The Royal Wolverhampton NHS Trust	

Trust Board Report

Meeting Date:	28 January 2013
Title:	Quality & Safety Reports
Executive Summary:	• The Q&S Report details Trust wide data for December 2012 • The Q&S Dashboard provides Group data for December 2012 • The Q&S Scorecard provides a divisional overview based on the directorate data for December 2012 • The exception reports provide information received from directorates where three red ragged indicators have been consecutively reported on
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 Q&S Report was approved by the Quality & Safety Committee on 22 January 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 28 January 2013

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

- ***Net Promoter (Friends & Family Score)***
  December saw a reduction in numbers of submissions and overall score for Division 2 (from 73.5 last month to 44.02 December). The reason for this was due to low numbers of responses from the division overall and this has been raised with the managers. A&E have started to collect their data in advance of the April deadline
- ***Falls:*** The number of falls had reduced below target September however there was a marginal increase in December by 0.5% per 1000 bed days. There were 4 falls causing serious injury
- ***Pressure Ulcers***: The number of health acquired avoidable pressure ulcers has reduced with 70% of the Trust reporting zero avoidable pressure ulcers at the end of December, the regional Ambition (zero avoidable pressure ulcers) was to achieve 100% by December. None of the other Trusts in the region have achieved this to date..
- ***Recognising the deteriorating patient***: The % of late observations has increased to 16%, more training using the new devices is taking place and the league tables are being circulated.
- ***Hand Hygiene***: Five moments reporting demonstrates sustained high levels of practice except in orthopaedics. Quarter 3 standards for Hand hygiene and environmental standards are sustained
- ***Safe staffing:*** Division 1 have reported 50 staffing breaches in December due to increased acuity and dependency levels particularly in Trauma and Orthopaedics

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

Division 1

Patient Experience: There has been an improvement in overall patient experience with a reduction in numbers and seriousness of complaints received for the division or accepted by the Ombudsman. However December saw a reduction in patients answering two of the tracker questions in obstetrics and gynaecology. Plans are now in place to include the MLU in the tracker responses to ensure we capture all the positivity from this area.

Patient Safety: The numbers of falls has increased marginally in the Division by 0.5% per 1000 bed days of note these have been traced to BSS and Gynaecology due to the number of medical outlying patients. There have been improvements in infection prevention notably C.Difficile. The percentage of late observations remain high however the numbers are stabilising and some improvement is noted in some areas.

Patient Outcomes: The length of stay in non-elective patients has increased in December, of note in T&O. Clinical correspondence turnaround within 48 hours has deteriorated apart from in the diagnostics group and this is because of the increased activity which has generated more work and the issues with reduced clerical support due to leave and sickness.

Division 2

Patient Experience: The number of complaints referred to the PHSO has reduced however the number of serious complaints increased in December (Elderly care, respiratory/gastro and emergency services).The % of patients who were interviewed using the tracker expressed positive comments about care and compassion and being involved with their care.

Patient Safety: There was 1 red incident involving a sudden death, the patient was found on the floor however the fall did not cause the death, the incident was investigated fully. There has been a reduction in numbers of falls however the number of falls causing serious injury increased (4).

Patient outcomes: Clinical correspondence turnaround within 48 hours is deteriorating apart from in renal and diabetes group***.*** This is because of the same reasons as above.

THE ROYAL WOLVERHAMPTON NHS TRUST	
Report to:	Quality & Safety Report
Date:	22 January 2013
Subject:	Quality & Safety Report
Report by:	Deputy Chief Nursing Officer
Author:	Deputy Chief Nursing Officer
Purpose of Report	To provide the Quality & Safety Committee with information regarding performance and progress with Trust quality and safety.

Report

Review Committee Approval
Quality & Safety Committee to approve

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

Contents

1 Trust Safety & Quality Overview

1.1 Incident rate
1.2 Safeguarding Adults Incidents
1.3 Radiation Incidents
1.4 Net Promoter
1.5 Safety Thermometer

2 Preventing Harm, Improving Safety Measures

2.1 Mortality (HSMR)
2.2 Patient Falls
Number of inpatient falls
Number of falls resulting in serious injury
2.3 Pressure Ulcers by Grade
2.4 Recognition of the Deteriorating Patient
% late observations
Number of cardiac arrests
2.5 Healthcare Acquired Infections (HCAIs)
3.5.1 Clostridium Difficile – hospital Acquired for ages > 2
3.5.2 MSSA Bacteraemia
3.5.3 Device Related Hospital Acquired Bacteraemias
2.6 Venous Thrombo Embolism
% inpatient VTE risk assessment completed on admission
Number of hospital acquired VTE

3 Patient Safety and Quality (other)

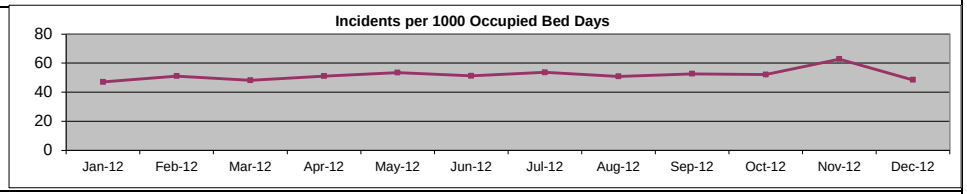
3.1 Hand Hygiene Practice
3.2 Environmental standards
3.3 Nursing & Midwifery staffing levels
3.4 Medication Incidents
3.5 Nutritional assessment

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.

	Oct-12	Nov-12	Dec-12
Div 1	440	458	454
Div2	760	827	599
Total	1200	1285	1053
Per 1000obd	52.1	62.8	48.5



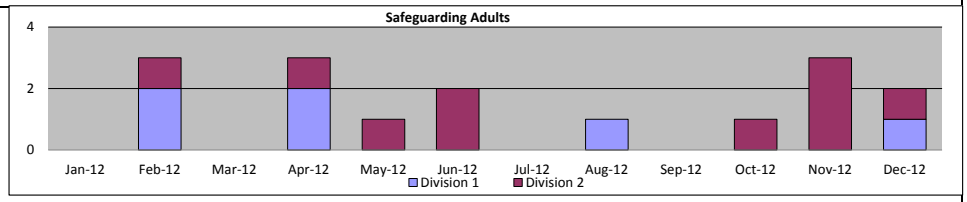
Analysis: The number of incidents reported during December has decreased by 18% from the previous month, as well as the incident rate (per 1000 occupied bed days). The majority of incidents are reported by nursing and midwifery staff and the largest category of incidents is patient falls (further information on patient falls in section 3.2).

