The Royal Wolverhampton NHS Trust	

Trust Board Report

Meeting Date:	25 March 2013
Title:	Quality & Safety Reports
Executive Summary:	• The Q&S Report details Trust wide data for February 2013 • The Q&S Dashboard provides Group data for February 2013 • The Q&S Scorecard provides a divisional overview based on the directorate data for February 2013 • The exception reports provide information received from directorates when three consecutive red rag indicators have been reported.
Action Requested:	For the Trust Board to note the report
Report of:	Ms Cheryl Etches, Chief Nursing Officer
Author: **Contact Details:**	Ms Charlotte Hall, Deputy Chief Nurse Quality & Safety Charlotte.Hall6@nhs.net 01902 696968
Resource Implications:	None
Public or Private:	Public
References:	The Quality and Safety Report was approved by the Quality & Safety Committee on 19 March 2013.
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

The Royal Wolverhampton NHS
NHS Trust

Trust Board Executive Summary – Quality & Safety Reports 2013

The Quality and Safety report provides data reported for February and details the monthly progress of the Quality & Safety indicators. There have been no never events this month.

- ***Net Promoter (Friends & Family Score):*** The overall net promoter score has improved to 76.2 and the Trust is expecting to achieve the CQUIN payment
- ***Falls:*** The number of falls per 1000 bed days has reduced further for February but the number at West Park has increased. There were 4 falls causing serious injury
- ***Pressure Ulcers***: The number of health acquired avoidable pressure ulcers has reduced with 75% of the Trust reporting zero avoidable pressure ulcers, one of the community nursing teams have won an award for most inspirational team awarded by NHS East and Midlands for their work in reducing pressure damage out in the community.
- ***Recognising the deteriorating patient***: The % of late observations has decreased Trust wide to 14% and 80% of the Trust is now trained and using the new vitalpac I pod touch screen devices. The new version incorporating more functionality will be introduced in May.
- ***Hand Hygiene***: Five moments reporting demonstrates sustained high levels of practice except in orthopaedics which is being addressed by the directorate
- ***Device Related Hospital Acquired Bacteraemia (DRHABs):*** The Trust has seen a reduction in this since last month which is positive.

Quality & Safety Trust Dashboards and scorecards use data from the quality, safety and performance reports to provide an overall view

Division 1

Patient Experience has gone from amber to red on the scorecard: The trend across the division is a slight increase in numbers of complaints more marked in general surgery/urology. There has been a deterioration on patient experience reported through the trackers for percentage of people answering yes to being treated with care and compassion in general surgery/urology and ophthalmology/head and neck services. The PALs team will concentrate on additional outreach in these areas to work with matron.

Patient Safety has improved from red to amber on the scorecard: There has been an overall improvement in safety indicators this month namely in the following indicators: Numbers of falls and DRHABs. The percentage of late observations remains high and of note in orthopaedics (18.5%) and Cardiac Services (18.4%)

Patient Outcomes remains amber on the scorecard: Clinical correspondence turnaround within 48 hours has continued to deteriorate with Respiratory/Gastroenterology reducing further from 91.4% down to 59.1%.

Resources have improved from red to amber on the scorecard: There is an improvement in sickness absence and numbers of staff who have undergone appraisal.

Division 2

Patient Experience remains amber on the scorecard: There has been an overall reduction in serious complaints across the division. Patient trackers are demonstrating a slight deterioration in renal/diabetes services and respiratory/gastroenterology services. There is no data for emergency services because of a fault with equipment this month.

Patient Safety has moved from red to amber on the scorecard: There has been a reduction in numbers of falls and DRHABs and an improving picture in percentage of late observations with 50% of wards achieving less than 10% late observations. All wards in division 2 are now using the new devices.

Patient outcomes remains amber on the scorecard: The length of elective stay has reduced

Resources have improved from red to amber on the scorecard: There is an improvement in sickness absence in month.

THE ROYAL WOLVERHAMPTON NHS TRUST	
Report to:	Trust Board
Date:	25 March 2013
Subject:	Quality & Safety Report
Report by:	Chief Nursing Officer
Author:	Deputy Chief Nurse
Purpose of Report	To provide the Board with information regarding performance and progress with Trust quality and safety.

Report

Review Committee Approval
The Board to receive the report

Recommendation(s)
The Board is asked to note the content of the report

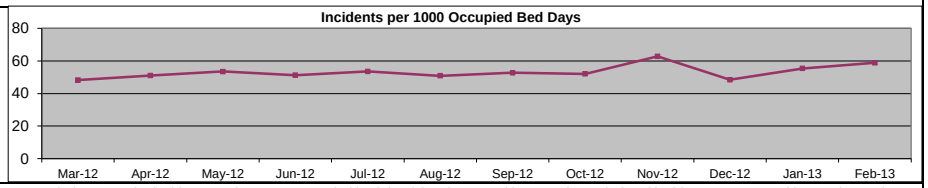
Contents

1.0 TRUST SAFETY & QUALITY OVERVIEW

1.1 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.

	Dec-12	Jan-13	Feb-13
Div 1	454	392	419
Div2	599	837	753
Total	1053	1229	1172
Per 1000obd	48.5	55.4	58.9



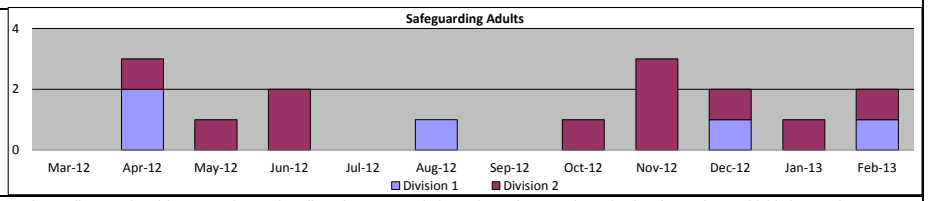
Analysis: The number of incidents reported during February appears to have decreased by 5% from the previous month, however the incident rate (per 1000 occupied bed days) has increased by 6%. The majority of incidents are reported by nursing and midwifery staff .

Actions: The reporting of incidents continues to be encouraged and the use of online reporting of incidents via Datix Web is extending. The managers are remined to ensure sisters and matrons review their datix reports in a timely fasion as per the incident reporting policy to ensure information is as live and accurate as possible. Further work between Governance/DCNO to ascertain where delays are occuring

1.2 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	Dec-12	Jan-13	Feb-13
Div 1	1	0	1
Div2	1	1	1
Total	2	1	2



Analysis: 1 referral attributed to B7, however on investigation not pressure damage and therefore should not be safeguarding. 1 referral (pressure damage) attributed to Community/ AMU/ C16, however investigation deemed unavoidable by scrutiny & challenge committee.

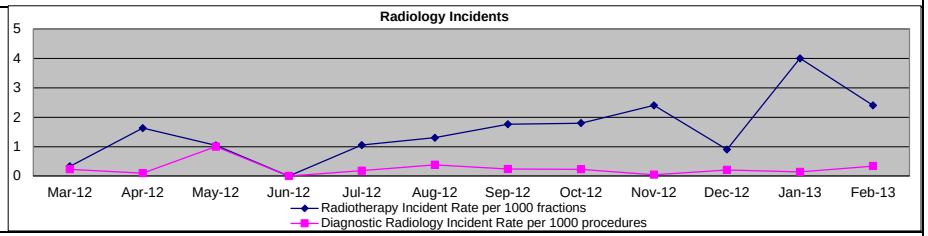
Action: To continue with investigation and update findings through Safeguarding Board

1.3 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	Dec-12	Jan-13	Feb-13
Radiotherapy	2	9	6
Diagnostic Radiology	4	1	7
Nuclear Medicine	0	0	1
Laser/Non-ionising	0	0	0

Rates	Dec-12	Jan-13	Feb-13
Radiotherapy Incident Rate per 1000 fractions	1	4	2
Diagnostic Radiology Incident Rate per 1000 procedures	0	0	0



Analysis:
The 1 MRI incident relates to an MRI conditional infusion pump being drawn into the magnet bore, there was no patient injury, however the pump requires repair. On further investigation there have been 2 other similar incidents within the Trust."
Action plan been in place since Nov in relation to changing work in planning of treatments

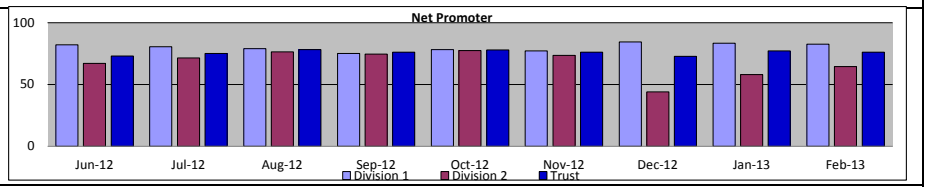
Action

Actions:
To continue to monitor

1.4 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.

