The Royal Wolverhampton Hospitals NHS Trust	

Trust Board Report

Meeting Date:	27 June 2011
Title:	Quality Account 2010/11
Executive Summary:	The Trust has produced the 2010/11 Quality Account in line with DH guidance. The aim being to provide a clear and realistic picture to the public of the Trust's approach to quality, highlighting areas for improvement alongside our successes.
Action Requested:	To approve the Quality Account for publication
Report of:	Director of Nursing & Midwifery
Author: **Contact Details:**	Patient Experience Lead Tel 01902695363 Email nina.dunmore@nhs.uk
Resource Implications:	Printing of Account if requested Translation to other languages
Public or Private: (with reasons if private)	Public
References: (eg from/to other committees)	
Appendices/ **References/** **Background Reading**	Appendix 1- Draft Quality Account 2010/11
NHS Constitution: (How it impacts on any decision-making)	In determining this matter, the Board 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

Background Details	
1	The Trust is required to produce an annual Quality Account to the public, as set out in the Health Act 2009. The aim of the report (a requirement of all providers of NHS healthcare services) is to provide the public with information about the quality of the services delivered. The Trust's account is intended for anyone who wants to know more about the quality of our services and how we aim to maintain and improve this. The audience may include patients and the public, staff, commissioners, regulators and partners. Quality Accounts aim to engage Trust leaders in a quality improvement agenda which reflects the views and needs of service users and the local population. The approach to improvement needs to be owned by the Trust. The Quality Account should present an honest picture of what the Trust delivers and its improvement plans. The 2010/2011 Quality Account is both retrospective and forward looking. It looks back on the previous year's information regarding quality of service, explaining what is being done well and where improvement is needed. Crucially, it also looks forward, explaining what the Trust has identified as its priorities for improvement for the 2011/12 financial year and how these will be achieved and measured. The Final draft QA has been forwarded to Wolverhampton PCT, Wolverhampton LINk and the Health Overview and Scrutiny Committee of Wolverhampton City Council for review and their subsequent statements have been added to the document. A copy of the Quality Account is attached at appendix 1; work is currently underway to develop the word version into a more visually appealing design including photographs for publication on 30 June 2011.

The Royal Wolverhampton Hospitals NHS Trust
Quality Account 2010/11

Contents

Acknowledgements

We would like to thank all of the patients, community representatives and members of staff who gave their time to help us select our priorities and ensure that the document is clear and accessible.

Glossary

CQC	**Care Quality Commission**
CQUIN	**Commissioning for Quality and Innovation**
DNA	**Did Not Attend**
DRHABS	**Device related hospital acquired bacteraemias**
HCAI	**Healthcare Associated Infection**
HIA	**High Impact Action**
KPI	**Key Performance Indicator**
LINk	**Local Involvement Network**
NHS	**National Health Service**
NICE	**National Institute of Clinical Excellence**
NPSA	**National Patient Safety Agency**
NRLS	**National Reporting and Learning Service**
OPD	**Out Patient Department**
OSC	**Overview and Scrutiny Committee**
OWL	**Outpatient Waiting List**
PCT	**Primary Care Trust**
QUIPP	**Quality, Innovation, Productivity and Prevention**
RWHT	**The Royal Wolverhampton Hospitals NHS Trust**
TCS	**Transforming Community Services**
TMT	**Trust Management Team**

Part 1 - Statement on quality from the Chief Executive

The Royal Wolverhampton Hospitals NHS Trust is one of the largest acute providers in the West Midlands providing a comprehensive range of services for the people of Wolverhampton, the wider Black Country, South Staffordshire, North Worcestershire and Shropshire.

The Trust is the largest teaching hospital in the Black Country providing teaching and training to around 130 medical students on rotation from the University of Birmingham Medical School. We also provide training for nurses, midwives and allied health professionals through well established links with the University of Wolverhampton. RWHT is a regional centre for cancer surgery and medical treatment, heart and lung surgery and medical treatment, neonatal intensive care and renal.

Quality and safety continues to be our top priority and the Trust has developed robust governance arrangements not only to ensure required standards are met but to drive continuous improvement and take action on any sub-standard performance. Our approach can be broken down into four key categories.

Quality drives our strategy The Board-approved Integrated Governance Strategy includes the following: - The aims and objectives for risk management in the organisation. - A description of the relationships between various corporate committees. - The Assurance Framework. -A description of the whole risk management process and a requirement for all risks to be recorded, when identified, in a risk register and prioritised using a standard scoring methodology. - The identification of the roles and responsibilities of all members of the organisation with regard to risk management, including accountability and reporting structures. - The promotion of risk management as an integral part of the philosophy, practices and business plans of the organisation	**Our Board has the skills and knowledge to ensure delivery of the quality agenda** RWHT Leadership and Quality walkabouts have been held on a monthly basis through 2010/11. They develop a leadership culture at Board level which promotes quality and patient safety and provides an environment where continuous improvement in harm reduction becomes routine throughout the organisation through a learning and action orientated approach. We have undertaken safety culture assessment with the Trust Board members and each of the Divisional senior teams using the Manchester Patient Safety Framework. We run annual risk management and safeguarding training for board members and senior managers in addition to the mandatory training modules in these areas for all Trust staff. We read a patient story at each Trust Board meeting to provide information on a variety of patient experiences of the Trust.
We have established clear quality governance roles and accountability Key roles have been identified across the Trust to lead on quality and governance from board to team levels. The Trust governance structure includes the following committees: - Audit Committee considers the annual plans, accounts and reports of both the External and Internal	**We use our quality information in a variety of ways** - During 2010/11 the Assurance Framework has been reviewed and amended at least quarterly by the Board Assurance Committee and monthly by Executive Directors. The information is reviewed by the Trust Board on a monthly basis, to ensure it remains aligned with the Trust's strategic objectives and the key risks to their achievement.

Auditors - Board Assurance Committee reviews the Strategic Risk Register and risks identified through trends highlighted as part of performance management, clinical governance, patient complaints and patient liaison activity - Quality and Safety Committee reviews clinical care against Key Performance Indicators set to monitor clinical governance performance against national standards as well as monitoring the effectiveness of action plans linked to identified Health and Safety and Serious Untoward Incidents - Infection Prevention and Control Committee approves the infection prevention programme for the year and monitors progress. It reviews divisional infection prevention performance, incidents and learning, to ensure achievement of local and national targets. It reviews Trust achievement against Hygiene Code standards. In addition Internal Audit carries out a continuous review of the internal control system and reports the results of reviews and recommendations for improvements in control to management and the Trust's Audit Committee.	During June/July 2010 a patient safety culture survey (MAPSAFF) was undertaken with all staff. The data we gather is used to produce a number of quality and governance reports throughout the Trust including: - The Chief Operating Officer's monthly report to the Trust Board measuring key performance indicators - The Quarterly Quality and Safety report to Trust Board The Governance Scorecard including key performance indicators - Matron Quality Rounds are carried out monthly Reports from Trust level committees are fed up to the Trust Board - Divisional and Directorate quality monitoring and reporting

This year's Quality Account provides an opportunity for us to demonstrate to the public, our patients and our staff the ambition and determination we have to deliver top class services.

All Trusts are required to produce a Quality Account to show the public, patients, commissioners and staff that they are continuously reviewing, measuring and improving the quality of all the services they deliver.

Our aim in this document has been to produce a clear and honest account of our performance during the year highlighting where we are excelling and setting out the areas where we need to improve.

In the past 12 months since our last Quality Account we have achieved success in infection prevention with a continued outstanding performance of no cases of MRSA bacteraemia (blood infection); we have opened our first dedicated dementia ward and worked towards integration with Wolverhampton City Primary Care Trust provider services.

However, we recognise that we still have a long way to go and during 2011/12 our key areas of focus will be nutrition and supporting our patients to eat well whilst in hospital, reducing delays in outpatient appointments, improving communication between clinicians and patients, reducing the number of healthcare acquired pressure ulcers and continuing to build on our record for infection prevention by reducing device related blood infections.

The coming year will be a challenging one for the NHS however we will not deviate from our vision to be a first class hospital providing top quality care in every way. The Trust will also take responsibility for the delivery of community services for Wolverhampton as part of the

Transforming Community Services agenda. This will provide us with a major opportunity to develop a seamless patient journey between acute and community care.

It is vital in these times of change that we continue to involve our local community in decisions about our priorities and services. To this end patients, members and community group representatives along with staff have worked together to select the priorities for 2011/12.

To the best of my knowledge, the information contained in the following Quality Report is accurate.

David Loughton CBE
Chief Executive
The Royal Wolverhampton Hospitals NHS Trust

Part 2 - Priorities for improvement 2011/12

Following discussions with staff, members, patients and community representatives over the past few months, the following quality improvement priorities are proposed for 2011/12 at RWHT:

Patient Experience

- Delays – Reduce the number of rescheduled and cancelled hospital outpatient appointments
- Communication with patients – Increase the number of patients who report that they are informed of side effects of medication before discharge

Patient Safety

- Pressure Ulcers – Reduce the number of healthcare acquired pressure ulcers
- Infection prevention – Reduce the number of device related blood infections (DRHABs)

Clinical Effectiveness

- Nutrition – Improve inpatient nutrition risk screening, care planning, and optimise nutritional intake

Priority One: Delays - Reduce the number of outpatient appointments rescheduled and cancelled

Why is this important?
Feedback from patients tells us that rescheduling and cancellation of outpatient appointments is a significant issue. Our stakeholder group also highlighted this as one of the top priorities for the local community. Currently patients may receive several letters rescheduling their outpatient appointments which can be both frustrating and confusing, and lead to delay for patients as their appointments are pushed back repeatedly. Did Not Attend rates (DNA) can also be increased as reschedule letters can be received too late for the patient to act upon them or they may clash with long-standing commitments. Our aim is to implement a new appointment system to reduce the number of rescheduled appointments and provide patients with a single appointment letter.

Baseline

	At or less than six weeks before the appointment	At or more than six weeks before the appointment
Number of appointments rescheduled in 2010/11	43,932	46,454

Goal for 2011/12
We will reduce the number of hospital re-schedules at greater than 6 weeks to zero through the introduction of the Outpatient Waiting List (OWL) booking system.

How will we monitor and report?
The Clinic Visibility Tool used with the OWL has a built in KPI reporting system that monitors patient reschedules as part of its standard reporting structure. KPIs for outpatients will be reviewed weekly by departmental managers. Any hospital reschedules at greater than 6 weeks before appointment time will flag up as red to be investigated by the departmental manager. For the duration of the project these will also be monitored by the Outpatient Improvement Team. OWL metrics and KPIs are currently being added to the weekly Chief Operating Officer report sent to directors.

We will monitor our PALS and complaints themes quarterly regarding outpatient appointment cancellations.

Action required
The project has been initially launched in Rheumatology and will be rolled out across all outpatient departments by the end of 2011. The roll out across all outpatient departments will be managed in three phases each lasting 3 months. Phase 3 is planed to commence in mid July 2011.