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

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	Oct-12	Nov-12	Dec-12
Div 1	0	0	1
Div2	1	3	1
Total	1	3	2



Analysis: 1 referral against A&E
1 referral against D1/D3

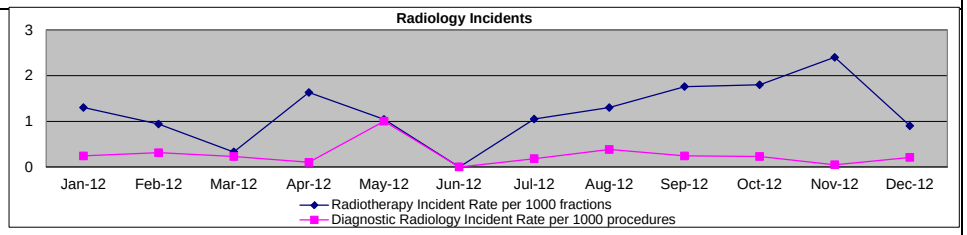
Action: To continue with investigation and update findings through Safeguarding Board

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	Oct-12	Nov-12	Dec-12
Radiotherapy	5	7	2
Diagnostic Radiology	5	1	4
Nuclear Medicine	0	0	0
Laser/Non-ionising	0	0	0

Rates	Oct-12	Nov-12	Dec-12
Radiotherapy Incident Rate per 1000 fractions	1.8	2.4	0.9
Diagnostic Radiology Incident Rate per 1000 procedures	0.23	0.047	0.21



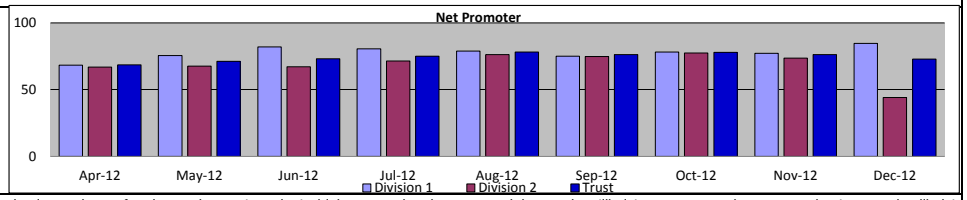
Analysis:
Nuclear medicine and laser/non-ionising radiation continue at zero reportable incidents for Dec.

Actions:

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.

	Oct-12	Nov-12	Dec-12
Div 1	78.2	77.1	84.46
Div2	77.5	73.5	44.02
Trust	77.9	76.25	72.78



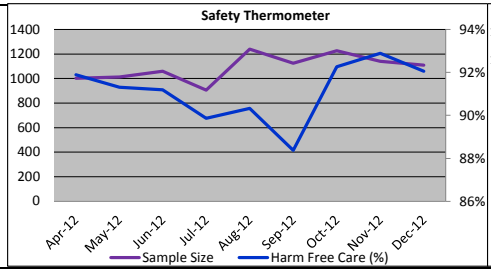
Analysis: The Trust wide Net Promoter score is 72.78. Division 2 is lower than normal because of the rise in numbers of patients who are 'passive' which means they have scored the ward as 'likely' to recommend as opposed to 'extremeley likely'. This is a shortfall in the methodology of the tool however a number of wards that do not routinely submit cards (wards D17 - 22) could improve the results of the division overall if they provided data because traditionally these wards have had very positive responses.

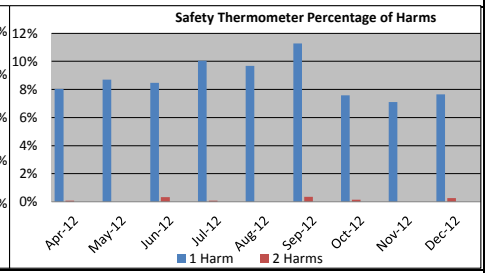
Action: A&E have started to survey in advance of April 2013. Each ward receives their ward results weekly.

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.

	Oct-12	Nov-12	Dec-12
Target	95%	95%	95%
Trust result	92.26%	92.89%	92.06%
Sample Size	1227	1140	1109





Analysis: Sample size for the December submission has fallen due to no data being submitted by two wards - This data can be submitted retrospectively if it is sent in after the deadline. The percentage of harm free care remains above 92%. Our ambition is to achieve 95% harm free care across the organisation.

Actions: To consistently work with wards to ensure timely submission and teach wards to use the additional 22 computers on whels 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	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	99.8	96.96	96.1
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%	3.40%	3.40%	3.60%
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%	3.70%
No of In Hospital Deaths	116	96	111	96	93	139	129	126	117	1023	115	121	121	103	105	96	661
Expected Deaths	120	107	114	114	110	132	130	140	129	1096	129	120.1	114.3	119.5	105.2	99.4	687.8
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**	**0**	**-3**	**-27**

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	520	109	99.0	21.5%
Acute cerebrovascular disease	469	73	113.2	18.9%
Congestive heart failure, nonhypertensive	**281**	**54**	**136.2**	**19.5%**
Acute myocardial infarction	623	36	91.9	5.8%
Septicemia (except in labour)	118	31	109.9	26.7%
Aspiration pneumonitis, food/vomitus	59	31	142.8	52.5%

Alert Status

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

Associated Indicators of Mortality

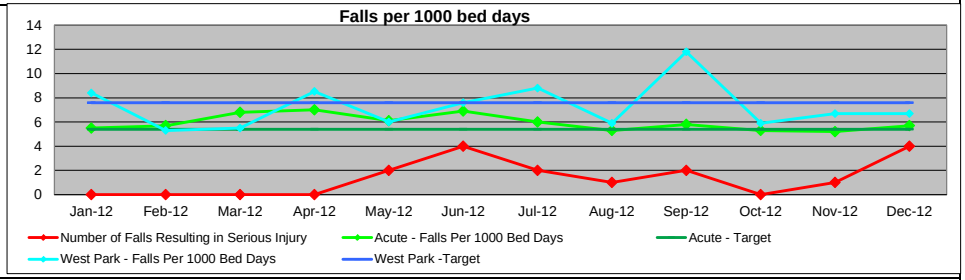
Indicator	Period	Actual	RAG	TREND
Charlson Codes Per Spell (HED)	Apr-March12	5.56		➲
Palliative Care Deaths Per 1000 Discharges (HED)	Apr-August 12	24	NHS England average is 24	
% Palliative Care Deaths	Apr 10-March 12	20%	NHS England range for large acute Trusts is 0-40%	
Expected Death Rate	Apr-August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

	Sep-12	Oct-12	Nov-12	Dec-12
Acute - Target per occupied bed days	<5.4	<5.4	<5.4	<5.4
Acute - Number of falls per occupied bed	5.8	5.3	**5.2**	**5.7**
West Park- Target per occupied bed days	7.6	7.6	7.6	7.6
West Park - Number of falls per occupied bed	11.8	5.9	**6.7**	**6.7**
Number of falls resulting in serious injury	2	0	1	4



Analysis: There were four falls causing harm during December: 2 on C22 (D22), 1 on C9 (D3) and 1 on A7 (D7). The number of falls in acute has increased marginally by 0.5% per 1000 bed days and this is tracked to gynaecology and BSSD due to numbers of outlying medical patients.

