The Royal Wolverhampton Hospitals NHS Trust	

Trust Board Report

Meeting Date:	25 June 2012
Title:	Quality & Safety Reports
Executive Summary:	• The Q&S Report details Trust wide data for April 2012 • The Q&S Dashboard provides directorate data for May 2012 • The Q&S Scorecard provides a divisional overview based on the directorate data for May 2012
Action Requested:	For the Trust Board to note the report
Report of:	Cheryl Etches, Chief Nursing Officer C.Etches@nhs.net
Author: **Contact Details:**	Charlotte Hall, Deputy Chief Nurse Quality & Safety Charlotte.Hall6@nhs.net
Resource Implications:	None
Public or Private:	Public
References:	Q&S Report approved by the Quality & Safety Committee on 12 June 2012
NHS Constitution:	In determining this matter, the committee should have regard to the core principles contained in the constitution of: • Equality of treatment and access to services • High standards of excellence and professionalism • Service user preferences • Cross community working • Best value • Accountability through local influence and scrutiny

Executive Summary

The Quality and Safety report provides April data and details the monthly progress of the quality and safety indicators. This month the trend analysis includes 12 months of data. It also reports two new indicators, Safety Thermometer and the Net Promoter Score.

Of significant note in month are the following:

- There have been no inpatient falls that have caused serious injury since January 2012
- Pressure ulcers continue to be reported and monitored with excellent incident reporting. The 12 month data hides improvements due to the changes in how pressure ulcers are categorised and the more recent inclusion of deep tissue injuries now reported as grade 3 ulcers
- VTE risk assessment continues to achieve trajectory with April data at 96.3% of patients receiving a VTE assessment
- Monthly reporting on Hand Hygiene was agreed to include additional reporting on the 5 moments Hand Hygiene, this is attached below the quality and safety report and highlights individual groups performance within each division
- Recognition of deteriorating patients continues to demonstrate a reduction in late and missed observations. Mapping this data with the incidence of cardiac arrests since April 2009 demonstrates a decline in numbers of arrests in patients

Divisional Quality and Safety Scorecard reporting on May data

- There has been no movement in the overall rating in each divisional scorecard

Divisional Quality and Safety Dashboards reporting on May data

- In two areas there has been deterioration in patients who felt they were treated with care and compassion (Surgery/Urology and Renal/Diabetes) the remaining groups remained either static or improved
- There has been no deterioration in numbers of device related hospital bacteraemia overall
- The number of trained nursing vacancies per funded establishment has worsened in 10 out of 16 groups (62%).

THE ROYAL WOLVERHAMPTON HOSPITALS NHS TRUST

Report to:	Quality & Safety Report
Date:	25 June 2012
Subject:	Quality & Safety Report
Report by:	Healthcare Governance and Quality Manager/CNO - Quality & Safety
Author:	Chief Nurse
Purpose of Report	To provide the Board with information regarding performance and progress with Trust quality and safety.

Report

The report relates to April 2012 and includes progress on patient safety and quality indicators.

Review Committee Approval

Approved by the Quality & Safety Committee on the 12 June 2012

Recommendation(s)

The Board 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 April 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 includes performance on areas that impact on patient safety and quality

The areas to note regarding progress for the month of April 2012 are as follows:

- 3 serious complaints
- 3 safeguarding adult incidents
- 2 radiotherapy incidents reported to CQC
- Increase in Grade 2 pressure ulcers
- Four MSSA bacteraemias
- Increase in medication incidents

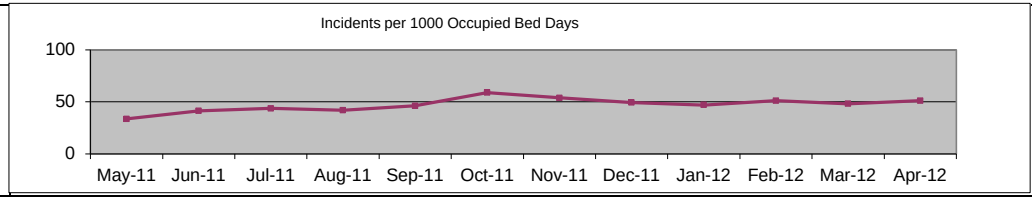
- No falls resulting in serious injury
- Reduction in cases of C Diff
- VTE risk assessments above national target
- Reduction in complaints
- No single sex accommodation incidents

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.

	Feb-12	Mar-12	**Apr-12**
Div 1	396	415	373
Div2	784	714	768
Total	1180	1129	1141
Per 1000obd	51.1	48.2	51.1



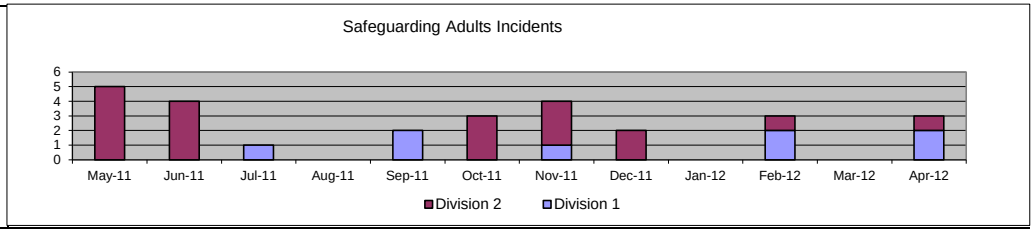
Analysis: The number of incidents reported during April has increased by 1% from the previous month, the incident rate (per 1000 occupied bed days) has also increased. The majority of incidents are reported by nursing and midwifery staff and the largest category of incidents is patient falls (further 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 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	Feb-12	Mar-12	**Apr-12**
Div 1	2	0	2
Div2	1	0	1
Total	3	0	3



Analysis: Two safeguarding referrals were received alleging neglect - grade 3 pressure damage against VSU and D5/D6. 1 safeguarding referral alleging multiple pressure damage involving D17/C3/ D7.

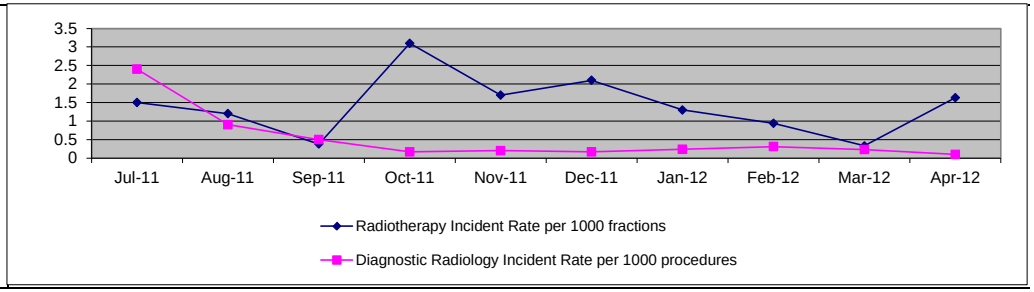
Action: Both safeguarding referrals alleging neglect - grade 3 pressure damage against VSU and D5/D6 were closed by the Hospital Social Work team as neither of these incidents should be investigated under safeguarding. Both incidents had been discussed at the trust pressure ulcer accountability meeting. Safeguarding referral alleging multiple pressure damage involving D17/C3/ D7 has been investigated by the trust and report completed. Hospital acquired pressure damage has also been discussed by Trust pressure ulcer accountability meeting and actions identified.