The changes are being communicated by:

- Posters and leaflets have been developed with the aid of PALS to be displayed in waiting areas.
- The project team are attending patient forums to promote the project and get feedback on developments.

- A letter explaining the change to each patient is sent out as they are moved onto the OWL.

A dedicated telephone line has been established to deal with any patient questions.

Nominated lead: Divisional Managers

Priority two: Increase the number of patients who are informed of side effects of medication before discharge

Why is this important?
It is vital that we provide clear and concise information to patients about their condition and treatment. When patients are discharged from hospital they are provided with a large amount of information to remember about their condition, treatment, medication and follow up arrangements. Feedback from the national inpatient survey tells us that we need to do more work to ensure patients understand and remember the information we provide about possible side effects of medication that they are given on discharge from hospital.

Baseline
39% of participants in the 2010 national inpatient survey reported that they were not given this information.

Goal for 2011/12
We will reduce the percentage of patients answering no to the national inpatient survey question 'did a member of staff tell you about medication side effects to watch for when you went home' to no more than 25%.

How will we monitor and report?
The national inpatient survey will be used to measure progress, survey results are provided to the Trust Board.

A local audit will also be carried out in quarters two and four of 2011/12 of 100-150 patients to assess their understanding of

- their medicines on admission,
- any changes made to their medication
- their medicines on discharge
- their understanding of their discharge summary to their GP

This audit will provide an opportunity for the Trust to assess progress towards the target throughout the year.

Action required
Pilot of the electronic discharge summary system, providing patients with a clear and standardised summary document when they are discharged from RWHT due to be carried out summer 2011.

Develop and run a discharge information awareness campaign to ensure all RWHT staff are aware of best practice approaches to providing clear and timely information to patients about medication side effects.

Carry out medicines adherence audit in quarter two to gather local baseline data.

Develop action plan to address issues raised.

Carry out quarter four audit to measure any change.

Nominated lead: Assistant Director of Pharmacy - Clinical Services/Medicines Management

Priority three: Reduce the number of healthcare acquired pressure ulcers

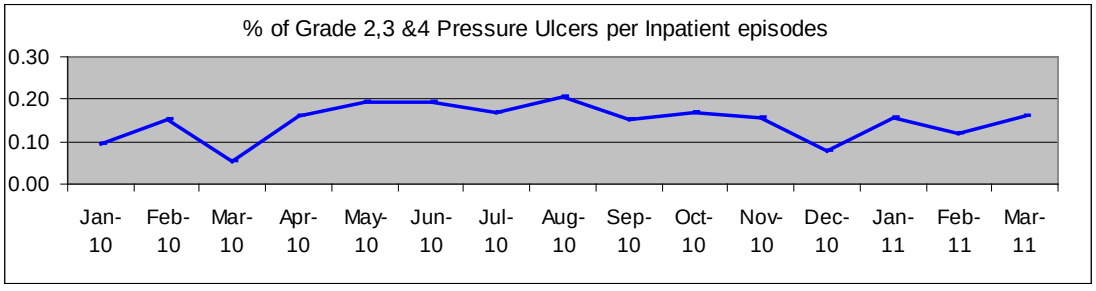
Why is this important?
Healthcare Acquired Pressure Ulcers are a widespread and often underestimated health problem. They are distressing, painful and debilitating and can prolong a patient's time in hospital. Even with the best possible medical and nursing care, pressure ulcers can be difficult to prevent, however a large number are avoidable.

Pressure ulcers are graded from 1, the least serious, to grade 4 the most serious.

New pressure ulcers are estimated to occur in 4 – 10% of patients, admitted to acute hospitals in the UK. It is also estimated that up to 30% of patients may suffer in the community and 20% in nursing and residential homes may be affected.
Pressure ulcers can occur in any patient, but are more likely in high risk groups such as the obese, elderly, malnourished and those with certain underlying conditions. The presence has been associated with an increased risk of secondary infection and a two to four fold risk of death in older people in intensive care units.

Baseline

	Apr 10	May 10	Jun 10	Jul 10	Aug 10	Sep 10	Oct 10	Nov 10	Dec 10	Jan 11	Feb 11	Mar 11
Grade 2	18	21	22	19	24	18	21	20	10	20	11	15
Grade 3	1	1	2	2	1	1	0	0	0	0	3	5
Grade 4	0	1	0	0	0	0	0	0	0	0	0	1
Total	19	23	24	21	25	19	21	20	10	20	14	21
% Inpatient Episodes	0.16	0.19	0.19	0.17	0.21	0.15	0.17	0.16	0.08	0.16	0.12	0.16



Goal for 2011/12
We will aim to ensure all patients admitted to a bed and within a minimum of 6 hours should be assessed by a suitable competent and experienced Registered Nurse for their risk of developing a pressure ulceration using a recognised evidence based tool. Exclusions from this are paediatrics, day cases, maternity and other patients where this may not be appropriate.

If patients are required to go directly to theatre, they will be assessed within 2 hours of return to the ward.

Patients assessed to be at risk of ulceration with a Waterlow score of 15 and above, or who have an ulcer, will have appropriate preventative / treatment actions documented in their care plan.

100% of patients who are identified as being at risk of ulceration or who currently have a pressure ulcer will have preventative actions documented in their care plan.

How will we monitor and report?
Progress will be monitored by the Quality and Safety Committee and Trust Board as part of the Trust's Quality Performance report.

We will carry out a biannual audit of patient records and a report by the Director of Nursing on both point prevalence and incidence will be provided to each CQR.

Action required

- Develop a strategy for the prevention and management of pressure ulcers
- Develop a strategic working group to provide ongoing review and monitoring of the implementation of the strategy
- Introduce a care bundle approach for management of patients at risk of developing pressure ulcers
- Establish monthly 'point prevalence' audit of pressure ulcers

Nominated lead: Deputy Director of Nursing and Midwifery – Transformation and Workforce

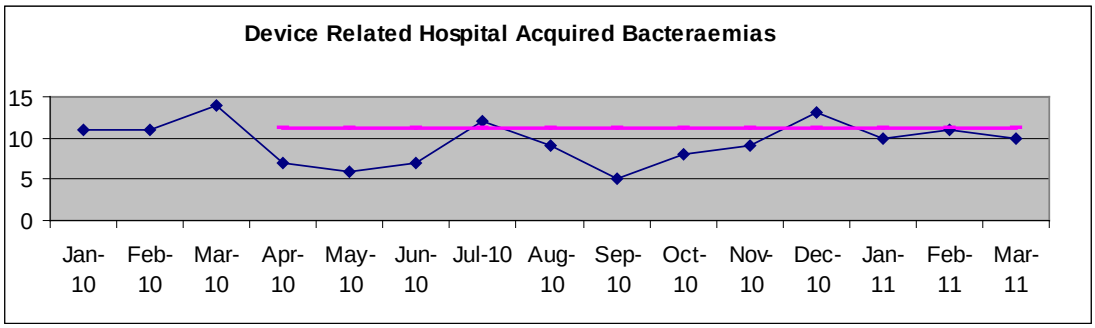
Priority four: Reduce the number of device related blood infections

Why is this important?
Intravenous (IV) therapies and the use of penetrating devices such as catheters and ports (for giving intravenous fluids and drugs) are common and frequently essential interventions for patients. The positive effects on the health of a person in receipt of such therapies are clear; however they are not without risk. Any breach in the integrity of the skin, caused by wounds or incisions will increase the risk of healthcare-associated infection. Patients receiving IV therapy are four times more susceptible to healthcare-associated bacteraemia than those not receiving this form of intervention.

The simplest and most effective method of reducing the rate of IV device-related complications is to ensure that the line is not left in place for longer than is necessary. IV devices should not be left in situ once the reason for their use has ceased.

In recent years MRSA bacteraemia rates have acted as a reasonable surrogate marker of healthcare associated infections (HCAIs) until practices were introduced that were aimed solely at reducing the number of MRSA bacteraemias rather than reducing HCAIs overall and improving the quality of health care. MSSA bacteraemias, another potential marker of HCAI, have reduced by over 70% in Wolverhampton since improvements in infection prevention practices were introduced. The Trust was gaining limited information from the investigation of just the MRSA causing *Staph. aureus* bacteraemias, so surveillance of all hospital acquired bacteraemias (HABs) was introduced. It was quickly recognised that only a proportion of HABs were due to causes that could be influenced by clinical or infection prevention practices, but of those that can be influenced we have initially targeted the ones due to medical devices (device-related hospital acquired bacteraemias – DRHABs), such as intravenous lines, urinary catheters and ventilators. Infections due to such devices impact on the most vulnerable patients in the hospital, and any actions that lead to a reduction in these infections will improve the quality of care and the patient experience, while also reducing mortality and length of inpatient stays.

Baseline
In the first full year of surveillance (2009-10) there were 333 HABs, of which 140 were DRHABs (the target had been set at 151). In 2010-11 the number of HABs had fallen to 300 and DRHABs to 105, against a target of 134.



The pink line in the graph indicates the target that the Trust aims to achieve

Goal for 2011/12
We will work to meet the target of no more than 8 DRHABs occurring per month, or 96 for the year 2011/12.

How will we monitor and report?
The performance will be reported through the Infection Prevention and Control Committee on a monthly basis and through reports to the Trust Management Team and the Wolverhampton Health Economy Infection Prevention Forum on a quarterly basis.

Action required
Policies concerning the insertion and management of medical devices will be regularly reviewed to ensure a consistent approach across the organisation. Databases are being devised to allow the audit of all appropriate devices and a programme of training and education, allied to general training of all clinical staff on the aseptic non-touch technique (ANTT) will be put in place.

Nominated lead: Deputy Director of Nursing and Midwifery– Transformation and Workforce

Priority five: Improve inpatient nutrition risk screening, care planning, and optimise nutritional intake

Why is this important?
Malnutrition is both a cause and a consequence of disease. Approximately one in four patients in NHS hospitals are either malnourished or at risk of malnutrition. The consequences of malnutrition include vulnerability to infection, delayed wound healing, impaired function of heart and lungs, decreased muscle strength and depression. These effects can impair the response to treatment and prolong recovery.

We know that improving nutritional intake results in improved outcomes, helping people to get better quicker and providing a better patient and carer experience. Whilst we have already introduced a number of initiatives to improve this, such as; a catering strategy which has improved the quality of food and availability of meals outside of usual meal times; a method of signposting for patients who require assistance with eating and drinking; patient comfort rounds which are a means of regular checking of patients to ensure their needs are met; work with our dementia strategy which has focussed on care of this particularly vulnerable group, we feel that more can be done to improve patients nutritional intake.

Even people who are well nourished tend to eat and drink less when they are unwell. Ongoing poor intake of food and drink, if not detected and treated, can lead to weight loss and malnutrition.

Nutrition risk screening on admission to hospital, and then regularly throughout a patient's stay helps to identify those at nutritional risk so that an appropriate plan of care can be implemented.

