THE ROYAL WOLVERHAMPTON HOSPITALS NHS TRUST

Report to:	Trust Board
Date:	27 February 2012
Subject:	Quality & Safety Report
Report by:	Chief Nursing Officer
Author:	Patient Safety Manager
Purpose of Report	To provide the Committee with information regarding performance and progress with Trust quality and safety.

Report

The report relates to December 2011 and includes progress of the Trust's campaign to prevent harm and improve patient safety in addition to an organisational overview of incidents, complaints, inquests, and claims. It also provides information on issues that fall outside of the campaign but contribute to the quality and safety agenda.

Review Committee Approval

Presented to the Quality & Safety Committee 7 February 2012

Recommendation(s)

The Board is asked to note the content of the report

Contents

1) EXECUTIVE SUMMARY

This report on Quality and Safety includes progress on the Campaign for Preventing Harm, Improving Safety. The report refers to the period December 2011.

Section 2 provides an overview of organisational quality and safety.

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

Section 4 reports on the patient experience.

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

The areas to note regarding progress are as follows:

- Two safeguarding adult incidents reported (allegations of poor care and poor pain relief)
- One radiation incident requiring external reporting to IRMER
- Eleven cases of C Diff (using our internal definition of attribution)
- Three complaints referred to the Ombudsman
- Increase in avoidable pressure ulcers compared to last month
- Slight decrease in percentage of VTE risk assessments

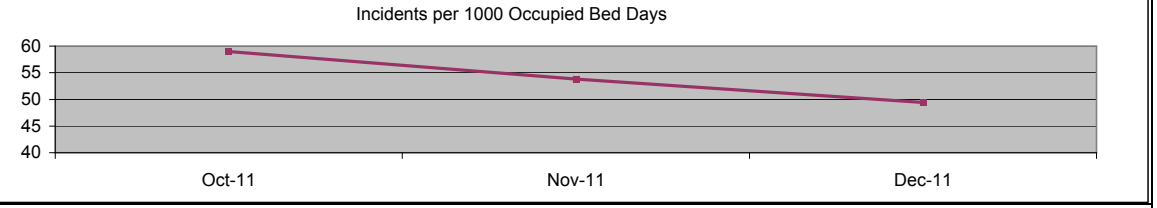
- No serious complaints this month
- Slight improvement in the percentage of late observations
- 96% complaints responded to within 25 working days (or with consent to extend deadline)
- 95% patients answered 'excellent' or 'good' to the question: Overall, how would you rate the care and attention you received?

2) TRUST SAFETY & QUALITY OVERVIEW

2.1 Incident Rate

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

	Oct-11	Nov-11	**Dec-11**
Div 1	381	399	327
Div2	790	678	741
Total	1171	1077	1068
Per 1000obd	59	53.8	49.4



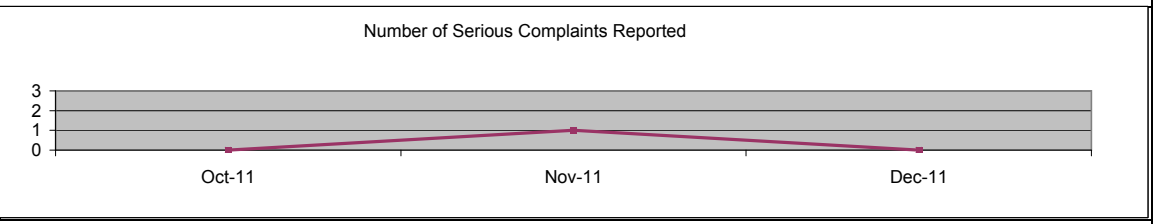
Analysis: The number of incidents reported during December has decreased by 0.8% from the previous month. The majority of incidents are reported by nursing and midwifery staff and the largest category of incidents is patient falls (further information on patient falls in section 3.2).

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

2.2 Serious Complaints

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

	Oct-11	Nov-11	**Dec-11**
Div 1	0	0	0
Div2	0	1	0
Corp	0	0	0
Total	0	1	0



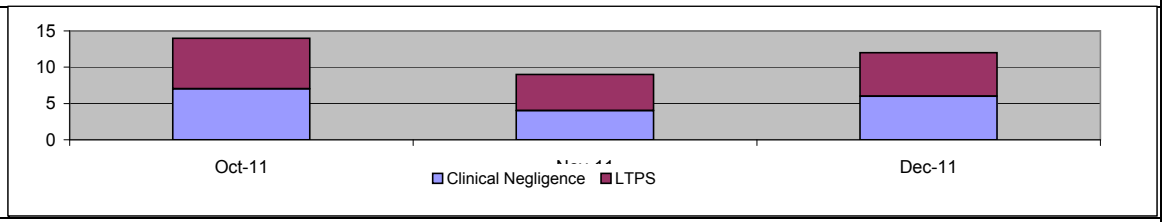
Analysis: There were no complaints graded red or amber for this reporting period.

Actions: No actions required.

2.3 New Litigation

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

	Oct-11	Nov-11	**Dec-11**
Clinical Negligence	7	4	6
LTPS	7	5	6
Total New	14	9	12



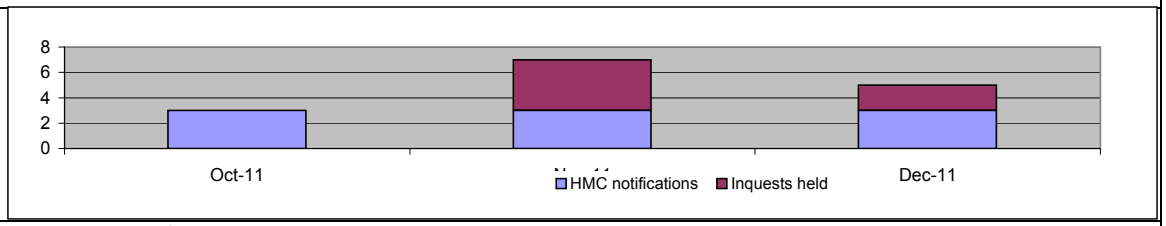
Analysis: During December 2011 clinical negligence claims received relate to treatment, diagnosis and obstetrics.

Actions: The details of all new claims are provided to the Divisions so that they can take the necessary action to assist them in the risk management process and prevention of recurrence.

2.4 Inquests

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

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



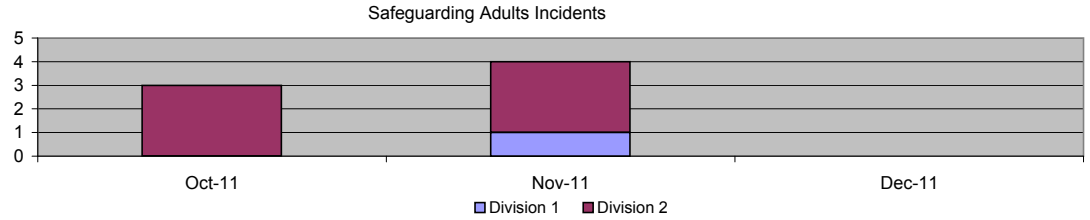
Analysis: During December 2 inquests were held of which verdicts are abbreviated as follows: died of an accident, combination of accident and natural causes

Actions: No action required.

2.5 Safeguarding Adults Incidents

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

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



Analysis: Two referrals alleging poor care and poor pain relief.

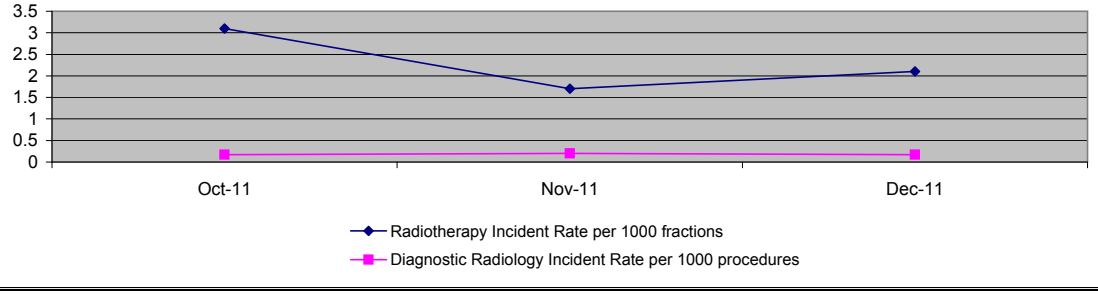
Actions: 48 hour safeguarding reports completed. Investigations in progress.

2.7 Radiation Incidents

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

Radiation Incidents	Oct-11	Nov-11	**Dec-11**
Radiotherapy	8	2	6
Diagnostic Radiology	3	4	3
Nuclear Medicine	0	0	1
Laser/Non-ionising	0	0	0

Rates	Oct-11	Nov-11	**Dec-11**
Radiotherapy Incident Rate per 1000 fractions	3.1	0.7	2.1
Diagnostic Radiology Incident Rate per 1000 procedures	0.17	0.2	0.17



Analysis:

▪ Radiotherapy - 4 of the incidents were as a result of failure to follow treatment sheets ▪ Diagnostic Radiology - one incident reported externally to IRMER as a result of two request forms being completed for the same investigation therefore patient had same x-ray twice ▪ Nuclear Medicine - one incident involving a sharps box being left open which contained low level radioactive material and should have been removed to another area.

