The Royal Wolverhampton NHS Trust	

Trust Board Report

Meeting Date:	25 February 2013
Title:	Quality & Safety Reports
Executive Summary:	• The Q&S Report details Trust wide data for January 2013 • The Q&S Dashboard provides Group data for January 2013 • The Q&S Scorecard provides a divisional overview based on the directorate data for January 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 February 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 25 February 2013

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

- ***Net Promoter (Friends & Family Score)***
  The score has increased to 77.2 Trust wide, an improvement by 5 points. Early scores from the Emergency Department demonstrate high levels of satisfaction at 77 as well.
- ***Falls:*** There were no falls causing serious harm in January.
- ***Pressure Ulcers***: The number of avoidable pressure ulcers has reduced with 75% of the Trust reporting zero avoidable pressure ulcers at the end of December. There have been improvements in the supply of equipment to patients in their own homes, the Trust now supplies this out of hours as a pilot with all requests completed in 4 hours.
- ***Recognising the deteriorating patient***: The % of late observations remains static at 16% despite further training and league tables. An accountability review is being planned for wards with the highest % of late observations if deterioration continues with the internal 2 weekly reports.
- ***Device related hospital acquired bacteraemia (DRHABs)***: The nurse led line insertion team is very successful and this has increased the number of patients now able to receive parental nutrition, however this has identified practice issues with the bag changes which is being addressed by the team

The Divisional Scorecard provides an overview of the data captured under the three domains of quality and also includes the use of resources. They also highlight improvement or deterioration on a monthly basis.

The Quality & Safety Trust Dashboards uses data from the quality, safety and performance indicators to provide an overall view for each clinical division

Division 1

Patient Experience: Three Groups reported a deterioration in the percentage of patients who said they were treated with care and compassion and these were; Surgery/Urology, Orthopaedics and Ophthalmology/Head & Neck. However improvements have been sustained in Obstetrics & Gynaecology

Patient Safety: The number of DRHABs have increased in Surgery/Urology and Orthopaedics. There has been an increase in the number of falls in Cardiac services which was due to the increased number of medical patients accommodated there prior to discharge home (the practice of outlying patients fit for discharge). The cardiac wards have been instrumental in accommodating patients intended for day care, these areas have always been staffed appropriately.

Patient Outcomes: Clinical correspondence is improving across the division.

Support Services: The level of sickness is increasing with two groups now red RAG rated; Theatres/ICCU and Orthopaedics.

Division 2

Patient Experience: The percentage of patients who commented their overall satisfaction was good or excellent has increased across all Groups in the division.

Patient Safety: The number of falls across the division increased within three areas, community services (clinics held off site), paediatrics and therapies. Of note there were no increases in the adult inpatients wards which is encouraging. DRHABs increased within the Oncology/Haematology Group and a specific action plan is now in place to manage this.

Patient outcomes: Clinical correspondence improved across the division. An increase is noted in Respiratory/Gastro Group for numbers of patients readmitted within 30 days of discharge.

Support Services: The level of staff sickness has deteriorated in Adult Community Services, Elderly Care and Renal/Diabetes with an increase in vacancies noted in this Group.

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

Report

Review Committee Approval
Trust Board to receive the report

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

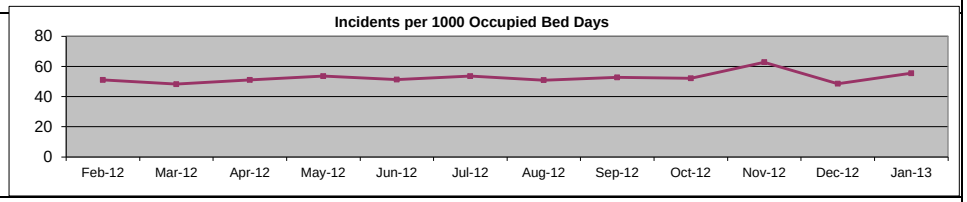
Contents

1 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.

	Nov-12	Dec-12	Jan-13
Div 1	458	454	392
Div2	827	599	837
Total	1285	1053	1229
Per 1000obd	62.8	48.5	55.4



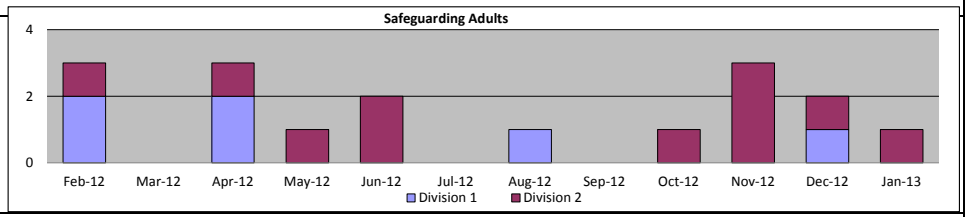
Analysis: The number of incidents reported during January appears to have increased by 16% from the previous month, as well as the incident rate (per 1000 occupied bed days). The majority of incidents are reported by nursing and midwifery staff . However because the figure reported for Division 2 appeared abnormally low suggesting an increase in January 2013, we have reviewed the data again for December in Division 2 and noted an additional 118 incidents were uploaded onto datix after the cut off date for the reporting period (the same day of the month is used for all Trust reports which is around the 16th of each month) . This suggests either a sudden increase towards the end of the month which we know is not the case because other indicators do not suport this so we believe it is due late sign off of datix forms by managers, sisters or matrons. Further work is being done to confirm this case and evidence where and why this happened.

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	Nov-12	Dec-12	Jan-13
Div 1	0	1	0
Div2	3	1	1
Total	3	2	1



Analysis: 1 referral attributed to A&E 1 safeguarding referral previously attributed to A&E , investigation complete and report is with social services

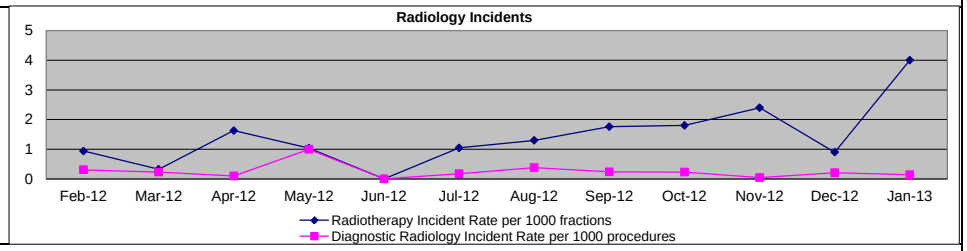
Action: To continue with investigation and update findings through Safeguarding Board

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

Rates	Nov-12	Dec-12	Jan-13
Radiotherapy Incident Rate per 1000 fractions	2.4	0.9	4
Diagnostic Radiology Incident Rate per 1000 procedures	0.047	0.21	0.14