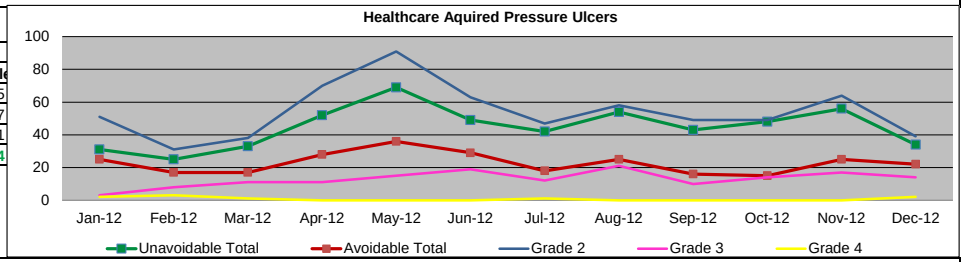
Actions: .The two falls on C22 (D22) were caused by patients mobilising on their own in the bays whilst nurses were managing C.Difficile with another patient. All RCAs are scrutinised at the CEO's accountability meeting and discussed at the Falls Strategy Group

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)

	Oct-12		Nov-12		Dec-12	
	Avoidable	Unavoidable	Avoidable	Unavoidable	Avoidable	Unavoidable
Grade 2	13	36	20	44	14	25
Grade 3	2	12	5	12	7	7
Grade 4	0	0	0	0	1	1
Total	15	48	25	56	22	34



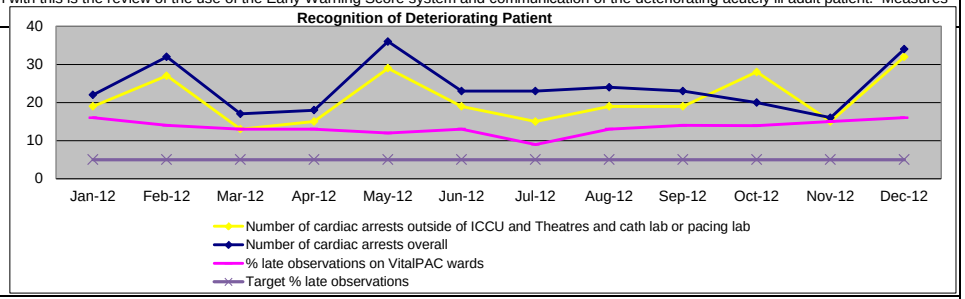
Analysis: The number of acquired unavoidable and avoidable pressure ulcers has fallen in December, most significantly in the number of unavoidable pressure ulcers reported. 70% of the Trust's wards achieved zero avoidable pressure ulcers by the end of the month of December so achieving the SHA's Pressure Ulcer Ambition.

Actions: To focus education and support on ward areas that have not achieved the ambition 1. Emergency portals TVN to start in post January 2013 to proactively prevent pressure ulxcers from admission community services are using the safety cross as an early identification process. community equipment service level agreement being reviewed.

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.

	Oct-12	Nov-12	Dec-12
Number cardiac arrests	28	16	34
% observations late	13.90%	15.00%	16.00%
Target (late observations)	5%	5%	5%



Analysis: The number of late observations is increasing to 16% . The new Apple Ipod Touch devices are on order and awaiting installation, this was due to start in December however due to difficulties in procurement and delivery this date has slipped to January start. We will roll out across the Trust as rapidly as possible undertaking 4 wards at a time. Open events for staff have taken place in December showing staff how to use the new devices.

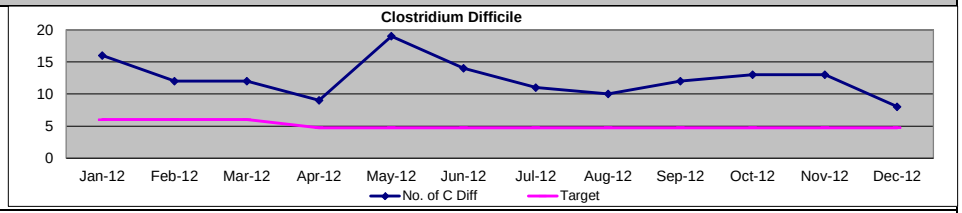
Actions: To consider the results of the NCEPOD Cardiac Arrest report discuss recommendations at resuscitation Committee

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

	Oct-12	Nov-12	Dec-12
Number of C Diff	13	13	8
Cum Plan	63	72	81
Cum Actual	88	101	109
Cum Variance	25	29	28

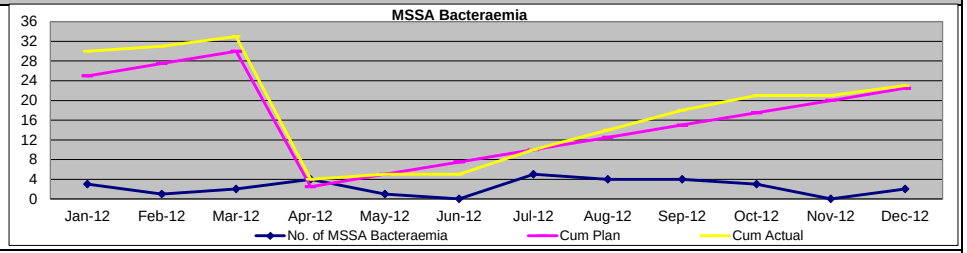


Analysis: The internal target is based on PCR results. The external target is based on Toxin EIA results. In November we reported 2 against the external target (which is 4.75 per month) for New Cross and 0 for West Park (target 1 per month). This takes our total for the year to 30 (target 38) excluding West Park and 33 (target 46) including West Park.

Actions: C diff ward rounds and review of all new patients on same day as diagnosis continues. All in-patients are reviewed daily by an Infection Prevention Nurse. 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. Review of C diff mortality being undertaken.