Actions:

▪ All areas - staff reminded to be vigilant when documenting and performing moves for treatment

3) PREVENTING HARM, IMPROVING SAFETY MEASURES

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

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

3.1 Mortality

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

	Oct-10	Nov-10	Dec-10	Jan-11	Feb-11	Mar-11	Outturn	Apr-11	May-11	Jun-11	Jul-11	Aug-11	Sep-11	Oct-11	Nov-11	YTD
HSMR	99.9	97.5	106.4	103.4	103.4	95	102 [113]	94.2	90	73.7	97.2	89.3	94.7	81.7	84	90
Observed Death Rate (56 CCS Groups)	4.30%	4.00%	5.10%	4.90%	4.50%	3.90%	4.45%	4.40%	3.50%	2.70%	3.90%	3.20%	3.50%	3.10%	3.10%	3.40%
Expected Death Rate (56 CCS Groups)	4.30%	4.10%	4.80%	4.80%	4.30%	4.10%	4.40%	4.70%	3.90%	3.70%	4.00%	3.60%	3.70%	3.80%	3.70%	3.90%
No of In Hospital Deaths	128	126	165	157	128	130	1506	125	100	84	116	95	107	93	92	819
Expected Deaths	115.2	116.2	141.6	137.6	112.8	125.4	1343	132.7	111.1	114	119.3	106.4	113	113	110	921
Excess Deaths	13	10	23	19	15	5	163	-7.7	-11.1	-30	-3.3	-11.4	-6	-20	-18	-102

Analysis: April- November 2011 is the latest available data as at December 2011. The Trust's YTD HSMR based on 8 months data is 90 with a probable rebased value of 98-100. It is to be noted that HSMR and other high level measures of mortality are subject to in year variation.

The 2010/11 end of year aggregate position was 102, this was rebased to 112 which was published in The Good Hospital Guide in November 2011.

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

Top Diagnostic Groups Contributing to Patient Deaths by Volume

April to November 2011

Diagnosis group	Spells	Deaths	%	SMR
Pneumonia	550	116	21.70%	104.1
Acute cerebrovascular disease	616	91	17.30%	93.1
Acute myocardial infarction	618	41	6.70%	100
Congestive heart failure, nonhypertensive	315	36	11.60%	84.9
Acute and unspecified renal failure	150	32	21.80%	104.8
Cancer of bronchus, lung	570	30	5.30%	95.3

Alert Status

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

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

Associated Indicators of Mortality

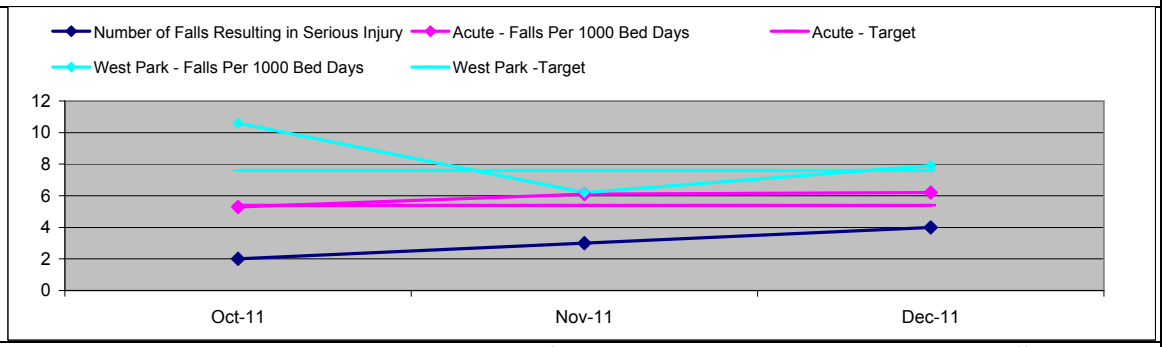
Indicator	Period	Actual	RAG	TREND
Charlson Codes Per Spell (HED)	Apr-Oct 11	**5.56**		➲
Palliative Care Deaths Per 1000 Spells (HED)	Apr-Oct11	**35**		➲
Expected Death Rate	Apr-Nov 11	**3.90%**		➲

Analysis: The Trust's Specialist Palliative Care team has received a 67% increase in Referrals since 2009. On average 100 referrals to the Specialist Palliative Care Team are received monthly. The number presented in this report is [35] palliative care deaths per 1000 discharges, this should be viewed in the context of over 100 referrals per month to the Trust's Specialist Palliative Care Team.

3.2 Inpatient Falls

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

	Oct-11	Nov-11	**Dec-11**
Acute - Target per occupied bed days	<5.4	<5.4	<5.4
Acute - Number of falls per occupied bed	5.3	6.1	6.2
West Park- Target per occupied bed days	7.6	7.6	7.6
West Park - Number of falls per occupied bed	10.6	6.2	7.9
Number of falls resulting in serious injury	2	3	4



Analysis: The Falls Committee is currently recalculating the occupied bed day rate due to the number of extra bed days used in November and December 2011. Following the falls with serious harm in November and December, the 50% reduction target in falls with serious harm set for this financial year has been breached for the first time.

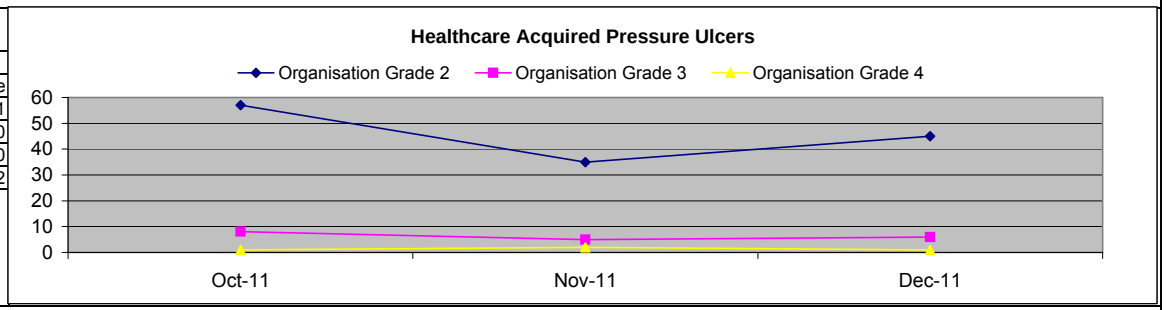
Actions: Continue to embed use of falls prevention care bundle and ensure full use of tool by all professional groups, medics, therapists and nursing.

3.3 Pressure Ulcers

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

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

	Oct-11		Nov-11		**Dec-11**	
	Avoidable	Unavoidable	Avoidable	Unavoidable	Avoidable	Unavoidable
Grade 2	14	32	12	23	15	31
Grade 3	3	5	1	4	5	0
Grade 4	2	1	1	1	1	0
Total		57		42		52



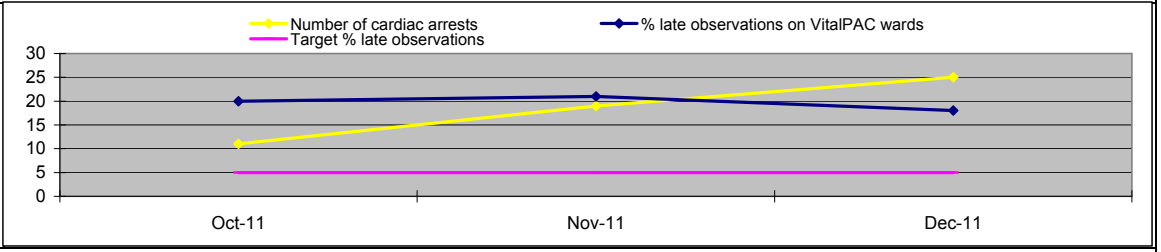
Analysis: There has been an increase of reported Grade 2's however approximate 50% were avoidable based on ward managers opinions. All reported Grade 3 & 4 pressure ulcers were deemed avoidable. Winter pressures and new care package are likely to be the factors associated with the increased reported Grade 2's. Action plans and shared learning are cascaded. Pressure ulcer management and prevention training continues to take place for the Health economy.

Actions: Concise investigations lead to actions plans to be shared with Divisions. CQUIN audit of documentation to take place March 2012 to audit sustainability. Ward managers continue to monitor patient safety.

3.4 Recognition of the Deteriorating Patient

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

	Oct-11	Nov-11	**Dec-11**
Number cardiac arrests	11	19	25
% observations late	20%	21%	18%
Target (late observations)	5%	5%	5%



Analysis: Slight improvement in percentage of late observations. More significant improvements have occurred in specific areas such as D18, 19 & 20.

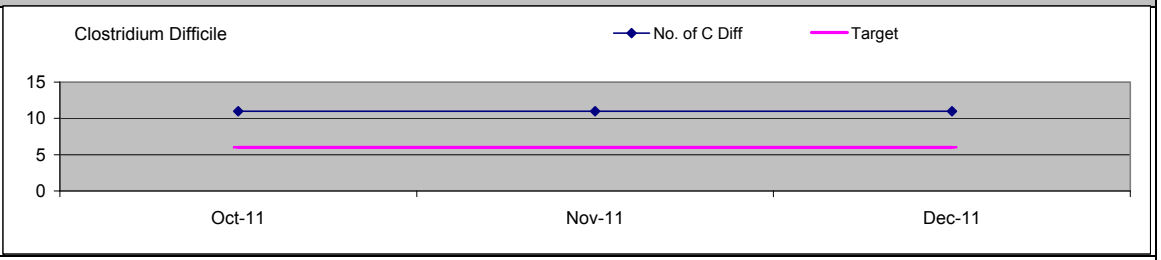
Actions: Action plans in place for worst performing areas. Matrons conducting spot audits on missed obs associated with blood transfusions.

3.5 Healthcare Acquired Infections (HCAIs)

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

3.5.1 Clostridium Difficile - hospital acquired for ages >2 years

	Oct-11	Nov-11	**Dec-11**
Number of C Diff	11	11	11
Cum Plan	42	48	54
Cum Actual	84	95	106
Cum Variance	42	47	52

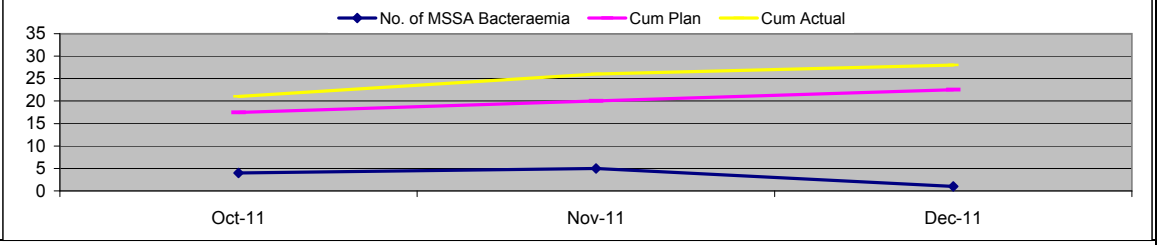


Analysis: 11 cases counting against RWHT using our internal definition of attribution. Two of these were recurrences. Several almost certainly did not have C. difficile disease, but asymptomatic infection.