Baseline
Audit results from October 2010 showed 49% of patients are screened for malnutrition.

Goal for 2011/12
We will ensure that 90% of high risk patients have a care plan in place.

How will we monitor and report?
Progress will be monitored and reported through the Nutrition Support Steering Committee and monthly directorate governance meetings.

Action required
Review of nutrition risk screening policy, including development and implementation of a care plan for high risk patients.

Implementation of protected mealtimes.

Review content of nutrition teaching session delivered at nurse induction, and as part of the mandatory training programme. Development of e-learning packages to support induction and mandatory training.

During 2010 we have been working with Wolverhampton LINK to develop an improvement action plan for patient nutrition and will be providing them with further information as work progresses.

Nominated lead: Divisional Nurses and Chair of Nutrition Support Steering Committee.

Statements of assurance from the Board

Mandatory Quality Statements - All NHS providers must present the following statements in their quality account, this is to allow easy comparison between organisations.

Review of services

During 2010/11 The Royal Wolverhampton Hospitals NHS Trust provided and/or sub-contracted 32 NHS services.

The Royal Wolverhampton Hospitals NHS Trust has reviewed all the data available to them on the quality of care in all of these NHS services.

The income generated by the NHS services reviewed in 2010/11 represents 91.2 per cent of the total income generated from the provision of NHS services by The Royal Wolverhampton Hospitals NHS Trust for 2010/11.

Participation in clinical audits

During 2010/11, 42 national clinical audits and 5 national confidential enquiries covered NHS services that The Royal Wolverhampton Hospitals NHS Trust provides.

During that period The Royal Wolverhampton Hospitals NHS Trust participated in 81% national clinical audits and 83% of national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that The Royal Wolverhampton Hospitals NHS Trust participated in, and for which data collection was completed during 2010/11, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

National Clinical Audit	Eligible	Participated	% Submitted
Peri & Neonatal			
Peri-natal mortality (CEMACH)	Yes	Yes	100%
Children			
Paediatric pneumonia (British Thoracic Society)	Yes	No	N/A
Paediatric asthma (British Thoracic Society)	Yes	No	N/A
Paediatric fever (College of Emergency Medicine)	Yes	Yes	100%
Childhood epilepsy (RCPH National Childhood Epilepsy Audit)	Yes	No	N/A
Paediatric cardiac surgery (NICOR Congenital Heart Disease Audit)	Yes	Yes	100%
Diabetes (RCPH National Paediatric Diabetes Audit)	Yes	No	N/A
Acute care			
Emergency use of oxygen (British Thoracic Society)	Yes	Yes	100%
Adult community acquired pneumonia (British Thoracic Society)	Yes	Yes	100%
Non-invasive ventilation (NIV) - adults (British Thoracic Society)	Yes	Yes	100%
Pleural procedures (British Thoracic Society)	Yes	Yes	100%
Cardiac arrest (National Cardiac Arrest Audit)	Yes	Yes	100%

Vital signs in majors (College of Emergency Medicine)	Yes	Yes	100%
Adult critical care (Case Mix Programme)	Yes	Yes	100%
Long term conditions			
Heavy menstrual bleeding (RCOG National Audit of HMB)	Yes	Yes	100%
Chronic pain (National Pain Audit)	Yes	No	N/A
Ulcerative colitis & Crohn's disease (National IBD Audit)	Yes	Yes	100%
Parkinson's disease (National Parkinson's Audit)	Yes	Yes	100%
COPD (British Thoracic Society/European Audit)	Yes	No	N/A
Adult asthma (British Thoracic Society)	Yes	Yes	100%
Bronchiectasis (British Thoracic Society)	Yes	No	N/A
Elective procedures			
Hip, knee and ankle replacements (National Joint Registry)	Yes	Yes	100%
Elective surgery (National PROMs Programme)	Yes	Yes	80%
Coronary angioplasty (NICOR Adult cardiac interventions audit)	Yes	Yes	100%
Peripheral vascular surgery (VSGBI Vascular Surgery Database)	Yes	Yes	100%
Carotid interventions (Carotid Intervention Audit)	Yes	Yes	100%
CABG and valvular surgery (Adult cardiac surgery audit)	Yes	Yes	100%
Cardiovascular disease			
Familial hypercholesterolemia (National Clinical Audit of Mgt of FH)	Yes	Yes	100%
Acute Myocardial Infarction & other ACS (MINAP)	Yes	Yes	100%
Heart failure (Heart Failure Audit)	Yes	Yes	100%
Acute stroke (SINAP)	Yes	No	N/A
Stroke care (National Sentinel Stroke Audit)	Yes	Yes	100%
Renal disease			
Renal replacement therapy (Renal Registry)	Yes	Yes	100%
Patient transport (National Kidney Care Audit)	Yes	Yes	100%
Renal colic (College of Emergency Medicine)	Yes	Yes	100%
Cancer			
Lung cancer (National Lung Cancer Audit)	Yes	Yes	100%
Bowel cancer (National Bowel Cancer Audit Programme)	Yes	Yes	100%
Head & neck cancer (DAHNO)	Yes	Yes	100%
Trauma			
Hip fracture (National Hip Fracture Database)	Yes	Yes	100%
Severe trauma (Trauma Audit & Research Network)	Yes	Yes	100%
Falls and non-hip fractures (National Falls & Bone Health Audit)	Yes	Yes	100%
Blood transfusion			
O neg blood use (National Comparative Audit of Blood Transfusion) Platelet use (National Comparative Audit of Blood Transfusion)	Yes	Yes	100%

National confidential enquiries

National Confidential Enquiries	Eligible	Participated
NCEPOD (National Confidential Enquiry into Perioperative Deaths)	Yes	Yes
Surgery in children	Yes	Yes
Cardiac arrest in hospital	Yes	Yes
Peri-operative care	Yes	Yes
CMACE (centre for maternal and child enquiries)	Yes	Yes

Reviewing reports of national clinical audits

The reports of seven national clinical audits were reviewed by the provider in 2010/11 The Royal Wolverhampton Hospitals NHS Trust does not currently have a process for monitoring actions taken to improve the quality of healthcare provided.

This has been identified as a gap in performance monitoring and will be addressed in 2011/12 when it is incorporated within the Clinical Audit Committee's remit.

Reviewing reports of local clinical audits

The reports of 265 local clinical audits were reviewed by the provider in 2010/11 and The Royal Wolverhampton Hospitals NHS Trust intends to take the following actions to improve the quality of healthcare provided:

- Construct patient information leaflets to inform patients of care and expected outcomes following treatment or procedure.
- Introduction of a pro-forma for all head injury patients based upon NICE guidance.
- Employment of a specialist end of life practitioner to support palliative care team.
- Employment of additional staff to reduce waiting time.
- Implement Integrated Care Pathways to introduce uniformed high level care.
- Implement pressure ulcer awareness notice board on ward to highlight patient's assessment level.
- Ensure that all patients newly started on Warfarin are given Warfarin information pack.
- Add ECG to the Triage blood taking chart to determine who should be given an ECG based on clinical need.
- All admitted patients should have urinalysis done and recorded on clerking sheet.
- Junior Doctors to assess patient inhaler technique prior to discharge.
- Consultants to review current VTE risk assessment on each ward round.
- An e-learning package has been made available to all staff on the intranet aimed at understanding the safe use of insulin and has been produced in association with NHS Diabetes and NPSA.
- An emergency insulin substitute guide has been designed and issued to all inpatient areas. This guide aims to ensure insulin is given to patients who do not have their own insulin with them and pharmacy is closed. Suitable substitute insulin is suggested with safety caveats.

- To fully integrate with GPS to ensure continuity of care - Training and discussion with pharmacists to raise vigilance and ensure standardised interventions at ward level to ensure insulin prescription and dispensing is to the required standard.
- A 7 day awareness campaign has been launched on trust computer desk tops regarding safe use of insulin.

Participation in clinical research

The number of patients receiving NHS services provided or sub-contracted by The Royal Wolverhampton Hospitals NHS Trust in 2010/11 that were recruited during that period to participate in research approved by a research ethics committee was 2396. Of which 656 have been recruited into randomised clinical controlled trials (574 non commercial, 82 commercial). This is a considerable increase on RCT recruitment compared to 09/10.

Participation in clinical research demonstrates the Trust's commitment to improving the quality of care we offer and to making our contribution to wider health improvement. Our clinical staff stay abreast of the latest possible treatment possibilities and active participation in research leads to successful patient outcomes.

Last year Research and Development achieved a £3.7 million turnover for the Trust. The team works closely with a number of key partners to facilitate the advancement of knowledge, treatment, care and modernisation through research and innovation activity which will, ultimately, benefit our current and future patients. Key partners include the West Midlands Comprehensive Local Research Network, Greater Midlands Cancer Research Network, Stroke Research Network and Medicines for Children Research Network.

During 2010/11 the Research and Development Directorate has achieved credit for its innovation management work with staff, academia, industry and patients. Championing innovators to local and national recognition leading to products supported, developed and commercialised by the Trust are now being commercially sold back into the NHS, Private healthcare, on-line and via prescription.

In August 2010 the Trust implemented a new Research and Development Directorate approval pathway. This pathway has been shared with the West Midlands North Comprehensive Local Research Network (WMNCLRN) Governance team as an example of good practice.

By March 2011 there were 287 active studies (including patients who are being followed up after involvement in a study) open across the Trust a measured increase of more than 130 trials since 2008/2009. There is a continued stream of projects being reviewed and processed each month with an average of 10 new studies a month being received.

We can demonstrate research activity across a number of Departments with notable success in developing new areas such as critical care, A&E and Rheumatology. Areas such as Diabetes have found this route difficult but are reviewing new commercial and own account research opportunities until such time that the National Institute for Health Research trials are available. The Oncology and Haematology directorate still dominate the Trust portfolio in terms of active trials but these are also linked to rare disease and very complex trial inclusion/exclusion criteria and low patient recruitment targets.

The Trust has also gained significantly increased income streams to build research capacity across the Trust. The added support has allowed the Trust to increase its research capability

and funding support. Funding from the WMNCLRN supports Research Management, Clinical Support and Support Service activity linked to trials open to recruitment.

The Trust's commitment to excellence is further confirmed by the appointment, in September 2010, of a Professor of Clinical Practice and Innovation, a joint post between the Trust and the School of Health and Wellbeing at the University of Wolverhampton. Prof. Sque's focus is to raise research awareness within the Trust and advance the development of multi-disciplinary research, to drive forward innovation and enhanced quality in clinical care. She provides research leadership and support, and acts as role model for the professions allied to medicine. A major part of her role is to unlock research talent in the Trust and School to further a culture of enquiry. This initiative will be led through the establishment of a research network and the development of a high impact, practice focused strategy that engages stakeholders, and offers them the opportunity to influence the direction taken towards a shared research vision.