2.3 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	Feb-12	Mar-12	**Apr-12**
Radiotherapy	3	1	4
Diagnostic Radiology	5	5	2
Nuclear Medicine	0	0	0
Laser/Non-ionising	0	0	0

Rates	Feb-12	Mar-12	**Apr-12**
Radiotherapy Incident Rate per 1000 fractions	0.94	0.33	1.63
Diagnostic Radiology Incident Rate per 1000 procedures	0.31	0.23	0.1



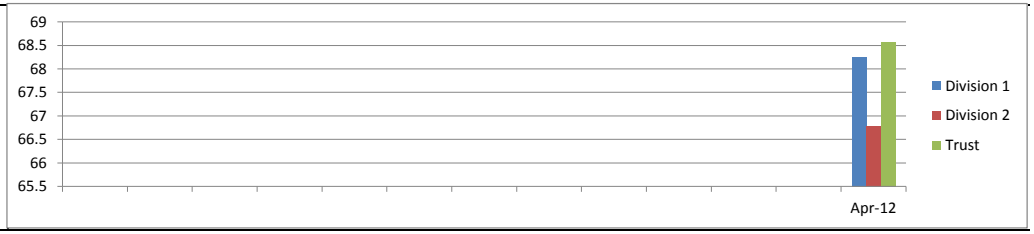
Analysis: Radiotherapy – Approximately 2450 fractions of radiotherapy were delivered in total this month. There were 2 externally reportable incidents this month. Of four recorded incidents two involved Procedure Not Followed. One of these was a positional error when delivering a fraction and has been reported to CQC. The second PNF involved 5 of 15 fractions being delivered without the prescribed bolus on the skin. There were two incidents due to Human Error, the first being a positional error. The second HE involved a brachy treatment; 8Gy was delivered in 1 fraction instead of 2. This has been reported to the CQC.
Diagnostic Radiology – Approximately 21,000 radiological examinations were carried out this month. There were two incidents in April, both attributed to Equipment faults. The first was a fault with an X-ray tube that failed to complete an exposure. The patient was transferred to another X-ray room where the examination was completed. The faulty tube has since been replaced. The second incident involved the loss of images from a portable Image Intensifier. When the radiographer tried to print the images the unit displayed an error message. The equipment had to be re-booted but the images could not be retrieved.

Actions: The Radiation Safety Group will review the incident investigations and advise on actions required.

2.4 Net promoter

The net promoter score is the number individual wards attain when asking patients they discharge if they would recommend our service to their friends and family. The score is calculated using promoters, detractors and passive answers.

	Feb-12	Mar-12	**Apr-12**
Div 1	n/a	n/a	68.25
Div2	n/a	n/a	66.79
Trust	n/a	n/a	68.57



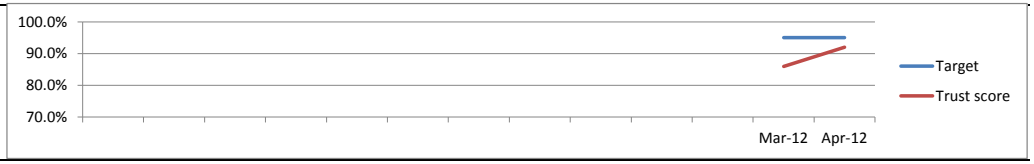
Analysis: From April 1st 2012, the Trust started to measure the Net Promoter score as part of the SHA ambition towards a Patient Revolution. Individual wards are required to give out a card to all patients who are discharged. Patients are asked to consider if they would recommend our service to their family and friends. The card is anonymous and we ask for it to be deposited in the ward / departmental box which is emptied weekly by the patient information team using volunteers and a member of the team to oversee data input. In order to achieve the CQUIN payment, we are required to sample a minimum of 10% of our weekly footfall of patients who are discharged which is approximately 2200 patients per week. To date we

Action: This is regularly addressed through the operational divisions through the management teams. The divisions need to consider how to raise the numbers of patients sampled.

2.5 Safety Thermometer

The Safety Thermometer is a national tool that measures the percentage of harm free care delivered by the organisation on one particular day of the month. The target is to achieve 95% harm free care based on four measured harms.

	Feb-12	Mar-12	**Apr-12**
Target	n/a	95.0%	95.0%
Trust result	n/a	86.0%	92.0%



Analysis: The Safety Thermometer started in April 2012 where we measure the four harms. The Trust had undertaken two studies to date and the April data demonstrated 91.5% harm free care is delivered to our patients, the sample size for April was 1013 patients on one day. The target we aim to acieve is 95% harm free care.

Action: To continue monitoring Safety Thermometer ward by ward and to provide individual data to wards from June onwards.

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.

	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	Jan-11	Feb-11	Mar-11	YTD
HSMR	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	94	89	90.5	**92**
Observed Death Rate (56 CCS	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%	3.70%	3.80%	3.50%	3.60%
Expected Death Rate (56 CCS	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%	4.30%	3.90%	3.90%
No of In Hospital Deaths	165	157	128	130	1506	125	100	84	116	96	111	93	92	139	123	122	117	1318
Expected Deaths	141.6	137.6	112.8	125.4	1343	132.7	111.1	114	119.3	106.4	113	113	110	131	130	137	129	1447
Excess Deaths	23	19	15	5	163	-7.7	-11.1	-30	-3.3	-10.4	-2	-20	-18	8	-7	-15	-12.2	-121

Analysis: April 2011 to March 2012 is the latest available. The Trust's YTD HSMR based on 12 months PRELIMINARY data is 92 with a probable rebased value of 101 (a rebase factor of +9). The rebased figure is subject to change and will be finalised in August 2012. In previous years there movements in both directions of 2-3 points across the region. The trust anticipates its finalised rebased figure to be close to 100.

The latest SHMI is a 12 month average from Oct 2010 to Sep 2011 and the Trust SHMI score was 108.5.The 2011/12 Q1+ Q2 only SHMI for RWHT is 98.06

Top Diagnostic Groups Contributing to Patient Deaths by Volume

April-March 2012

Diagnosis group	Spells	Deaths	SMR
Pneumonia	932	185	97.5
Acute cerebrovascular disease	954	154	100.2
Acute myocardial infarction	985	63	94.9
Congestive heart failure, nonhypertensive	488	60	89.4
Septicaemia (except in labour)	180	50	95.6
Acute and unspecified renal failure	251	49	95.9

Alert Status

Analysis: An Outlier alert from Imperial College/Dr Foster Intelligence unit for Alcholic liver deaths was received in March 2012, relating to a total of 7 excess deaths in the 2011/12 financial year. A voluntary forensic analysis approved by MORAG was submitted to Imperial College and the CQC.

Actions: These deaths had already been reviewed as part of the Trust's total vigilance protocol. There were no avoidable deaths however there have been changes to the management of ALD patients who are all now managed by a consultant Gastroenterologist.

Associated Indicators of Mortality

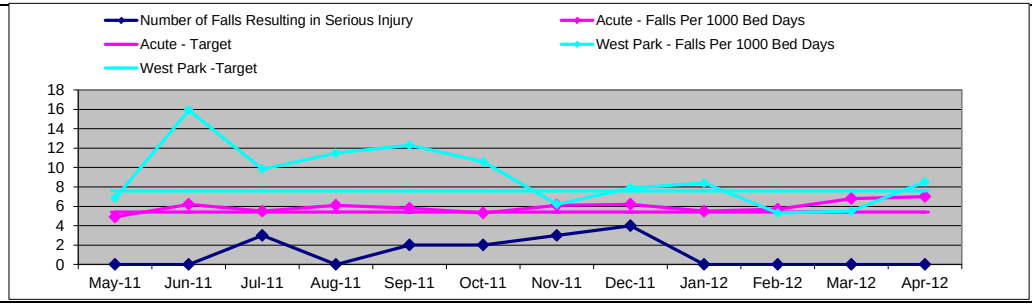
Indicator	Period	RAG	TREND
Charlson Codes Per Spell (HED)	Apr-Feb12		➲
Palliative Care Deaths Per 1000 Discharges (HED)	Apr-Feb 12		➲
Expected Death Rate (Dr F)	Apr-March 12		➲

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 [30] palliative care deaths per 1000 discharges with the national average being 23 per 1000 discharges, this should be viewed in the context of over 100 referrals per month to the Trust's Specialist Palliative Care Team and the Trust's status as a cancer centre.

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.

	Feb-12	Mar-12	**Apr-12**
Acute - Target per occupied bed days	<5.4	<5.4	<5.4
Acute - Number of falls per occupied bed	5.7	6.8	7
West Park- Target per occupied bed days	7.6	7.6	7.6
West Park - Number of falls per occupied bed	4.9	5.5	8.53
Number of falls resulting in serious injury	0	0	0



Analysis: Targets for 2012/13 remain the same as for 2011/12. Progress to end of April for prevention of falls with serious injury remains positive with no serious incident for over four months.