Actions: C. difficile ward rounds and same-day visits of all new patients diagnosed continues. This has shown that use of hydrogen peroxide environmental decontamination continues to be compromised by capacity issues. This has been raised at IPCC. New guidance from DH that stated that that not all positive test should be reported as cases on the national mandatory surveillance database will be adopted in RWHT from 1st Jan 1012. The clinical and infection prevention of all patients found to be C diff positive will be unaffected by this change.

3.5.2 MSSA Bacteraemia

	Oct-11	Nov-11	**Dec-11**
No. of MSSA Bacteraemia	4	5	1
Cum Plan	17.5	20	22.5
Cum Actual	21	26	28
Cum Variance	3.5	4	5.5



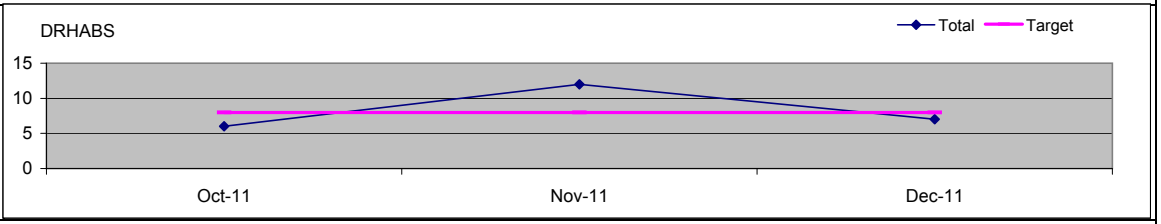
Analysis: 1 RWHT-attributable MSSA bacteraemias. The source of this bacteraemia was very hard to confirm - it was in a very complicated, terminally ill patient with medical devices plus skin lesions.

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

3.5.3 Device Related Hospital Acquired Bacteraemias

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

	Oct-11	Nov-11	**Dec-11**
Target (monthly)	8	8	8
DRHABS	6	12	7



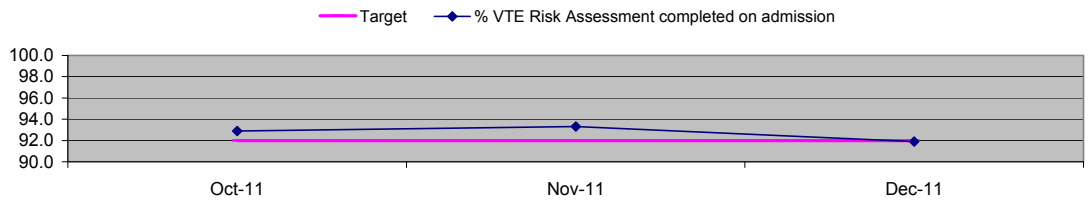
Analysis: 6 bacteraemias related to central lines and 1 to a urethral catheter (self catheterisation - intermittent). RCA's continue to show learning points and areas for improvements.

Actions: Improved links with IP Team. Sharing of learning at divisional forums. Central line access teaching ongoing in clinical areas within the hospital and community.

3.6 Venous Thrombo Embolism

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

	Oct-11	Nov-11	**Dec-11**
% adult patients with completed VTE risk assessment	92.9%	93.3%	91.9%
Number of patients with hospital acquired VTE	11	5	4
Number of patients with community acquired VTE	23	19	23



Analysis: Slight reduction with completion of VTE risk assessments.

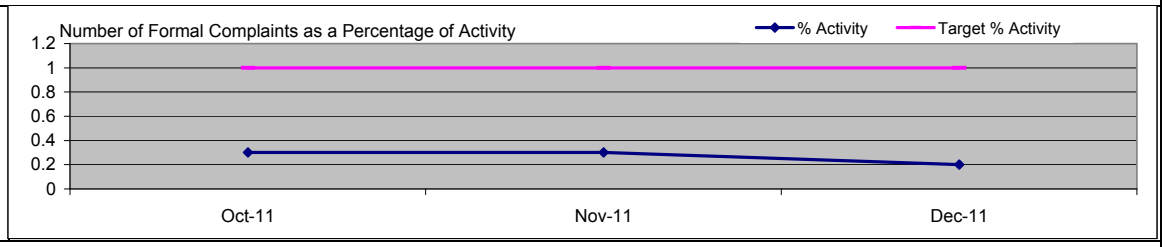
Actions: Medical Director sent reminder to senior clinicians regarding completion of VTE risk assessments. VTE nurses meeting with Divisions to review VTE RCA tool and improve quality of these RCAs.

4) PATIENT EXPERIENCE

4.1 Formal complaints

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

Target	Oct-11	Nov-11	**Dec-11**
1.00%	0.3%	0.3%	0.2%



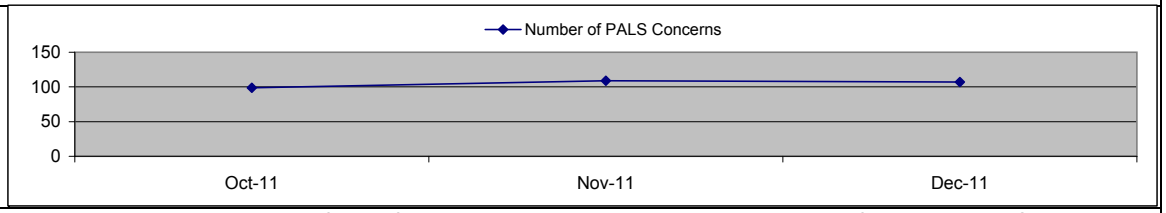
Analysis: 26 complaints were received in November 2011 which equates to 0.2% of Trust activity.

Actions:

4.2 PALS Concerns

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

Oct-11	Nov-11	**Dec-11**
99	109	107



Analysis: PALS remain consistently busy. The 3 most common themes for PALS are communication (poor communication with patient/relatives, conflicting information), delay (in receiving review appointments) and information (patient's/GP's not receiving discharge documentation or patients not receiving the correct clinical information).

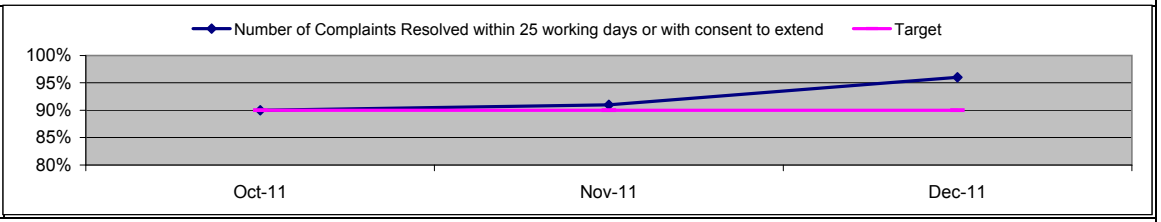
Actions: The PALS outreach service will be working in conjunction with the Accident and Emergency Department in order to use the identified themes of concerns raised as a trigger to enhance the patient experience.

4.3 Formal Complaints resolved within 25 days

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

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

Oct-11	Nov-11	**Dec-11**
90%	91%	96%



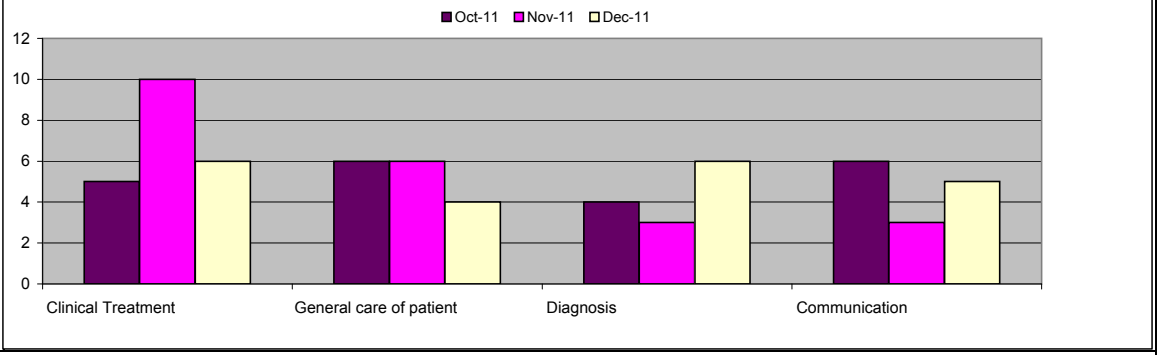
Analysis: The Trust has consistently achieved its target of 90% this month.

Actions: No action needed.

4.4 Formal Complaints trends

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

	Oct-11	Nov-11	**Dec-11**
Number of formal complaints	39	33	26



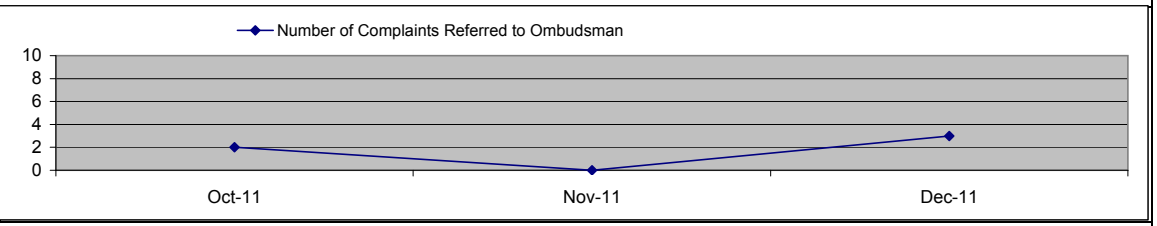
Analysis: The top four themes raised in formal complaints during December were clinical treatment, general care, diagnosis and communication.

