group Management to the Trust Board.

HIGH LEVEL INDICATOR EXCEPTION REPORT TO TRUST BOARD (26 March 2012)

Report from: Directorate/Group	Obstetrics & Gynaecology
Report prepared by: Name, Job Title	Helen Read Directorate Manager

Description of indicator:	Cancelled operations as a % of elective admissions	Ward pay budget
Indicator tolerance:	Target = 0.8% Red = >0.8%	Target = in balance Red = not in balance
Period of alert: (i.e. Jun, Jul, Aug 2011)	Nov, Dec 2011 & Jan 2012	Nov, Dec 2011 & Jan 2012
Actions: Please identify where completed or a timescale for completion and who by	All cancelled cases are reviewed and RCA's completed for reasons for cancellations.	HoM reviewing staffing levels on a weekly basis. Bank usage is less than hours down. Maternity leave is at 4.5% on top of sickness levels.
Assurance/Monitoring: Please identify monitoring arrangements in place to sustain improvements	Cancelled operations report/monthly governance meetings	Monthly budget surgeries

The Royal Wolverhampton Hospitals NHS Trust

The completion of this report is prompted by the existence of red alerts in the Quality & Safety Dashboard indicators on 3 occasions in any rolling 3 month period and is submitted by the Directorate/Group Management to the Trust Board.

HIGH LEVEL INDICATOR EXCEPTION REPORT TO TRUST BOARD (26 March 2012)

Report from: Directorate/Group	Ophthalmology, Head & Neck Services Group
Report prepared by: Name, Job Title	No update available from February position

Description of indicator:	% people responding yes to: 'Are you being involved as much as you want to be in decisions about your care & treatment?'	% Late observations (VitalPAC wards only)	Ward pay budget
Indicator tolerance:	Target = 95% Red = <85%	Target = 5% Red = >10%	Target = in balance Red = not in balance
Period of alert: (i.e. Jun, Jul, Aug 2011)	Nov, Dec 2011 & Jan 2012	Nov, Dec 2011 & Jan 2012	Nov, Dec 2011 & Jan 2012
Actions: Please identify where completed or a timescale for completion and who by	% saying 'no' has improved on D4. October 7.69%, November 0, December 0. Staff aware of performance. Extra capacity open resulting in patients not attending hospital for H+N or ophthalmology surgical conditions being nursed on the ward. Staff ensure medical teams are contacted to ensure prompt review.	13% of late observations on H+N D4. <5% during the daytime.	D4 ward is overspent due to additional unfunded capacity being opened to accommodate medical and surgical activity. Escalated to Division.
Assurance/Monitoring: Please identify monitoring arrangements in place to sustain improvements	Agenda item next governance meeting, 3 x day bed meeting to ensure patients are seen promptly	Band 7 monitoring trends during the month of February, staff have been spoken to, reviewing VitalPAC set up.	Financial budgets, off duty

Medical Division - Quality & Safety Scorecard - January 2012 data

Patient Experience	This Month	Last Month	Trend
Patient Complaints as a percentage of activity	A	G	↓
Number of complaints accepted for investigation by Ombudsmen	G	A	↑
Number of serious complaints received	G	G	↔
Percentage of complaints responded to within 25 working days (or with consent to breach)	G	A	↑
% of people responding "yes" to the question - Are you being involved as much as you want to be in decisions about your care and treatment?	R	R	↔
Percentage of patients who rated overall satisfaction good/excellent			
Percentage of patients who answered "yes" to being treated with care and compassion	R	G	↓
Number of cancelled/rescheduled outpatient appointments	G	G	↔
Overall Rating	A		↔

Patient Safety	This Month	Last Month	Trend
Number of red incidents	A	G	↓
Number of healthcare/inpatient falls	A	A	↔
Number of healthcare/inpatient falls - resulting in serious injury	G	A	↑
Number of healthcare acquired avoidable pressure ulcers acquired/deteriorated	R	R	↔
Percentage of inpatient MUST assessments completed within 24 hours of admission	A	A	↔
MSSA Bacteraemia	G	G	↔
Clostridium Difficile - hospital acquired for ages >2 years	A	A	↔
Device related bacteraemias	A	G	↓
Percentage of VitalPAC VTE risk assessments on admitting ward	G	A	↑
Percentage of late observations (VitalPAC wards only)	R	R	↔
Overall Rating	A		↔