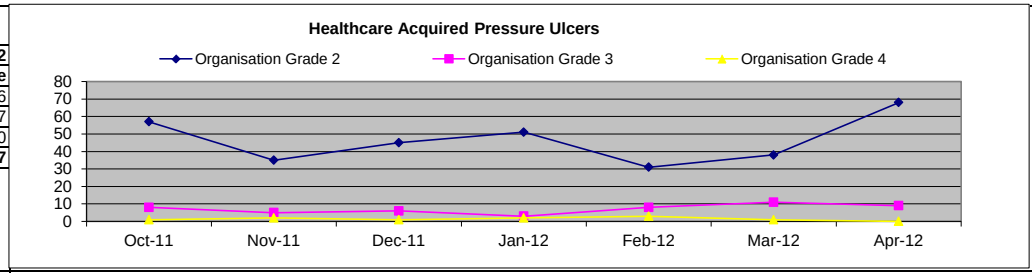
Actions: Continue to embed use of preventative falls care bundle across relevant professional groups. Audit to be undertaken bi-monthly. Develop an e-Learning package.

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)

	Feb-12		Mar-12		**Apr-12**	
	Avoidable	Unavoidable	Avoidable	Unavoidable	**Avoidable**	**Unavoidable**
Grade 2	11	20	12	26	22	46
Grade 3	4	4	4	7	2	7
Grade 4	2	1	1	0	0	0
Total	42		50			**77**



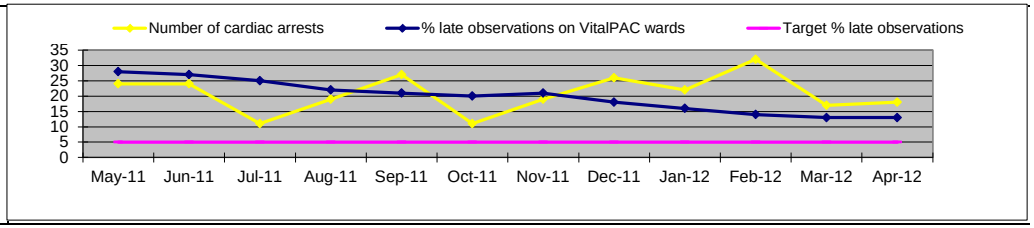
Analysis: There has been an increase in reported grade 2 pressure ulcers and also grade 3 pressure ulcers, which is partly as a result of the SHA recommended changes to the grading system for pressure ulcers. Blood blisters and suspected deep tissue injuries are now classed as grade 3 pressure ulcers. Serious incidents continue to be investigated and confirmed as either avoidable or unavoidable pressure ulcers.

Actions: Matrons and senior sisters continue to monitor adherence to preventative care standards. A targeted focus on areas for improvement is in place for the next three months. A communication strategy is underway within the organisation to raise awareness of accountability and actions. The service level agreement for community equipment provision requires revision to improve community access to pressure relieving equipment. A business case for the sustainability and expansion of the specialist tissue viability nursing service is in progress.

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 that 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.

	Feb-12	Mar-12	**Apr-12**
Number cardiac arrests	32	17	18
% observations late	14%	13%	13%
Target (late observations)	5%	5%	5%



Analysis: There were 18 cardiac arrests during the month of April. The percentage of observations remain the same as the previous month.

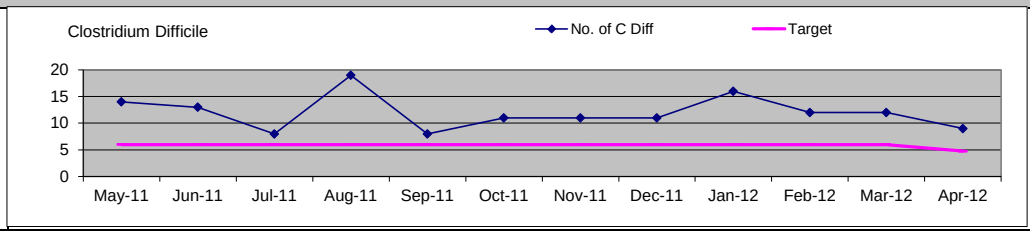
Actions: The percentage of late observations are reported by Group and Directorate as part of the Q&S Dashboard. Exception reports detail the actions being taken to improve compliance with late observations.

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

	Feb-12	Mar-12	**Apr-12**
Number of C Diff	12	12	9
Cum Plan	66	72	9
Cum Actual	134	146	9
Cum Variance	68	74	0

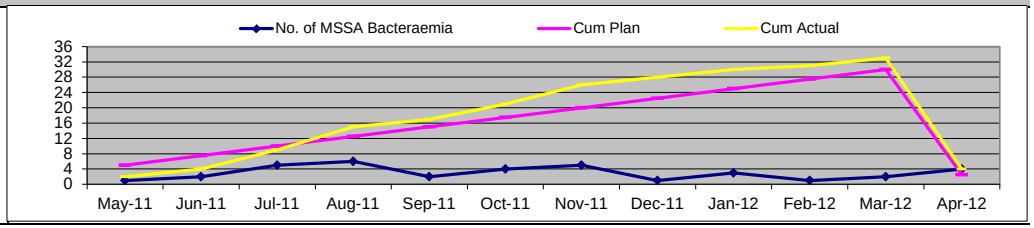


Analysis: The internal target is based on PCR results. The external target is based on Toxin EIA results. In April we reported 2 against the external target (which is 4.75 per month).

Actions: C diff ward rounds and review of all new patients on same day as diagnosis continues. Antimicrobial Stewardship Group has now met. HPV of rooms that have housed C diff patients is now happening more reliably than previously. Education on hand hygiene and general infection prevention continues.

3.5.2 MSSA Bacteraemia

	Feb-12	Mar-12	**Apr-12**
No. of MSSA Bacteraemia	1	2	4
Cum Plan	27.5	30	2.5
Cum Actual	31	33	4
Cum Variance	3.5	3	1.5



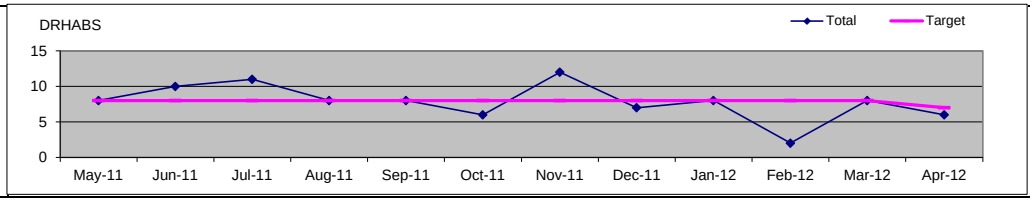
Analysis: Of the 4 cases 2 were undoubtedly admitted with the infection but the blood culture was not taken within 48 hours of admission. One of the remaining cases was line-associated.

Actions: The IV Team is being recruited to. Education on hand hygiene and general infection prevention continues.

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.

	Feb-12	Mar-12	**Apr-12**
Target (monthly)	8	8	7
DRHABS	2	8	6



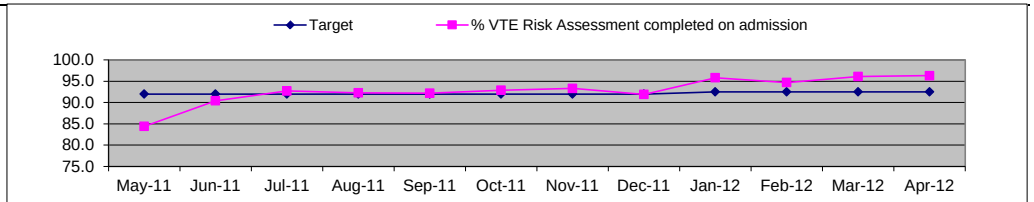
Analysis: Of the 6 DRHABS this month 5 were line-related and one secondary to a urinary catheter.