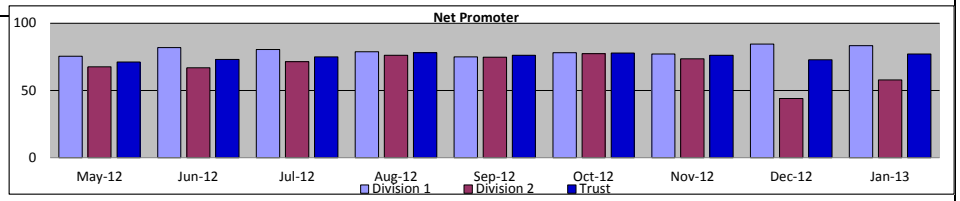
Analysis:
The 1 MRI incident relates to an MRI conditional infusion pump being drawn into the magnet bore, there was no patient injury, however the pump requires repair. On further investigation there have been 2 other similar incidents within the Trust." The number of Radiotherapy incidents appears to have increased however we are assured there has not been a particular type of radiotherapy where more incidents have occurred and the numbers are tracking around about same number as usual. However the percentage is apearing higher due to there being less treatments in what was a quiet month.

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.

	Nov-12	Dec-12	Jan-13
Div 1	77.1	84.46	83.39
Div2	73.5	44.02	57.94
Trust	76.25	72.78	77.2



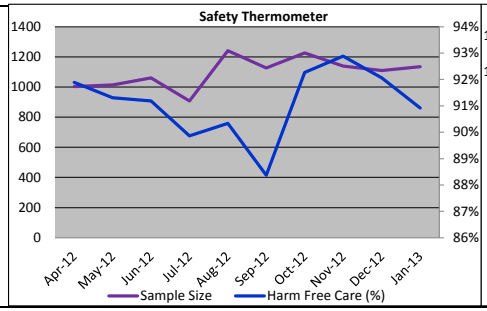
Analysis: There has been an improvement in the Net promoter Scroe , also called the Friends and Family Test (FFT) with improved reporting in all areasby 25%. The Emergency Department has started to collect information in minors and review clinic and have so far achieved a score of 77. The Trust is rated two points over the regional average for the FFT in recent reports.

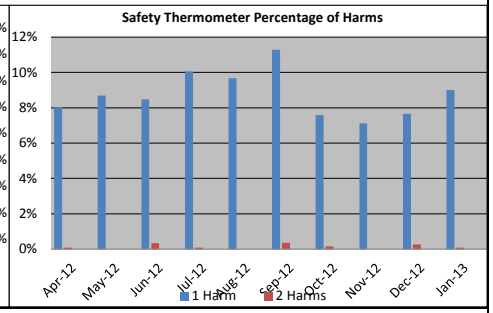
Action: To send out individual wards their net promoter scores monthly

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.

	Nov-12	Dec-12	Jan-13
Target	95%	95%	95%
Trust result	92.89%	92.06%	90.92%
Sample Size	1140	1109	1134





Analysis: The sample size for January has increased because all wards completed submission on time, however the percentage of overall harm free care has fallen slightly to 90.92%. There was a slight increase in the number of falls with harm and the number of catheters and new UTIs recorded. New VTEs recorded increased from 0.09% in December to 0.62% in January.

Actions: To consistently work with wards to ensure timely submission and teach wards to use the additional 22 computers on wheels that have been distributed round the Trust ensriung monitoring takes place as close to patients as possible. To provide to ward sisters and HoNs with outlying wards across New Cross, West Park and community

2 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.

	Jul-11	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	YTD
HSMR	97.2	89.3	94.7	81.7	84	104.7	94	89	90.5	92 [100]	89.0	100.8	105.8	86.2	101.7	98.5	104.5	101.6	98.3
Observed Death Rate (56 CCS Groups)	3.90%	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%	3.40%	3.80%	3.70%	3.70%
Expected Death Rate (56 CCS Groups)	4.00%	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%	3.40%	3.50%	3.60%	3.60%	3.70%
No of In Hospital Deaths	116	96	111	96	93	139	129	126	117	1023	115	121	121	103	107	98	123	118	906
Expected Deaths	120	107	114	114	110	132	130	140	129	1096	129.3	120.3	114.3	119.5	105.2	99.5	117.3	116.2	921.5
Excess Deaths	**-3.9**	**-10.8**	**-3.4**	**-18.1**	**-17.1**	**7.4**	**-1.3**	**-13.8**	**-12.2**	**-73**	**-14**	**1**	**7**	**-17**	**2**	**-2**	**6**	**2**	**-16**

Analysis: April 2011 to September 2012 is the latest available. The Trust's 2011/12 final HSMR is 100, this is the figure that will be 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	687	153	104.1	22.9%
Acute cerebrovascular disease	625	90	108.3	17.6%
Congestive heart failure, nonhypertensive	380	73	135.0	19.5%
Acute myocardial infarction	830	58	107.6	7.0%
Septicemia (except in labour)	164	42	104.0	25.9%
Aspiration pneumonitis, food/vomitus	83	34	108.5	41.0%

Alert Status

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

Associated Indicators of Mortality

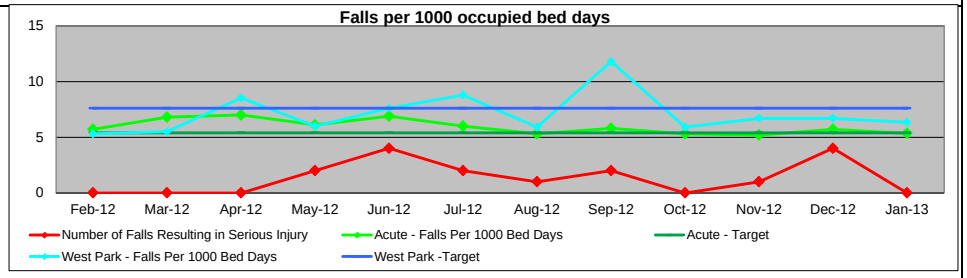
Indicator	Period	Actual	RAG	TREND
Charlson Codes Per Spell (HED)	Apr-March12	5.56		➲
Palliative Care Deaths Per 1000 Discharges (HED)	Apr-August 12	24	NHS England average is 24	
% Palliative Care Deaths	Apr 10-March 12	20%	NHS England range for large acute Trusts is 0-40%	
Expected Death Rate	Apr-August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

	Nov-12	Dec-12	Jan-13
Acute - Target per occupied bed days	<5.4	<5.4	<5.4
Acute - Number of falls per 1K occupied bedbed days	**5.2**	**5.7**	**5.35**
West Park- Target per occupied bed days	7.6	7.6	7.6
West Park - Number of falls per occupied bed	**6.7**	**6.7**	**6.34**
Number of falls resulting in serious injury	1	4	0



Analysis: There were no falls causing serious harm during the month of January. Similarly the number of falls per 1000 ocupied bed days is marginally below target in both acute and rehabilitation settings which is encouraging despite the increased acuity and dependancy of patients during the continued norovirus outbreak which presents challenge to staff caring for patientsat risk of falling.