Use of the CQUIN payment framework

A proportion of The Royal Wolverhampton Hospitals NHS Trust income in 2010/11 was conditional on achieving quality improvement and innovation goals agreed between The Royal Wolverhampton Hospitals NHS Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of NHS services, through the Commissioning for Quality and Innovation payment framework.

Further details of the agreed goals for 2010/11 and for the following 12 month period are available from David.Butterworth@nhs.net.

Statements from the Care Quality Commission

The Royal Wolverhampton Hospitals NHS Trust is required to register with the Care Quality Commission and its current registration status is fully compliant. The Royal Wolverhampton Hospitals NHS Trust has no conditions on registration.

The Care Quality Commission has not taken enforcement action against The Royal Wolverhampton Hospitals NHS Trust during 2010/11.

The Royal Wolverhampton Hospitals NHS Trust has participated in one special review and one responsive review by the Care Quality Commission relating to the following areas during 2010/11

Special reviews

- Paediatrics

Responsive review

- Privacy and dignity, nutrition

The Royal Wolverhampton Hospitals NHS Trust is awaiting the CQC report following the responsive review, once received the Trust will develop an action plan to address the conclusions or requirements reported by the CQC.

Statement on relevance of Data Quality and your actions to improve your Data Quality

The Royal Wolverhampton Hospitals NHS Trust will be taking the following actions to improve data quality:

- Conducting a regular audit cycle as per Information Governance Toolkit (IGT) standard 506.
- Performing a monthly Completeness and Validity check across Inpatients, Outpatients and Waiting List data sets as per IGT 507.
- Monitoring activity variances as per IGT 504.
- Using external data quality reports as per IGT 502.
- Using standardised and itemised data quality processes in SUS data submissions every month.
- Holding the monthly Contracting and Commissioning Forum/Data Quality Subgroup with an established agenda of issues for scrutiny.

NHS Number and General Medical Practice Code Validity

The Royal Wolverhampton Hospitals NHS Trust submitted records during 2010/11 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data:

The percentage of records in the published data which included the patient's valid **NHS number** was:

98.0% for admitted patient care
97.0% for out patient care
92.5% for accident and emergency care

The percentage of records in the published data which included the patient's valid **General Medical Practice Code** was:

100% for admitted patient care
100% for out patient care
100% for accident and emergency care

Information Governance Toolkit attainment levels

The Royal Wolverhampton Hospitals NHS Trust Information Governance Assessment Report overall score for The Royal Wolverhampton Hospitals NHS Trust was 73% and was graded red under the IGT Grading Scheme.

Work has been ongoing to implement the online Information Governance Training Tool, provided by Connecting for Health. The training initiative provides guidance and information on good practice to ensure necessary safeguards for the appropriate use of corporate, patient and personal information and is available to all staff.

Clinical coding error rate

The Royal Wolverhampton Hospitals NHS Trust was subject to the Payment by Results clinical coding audit during the reporting period by the Audit Commission and the error rates reported in the latest published audit for that period for diagnoses and treatment coding (clinical coding) were:

Primary Diagnoses Incorrect [21.3%]
Secondary Diagnoses Incorrect [15.3%]
Primary Procedures Incorrect [23%]
Secondary Procedures Incorrect [13.7%]

This level of error is above the average experienced at trusts in England. The position has however improved since 2009-10. The Trust has a detailed action plan in place to ensure its performance improves further.

Part3 - Review of quality performance

Our performance against our 2010/11 priorities

RWHT set out four priorities for improvement in 2010/11 these were:

- Infection Prevention and Control
- Cancelled Operations
- Privacy and Dignity
- Dementia Project

Throughout the year we have worked hard to deliver against each of these priorities and the measures set out in the quality account document. The tables below show our progress to date and any further actions required over the coming year.

2010/11 Priority One: Infection Prevention and Control

Measure 1: No more than 4 MRSA bacteraemia attributable to the hospital during the year.

Performance in 2010/11: There have been no MRSA bacteraemia attributable to the Trust during 2010/11.

Measure 2: Continue to reduce the carriage rate of MRSA in all local care homes in partnership with Wolverhampton City Primary Care Trust.

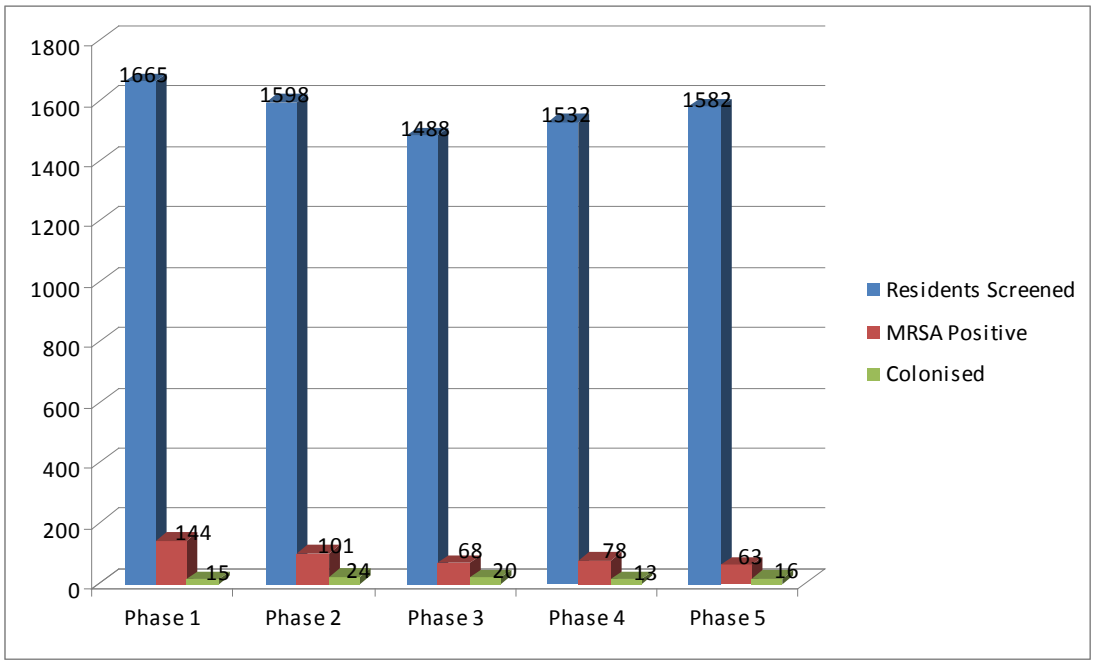
Performance in 2010/11: The PREVENT charter was implemented in partnership with the PCT Infection Prevention Team:

Promote best practice through a nominated infection prevention champion
Regularly monitor for compliance of the required standards and take remedial action as appropriate
Ensure high standards of hand hygiene awareness and compliance
Visible compliance with dress code standards
Ensure high standards of environmental cleanliness and an annual deep clean and declutter
Never accept poor standards and practice and implement best practice guidance into local practice
Take action and protect patients and the public

One aspect of this is related to developing an MRSA screening programme within Care Homes, the table below shows that MRSA colonisation* figures have improved over time as this programme has been implemented.

* colonisation means that the organism is present in or on the body but is not causing illness

MRSA colonisation figures



Further action required in 2011/12: Work will continue in this area in the following ways:

- MRSA screen of care homes residents will continue on a six monthly rotational basis, as part of Wolverhampton MRSA screening strategy.
-
- A Care Home audit programme will be carried out by the Infection Prevention Team on an annual basis using a locally devised audit tool which reflects the DH infection control guidance for care homes (2006). Homes are offered the opportunity to sign a PREVENT pledge of commitment to improve standards within the home year on year. Dependent upon audit score, a certificate of compliance is awarded in an annual awards ceremony.

- Education and training, a locally produced infection prevention training DVD has been circulated to every care home free of charge, this allows mandatory training to be facilitated within the home on an annual basis and on induction for new starters.

Measure 3: To meet the stretch target and reduce the number of cases of *C. difficile* infection with no more than 76 cases attributable to the hospital during the year.

Performance in 2010/11: 80 cases of *C. difficile* were attributable to the hospital in 2010/11, meaning the Trust achieved and bettered the Department of Health MRSA target set at no more than 106 cases, however we unfortunately failed to meet our internal stretch target of no more than 76 cases by four cases. Failure to hit the target was due to the Trust changing the testing methodology for *C.difficile* to a more sensitive method for the identification in the final two months of the year. By changing our testing methodology we are now able to reduce the number of false negative results, and ensure patients receive appropriate treatment promptly.

Further action required in 2011/12: An action plan has been developed to continue to improve our performance in reducing *C. difficile.* This action plan will be implemented across the hospital, reviewed regularly and adjusted accordingly.

Measure 4: Reduce the number of hospital-acquired bacteraemia (blood infections) known within the Trust as DRHABs, particularly those associated with medical devices.

Performance in 2010/11: In 2010-11 the number of HABs had fallen to 300 from 333 in 2009-10. DRHABs fell to 105 (against a target of 134) in 2010-11 from 140 (against a target of 151) in 2009-10.

Work has been ongoing to raise awareness around device related hospital acquired bacteraemia. In relation to standardising equipment used for urinary catheterisation, peripheral venous cannulation clinical procedures have been developed for central venous catheterisation and urinary catheterisation.

We have implemented a urinary catheterisation and central venous catheterisation group meeting.

During March 2011 we held a Trust wide DRHABs awareness month, with training and clinical assessment related to central venous catheterisation conducted.

Further action required in 2011/12: As set out in part two of this document this will be one of the Trust's priorities for 2011/12. Our aim being to ensure no more than 8 DRHABs occur each month, or 96 in total for 2011/12.

We will continue the work that has already been achieved by the Patient Safety DRHAB project lead, and continue to monitor DRHABs.

We will combine the urinary catheterisation group with the group from the PCT.

Policies concerning the insertion and management of medical devices will be reviewed to ensure a consistent approach across the organisation.

We will implement the urinary catheterisation pack – closed system thereby reducing the risk of contamination which could lead to infection.

We will also implement a programme of training and education, allied to general training of all clinical staff on the aseptic non-touch technique (ANTT).

Measure 5: Expand the current surgical site surveillance programme.

Performance in 2010/11: The surgical site infection surveillance programme is ongoing within the established areas of cardiac and orthopaedics. A trial was conducted within Maternity during April – June and June – September 2009.

Measure 6: Work with the Primary Care Trust to reduce infections associated with chronic wounds and urinary catheters across the community.

Performance in 2010/11: The Infection Prevention System Improvement Manager post was successfully recruited to in March 2011.

Work is under way with Tissue Viability to develop a database across the health economy to help monitor chronic wound infections.

The Urinary catheter working groups have been established in both the community and the acute trust.

We have developed an approach based on the principle that if we reduce the number of catheters inserted and reduced the number of days they are in inserted for, then the number of catheter associated urinary infections should also drop.

Policies have been developed and implemented in relation to urinary catheter insertion and management.