Actions: Continuing current strategies and with the development of the IV team.

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.

	Feb-12	Mar-12	**Apr-12**
% adult patients with completed VTE risk assessment	94.70%	96.10%	96.30%
Number of patients with hospital associated VTE	11	3	4
Number of patients identified in the community with VTE	48	15	16



Analysis: VTE risk assessment remains consistently above the national target. Hospital associated VTE - four RCA investigations requested, 3 completed. Sixteen community patients were identified with a VTE, of these 7 had pre existing factors, 3 had no know risk factors and 6 not known.

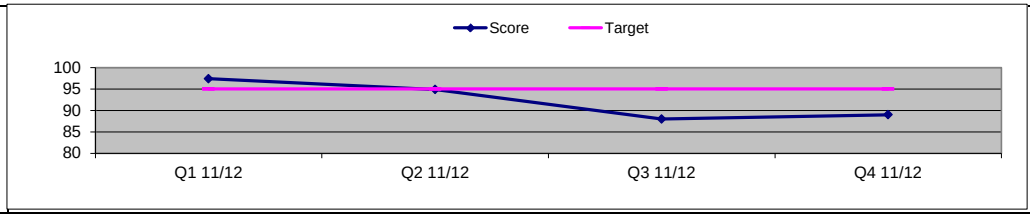
Actions: RCAs to be discussed at Directorate governance meetings and action plans developed.

4) PATIENT SAFETY AND QUALITY

4.1 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%.

	2011/12			
Target	Q1	Q2	Q3	**Q4**
95%	97.4%	94.90%	88%	89%



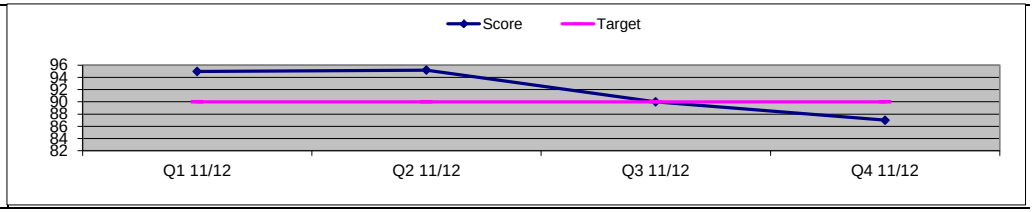
Analysis: There is an improving trend across Division 1, the main outstanding area of concern is within the Trauma and orthopaedic wards

Actions:
Division 1 - Local action plans are in place to further improve compliance
Division 2 - Each area below acceptable standard have produced action plans and are being monitored by the Head of Nursing

4.2 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%.

	2011/12			
Target	Q1	Q2	Q3	**Q4**
90%	95.0%	95.20%	90.00%	87.00%



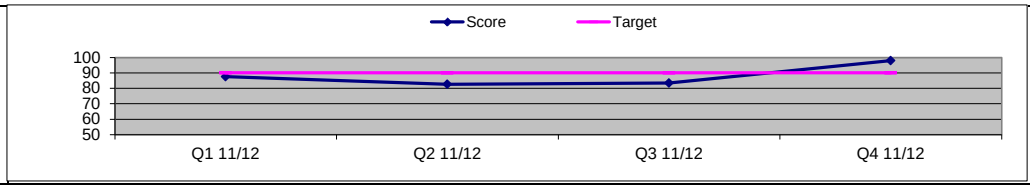
Analysis:
There has been a slight downward trend over the previous quarters performances. There is no one specific are or trend identified.

Actions:
Division 1 - Continue to monitor
Division 2 - Each area below acceptable standard have produced action plans and are being monitored by the Head of Nursing

4.3 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.

	Feb-12	Mar-12	**Apr-12**
Division 1	22	17	20
Division 2	29	25	23
Total	51	42	43
Target	45	45	45



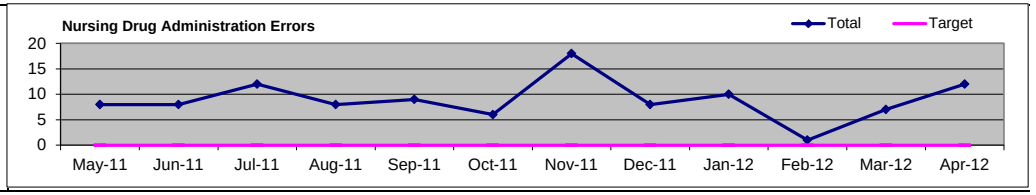
Analysis: Division 1 - one amber incident reported - no patient harm. Vacancies at a minimum within Division. Of the 23 incidents in Division 2 - 7 were graded amber however none resulted in direct patient harm

Actions: Division 1 - continue to monitor trends. Division 2 - Matrons are actively risk assessing incidents of staffing shortfall and putting in control measures in place to mitigate.

4.4 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.

	Feb-12	Mar-12	**Apr-12**
Division 1	0	3	3
Division 2	1	4	9
Total	1	7	12
Target	0	0	0



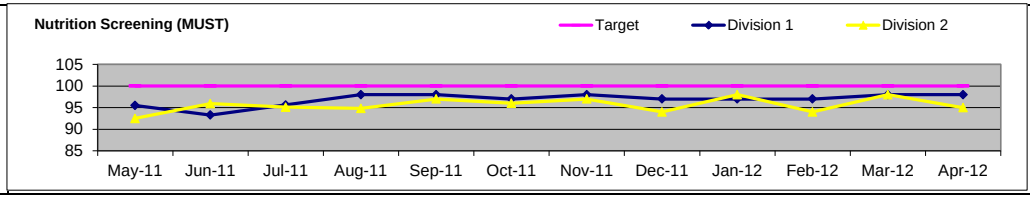
Analysis: Division 1 - no patient harm reported as a result of errors. Policy for retraining following drug errors followed in each case. Division 2 - These incidents occurred in 9 different areas and no common themes were identified. Examples of incidents include prescription and administration incidents including incorrect paediatric dose calculation, incorrect amount of diluent in paediatric IV administration and prescribing errors not identified by the nursing staff.

Actions: Division 1 - continue to monitor trends. Division 2 - The nurses involved in the incident have been managed according to Trust policy

4.5 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	Feb-12	Mar-12	**Apr-12**
Division 1	97%	98%	98%
Division 2	94%	98%	95%
Target	100%	100%	100%



Analysis: Division 1 - Continued high standards achieved. Division 2 - All areas achieved over 90% the implementation of care plan post assessment has improved this month however more improvement is required.

Actions: Division 1 - Two areas scoring less than 100% - continue to enforce high standards & monitor. Division 2 - Matrons are doing spot checks for completeness of assessment and care planning.

Divisional Infection Prevention Performance Monitoring - 5 Moments
May 2012

	TOTAL	General Surgery/Urology	Cardiac	Critical care/Theatres	Orthopaedic	Gynaecology	Head and Neck	Ophthalmology/ Outpatients	Maternity
Division One	**91%**	87%	100%	88%	79%	91%	91%	100%	100%

	TOTAL	Acute Children and NNU	Care of Elderly and Stroke	Neuro, Rheum, Derm and GUM	Renal/ Diabetes	Resp/Gastro	Emergency services	Oncology /Haematology
Division Two	**94%**	100%	96%	99%	98%	94%	73%	90%

Green	> 90%
Amber	70-89%
Red	<70%

5 Moments is an internationally recognised method of promoting hand hygiene across care settings with an associated audit process.