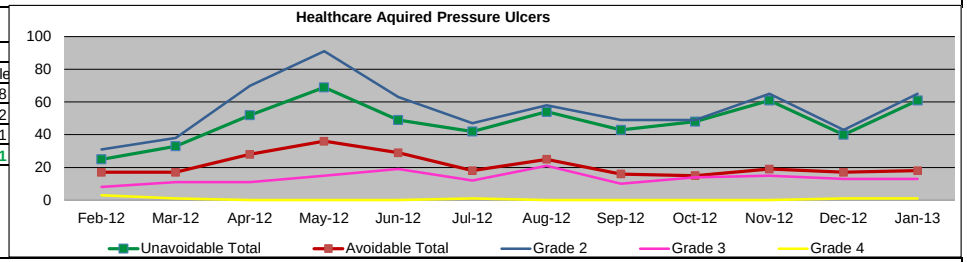
Actions: To review the implementation of the falls bundle in line with the NHSLA Report guidance.To determine new targets for falls for each ward and set an overall trajectory for Trust wide performance. To review every falls that cause serious harm at the weekly CNO Accountability meetings.

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)

	Nov-12		Dec-12		Jan-13	
	Avoidable	Unavoidable	Avoidable	Unavoidable	Avoidable	Unavoidable
Grade 2	16	49	14	29	17	48
Grade 3	3	12	2	11	1	12
Grade 4	0	0	0	1	0	1
Total	**19**	**61**	**16**	**41**	**18**	**61**



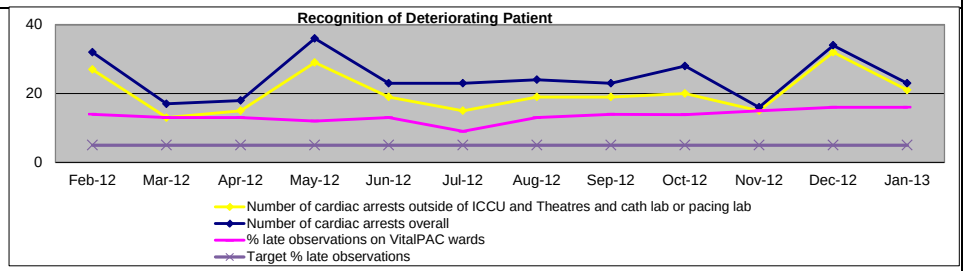
Analysis: The number of acquired unavoidable pressure ulcers has increased by 21 from December to January. The number of avoidable pressure ulcers continues to remain stable with 75% of the organisation now achieving the SHA Ambition One: Zero avoidable Pressure Ulcers by December 31 2012. The TV Team continue to work with nursing and residential homes to improve eduaction and surveliillance

Actions: To focus education and support on ward areas that have not achieved the ambition (25% of our wards). Community services are using the safety cross as an early identification process to stop the pressure and reducing the incidence of Grade 1 tissue damage occuring. The out of hours community equipment contract is now being run by the Trust's equipment library as a pilot for 6 months, this is demonstrating succesful early delivery of mattresses delivered to patients homes out of hours within four hours as oppossed to 7 days which is the service provided by the current contract.

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.

	Nov-12	Dec-12	Jan-13
Number cardiac arrests	16	34	21
% observations late	15.00%	16.00%	16.50%
Target (late observations)	5%	5%	5%



Analysis: The percentage of late observations has remained fairly static over the last 12 months despite the introduction of new devices which will be in place across the organisation. A renewed focus is being applied to the rationale behind a ViEWS system and the purpose of a track and trigger system by the Ipod trainer whilst they are educating staff in it's use

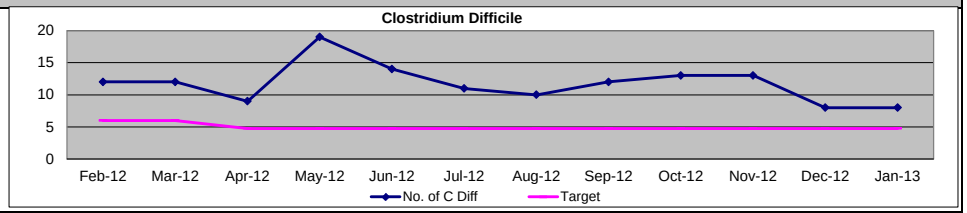
Actions: To circulate twice monthly league tables identifying % of late observations by ward

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

	Nov-12	Dec-12	Jan-13
Number of C Diff	13	8	8
Cum Plan	72	81	90
Cum Actual	101	109	117
Cum Variance	29	28	27

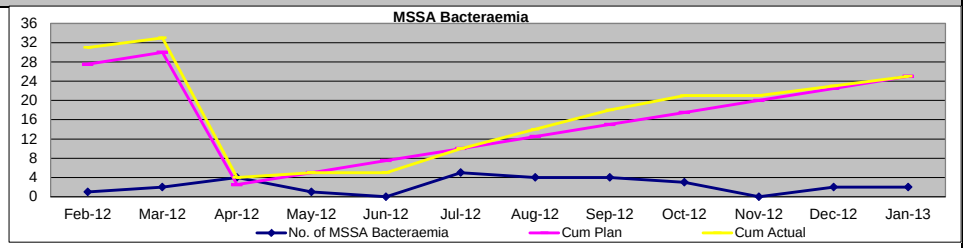


Analysis: The internal target is based on PCR results. The external target is based on Toxin EIA results. In January we reported 2 against the external target (which is 4.75 per month) for New Cross and 0 for West Park (target 1 per month). This takes our total for the year to 36 (target 47) excluding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

	Nov-12	Dec-12	Jan-13
No. of MSSA Bacteraemia	0	2	2
Cum Plan no. Cases as target	20	22.5	25
Cum Actual no. of cases to date	21	23	25
Cum Variance of actual versus pla	1	0.5	0



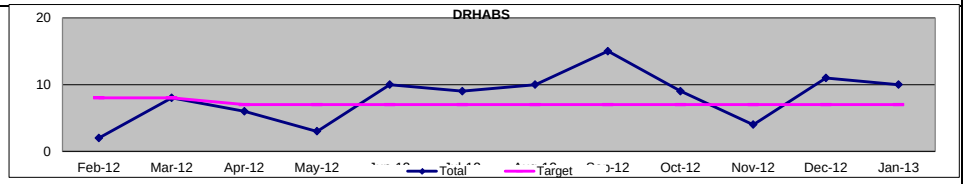
Analysis: Two RWHT-attributable cases. One was a DRHAB related to either a line or PEG. The other was due to a pneumonia in a Chemotherapy patient, and was therefore probably unavoidable.

Actions: For DRHAB: Urinary Catheter Working Group active. IV Team active.