2.5.2 MSSA Bacteraemia

	Oct-12	Nov-12	Dec-12
No. of MSSA Bacteraemia	3	0	2
Cum Plan no. Cases as target	17.5	20	22.5
Cum Actual no. of cases to date	21	21	23
Cum Variance of actual versus pla	3.5	1	0.5



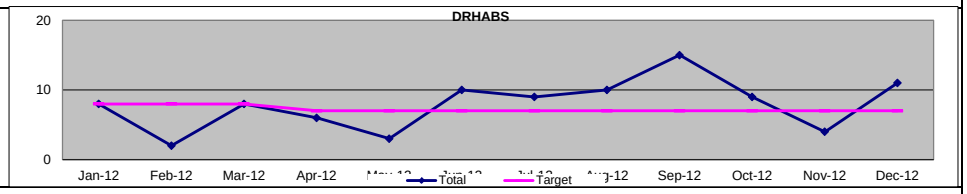
Analysis: Two RWHT-attributable cases. One was a contaminant - the first Staph aureus to be taken by a phlebotomist in the four years since this service started. The other was a DRHAB related to a urinary catheter.

Actions: For DRHAB: Urinary Catheter Working Group active. Feedback to phlebotomists about contaminants.

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.

	Oct-12	Nov-12	Dec-12
Target (monthly)	7	7	7
DRHABS	9	4	11

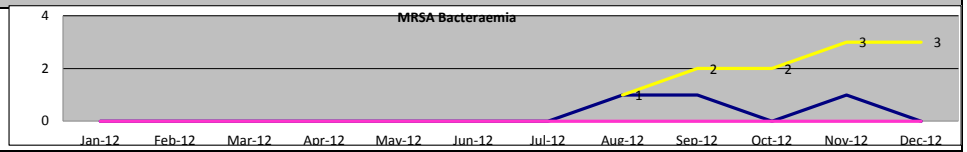


Analysis: 9 line related, 2 urinary catheter related

Actions: For lines : IV team now operational.

2.5.4 MRSA Bacteraemia

	Oct-12	Nov-12	Dec-12
No. of MRSA Bacteraemia	0	1	0
Cum Plan	0	0	0
Cum Actual	2	3	3
Cum Variance	2	3	3



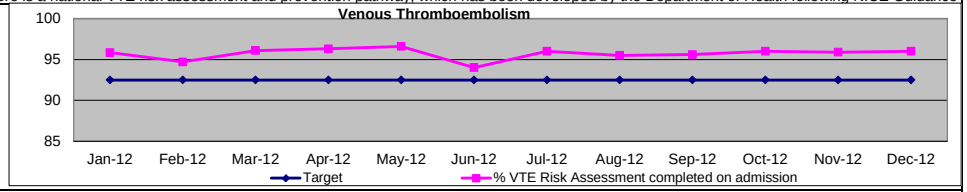
Analysis: August and November cases not attributable to RWHT according to external definition of attribution. Two pre-48-hour cases in December.September case attributable to RWHT by internal and external definitions of attribution.

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

	Oct-12	Nov-12	Dec-12
% adult patients with completed	96%	96%	96%
Number of patients with hospital	14	15	12
Number of patients identified in	14	26	17



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.

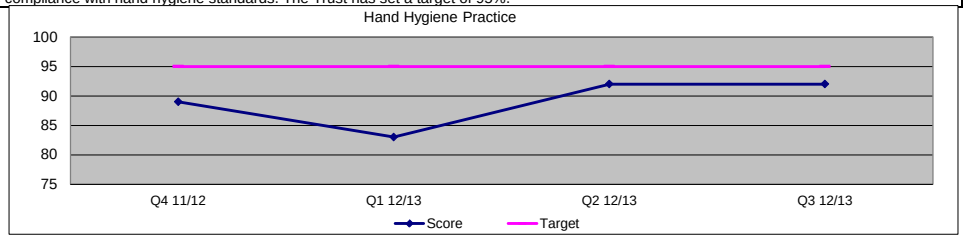
Actions: To consider how to report reassessment of VTE on vitalpac within 24 hour time frame.

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%**



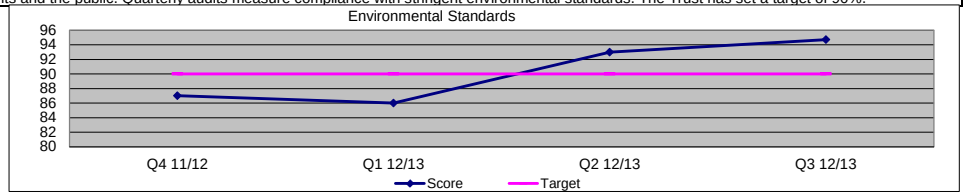
Analysis: There is an improving trend across both divisions with a continued focuis on monthly reporting of five moments

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%**



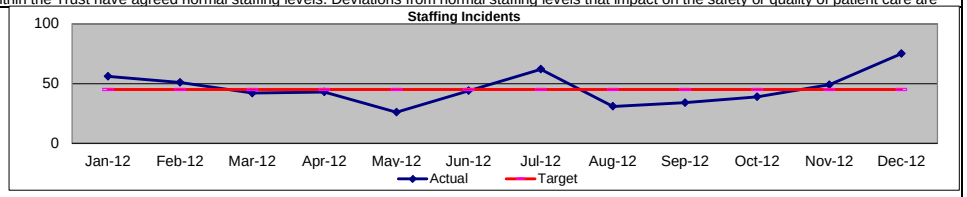
Analysis: There has been an improvement in the environment audits conducted by the Matrons

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

	Oct-12	Nov-12	Dec-12
Division 1	16	25	50
Division 2	23	24	25
Total	**39**	**49**	**75**
Target	**45**	**45**	**45**



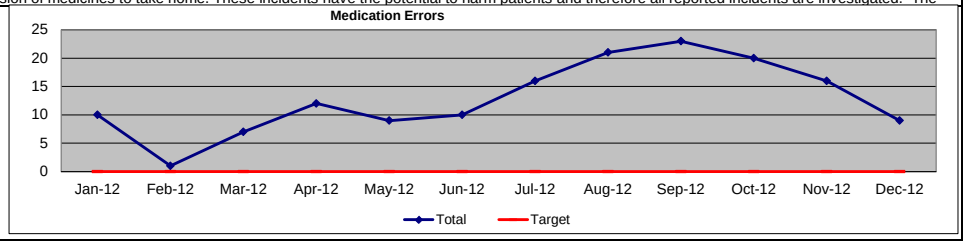
Analysis:, Division 1: 7 graded amber (2 gynae ward and 5 in A5 trauma & orthopaedics)- whereby unable to deliver required care for dependent patients and increasing concern that staffing levels are sub-optimal on a regular basis. .Div2: Figure remains similar to previous months

Action Dependnancy and acuity scoring concludinh on T&O this month following concerns about this, staff are now reporting incidnets

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

	Oct-12	Nov-12	Dec-12
Division 1	7	4	5
Division 2	14	12	4
Total	21	16	9
Target	**0**	**0**	**0**