	Dec-12	Jan-13	Feb-13
Div 1	84.5	83.4	82.6
Div2	44.0	57.9	64.5
Trust	72.8	77.2	76.2



Analysis: The Trust has achieved the CQUIN target of 10 points above baseline. Reporting will be undertaken nationally from April 2013 with eqach ward score available through NHS Choices

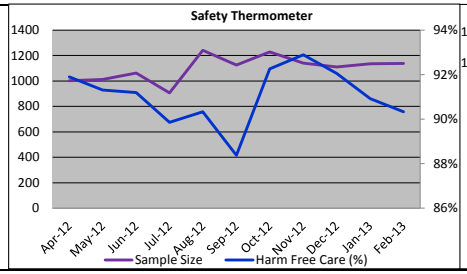
Action: To continue to send out monthly scores to wards and for matrons/Directorate Managers to manage ward scores with less than 20% footfall responses and low scores

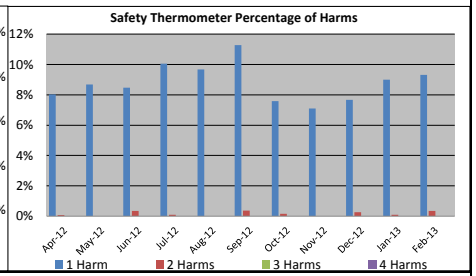
1.5 Safety Thermometer

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.

	Dec-12	Jan-13	Feb-13
Target	95%	95%	95%
Trust result	92.06%	90.92%	90.33%
Sample Size	1109	1134	1137

	Dec-12	Jan-13	Feb-13
1 Harm	7.66%	8.99%	9.32%
2 Harms	0.27%	0.09%	0.35%
3 Harms	0.00%	0.00%	0.00%
4 Harms	0.00%	0.00%	0.00%





Analysis: Harm free care for February has remained just above 90%. This has slowly decreased from 92.89% in November with the number of harmful falls rising from 0.18% (Nov) to 0.70% (Feb). There has also been an increase in the number of patients suffering 2 harms with no patients having 2 harms in November to 0.35% suffering 2 harms in February. Pressure ulcers have also increased from 6.14% in Novemeber to 7.74% in February. This is mainly due to the increase in old (inherrited) pressure ulcers that have increased from 4.82% in November to 6.42% in February. The number of new (acquired) pressure ulcers has remained the same.
The sample size has stabilised in the last 5 months.

Actions: To continue to use the Safety Thermometer data to triangulate with locally held databases on falls and pressure ulcers.

2.0 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.

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.

	Aug-11	Sep-11	Oct-11	Nov-11	Dec-11	Jan-12	Feb-12	Mar-12	OUTTURN	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	YTD
HSMR	89.3	94.7	81.7	84.0	104.7	94.0	89.0	90.5	92 [100]	**89.0**	100.6	105.6	86.2	98.4	96.5	104.9	103.3	106.6	99.0
Observ	3.20%	3.50%	3.10%	3.10%	4.30%	3.80%	3.90%	3.50%	3.60%	3.90%	3.80%	4.00%	3.20%	3.50%	3.50%	3.80%	3.80%	4.40%	3.70%
Expecte	3.60%	3.70%	3.80%	3.70%	4.10%	3.90%	4.30%	3.90%	3.90%	4.40%	3.70%	3.80%	3.70%	3.50%	3.60%	3.60%	3.60%	4.10%	3.70%
No of In Hospital Deaths	96	111	96	93	139	129	126	117	1023	115	121	121	103	107	99	123	120	136	1045
Expected Deaths	107	114	114	110	132	130	140	129	1096	129	120.3	114.3	119.5	105.2	99.5	117.3	116.2	127.5	1055.9
Excess Deaths	**-10.8**	**-3.4**	**-18.1**	**-17.1**	**7.4**	**-1.3**	**-13.8**	**-12.2**	**-73.0**	**-14.0**	**1**	**7**	**-17**	**2**	**-1**	**6**	**4**		**-11**

Analysis: April 2012 to November 2012 is the latest available. The Trust's 2011/12 final HSMR was 100, this was the figure that was published in the Dr Foster Good Hospital Guide.

The latest SHMI published in Nov 2012 is a 12 month average from April 2011 to March 2012 and the Trust SHMI score is 102.5.

The last 4 SHMI data points Q1-Q4 2011/12 show the Trust's SHMI to be at 102.5 therefore showing a close degree of congruence with HSMR for the equivalent period.

Top Diagnostic Groups Contributing to Patient Deaths by Volume -2012/13

April-June 12

Diagnosis group	Spells	Deaths	SMR	Crude Rate
Pneumonia	809.0	192.0	110.2	24.4%
Acute cerebrovascular disease	712.0	108.0	112.8	18.5%
Congestive heart failure, nonhypertensive	434.0	80.0	126.8	18.7%
Acute myocardial infarction	939.0	63.0	104.9	6.7%
Septicemia (except in labour)	193.0	46.0	100.0	24.1%
Aspiration pneumonitis, food/vomitus	89.0	39.0	112.8	43.8%

Alert Status

The Trust internally alerted for Complex Elderly and Aspiration Pneumonitis in October 2012.

Associated Indicators of Mortality

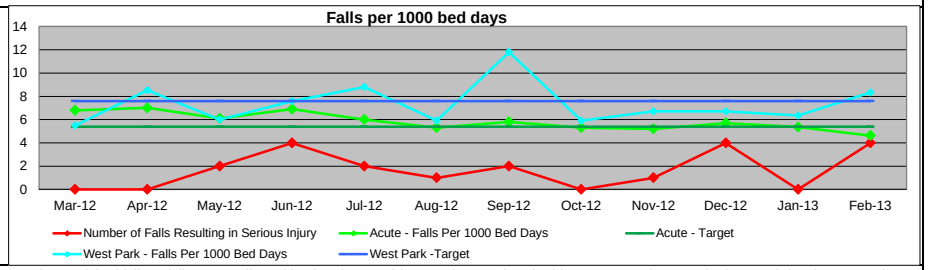
Indicator	Period	Actual	RAG	TREND
Charlson Codes Per Spell (HED)	Apr-March12	5.56		➲
Palliative Care Deaths Per 1000 Discharges (HED)	Apr-August 12	24.00	NHS England average is 24	
% Palliative Care Deaths	Apr 10-March 12	20%	NHS England range for large acute Trusts is 0-40%	
Expected Death Rate	Apr-August 12	3.70%		➲

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 with the national average being 24 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.

2.2 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.

	Dec-12	Jan-13	Feb-13
Acute - Target per occupied bed days	<5.4	<5.4	<5.4
Acute - Number of falls per 1K occupied bedbed days	**5.70**	**5.35**	**4.63**
West Park- Target per occupied bed days	7.60	7.60	7.60
West Park - Number of falls per occupied bed	**6.70**	**6.34**	**8.32**
Number of falls resulting in serious injury	4.00	0.00	4.00



Analysis: There were 4 falls causing serious harm, a fractured humeral head on C18, patient had not been assessed as at risk of falls, a fall on Durnell resulting in a fractured femur,a fractured neck of femur on Ward C24 and a fracture left wrist on Ward A5. All have had root cause analysis completed and presented at the accountability meeting

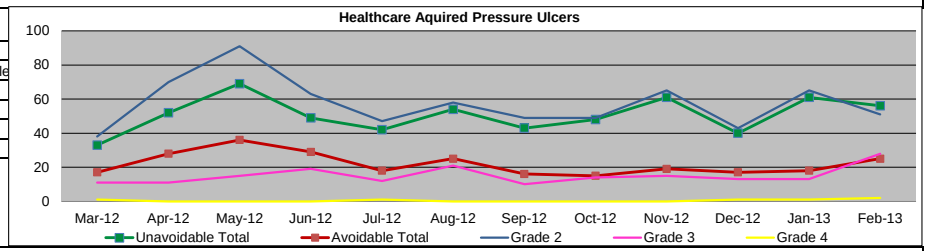
Actions: To review the implementation of the falls bundle in line with the NHSLA Report guidance.To determine new targets for falls for each ward and set an overall trajectory for Trust wide performance. To review every falls that cause serious harm at the weekly CNO Accountability meetings.