Actions: The Trust has appointed a Complaints Services Manager who will be working closely with the divisions to ensure that the quality of the Trust responses are consistent and robust. The revised complaints policy is in the consultation period.

4.5 Ombudsman

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

	Oct-11	Nov-11	**Dec-11**
Number of complaints referred to the PHSO	2	0	3

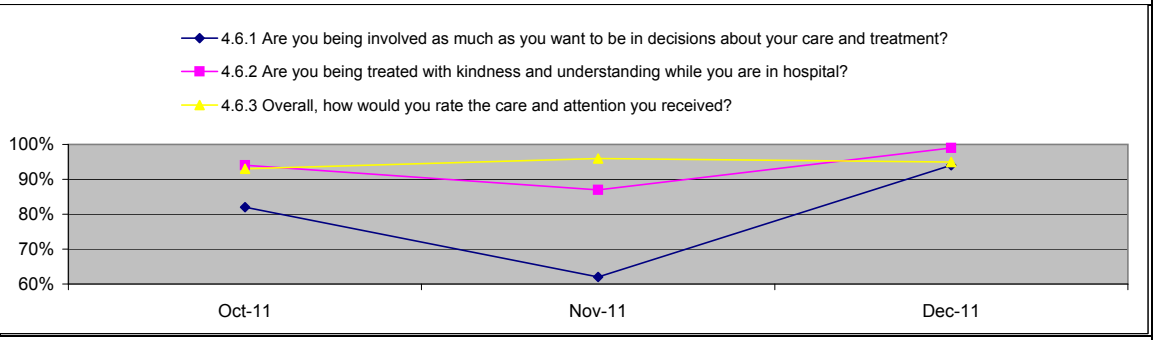


Analysis: There were 3 complaints referred to the PHSO in December. Papers were requested and sent and we await the PHSO's decision following their assessment.

Actions: The Complaints Services Manager will be monitoring the information provided and any subsequent action plans to ensure a consistent approach is followed throughout the Trust.

4.6 Patient Experience Tracker

	Oct-11	Nov-11	**Dec-11**
4.6.1 People that said yes definitely to: Are you being involved as much as you want to be in decisions about your care and treatment?	82%	62%	94%
4.6.2 People that answered yes all of the time to :Are you being treated with kindness and understanding while you are in hospital?	94%	87%	99%
4.6.3 People that answered 'excellent or good' to :Overall, how would you rate the care and attention you received?	93%	96%	95%



Analysis: 304 patients were surveyed in December, these figures exclude the additional 15 patients which were surveyed on EAU and Neonatal as the surveys undertaken on these areas. In relation to the Best Practice Rapid Improvement surveys which are undertaken for 12 weeks 30 patients were surveyed on ward D18, 28 patients on ward D19 and 30 patients on ward D20.

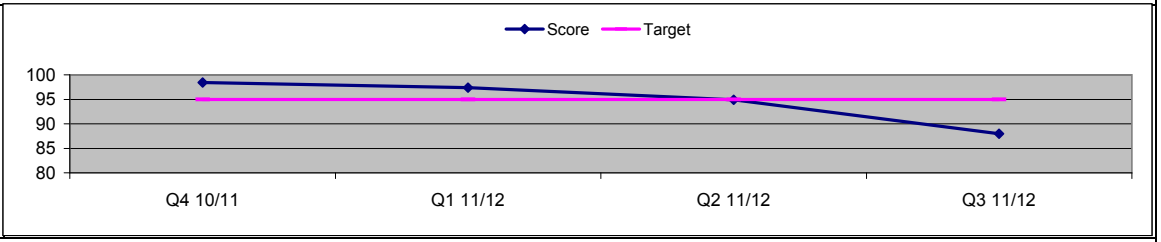
Actions: Surveys to be continued with a view of adapting a department specific survey for the Accident and Emergency department.

5) PATIENT SAFETY AND QUALITY

5.1 Hand Hygiene Practice

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

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



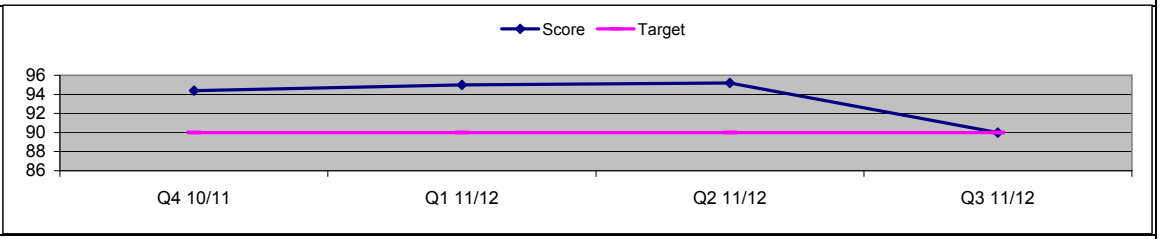
Analysis:
Division 1 - Q3 data amber at 81%, reds in ophthalmology, orthopaedics and community dental.
Division 2 - Q3 data overall compliance green (overall compliance 95 - 100%).

Actions:
Division 1 - re-profiling requirement for full compliance both at ward level and with medical staff.
Division 2 - Maintain compliance.

5.2 Environmental standards

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

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



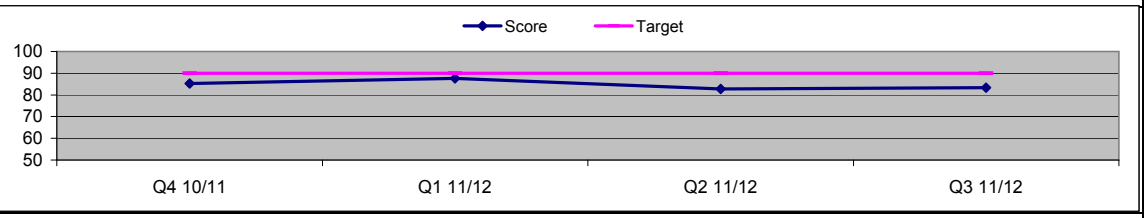
Analysis:
Division 1 - most areas consistently high scoring.
Division 2 - most areas consistently high scoring

Actions:
Division 1 - Remedial actions taken at time of audits. Provision of new doctors office on ward D3.
Division 2 - Issues addressed at time of audit. Continue to maintain performance.

5.3 Essence of Care standards

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

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



Analysis:
Division 1 - generally high scoring with exception of MCA training provision in many areas and Learning Disability training in a few areas.

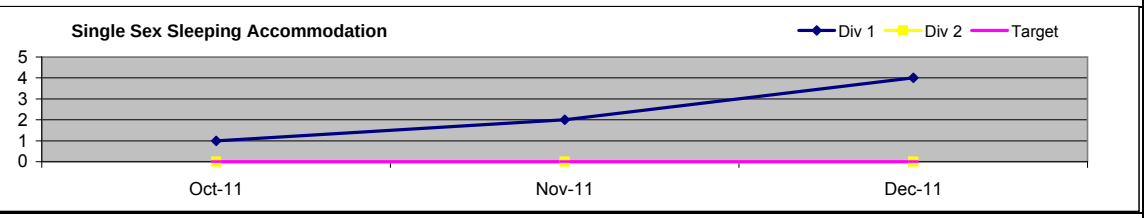
Actions:
Division 1 - Focus on MCA training during Q4.

5.4 Single sex accommodation

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

Number of incidents	Oct-11	Nov-11	**Dec-11**
Division 1	1	2	4
Division 2	0	0	0
Target	0	0	0

Definition of Single sex incident: A patient located in a bay with 3 other patients of the opposite sex is defined as four incidents



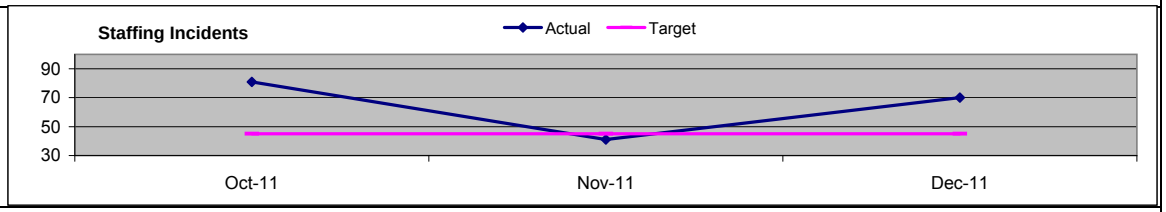
Analysis:
Division 1 - Q3 shows an increase in non-clinically justified breaches in the same sex policy. All of these cases were within ICCU and were associated with Trust challenges of managing emergency medical activity.
Division 2 - no breaches

Actions:
Division 1 - An improved reporting process needs to be embedded to ensure that accurate data is provided.

5.5 Nursing & Midwifery staffing levels

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

	Oct-11	Nov-11	**Dec-11**
Division 1	36	15	24
Division 2	45	26	46
Total	81	41	70
Target	45	45	45



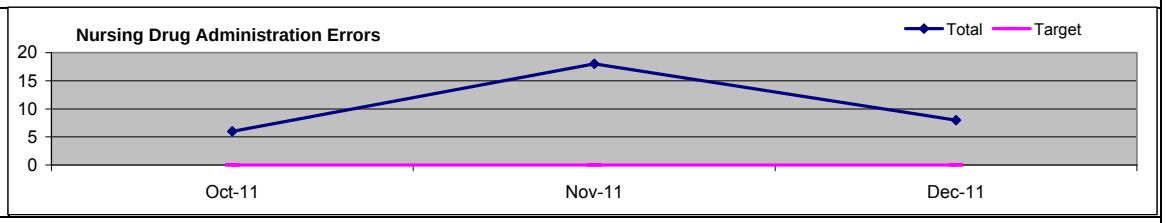
Analysis:
Division 1 - minimal substantive vacancies, however difficulty ensuring temporary staffing availability to cover gaps in staff numbers. Breaches are mainly associated with additional emergency medical capacity, especially D4 and the Cardiac Day Case Unit.
Division 2 - Overall vacancy levels reduced.