Patient Outcomes	This Month	Last Month	Trend
Length of stay (elective)	A	A	↔
Length of stay (non-elective)	G	G	↔
Percentage of emergency re-admissions within 30 days	G	G	↔
Delayed discharges	G		
18 week RTT - admitted	G	G	↔
18 week RTT - non-admitted	G	G	↔
Clinical correspondence turnaround within 48 hours	A	R	↑
Overall Rating	A		↔

Resources	This Month	Last Month	Trend
Sickness absence	A	R	↑
Percentage of staff who have undergone an annual appraisal	R	R	↔
Percentage of trained nursing vacancies per funded establishment	A	A	↓
Percentage of medical training grade vacancies per funded establishment	G	G	↔
Pay budget (ward pay budget only)	R	R	↔
WTE budgeted against actual (ward WTE only)	A	A	↔
Overall Rating	A		↑

Trust Dashboard: February 2012

Emergency, Medical & Community Service Division

Directorates with any indicator that is red on 3 occasions during any 3 month rolling period is required to submit an exception report on the third occasion.

N/A=data not available, hash box=not reportable

Trends:
→ No change
↑ Improvement on previous month
↓ Deterioration on previous month

Patient Experience	Target	Tolerance	Data Source	Children's Services Group			Adult Community Services Group			Elderly Care & Stroke			Rehab (West Park)			Neurology Rheumatology Dermatology			Renal & Diabetes			Resp & Gastro			Emergency Services Group			Therapies & Pharmacy Group			Oncology & Haematology Group		
				This Month	Last Month	Trend	This Month	Last Month	Trend	This Month	Last Month	Trend	This Month	Last Month	Trend	This Month	Last Month	Trend	This Month	Last Month	Trend	This Month	Last Month	Trend	This Month	Last Month	Trend	This Month	Last Month	Trend	This Month	Last Month	Trend
Patient complaints as a percentage of activity	<0.5%	<0.5 = Green, 0.5+ = Red	Nina Dunmore	N/A	N/A		N/A	0.1%		N/A	0.1%		N/A	N/A		0.2%	0.2%	→	0.1%	0.3%	↑	0.3%	0.1%	↓	0.6%	0.7%	↑	0.1%	N/A		0.1%	0.1%	→
Number of complaints accepted for investigation by the Ombudsman	0	0 = Green, else Red	Nina Dunmore	0	0	→	1	0		0	0	→	0	0	→	0	0	→	0	0	→	0	0	→	1	0	↓	0	0	→	0	0	→
Number of serious complaints received	0	0 = Green, else Red	Nina Dunmore	0	0	→	0	0	→	0	0	→	0	0	→	0	0	→	0	0	→	0	0	→	0	0	→	0	0	→	0	0	→
Percentage of complaints responded to within 25 working days (or with consent to breach)	90%	>/= 90% = Green, else Red	Nina Dunmore	N/A	N/A		N/A	100%		N/A	100%		N/A	N/A		100%	100%	→	100%	100%	→	100%	100%	→	100%	100%	→	100%	N/A		100%	100%	→
% of people responding "yes" to the question - Are you being involved as much as you want to be in decisions about your care and treatment?	95%	>95% = Green, 85-95% = Amber, <85% = Red	Nina Dunmore	N/A	N/A		N/A	N/A		63%	82%	↓	N/A	N/A		N/A	N/A		55%	59%	↓	60%	49%		80%	55%	↑		N/A		78%	81%	↓