An audit was conducted in relation to documentation, and systems are in development to improve this area. A trial is in progress for a closed drainage catheterisation pack and a prevalence survey was also conducted across the health economy in March 2011.

Measure 7: Review and revise the staff infection prevention education programme.

Performance in 2010/11: Infection Prevention Induction and Mandatory training at both Level 1 and Level 2 have been reviewed to ensure that they comply with the West Midlands Passport for mandatory training.

A training package has been developed for both levels for face-to-face presentation as well as an e-learning package. A support pack for level 2 has been developed and was implemented in March 2011; a support pack for level 1 is in development and is due for implementation in June 2011.

Mandatory training requirements have been changed meaning all staff (both clinical and non-clinical) are required to complete an annual infection prevention update, this involves either attending the face-to-face session or completing the e-learning package, and undertaking hand hygiene competence.

2010/11 Priority Two: Cancelled Operations

Measure 1: Review the planning of theatre lists to ensure that, where possible, we reduce the number of operations cancelled for non-clinical reasons as part of the Productive Operating Theatre Programme.

Performance in 2010/11: During 2010/11 the Trust implemented The Productive Operating Theatres Programme. The scheduling module has been used in two of our theatres, and this is helping teams create consistent and realistic theatre lists through better planning and helping to prevent some of the cancelled operations.

We have developed protocols for identifying patients and/or lists that may be cancelled.

We also undertake detailed analysis of each cancelled operation so we can learn from this and aim to prevent reoccurrence.

Further action required in 2011/12: We will evaluate the effectiveness of the work and if successful, it will roll out to other areas in 2012.

Measure 2: Decrease the number of patients whose discharge is delayed via joint project with Wolverhampton City Primary Care Trust and the Local Authority.

Performance in 2010/11: The joint project has developed a Wolverhampton city discharge from hospital and transfer of care strategy; a practical resource for practitioners and organisations with advice to support improvements in how they manage the discharge of individuals and transfer of care between settings, including criteria for use of step down beds.

Measure 3: Develop more facilities to support additional activity with a possible option to include building 2 additional operating theatres with recovery room facilities.

Performance in 2010/11: Two new theatres and recovery facilities have been built to accommodate the increasing demand on our service, and are due to open in May 2011.

Measure 4: Review and streamline pre-operative assessment.

Performance in 2010/11: RWHT has carried out a review of all pre-operative documentation to streamline the assessment process; this allows early identification of any clinical issues that would otherwise lead to on the day cancellations.

Case study - Cardiothoracic Services Cancelled Operations

In order to reduce the number of cancelled operations the directorate now runs an additional pre-operative assessment clinic on a Monday for cardiac surgical patients as there was previously insufficient capacity. This now ensures, as far as possible, that most patients will be seen pre-operatively within 4 weeks of their surgery and will minimise any cancellations due to lack of pre-op assessment.

An additional thoracic pre-operative assessment clinic is now also provided on a Tuesday afternoon to run alongside the Thoracic and Respiratory outpatient sessions so any identified cancer patients for surgery within 7-14 days are seen in pre-operative assessment. This is a much improved pathway for patients, ensures they are seen pre-operatively and avoids a return visit to the Trust.

A prototype patient discharge board (to be at every patient bed space) has been developed with a multi-disciplinary team. This will shortly be piloted on Cardiology ward, to identify early in the patient's pathway what is required prior to discharge and involves patients and their carers at an early stage of this process.

2010/11 Priority Three: Privacy and Dignity

Measure 1: Provide same sex accommodation in the new emergency surgical ward.

Performance in 2010/11: This has been achieved following the opening of the new emergency surgical ward in July 2010.

Measure 2: Complete same sex accommodation programme.

Performance in 2010/11: Our Day Surgery ward has been reconfigured to ensure same sex accommodation and a new location for paediatric surgery. Building work was completed March 2011.

Measure 3: Modernise wards to provide more single bedroom and private bathroom facilities.

Performance in 2010/11: The Integrated Critical Care Unit has undergone building work to install two new bathroom facilities in order to support same sex accommodation.

The new Head and Neck ward has en suite bathroom facilities in each of the four bedded bay and seven side wards. The emergency surgical ward also has a similar layout with all four bedded bays having en suite bathroom facilities.

The dementia services, surgical admissions unit, women's cancer treatment ward and neonatal unit have also been refurbished.

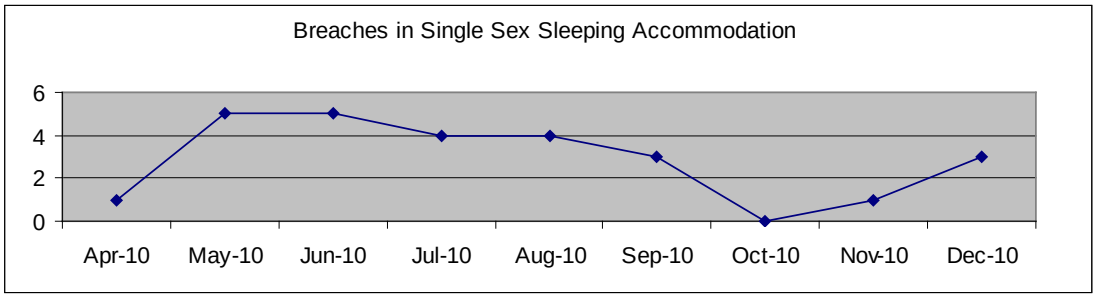
Measure 4: Install improved signage in wards so that it is clear which facilities are for men and which are for women.

Performance in 2010/11: New Dementia friendly signage has been installed in all inpatient areas to identify which facilities are for men and which are for women.

Measure 5: Where same sex accommodation breaches occur for non-clinical reasons the Matron will be informed, prompt action will be taken to rectify the situation, and a thorough investigation using root cause analysis will be carried out.

Performance in 2010/11: This process has been implemented and all breaches are reported as an incident onto the Datix system, a root cause analysis is undertaken and decision taken whether the breach was required under clinical reasons. For December and January the incidents which were reported all occurred in ICCU and on review were all due to clinical requirements. These breaches are reported through to Trust Board and commissioners.

The graph below shows that RWHT had no more than five breaches in any one month for single sex accommodation during 2010/11.



Measure 6: Same sex accommodation issue will feature highly in all service redesign discussions.

Performance in 2010/11: We are currently looking to review the services and facilities we provide in OPD1 and same sex accommodation and signage is a feature.

Measure 7: The importance of same sex accommodation will be incorporated into our local staff induction process and included in our integrated business plan.

Performance in 2010/11: Local induction for nurse is currently under review and the criteria and actions to be taken in relation to same sex care will be included.

Measure 8: We will include same sex accommodation into all of our future local patient surveys.

Performance in 2010/11: We are currently developing a Trust wide patient experience survey programme. Information regarding single sex accommodation will be routinely included.

Case study – Head and Neck Ward Single Sex Accommodation

D4 Head and Neck ward provides single sex accommodation. In July 2010 the ward relocated from C5 to a new and improved facility (D4). The new 15 bedded ward comprises three spacious bays accommodating 3 beds and 1 side room. Bays now comprise designated en suite bathroom facilities within the bay which previously was not in place.

The side rooms within the bays each have individual en suite facilities. The new layout provides excellent en suite facilities for privacy and dignity of patients and maintains 100% compliance with same sex accommodation at all times.

The ward has in total 6 side rooms all with individual en suite facilities which provide the speciality flexibility in barrier nursing and to nurse more complex/unwell patients.

Following the relocation of the ward a significant improvement in the environment has been evident; in particular the bed space within the bays providing more room for staff to work with patients. Windows are also in place at the front of the bays so visibility for patients has also improved.

2010/11 Priority Four: Dementia Project

Measure 1: The ward will be completed by the end of September 2010 and the new model of person centred care will be introduced.

Performance in 2010/11: The ward was opened on 22nd November 2010 and the new model of person centred care introduced from the outset. The care bundle has been tested and refined during the months since opening.

Further action required in 2011/12: There will be a review of the operational guidelines in 2011/12 and a final refinement of the care bundle prior to publication in June 2011.

Measure 2: Baseline data regarding standards of care is currently being collected. An external evaluation is planned and will monitor success in meeting key aims and objectives during the next 18 months.

Performance in 2010/11: Baseline Data has been collected using a number of methodologies. The external evaluation is actively underway and an interim report is due for publication in June 2011.

Further action required in 2011/12: The final report is due for publication in December 2011 by which time it is expected that it will be possible to evaluate the impact of the new service.

Measure 3: An outreach team for wards and departments across the hospital will be piloted offering expert support and advice for staff caring for patients with dementia.

Performance in 2010/11: All but one member of the Outreach Team are in post as at April 2011. It is expected that the final post will be taken up by June 2011. A phased implementation across the hospital is planned with the Emergency Assessment Unit being targeted initially along with a further medical and surgical ward to test the care bundle. A Senior Lecturer has been seconded to the Trust from the University of Wolverhampton to design a dementia educational strategy and deliver training programmes and educational activity to a wide range of staff.

Further action required in 2011/12: In 2011/12 the outreach team will extend its service throughout the hospital and this together with the training programme for staff throughout the hospital will improve the skills and knowledge of staff to respond more effectively to the needs of people with dementia.

Patient experience

Providing an excellent patient experience is a key driver of RWHT services, we recognise however that we still have some way to go in achieving this. During 2010/11 we have been focused on developing the foundations required to meet this goal.

Patient Experience Strategy
During 2010/11 the Trust developed its first Patient Experience Strategy which sets out the Trust's approach to measuring, capturing and improving patient experience. The aim of the strategy is to develop a culture that places quality of patient experience at the heart of all we do, where "seeing the person in the patient" is the norm.

We believe that the six key areas set out in the diagram below need to be addressed in order to capture, measure and improve patient experience. The strategy examines each of these six key areas in turn and explores the steps we will take to improve each area.

The patient experience strategy contains 11 objectives to be met over the next three years. The table below sets out the objectives and progress achieved during 2010/11.