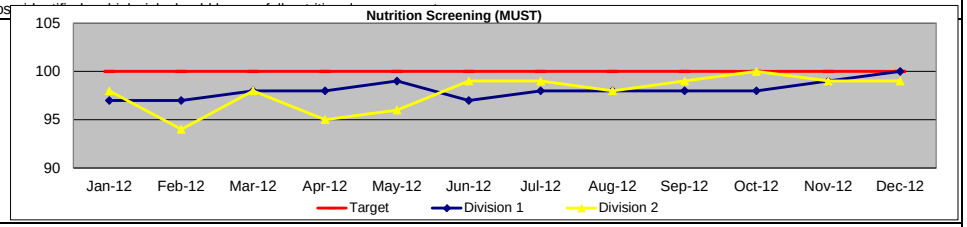
Analysis: Following discussion with the Director of Pharmacy, there appers to be low reporting of medication incidents and at the last QSC discussion was had about a single report that brings together all medication incidents by staff:medical, nursing and pharmaceutical. This will be discussed at MMC. The processes for management of all errors and subsequent actions with staff and patients is in place, this is evdicned well in community services however is not

Actions: Medication incidents to be raised at MMC.

3.5 Nutrition

MUST is a nutritional screening tool. All adult patients should undergo nutrition risk screening and thos

% adult inpatients with completed MUST	Oct-12	Nov-12	Dec-12
Division 1	98%	99%	100%
Division 2	100%	99%	99%
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
November 2012

	General Surgery	Urology	Cardiac	Critical care	Orthopaedic	Gynaecology	Head and Neck	Ophthalmology	Maternity
Division One	95% ↔	100% ↔	100% ↔	100% ↑	76% ↔	100% ↑	90% ↓	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	100% ↑	100% ↔	100% ↔	100% ↑	100% ↑	98% ↑	99% ↑	96% ↑	97% ↑	100% ↑

Green	≥ 90%
Amber	70-89%
Red	<70%

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

Patient Experience	This Month	Last Month	Trend
Patient Complaints as a percentage of activity	G	G	↔
Number of complaints accepted for investigation by Ombudsmen	G	R	↑
Number of serious complaints received	G	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?	G	G	↔
Percentage of patients who rated overall satisfaction good/excellent	A	G	↓
Percentage of patients who answered "yes" to being treated with care and compassion	A	G	↓
Number of cancelled/rescheduled outpatient appointments	A	G	↔
Cancelled operations as a percentage of elective admissions	R	R	↔
Overall Rating	A		↑

Patient Safety	This Month	Last Month	Trend
Number of red incidents	G	G	↔
Number of healthcare/inpatient falls	R	A	↓
Number of healthcare/inpatient falls - resulting in serious injury	R	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	R	↑
Device related bacteraemias	A	G	↓
Percentage of VitalPAC VTE risk assessments on admitting ward		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	A	↔
Percentage of emergency re-admissions within 30 days	G	G	↔
Delayed discharges	G	G	↔
18 week RTT - admitted	G	G	↔
18 week RTT - non-admitted	G	G	↔
Clinical correspondence turnaround within 48 hours	R	R	↑
Overall Rating	R		↓