Percentage patients who rated overall satisfaction good/excellent	95%	>95% = Green, 85-95% = Amber, <85% = Red	Nina Dunmore	N/A	N/A		N/A	N/A		N/A	N/A		N/A	N/A		N/A	N/A		N/A	N/A		N/A	N/A		N/A	N/A			N/A		N/A	N/A	
Percentage of patients who answered "yes" to being treated with care and compassion	95%	>95% = Green, 85-95% = Amber, <85% = Red	Nina Dunmore	N/A	N/A		N/A	N/A		100%	45%	↑	N/A	N/A		N/A	N/A		79%	59%		88%	49%		95%	74%	↑		N/A		100%	73%	↑
Number of cancelled/rescheduled outpatient appointments	–	Reduction of 40% in year	Lesley Taff	487	291	↓	N/A	N/A		20	40	↑	N/A	N/A		83	100	↑	170	149	↓	7	52	↑				0	0	→	167	99	↓
Patient Safety																																	
Number of red incidents	0	0 = Green, else Red	Sukhy Khunkhuna	0	0	→	0	0	→	0	0	→	0	0	→	0	0	→	0	0	→	0	1	↑	0	0	→	0	0	→	0	0	→
Number of healthcare/inpatient falls *RAG= tolerance multiplied by the number of inpatient wards	0	Ward specific	Sukhy Khunkhuna	0	1	↑	0	2	↑	36	38	↑	13	27	↑	0	1	↑	14	16	↑	18	23	↑	7	9	↑	1	1	→	6	5	↓
Number of healthcare/inpatient falls - resulting in serious injury *RAG= tolerance multiplied by the number of inpatient wards	0	*Green = 0, Amber = 1-4, Red = 4+	Sukhy Khunkhuna	0	0	→	0	1	↑	0	0	→	0	0	→	0	0	→	0	0	→	0	0	→	0	0	→	0	0	→	0	0	→
Number of healthcare acquired avoidable pressure ulcers acquired/deteriorated (Grade 2, 3 & 4)	0	0 = Green, else Red	Sukhy Khunkhuna	1	1	→	3	6	↑	3	6	↑	1	0	↓	0	0	→	1	0	↓	1	4	↑	0	0	→	0	0	→	0	0	→
Percentage inpatient MUST assessments completed within 6 hours of admission	100%	100% = Green, 75-99% = Amber, <75% Red	Rose Baker Zena Young	100%	100%	→	100%	N/A		100%	100%	→	96%	100%	↓				94%	96%	↓	94%	94%	→	90%	93%	↓				100%	100%	→
MSSA bacteraemia	–	<2 = Green, 2-3 = Amber, >3 = Red	Mike Cooper	0	0	→	0	0	→	1	2	↑	0	0	→	0	0	→	0	0	→	0	1	↑	0	0	→				0	0	→
Clostridium Difficile - hospital acquired for ages >2 years	–	Green = 0,Amber = 1-2, Red = >2	Mike Cooper	0	0	→	0	0	→	0	1	↑	2	0	↓	0	0	→	0	4	↑	1	4	↑	3	3	→				0	2	↑
Device related bacteraemias	–	Green = 0,Amber = 1,Red = >1	Mike Cooper	0	0	→	0	0	→	0	1	↑	0	1	↑	0	0	→	0	0	→	0	1	↑	0	0	→						
Device related bacteraemias (Haem/Onc, ICCU, Renal, Neonates)	–	Green = 0,Amber = 1- 2 Red = >2	Mike Cooper	2	0	↓													0	0	→										0	4	↑
Percentage VitalPAC VTE risk assessments assessed on admitting ward (VitalPAC wards only represented by Directorate, excludes maternity & low risk cohorts)	90%	90% = Green, 70-89% = Amber, <70% = Red	Jayne Lawrence							95.0%	93.75%	↑	N/A	N/A		96.6%	91.14%	↑	99.79%	99.87%	↓	80.0%	100%	↓	89.4%	93.99%	↓				99.72%	100%	↓
Percentage of late observations (VitalPAC wards only)	5%	<5% = Green, 5-10% = Amber, >10% = Red								14.8%	23.2%	↑							19.5%	27.5%	↑	8.8%	8.7%	↓	19.0%	18.0%	↓				9.0%	10.7%	↑