Objective	**Progress achieved during 2010/11**
1: Build on existing work to further develop robust systems and processes for gaining both quantitative and qualitative feedback from users	The real time patient experience tracker system has been purchased, protocols for its use have been developed, the survey has been developed and tested and volunteers have been trained to deliver the survey
	Patient stories have been presented at each Trust Board meeting since December 2010
	An outreach PALS service has been piloted on three wards and one outpatient area since January 2011
	New branding, posters and leaflets have been developed for the PALS service and distributed across the hospital since December 2010
2: Develop more robust analysis of complaints and PALS to inform service improvement.	A review of the complaints service was carried out in June/July 2010. As a result the team structure was subsequently revised
	A survey of complainants gathering feedback on the complaints process has been piloted in October 2010

	All complaints reports produced by the patient experience team were reviewed and revised in summer 2010
3: Develop systems and processes that appropriately link willing patients, governors and other stakeholders with teams trying to make service improvements.	A review of Patient Experience Forum took place in July 2010 as a result new terms of reference have been agreed, membership of the forum has been refreshed and a work programme will be developed for 2011/12.
4: Develop training and an accompanying toolkit to assist team / department leaders to maximise and sustain the capacity and capability of individual team members to impact positively on patient experience	Patient experience, complaints and Equality and Diversity training packages have been reviewed and amended throughout 2010
5: The Trust Board will play an active leadership role in advocating improvements in the patient experience	Background work has taken place to strengthen the patient experience element of the Board members Leadership walkabouts. The revised approach will begin in April 2011
6: Develop a minimum data set and dashboard for teams and departments to drive reliability and consistency of patient experience	Directorates and divisions receive a range of reports on complaints, this will be further strengthened in 2011 with the roll out of the new quality dashboard and real time patient experience tracker
7: Every service within the Trust will use patient experience to gain insight and identify opportunities for improvement.	See above
8: Every service within the Trust will, having identified opportunities for improvement, implement at least one patient experience improvement project annually.	Work on this objective will take place in 2011/12
9: The Patient Experience team lead a Trust wide 'campaign' style approach to make improvements in the identified themes.	Work on this objective will take place in 2011/12
10: The Trust will further develop systems and processes to provide feedback to users and other stakeholders, both at service / department and corporate level.	Work on this objective will take place in 2011/12
11: Develop new Patient Experience key performance indicators for corporate monitoring, and a system of service reviews to theme/ triangulate patient experience data.	Directorates and divisions receive a range of reports on complaints, this will be further strengthened in 2011 with the roll out of the new quality dashboard and real time patient experience tracker

We use a range of methods to gather feedback from patients, carers, community representatives and other stake holders. Some of the projects that we have involved local people in during 2010/11 include:

- Holding a stakeholder event at the preliminary planning stage of the single emergency portal project to develop a stakeholder brief setting out the needs and requirements of both our local geographic community and several local communities of interest. This brief was subsequently fed into the service design considerations at the trust.
- Patient and visitor feedback told us that hospital signage is considered poor and inconsistent. The Trust therefore organised the Navigating New Cross event, engaging with various groups including learning disability and vision impaired groups to test out the proposed new signage system prior to purchase. The feedback gathered from the event has fed into the signage development plan.
- Stakeholders have played a key role in shaping RWHT Quality Account documents since our first in 2009/10. This continued in 2010 when patients and public helped to decide the Quality Account priorities for 2011/12. When we held a prioritisation event to understand the key issues for the local community, this has directly shaped the final priorities chosen.
- A patient information reading group has been established to feedback on the readability, content and style of all new patient information developed by the Trust whilst in draft form to ensure all patient information is accessible and useful. The group is made up of members, volunteers and patient representatives.

Patient surveys

The table below sets out RWHT's performance for three key questions in the national inpatient survey. Each year a randomly selected sample of RWHT patients take part in the National inpatient survey. The findings of the survey are reported to the Trust Board and divisional action plans are formulated annually and monitored throughout the year to address any issues raised.

We are keen to continue to improve our performance in the national surveys and have therefore selected our weakest area as demonstrated by this survey as one of our Trust priorities for 2011/12.

Table: National inpatient survey results

	2006/07	2007/08	2008/09	2009/10	2010/11
Involved as much as want to be in decisions about care definitely/ to some extent	88%	87%	91%	87%	90%
Treated with respect and dignity always/sometimes	97%	97%	97%	97%	97%
Overall care rated as excellent/very good/ good	90%	92%	92%	94%	93%

Alongside the national patient surveys RWHT gathers patient feedback via local surveys. To build on this we will be rolling out a systematic approach to gathering patient feedback on a monthly basis using a real time patient experience tracker system. Starting in April 2011, initially with adult inpatient wards, volunteers will use hand held devices to gather feedback

on a range of issues including privacy and dignity, food, hygiene, staff attitude and involvement in decision making.

Case study - learning from our cancer patient surveys

The Trust took part in a 'one off' nationally co-ordinated cancer patient survey to monitor national progress on cancer care in early 2010. The results showed that the Trust performed within the top 20% of all UK hospitals regarding the following:

- Provision of good written information re side effects of diagnostic tests & treatment.
- Opportunity to talk to a doctor when needed.
- Privacy.
- Good information regarding follow up care and good support post discharge.

However performance was in the lowest 20% of UK hospitals regarding the following:

- Patient perception of an inadequate number of nurses on duty.
- Patient perception of not enough being done to control the side effects of radiotherapy (particularly breast patients).
- More than a 30 minute wait to be seen in OPD clinics.

In addition to the national survey Wolverhampton patients have developed their own local survey funded by the PCT. The survey is conducted in 2 parts covering care in both the PCT and at the Trust. The survey commenced in February 2010 and to date, each roll out of the survey has generated approximately 90 responses (a 75% return rate). The roll out is scheduled to continue on a "rolling basis" for 18-24mths.

The findings of both surveys alongside feedback from staff and patients have led to a number of actions being taken to improve patients' experiences. These include:

- A Walk-in facility has been developed between Respiratory OPD Clinic and Thoracic OPD clinic to facilitate same day referral as New OPD appointment.
- Appointment changes now handled via the Surgical Co-ordinator rather than being re-directed back to clinic management for timeliness control.
- Biopsy samples are now fast-tracked (labelled 62 day cancer patient) between Theatres and Pathology Labs.
- Weekly review of 62 Day Pathways by Directorate Manager/Surgical Co-ordinator.
- Effective communication structure in place between MDT Co-ordinator, Surgical Co-ordinator for timely management of patients.
- Robust Cover arrangements in place for Surgical Co-ordinator cover to ensure continuity of timely management of patients.
- Directorate Manager reports Performance against target for review and monitoring at Directorate Board Committee meetings.
- Directorate Manager maintains regular liaison with Cancer Services Manager to review service improvement ideas.
- Other speciality Consultants now able to call on call Consultant Cardiologist to obtain immediate advice concerning medication (Clopidogrel) to progress cancer treatment (previously written process).

PALS and Complaints

The Trust recognises the importance of learning lessons when things go wrong and taking action to stop mistakes being repeated. We continue to work on improving our reporting systems and understanding the underlying issues that we need to address in order to improve patient experience and reduce complaints.

During 2010/11 there has been a drive to raise the profile of the Patient Advice and Liaison Service (PALS) to patients and visitors of the Trust. We have developed new posters and leaflets promoting the service and piloted an outreach PALS service, where the team visits wards to support patients with any questions or concerns they may have. The service has been well received by both staff and patients and has allowed us to support patients and deal with issues as they arise. The aim is to roll this service out to more areas of the Trust in 2011/12.

The number of people using the service continues to rise year on year as can be seen in the table below.

PALS contacts

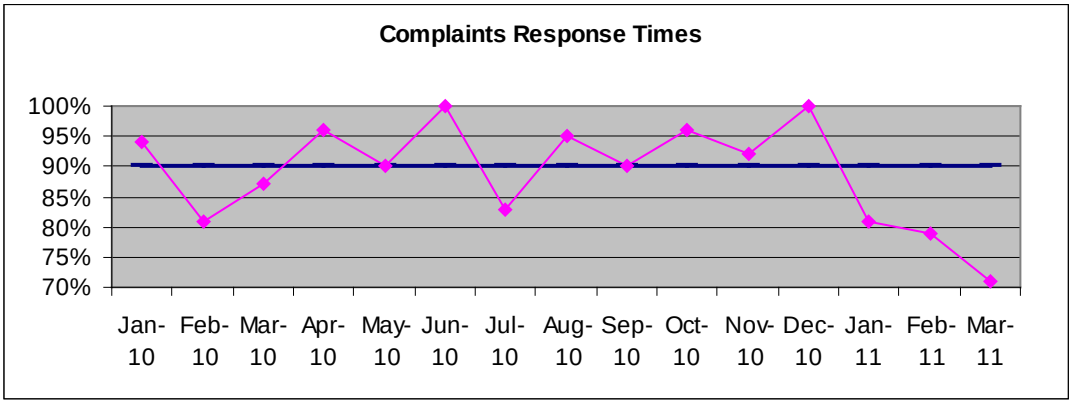
	2008/09	2009/10	2010/11
No of PALS Contacts	434	549	858

During 2010/11 RWHT integrated the PALS and complaints services. The aim of this reconfiguration was to move away from the process driven approach towards a more person focused and responsive service in line with the 2009 NHS complaints legislation and the Parliamentary and Health Service Ombudsman principles. The next phase of embedding this approach will include a revised complaints policy and investigating officer training programme in 2011.

The table below shows RWHT complaints data

	2006/07	2007/08	2008/09	2009/10	2010/11
Total number of complaints	342	449	382	424	289
Response within deadline	85%	94%	93%	90%	82%

The recent fall in providing complaints responses within the Trust's local target of 25 working days is disappointing and work is underway with directorates to understand why this is has occurred and identify actions to ensure we reach 90% or above in 2011/12.



Ratio of complaints to activity

		2006/07	2007/08	2008/09	2009/10	2010/11
Inpatient	No. of Inpatient episodes	110,084	114,224	127,419	136,383	136,335
	No. of complaints	97	136	110	146	113
	Rate per 1000 Inpatient episodes	0.9	1.2	0.9	1.1	0.8
Outpatient	No. of Outpatients seen	376,373	388,676	428,981	462,563	450,230
	No. of complaints	113	197	133	175	95
	Rate per 1000 Outpatients seen	0.3	0.5	0.3	0.4	0.2
Acute Emergency Medicine	No. of Patients seen	32,934	33,521	35,130	40,071	37,781
	No. of complaints	66	47	39	70	61
	Rate per 1000 admissions	2.0	1.4	1.1	1.7	1.6

Case study – A complainant's story

As part of a family "team" I helped care for my mother-in-law, who suffered from dementia, during her stay in New Cross because of the problems of care, mainly with feeding, medication and physical well being that occurred. As she was on an orthopaedic ward they were just not organised to cope with patients, often, although not exclusively elderly with dementia, who often cannot speak or do little for themselves. After discussions with Matron we were given every assistance to carry out our caring role until eventually she was discharged to a nursing home. As a consequence of this contact one of the family was invited to join the Person Centred Care Group, set up to develop the care package for the new dementia ward and subsequent outreach to other wards. As I felt very strongly that the hospital's treatment of patients disadvantaged with dementia and similar problems needed to be improved I readily agreed to become the carer representative on this working group.

Having spent my working life in industry until I retired 11 years ago it was quite an experience and a challenge to work with professionals from a very different environment, the NHS! The experience became even more challenging when I found myself as part of the 5 person team from the hospital working to improve the physical environment for patients with dementia as part of the Enhancing the Healing Environment Project run by the King's Fund. This has involved residential training courses and seminars to enable the team, which has its own budget, to manage the design and planning and eventually see through to completion the provision of a garden for the new dementia ward, D22, and the transformation of part of the EAU to make it much more dementia friendly. As my "official" title is volunteer research assistant I've also carried out surveys and taken part in meetings planning for the future at New Cross. It has been most rewarding to be able to put to use the experience gained during my working life to help others less fortunate than myself.