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.

	Nov-12	Dec-12	Jan-13
Target (monthly)	7	7	7
DRHABS	4	11	10



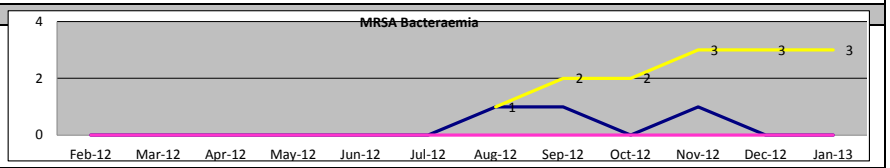
Analysis: 6 line related, 3 urinary catheter related and 1 VAP. All three catheters were recatheterisations by medical staff. The number of IV lines has preciptated the question about how nurses change TPN bags as the Trust has seen an increase in numbers of patients receiving TPN since the advent of the PICC team

Actions: For lines : To review practice in changing TPN bags

2.5.4 MRSA Bacteraemia

	Nov-12	Dec-12	Jan-13
No. of MRSA Bacteraemia	1	0	0
Cum Plan	0	0	0
Cum Actual	3	3	3
Cum Variance	3	3	3

Blue line =MRSA in mon
Yellow line = cumul actu



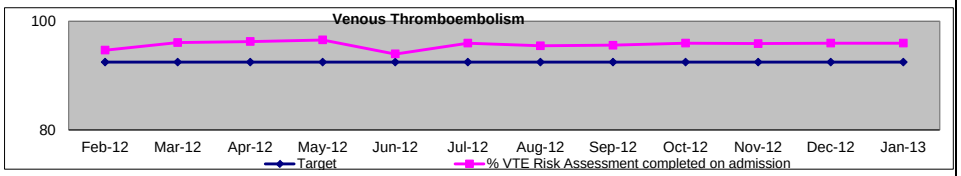
Analysis: August and November cases not attributable to RWHT according to external definition of attribution. Two pre-48-hour cases in December.September case attributable to RWHT by internal and external definitions of attribution.

Actions: Repeated raising of awareness of five moments hand hygiene, appropriate MRSA screening on admission and scrupulous line care as well as only inserting lines if absolutely required.

2.6 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

	Nov-12	Dec-12	Jan-13
% adult patients with completed	96%	96%	96%
Number of patients with hospital	15	12	tbc
Number of patients identified in	26	17	tbc



Analysis: Of the 17 non hospital related VTE episodes 4 were high risk due to patients eceiving chemotherapy, 2 were recurrent and 1 a high risk drug user. Of the 12 hospital associated 1 inherited from Walsall, 2 known oncology relayed admissions and 2 orthopoedic admissions, the remaindr are waiting to have an RCA completed and will be reported at the Thrombosis Committee. Repeat VTE assessment has highlighted poor compliance through the recent live health records audit.

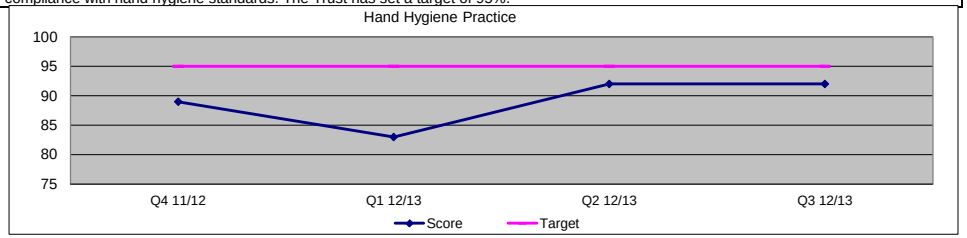
Actions: The aleting of the 24 hour reassessment on VTE vitalpac is being changed to enable improved performance management of this safety target

3 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%**



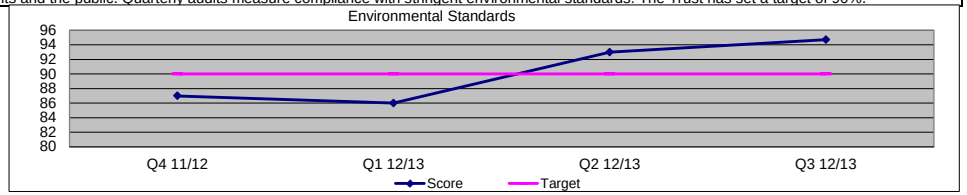
Analysis: There is an improving trend across both divisions with a continued focus on monthly reporting of five moments

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%**



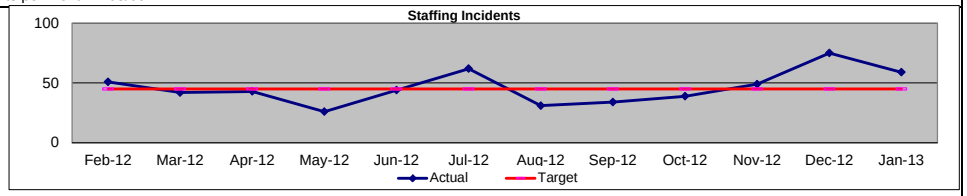
Analysis: There has been an improvement in the environment audits conducted by the Matrons

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.

	Nov-12	Dec-12	Jan-13
Division 1	25	50	39
Division 2	24	25	20
Total	**49**	**75**	**59**
Target	**45**	**45**	**45**



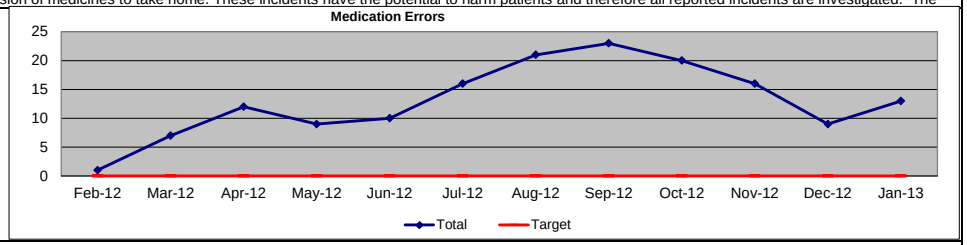
Analysis:, Division 1: The majority of staffing incidents reported in Div 1 were from Obstetrics and Gynaecology with no reason provided (12 out of 16 incidents). The number of incidents reported by Trauma and Orthopeadics has reduced from 15 incidents in December to 10 in January suggesting improved staffing and morale.