2.3 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)

	Dec-12		Jan-13		Feb-13	
	Avoidable	Unavoidable	Avoidable	Unavoidable	Avoidable	Unavoidable
Grade 2	14	29	17	48	10	41
Grade 3	2	11	1	12	14	14
Grade 4	0	1	0	1	1	1
Total	**16**	**41**	**18**	**61**	**25**	**56**



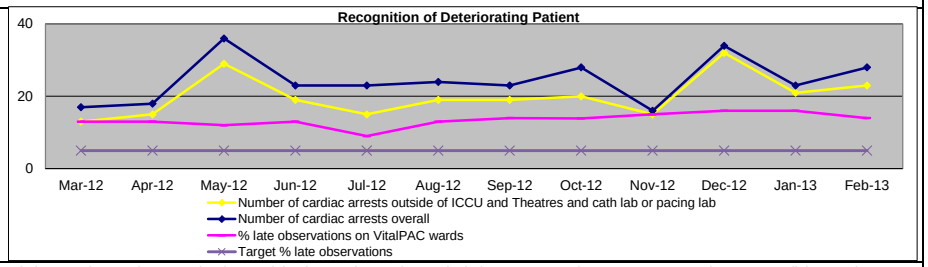
Analysis: There were no Grade 4 pressure ulcers in February. There has been an increase in reported Grade 3 pressure ulcers which are waiting to be vailidated at the accountability meeting. Grade 2 Pressure ulcers have reduced in number, the district nursing services have been actively using a 'Stop the Pressure' campaign (part of SHA Ambition 1) and this has resulted in a decrease in Grade 2s and also the SHA award for most inspirational team. The Tissue Viability team plan to run a pressure ulcer quiz for nurses to test out the grading knowledge. We have also purchased two more simulation dummies.

Actions: To continue to test out staff knowledge and challenge grading decisions. To review working of district nurses and TV nurses in managing non healing wounds.

2.4 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 calls.

	Dec-12	Jan-13	Feb-13
Number cardiac arrests	34	21	28
% observations late	16.00%	16.50%	14.00%
Target (late observations)	5%	5%	5%



Analysis: The percentage of late observations has marginally decreased (improved) and the roll out of the new Vitalpac Ipods complete. Wards where training has not been taken up include: B7, CHU and CHU Day Case, Endoscopy, Cardiology and Cardiothoracic and Gynaecology.

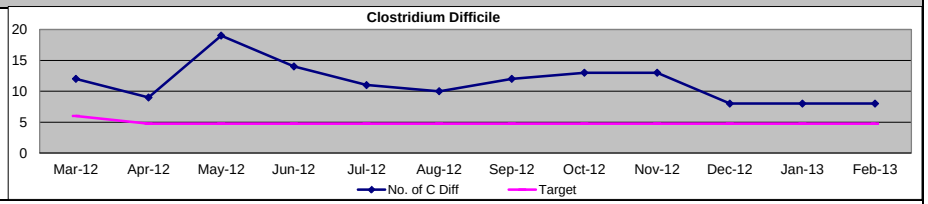
Action: To complete training and upgrade version to 2.1 which will incorporate: 24 hour VTE assessment, Pain Management, Blood Observations and devices (catheters, canullas, PIC lines). A suite of reports will be able to inform ward sisters of their compliance as part of the monitoing of outcomes .

2.5 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 2012/13, using the RWHT internal definition of attribution of cases, is no more than 4.75 C diff cases per month (2011-12 target was <6 per month) and 2.5 MSSA bacteraemias per month (30 per year attributable to RWHT).

2.5.1 Clostridium Difficile - hospital acquired for ages >2 years

	Dec-12	Jan-13	Feb-13
Number of C Diff	8	8	8
Cum Plan	81	90	99
Cum Actual	109	117	125
Cum Variance	28	27	26

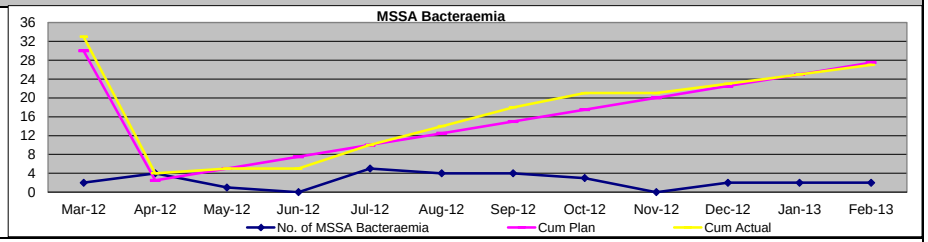


Analysis: The internal target is based on PCR results. The external target is based on Toxin EIA results. In January we reported 2 against the external target (which is 4.75 per month) for New Cross and 0 for West Park (target 1 per month). This takes our total for the year to 36 (target 47) excluding West Park and 39 (target 57) including West Park.

Actions: C diff ward rounds and review of all new patients on same day as diagnosis continues. Antimicrobial Stewardship Group meeting regularly and regular audits being undertaken. 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.

2.5.2 MSSA Bacteraemia

	Dec-12	Jan-13	Feb-13
No. of MSSA Bacteraemia	2	2	2
Cum Plan no. Cases as target	23	25	28
Cum Actual no. of cases to date	23	25	27
Cum Variance of actual versus plan	1	0	0



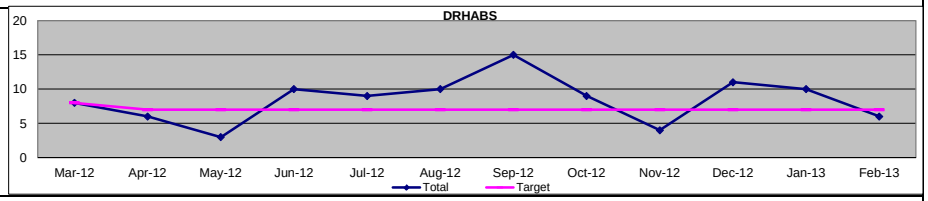
Analysis: Two RWHT-attributable cases. One was a DRHAB related to either a line or PEG. The other was due to a pneumonia in a Chemotherapy patient, and was therefore probably unavoidable.

Actions: For DRHAB: Urinary Catheter Working Group to continue to be active and drive up standards.

2.5.3 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.

	Dec-12	Jan-13	Feb-13
Target (monthly)	7	7	7
DRHABS	11	10	6

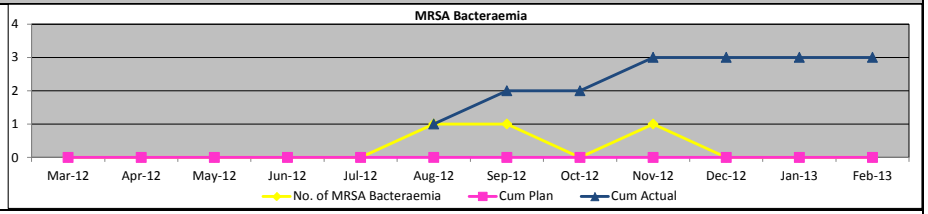


Analysis: 6 line related, 1 urinary catheter related

Actions: Implementation of the urinary catheter policy, changes to be made to incorporate the continence team cross Trust working in and out of hospital in train which will improve education and knowledge around when and when not to catheterise

2.5.4 MRSA Bacteraemia

	Dec-12	Jan-13	Feb-13
No. of MRSA Bacteraemia	0	0	0
Cum Plan	0	0	0
Cum Actual	3	3	3
Cum Variance	3	3	3



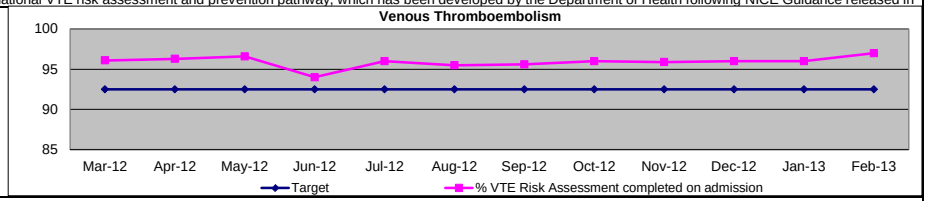
Analysis: There were no cases of MRSA Bacteraemia

Actions: Continue to manage antimicrobial stewardship and target hand hygiene in all areas

######	**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

	Nov-12	Dec-12	Jan-13	Feb-13
% adult patients with completed VTE	96%	96%	96%	97%
Number of patients with hospital associated VTE	15	12	23	12
Number of patients identified in the	26	17	31	18



Analysis: Of the 12 hospital related VTE episodes 1 was inheritedt.