Complaints to the Parliamentary and Health Services Ombudsman (PHSO)
During 2010/11 the PHSO upheld six complaints against the Trust. Action plans have been developed for each of these complaints setting out how lessons will be learnt and action taken. Some of the key actions arising from these action plans include:

- We have raised nutritional awareness within the Trust by means of a "30 day to make a change" campaign.

- Our Heads of Nursing rounds now include nutrition as an area for monitoring.

- The Integrated Critical Care Unit now has an End of Life care bundle which was implemented by the ICCU clinicians and senior nursing staff. This replaced the existing End of Life Care Pathway. The care bundle includes multi disciplinary meetings, family meetings and clear guidelines for the management of symptoms and withdrawal of supportive treatment.

- We have produced and implemented a Patient Information Leaflet on the use of unlicensed medicines.

- We have adopted and incorporated in training the SBARD safety/communication improvement technique to cover communication in the adult deteriorating patient.

Patient Safety

VitalPAC
During October to December 2010 the Trust introduced VitalPAC in our adult medical and surgical wards. VitalPAC is an electronic, wireless point-of-care system. The core system enables staff to enter patients' physiological observations using hand held computers. The system automatically calculates an early warning score, prompts action based on the Trust's protocols and reminds staff when the patient's next set of observations is due.

Clinical staff can review observation charts and other information including test results and the location of patients on tablet PCs or on any PC in the Trust via the hospital Intranet.

Additional modules include the ability to complete thrombosis risk assessment and intravenous cannulae management.

The key benefits identified by other Trusts using VitalPAC include:

- Reduction in cardiac arrest rates, length of stay
- Reduction in mortality
- Complete, accurate, timely and fully auditable observations
- Timing of observations tailored to patient need
- Prompt, appropriate and audited escalation of care
- Automated track and trigger system (early warning score)
- Improved communication
- Compliance with NICE guidance
- Compliance with screening protocols
- High quality information

High Impact Actions
The High Impact Actions (HIA) for Nursing and Midwifery were developed following a 'call for action' from The Department of Health, Royal College of Nursing, Nursing and Midwifery Council, and Royal College of Midwives through the NHS Institute for Innovation and Improvement which asked frontline staff to submit examples of high quality and cost effective care that, if adopted widely across the NHS, would make a transformational difference.

In total eight 'essential' high impact actions have been identified set out in the table below:

HIA	Action
Your skin matters	No avoidable pressure ulcers in NHS provided care.
Staying safe – preventing falls	Demonstrate a year on year reduction in the number of falls sustained by older people in NHS provided care.
Keeping nourished – getting better	Stop inappropriate weight loss and dehydration in NHS provided care.
Promoting normal birth	Increase the normal birth rate and eliminate unnecessary caesarean sections through midwives

	taking the lead role in the care of normal pregnancy and labour, focusing on informing, education, and providing skilled support to first time mothers and women who have had one previous caesarean section.
Important choices – where to die when the time comes	Avoid inappropriate admission to hospital and increase the number of people who are able to die in the place of their choice.
Fit and well to care	Reduce sickness absence in nursing and midwifery workforce to less than 3%.
Ready to go – no delay	Increase the number of patients in NHS provided care who have their discharge managed and led by a nurse or midwife where appropriate.
Protection from infection	Demonstrate a dramatic reduction in the rate of Urinary Tract Infections (UTIs) for patients in NHS provided care.

RWHT has been working to develop, implement and measure actions in each of these areas. We have identified a Trust lead to oversee our progress and gather evidence of progress. So far we have achieved the following:

- The decision was taken to mainstream these eight HIA's into our existing quality framework rather than having an entirely separate approach. This has led us to rethink the format of our quality framework and the related performance indicators.
- For each HIA a nominated lead nurse was appointed (HIA champion).
- The Trust provided an SHA self assessment update in June on progress against the actions.
- The leads attended an SHA sponsored study day.
- There has been a 30 day improvement event for both pressure ulcer prevention and nutrition.
- The Falls Working Group has revisited their terms of reference and work plan.
- Normal birth rate data is collected monthly.
- A working group has been established to revisit or rejuvenate professional led discharge.
- Communication to nursing teams has been taking place at Divisional and Directorate level. This communication is ongoing and Matrons are raising awareness at team meetings.
- We are developing a collection of case studies showcasing examples of how our teams have contributed to high quality care through local innovations. This collection will be called the RWHT Essential Collection. Matrons are encouraging teams to continue to provide evidence of quality care implementation.
- HIA Steering Group has been established, leads have been identified for each HIA and an implementation strategy is under development.
- A self assessment has been undertaken (see attached), actions identified will address reporting, escalation and governance processes, including frequency of updates and communication to Trust Board, and metrics agreement where there are none currently established.

We will continue to build on our HIA work during 2011, developments will include:

- Producing a web based Quality Standards Directory to provide both a resource base and performance monitoring data collection tool for staff.
- The HIA Steering Group will monitor progress of implementation of HIAs and provide reports to TMT, Trust Board.
- The HIAs and the Preventing Harm - Improving Safety campaign will provide the focus for Nurses' Day 2011.
- Publication of an RWHT Essential Collection.

Patient Environment Action Team assessment

RWHT has continued to improve performance against the Patient Environment Action Team (PEAT) annual assessment gaining excellent ratings in all three areas in 2010. The PEAT assessment inspects standards across a range of services including food, cleanliness, infection control and patient environment, including bathroom areas, décor, lighting, floors and patient areas.

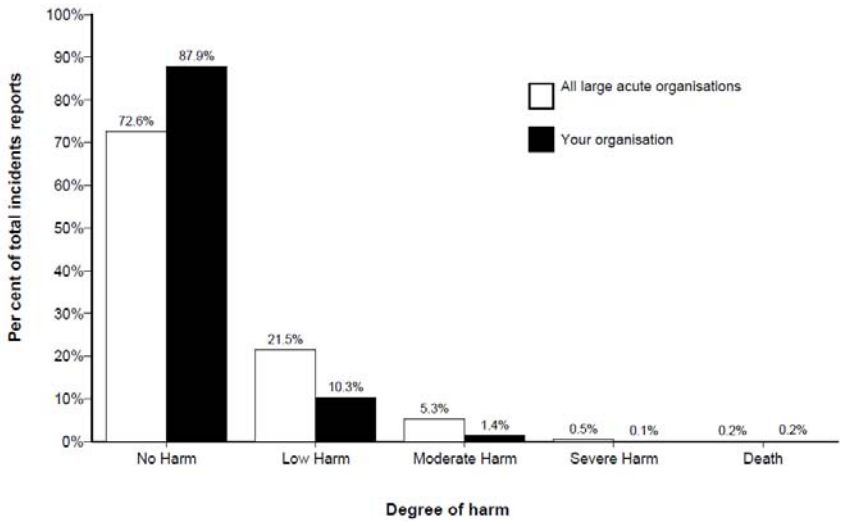
The table below sets out RWHT PEAT scores from 2006-2010

	2006	**2007**	**2008**	**2009**	**2010**
Environment	Good	Acceptable	Good	Good	Excellent
Food	Good	Good	Good	Good	Excellent
Privacy and dignity				Good	Excellent

Incident reporting

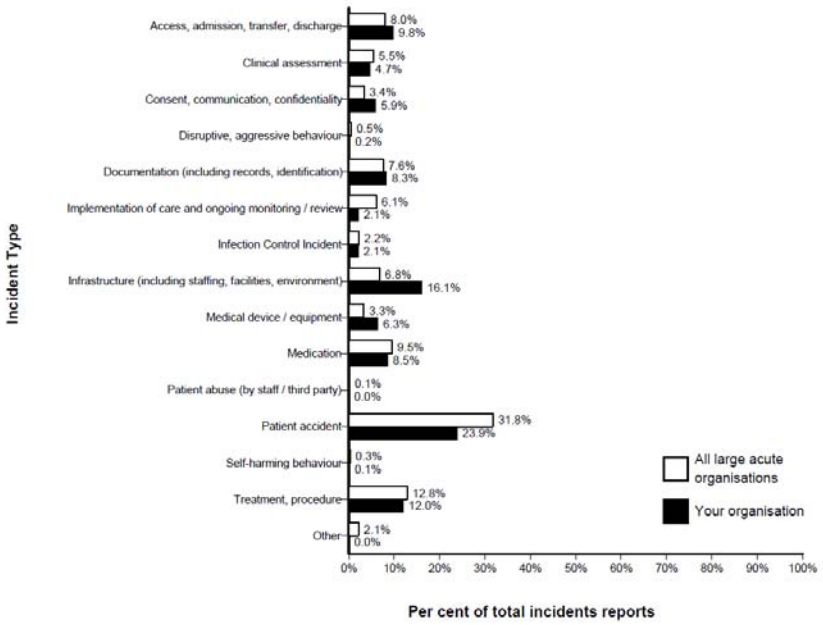
The Trust prides itself in reporting all types of incidents to ensure that we learn lessons from such occurrences. We upload our Patient Safety incidents to the NPSA / NRLS every month. As a result of this, the NPSA produces a worksheet (every 6 months) that compares our data with the rest of the country. The type of data presented is regarding types of incidents occurring, degree of harm to patients and how we (as a Trust) compare to similar sized Trust's across the NHS. The Trust reports the feedback from the NPSA / NRLS reports to the Board Assurance Committee every six months. Examples of information shared with the Board are:

Degree of harm to patients



The above graph shows that the Trust differs from other organisations in reporting more 'No Harm' incidents we believe that this is due to the quality checks performed and the Trust encouraging the reporting of near misses. As a Trust, it is agreed that we can learn from near misses which aids in creating a safer environment for patients and staff.

Types of incidents reported



The Trust reports proportionally more incidents relating to transfer, clinical equipment, assessment, documentation, and infrastructure than other large acute organisations. This can be directly linked to our reporting culture. Our equipment incidents may be skewed by the reporting of non-conformities by theatres – which makes up a significant proportion. It is worth noting that compared to organisations of a similar size we are reporting fewer patient accidents.

Reporting Culture

The Trust reports all patient safety incidents monthly in lieu; averaging over the period in the report 470 incidents a month. The broadly similar numbers reported to the NPSA indicate that the Trust has well established systems for regularly reporting to the NRLS. The Trust reports around 6.2 incidents per one hundred admissions, we believe this is indicative of the strong reporting and learning culture. This can also be triangulated with other available information on safety culture, e.g. high scoring on the staff survey questions regarding reporting and learning from incidents and achievement of NHSLA Level 2 General Standards.

In addition to this, The Trust looks at the top themes of incidents via Trends Analyses. This is undertaken at three levels:

- Directorate Trends – presented and discussed at Directorate Governance meetings
- Divisional Trends – presented and discussed at Divisional Governance meetings
- Trust Trends – presented and discussed at Quality and Safety Committee (also discussed in Board Assurance Committee)

The Trust recognises the importance of Trends Analyses as it ensures that we are pinpointing and tackling potential issues. It enables the Trust to share any lessons learned from direct actions taken as a result of an investigation / action plan.