Action To continue to monitor Trauma and orthopeadics and ensure Obstetrics and Gynaecology complete reasons for incidences reported as short staffed

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

	Nov-12	Dec-12	Jan-13
Division 1	4	5	1
Division 2	12	4	12
Total	16	9	13
Target	**0**	**0**	**0**



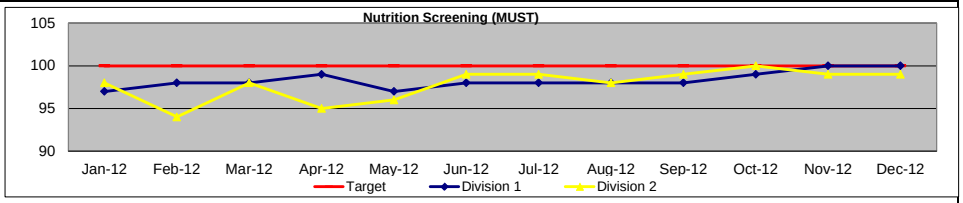
Analysis: The number of medication incidents continues to be monitored by each division. Ther bare no apparent themes arising from the data, nursing errors are scrutinised by the heads of nursing, doctors incidents are reported through the Deanary and they receive supervision from their supervisors and pharmacy manages the predominantly dispensing errors as per the medication policy.

Actions: To consider how best to monitor if medications are administered on time because this impacts on patient safety and in particular the sepsis bundle with timely administration of IV antibiotics for instance, delays in medications are not all captured on datix which feeds the data for this indicator. Late or missed medication errors are a key recommendation for action in the Francis Report (2013). To continue to try to identify errors not reported on datix with Dr Fitzpatrick through

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



Analysis: Excellent compliance continues with MUST assessment and the 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
December 2012

	General Surgery	Urology	Cardiac	Critical care	Orthopaedic	Gynaecology	Head and Neck	Ophthalmology	Maternity
Division One	92% ↓	NA	96% ↓	97% ↓	66% ↓	100% ↔	100% ↑	95% ↓	NA

	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% ↔	96% ↓	100% ↔	98% ↓	100% ↑	100% ↑	99% ↑	100% ↔

Green	≥ 90%
Amber	70-89%
Red	<70%

Surgical Division (Division 1) - Quality & Safety Scorecard - January 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	A	G	↓
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	G	↓
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	A	↔
Number of cancelled/rescheduled outpatient appointments	A	A	↔
Cancelled operations as a percentage of elective admissions	R	R	↔
Overall Rating	A		↔

Patient Safety	This Month	Last Month	Trend
Number of red incidents	A	G	↓
Number of healthcare/inpatient falls	R	R	↔
Number of healthcare/inpatient falls - resulting in serious injury	G	R	↑
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	R	A	↓
Percentage of VitalPAC VTE risk assessments on admitting ward	A	A	↔
Percentage of late observations (VitalPAC wards only)	R	R	↔
Overall Rating	R		↔

Patient Outcomes	This Month	Last Month	Trend
Length of stay (elective)	G	G	↔
Length of stay (non-elective)	R	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	A	R	↑
Overall Rating	A		↑

Resources	This Month	Last Month	Trend
Sickness absence	R	A	↔
Percentage of staff who have undergone an annual appraisal	A	A	↔
Percentage of trained nursing vacancies per funded establishment	A	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)	A	A	↔
Overall Rating	R		↓

Trust Dashboard: January 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	0	→	0	0	→	0	<0.1%	↑	0.2%	0	↓	0.1%	0	↓	0.2%	0	↓	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	→	0	0	→	0	0	→
Number of serious complaints received	0	0 = Green, else Red	Jamie Emery	0	0	→	0	0	→	0	0	→	0	0	→	0	0	→	1	0	↓	0	1	↑
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							100%	100%	→	91%	100%	↓	90%	72%	↑	94%	92%	↑	100%	100%	→
Percentage patients who rated overall satisfaction good/excellent	95%	>95% = Green, 85-95% = Amber, <85% = Red	Jamie Emery							96%	100%	↓	98%	96%	→	97%	100%	↓	94%	78%	↑	92%	100%	↓
Percentage of patients who answered "yes" to being treated with care and compassion	95%	>95% = Green, 85-95% = Amber, <85% = Red	Jamie Emery							96%	100%	↓	87%	100%	↓	93%	100%	↓	92%	83%	↑	92%	100%	↓
Number of cancelled/rescheduled outpatient appointments	–	Reduction of 40% in year	Lesley Taff							48	11	↓	564	221	↓	201	143	↓	62	22	↓	800	209	↓
Cancelled operations as a percentage of elective admissions	0.8%	< 0.8% = Green, else Red	Lesley Taff							8.69%	18.08%	↑	3.47%	3.62%	↑	7.78%	6.59%	↓	1.20%	2.35%	↑	2.36%	1.91%	↓
Patient Safety																								
Number of red incidents	0	0 = Green, else Red	Sukhy Khunkhuna	0	0	→	1	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	↓	2	3	↑	10	4	↓	11	17	↑	9	7	↓	2	3	↑	2	3	↑
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	1	↑	0	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	3	↑	1	2	↑	3	1	↓	2	2	→	1	0	↓	0	1	↑
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%	→	100%	100%	→	100%	100%	→	100%	100%	→
MSSA bacteraemia	–	<2 = Green, 2-3 = Amber, >3 = Red	Mike Cooper	0	0	→	0	0	→	0	0	→	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	0	↓	1	1	→	1	0	↓	1	0	↓	0	1	↑	0	0	→
Device related bacteraemias	–	Green = 0,Amber = 1,Red = >1	Mike Cooper	0	0	→				1	1	→	2	2	→	2	0	↓	0	0	→	0	0	→
Device related bacteraemias (Haem/Onc, ICCU, Renal, Neonates)	–	Green = 0,Amber = 1- 2 Red = >2	Mike Cooper				0	1	↑															
Percentage VitalPAC VTE risk assessments assessed on admitting ward (VitalPAC wards only represented by Directorate, excludes maternity & low risk cohorts)	90%	90% = Green, 70-89% = Amber, <70% = Red	Jayne Lawrence	100%	100%	→	93.56%	95.74%	↓	90.36%	89.84%	↑	88.07%	82.13%	↑	89.33%	82.93%	↑	94.56%	94.93%	↓	99.23%	95.83%	↑
Percentage of late observations (VitalPAC wards only)	5%	<5% = Green, 5-10% = Amber, >10% = Red					5.00%	5.30%	↑	18.3%	17.4%	↓	12.4%	15.2%	↑	10.5%	23.5%	↑	11.0%	11.00%	→	19.0%	14.0%	↓
Patient Outcomes																								
Length of stay (elective)	specific	Specific	Lesley Taff							4.52	4.76	↑	2.6	2.79	↑	2.8	2.9	↑	2.5	2.5	→	1.69	1.63	↓
Length of stay (non elective)	specific	Specific	Lesley Taff							7.93	7.69	↓	3.56	3.51	↓	7.2	7.1	↓	0.9	1.0	↑	1.81	1.93	↑
Percentage of emergency readmissions within 30 days	4.19%	<4.19% = Green, 4.2-5% = Amber, >5%= Red	Lesley Taff							0.97%	2.25%	↑	0.13%	1.65%	↑	0.58%	0.82%	↑	0.00%	1.41%	↑	0.00%	0.38%	↑
Delayed discharges			Lesley Taff	0.0%	0.0%	→	0.0%	0.0%	→	1.0%	0.0%	↓	1.5%	1.0%	↓	1.0%	1.5%	↑	0.0%	0.0%	→	0.0%	0.0%	→
18 week RTT - admitted	90%	90% = Green, else Red	Lesley Taff							93.92%	91.67%	↑	91.47%	93.02%	↓	90.10%	90.16%	↓	90.09%	90.91%	↓	92.31%	91.89%	↑
18 week RTT - non-admitted	95%	95% = Green, else Red	Lesley Taff							97.19%	95.02%	↑	95.97%	96.91%	↓	95.09%	95.02%	↑	95.76%	95.25%	↑	98.69%	97.82%	↑
Clinical correspondence turnaround within 48 hours	100%	100% = Green, 75-99% = Amber, else Red	Lesley Taff	99.8%	94.9%	↑				88.9%	49.8%	↑	61.3%	44.5%	↑	89.7%	50.2%	↑	99.9%	77.3%	↑	66.5%	50.8%	↑
Support Services																								
Sickness absence	<3.74%	<3.74% = G, 3.74 - 6% = Amber, >6% = Red	Lesley Taff	2.64%	1.72%	↓	6.31%	5.36%	↓	4.27%	3.44%	↓	4.43%	4.98%	↑	7.54%	6.45%	↓	4.84%	5.03%	↑	3.31%	3.43%	↑
Percentage of staff who have undergone annual appraisal	80%	>/=80% = Green, 70-79% = Amber, <70% = Red	Lesley Taff	92.6%	91.7%	↑	87.3%	87.9%	↓	81.7%	82.1%	↓	76.8%	77.7%	↓	67.0%	67.5%	↓	87.5%	90.9%	↓	85.7%	86.3%	↓
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%	1.01%	↓	0.51%	0.89%	↑	0.24%	0.04%	↓	6.17%	4.83%	↓	3.68%	3.24%	↓	0.57%	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							£(155) k	£(135) k	↓	£(196) k	£(169) k	↓	£(171) k	£(146)k	↓	£(32) k	£(45) k	↑	£27 k	£25 k	↑
WTE budgeted against actual (ward WTE only)	In balance	variance < 5% = Green variance 5-10% = Amber variance >10% = Red	Alison Reynolds							(2.68) %	(3.81) %	↑	2.30 %	(0.47)%	↑	(3.55) %	(5.59) %	↑	16.28 %	9.01%	↑	(1.16) %	(2.55) %	↑