Actions:
Division 1 - recruiting substantively to nursing posts where additional capacity is in place, rather than relying on temporary staffing.
Division 2 - Recruitment ongoing for vacancies in Emergency Services.

5.6 Medication administration incidents

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

	Oct-11	Nov-11	**Dec-11**
Division 1	1	3	1
Division 2	5	15	7
Total	6	18	8
Target	0	0	0



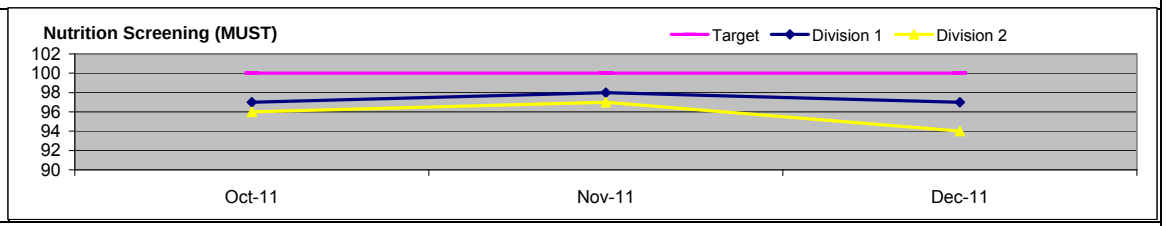
Analysis:
Division 1 - Increased incidence seen in ICCU in particular.

Actions: Appropriate actions taken at time of reporting. Wrong blood transfusion administered x 2 patients (D2 ward) being investigated.

5.7 Nutrition

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

% adult inpatients with completed MUST	Oct-11	Nov-11	**Dec-11**
Division 1	97%	98%	97%
Division 2	96%	97%	94%
Target	100%	100%	100%



Analysis:
Division 1 - shows a steady trend over quarter
Division 2 - slight decrease in December 2011

Actions: Continue with monthly audit and reporting of screening with a focus on care planning for those patients at risk. In addition Division 1 are undertaking weekly audits of emergency portals to ensure compliance with MUST screening and care plan completion. Focus on nutrition care planning with Matrons, SNOG, Heads of Nursing, Dieticians, desk-top for Nutrition & Hydration Week.

Surgical Division - Quality & Safety Scorecard - January 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	R	G	↓
Number of serious complaints received	G	G	↔
Percentage of complaints responded to within 25 working days (or with consent to breach)	G	G	↔
% of people responding "yes" to the question - Are you being involved as much as you want to be in decisions about your care and treatment?	R	A	↓
Percentage of patients who rated overall satisfaction good/excellent			
Percentage of patients who answered "yes" to being treated with care and compassion	R	A	↓
Number of cancelled/rescheduled outpatient appointments	G	G	↔
Cancelled operations as a percentage of elective admissions	R	R	↔
Overall Rating	R		↓

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

Patient Outcomes	This Month	Last Month	Trend
Length of stay (elective)	G	G	↔
Length of stay (non-elective)	A	A	↔
Percentage of emergency re-admissions within 30 days	G	G	↔
Delayed discharges	G		
18 week RTT - admitted	G	G	↔
18 week RTT - non-admitted	G	G	↔
Clinical correspondence turnaround within 48 hours	R	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	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: January 2012

Surgical Division

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

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

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

Patient Experience	Target	Tolerance	Data Source	Diagnostics Service Group			Theatres/ ICCU Service Group			Cardio- thoracic/ Cardiology Service Group			General Surgery/ Urology			Orthopaedics			Obstetrics & Gynaecology			Ophthalmology/ Head & Neck Services Group		
				This Month	Last Month	Trend	This Month	Last Month	Trend	This Month	Last Month	Trend	This Month	Last Month	Trend	This Month	Last Month	Trend	This Month	Last Month	Trend	This Month	Last Month	Trend
Patient complaints as a percentage of activity	<0.5%	<0.5 = Green, 0.5+ = Red	Nina Dunmore	0.1%	0%	↓	0%	0.1%	↑	0.1%	0.1%	→	0.1%	0.2%	↑	0.2%	0.1%	↓	0.5%	0.5%	→	0%	0.1%	↑
Number of complaints accepted for investigation by the Ombudsman	0	0 = Green, else Red	Nina Dunmore	0	0	→	0	1	↑	0	0	→	0	1	↑	0	0	→	1	0	↓	0	0	→
Number of serious complaints received	0	0 = Green, else Red	Nina Dunmore	0	0	→	0	0	→	0	0	→	0	0	→	0	0	→	0	0	→	0	0	→
Percentage of complaints responded to within 25 working days (or with consent to breach)	90%	>/= 90% = Green, else Red	Nina Dunmore	100%	N/A		N/A	100%		100%	100%	→	100%	100%	→	100%	100%	→	100%	100%	→	N/A	100%	
% of people responding "yes" to the question - Are you being involved as much as you want to be in decisions about your care and treatment?	95%	>95% = Green, 85-95% = Amber, <85% = Red	Nina Dunmore	N/A	N/A		N/A	N/A		77%	86%	↓	72%	59%	↑	81%	61%	↑	84%	76%	↑	50%	50%	→
Percentage patients who rated overall satisfaction good/excellent	95%	>95% = Green, 85-95% = Amber, <85% = Red	Nina Dunmore	N/A	N/A		N/A	N/A		N/A	N/A		N/A	N/A		N/A	N/A		N/A	N/A		N/A	N/A	
Percentage of patients who answered "yes" to being treated with care and compassion	95%	>95% = Green, 85-95% = Amber, <85% = Red	Nina Dunmore	N/A	N/A		N/A	N/A		71%	100%	↓	46%	100%	↓	48%	75%	↓	58%	96%	↓	45%	100%	↓
Number of cancelled/rescheduled outpatient appointments	–	Reduction of 40% in year	Lesley Taff	N/A	N/A					110	78	↓	216	200	↓	104	222	↑	111	94	↓	570	106	↓
Cancelled operations as a percentage of elective admissions	0.8%	< 0.8% = Green, else Red	Lesley Taff							5.7%	4.4%	↓	0.9%	1.98%	↑	0.2%	3.63%	↑	1.25%	0.8%	↓	0.32%	0.7%	↑
Patient Safety																								
Number of red incidents	0	0 = Green, else Red	Sukhy Khunkhuna	0	0	→	0	0	→	0	0	→	0	0	→	0	0	→	0	0	→	0	0	→
Number of healthcare/inpatient falls *RAG= tolerance multiplied by the number of inpatient wards	0	Ward specific	Sukhy Khunkhuna	0	0	→	2	2	→	4	4	→	9	2	↓	6	3	↓	0	0	→	4	1	↓
Number of healthcare/inpatient falls - resulting in serious injury *RAG= tolerance multiplied by the number of inpatient wards	0	*Green = 0, Amber = 1-4, Red = 4+	Sukhy Khunkhuna	0	0	→	0	0	→	0	0	→	0	0	→	0	0	→	0	0	→	0	0	→
Number of healthcare acquired avoidable pressure ulcers acquired/deteriorated (Grade 2, 3 & 4)		Basline to be agreed	Sukhy Khunkhuna	0	0	→	0	0	→	1	0	↓	1	0	↓	2	0	↓	0	0	→	0	0	→
Percentage inpatient MUST assessments completed within 6 hours of admission	100%	100% = Green, 75-99% = Amber, <75% Red	Rose Baker Zena Young				100%	100%	→	100%	100%	→	100%	99%	↑	84%	88%	↓	100%	100%	→	100%	100%	
MSSA bacteraemia	–	<2 = Green, 2-3 = Amber, >3 = Red	Mike Cooper	0	0	→	0	0	→	0	0	→	0	0	→	0	0	→	0	0	→	0	0	→
Clostridium Difficile - hospital acquired for ages >2 years	–	Green = 0,Amber = 1-2, Red = >2	Mike Cooper	0	0	→	1	0	↑	0	0	→	0	0	→	0	0	→	0	0	→	0	0	→
Device related bacteraemias	–	Green = 0,Amber = 1,Red = >1	Mike Cooper	0	0	→				0	1	↓	0	2	↓	0	0	→	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	100.0%	33.3%	↑	96.88%	95.68%	↑	90.35%	71.43%	↑	83.60%	77.73%	↑	86.21%	75.45%	↑	91.35%	89.54%	↑	98.48%	97.05%	↑
Percentage of late observations (VitalPAC wards only)	5%	<5% = Green, 5-10% = Amber, >10% = Red	Mandy Gibbs				3.7%	5.4%	↑	14.3%	16.0%	↑	13.0%	14.8%	↑	24.8%	27.2%	↑	10.0%	15.0%	↑	23.0%	13.0%	↓
Patient Outcomes																								
Length of stay (elective)	specific	Specific	Lesley Taff							4.18	4.27	↑	2.58	2.72	↑	3.0	3.2	↑	2.6	2.7	↑	1.8	1.7	↓
Length of stay (non elective)	specific	Specific	Lesley Taff							6.53	6.47	↓	3.29	3.19	↓	5.6	5.4	↓	1.1	1.1	→	2.39	2.25	↓
Percentage of emergency readmissions within 30 days	4.19%	<4.19% = Green, 4.2-5% = Amber, >5%= Red	Lesley Taff							1.79%	1.10%	↓	1.57	1.98%	↑	0.64%	0.24%	↓	2.08%	0.81%	↓	0.16%	0.18%	↑
Delayed discharges			Lesley Taff	0.0%	0.0%	→	0.0%	0.0%	→	0.50%	0.56%	↑	1.0%	0.9%	↓	0.12%	0.24%	↑	0.2%	0.2%	→	0.1%	0.04%	↓
18 week RTT - admitted	90%	90% = Green, else Red	Lesley Taff							96.93%	93.72%	↑	91.97%	91.56%	↑	90.31%	91.45%	↓	91.9%	92.59%	↓	94.29%	93.92%	↑
18 week RTT - non-admitted	95%	95% = Green, else Red	Lesley Taff							95.36%	96.3%	↓	95.24%	96.43%	↓	95.14%	95.1%	↑	95.04%	96.44%	↓	97.68%	98.93%	↓
Clinical correspondence turnaround within 48 hours	100%	100% = Green, 75-99% = Amber, else Red	Lesley Taff	82.9%	81.7%	↑				46.8%	36.7%	↑	59.0%	41.3%	↑	52.6%	64.7%	↓	59.8%	80.2%	↓	62.1%	76.1%	↓
Support Services																								
Sickness absence	<4%	<4% = Green, 4.1-5.9% = Amber, >6% = Red	Lesley Taff	3.74%	3.59%	↓	6.55%	5.39%	↓	4.00%	3.43%	↓	5.53%	6.56%	↑	7.76%	3.01%	↓	6.08%	4.54%	↓	5.20%	3.78%	↓
Percentage of staff who have undergone annual appraisal	80%	>/=80% = Green, 70-79% = Amber, <70% = Red	Lesley Taff	79.5%	80.2%	↓	81.9%	83.0%	↓	79.7%	82.7%	↓	82.9%	82.7%	↑	70.4%	62.1%	↑	85.5%	86.9%	↑	57.6%	66.3%	↓
Percentage of trained nursing vacancies per funded establishment			Lesley Taff	0.00%	0.00%	→	0.23%	0.87%	↑	-0.35%	-0.33%	↓	-1.55%	-0.55%	↓	1.55%	0.08%	↓	0.61%	-0.01%	↓	1.22%	1.78%	↑
Percentage of medical training grades vacancies per funded establishment			Lesley Taff	0.00%	0.00%	→	0.42%	0.00%	↓	0.00%	0.00%	→	0.00%	0.00%	→	0.00%	0.00%	→	0.58%	0.49%	↓	0.00%	0.00%	→
Staff feedback (Chat Back results to be reported in September 2011)			Caroline Marshal																					
Pay budget (ward pay budget only)	In balance	Yes = Green, Agreed = Amber, No = Red	Alison Reynolds							£(70) k	£(64) k	↓	£(181) k	£(160) k	↓	£(82) k	£(76) k	↓	£(54) k	£(40) k	↓	£(55) k	£(49) k	↓
WTE budgeted against actual (ward WTE only)	In balance	variance < 5% = Green variance 5-10% = Amber variance >10% = Red	Alison Reynolds							4.92%	1.33%	↑	3.38%	1.15%	↑	0.12%	(0.44)%	↑	(1.64)%	7.43%	↓	(3.68)%	(19.41)%	↑