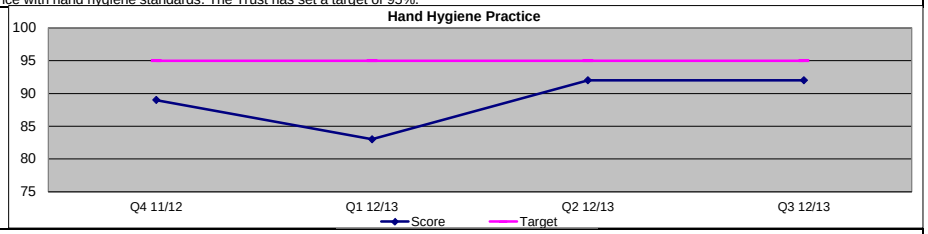
Actions: The alerting of the 24 hour reassessment on VTE vitalpac is being changed to enable improved performance management of this safety target

3.0 PATIENT SAFETY AND QUALITY

3.1 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%.

Target	Q4	Q1	Q2	**Q3**
95%	89%	83%	92%	**92%**



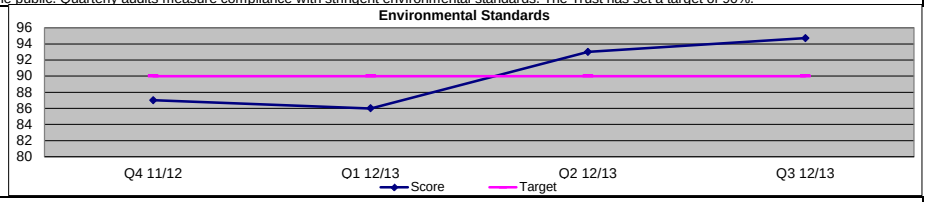
Analysis: There is an improving trend across both divisions with a continued focus on monthly reporting of five moments

Actions:
A relaunch of 5 moments for hand hygiene message has been undertaken and is now captured real time using a new system called Symbiotix

3.2 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%.

Target	Q4	Q1	Q2	**Q3**
90%	87.00%	86.00%	93.00%	**94.70%**



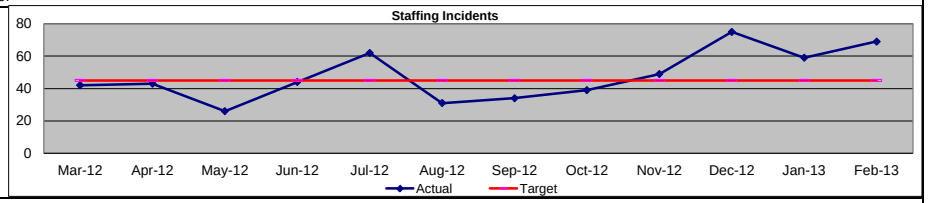
Analysis: There has been an improvement in the environment audits conducted by the Matrons

Actions: The environment Group, a sub group of the IPCC has undertaken a decluttering and improvements are demonstrated in the sustainability of the environmental audit scores.

3.3 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.

	Dec-12	Jan-13	Feb-13
Division 1	50	39	42
Division 2	25	20	27
Total	**75**	**59**	**69**
Target	**45**	**45**	**45**



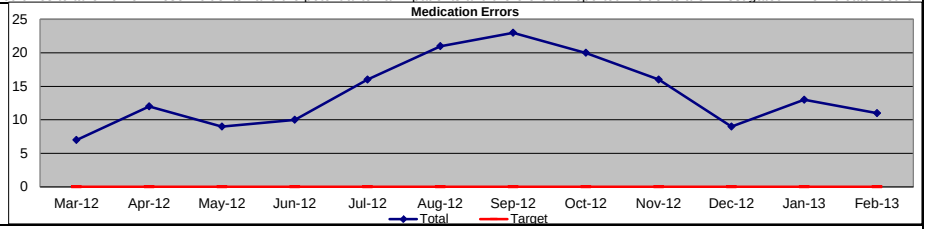
Analysis:, Division 1: There was an increase in staffing level incidents in division 1 in February the highest number noted in cardiac services with reasons due to sickness, and planned leave. **Division 2** had 5 staffing incidents from sexual health where there were insufficient numbers of staff due to unplanned leave

Action To monitor night time staff levels as part of workforce review

3.4 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

	Dec-12	Jan-13	Feb-13
Division 1	5	1	3
Division 2	4	12	8
Total	9	13	11
Target	**0**	**0**	**0**



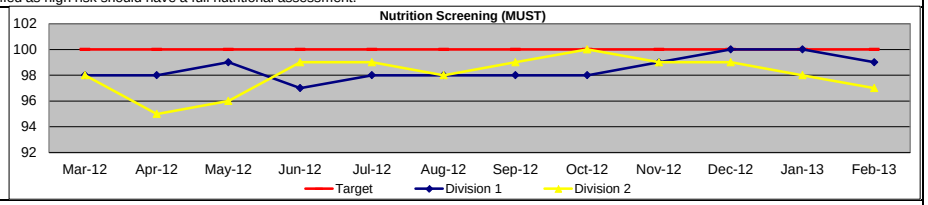
Analysis: Division 1: Three errors noted 1; pharmacy, 1 doctor and 1 nurse administration**. Division 2:** 8 errors reported, 1: WMAS, 3 community services mistakes. Paediatric error involved mis prescribing of dextrose to adolesant which should have been titrated to weight.

Actions: Appropriate actions in policy in place to manage errors, discussion to be had within divisions about monitoring of incidents in light of Francis Report.

3.5 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	Dec-12	Jan-13	Feb-13
Division 1	100%	100%	99%
Division 2	99%	98%	99%
Target	100%	100%	100%



Analysis: Excellent compliance continues with MUST assessment inn Division 2, no results from Division 1 at time of report. Availability of nutritious snacks and soups has been well evaluated by patients and continues for a further month

Actions:

To fully evaluate the evidence around provision of snacks by the Hotel Services ensuring a 'food first' approach is still followed in the Trust.

Divisional Infection Prevention Performance Monitoring - 5 Moments

Feb-13

	General Surgery	Urology	Cardiac	Critical care	Orthopaedic	Gynaecology	Head and Neck	Ophthalmology	Maternity
Division One	96% ↔	100% ↔	100% ↔	88%↓	67%↓	94%↓	100%	100%	100%

	Acute Children and NNU	Community Children	Adult Community	West Park rehab	Care of Elderly and Stroke	Neuro, Rheum, Derm and GUM	Renal/ Diabetes	Resp/Gastro	Emergency services	Oncology /Haematology
Division Two	98% ↔	100% ↔	100% ↔	100% ↔	97%↓	98% ↔	98% ↓	96% ↓	100% ↔	100% ↔

Green	≥ 90%
Amber	70-89%
Red	<70%

Surgical Division (Division 1) - Quality & Safety Scorecard - February 2013 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	G	↔
Number of serious complaints received	R	A	↓
Percentage of complaints responded to within 25 working days (or with consent to breach)			
% 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	A	↔
Percentage of patients who rated overall satisfaction good/excellent	A	A	↔
Percentage of patients who answered "yes" to being treated with care and compassion	R	A	↓
Number of cancelled/rescheduled outpatient appointments	A	A	↔
Cancelled operations as a percentage of elective admissions	R	R	↔
Overall Rating	R		↓

Patient Safety	This Month	Last Month	Trend
Number of red incidents	A	A	↔
Number of healthcare/inpatient falls	A	R	↑
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	G	G	↔
MSSA Bacteraemia	G	G	↔
Clostridium Difficile - hospital acquired for ages >2 years	A	A	↔
Device related bacteraemias	G	R	↑
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)	G	G	↔
Length of stay (non-elective)	A	R	↑
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	A	↓
Overall Rating	A		↔

Resources	This Month	Last Month	Trend
Sickness absence	A	R	↑
Percentage of staff who have undergone an annual appraisal	G	A	↑
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 2013