1) Before patient contact
2) Before aseptic technique
3) After a body fluid risk
4) After patient contact
5) After contact with surroundings

Infection Prevention Action Plan

Re-launch 5 moments using an organisational approach - July1st
High profile promotional literature
5 moments prompt card lauch planned.
In practice observational hand hygiene audits weekly by IP
Challenging hand hygiene compliance locally
City Show launch 7/8 July

Surgical (Division 1) - Quality & Safety Scorecard - May 2012 data

Patient Experience	This Month	Last Month	Trend
Patient Complaints as a percentage of activity	G	G	↔
Number of complaints accepted for investigation by Ombudsmen	A	A	↔
Number of serious complaints received	A	G	↓
Percentage of complaints responded to within 25 working days (or with consent to breach)	R	n/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	A	A	↔
Percentage of patients who answered "yes" to being treated with care and compassion	A	R	↑
Number of cancelled/rescheduled outpatient appointments		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	A	A	↔
Number of healthcare/inpatient falls - resulting in serious injury	G	G	↔
Number of healthcare acquired avoidable pressure ulcers acquired/deteriorated	A	A	↔
Percentage of inpatient MUST assessments completed within 24 hours of admission	G	A	↑
MSSA Bacteraemia	G	G	↔
Clostridium Difficile - hospital acquired for ages >2 years	A	A	↔
Device related bacteraemias	G	G	↔
Percentage of VitalPAC VTE risk assessments on admitting ward	A	G	↓
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)	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	A	↔
Percentage of staff who have undergone an annual appraisal	A	R	↑
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)	R	A	↔
Overall Rating	A		↔

Trust Dashboard: May 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	Sharon Reilly	0	0	→	0	0	→	0	<0.5%	↑	<0.5%	<0.5%	→	<0.5%	<0.5%	→	<0.5%	<0.5%	→	0	0	→
Number of complaints accepted for investigation by the Ombudsman	0	0 = Green, else Red	Sharon Reilly	0	0	→	0	0	→	0	0	→	0	1	↑	0	0	→	0	0	→	0	0	→
Number of serious complaints received	0	0 = Green, else Red	Sharon Reilly	0	0	→	0	0	→	0	0	→	1	0	↓	0	0	→	1	0	↓	0	0	→
Percentage of complaints responded to within 25 working days (or with consent to breach)	90%	>/= 90% = Green, else Red	Sharon Reilly	100%	100%	→	N/A	N/A	↑	100%	100%	→	63%	67%	↑	67%	67%	→	50%	100%	↓	100%	33%	↑
% 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	Sharon Reilly		N/A			N/A		75%	73%	↑	62%	82%	↓	100%	86%	↑	86%	79%	↑	71%	60%	↓
Percentage patients who rated overall satisfaction good/excellent	95%	>95% = Green, 85-95% = Amber, <85% = Red	Sharon Reilly		N/A			N/A		96%	100%	↓	100%	87%	↑	80%	77%	↑	64%	84%	↓	100%	100%	↑
Percentage of patients who answered "yes" to being treated with care and compassion	95%	>95% = Green, 85-95% = Amber, <85% = Red	Sharon Reilly		N/A			N/A		98%	82%	↑	86%	90%	↓	80%	77%	↑	92%	79%	↑	100%	90%	↑
Number of cancelled/rescheduled outpatient appointments	–	Reduction of 40% in year	Lesley Taff							71	34	↓	395	348	↓	237	239	↑	46	68	↑	436	298	↓
Cancelled operations as a percentage of elective admissions	0.8%	< 0.8% = Green, else Red	Lesley Taff							2.45%	1.71%	↓	1.16%	1.06%	↓	2.45%	0.95%	↓	1.62%	1.01%	↓	1.19%	0.5%	↓
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	→	2	0	↓	10	3	↓	10	12	↑	3	14	↑	2	2	→	0	2	↑
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	→	5	4	↓	1	0	↓	2	2	→	4	4	→	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%	→	100%	97%	↑	100%	98%	↑	100%	100%	→	100%	100%	→
MSSA bacteraemia	–	<2 = Green, 2-3 = Amber, >3 = Red	Mike Cooper	0	0	→	0	0	→	0	1	↑	0	1	↑	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	→	1	1	→	1	2	↑	4	0	↓	1	0	↓	0	0	→	0	0	→
Device related bacteraemias	–	Green = 0,Amber = 1,Red = >1	Mike Cooper	0	0	→				0	0	→	0	1	↑	0	0	→	0	0	→	0	0	→
Device related bacteraemias (Haem/Onc, ICCU, Renal, Neonates)	–	Green = 0,Amber = 1- 2 Red = >2	Mike Cooper				0	0	→															
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%	100%	→	97.31%	96.57%	↑	97.30%	92.39%	↑	87.34%	86.67%	↑	86.52%	94.52%	↓	93.95%	95.86%	↓	95.54%	95.29%	↑
Percentage of late observations (VitalPAC wards only)	5%	<5% = Green, 5-10% = Amber, >10% = Red					5.3%	5.0%	↓	12.0%	15.2%	↑	12.3%	12.5%	↑	22.0%	20.5%	↓	14.0%	11.0%	↓	14.0%	9.6%	↓
Patient Outcomes																								
Length of stay (elective)	specific	Specific	Lesley Taff							4.03	3.93	↓	2.59	2.59	→	3.0	3.1	↑	2.5	2.4	↓	1.88	1.8	↓
Length of stay (non elective)	specific	Specific	Lesley Taff							6.49	6.67	↑	3.65	3.5	↓	6.1	6.0	↓	1.3	1.3	→	1.94	1.97	↑
Percentage of emergency readmissions within 30 days	4.19%	<4.19% = Green, 4.2-5% = Amber, >5%= Red	Lesley Taff							0.35%	1.71%	↑	0.70%	0.60%	↓	0.61%	0.00%	↓	0.40%	0.24%	↓	0.00%	0.00%	→
Delayed discharges			Lesley Taff	0.0%	0.0%	→	0.0%	0.0%	→	0.3%	0.5%	↑	0.9%	0.6%	↓	0.5%	0.0%	↓	0.6%	0.3%	↓	0.0%	0.3%	↑
18 week RTT - admitted	90%	90% = Green, else Red	Lesley Taff							99.13%	96.89%	↑	92.45%	92.67%	↓	90.18%	90.03%	↑	90.78%	95.11%	↓	94.64%	92.32%	↑
18 week RTT - non-admitted	95%	95% = Green, else Red	Lesley Taff							96.27%	95.65%	↑	95.37%	96.30%	↓	95.12%	95.02%	↑	97.08%	97.6%	↓	98.19%	98.64%	↓
Clinical correspondence turnaround within 48 hours	100%	100% = Green, 75-99% = Amber, else Red	Lesley Taff	74.1%	79.7%	↓				54.1%	37.6%	↑	34.9%	57.0%	↓	23.6%	79.8%	↓	98.5%	72.2%	↑	89.2%	61.4%	↑
Support Services																								
Sickness absence	<4%	<4% = Green, 4.1-5.9% = Amber, >6% = Red	Lesley Taff	2.65%	2.52%	↓	3.66%	3.79%	↑	4.32%	4.34%	↑	4.46%	3.84%	↓	4.47%	5.03%	↑	4.51%	4.45%	↓	3.08%	3.38%	↑
Percentage of staff who have undergone annual appraisal	80%	>/=80% = Green, 70-79% = Amber, <70% = Red	Lesley Taff	83.8%	84.3%	↓	72.6%	77.6%	↓	78.5%	67.2%	↑	86.1%	86.3%	↓	69.6%	63.3%	↑	81.5%	84.8%	↓	54.5%	51.7%	↑
Percentage of trained nursing vacancies per funded establishment			Lesley Taff	0.00%	0.00%	→	1.37%	1.21%	↓	-0.32%	-0.41%	↑	-0.03%	-0.94%	↑	0.50%	2.18%	↑	4.71%	4.41%	↓	1.64%	1.30%	↓
Percentage of medical training grades vacancies per funded establishment			Lesley Taff	0.00%	0.00%	→	0.00%	0.00%	→	0.00%	0.00%	→	0.00%	0.00%	→	0.00%	0.00%	→	0.37%	0.37%	→	0.00%	0.00%	→
Pay budget (ward pay budget only)	In balance	Yes = Green, Agreed = Amber, No = Red	Alison Reynolds							£(49) k	£(26) k	↓	£(49) k	£(25) k	↓	£(51) k	£(28) k	↓	£(21) k	£(8) k	↓	£(17) k	£(8) k	
WTE budgeted against actual (ward WTE only)	In balance	variance < 5% = Green variance 5-10% = Amber variance >10% = Red	Alison Reynolds							(0.82) %	(3.82) %	↑	1.70 %	(1.93) %	↑	(7.49) %	(15.50) %	↑	4.72 %	2.15 %	↑	(7.50) %	(6.77) %	