Patient Outcomes																																	
Length of stay (elective)	specific	Specific	Lesley Taff	1.5	1.6	↑										0.2	0.2	→	0.6	0.9	↑	2.7	3.2	↑							5.4	4.9	↓
Length of stay (non elective)	specific	Specific	Lesley Taff	0.7	0.7	→										2.1	2.3	↑	1.7	2.0	↑	3.2	3.2	→							5.62	5.59	↓
Percentage of emergency readmissions within 30 days	4.19%	<4.19% = Green, 4.2-5% = Amber, >5%= Red	Lesley Taff	3.4%	0.31%	↓				0.0%	0.0%	→	0.0%	0.0%	→	0.0%	0.0%	→	0.0%	0.0%	→	0.0%	0.0%	→	0.0%	0.0%	→				0.17%	0.0%	↓
Delayed discharges			Lesley Taff	0.0%	0.0%	→				1.5%	1.3%	↓	0.75%	0.4%	↓	0.0%	0.0%	→	0.0%	0.0%	→	0.0%	0.4%	↑	0.0%	0.0%	→				0.0%	0.25%	↑
18 week RTT - admitted	90%	90% = Green, else Red	Lesley Taff													100%	100%	→	100%	100%	→	100%	100%	→				100%	100%	→	100%	94.44%	↑
18 week RTT - non-admitted	95%	95% = Green, else Red	Lesley Taff	99.5%	98.4%	↑	100%	100%	→	98.6%	100%	↓				96.7%	96.6%	↑	100%	98.74%	↑	96.4%	95.36%	↑				100%	100%	→	97.7%	96.0%	↑
Clinical correspondence turnaround within 48 hours	100%	100% = Green, 75-99% = Amber, else Red	Lesley Taff	50.5%	77.2%	↓	N/A	N/A		52.1%	55.9%	↓	N/A	N/A		62.6%	59.7%	↑	99.2%	97.5%	↑	62.9%	90.3%	↓	64.2%	53.7%	↑				91.5%	94.9%	↓
Support Services																																	
Sickness absence	<4%	<4% = Green, 4.1-5.9% = Amber, >6% = Red	Lesley Taff	5.35%	3.89%	↓	8.48%	8.37%	↓	5.23%	5.86%	↑	8.05%	7.43%	↓	2.80%	2.60%	↓	4.73%	2.60%	↓	3.80%	2.47%	↓	7.72%	5.69%	↓	4.43%	4.03%	↓	5.84%	5.27%	↓
Percentage of staff who have undergone annual appraisal	80%	>/=80% = Green, 70-79% = Amber, <70% = Red	Lesley Taff	62.1%	60.5%	↑	68.8%	59.8%	↑	79.5%	77.6%	↑	48.0%	53.3%	↓	70.2%	56.4%	↑	64.3%	66.5%	↓	79.1%	78.6%	↑	69.2%	69.4%	↓	56.6%	50.3%	↑	64.9%	70.6%	↓
Percentage of trained nursing vacancies per funded establishment			Lesley Taff	3.08%	6.70%	↑	0.00%	1.15%	↑	-0.90%	-1.16%	↑	1.02%	0.13%	↓	#####	-0.97%	↓	2.34%	0.74%	↓	2.26%	1.98%	↑	2.27%	3.48%	↑	0.00%	0.00%	→	-2.75%	-3.27%	↑
Percentage of medical training grades vacancies per funded establishment			Lesley Taff	0.00%	0.00%	→	0.00%	0.00%	→	0.00%	2.42%	↑	0.00%	0.00%	→	0.00%	0.00%	→	2.45%	1.67%	↓	0.00%	2.30%	↑	0.00%	0.99%	↑	0.00%	0.00%	→	0.00%	0.00%	→
Pay budget (ward pay budget only)	In balance	Yes = Green, Agreed = Amber, No = Red	Alison Reynolds	£(29) k	£(28) k	↓	£(4) k	£(2) k	↓	£(433) k	£(413) k	→	£(2) k	£(1) k	↓				£(170) k	£(145) k	↓	£(270) k	£(187) k	↓	£16 k	£11 k	↑				£(51) k	£(46) k	↓
WTE budgeted against actual (ward WTE only)	In balance	variance < 5% = Green variance 5-10% = Amber variance >10% = Red	Alison Reynolds	5.85%	6.23 %	↓	0.28 %	(10.29) %	↑	(1.57) %	(19.82) %	↑	3.62 %	5.58 %	↓				(10.04)%	(8.37)%	↓	(28.88)%	(3.75) %	↓	6.49%	4.89 %	↑				(0.86) %	2.61 %	↓