The Royal Wolverhampton Hospitals NHS Trust

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HIGH LEVEL INDICATOR EXCEPTION REPORT TO TRUST BOARD
February 2013

Report from: Directorate/Group	Orthopaedics
Report prepared by: Name, Job Title	Helen Read, Directorate Manager Bev Morgan 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 % elective admissions**
Indicator tolerance:	Target = 5% Red = >10%	Target = 100% Red = < 75%	0 = Green, else Red	Target = 0.8% Red = >0.8%
Period of alert:	November, December 2012 and January 2013	November, December 2012 and January 2013	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	Matron has met and discussed late observations with Ward Managers.	Secretaries back from long-term sickness. New Team Leader appointed and different ways of working initiated.	Training for staff by tissue viability to improve education and standards. All staff have been written to regarding importance of pressure area care and correct documentation. Disciplinary action has been taken with staff failing to comply with instructions.	Operations continue to be cancelled on a regular basis to support capacity issues in the Trust. This is a concern for the Directorate as we are losing a lot of activity. However we recognise the need to support the Trust position and support medicine during this difficult time.
Assurance/Monitoring: Please identify monitoring arrangements in place to sustain improvements	Ward Manager/Matron rounds and monitoring of standards on the wards. Our new Matron Bev Morgan will be reviewing standards.	Current turnaround figures show that we have only 5 hours of dictation backlog. As of 6.2.13 we are typing work from Sunday 3.2.13 which is a vast improvement as there was a backlog of 53 hours in October 2012. We are expect to be green by the end of February 2013.	Matron and Ward Manager rounds and checks on documentation. Accountability meetings taking place a ward level with ward manager.	We have reviewed opportunities to see if there was a possibility of improving throughput by putting on additional day case high volume lists however Beynon Short Stay has become a medical ward and even day case patients are now being regularly cancelled the day

				prior to surgery in order to support medicine and therefore we are not able to put through additional day case sessions. We are increasingly using Appleby as a facility to receive complex patients who are being treated as day case and operated on in Nucleus Theatres.

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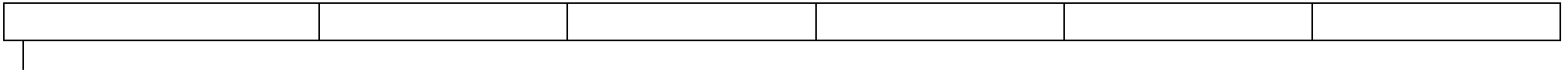
HIGH LEVEL INDICATOR EXCEPTION REPORT TO TRUST BOARD February 2013

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)	Clinical correspondence turnaround within 48 hours
Indicator tolerance:	Target = 0.8% Red = >0.8%	Target = 5% Red = >10%	Specific	0 = Green, else Red	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	November, December 2012 and January 2013	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	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	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	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	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.	Across November and December the Medical Secretariat were reduced in number, with staff pulled out to cover Cardiac Investigations Reception/Clerks (due to long term sickness) this was necessary to ensure

	due to other issues e.g. 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.	Patient safety improvement co-ordinator Monthly report via KPI On-going	specific target which we can then respond to?	Ward managers investigate all Grade 2 and 3 pressure sores. When a grade 3 pressure 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%	inpatient and outpatient referrals where handled timely, clinics where managed and covered and we avoided 6 week diagnostic breaches. Protected Typing Sessions have been facilitated throughout January to improve our position, in addition one full time Team Secretary vacancy was filled on 7th January. We expect to see our position improve for January with a further improvement in February.
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.	Responsibility of Business manager



The Royal Wolverhampton Hospitals NHS Trust

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HIGH LEVEL INDICATOR EXCEPTION REPORT TO TRUST BOARD
February 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)	November, December 2012 and January 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

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HIGH LEVEL INDICATOR EXCEPTION REPORT TO TRUST BOARD
February 2013