The Royal Wolverhampton Hospitals NHS Trust

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HIGH LEVEL INDICATOR EXCEPTION REPORT TO TRUST BOARD
25 June 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	Length of Stay (non-elective)	Clinical correspondence turnaround within 48 hrs	Ward pay budget	% late observations
Indicator tolerance:	Target = 0.8% Red = >0.8%	Target & Tolerance = specific	Target = 100% Red = < 75%	Target = in balance Red = not in balance	Target = 5% Red = >10%
Period of alert: (i.e. Jun, Jul, Aug 2011)	Feb, Mar & Apr 2012	Feb, Mar & Apr 2012	Feb, Mar & Apr 2012	Feb, Mar & Apr 2012	Feb, Mar & Apr 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. Due to the nature of cardiac surgery, occasionally elective cases have to be cancelled for a non-elective patient. If cancellations are due to other issues eg staff or lack of beds, the Directorate will look at using beds in other areas or transferring staff wherever possible, extending the working day and considering all options in order to avoid cancellation. Ongoing.	*Further clarity required around this target and the benchmark used.*	Dedicated 'typing time' continues. Overtime was approved to address the backlog. Working with consultants, a review is presently being undertaken of letters generated by junior doctors, length of letters and quality and feeding back accordingly.	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. Some of these pressures have been addressed in the new budget settlement.	

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.	The Directorate reviews all performance indicators monthly at its Directorate meetings and will explore reasons for any increases in LOS etc with the clinical teams, or investigate further.	Practice manager monitors typing correspondence and turnaround on a daily basis, reallocating jobs where necessary and proactively managing workloads to ensure equitable.	Ongoing monitoring by ward manager, Matron and DM during budget meetings.	

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HIGH LEVEL INDICATOR EXCEPTION REPORT TO TRUST BOARD
25 June 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	Clinical correspondence turnaround within 48 hrs	Ward pay budget	% late observations
Indicator tolerance:	Target = 95% Red = <85%	Target = 0.8% Red = >0.8%	Target = 100% Red = < 75%	Target = in balance Red = not in balance	Target = 5% Red = >10%
Period of alert:	Feb, Mar & Apr 2012	Feb, Mar & Apr 2012	Feb, Mar & Apr 2012	Feb, Mar & Apr 2012	Feb, Mar & Apr 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.	The biggest issues relates to Urology. The Directorate interview on 1st June for a 5th substantive Consultant. Funding available from April 1st for all associated support to this post. Non-pay monies currently being used to fund outsourcing to Dict8 to mitigate the impact. Reduction in backlog of 50% from January to March.	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. Review at individual ward meetings	Weekly reporting via Chief Operating Officers report	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 Managers. Monthly Finance and Performance Meetings chaired by deputy Chief	

				Operating Officer in conjunction with Clinical Finance Manager	

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HIGH LEVEL INDICATOR EXCEPTION REPORT TO TRUST BOARD
25 June 2012

Report from: Directorate/Group	Obstetrics & Gynaecology
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?'	Cancelled operations as a % of elective admissions	Ward pay budget	% late observations
Indicator tolerance:	Target = 95% Red = <85%	Target = 0.8% Red = >0.8%	Target = in balance Red = not in balance	Target = 5% Red = >10%
Period of alert: (i.e. Jun, Jul, Aug 2011)	Feb, Mar & Apr 2012	Feb, Mar & Apr 2012	Feb, Mar & Apr 2012	Feb, Mar & Apr 2012
Actions: Please identify where completed or a timescale for completion and who by	All clinical staff to actively involve patients in decisions regarding their care and treatment, offering choice where appropriate.	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	Discuss at Clinical Governance Meetings and review of data to identify if any particular individuals are less compliant than others.	Cancelled operations report/monthly governance meetings	Monthly budget surgeries	

The Royal Wolverhampton Hospitals NHS Trust

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HIGH LEVEL INDICATOR EXCEPTION REPORT TO TRUST BOARD
25 June 2012

Report from: Directorate/Group	Ophthalmology, Head & Neck
Report prepared by: Name, Job Title	Kate Middlemiss, Group Manager for Ophthalmology Ruth Horton, Group Manager for Acute Head & Neck

Description of indicator:	Clinical correspondence turnaround within 48 hrs.	Percentage of staff who have undergone annual appraisal	Ward pay budget
Indicator tolerance:	Target = 100% Red = < 75%	Target = 80% Red = <70%	Target = in balance Red = not in balance
Period of alert: (i.e. Jun, Jul, Aug 2011)	Feb, Mar & Apr 2012	Feb, Mar & Apr 2012	Feb, Mar & Apr 2012
Actions: Please identify where completed or a timescale for completion and who by	Overtime authorised for medical secretarial team. A review is being undertaken looking at volume of letters and secretaries per consultant to ensure there are sufficient resources to meet the demand. An additional 'bank' secretary (to minimise overtime costs) has been approved. A Band 2 from the Directorate office has been redeployed to assist the medical secretarial team. A Band 5 team leader joined the department in April to provide greater leadership and performance management.	All clinical and team leads have been told appraisals have to be up to 95% complete by early July and the database completely up-to-date and accurate. All appraisals, once completed, have to be 'reported' to the Directorate office as a way of ensuring this work is being done and progress is being made.	The ward has an additional 6 'unfunded' beds open to support Trust wide winter pressures. Additional staff have been recruited on a temporary basis to ensure continuity of staffing levels.
Assurance/Monitoring: Please identify monitoring arrangements in place to sustain improvements	Ongoing monitoring by the Team leader, Practice Manager and DM.	The Directorate secretary is keeping an accurate record of all appraisals completed and the dates. DM regularly monitoring. Discussed at governance meeting.	Monthly budget meetings with Group Manager and Matron. Weekly authorisation of bank expenditure by Matron to ensure appropriate usage

The Royal Wolverhampton Hospitals NHS Trust

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HIGH LEVEL INDICATOR EXCEPTION REPORT TO TRUST BOARD
25 June 2012

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

Description of indicator:	% late observations	Ward pay budget
Indicator tolerance:	Target = 5% Red = >10%	Target = in balance Red = not in balance
Period of alert:	Feb, Mar & Apr 2012	Feb, Mar & Apr 2012
Actions: Please identify where completed or a timescale for completion and who by		Sickness absence being actively managed. Matron agreeing additional bank shifts requested.
Assurance/Monitoring: Please identify monitoring arrangements in place to sustain improvements		Monthly finance meetings with budget holder.

Emergency, Medical and Community Services (Division 2) - Quality & Safety Scorecard - May 2012 data

Patient Experience	This Month	Last Month	Trend
Patient Complaints as a percentage of activity	G	G	↔
Number of complaints accepted for investigation by Ombudsmen	G	A	↑
Number of serious complaints received	A	G	↓
Percentage of complaints responded to within 25 working days (or with consent to breach)	R	n/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?	A	R	↑
Percentage of patients who rated overall satisfaction good/excellent	G	A	↑
Percentage of patients who answered "yes" to being treated with care and compassion	A	A	↔
Number of cancelled/rescheduled outpatient appointments	G	G	↔
Overall Rating	A		↔

Patient Safety	This Month	Last Month	Trend
Number of red incidents	G	G	↔
Number of healthcare/inpatient falls	A	A	↔
Number of healthcare/inpatient falls - resulting in serious injury	A	G	↓
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	G	A	↑
Percentage of VitalPAC VTE risk assessments on admitting ward	A	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)	A	A	↔
Percentage of emergency re-admissions within 30 days	G	A	↑
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	R	R	↔
Percentage of staff who have undergone an annual appraisal	R	R	↔
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)	R	A	↓
Overall Rating	R		↔