The Royal Wolverhampton Hospitals NHS Trust

The completion of this report is prompted by the existence of red alerts in the Quality & Safety Dashboard indicators on 3 occasions in any rolling 3 month period and is submitted by the Directorate/Group Management to the Trust Board.

HIGH LEVEL INDICATOR EXCEPTION REPORT TO TRUST BOARD (26 March 2012)

Report from: Directorate/Group	Children's Services Group
Report prepared by: Name, Job Title	Christine Webb, Group Manager Children's Services

Description of indicator:	Ward pay budget
Indicator tolerance:	Target = In balance Red = not in balance
Period of alert: (i.e. Jun, Jul, Aug 2011)	Nov & Dec 2011 & Jan 2012
Actions: Please identify where completed or a timescale for completion and who by	The ward pay budgets for the NNU and the C1/C2 have been amalgamated in this report. The directorate is working with HR closely to try and reduce the sickness rates on the wards. The Directorate is also supporting an increasing amount of day surgery activity for which it is seeking further financial support. The skill mix on the ward is being closely monitored and managed by the Senior Matron This remains unchanged in Feb 2012 – It is also worth noting that the activity in PAU has increased by over 400 attendances in comparison to the same period last year.
Assurance/Monitoring: Please identify monitoring arrangements in place to sustain improvements	Both ward managers are closely monitoring the spend on bank staff to cover sickness. The sickness management policy is being closely adhered to and monitored monthly. The increased surgical activity on C1/C2 is being monitored as a lot of this activity is not fully funded. The Directorate is however considerably over-performing in its activity levels.

The Royal Wolverhampton Hospitals NHS Trust

The completion of this report is prompted by the existence of red alerts in the Quality & Safety Dashboard indicators on 3 occasions in any rolling 3 month period and is submitted by the Directorate/Group Management to the Trust Board.

HIGH LEVEL INDICATOR EXCEPTION REPORT TO TRUST BOARD (26 March 2012)

Report from: Directorate/Group	Adult Community Services Group
Report prepared by: Name, Job Title	Molly Henriques-Dillon, Group Manager, Tracey Slater Senior Matron Adult Community Services Group

Description of indicator:	Number of healthcare acquired avoidable pressure ulcers (acquired/deteriorated) Grades 2,3 &4
Indicator tolerance:	Target = 0 Red = >0
Period of alert: (i.e. Jun, Jul, Aug 2011)	Nov & Dec 2011 & Jan 2012
Actions: Please identify where completed or a timescale for completion and who by	• Adult Community Quality group in place. • Key learning points fed back at team meetings, Structured handovers within each team ongaing. • Admission to caseload checklist approved. • Full implementation of multi-disciplinary meetings and nurse led ward rounds in localities (Tracey Slater). • Peer review continues to be rolled out – Ongoing (Tracey Slater). • Significant increase in of PUMP / wound care / ABPI training – Ongoing (Tracey Slater)
Assurance/Monitoring: Please identify monitoring arrangements in place to sustain improvements	The introduction of Adult Community Services Group Quality Group to monitor action plans from RCA's. The group meet monthly and provide assurance to the Group Governance board. Monitoring includes: • Implementation • Uptake of training • Monitoring of performance management of staff/capability/disciplinary issues • Trend monitoring

The Royal Wolverhampton Hospitals NHS Trust

The completion of this report is prompted by the existence of red alerts in the Quality & Safety Dashboard indicators on 3 occasions in any rolling 3 month period and is submitted by the Directorate/Group Management to the Trust Board.

HIGH LEVEL INDICATOR EXCEPTION REPORT TO TRUST BOARD (26 March 2012)

Report from: Directorate/Group	Elderly Care & Stroke
Report prepared by: Name, Job Title	Wendy Worth, Group Manager Ambulatory and Rehabilitation