Division 1 - 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	Jamie Emery	0.1%	0	↓	0	0	→	0.1%	0	↓	0.5%	0.2%	↓	0.2%	0.1%	↓	0.3%	0.2%	↓	0.1%	0.2%	↑
Number of complaints accepted for investigation by the Ombudsman	0	0 = Green, else Red	Jamie Emery	0	0	→	0	0	→	0	0	→	0	0	→	0	0	→	0	0	→	0	0	→
Number of serious complaints received	0	0 = Green, else Red	Jamie Emery	0	0	→	0	0	→	0	0	→	2	0	↓	0	0	→	0	1	↑	0	0	→
Percentage of complaints responded to within 25 working days (or with consent to breach)	90%	>/= 90% = Green, else Red	Jamie Emery																					
% 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	Jamie Emery							96%	100%	↓	92%	91%	↑	94%	90%	↑	100%	94%	↑	86%	100%	↓
Percentage patients who rated overall satisfaction good/excellent	95%	>95% = Green, 85-95% = Amber, <85% = Red	Jamie Emery							100%	96%	↑	93%	98%	↓	96%	97%	↓	92%	94%	↓	96%	92%	↑
Percentage of patients who answered "yes" to being treated with care and compassion	95%	>95% = Green, 85-95% = Amber, <85% = Red	Jamie Emery							93%	96%	↓	81%	87%	↓	88%	93%	↓	92%	92%	↓	81%	92%	↓
Number of cancelled/rescheduled outpatient appointments	–	Reduction of 40% in year	Lesley Taff							0	48	↑	222	564	↑	95	201	↑	16	62	↑	429	800	↑
Cancelled operations as a percentage of elective admissions	0.8%	< 0.8% = Green, else Red	Lesley Taff							6.25%	8.69%	↑	1.80%	3.47%	↑	10.84%	7.78%	↓	3.26%	1.20%	↓	1.89%	2.36%	↑
Patient Safety																								
Number of red incidents	0	0 = Green, else Red	Sukhy Khunkhuna	0	0	→	0	1	↑	0	0	→	0	0	→	0	0	→	1	0	↓	0	0	→
Number of healthcare/inpatient falls *RAG= tolerance multiplied by the number of inpatient wards	0	Ward specific	Sukhy Khunkhuna	2	1	↓	0	2	↑	2	10	↑	12	11	↓	8	9	↑	0	2	↓	4	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	→	1	0	↓	0	0	→	0	0	→
Number of healthcare acquired avoidable pressure ulcers acquired/deteriorated (Grade 2, 3 & 4)		Basline to be agreed	Julie Evans	0	0	→	0	0	→	1	1	→	1	3	↑	5	2	↓	0	1	↑	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%	100%	→	100%	100%	→	96%	100%	↓	100%	100%	→	100%	100%	→
MSSA bacteraemia	–	<2 = Green, 2-3 = Amber, >3 = Red	Mike Cooper	0	0	→	0	0	→	1	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	↑	0	1	↑	2	1	↓	1	1	→	1	0	↓	0	0	→
Device related bacteraemias	–	Green = 0,Amber = 1,Red = >1	Mike Cooper	0	0	→				0	1	↑	0	2	↑	0	2	↑	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%	→	95.14%	93.56%	↑	91.16%	90.36%	↑	88.10%	88.07%	↑	81.16%	89.33%	↓	93.79%	94.56%	↓	98.20%	99.23%	↓
Percentage of late observations (VitalPAC wards only)	5%	<5% = Green, 5-10% = Amber, >10% = Red					6.50%	5.00%	↓	18.4%	18.3%	↓	12.0%	12.4%	↑	18.5%	10.5%	↓	11.00%	11.00%	→	19.0%	19.0%	→
Patient Outcomes																								
Length of stay (elective)	specific	Specific	Lesley Taff							4.8	4.5	↓	2.6	2.6	→	2.8	2.8	→	2.5	2.5	→	1.6	1.7	↑
Length of stay (non elective)	specific	Specific	Lesley Taff							7.10	7.9	↑	3.5	3.6	↑	7.5	7.2	↓	1.0	0.9	↓	2.0	1.8	↓
Percentage of emergency readmissions within 30 days	4.19%	<4.19% = Green, 4.2-5% = Amber, >5%= Red	Lesley Taff							2.08%	0.97%	↓	1.65%	0.13%	↓	0.00%	0.58%	↑	0.93%	0.00%	↓	0.31%	0.00%	↓
Delayed discharges			Lesley Taff	0.0%	0.0%	→	0.0%	0.0%	→	1.5%	1.0%	↓	1.0%	1.5%	↑	0.0%	1.0%	↑	0.0%	0.0%	→	0.0%	0.0%	→
18 week RTT - admitted	90%	90% = Green, else Red	Lesley Taff							95.03%	93.92%	↑	92.00%	91.47%	↑	90.04%	90.10%	↓	90.66%	90.09%	↑	92.29%	92.31%	↓
18 week RTT - non-admitted	95%	95% = Green, else Red	Lesley Taff							98.67%	97.19%	↑	95.93%	95.97%	↓	95.14%	95.09%	↑	97.46%	95.76%	↑	98.29%	98.69%	↓
Clinical correspondence turnaround within 48 hours	100%	100% = Green, 75-99% = Amber, else Red	Lesley Taff	76.5%	99.8%	↓				84.3%	88.9%	↓	58.4%	61.3%	↓	69.0%	89.7%	↓	84.8%	99.9%	↓	57.5%	66.5%	↓
Support Services																								
Sickness absence	<3.74%	<3.74% = G, 3.74 - 6% = Amber, >6% = Red	Lesley Taff	1.62%	2.64%	↑	4.62%	6.31%	↑	4.34%	4.27%	↓	3.80%	4.43%	↑	4.00%	7.54%	↑	4.35%	4.84%	↑	2.27%	3.31%	↑
Percentage of staff who have undergone annual appraisal	80%	>/=80% = Green, 70-79% = Amber, <70% = Red	Lesley Taff	88.6%	92.6%	↓	85.6%	87.3%	↓	83.0%	81.7%	↑	72.6%	76.8%	↓	70.5%	67.0%	↑	84.6%	87.5%	↓	81.3%	85.7%	↓
Percentage of trained nursing vacancies per funded establishment	2%	</=2% funded est = G, 2% 5% = A, else Red	Lesley Taff	0.00%	0.00%	→	1.10%	1.10%	→	1.00%	0.51%	↓	0.50%	0.24%	↓	5.55%	6.17%	↑	3.23%	3.68%	↑	1.00%	0.57%	↓
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%	0.00%	→	0.00%	0.00%	→	0.55%	0.55%	→	0.00%	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							£(168)k	£(155) k	↓	£(218)k	£(196) k	↓	£(198)k	£(171)k	↓	£(18)k	£(32) k	↑	£32k	£27 k	↑
WTE budgeted against actual (ward WTE only)	In balance	variance < 5% = Green variance 5-10% = Amber variance >10% = Red	Alison Reynolds							(4.5)%	(2.68) %	↓	(0.8)%	2.30%	↑	(14.4)%	(3.55) %	↓	13.40%	16.28%	↑	1.80%	(1.16) %	↓

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
March 2013

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

Description of indicator:	Cancelled operations as a % elective admissions	% late observations	Length of Stay (Non-elective)	Number of healthcare acquired avoidable pressure ulcers acquired/deteriorated (Grade 2, 3 & 4)
Indicator tolerance:	Target = 0.8% Red = >0.8%	Target = 5% Red = >10%	Specific	0 = Green, else Red
Period of alert: (i.e. Jun, Jul, Aug 2011)	December 2012 and January, February 2013	December 2012 and January, February 2013	December 2012 and January, February 2013	December 2012 and January, February 2013
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 e.g. staff or lack of beds, the Directorate will look at	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 identified and reported to Patient safety improvement co-ordinator Monthly report via KPI	Confirmation of target for length of stay for non-electives needs to be provided as I am unclear as to what this is applicable to. It states the indicator tolerance is 'specific'. Could the Directorate be provided with this specific target which we can then respond to?	Each admission has the integrity of their skin assessed within 6 hours of admission and reassessed according to their waterlow score. Each pressures sores is graded, photographed and reported via Datix. Ward managers investigate all Grade 2 and 3 pressure sores. When a grade 3 pressure

	using beds in other areas or transferring staff wherever possible, extending the working day and considering all options in order to avoid cancellation. Ongoing.	On-going		sore is reported the ward managers complete a concise investigation report, Grade 3 HAPU are investigated at scrutiny committee where training compliance, documentation and risk assessments are looked at in great detail. If it is deemed that the sore has developed following admission then a full RCA is undertaken. Staff Competency = 97%
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.		Responsibility of Matron, Ward managers and nursing teams to ensure reduction HAPU Reported Monthly via KPI.