Trust Dashboard: May 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	→ No change	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%	↑ Improvement on previous month	Nina Dunmore	0	0	→	<0.5%	0	↓	<0.5%	<0.5%	→	<0.5%	<0.5%	→	<0.5%	<0.5%	→	<0.5%	<0.5%	→	<0.5%	<0.5%	→	<0.5%	<0.5%	→	<0.5%	0	↓	0	<0.5%	↑
Number of complaints accepted for investigation by the Ombudsman	0	↓ Deterioration on previous month	Nina Dunmore	0	1	↑	0	0	→	0	0	→	0	0	→	0	0	→	0	0	→	0	0	→	0	0	→	0	0	→	0	0	→
Number of serious complaints received	0	0 = Green, else Red	Nina Dunmore	0	0	→	0	0	→	0	0	→	1	0	↓	0	0	→	0	0	→	0	0	→	1	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	50%	↑	100%	N/A	↑	50%	100%	↓	100%	N/A	→	67%	N/A	→	67%	80%	↑	33%	33%	→	33%	60%	↑	100%	N/A	→	100%	33%	↑
% 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		54%	53%	↑	N/A	N/A		N/A	N/A		90%	63%	↑	89%	79%	↑	100%	73%	↑		N/A		85%	59%	↑
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		85%	82%	↑	N/A	N/A		N/A	N/A		100%	89%	↑	100%	93%	↑	100%	100%	↑		N/A		100%	91%	↑
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		85%	82%	↑	N/A	N/A		N/A	N/A		82%	86%	↓	97%	90%	↑	100%	100%	↑		N/A		92%	82%	↑
Number of cancelled/rescheduled outpatient appointments	–	Reduction of 40% in year	Lesley Taff	119	226	↑	N/A	N/A		14	0	↓	N/A	N/A		244	140	↓	138	89	↓	15	75	↑				0	0	→	145	14	↓
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	→	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	1	0	↓	0	0	→	42	45	↑	12	21	↑	2	0	↓	12	5	↓	19	17	↓	8	16	↑	2	2	→	4	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	0	→	1	0	↓	0	0	→	0	0	→	0	0	→	0	0	→	1	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	0	↓	7	4	↓	4	1	↓	1	3	↑	0	0	→	2	1	↓	9	4	↓	1	0	↓	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%	→				100%	96%	↑	98%	97%	↑	89%	98%	↓				100%	95%	↑
MSSA bacteraemia	–	<2 = Green, 2-3 = Amber, >3 = Red	Mike Cooper	0	0	→	0	0	→	0	0	→	0	0	→	0	0	→	0	1	↑	0	0	→	1	0	↓				0	1	↑
Clostridium Difficile - hospital acquired for ages >2 years	–	Green = 0,Amber = 1-2, Red = >2	Mike Cooper	0	0	→	0	0	→	1	1	→	0	0	→	0	0	→	3	1	↓	0	1	↑	1	0	↓				2	1	↓
Device related bacteraemias	–	Green = 0,Amber = 1,Red = >1	Mike Cooper	0	0	→	0	0	→	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	0	→													1	0	↓										2	5	↑
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							97.73%	97.62%	↑	N/A	N/A		98.1%	82.8%	↑	99.66%	99.75%	↓	77.27%	83.33%	↓	94.34%	94.39%	↓				99.54%	99.92%	↓
Percentage of late observations (VitalPAC wards only)	5%	<5% = Green, 5-10% = Amber, >10% = Red								10.7%	15.0%	↑							14.0%	14.7%	↑	8.5%	8.7%	↑	14.0%	14.0%	→				11.1%	10.1%	↓
Patient Outcomes																																	
Length of stay (elective)	specific	Specific	Lesley Taff	2.2	1.8	↓										0.8	0.8	→	0.5	0.5	→	2.1	2.2	↑							4.27	4.5	↑
Length of stay (non elective)	specific	Specific	Lesley Taff	0.7	0.7	→										4.5	3.68	↓	2.1	2.14	↑	3.3	3.2	↓							6.58	5.8	↓
Percentage of emergency readmissions within 30 days	4.19%	<4.19% = Green, 4.2-5% = Amber, >5%= Red	Lesley Taff	3.75%	5.06%	↑				0.0%	0.0%	→	0.0%	0.0%	→	0.0%	0.9%	↑	0.0%	0.0%	→	0.0%	0.0%	→	0.0%	0.0%	→				0.11%	0.00%	↓
Delayed discharges			Lesley Taff	0.0%	0.0%	→				2.0%	2.1%	↑	0.9%	1.1%	↑	0.0%	0.0%	→	0.0%	0.0%	→	0.0%	0.0%	→	0.0%	0.3%	↑				0.5%	0.5%	→
18 week RTT - admitted	90%	90% = Green, else Red	Lesley Taff													100%	100%	→	100%	100%	→	97.37%	100%	↓				100%	100%	→	100%	100%	→
18 week RTT - non-admitted	95%	95% = Green, else Red	Lesley Taff	100.0%	99.5%	↑	100%	100%	→	99.19%	100%	↓				98.1%	97.9%	↑	99.2%	100%	↓	96.1%	97.4%	↓				100%	100%	→	96.43%	100.0%	↑
Clinical correspondence turnaround within 48 hours	100%	100% = Green, 75-99% = Amber, else Red	Lesley Taff	100.0%	66.2%	↑	N/A	N/A		26.3%	89.1%	↓	N/A	N/A		27.1%	80.6%	↓	100.0%	91.7%	↑	57.0%	66.0%	↓	100.0%	76.2%	↑				100.0%	72.6%	↑
Support Services																																	
Sickness absence	<4%	<4% = Green, 4.1-5.9% = Amber, >6% = Red	Lesley Taff	5.15%	5.32%	↑	6.07%	6.29%	↑	4.54%	5.86%	↑	5.84%	7.18%	↑	2.73%	2.79%	↑	4.01%	2.99%	↓	6.83%	5.52%	↓	8.70%	6.45%	↓	2.81%	2.28%	↓	5.55%	4.75%	↓
Percentage of staff who have undergone annual appraisal	80%	>/=80% = Green, 70-79% = Amber, <70% = Red	Lesley Taff	69.9%	81.7%	↓	55.7%	55.9%	↑	80.9%	75.2%	↑	69.2%	67.5%	↑	77.4%	47.1%	↑	66.0%	64.2%	↑	84.3%	87.8%	↓	91.1%	80.9%	↑	61.6%	61.3%	↑	71.2%	54.5%	↑
Percentage of trained nursing vacancies per funded establishment			Lesley Taff	3.70%	3.06%	↓	1.14%	0.00%	↓	-0.96%	0.02%	↓	-0.85%	-0.39%	↓	-1.0%	0.00%	↓	-2.28%	0.21%	↓	-2.33%	-0.70%	↓	1.04%	-1.43%	↑	0.0%	0.0%	→	-0.50%	-0.64%	↑
Percentage of medical training grades vacancies per funded establishment			Lesley Taff	0.56%	0.56%	→	0.00%	0.00%	→	0.00%	0.97%	↑	0.00%	0.42%	↑	0.00%	0.00%	→	0.89%	0.89%	→	0.00%	0.00%	→	0.84%	0.00%	↓	0.00%	0.00%	→	0.00%	0.00%	→
Pay budget (ward pay budget only)	In balance	Yes = Green, Agreed = Amber, No = Red	Alison Reynolds	£(19) k	£(6) k	↓	£7 k	£(13) k	↑	£(191) k	£(115) k	↓	£(0) k	£(0) k	→				£(63) k	£(16) k	↓	£(58) k	£(11) k	↓	£(20) k	£(11) k	↓				£(33) k	£(21) k	↓
WTE budgeted against actual (ward WTE only)	In balance	variance < 5% = Green variance 5-10% = Amber variance >10% = Red	Alison Reynolds	4.81 %	2.33 %	↑	55.97 %	(100+) %	↑	(22.60) %	(39.13)%	↑	3.68 %	(4.25) %	↑				(17.52) %	(9.58)%	↓	(15.95) %	(2.30) %	↓	3.65 %	0.70 %	↑				0.20%	(5.85)%	↑