Description of indicator:	% people responding yes to: 'Are you being involved as much as you want to be in decisions about your care & treatment?'	Number of healthcare acquired avoidable pressure ulcers (acquired/deteriorated) Grades 2,3 &4	% Late observations (VitalPAC wards only)	Clinical correspondence turnaround within 48 hours	Ward pay budget
Indicator tolerance:	Target = 95% Red = <85%	Target = 0 Red = >0	Target = 5% Red = >10%	Target = 100% Red = <75%	Target = in balance Red = not in balance
Period of alert: (i.e. Jun, Jul, Aug 2011)	Nov, Dec 2011 & Jan 2012	Nov, Dec 2011 & Jan 2012	Nov, Dec 2011 & Jan 2012	Nov, Dec 2011 & Jan 2012	Nov, Dec 2011 & Jan 2012
Actions: Please identify where completed or a timescale for completion and who by	Ensure patients are actively involved in care planning and family meetings. Stakeholder event with all nursing staff on elderly care wards held and actions agreed to improve patient communication. Stroke specific work completed on the ward regarding patient communication Matron drop in sessions weekly and contact details at ward	Increased vigilance on pressure risk assessment and subsequent care delivery Completion of pressure care documentation , Comfort rounds to assure regular repositioning and patient compliance Safety brief to ensure adequate communication. Regular re assessment and care planning to prevent detraction of skin integrity. Pressure care bundle re enforced on wards.	Ward Managers checking Vital Pac requirements on a shift by shift basis for quality assurance. Refresher training for new staff. Equipment problems (connectivity) raised with patient safety coordinator for ASU where this has become a persistent issue and ongoing monitoring in place by ward manager trouble shooting guidance available at ward level.	TBC	Action plan in place to reduce overspend on wards D8 and ASU. There has been a significant decrease in the overspend on D8 month by month. The overspend on D8 was due to high levels of sickness and unfunded incremental drift on pay budgets and this is now being closely managed by the ward manager. ASU has an over establishment of band 6 nurses that were put in place to facilitate the thrombolysis rota and this was not funded, a

	entrances to encourage contact Percentage now green	Staff TV competency training underway			plan is now in place for rotation of band 6's/band 5 between the ASU and Ward 1 at West Park.
Assurance/Monitoring: Please identify monitoring arrangements in place to sustain improvements	Monitored by local governance meetings. Patient experience questionnaire for Trust Patient experience questionnaire for Quality Mark	Monitored by Nursing KPI Actions escalated via Senior nurse pressure care forum.	Monitored via Nursing KPI	TBC	Monitored by monthly sickness meetings. Monitored by Division Budget meetings.

The Royal Wolverhampton Hospitals NHS Trust

The completion of this report is prompted by the existence of red alerts in the Quality & Safety Dashboard indicators on 3 occasions in any rolling 3 month period and is submitted by the Directorate/Group Management to the Trust Board.

HIGH LEVEL INDICATOR EXCEPTION REPORT TO TRUST BOARD (26 March 2012)

Report from: Directorate/Group	Neurology, Rheumatology, Dermatology
Report prepared by: Name, Job Title	Victoria Holmes, Directorate Manager

Description of indicator:	Clinical correspondence turnaround within 48 hours	% of staff who have undergone annual appraisal
Indicator tolerance:	Target = 100% Red = <75% Jan report = 59.7 %	Target = 80% Red = <70% Jan report= 56.4%
Period of alert: (i.e. Jun, Jul, Aug 2011)	Nov & Dec 2011 & Jan 2012	Nov & Dec 2011 & Jan 2012
Actions: Please identify where completed or a timescale for completion and who by	Review activity/workload –VH- completed Identify additional resource required-VH- ongoing daily Recruitment of staff member on an as and when contract in progress.	Identify which directorates are non compliant - VH - completed Validation of dermatology data ongoing. Overall compliance showing on Kite site at date of report
Assurance/Monitoring: Please identify monitoring arrangements in place to sustain improvements	Weekly monitoring via COO and use of additional resource as required.	Planned appraisal dates confirmed Monthly monitoring at Dermatology Governance Monthly validation of data on the training database.

Dermatology Sect	20	11	**55.0%**
Neurology Sect	13	11	**84.6%**
Rheumatology Sect	24	18	**75.0%**
Overall compliance	57	40	**70.1%**

Projected compliance by end March

Dermatology Sect	20	14	**70.0%**
Neurology Sect	13	12	**92.3%**
Rheumatology Sect	24	20	**83.3%**
Overall compliance	57	46	**80.7%**

The Royal Wolverhampton Hospitals NHS Trust

The completion of this report is prompted by the existence of red alerts in the Quality & Safety Dashboard indicators on 3 occasions in any rolling 3 month period and is submitted by the Directorate/Group Management to the Trust Board.