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

Trust Dashboard: December 2012

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	Sharon Reilly	0	<0.1%	↑	0	0	→	<0.1%	<0.1%	→	0	<0.1%	↑	0	<0.1%	↑	0	<0.1%	↑	<0.1%	<0.1%	→
Number of complaints accepted for investigation by the Ombudsman	0	0 = Green, else Red	Sharon Reilly	0	0	→	0	0	→	0	0	→	0	1	↑	0	1	↑	0	0	→	0	0	→
Number of serious complaints received	0	0 = Green, else Red	Sharon Reilly	0	0	→	0	0	→	0	1	↑	0	2	↑	0	0	→	0	0	→	1	0	↓
Percentage of complaints responded to within 25 working days (or with consent to breach)	90%	>/= 90% = Green, else Red	Sharon Reilly																					
% of people responding "yes" to the question - Are you being involved as much as you want to be in decisions about your care and treatment?	95%	>95% = Green, 85-95% = Amber, <85% = Red	Sharon Reilly							100%	95%	↑	100%	95%	↑	72%	100%		92%	89%	↑	100%	100%	
Percentage patients who rated overall satisfaction good/excellent	95%	>95% = Green, 85-95% = Amber, <85% = Red	Sharon Reilly							100%	90%	↑	96%	95%	↑	100%	100%	→	78%	94%	↓	100%	92%	
Percentage of patients who answered "yes" to being treated with care and compassion	95%	>95% = Green, 85-95% = Amber, <85% = Red	Sharon Reilly							100%	95%	↑	100%	98%	↑	100%	100%	→	83%	100%	↓	100%	100%	
Number of cancelled/rescheduled outpatient appointments	–	Reduction of 40% in year	Lesley Taff							11	37	↑	221	182	↓	143	133	↓	22	12	↓	209	400	↑
Cancelled operations as a percentage of elective admissions	0.8%	< 0.8% = Green, else Red	Lesley Taff							18.08%	10.60%	↓	3.62%	3.35%	↓	6.59%	2.73%	↓	2.35%	2.65%	↑	1.91%	1.49%	↓
Patient Safety																								
Number of red incidents	0	0 = Green, else Red	Sukhy Khunkhuna	0	0	→	0	0	→	0	0	→	0	0	→	0	0	→	0	0	→	0	0	→
Number of healthcare/inpatient falls *RAG= tolerance multiplied by the number of inpatient wards	0	Ward specific	Sukhy Khunkhuna	0	0	→	3	2	↓	4	7	↑	17	8	↓	7	7	→	3	0	↓	3	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	→	1	0	↓	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	→	3	0	↓	2	1	↓	1	3	↑	2	4	↑	0	0	→	1	0	↓
Percentage inpatient MUST assessments completed within 6 hours of admission	100%	100% = Green, 75-99% = Amber, <75% Red	Rose Baker Zena Young				100%	100%	→	100%	100%	→	100%	99%	↑	100%	100%	→	100%	100%	→	100%	100%	→
MSSA bacteraemia	–	<2 = Green, 2-3 = Amber, >3 = Red	Mike Cooper	0	0	→	0	0	→	0	0	→	1	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	↑	1	1	→	0	3	↑	0	0	→	1	0	↓	0	0	→
Device related bacteraemias	–	Green = 0,Amber = 1,Red = >1	Mike Cooper	0	0	→				1	0	↓	2	0	↓	0	1	↑	0	0	→	0	0	→
Device related bacteraemias (Haem/Onc, ICCU, Renal, Neonates)	–	Green = 0,Amber = 1- 2 Red = >2	Mike Cooper				1	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%			96.62%			88.60%			87.07%			86.67%			96.57%			96.61%	
Percentage of late observations (VitalPAC wards only)	5%	<5% = Green, 5-10% = Amber, >10% = Red					5.30%	4.50%	↓	17.4%	19.7%	↑	15.2%	15.4%	→	23.5%	21.5%	↓	11.0%	8.70%	↓	14.0%	21.0%	↑
Patient Outcomes																								
Length of stay (elective)	specific	Specific	Lesley Taff							4.76	4.76	→	2.79	2.74	↓	2.9	3.0	↑	2.5	2.4	↓	1.63	1.66	↑
Length of stay (non elective)	specific	Specific	Lesley Taff							7.69	7.54	↓	3.51	3.61	↑	7.1	6.6	↓	1.0	1.1	↑	1.93	2.22	↑
Percentage of emergency readmissions within 30 days	4.19%	<4.19% = Green, 4.2-5% = Amber, >5%= Red	Lesley Taff							2.25%	1.84%	↓	1.65%	1.54%	↓	0.82%	0.00%	↓	1.41%	1.32%	↑	0.38%	0.59%	↑
Delayed discharges			Lesley Taff	0.0%	0.0%	→	0.0%	0.0%	→	0.0%	0.0%	→	1.0%	1.0%	→	1.5%	1.0%	↓	0.0%	0.0%	→	0.0%	0.0%	→
18 week RTT - admitted	90%	90% = Green, else Red	Lesley Taff							91.67%	94.97%	↓	93.02%	92.91%	↑	90.16%	90.14%	↑	90.91%	90.40%	↑	91.89%	92.47%	↓
18 week RTT - non-admitted	95%	95% = Green, else Red	Lesley Taff							95.02%	96.89%	↓	96.91%	96.04%	↑	95.02%	95.14%	↓	95.25%	96.40%	↓	97.82%	98.24%	↓
Clinical correspondence turnaround within 48 hours	100%	100% = Green, 75-99% = Amber, else Red	Lesley Taff	94.9%	91.9%	↑				49.8%	70.0%	↓	44.5%	66.6%	↓	50.2%	61.5%	↓	77.3%	93.1%	↓	50.8%	60.2%	↓
Support Services																								
Sickness absence	<3.74%	<3.74% = G, 3.74 - 6% = Amber, >6% = Red	Lesley Taff	1.72%	1.99%	↑	5.36%	4.26%	↓	3.44%	2.75%	↓	4.98%	3.98%	↓	6.45%	5.53%	↓	5.03%	4.35%	↓	3.43%	3.06%	↓
Percentage of staff who have undergone annual appraisal	80%	>/=80% = Green, 70-79% = Amber, <70% = Red	Lesley Taff	91.7%	93.9%	↓	87.9%	86.6%	↑	82.1%	83.2%	↓	77.7%	85.0%	↓	67.5%	66.4%	↑	90.9%	93.6%	↓	86.3%	86.6%	↓
Percentage of trained nursing vacancies per funded establishment	2%	</=2% funded est = G, 2%-5% = A, else Red	Lesley Taff	0.00%	0.00%	→	1.01%	1.01%	→	0.89%	-0.30%	↓	0.04%	1.06%	↑	4.83%	1.43%	↓	3.24%	2.21%	↓	0.57%	0.33%	↓
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%	0.85%	↑	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							£(135) k	£(110) k	↓	£(169) k	£(154) k	↓	£(146) k	£(139)k	↓	£(45) k	£(55) k	↑	£25 k	£20 k	↑
WTE budgeted against actual (ward WTE only)	In balance	variance < 5% = Green variance 5-10% = Amber variance >10% = Red	Alison Reynolds							(3.81) %	(0.27) %	↓	(0.47) %	0.42%	↓	(5.59) %	(10.81) %	↑	9.01 %	6.79%	↑	(2.55) %	(9.65) %	↑

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
January 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)
Indicator tolerance:	Target = 0.8% Red = >0.8%	Target = 5% Red = >10%	Specific
Period of alert: (i.e. Jun, Jul, Aug 2011)	October, November, December 2012	October, November, December 2012	October, November, December 2012
Actions: Please identify where completed or a timescale for completion and who by	Any potential cancellations are discussed with CD, Matron and/or DM. Due to the nature of cardiac surgery, occasionally elective cases have to be cancelled for a non-elective patient. If cancellations are due to other issues 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.	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 On-going	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?
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.	

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
January2013

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)
Indicator tolerance:	Target = 5% Red = >10%	Target = 100% Red = < 75%	0 = Green, else Red
Period of alert:	October, November, December 2012	October, November, December 2012	October, November, December 2012
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 surgery become part of the early wave of the role out programme.***	The biggest issues relates to Colorectal. Non-pay monies currently being used to fund outsourcing to Dict8 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 avidable/ unavoidable pressure ulcers, Full review of documentation and individual staff accountability meetings filtered to ward manager level.
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 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
January 2013

Report from: Directorate/Group	Obstetrics & Gynaecology
Report prepared by: Name, Job Title	Helen Read, Directorate Manager Robin Day, 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)	October, November, December 2012
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
January 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
Indicator tolerance:	<5% = Green, 5-10% = Amber, >10% = Red
Period of alert: (i.e. Jun, Jul, Aug 2011)	October, November, December 2012
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.
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
January 2013

Report from: Directorate/Group	Orthopaedics
Report prepared by: Name, Job Title	Helen Read, Directorate Manager Robin Day, 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:	October, November, December 2012	October, November, December 2012	October, November, December 2012	October, November, December 2012
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 cancelled due to pressure on beds in Trust.
Assurance/Monitoring: Please identify monitoring arrangements in place to sustain improvements	Ward Manager/Matron rounds and monitoring of standards on the wards.	Weekly turnaround figures scrutinised by DM. Work up-to-date as of 17 January 2013.	Matron and Ward Manager rounds and checks on documentation. Accountability meetings taking place a ward level with ward manager.	Every opportunity taken to increase throughput.