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
March 2013

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

Description of indicator:	% late observations	Clinical correspondence turnaround within 48 hrs	Number of healthcare acquired avoidable pressure ulcers acquired/deteriorated (Grade 2, 3 & 4)	Cancelled operations as a percentage of elective admissions	Device related bacteraemia
Indicator tolerance:	Target = 5% Red = >10%	Target = 100% Red = < 75%	0 = Green, else Red	< 0.8% = Green, else Red	Green = 0, Amber = 1, Red = >1
Period of alert:	December 2012 and January, February 2013	December 2012 and January, February 2013	December 2012 and January, February 2013	December 2012 and January, February 2013	December 2012 and January, February 2013
Actions: Please identify where completed or a timescale for completion and who by	Issues regarding IT interface affecting late observations. Trial on D2 of new I phone pda to improve input and compliance. To be spread to other areas following successful trial. ***Review of later observations now being undertaken weekly.*** ***Working with IT/Vital pac team to understand areas with significant issues e.g. Vascular Ward where none of the devices hold their charge.*** ***Weekly review of late observations now reported through to matron and form part of matron / ward manager 121.*** ***Expansion of I pod touch to other surgical areas over the next month as***	The biggest issues relates to Colorectal & Upper GI, due to maternity leave and long term sickness. In addition to which, additional clinics and waiting list initiative in-patient sessions are being undertaken Non-pay monies currently being used to fund outsourcing to Dict8 and funds from vacant posts in other subspecialties being used to support additional hours/overtime to existing staff to mitigate the impact.	Matron holding weekly scrutiny meetings with Ward Managers to review grade 2 ulcers to ensure allocation of attribution is correct i.e. avoidable or unavoidable. Reinstated weekly audit of pressure area documentation audit Weekly scrutiny meetings continue with matron to grade as avoidable/ unavoidable pressure ulcers, Full review of documentation and individual staff accountability meetings filtered to ward manager level.	Trust wide capacity pressures, particularly in relation to emergency medical admissions has resulted in a higher level of medical patients being accommodated in surgical beds. This has resulted in an increased number of patients cancelled on the day of surgery, although to try and reduce this, pre-planning and cancelling patients prior to their day of surgery is occurring in some instances (it is not always easy to predict).	

	surgery become part of the early wave of the role out programme.				
Assurance/Monitoring: Please identify monitoring arrangements in place to sustain improvements	Monthly monitoring via kpi. Weekly matron performance review with ward managers. Spot checks on performance by matron. Monthly review in senior sisters meeting and in divisional seniors meeting.	Weekly reports to Group Manager and standing agenda item at Directorate Meetings Weekly reporting via Chief Operating Officers report	Weekly meetings and datix updates Staff accountability meetings Review of pressure ulcers with	The surgical directorate continues to look for ways to reduce surgical LOS and one of the recent areas is the introduction of a day case/23 hour pathway for breast surgery. Additional capacity via Appleby Suite from end of April 2013 Individual root cause analysis undertaken of all cancellations on the day Weekly reporting via Chief Operating Officers Report Sit rep reporting	

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
March 2013

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

Description of indicator:	Cancelled operations as a percentage of elective admissions
Indicator tolerance:	Target = 0.8%
Period of alert: (i.e. Jun, Jul, Aug 2011)	December 2012 and January, February 2013
Actions: Please identify where completed or a timescale for completion and who by	Discussion regarding theatre efficiency and patterns of work held.
Assurance/Monitoring: Please identify monitoring arrangements in place to sustain improvements	Has improved in January 2013, only cancellations due to bed pressures.

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
March 2013

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

Description of indicator:	Percentage of late observations	Cancelled operations as a percentage of elective admissions	Number of healthcare acquired avoidable pressure ulcers acquired/deteriorated (Grade 2, 3 & 4)	Length of stay (Non- elective)	Sickness absence	Percentage of staff who have undergone annual appraisal
Indicator tolerance:	<5% = Green, 5-10% = Amber, >10% = Red	< 0.8% = Green, else Red			<3.74% = G, 3.74 - 6% = Amber, >6% = Red	>/=80% = Green, 70-79% = Amber, <70% = Red
Period of alert: (i.e. Jun, Jul, Aug 2011)	December 2012 and January, February 2013	December 2012 and January, February 2013	December 2012 and January, February 2013	December 2012 and January, February 2013	December 2012 and January, February 2013	December 2012 and January, February 2013
Actions: Please identify where completed or a timescale for completion and who by	Review of late observations now being undertaken weekly. IT interface being reported on datix and it are visiting ward almost daily to resolve interface issues. The weekly late observation data is therefore not reliable. Roll out of ipod touch hoping to improve issues Working with IT/Vital pac team to understand areas with significant issues.	Cancellations are being driven by the Trust bed position. The Directorate is pro-active with discharge planning for all patients.	This is being monitored closely by Matron.	Length of stay has gone up for trauma patients – we will discuss this to see if there is anything within our gift to improve the position. Contributing factors are delays in getting patients home with packages of care or to resource centres, residential homes etc. We have noticed a marked difficulty in the last few months. We have also lost our flow-co-ordinator who had to be pulled back to support the wards	Matron is working with the ward managers to actively manage sickness. Sickness has reduced on A5 dramatically. Work is ongoing on A6.	All line managers are working to bring their appraisals into line. Matron has devised a plan which is being enacted.

				and this post has only just been filled, and at present is part-time which has contributed to the position. We have 3 days covered now and are looking to cover the other 2.		
Assurance/Monitoring: Please identify monitoring arrangements in place to sustain improvements	Monthly monitoring via kpi. Weekly matron performance review with ward managers. Spot checks on performance by matron. Monthly review in senior sisters meeting and in divisional seniors meeting. Review of datix entries and consideration if adding to risk register appropriate					

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
March 2013

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

Description of indicator:	Percentage of late observations	Cancelled operations as a percentage of elective admissions	Clinical correspondence turnaround within 48 hours
Indicator tolerance:	<5% = Green, 5-10% = Amber, >10% = Red	< 0.8% = Green, else Red	100% = Green, 75-99% = Amber, else Red
Period of alert: (i.e. Jun, Jul, Aug 2011)	December 2012 and January, February 2013	December 2012 and January, February 2013	December 2012 and January, February 2013
Actions: Please identify where completed or a timescale for completion and who by	Review of late observations now being undertaken weekly. IT interface being reported on datix and it are visiting ward almost daily to resolve interface issues. The weekly late observation data is therefore not reliable. Roll out of ipod touch hoping to improve issues Working with IT/Vital pac team to understand areas with significant issues.	Trust wide capacity pressures, particularly in relation to emergency medical admissions has resulted in a higher level of medical patients being accommodated in surgical beds. This has resulted in an increased number of patients cancelled on the day of surgery, although to try and reduce this, pre-planning and cancelling patients prior to their day of surgery is occurring in some instances (it is not always easy to predict).	
Assurance/Monitoring: Please identify monitoring arrangements in place to sustain improvements	Monthly monitoring via kpi. Weekly matron performance review with ward managers. Spot checks on performance by matron. Monthly review in senior sisters meeting and in divisional seniors meeting. Review of datix entries and consideration if adding to risk register appropriate	New Head & Neck ward due to open 22nd April 2013 (A23 – old C3) Additional capacity via Appleby Suite from end of April 2013 Individual root cause analysis undertaken of all cancellations on the day Weekly reporting via Chief Operating Officers Report	

		Sit rep reporting	

Emergency, Medical and Community Services (Division 2) - Quality & Safety Scorecard - February 2013 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	A	G	↓
Number of serious complaints received	A	R	↑
Percentage of complaints responded to within 25 working days (or with consent to breach)			
% 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	A	↔
Percentage of patients who rated overall satisfaction good/excellent	G	G	↔
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	A	A	↔
Number of healthcare/inpatient falls	A	R	↑
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	G	G	↔
MSSA Bacteraemia	G	G	↔
Clostridium Difficile - hospital acquired for ages >2 years	G	G	↔
Device related bacteraemias	G	A	↑
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	R	↑
Length of stay (non-elective)	G	G	↔
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	A	A	↔
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	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 2013

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:

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

Division 2 - Emergency, Medical & Community Service Division

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	Jamie Emery	0.1%	0.2%	↑	0.4%	0.1%	→	0.1%	0.1%	→	0.10%	0.1%	→	0%	0%	→	0.1%	0.2%	↑	0.2%	0.2%	→	0.7%	0.30%	↓	0%	0.1%	↑	0.2%	0.1%	↑
Number of complaints accepted for investigation by the Ombudsman	0	0 = Green, else Red	Jamie Emery	0	0	→	0	0	→	0	0	→	0	0	→	0	0	→	1	0	↓	0	0	→	0	0	→	0	0	→	0	0	→
Number of serious complaints received	0	0 = Green, else Red	Jamie Emery	0	0	→	0	0	→	0	1	↑	0	0	→	0	0	→	0	1	↑	0	0	→	1	1	→	0	0	→	0	0	→
Percentage of complaints responded to within 25 working days (or with consent to breach)	90%	>/= 90% = Green, else Red	Jamie Emery																													
% of people responding "yes" to the question - Are you being involved as much as you want to be in decisions about your care	95%	>95% = Green, 85-95% = Amber, <85%	Jamie Emery							100%	89%	↑	N/A	N/A					89%	100%	↓	81%	100%	↓		89%					94%	91.0%	↑
Percentage patients who rated overall satisfaction good/excellent	95%	>95% = Green, 85-95% = Amber, <85%	Jamie Emery							100%	100%	→	N/A	N/A					89%	93%	↓	87%	97%	↓		100%					100%	100%	→
Percentage of patients who answered "yes" to being treated with care and compassion	95%	>95% = Green, 85-95% = Amber, <85%	Jamie Emery							100%	100%	→	N/A	N/A					89%	85%	↑	87%	89%	↓		89%					97%	100%	↓
Number of cancelled/rescheduled outpatient appointments	–	Reduction of 40% in year	Lesley Taff	73	248	↑	N/A	N/A		1	21	↑	N/A	N/A		114	403	↑	105	35	↓	80	220	↑				0	0	→	94	58	↓
Patient Safety																																
Number of red incidents	0	0 = Green, else Red	Sukhy Khunkhuna	1	0	↓	0	0	→	0	0	→	0	0	→	0	0	→	0	0	→	0	1	↑	1	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	2	↑	0	2	↑	29	33	↑	18	17	↓	1	0	↓	9	16	↑	13	16	↓	13	7	↓	2	1	↓	8	7	↓
Number of healthcare/inpatient falls - resulting in serious injury *RAG= tolerance multiplied by the number of inpatient wards	0	*Green = 0, Amber = 1-4,	Sukhy Khunkhuna	0	0	→	0	0	→	0	0	→	0	0	→	0	0	→	0	0	→	1	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	Julie Evans	0	0	→	2	2	→	2	4	↑	4	0	↓	0	0	→	1	2	↑	6	3	↓	0	0	→	0	0	→	1	0	↓
Percentage inpatient MUST assessments completed within 6 hours of admission	100%	100% = Green, 75-99% = Amber, <75%	Rose Baker Zena Young							100%	100%	→	100%	100%	→				100%	100%	→	100%	100%	→	94%	96%	↓				100%	100%	→
MSSA bacteraemia	–	<2 = Green, 2-3 = Amber, >3 = Red	Mike Cooper	0	0	→	0	0	→	0	0	→	0	0	→	0	0	→	0	1	↑	1	0	↓	0	0	→				0	1	↑
Clostridium Difficile - hospital acquired for ages >2 years	–	Green = 0,Amber = 1-2,	Mike Cooper	0	0	→	0	0	→	0	0	→	0	0	→	0	0	→	0	0	→	2	1	↓	1	0	↓				0	0	→
Device related bacteraemias	–	Green = 0,Amber = 1,Red = >1	Mike Cooper	0	0	→	0	0	→	1	0	↓	0	0	→	0	0	→	0	0	→	1	0	↓	0	0	→						
Device related bacteraemias (Haem/Onc, ICCU, Renal, Neonates)	–	Green = 0,Amber = 1-2	Mike Cooper	0	1	↑													1	1	→										3	3	→
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							91.11%	97.73%	↓	N/A	N/A		99.4%	98.8%	↑	99.71%	99.96%	↓	62.50%	88.24%	↓	93.23%	95.43%	↓				99.93%	99.67%	↑
Percentage of late observations (VitalPAC wards only)	5%	<5% = Green, 5-10% = Amber, >10% =	Lisa Miller							19.5%	23.0%	↑							11.2%	11.6%	↑	11.3%	20.0%	↑	11.0%	17.0%	↑				11.1%	11.6%	↑
Patient Outcomes																																
Length of stay (elective)	specific	Specific	Lesley Taff	1.8	1.7	↓										0.6	1.3	↑	0.4	0.4	→	3.2	3.8	↑							3.2	2.7	↓
Length of stay (non elective)	specific	Specific	Lesley Taff	0.7	0.7	→										2.8	1.7	↓	2.5	2.1	↓	3.5	3.6	↑							3.9	4.4	↑
Percentage of emergency readmissions within 30 days	4.19%	<4.19% = Green, 4.2-5% = Amber, >5%=	Lesley Taff	1.20%	3.37%	↑				0.00%	0.00%	→	0.0%	0.0%	→	0.00%	0.68%	↑	10.0%	0.0%	↓	0.00%	5.26%	↑	0.0%	0.0%	→				0.12%	0.10%	↓
Delayed discharges			Lesley Taff	0.0%	0.0%	→				2.0%	2.0%	→	1.5%	1.0%	↓	0.0%	0.0%	→	0.0%	0.0%	→	0.0%	1.0%	↑	0.0%	0.0%	→				0.0%	0.5%	↑
18 week RTT - admitted	90%	90% = Green, else Red	Lesley Taff													100%	100%	→	100%	100%	→	97.34%	96.82%	↑				100%	100%	→	95.7%	100.00%	↓
18 week RTT - non-admitted	95%	95% = Green, else Red	Lesley Taff	100%	98.78%	↑	100%	100%	→	99.07%	100.00%	↓				99.2%	98.9%	↑	99.39%	99.51%	↓	97.75%	97.89%	↓				100%	100%	→	100.00%	100.00%	→
Clinical correspondence turnaround within 48 hours	100%	100% = Green, 75-99% = Amber, else	Lesley Taff	87.0%	88.6%	↓	N/A	N/A		96.6%	95.8%	↑	N/A	N/A		80.0%	88.2%	↓	99.7%	99.7%	→	59.1%	91.4%	↓	84.8%	78.8%	↑				94.1%	78.7%	↑
Support Services																																
Sickness absence	<3.74%	<3.74% = G, 3.74 - 6% = Amber, >6% =	Lesley Taff	3.97%	4.89%	↑	4.66%	7.26%	↑	4.28%	6.06%	↑	3.69%	4.17%	↑	0.92%	2.97%	↑	2.08%	8.42%	↑	3.01%	3.92%	↑	3.66%	5.55%	↑	1.92%	4.52%	↑	4.63%	6.72%	↑
Percentage of staff who have undergone annual appraisal	80%	>/=80% = Green, 70-79% = Amber, <70%	Lesley Taff	94.1%	95.4%	↓	88.7%	90.4%	↓	87.5%	85.6%	↑	94.8%	94.7%	↑	77.8%	89.5%	↓	81.4%	80.6%	↑	84.6%	84.5%	↑	63.6%	69.3%	↓	92.4%	93.4%	↓	92.1%	87.1%	↑
Percentage of trained nursing vacancies per funded establishment	2%	</>2% funded est = G, 2%-5% = A, else	Lesley Taff	3.50%	4.05%	↑	1.50%	1.81%	↑	-0.97%	-0.97%	→	0.50%	0.24%	↓	0.38%	0.38%	→	4.50%	5.75%	↑	1.00%	1.88%	↑	1.50%	2.02%	↑	0.0%	0.0%	→	1.94%	1.94%	→
Percentage of medical training grades vacancies per funded establishment	2%	</>2% funded est = G, 2%-5% = A, else	Lesley Taff	0.22%	0.22%	→	0.00%	0.00%	→	0.52%	1.52%	↑	0.00%	0.00%	→	0.00%	0.00%	→	0.00%	0.00%	→	0.79%	0.79%	→	2.50%	2.50%	→	0.00%	0.00%	→	0.00%	0.00%	→
Pay budget (ward pay budget only)	In balance	Yes = Green, Agreed = Amber, No = Red	Alison Reynolds	£33k	£22 k	↑	£(5) k	£(5) k	→	£(264) k	£(294) k	↑	£(73) k	£(59) k	↓				£(82) k	£(188) k	↑	£(148) k	£(100) k	↓	£(80) k	£(72) k	↓				£(140) k	£(131) k	↓
WTE budgeted against actual (ward WTE only)	In balance	variance < 5% = Green variance 5-10% = Amber	Alison Reynolds	6.50%	6.36%	↑	None	None		(2.9%	(8.51)%	↑	(6.7)%	(4.91)%	↓				(38.5)%	(6.04)%	↓	3.70%	8.47%	↑	3.70%	4.12%	↓				(3.20)%	(2.20)%	↓

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
March 2013

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

Description of indicator:	% late observations	Number of healthcare acquired avoidable pressure ulcers	Number of serious complaints received
Indicator tolerance:	Target = 5% Red = > 10%	Target = 0	0 = Green, else Red
Period of alert: (i.e. Jun, Jul, Aug 2011)	December 2012 and January, February 2013	December 2012 and January, February 2013	
Actions: Please identify where completed or a timescale for completion and who by	Late Vital signs records-improving picture seen for A8&C22-to continue monitoring-have enquired re installing vibrate alerts to new IPods	HAPU-1 incident declared avoidable for Q4 on A7, actions to address responsibility for poor evidence of care/record keeping. Noted datix for staffing levels.	
Assurance/Monitoring: Please identify monitoring arrangements in place to sustain improvements	Quality Rounds.		