HIGH LEVEL INDICATOR EXCEPTION REPORT TO TRUST BOARD (26 March 2012)

Report from: Directorate/Group	Renal & Diabetes
Report prepared by: Name, Job Title	Dean Gritton, Group Manager

Description of indicator:	% people responding yes to: 'Are you being involved as much as you want to be in decisions about your care & treatment?'	% Late observations (VitalPAC wards only)	% staff who have undergone annual appraisal	Ward pay budget
Indicator tolerance:	Target = 95% Red = <85%	Target = 5% Red = >10%	Target = 80% Red = <70%	Target = in balance Red = not in balance
Period of alert: (i.e. Jun, Jul, Aug 2011)	Nov, Dec 2011 & Jan 2012	Nov, Dec 2011 & Jan 2012	Nov, Dec 2011 & Jan 2012	Nov, Dec 2011 & Jan 2012
Actions: Please identify where completed or a timescale for completion and who by	Junior doctors encouraged to communicate with patients and relatives as well as nursing staff.	Track and trigger information system in place to communicate with teams.	Meet with department heads to agree timescales to achieve target.	End of year forecasts have been agreed with each Directorate. Individual wards to submit action plans in conjunction with Matron be end of February.
Assurance/Monitoring: Please identify monitoring arrangements in place to sustain improvements	Following introduction of comfort rounds patients can feedback concerns to staff. Continue to show improving trend.	Weekly basis with ward managers and matrons. Best Practice Project to be extended to these areas.	Monitor on a monthly basis with managers concerned.	Meet with budget holders on a monthly basis. Monitor sickness and take appropriate action.

The Royal Wolverhampton Hospitals NHS Trust

The completion of this report is prompted by the existence of red alerts in the Quality & Safety Dashboard indicators on 3 occasions in any rolling 3 month period and is submitted by the Directorate/Group Management to the Trust Board.

HIGH LEVEL INDICATOR EXCEPTION REPORT TO TRUST BOARD (26 March 2012)

Report from: Directorate/Group	Respiratory & Gastroenterology
Report prepared by: Name, Job Title	Dean Gritton, Group Manager

Description of indicator:	% people responding yes to: 'Are you being involved as much as you want to be in decisions about your care & treatment?'	Number of healthcare acquired avoidable pressure ulcers acquired/ deteriorated (Grade 2,3,4)	Length of stay (elective)	Ward pay budget
Indicator tolerance:	Target = 95% Red = <85%	Target = 0 Red = >0 4 in Jan	Target – specialty specific	Target = in balance Red = not in balance
Period of alert: (i.e. Jun, Jul, Aug 2011)	Nov, Dec 2011 & Jan 2012	Nov, Dec 2011 & Jan 2012	Nov, Dec 2011 & Jan 2012	Nov, Dec 2011 & Jan 2012
Actions: Please identify where completed or a timescale for completion and who by	Junior doctors encouraged to communicate with patients and relatives. Best Practice initiatives introduced on wards.	TBC	Reduced from 3.2 to 2.7 which is a significant reduction	End of year forecasts have been agreed with each Directorate. Individual wards to submit action plans in conjunction with Matron by end of February.
Assurance/Monitoring: Please identify monitoring arrangements in place to sustain improvements	Following introduction of comfort rounds patients can feedback concerns to staff. Continue to show improving trend.	TBC		Meet with budget holders on a monthly basis. Monitor sickness and

The Royal Wolverhampton Hospitals NHS Trust

The completion of this report is prompted by the existence of red alerts in the Quality & Safety Dashboard indicators on 3 occasions in any rolling 3 month period and is submitted by the Directorate/Group Management to the Trust Board.