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 (27 February 2012)

Report from: Directorate/Group	Diagnostics Services Group
Report prepared by: Name, Job Title	Anthony Leese Group Manager Radiology

Description of indicator:	% of VitalPAC VTE Risk Assessments	Activity against contract
Indicator tolerance:	Target = 90% <70% = Red	Target 2% Red = >5%
Period of alert: (i.e. Jun, Jul, Aug 2011)	Oct, Nov & Dec 2011	Oct, Nov & Dec 2011
Actions: Please identify where completed or a timescale for completion and who by	Jayne Lawrence Head of Information has confirmed that A change in clinic name in PAS has led to the recording of radiology patients as requiring Vital PAC checks in error These patients will disappear from the dashboard next month	Radiology has a target for interventional activity but no income, the income goes to the specialty that refers the patient This anomaly was identified at Budget Setting and is to be rectified from April 2012
Assurance/Monitoring: Please identify monitoring arrangements in place to sustain improvements		

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HIGH LEVEL INDICATOR EXCEPTION REPORT TO TRUST BOARD (27 February 2012)

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

Description of indicator:	Cancelled operations as a % elective admissions	% Late observations (VitalPAC wards only)	Clinical correspondence turnaround within 48 hrs	Activity against contract	Ward pay budget
Indicator tolerance:	Target = 0.8% Red = >0.8%	Target = 5% Red = >10%	Target = 100% Red = < 75%	Target = 2% Red = >5%	Target = in balance Red = not in balance
Period of alert: (i.e. Jun, Jul, Aug 2011)	Oct, Nov, Dec 2011	Oct, Nov, Dec 2011	Oct, Nov, Dec 2011	Oct, Nov, Dec 2011	Oct, Nov, Dec 2011
Actions: Please identify where completed or a timescale for completion and who by	Any potential cancellations are discussed with CD, Matron and/or DM. All cancellations are minimised by looking at utilising beds in other areas or transferring staff wherever possible (if staffing issues), extending the working day, reviewing all options in order to avoid cancellation. Ongoing.	Matron monitoring compliance.	Dedicated 'typing time' was created for the team of secretaries by putting all calls through to another office and these were dealt with by the Band 2's in the department. This enabled a rapid reduction in outstanding correspondence and is a practice the department is routinely going to introduce. Ongoing.	There will be a continued risk against this target as the plan was set higher than in previous years and it has not been possible to achieve this level of activity. This has been remedied in contract planning for 2012-13. The Directorate continues to try and 'catch-up' on activity but higher than normal cancellations and bed capacity has introduced further challenges. Ongoing	Continued overspend due to incremental increases (not funded at budget setting) and newly created posts being funded at bottom of scale. Both areas also changed staffing skillmix at weekends to ensure more senior cover was visible which has created budget pressures. Bank spend and all other pay spend is closely monitored and minimised. Due to ongoing opening of the cath lab day ward overnight for capacity pressures, bank spend will continue to be high and pay spend out of balance.

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

The Royal Wolverhampton Hospitals NHS Trust

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HIGH LEVEL INDICATOR EXCEPTION REPORT TO TRUST BOARD
(27 February 2012)

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

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

The Royal Wolverhampton Hospitals NHS Trust

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HIGH LEVEL INDICATOR EXCEPTION REPORT TO TRUST BOARD (27 February 2012)

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

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

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HIGH LEVEL INDICATOR EXCEPTION REPORT TO TRUST BOARD (27 February 2012)

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

Description of indicator:	Cancelled operations as a % of elective admissions	% Late observations (VitalPAC wards only)	Ward pay budget
Indicator tolerance:	Target = 0.8% Red = >0.8%	Target = 5% Red = >10%	Target = in balance Red = not in balance
Period of alert: (i.e. Jun, Jul, Aug 2011)	Oct, Nov, Dec 2011	Oct, Nov, Dec 2011	Oct, Nov, Dec 2011
Actions: Please identify where completed or a timescale for completion and who by	All cancelled cases are reviewed and RCA's completed for reasons for cancellations. Majority of cases are cancelled due to emergency patients requiring theatre. Discussions taking place at theatre user group and theatre speciality manager to ensure that cases are not cancelled due to lack of theatre time	Matron monitoring late observations on a daily basis. Reviewing use of 'off ward' facility Ward manager to develop action plan to reduce further.	Review all ward budgets with accountant and HoM to ensure that the minimum staffing levels exist. Management of all sickness and maternity leave as appropriate with HR support. Review of staffing Pay budgets are overspending due to activity levels/over-performance within the unit
Assurance/Monitoring: Please identify monitoring arrangements in place to sustain improvements	Cancelled operations report/monthly governance meetings	Governance meetings & risk meetings	Monthly budget surgeries

The Royal Wolverhampton Hospitals NHS Trust

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HIGH LEVEL INDICATOR EXCEPTION REPORT TO TRUST BOARD (27 February 2012)

Report from: Directorate/Group	Ophthalmology, Head & Neck Services Group
Report prepared by: Name, Job Title	