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

Description of indicator:	No of falls in health care
Indicator tolerance:	Target = 0 Red = 1 or more
Period of alert:	November, December 2012 and January 2013
Actions: Please identify where completed or a timescale for completion and who by	November 2012. - ICCU x1, patient helped to the floor, no injury, no RCA required. Beynon Short Stay Ward x 1, patient stumbled back, no injury sustained, No RCA required. December 2012 – Beynon Short Stay x 1, Medical patient walked to nurses station and asked if staff could let her out for a cigarette and the she fell backwards and landed on her bottom – no harm to patient, protocol followed, No RCA required January 2013 – Beynon Short Stay x 1 Patient found on floor in bay 3, Patient states he slid off the bed when trying to use the urine bottle, did not sustain any injury. Action taken, observations were done, SHO sent for, no harm to the patient, no RCA required.
Assurance/Monitoring: Please identify monitoring arrangements in place to sustain improvements	Following evaluation, no additional actions required

Emergency, Medical and Community Services (Division 2) - Quality & Safety Scorecard - January 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	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	A	↑
Percentage of patients who answered "yes" to being treated with care and compassion	A	G	↓
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	R	A	↓
Number of healthcare/inpatient falls - resulting in serious injury	G	R	↓
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	A	↑
Device related bacteraemias	A	G	↓
Percentage of VitalPAC VTE risk assessments on admitting ward	G	G	↔
Percentage of late observations (VitalPAC wards only)	R	R	↔
Overall Rating	R		↔

Patient Outcomes	This Month	Last Month	Trend
Length of stay (elective)	R	R	↔
Length of stay (non-elective)	G	G	↔
Percentage of emergency re-admissions within 30 days	A	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	R	↑
Overall Rating	A		↑

Resources	This Month	Last Month	Trend
Sickness absence	R	A	↓
Percentage of staff who have undergone an annual appraisal	A	G	↓
Percentage of trained nursing vacancies per funded establishment	A	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)	A	R	↑
Overall Rating	R		↔

Trust Dashboard: Januarv 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	0.2%	<0.1%	↓	0.1%	0	↓	0.1%	<0.1%	→	0.10%	0	↓	0%	<0.1%	↓	0.2%	<0.1%	↓	0.2%	<0.1%	↓	0.3%	<0.1%	↓	0.1%	0	↓	0.1%	<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	→	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	→	1	1	→	0	0	→	0	0	→	1	0	↓	0	1	↑	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							89%	100%	↓	N/A	N/A					100%	81%	↑	100%	100%	→	89%	100%	↓				91%	100%	↓
Percentage patients who rated overall satisfaction good/excellent	95%	>95% = Green, 85-95% = Amber, <85%	Jamie Emery							100%	92%	↑	N/A	N/A					93%	84%	↑	97%	100%	↓	100%	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					85%	94%	↓	89%	100%	↓	89%	100%	↓				100%	100%	→
Number of cancelled/rescheduled outpatient appointments	–	Reduction of 40% in year	Lesley Taff	248	104	↓	N/A	N/A		21	6	↓	N/A	N/A		403	230	↓	35	53	↑	220	98	↓				0	0	→	58	3	↓
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	→	1	1	→	0	0	→	0	0	→	0	0	→
Number of healthcare/inpatient falls *RAG= tolerance multiplied by the number of inpatient wards	0	Ward specific	Sukhy Khunkhuna	2	0	↓	2	0	↓	33	37	↑	17	17	→	0	1	↑	16	4	↓	16	22	↑	7	14	↑	1	2	↑	7	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,	Sukhy Khunkhuna	0	0	→	0	0	→	0	2	↑	0	0	→	0	0	→	0	0	→	0	0	→	0	1	↑	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	3	↑	4	1	↓	0	2	↑	0	0	→	2	1	↓	3	6	↑	0	1	↑	0	0	→	0	1	↑
Percentage inpatient MUST assessments completed within 6 hours of admission	100%	100% = Green, 75-99% = Amber, <75%	Rose Baker Zena Young							100%	91%	↑	100%	100%	→				100%	100%	→	100%	100%	→	96%	96%	→					100%	
MSSA bacteraemia	–	<2 = Green, 2-3 = Amber, >3 = Red	Mike Cooper	0	0	→	0	0	→	0	0	→	0	0	→	0	0	→	1	0	↓	0	0	→	0	0	→				1	0	↓
Clostridium Difficile - hospital acquired for ages >2 years	–	Green = 0,Amber = 1-2,	Mike Cooper	0	0	→	0	0	→	0	1	↑	0	1	↑	0	0	→	0	0	→	1	3	↑	0	0	→				0	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	1	↑	0	0	→						
Device related bacteraemias (Haem/Onc, ICCU, Renal, Neonates)	–	Green = 0,Amber = 1-2	Mike Cooper	1	0	↓													1	1	→										3	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%	95.74%	↑	N/A	N/A		98.8%	100%	↓	99.96%	99.88%	↑	88.24%	69.23%	↑	95.43%	91.49%	↑				99.67%	99.49%	↑
Percentage of late observations (VitalPAC wards only)	5%	<5% = Green, 5-10% = Amber, >10% =	Lisa Miller							23.0%	26.9%	↑							11.6%	11.3%	↓	20.0%	15.4%	↓	17.0%	16.0%	↓				11.6%	10.30%	↓
Patient Outcomes																																
Length of stay (elective)	specific	Specific	Lesley Taff	1.7	1.8	↑										1.3	1.3	→	0.4	0.5	↑	3.8	4.6	↑							2.74	3.17	↑
Length of stay (non elective)	specific	Specific	Lesley Taff	0.7	0.7	→										1.73	1.73	→	2.1	2.0	↓	3.6	3.5	↑							4.42	4.62	↑
Percentage of emergency readmissions within 30 days	4.19%	<4.19% = Green, 4.2-5% = Amber, >5%=	Lesley Taff	3.37%	2.89%	↓				0.00%	0.00%	→	0.0%	0.0%	→	0.68%	0.0%	↓	0.0%	0.0%	→	5.26%	0.00%	↓	0.0%	0.0%	→				0.10%	0.18%	↑
Delayed discharges			Lesley Taff	0.0%	0.0%	→				2.0%	1.5%	↓	1.0%	0.0%	↓	0.0%	0.0%	→	0.0%	0.0%	→	1.0%	1.0%	→	0.0%	0.0%	→				0.5%	0.5%	→
18 week RTT - admitted	90%	90% = Green, else Red	Lesley Taff													100%	100%	→	100%	100%	→	96.82%	100.00%	↓				100%	100%	→	100.0%	100.00%	→
18 week RTT - non-admitted	95%	95% = Green, else Red	Lesley Taff	98.78%	98.62%	↑	100%	100%	→	100.00%	97.67%	↑				98.9%	98.0%	↑	99.51%	99.30%	↑	97.89%	96.05%	↑				100%	100%	→	100.00%	97.30%	↑
Clinical correspondence turnaround within 48 hours	100%	100% = Green, 75-99% = Amber, else	Lesley Taff	88.6%	76.2%	↑	N/A	N/A		95.8%	95.1%	↑	N/A	N/A		88.2%	58.8%	↑	99.7%	94.4%	↑	91.4%	72.3%	↑	78.8%	35.7%	↑				78.7%	80.2%	↓
Support Services																																
Sickness absence	<3.74%	<3.74% = G, 3.74 - 6% = Amber, >6% =	Lesley Taff	4.89%	4.92%	↑	7.26%	7.39%	↑	6.06%	4.67%	↓	4.17%	4.74%	↑	2.97%	3.73%	↑	8.42%	1.39%	↓	3.92%	4.12%	↑	5.90%	4.21%	↓	4.52%	3.81%	↓	6.72%	4.20%	↓
Percentage of staff who have undergone annual appraisal	80%	>/=80% = Green, 70-79% = Amber, <70%	Lesley Taff	95.4%	93.7%	↑	90.4%	90.6%	↓	85.6%	80.6%	↑	94.7%	91.5%	↑	89.5%	90.9%	↓	80.6%	81.0%	↓	84.5%	84.4%	↑	69.3%	75.7%	↓	93.4%	87.7%	↑	87.1%	86.1%	↑
Percentage of trained nursing vacancies per funded establishment	2%	</=2% funded est = G, 2%-5% = A, else	Lesley Taff	4.05%	3.00%	↓	1.81%	3.77%	↑	-0.97%	0.18%	↓	0.24%	1.17%	↑	0.38%	1.95%	↑	5.75%	1.50%	↓	1.88%	1.14%	↓	2.02%	1.45%	↓	0.0%	0.0%	→	1.94%	1.47%	↓
Percentage of medical training grades vacancies per funded establishment	2%	</=2% funded est = G, 2%-5% = A, else	Lesley Taff	0.22%	0.27%	↑	0.00%	0.00%	→	1.52%	0.76%	↓	0.00%	0.00%	→	0.00%	0.00%	→	0.00%	0.00%	→	0.79%	0.94%	↑	2.50%	0.99%	↓	0.00%	0.00%	→	0.00%	0.00%	→
Pay budget (ward pay budget only)	In balance	Yes = Green, Agreed = Amber, No = Red	Alison Reynolds	£22k	£19 k	↑	£(5) k	£(5) k	→	£(294) k	£(251) k	↓	£(59) k	£(41) k	↓				£(188) k	£(170) k	↓	£(100) k	£(98) k	↓	£(72) k	£(62) k	↓				£(131) k	£(118) k	↓
WTE budgeted against actual (ward WTE only)	In balance	variance < 5% = Green variance 5-10% = Amber	Alison Reynolds	6.36%	1.53%	↑	None	100.00%	n/a	(8.51) %	(4.53)%	↓	(4.91) %	(6.05)%	↑				(6.04) %	(15.03)%	↑	8.47 %	2.43%	↑	4.12 %	1.51%	↑				(2.20) %	(3.44)%	↑