The Royal Wolverhampton Hospitals NHS Trust

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HIGH LEVEL INDICATOR EXCEPTION REPORT TO TRUST BOARD
25 June 2012

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

Description of indicator:	Number of healthcare acquired avoidable pressure ulcers (acquired/deteriorated) Grades 2,3 &4	Sickness Absence	Percentage of staff who have undergone annual appraisal
Indicator tolerance:	Target = 0 Red = >0	Target = <4% Red = >6%	Target = 80% Red <70%
Period of alert: (i.e. Jun, Jul, Aug 2011)	Feb, Mar & Apr 2012	Feb, Mar & Apr 2012	Feb, Mar & Apr 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 on-going. • 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)	• All 3 District nursing localities to be part of the sickness absence pilot project (target date end of May 2012) • Sickness absence management to be on all 1:1 meeting and team meeting agendas (target date end of May 2012) • Individual managers to arrange any additional HR support required (target date end of May 2012)	• Cross reference local data with Trust data base to ensure accuracy of reporting (target date end of May 2012) • Target numbers of appraisals to be completed each month (target date end of May 2012) • All PDPs that are overdue to have dates given to them (target date end of May 2012) • Leads to be identified for monitoring of appraisals (target date end of May 2012)
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	• Sickness absence management being monitored via ACSG sickness review meetings	• Monitored at Directorate and Group Governance meetings

	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	• Sickness absence management workshops held for service leads	

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HIGH LEVEL INDICATOR EXCEPTION REPORT TO TRUST BOARD
25 June 2012

Report from: Directorate/Group	Therapy Services (Community)
Report prepared by: Name, Job Title	Sue Perks

Description of indicator:	% staff who have undergone annual appraisal
Indicator tolerance:	Target = 80% Red = <70%
Period of alert: (i.e. Jun, Jul, Aug 2011)	Feb, Mar & Apr 2012
Actions: Please identify where completed or a timescale for completion and who by	Service spread sheet indicates 66% compliance for annual appraisals- indication that appraisals not being notified to Training database- action – forms to be completed and sent to training data base. More individual staff appraisals scheduled for May 12 to bring compliance to 71% Dates to be arranged for June to bring compliance to 80% by 30/6/12
Assurance/Monitoring: Please identify monitoring arrangements in place to sustain improvements	Staff reminded at staff meetings to book appraisal dates within 12 months of last appraisal.. Copies of compliance forms to be logged with office manager with monthly check

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HIGH LEVEL INDICATOR EXCEPTION REPORT TO TRUST BOARD
25 June 2012

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

Description of indicator:	Number of healthcare acquired avoidable pressure ulcers (acquired/deteriorated) Grades 2,3 &4	Ward pay budget	% late observations
Indicator tolerance:	Target = 0 Red = >0	Target = in balance Red = not in balance	Target = 5% Red = > 10%
Period of alert: (i.e. Jun, Jul, Aug 2011)	Feb, Mar & Apr 2012	Feb, Mar & Apr 2012	Feb, Mar & Apr 2012
Actions: Please identify where completed or a timescale for completion and who by	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. Staff TV competency training underway	Action plan in place to reduce overspend on wards D8 and ASU. D8 continues to have pressure on funded establishment and this is subject to a staffing review as part of the workforce review, sickness levels are also high and the ward participate in the Sickness Pilot. 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 plan is now in place for rotation of band 6's/band 5 between the ASU and Ward 1 at West Park. Band 6 on Stroke has applied for MARS and the second post over established will retire in October.	There have been issues around connectivity on the ASU for VitalPAC which are ongoing. The Ward Manager and Matrons are actively working to resolve the issues around late observations recorded.
Assurance/Monitoring: Please identify monitoring arrangements in place to sustain improvements	Monitored by Nursing KPI Actions escalated via Senior nurse pressure care forum.	Monitored by monthly sickness meetings. Monitored by Division Budget meetings.	Quality Rounds.

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HIGH LEVEL INDICATOR EXCEPTION REPORT TO TRUST BOARD
25 June 2012

Report from: Directorate/Group	Emergency Services Group (A&E, EAU)
Report prepared by: Name, Job Title	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
Indicator tolerance:	Target = 95% Red = <85%	Target = 5% Red = >10%
Period of alert: (i.e. Jun, Jul, Aug 2011)	Feb, Mar & Apr 2012	Feb, Mar & Apr 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. 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 colleagues _ RL RR to discuss at team meetings with nursing staff RR – undertakes daily rounds to alleviate/minimise concerns/complaints	
Assurance/Monitoring: Please identify monitoring arrangements in place to sustain improvements	Governance meetings Real time feedback results Complaint trends	

The Royal Wolverhampton Hospitals NHS Trust

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HIGH LEVEL INDICATOR EXCEPTION REPORT TO TRUST BOARD
25 June 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?'	Ward pay budget
Indicator tolerance:	Target = 95% Red = <85%	Target = in balance Red = not in balance
Period of alert: (i.e. Jun, Jul, Aug 2011)	Feb, Mar & Apr 2012	Feb, Mar & Apr 2012
Actions: Please identify where completed or a timescale for completion and who by	Full results of survey for Jan, Feb Mar received from PALS. To be shared with Directorate at Governance meeting on 5 June 2012. Importance of ensuring patients are involved in decision-making to be discussed again and actions to be taken moving forward.	Action plan devised and implemented for new financial year. Savings predicted for May with full effect from June 12. Year end forecast agreed with Division. Staffing levels reviewed on a daily basis. Off-duty continues to be monitored directly by Matron.
Assurance/Monitoring: Please identify monitoring arrangements in place to sustain improvements	Results of future patient surveys undertaken by PALS to be reviewed monthly.	Weekly monitoring of off-duty by Matron. Review at Divisional performance meeting.

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HIGH LEVEL INDICATOR EXCEPTION REPORT TO TRUST BOARD
25 June 2012

Report from: Directorate/Group	Rehab (West Park)
Report prepared by: Name, Job Title	Wendy Worth, Group Manager Ambulatory and Rehabilitation

Description of indicator:	Sickness Absence	Percentage of staff who have undergone annual appraisal
Indicator tolerance:	Target = <4% Red = >6%	Target = 80% Red = <70%
Period of alert: (i.e. Jun, Jul, Aug 2011)	Feb, Mar & Apr 2012	Feb, Mar & Apr 2012
Actions: Please identify where completed or a timescale for completion and who by	Monthly meetings with HR and ward managers and support from Group matron in reducing sickness levels. Long term sickness being managed with Occupational Health.	An action plan is in place and work has been undertaken with the training and appraisal database to correct information held, local records suggest 85% compliance.
Assurance/Monitoring: Please identify monitoring arrangements in place to sustain improvements	Group Performance meeting monthly	Group Performance meeting monthly

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HIGH LEVEL INDICATOR EXCEPTION REPORT TO TRUST BOARD
25 June 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?'	% staff who have undergone annual appraisal	Ward pay budget	% late observations
Indicator tolerance:	Target = 95% Red = <85%	Target = 80% Red = <70%	Target = in balance Red = not in balance	Target = 5% Red = >10%
Period of alert: (i.e. Jun, Jul, Aug 2011)	Feb, Mar & Apr 2012	Feb, Mar & Apr 2012	Feb, Mar & Apr 2012	Feb, Mar & Apr 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.	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 before end of May.	
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.	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

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HIGH LEVEL INDICATOR EXCEPTION REPORT TO TRUST BOARD
25 June 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?'	Clinical correspondence turnaround within 48 hours	Ward pay budget
Indicator tolerance:	Target = 95% Red = <85%	Target = 100% Red = <75%	Target = in balance Red = not in balance
Period of alert: (i.e. Jun, Jul, Aug 2011)	Feb, Mar & Apr 2012	Feb, Mar & Apr 2012	Feb, Mar & Apr 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.	Issues following sickness and maternity leave. Staff now returned from maternity leave and reduction in hours covered by other staff Manage sickness in line with policy	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.	Team Leader to monitor turnaround times on a weekly basis.	Meet with budget holders on a monthly basis. Monitor sickness and