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

Medical Division - Quality & Safety Scorecard - January 2012 data

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

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

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

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

Trust Dashboard: January 2012

Emergency, Medical & Community Service Division

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

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

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

Patient Experience	Target	Tolerance	Data Source	Children's Services Group			Adult Community Services Group			Elderly Care & Stroke			Rehab (West Park)			Neurology Rheumatology Dermatology			Renal & Diabetes			Resp & Gastro			Emergency Services Group			Therapies & Pharmacy Group			Oncology & Haematology Group		
				This Month	Last Month	Trend	This Month	Last Month	Trend	This Month	Last Month	Trend	This Month	Last Month	Trend	This Month	Last Month	Trend	This Month	Last Month	Trend	This Month	Last Month	Trend	This Month	Last Month	Trend	This Month	Last Month	Trend	This Month	Last Month	Trend
Patient complaints as a percentage of activity	<0.5%	<0.5 = Green, 0.5+ = Red	Nina Dunmore	N/A	N/A		0.1%	N/A		0.1%	N/A		N/A	N/A		0.2%	0.1%	↓	0.3%	N/A		0.1%	0.1%	→	0.7%	0.4%	↓	N/A	0.1%		0.1%	N/A	
Number of complaints accepted for investigation by the Ombudsman	0	0 = Green, else Red	Nina Dunmore	0	0	→	0	0	→	0	0	→	0	0	→	0	0	→	0	0	→	0	0	→	0	1	↑	0	0	→	0	0	→
Number of serious complaints received	0	0 = Green, else Red	Nina Dunmore	0	0	→	0	0	→	0	0	→	0	0	→	0	0	→	0	0	→	0	0	→	0	0	→	0	0	→	0	0	→
Percentage of complaints responded to within 25 working days (or with consent to breach)	90%	>/= 90% = Green, else Red	Nina Dunmore	N/A	N/A		100%	N/A		100%	N/A		N/A	N/A		100%	100%	→	100%	N/A		100%	100%	→	100%	100%	→	N/A	0%		100%	N/A	
% of people responding "yes" to the question - Are you being involved as much as you want to be in decisions about your care and treatment?	95%	>95% = Green, 85-95% = Amber, <85% = Red	Nina Dunmore	N/A	N/A		N/A	N/A		82%	72%	↑	N/A	N/A		N/A	N/A		59%	71%	↓	49%	79%	↓	55%	82%	↓	N/A	N/A		81%	70%	↑
Percentage patients who rated overall satisfaction good/excellent	95%	>95% = Green, 85-95% = Amber, <85% = Red	Nina Dunmore	N/A	N/A		N/A	N/A		N/A	N/A		N/A	N/A		N/A	N/A		N/A	N/A		N/A	N/A		N/A	N/A		N/A	N/A		N/A	N/A	
Percentage of patients who answered "yes" to being treated with care and compassion	95%	>95% = Green, 85-95% = Amber, <85% = Red	Nina Dunmore	N/A	N/A		N/A	N/A		45%	100%	↓	N/A	N/A		N/A	N/A		59%	100%	↓	49%	100%	↓	74%	100%	↓	N/A	N/A		73%	97%	↓
Number of cancelled/rescheduled outpatient appointments	–	Reduction of 40% in year	Lesley Taff	291	77	↓	N/A	N/A	→	40	15	↓	N/A	N/A	→	100	98	↓	149	32	↓	52	56	↑				0	0	→	99	64	↓
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	1	0	↓	2	1	↓	38	19	↓	27	15	↓	1	1	→	16	13	↓	23	38	↑	9	29	↑	1	5	↑	5	2	↓
Number of healthcare/inpatient falls - resulting in serious injury *RAG= tolerance multiplied by the number of inpatient wards	0	*Green = 0, Amber = 1-4, Red = 4+	Sukhy Khunkhuna	0	0	→	1	0	↓	0	1	↑	0	1	↑	0	0	→	0	0	→	0	1	↑	0	1	↑	0	0	→	0	0	→
Number of healthcare acquired avoidable pressure ulcers acquired/deteriorated (Grade 2, 3 & 4)	0	0 = Green, else Red	Sukhy Khunkhuna	1	0	↓	6	3	↓	6	9	↑	0	1	↑	0	0	→	0	0	→	4	3	↓	0	2	↑	0	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%	98%	↑	100%	100%	→				96%	95%	↑	94%	93%	↑	93%	90%	↑				100%	98%	↑
MSSA bacteraemia	–	<2 = Green, 2-3 = Amber, >3 = Red	Mike Cooper	0	0	→	0	0	→	2	0	↓	0	0	→	0	0	→	0	0	→	1	1	→	0	0	→				0	0	→
Clostridium Difficile - hospital acquired for ages >2 years	–	Green = 0,Amber = 1-2, Red = >2	Mike Cooper	0	0	→	0	0	→	1	1	→	0	0	→	0	0	→	4	1	↓	4	2	↓	3	2	↓				2	2	→
Device related bacteraemias	–	Green = 0,Amber = 1,Red = >1	Mike Cooper	0	0	→	0	0	→	1	0	↓	1	1	→	0	0	→	0	0	→	1	0	↓	0	0	→						
Device related bacteraemias (Haem/Onc, ICCU, Renal, Neonates)	–	Green = 0,Amber = 1- 2 Red = >2	Mike Cooper	0	0	→													0	1	↑										4	2	↓
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							93.75%	87.3%	↑	N/A	N/A	→	91.14%	92.06%	↓	99.87%	99.92%	↑	100%	88.89%	↑	93.99%	82.15%	↑				100%	99.91%	↑
Percentage of late observations (VitalPAC wards only)	5%	<5% = Green, 5-10% = Amber, >10% = Red								23.2%	23.2%	→							27.5%	29.7%	↑	8.7%	12.6%	↑	18.0%	22.8%	↑				10.7%	15.1%	↑
Patient Outcomes																																	
Length of stay (elective)	specific	Specific	Lesley Taff	1.6	1.6	→										0.2	0.2	→	0.9	1.0	↑	3.2	3.2	→							4.9	5.3	↑
Length of stay (non elective)	specific	Specific	Lesley Taff	0.7	0.7	→										2.3	2.3	→	2.0	2.4	↑	3.2	3.1	↓							5.59	5.49	↓
Percentage of emergency readmissions within 30 days	4.19%	<4.19% = Green, 4.2-5% = Amber, >5%= Red	Lesley Taff	0.31%	0.0%	↓				0.0%	0.0%	→	0.0%	0.0%	→	0.0%	0.0%	→	0.0%	0.0%	→	0.0%	0.0%	→	0.0%	0.0%	→				0.0%	0.3%	↑
Delayed discharges			Lesley Taff	0.0%	0.0%	→				1.3%	1.0%	↓	0.4%	0.2%	↓	0.0%	0.3%	↑	0.0%	0.0%	→	0.4%	0.2%	↓	0.0%	0.0%	→				0.25%	0.3%	↑
18 week RTT - admitted	90%	90% = Green, else Red	Lesley Taff													100%	90.0%	↑	100%	97.9%	↑	100%	100%	→				100%	100%	→	94.44%	100%	↓
18 week RTT - non-admitted	95%	95% = Green, else Red	Lesley Taff	98.4%	100%	↓	100%	100%	→	100%	100%	→				96.6%	97.08%	↓	98.74%	99.28%	↓	95.36%	97.89%	↓				100%	100%	→	96.0%	100%	↓
Clinical correspondence turnaround within 48 hours	100%	100% = Green, 75-99% = Amber, else Red	Lesley Taff	77.2%	79.8%	↓	N/A	N/A	→	55.9%	43.8%	↑	N/A	N/A	→	59.7%	54.6%	↑	97.5%	88.0%	↑	90.3%	59.8%	↑	53.7%	76.7%	↓				94.9%	69.5%	↑
Support Services																																	
Sickness absence	<4%	<4% = Green, 4.1-5.9% = Amber, >6% = Red	Lesley Taff	3.89%	7.02%	↑	8.37%	5.97%	↓	5.86%	7.38%	↑	7.43%	5.07%	↓	2.60%	0.62%	↓	2.60%	2.57%	↓	2.47%	3.30%	↑	5.69%	2.41%	↓	4.03%	3.37%	↓	5.27%	6.43%	↑
Percentage of staff who have undergone annual appraisal	80%	>/=80% = Green, 70-79% = Amber, <70% = Red	Lesley Taff	60.5%	63.8%	↓	59.8%	67.3%	↓	77.6%	71.8%	↑	53.3%	59.7%	↓	56.4%	57.4%	↓	66.5%	69.4%	↓	78.6%	79.5%	↓	69.4%	65.0%	↑	50.3%	70.7%	↓	70.6%	73.8%	↓
Percentage of trained nursing vacancies per funded establishment			Lesley Taff	6.70%	6.70%	→	1.15%	0.30%	↓	-1.16%	-0.94%	↓	0.13%	0.29%	↑	-0.97%	-2.43%	↑	0.74%	0.08%	↓	1.98%	3.16%	↑	3.48%	3.28%	↓	0.00%	0.00%	→	-3.27%	-3.66%	↑
Percentage of medical training grades vacancies per funded establishment			Lesley Taff	0.00%	0.00%	→	0.00%	0.00%	→	2.42%	1.96%	↓	0.00%	0.00%	→	0.00%	0.00%	→	1.67%	1.28%	↓	2.30%	2.84%	↓	0.99%	0.37%	↓	0.00%	0.00%	→	0.00%	0.00%	→
Pay budget (ward pay budget only)	In balance	Yes = Green, Agreed = Amber, No = Red	Alison Reynolds	£(28) k	£(25) k	↓	£(2) k	£2 k	↓	£(240) k	£(210) k	↓	£(1) k	£(8) k	↑				£(122) k	£(104) k	↓	£(125) k	£(124) k	↓	£(249) k	£(163) k	↓				£(46) k	£(45) k	↓
WTE budgeted against actual (ward WTE only)	In balance	variance < 5% = Green variance 5-10% = Amber variance >10% = Red	Alison Reynolds	6.23%	3.95%	↑	10.29%	0.83%	↓	(5.15)%	(2.38)%	↓	5.58%	(1.19)%	↑				(10.11)%	(20.69)%	↑	8.23%	0.03%	↑	(17.66)%	(18.11)%	↑				2.61%	2.59%	↑

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HIGH LEVEL INDICATOR EXCEPTION REPORT TO TRUST BOARD (27 February 2012)

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

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

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HIGH LEVEL INDICATOR EXCEPTION REPORT TO TRUST BOARD (27 February 2012)

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

Description of indicator:	Number of healthcare acquired avoidable pressure ulcers (acquired/deteriorated) Grades 2,3 &4
Indicator tolerance:	Target = 0 Red = >0
Period of alert: (i.e. Jun, Jul, Aug 2011)	Oct, Nov & Dec 2011
Actions: Please identify where completed or a timescale for completion and who by	• Implementation of Adult Community Quality group- January 2012 (Tracey Slater) • Raising awareness with staff that there has been an increase in avoidable pressure ulcers – February 2012 via locality meetings (Locality lead nurses/service leads) • Introduction of structured handovers within each team utilising an action plan proforma.- introduced December 2011 (Tracey Slater) • Introduction of locality lead nurses – July 2011 • Introduction of an admission to caseload checklist (awaiting approval at ESG March 12) to be utilised at handover/admission- (Tracey Slater) • Introduction of multi-disciplinary meetings within each team including specialist nursing teams to ensure that complex patients are being pro-actively managed –February 2012 (Tracey Slater) • Introduction of closer working arrangements with Community Matron's and Disctrict nursing teams- February 2012 (Tracey Slater) • Introduction of peer review - August 2011- (Tracey Slater) • Monitoring of uptake of PUMP /wound care/ABPI training – On-going (Tracey Slater) • Introduction of clinical escalation process
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

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HIGH LEVEL INDICATOR EXCEPTION REPORT TO TRUST BOARD (27 February 2012)

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

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

					plan is now in place for rotation of band 6's/band 5 between the ASU and Ward 1 at West Park.
Assurance/Monitoring: Please identify monitoring arrangements in place to sustain improvements	Monitored by local governance meetings.	Monitored by Nursing KPI Actions escalated via Senior nurse pressure care forum.	Monitored via Nursing KPI		Monitored by monthly sickness meetings. Monitored by Division Budget meetings.