The Royal Wolverhampton Hospitals NHS Trust

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HIGH LEVEL INDICATOR EXCEPTION REPORT TO TRUST BOARD
February 2013

Report from: Directorate/Group	Emergency Services Group (ED AMU)
Report prepared by: Name, Job Title	Jane McKiernan Group 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 from the AMU data • 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)	• Additional secretarial staff to be deployed from 18th Feb for a period of 4 weeks.
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	• Weekly monitoring via Support Sec Leads

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HIGH LEVEL INDICATOR EXCEPTION REPORT TO TRUST BOARD
February 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 healthcare/inpatient falls - resulting in serious injury
Indicator tolerance:	Target = 5% Red = > 10%	Target = 0	Green = 0, Amber = 1-4,
Period of alert: (i.e. Jun, Jul, Aug 2011)	November, December 2012 and January 2013	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	New hardware installed on C22 last week to input vital sign data. Responsibilities reiterated to band 7's in personal letters 11th. Feb 2013	No grade 3 HAPU Jan 13	No falls with serious injury Jan 13 and below monthly target.
Assurance/Monitoring: Please identify monitoring arrangements in place to sustain improvements	Quality Rounds.		

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HIGH LEVEL INDICATOR EXCEPTION REPORT TO TRUST BOARD
February 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:	Clinical correspondence turnaround within 48 hours	Length of stay (elective)
Indicator tolerance:	Target = 100% Red = <75% Jan report = 59.7 %	Specific
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	Overtime identified for month January to clear backlog of correspondence. Medium term plan in progress within group to provide on-going support to medical secretariat to manage the clinical correspondence turn round. Longer term plan to be reviewed once the commissioners have identified requirements for community dermatology contract for 2013-14. Review of manpower resources requirements to be undertaken at that time.	Reduction in length over last 2 months is 0.6 From 1.9 – 1.3 at December 2012.
Assurance/Monitoring: Please identify monitoring arrangements in place to sustain improvements	Via COO and use of additional resource.	

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HIGH LEVEL INDICATOR EXCEPTION REPORT TO TRUST BOARD
February 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	Percentage of complaints responded to within 25 working days (or with consent to breach)	Number of healthcare acquired avoidable pressure ulcers acquired/deteriorated (Grade 2, 3 & 4)
Indicator tolerance:	<5% = Green, 5-10% = Amber, >10% = Red	>/= 90% = Green, else Red	0 = Green, else Red
Period of alert: (i.e. Jun, Jul, Aug 2011)	November, December 2012 and January 2013	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	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		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

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HIGH LEVEL INDICATOR EXCEPTION REPORT TO TRUST BOARD
February 2013

Report from: Directorate/Group	Therapy Services (Acute and Community)
Report prepared by: Name, Job Title	Sheila Stringer

Description of indicator:	Number of healthcare/inpatient falls *RAG= tolerance multiplied by the number of inpatient wards
Indicator tolerance:	Ward Specific Target = 0
Period of alert: (i.e. Jun, Jul, Aug 2011)	January 2013,
Actions: **Please identify where completed or a timescale for completion and who by**	DATIX 99022 January 2013 Adaptation to child's wheelchair brakes not fully explained to parent. Parent applied brakes , child released brakes and fell from chair sustaining moderate graze to face.
Assurance/Monitoring: **Please identify monitoring arrangements in place to sustain improvements**	Adverse weather conditions caused disruption to school transport – opportunity missed to fully explain new adaptations to brakes to father of child. Only recorded incident. Full discussion with regard to this at Governance meetings to ensure no repeat.

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HIGH LEVEL INDICATOR EXCEPTION REPORT TO TRUST BOARD
February 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
Indicator tolerance:	Specific	Target = 0 Red = >0	<5% = Green, 5-10% = Amber, >10% = Red
Period of alert: (i.e. Jun, Jul, Aug 2011)	November, December 2012 and January 2013	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	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.	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.
Assurance/Monitoring: Please identify monitoring arrangements in place to sustain improvements		Action Plan monitoring in place through local Governance routes. No further changes to report 01.13. Action continues.	Close monitoring on C19 will continue by the ward manager and matron to facilitate improved compliance.