HIGH LEVEL INDICATOR EXCEPTION REPORT TO TRUST BOARD (26 March 2012)

Report from: Directorate/Group	Emergency Services Group (A&E, EAU)
Report prepared by: Name, Job Title	Hayley Flavell, Matron Qadar Zada, Directorate Manager

Description of indicator:	% people responding yes to: 'Are you being involved as much as you want to be in decisions about your care & treatment?'	% Late observations (VitalPAC wards only)	% staff who have undergone annual appraisal	Ward pay budget
Indicator tolerance:	Target = 95% Red = <85%	Target = 5% Red = >10%	Target = 80% Red = <70%	Target = in balance Red = not in balance
Period of alert: (i.e. Jun, Jul, Aug 2011)	Nov, Dec 2011 & Jan 2012	Nov, Dec 2011 & Jan 2012	Nov, Dec 2011 & Jan 2012	Nov, Dec 2011 & Jan 2012
Actions: Please identify where completed or a timescale for completion and who by	PALS outreach to commence in A&E – HF to link with JD from PALS EAU – RR and HF to review real-time feedback performance. Performance is increasing month on month. Action plan any deficits which will be discussed at governance To discuss at governance with action planning and link in with complaints to triangulate the data Clinical Lead aware and to discuss with medical	Work ongoing – compliance remains static 19% late observation – Feb 2012 - increasing nursing numbers per shift following recruitment of band 6. Band 6 to support co coordinator. Safety briefing utilised to cascade information Nurse coordinator, Ward Manager and Matron to undertake regular spot check throughout the day and tackle poor performance with individuals	Feb performance Nursing 81% as a directorate Plans in place for all areas and Feb shows a steady increase overall % EAU – RR continuing with plans for completion and engaging with Band 6's A&E – team structure in place 8a in post A&E Nil LBR/any funding if PDR nil completed	D17 which is no longer part of Emergency Services A&E and EAU together are in balance. D17 overspent and the ward will be transferred to General Medicine Overspend is due to increased dependency of patients on ward, which requires an increased skill mix

	colleagues _ RL RR to discuss at team meetings with nursing staff RR – undertakes daily rounds to alleviate/minimise concerns/complaints	Persistent offenders utilise capability policy	Increased training re appraisals facilitated – KW (PEF) Monitored via 121 with Matron	
Assurance/Monitoring: Please identify monitoring arrangements in place to sustain improvements	Governance meetings Real time feedback results Complaint trends	Quality rounds Spot check – HF, RR Matron rounds	Matron KPI Governance meeting Senior Nurse spot checks	Matron KPI Governance

The Royal Wolverhampton Hospitals NHS Trust

The completion of this report is prompted by the existence of red alerts in the Quality & Safety Dashboard indicators on 3 occasions in any rolling 3 month period and is submitted by the Directorate/Group Management to the Trust Board.

HIGH LEVEL INDICATOR EXCEPTION REPORT TO TRUST BOARD (26 March 2012)

Report from: Directorate/Group	Oncology & Haematology
Report prepared by: Name, Job Title	Maurice Hakkak, Group Manager

Description of indicator:	% people responding yes to: 'Are you being involved as much as you want to be in decisions about your care & treatment?'	% Late observations (VitalPAC wards only)	Ward pay budget
Indicator tolerance:	Target = 95% Red = <85%	Target = 5% Red = >10%	Target = in balance Red = not in balance
Period of alert: (i.e. Jun, Jul, Aug 2011)	Nov, Dec 2011 & Dec 2012	Nov, Dec 2011 & Dec 2012	Nov, Dec 2011 & Dec 2012
Actions: Please identify where completed or a timescale for completion and who by	Full results of survey for Oct, Nov and Dec received from PALS. Shared with Directorate at Governance meeting on 7 February 2012. Importance of ensuring patients are involved in decision-making discussed. Ongoing improvements to be led by the Trust's Lead Cancer Nurse With the exception of one individual, all core MDT members have attended advanced communication skills training; outstanding individual will book into future course date	Action plan formulated and implemented. Matron tracking progress. Staff issued with letter from Matron detailing that non compliance will result in disciplinary action	Action plan devised and implemented. Staffing levels reviewed on a daily basis. Off-duty monitored directly by Matron. Year end forecast agreed with Division
Assurance/Monitoring: Please identify monitoring arrangements in place to sustain improvements	Results of future patient surveys undertaken by PALS to be reviewed monthly	Direct review of ongoing performance by Matron	Weekly monitoring of off-duty by matron. Review at Divisional performance meeting