The Royal Wolverhampton Hospitals NHS Trust

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HIGH LEVEL INDICATOR EXCEPTION REPORT TO TRUST BOARD (27 February 2012)

Report from: Directorate/Group	Rehabilitation
Report prepared by: Name, Job Title	Wendy Worth Group Manager Amb/Rehab

Description of indicator:	Ward pay budget
Indicator tolerance:	Target = In balance Red = not in balance
Period of alert: (i.e. Jun, Jul, Aug 2011)	Oct, Nov & Dec 2011
Actions: Please identify where completed or a timescale for completion and who by	The 4 Rehab wards have a combined overspend of £8K @Month 9 year to date position. Overall the Rehab budget is £16k underspent @month 9 year to date and the directorate is forecasting an overall underspend position at year end, with underspends off setting the small overspend on the wards. An action plan is in place regarding authorisation of bank shifts which has significantly reduced ward spends.
Assurance/Monitoring: Please identify monitoring arrangements in place to sustain improvements	A monthly financial monitoring meeting is already in place, within the group and a performance monitoring meeting is in place at Division level

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HIGH LEVEL INDICATOR EXCEPTION REPORT TO TRUST BOARD (27 February 2012)

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

Description of indicator:	Clinical correspondence turnaround within 48 hours	% of staff who have undergone annual appraisal
Indicator tolerance:	Target = 100% Red = <75% Dec report = 66.5%	Target = 80% Red = <70% Dec report= 58.2%
Period of alert: (i.e. Jun, Jul, Aug 2011)	Oct, Nov & Dec 2011	Oct, Nov & Dec 2011
Actions: Please identify where completed or a timescale for completion and who by	Validate data-VH completed Identify which directorates are non compliant - VH - completed Review activity/workload –VH- completed Identify additional resource required-VH- ongoing daily	Validate data-VH- completed Identify which directorates are non compliant - VH - completed Identify dates for completion and projected compliance –VH – end Feb 2012 Overall compliance at date of report Dermatology Sect 20 11 **55.0%** Neurology Sect 13 11 **84.6%** Rheumatology Sect 24 19 **79.2%** Overall compliance 57 41 **71.9%** Projected compliance by end February Dermatology Sect 20 14 **70.0%** Neurology Sect 13 12 **92.3%** Rheumatology Sect 24 20 **83.3%** Overall compliance 57 46 **80.7%**

Assurance/Monitoring: Please identify monitoring arrangements in place to sustain improvements	Weekly monitoring via COO and use of additional resource as required.	Planned appraisal dates confirmed Monthly monitoring at Dermatology Governance Monthly validation of data on the training database.

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HIGH LEVEL INDICATOR EXCEPTION REPORT TO TRUST BOARD (27 February 2012)

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

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

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HIGH LEVEL INDICATOR EXCEPTION REPORT TO TRUST BOARD (27 February 2012)

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

Description of indicator:	% people responding yes to: 'Are you being involved as much as you want to be in decisions about your care & treatment?'	% Late observations (VitalPAC wards only)	Length of stay (elective)	Clinical correspondence turnaround within 48 hours	Activity against contract	Ward pay budget
Indicator tolerance:	Target = 95% Red = <85%	Target = 5% Red = >10%	Target – specialty specific	Target = 100% Red = <75%	Target = 2% Red = >5%	Target = in balance Red = not in balance
Period of alert: (i.e. Jun, Jul, Aug 2011)	Oct, Nov, Dec 2011	Oct, Nov, Dec 2011	Oct, Nov, Dec 2011	Oct, Nov, Dec 2011	Oct, Nov, Dec 2011	Oct, Nov, Dec 2011
Actions: Please identify where completed or a timescale for completion and who by	Junior doctors encouraged to communicate with patients and relatives. Best Practice initiatives introduced on wards.	Track and trigger information system in place to communicate with teams.	N/A	Respiratory now at 48 following introduction of note less clinics and re organisation of team. Need to maintain Gastro to introduce note less system. Issues regarding sickness being managed	Both Directorates are performing above contract. This is to meet additional activity in Endoscopic procedures and lung function testing in Respiratory. Need to ensure agreement is reached with Commissioners.	End of year forecasts have been agreed with each Directorate. Individual wards to submit action plans in conjunction with Matron by end of February.
Assurance/Monitoring: Please identify monitoring arrangements in place to sustain improvements	Following introduction of comfort rounds	Weekly basis with ward managers and matrons.		Monitor with team leader on weekly basis. Ensure	Scrutinise activity on a monthly basis with Finance and	Meet with budget holders on a monthly

	patients can feedback concerns to staff. Continue to show improving trend.			sickness is managed.	Information.	basis. Monitor sickness and

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HIGH LEVEL INDICATOR EXCEPTION REPORT TO TRUST BOARD (27 February 2012)

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

Description of indicator:	% people responding yes to: 'Are you being involved as much as you want to be in decisions about your care & treatment?'	Number of healthcare acquired avoidable pressure ulcers (acquired/deteriorated) Grades 2,3 &4	% Late observations (VitalPAC wards only)	% staff who have undergone annual appraisal	Ward pay budget
Indicator tolerance:	Target = 95% Red = <85%	Target = 0 Red = >0	Target = 5% Red = >10%	Target = 80% Red = <70%	Target = in balance Red = not in balance
Period of alert: (i.e. Jun, Jul, Aug 2011)	Oct, Nov, Dec 2011	Oct, Nov, Dec 2011	Oct, Nov, Dec 2011	Oct, Nov, Dec 2011	Oct, Nov, Dec 2011
Actions: Please identify where completed or a timescale for completion and who by	PALS outreach to commence in A&E – HF to link with JD from PALS EAU – RR and HF to review real-time feedback performance. Performance is increasing month on month. Action plan any deficits which will be discussed at governance To discuss at governance with action planning and link in with	Nil HAPU in December *2 identified were attributable to D17 Plans in place regarding PU management EAU Improve compliance with competencies, 71% currently – RR and KW (PEF) New documentation training continues Utilising safety briefings to identify those vulnerable pts/at risk	19% late observation Steady improvement month on month (KPI) Discussed at governance (Jan 12) with regard to Senior spot checking – Nurse and medical Team Nurse coordinator, Ward Manager and Matron to undertake regular spot check throughout the day and tackle poor performance with individuals	December – Nursing performance A&E 62% WIC 88% EAU 78% Plans in place for all areas and Jan shows a steady increase overall % = 78% EAU – RR continuing with plans for completion and engaging with Band 6's A&E – team structure in	A&E and EAU together is in balance. D17 overspent and the ward will be transferred to General Medicine Overspend is due to increased dependency of patients on ward, which requires an increased skill mix

	complaints to triangulate the data Clinical Lead aware and to discuss with medical colleagues _ RL RR to discuss at team meetings with nursing staff RR – undertakes daily rounds to alleviate/minimise concerns/complaints	A&E Bespoke training LJ and KW to facilitate Daily spot checks – HF, RR, band 6 coordinator Lessons learnt from recent inherited – share with all of the team Discuss inherited case (Jan 12) at EAU governance Feb 12	Persistent offenders utilise capability policy	place Nil LBR/any funding if PDR nil completed Increased training re appraisals facilitated – KW (PEF) Monitored via 121 with Matron	
Assurance/Monitoring: Please identify monitoring arrangements in place to sustain improvements	Governance meetings Real time feedback results Complaint trends	Quality rounds Spot check – HF, RR Matron rounds	Matron KPI Governance meeting Senior Nurse spot checks	Matron KPI Governance	Monitoring through Directorate Finance meetings

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HIGH LEVEL INDICATOR EXCEPTION REPORT TO TRUST BOARD (27 February 2012)

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

Description of indicator:	% people responding yes to: 'Are you being involved as much as you want to be in decisions about your care & treatment?'	% Late observations (VitalPAC wards only)	Activity against contract	Ward pay budget
Indicator tolerance:	Target = 95% Red = <85%	Target = 5% Red = >10%	Target = 2% Red = >5%	Target = in balance Red = not in balance
Period of alert: (i.e. Jun, Jul, Aug 2011)	Oct, Nov, Dec 2011	Oct, Nov, Dec 2011	Oct, Nov, Dec 2011	Oct, Nov, Dec 2011
Actions: Please identify where completed or a timescale for completion and who by	Full results of survey for Oct, Nov and Dec received from PALS. Shared with Directorate at Governance meeting on 7 February 2012. Importance of ensuring patients are involved in decision-making discussed. Ongoing improvements to be led by the Trust's Lead Cancer Nurse With the exception of one individual, all core MDT members have attended advanced communication skills training; outstanding individual will book into future course date	Action plan formulated and implemented. Matron tracking progress. Staff issued with letter from Matron detailing that non compliance will result in disciplinary action	Under-performance in oncology elective activity relates to contract being within haematology (reciprocally over-performing); under-performance in contract income for drugs relates to known financial shortfall within contract; radiotherapy fractions under-performing ytd but recent increase in demand will result in final outturn at contract volume	Action plan devised and implemented. Staffing levels reviewed on a daily basis. Off-duty monitored directly by Matron. Year end forecast agreed with Division

Assurance/Monitoring: Please identify monitoring arrangements in place to sustain improvements	Results of future patient surveys undertaken by PALS to be reviewed monthly	Direct review of ongoing performance by Matron	Directorate teams to monitor monthly performance reported in SLAM	Weekly monitoring of off-duty by matron. Review at Divisional performance meeting