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
January 2013

Report from: Directorate/Group	Theatres/ICCU
Report prepared by: Name, Job Title	Directorate Manager

Description of indicator:	No of falls in health care
Indicator tolerance:	Target = 0 Red = 1 or more
Period of alert:	October, November, December 2012
Actions: Please identify where completed or a timescale for completion and who by	Nevember 2012. - ICCU x1, patient helped to the floor, no injury, no RCA required. Beynon Sort Stay Ward, patient stumbled back, no injury sustained, No RCA required. December 2013 – Beynon Short Stay, Medical patient, 0 did 0not sustain any injury, 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 - December 2012 data

Patient Experience	This Month	Last Month	Trend
Patient Complaints as a percentage of activity	G	G	↔
Number of complaints accepted for investigation by Ombudsmen	G	R	↑
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	R	↑
Percentage of patients who rated overall satisfaction good/excellent	A	A	↔
Percentage of patients who answered "yes" to being treated with care and compassion	G	G	↑
Number of cancelled/rescheduled outpatient appointments	G	A	↑
Overall Rating	A		↑

Patient Safety	This Month	Last Month	Trend
Number of red incidents	A	G	↓
Number of healthcare/inpatient falls	A	R	↑
Number of healthcare/inpatient falls - resulting in serious injury	R	A	↓
Number of healthcare acquired avoidable pressure ulcers acquired/deteriorated	R	R	↔
Percentage of inpatient MUST assessments completed within 24 hours of admission	G	A	↑
MSSA Bacteraemia	G	G	↔
Clostridium Difficile - hospital acquired for ages >2 years	A	A	↔
Device related bacteraemias	G	G	↔
Percentage of VitalPAC VTE risk assessments on admitting ward		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	G	G	↔
Delayed discharges	G	G	↔
18 week RTT - admitted	G	G	↔
18 week RTT - non-admitted	G	G	↔
Clinical correspondence turnaround within 48 hours	R	R	↔
Overall Rating	R		↔

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

Trust Dashboard: December 2012

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%	<0.1%	→	0	<0.1%	↑	<0.1%	0	↓	0	nil	→	<0.1%	0	↓	<0.1%	<0.1%	→	<0.1%	nil	↓	<0.1%	<0.1%	→	0	nil	→	<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	1	↑	0	0	→	0	0	→	0	0	→	0	1	↑	0	0	→	0	0	→
Number of serious complaints received	0	0 = Green, else Red	Jamie Emery	0	0	→	0	0	→	1	0	↓	0	2	↑	0	0	→	0	0	→	1	0	↓	1	0	↓	0	0	→	0	0	→
Percentage of complaints responded to within 25 working days (or with consent to breach)	90%	>/= 90% = Green, else Red	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%	76%	↑	N/A	N/A					81%	84%	↓	100%	94%	↑	100%	98%	↑				100%	88%	↑
Percentage patients who rated overall satisfaction good/excellent	95%	>95% = Green, 85-95% = Amber, <85%	Jamie Emery							92%	90%	↑	N/A	N/A					84%	86%	↓	100%	90%	↑	100%	90%	↑				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%	97%	↑	N/A	N/A					94%	94%	→	100%	94%	↑	100%	98%	↑				100%	100%	↑
Number of cancelled/rescheduled outpatient appointments	–	Reduction of 40% in year	Lesley Taff	104	75	↓	N/A	N/A		6	0	↓	N/A	N/A		230	329	↑	53	40	↓	98	130	↑				0	0	→	3	214	↑
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	0	↓	0	0	→	0	0	→	0	0	→
Number of healthcare/inpatient falls *RAG= tolerance multiplied by the number of inpatient wards	0	Ward specific	Sukhy Khunkhuna	0	0	→	0	2	↑	37	38	↑	17	17	→	1	0	↓	4	7	↑	22	18	↓	14	15	↑	2	1	↓	5	0	↓
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	→	2	1	↓	0	0	→	0	0	→	0	0	→	0	0	→	1	0	↓	0	0	→	0	0	→
Number of healthcare acquired avoidable pressure ulcers acquired/deteriorated (Grade 2, 3 & 4)	0	0 = Green, else Red	Julie Evans	0	0	→	3	7	↑	1	1	→	2	1	↓	0	0	→	1	2	↑	6	3	↓	1	1	→	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							91	97	↓	100	100	→				100	100	→	100	100	→	96	98	↓				100	100	→
MSSA bacteraemia	–	<2 = Green, 2-3 = Amber, >3 = Red	Mike Cooper	0	0	→	0	0	→	0	0	→	0	0	→	0	0	→	0	0	→	0	0	→	0	0	→				0	0	→
Clostridium Difficile - hospital acquired for ages >2 years	–	Green = 0,Amber = 1-2,	Mike Cooper	0	1	↑	0	0	→	1	1	→	1	0	↓	0	0	→	0	1	↑	3	0	↓	0	0	→				1	2	↑
Device related bacteraemias	–	Green = 0,Amber = 1,Red = >1	Mike Cooper	0	1	↑	0	0	→	0	1	↑	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	0	→													1	1	→										5	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								100.00%		N/A	N/A			98.2%			99.96%			90.00%			92.59%						95.73%	
Percentage of late observations (VitalPAC wards only)	5%	<5% = Green, 5-10% = Amber, >10% =	Lisa Miller							26.9%	21.0%	↓							11.3%	15.0%	↑	15.4%	11.6%	↓	16.0%	16.0%	→				10.30%	10.30%	→
Patient Outcomes																																
Length of stay (elective)	specific	Specific	Lesley Taff	1.8	1.7	↓										1.3	1.3	→	0.5	0.5	→	4.6	4.7	↑							3.17	3.94	↑
Length of stay (non elective)	specific	Specific	Lesley Taff	0.7	0.7	→										1.73	1.68	↓	2.0	2.2	↑	3.5	3.5	→							4.62	5.43	↑
Percentage of emergency readmissions within 30 days	4.19%	<4.19% = Green, 4.2-5% = Amber, >5%=	Lesley Taff	2.89%	0.00%	↓				0.00%	0.00%	→	0.0%	0.0%	→	0.0%	0.0%	→	0.0%	0.0%	→	0.00%	1.25%	↑	0.0%	0.0%	→				0.18%	0.00%	↓
Delayed discharges			Lesley Taff	0.0%	0.0%	→				1.5%	2.0%	↑	0.0%	1.0%	↑	0.0%	0.0%	→	0.0%	0.0%	→	1.0%	0.5%	↓	0.0%	0.0%	→				0.5%	1.0%	↑
18 week RTT - admitted	90%	90% = Green, else Red	Lesley Taff													100%	100%	→	100%	100%	→	100.00%	96.83%	↑				100%	100%	→	100.0%	100.00%	→
18 week RTT - non-admitted	95%	95% = Green, else Red	Lesley Taff	98.62%	99.55%	↓	100%	100%	→	97.67%	100.00%	↓				98.0%	98.5%	↓	99.30%	98.56%	↑	96.05%	96.40%	↓				100%	100%	→	97.30%	100.00%	↓
Clinical correspondence turnaround within 48 hours	100%	100% = Green, 75-99% = Amber, else	Lesley Taff	76.2%	81.6%	↓	N/A	N/A		95.1%	100.0%	↓	N/A	N/A		58.8%	62.4%	↓	94.4%	53.9%	↑	72.3%	96.1%	↓	35.7%	70.5%	↓				80.2%	99.2%	↓
Support Services																																
Sickness absence	<3.74%	<3.74% = G, 3.74 - 6% = Amber, >6% =	Lesley Taff	4.92%	4.53%	↓	7.39%	6.62%	↓	4.67%	4.96%	↑	4.74%	6.26%	↑	3.73%	1.89%	↓	1.39%	4.58%	↑	4.12%	3.05%	↓	4.21%	6.25%	↑	3.81%	4.19%	↑	4.20%	4.09%	↓
Percentage of staff who have undergone annual appraisal	80%	>/=80% = Green, 70-79% = Amber, <70%	Lesley Taff	93.7%	92.2%	↑	90.6%	92.4%	↓	80.6%	84.9%	↓	91.5%	87.9%	↑	90.9%	90.6%	↑	81.0%	84.0%	↓	84.4%	91.1%	↓	75.7%	72.9%	↑	87.7%	77.1%	↑	86.1%	86.3%	↓
Percentage of trained nursing vacancies per funded establishment	2%	</=2% funded est = G, 2%-5% = A, else	Lesley Taff	3.00%	0.29%	↓	3.77%	0.94%	↓	0.18%	1.35%	↑	1.17%	0.44%	↓	1.95%	1.3%	↓	1.50%	-1.08%	↓	1.14%	0.19%	↓	1.45%	0.69%	↓	0.0%	0.0%	→	1.47%	0.00%	↓
Percentage of medical training grades vacancies per funded establishment	2%	</=2% funded est = G, 2%-5% = A, else	Lesley Taff	0.27%	0.27%	→	0.00%	0.00%	→	0.76%	0.00%	↓	0.00%	0.00%	→	0.00%	0.00%	→	0.00%	0.00%	→	0.94%	0.79%	↓	0.99%	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	£19 k	£35 k	↓	£(5) k	£(5) k	→	£(251) k	£(227) k	↓	£(41) k	£(32) k	↓				£(170) k	£(145) k	↓	£(98) k	£(94) k	↓	£(62) k	£(57) k	↓				£(118) k	£(109) k	↓
WTE budgeted against actual (ward WTE only)	In balance	variance < 5% = Green variance 5-10% = Amber	Alison Reynolds	1.53 %	5.19%	↓	100 %	100.00%	→	(4.53) %	30.47%	↓	(6.05) %	(4.93)%	↓				(15.03) %	2.72%	↓	2.43 %	9.03%	↓	1.51 %	3.69%	↓				(3.44) %	1.15%	↓