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
February 2013

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

Description of indicator:	% late observations	Clinical correspondence turnaround within 48 hours
Indicator tolerance:	Target = 5% Red = >10%	100% = Green, 75-99% = Amber, else Red
Period of alert: (i.e. Jun, Jul, Aug 2011)	November, December 2012 and January 2013	November, December 2012 and January 2013
Actions: Please identify where completed or a timescale for completion and who by	• we have removed AAA off the eau side • slight improvements made to % in November and December • Lisa Millar to support as her role in patient safety and work alongside Nicky Dimmock as quality lead to address • Discussed at length in band 6 meeting (Jan 13) regarding coordinator role in reference to late observations • Practice Education Facilitator to work with teams • Lisa Millar to lead productive ward “late obs” module • Email to all band 6’s from SR Dimmock to reassure expectation – improvements made average 14% (feb)	• December complaint MH. Amber, meeting with family arranged for March 13th • January complaint DP Amber. Treatment in ED Initial investigation reveals no fault with care. Awaiting further information from radiology. Grading will be downgraded to yellow • February complaint JW Amber Investigation reveals no fault with care Grading will be downgraded to yellow
Assurance/Monitoring: Please identify monitoring arrangements in place to sustain improvements	• KPI • Governance meetings • 121 with Matron/Dept. leader • Matron rounds • Daily spot checks • Challenge poor practice • Utilise 9th nurse on day shift to support • Individual performance to be drilled down – discussed at performance review	•

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
March 2012

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

Description of indicator:	Device related bacteraemias (Haem/Onc,)
Indicator tolerance:	Green = 0,Amber = 1- 2
Period of alert: (i.e. Jun, Jul, Aug 2011)	December 2012 and January, February 2013
Actions: Please identify where completed or a timescale for completion and who by	DRHAB action plan formulated for CHU in Jan 2013 – this is being monitored on a monthly basis. A further meeting with IP and Consultant Microbiologist has been scheduled for 19 March 2013 to expand the action plan to cover all areas across the Directorate. Awaiting sign off to trial Curos Caps. ANTT has also been integrated into the annual chemotherapy competence framework.
Assurance/Monitoring: Please identify monitoring arrangements in place to sustain improvements	Action plan is being monitored and reviewed every 2 months for progress. IPT have been carrying out spot checks. This issue and action plan is being discussed at every monthly Directorate Governance Meetings. 1-1's with Matron and Senior Sister for each area. All nursing staff on CHU have been reassessed to ensure compliance.

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
March 2013

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

Description of indicator:	Percentage of late observations	Number of healthcare acquired avoidable pressure ulcers acquired/deteriorated (Grade 2, 3 & 4)
Indicator tolerance:	<5% = Green, 5-10% = Amber, >10% = Red	0 = Green, else Red
Period of alert: (i.e. Jun, Jul, Aug 2011)	December 2012 and January, February 2013	December 2012 and January, February 2013
Actions: Please identify where completed or a timescale for completion and who by	Existing action plan reviewed and discussed with Senior Sister/Charge Nurse by Matron 15/11/12 Implement capability/disciplinary policy as appropriate Ensure all patients "off ward" are entered on vitalpac Ward receptionist to update PAS each morning Shift Leader to check vitalpac is live and up to date Report all technical issues in a timely manner There are some weeks when we have achieved < 10% unfortunately this is not sustained.	All staff to ensure that skin assessment per shift is carried out (three times in 24 hours). All trained staff to take responsibility for their high risk pressure ulcer patients. All staff to ensure that skin assessment per shift is carried out (three times in 24 hours). All trained staff to take responsibility for their high risk pressure ulcer patients. Staff involved in incident seen face to face by Senior Sister & matron and omissions discussed Incident discussed with wider team and actions identified on patient safety briefing / handover sheet.
Assurance/Monitoring: Please identify monitoring arrangements in place to sustain improvements	Daily monitoring by shift leader/ Senior Sister/Charge Nurse Weekly monitoring of performance report by Matron Weekly reporting to Head of Nursing	Twice weekly documentation audit Non-compliance addressed at the time of audit by Senior Sister

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
March 2013

Report from: Directorate/Group	Adult Community Services Group
Report prepared by: Name, Job Title	Tracey Slater, Senior Matron Community Services

Description of indicator:	Number of healthcare acquired avoidable pressure ulcers (acquired/deteriorated) Grades 2,3 &4	Sickness absence
Indicator tolerance:	Target = 0 Red = >0	<3.74% = G, 3.74 - 6% = Amber, >6% = Red
Period of alert: (i.e. Jun, Jul, Aug 2011)	December 2012 and January, February 2013	December 2012 and January, February 2013
Actions: Please identify where completed or a timescale for completion and who by	• Adult Community Quality group continue to monitor. • Admission to caseload checklist continues to be utilised • Daily Nurse-led ward rounds (DN and CM Pressure ulcer prevention collaborative programme –Sept 12	• ACSG monitor sickness levels at monthly workshops with service leads • ACSG has adopted the HWB call-back system
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 • Concise meeting • Peer review • KPI update : 11.1.13 ACSg have seen a decrease in avoidable G3 pressure ulcers and continue to monitor through monthly KPI's and performance meetings. Update 11.3.13- ACSG have had no avoidable pressure ulcers	• Monthly attendance and confirm and challenge at sickness workshops. • Monitoring of KPI's via division and HR

	for this period	

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
March 2013

Report from: Directorate/Group	Neurology, Rheumatology, Dermatology
Report prepared by: Name, Job Title	Christine Dunphy, Interim Directorate Manager Iris Fitzgibbon, Senior Matron

Description of indicator:	Length of stay (elective)
Indicator tolerance:	Specific
Period of alert: (i.e. Jun, Jul, Aug 2011)	December 2012 and January, February 2013
Actions: Please identify where completed or a timescale for completion and who by	Reduction in length over last 3 months is 0.6 From 1.9 – 1.3 At January 2013. This relates to 2 FCEs for Rheumatology in month of January.
Assurance/Monitoring: Please identify monitoring arrangements in place to sustain improvements	Monitored via COO report

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
March 2013

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

Description of indicator:	Length of stay (elective)	Number of healthcare acquired avoidable pressure ulcers (acquired/deteriorated) Grades 2,3 &4	Percentage of late observations	Number of red incidents
Indicator tolerance:	Specific	Target = 0 Red = >0	<5% = Green, 5-10% = Amber, >10% = Red	0 = Green, else Red
Period of alert: (i.e. Jun, Jul, Aug 2011)	December 2012 and January, February 2013	December 2012 and January, February 2013	December 2012 and January, February 2013	December 2012 and January, February 2013
Actions: Please identify where completed or a timescale for completion and who by	LOS doesn't apply to these areas in terms of electives	Although there remains a number of avoidable Grade 2 and 3 Pressure ulcers the current trends continue to show an improved picture. C15 shows a reduction from 9 avoidable PU's in Qtr 1 to 1 in Qtr 3 and no Grade 3's. C19 shows a reduction from 7 avoidable PU's in Qtr 1 to 3 in Qtr 3 and no Grade 3 ulcers. Local monitoring of documentation compliance continues and pump training of staff who have not received it also continues. Update 02.13 5 Grade 3 or 4 HAPU so far in Qtr 4, however only one has been agreed as avoidable with a full RCA	C15 showed a reduction in compliance for December, however have resumed their previous excellent performance for January with a percentage of 5.2% for January. Ongoing monitoring will continue to ensure consistency in the future. C19 have seen a fall in compliance in part due to the availability of Vitalpac hand held devices in an acceptable working condition at ward level. The introduction of IPod devices in February should assist in part with an improved compliance. All I Pod devices are now in place and early indications continue to show a favourable performance in particular C15	

		pending and so far end of February's data shows a reduced number of Grade 1 and 2 HAPU.	are now back at 4.6% for end February and C19 are starting to show an improvement and reduced their % to 12% at end February.	
Assurance/Monitoring: Please identify monitoring arrangements in place to sustain improvements		Action Plan monitoring in place through local Governance routes. . Monitoring and action continues through Qtr 4..	Close monitoring on C19 will continue by the ward manager and matron to facilitate improved compliance.	