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
January 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
Indicator tolerance:	Target = 5% Red = > 10%	Target = 0
Period of alert: (i.e. Jun, Jul, Aug 2011)	October, November, December 2012	October, November, December 2012
Actions: Please identify where completed or a timescale for completion and who by	Awareness session held by Matron highlighting importance of recognition of deteriorating patients and triggers for EWS New hardware to be implemented on ward C22 and Trust wide staff training to improve compliance.	
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
January 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
Indicator tolerance:	Target = 5% Red = >10%
Period of alert: (i.e. Jun, Jul, Aug 2011)	October, November, December 2012
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
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 •

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
January 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)	October, November, December 2012	October, November, December 2012
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.	

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
January 2013

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

Description of indicator:	Number of healthcare acquired avoidable pressure ulcers acquired/deteriorated (Grades 2.3.4)
Indicator tolerance:	Target = 0 Red = >0
Period of alert: (i.e. Jun, Jul, Aug 2011)	October, November, December 2012
Actions: Please identify where completed or a timescale for completion and who by	Senior sisters meet on a monthly basis to share lessons learnt across the rehabilitation setting as the wards sit in different directorate through action learning . On-going Peer review of Pressure ulcer documentation on a monthly basis a through quality indicators On-going Additional training for community based team who work with social care givers Ccompleted 27th Nov 2012close liaison TVN service to assure consistency in assessment and escalation processes continue. Completed Nov 5th 2012
Assurance/Monitoring: Please identify monitoring arrangements in place to sustain improvements	Action plans from RCA's.are monitored through governance groups Nursing 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
January 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
Indicator tolerance:	<5% = Green, 5-10% = Amber, >10% = Red
Period of alert: (i.e. Jun, Jul, Aug 2011)	October, November, December 2012
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
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

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
January 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)	October, November, December 2012
Actions: Please identify where completed or a timescale for completion and who by	Datix ID: 95130. GREEN no harm October 2012. The patient slipped from a stool whilst showering and was not harmed. Whilst in the shower patient requested a stool to sit on and OT student gave the nearest but incorrect stool to use. Incident recorded, discussed / reflected upon. No Further actions
Assurance/Monitoring: Please identify monitoring arrangements in place to sustain improvements	First recorded incident of this type, All students are reminded not to use a perching stool in the shower.
Actions: Please identify where completed or a timescale for completion and who by	Datix ID 95637 GREEN no harm November 2012 Patient independently mobilising with crutches lost balance fell against a cabinet and slid to floor. Patient hoisted back into bed. No further actions
Assurance/Monitoring: Please identify monitoring arrangements in place to sustain improvements	Rare event, patient was independently mobile and momentarily lost balance.
Actions: Please identify where completed or a timescale for completion and who by	Datix ID 97108 GREEN no Harm December 2012 Outpatient slipped off chair whilst exercising (had performed same exercise / actions many times before)
Assurance/Monitoring: Please identify monitoring arrangements in place to sustain improvements	All staff are aware of ensuring patients are well taught with regard to exercise positions and equipment being used. Patients reminded at each attendance.
Actions: Please identify where completed or a timescale for completion and who by	Datix ID 97743 GREEN no Harm Patient was observed from a distance; patient lost her balance and lowered herself to the floor. Patient unharmed. No actions to take

Assurance/Monitoring: Please identify monitoring arrangements in place to sustain improvements	

The Royal Wolverhampton Hospitals NHS Trust

Formatted: Bottom: 1 cr

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
January 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	WTE budgeted against actual (ward WTE only)
Indicator tolerance:	Target = 0 Red = >0	variance < 5% = Green variance 5-10% = Amber variance >10% = Red
Period of alert: (i.e. Jun, Jul, Aug 2011)	October, November, December 2012	October, November, December 2012
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	• We have reviewed all our vacancies and where possible we have delayed recruitment and we have restricted bank unless absolutely necessary
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.	• It is expected that we will be in budgetary balance as of end Oct beginning Nov 12 this will be reported through performance meeting Nov 12 update 11.1.13 ACSG have been green for pay budget for quarter Q3

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
January 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
Indicator tolerance:	Specific	Target = 0 Red = >0
Period of alert: (i.e. Jun, Jul, Aug 2011)	October, November, December 2012	October, November, December 2012
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.
Assurance/Monitoring: Please identify monitoring arrangements in place to sustain improvements		Action Plan monitoring in place through local Governance routes.