Responding to safety alerts
Patient and staff safety is a highly regarded Trust priority and therefore the Trust has rigorous systems in place to respond to safety alerts. RWHT has reviewed its policy and process for the receipt, distribution and response to safety alerts. New alerts are received and distributed promptly to relevant service areas for action and response within a given timeframe. If an alert becomes overdue it is monitored monthly for progress until completion and signed off at a Trust committee.

RWHT works on the premise that closure of alerts will only take place when it can be satisfied that sufficient assurance is available on completion of actions.

There is little objective guidance regarding the point at which an organisation can be satisfied with its progress and close a safety alert and the Trust has erred on the side of caution in many cases choosing to maintain close internal monitoring whilst the alert remained open on the system.

As a result a number of alert responses that were commenced within timescale have not been closed until sufficient assurance allows for full closure of every action. An example of this is the right patient right blood alert, where we carried out a 100% competency based review for all identified staff. Other alerts such as safer use of injectable medicines have required the risk assessment and action management of hundreds of injectable medicines across the Trust.

The Trust remains committed to its responsibilities in maintaining patient safety and strives to ensure safe practice is applied through prompt distribution and monitoring of safety alerts, robust redress of its recommendations and reliable assurance of safety compliance.

Below are two examples of the actions RWHT has taken as a result of safety alerts

NPSA/2008/RRR011 Reducing risk of overdose with Midazolam injection in adults –
All actions in relation to this alert have been completed, including the development of a conscious sedation policy, which clearly identifies the roles and responsibilities of staff involved in the use of Midazolam in conscious sedation. This policy contains minimum training standards and local protocols for those areas involved in the use of Midazolam.
A training package has also been developed to ensure that staff involved directly or participating in sedation techniques have the necessary knowledge, skills and competences required. Monitoring of this training package has been ongoing to ensure that staff are undertaking the training.

NPSA/2010/RRR011 - Checking Pregnancy before Surgery –
All relevant policies were reviewed to ensure pregnancy status is checked in the immediate preoperative period and the checks are completed on the preoperative checklist, which now includes a checking for pregnancy. Incidents are monitored to ensure that there are no instances where the checks are not undertaken. If an incident were identified an investigation would be undertaken to learn lessons. There have been no incidents of this nature.

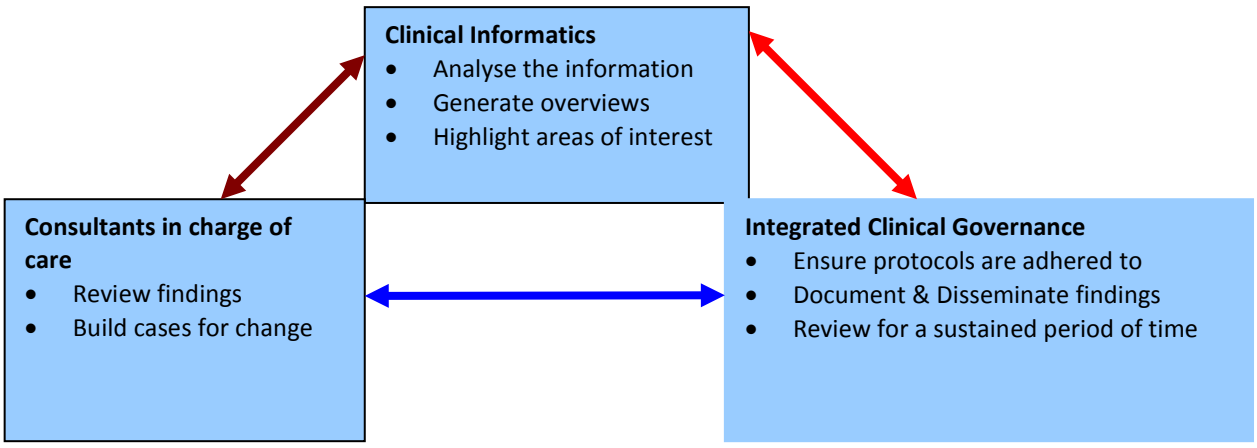
Clinical effectiveness

Adopting National Institute for Clinical Excellence (NICE) quality standards
RWHT uses a process of gap analysis and action planning to review and monitor compliance with the NICE quality standards. Work streams are in progress for standards published to date e.g. Venous thrombo embolism, Dementia and Stroke. Reports on how well the trust complies or where further actions are needed are made to Trust committees.

Hospital Mortality
Mortality performance at RWHT is driven by the Director of Governance and the established Mortality Review Committee which monitors a suite of mortality information to improve the quality of patient care. The group's terms of reference encompasses the following:

- Monthly monitoring of mortality.
- Quarterly reporting to the Board.
- Collation and dissemination of mortality intelligence from directorate level mortality meetings.
- Coordination of audits for every unexpected in-hospital death.
- Investigation of each safety alert in an open and transparent way.
- Ensuring that clinicians are at the centre of any investigation i.e. at mortality meetings.
- Dissemination of information from real time monitoring systems such as Dr Foster's RTM tool and University Hospitals Birmingham's HED health informatics system to clinical leads across the Trust, so that there is ongoing review of mortality performance.

The RWHT three fold approach to mortality monitoring:



RWHT proactively investigates mortality in an open and transparent way, and is working towards developing sophisticated risk stratification models and electronic alerts. Currently our attempts at reducing mortality rates can be summarised as follows:

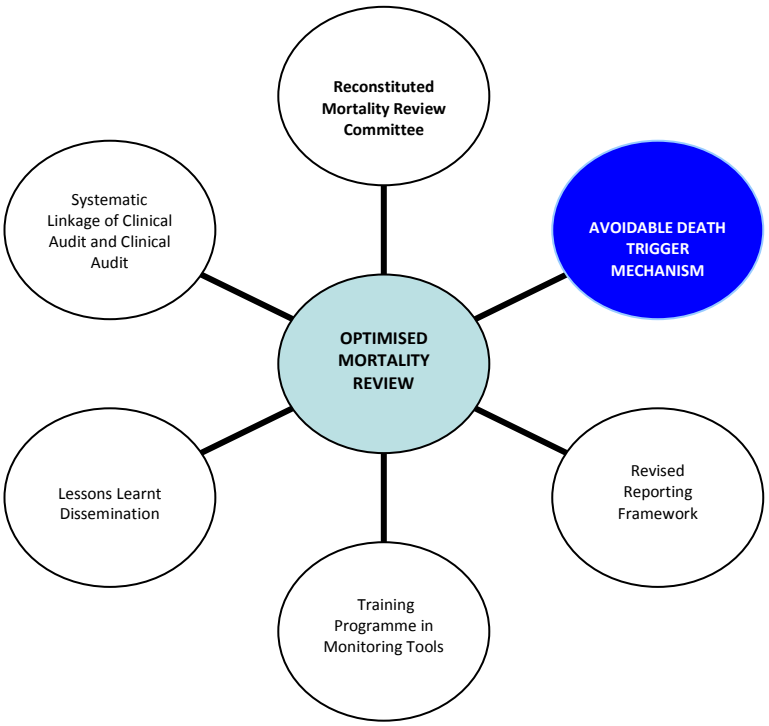
- Performed locally as part of an ongoing review
- Investigating signals when necessary always with clinician engagement
- Looking beyond the mortality ratios
- Rigorously check coding practices
- Review the information over time not just a snapshot view at the end of year

The Trust stance on mortality surveillance is one of vigilance and includes looking at clinical processes, coding architecture and following evidence based improvement strategies. We are not attributing the high HSMR to just coding but rather openly investigating all avenues of enquiry.

In August 2010 the Director of Governance reviewed the mortality process that was in place and identified the following areas that required changes:

- Over reliance on the Hospital Standardised Mortality Ratio (HSMR)-- There was a need to supplement HSMR data with other mortality data to provide an accurate picture of the quality of care provided by the Trust.
- Mortality Review Committee- It was accepted that the Committee needed to take steps to become an overview group which further harmonised Trust-wide mortality review processes. The information flow for mortality had placed constraints upon the investigative efforts of the group.
- Information Flows- The flow of information from directorate level reviews required centralised co-ordination and dissemination of lessons learnt.
- Quarterly Reports- Presented a narrow perspective of mortality relying solely on the Hospital Standardised Mortality Ratio. They were unable to look forward and anticipate Care Quality Commission alerts.

The chart below shows the revised Mortality Review Process



A significant amount of work has taken place during 2010/11 including:

- Further resources invested in bolstering mortality monitoring by acquiring access to HED analytics. The Trust will build on this and move towards an electronic monitoring system to ensure relevant information is available immediately to clinicians and managers. The dynamic observance of mortalities on a daily (alert),

weekly (operational assessment), and monthly basis (robust clinical review) will allow the Trust to discern when there are coding issues and when further investigation is required.

- The Trust has initiated a joint investigation in conjunction with the Dr Foster's analytics team to assess the risk factors contributing to the expected mortality rate and their possible link with prevalent coding practices.
- In addition to senior clinical membership the Mortality Review Committee has now been augmented with personnel from senior management, information and other professional groups to ensure a more rounded approach. The Trust Mortality Review Committee will take further responsibility for deriving organisational learning from multiple assessments of mortality based on local and national data. The Mortality Review Committee will report to the Board Assurance Committee and Quality and Safety Committee.
- An innovative unified pro-forma has been developed based on the Institute for Healthcare Improvement global trigger tool. This will identify if there are any clinical process issues or delays in treatments and link them with coding architecture. This new system of monthly structured evaluation on a Trust-wide basis should enable anticipation of alerts and offset often costly and ad hoc pieces of work needed to be undertaken.
- After consultation with clinical leaders at different levels of the organisation, it is clear that there needs to be a greater appreciation of mortality assessment tools and the determinant factors of methodologies. A training programme has been initiated which will cover Clinical Directors and Directorate Managers. Once this is done directorates can nominate key individuals to become local champions and ensure local monitoring is comprehensive and continual.
- The Trust has put in place improvement plans to address the issues linking clinical coding and reported Hospital Standardised Mortality Ratios. With the completion of these work streams we are in a better position to distinguish if mortality alerts are coding related or clinical matters that require substantive audit.
- The Trust's Director of Governance is developing the Trust's own mortality trigger tool which will seek to identify clinical process failures. If a set of conditions are met, these will be classed as avoidable deaths and a full Root Cause Analysis will ensue for each case.

Case Study – Reviewing mortality in the Respiratory Directorate

The Respiratory Department reviews all mortality on a monthly basis as standard practice. A wide range of data is collected and analysed, clinical staff are encouraged to discuss openly how the quality of care can be optimised for patient safety and suggested changes to procedures and processes. Findings are presented back to the Trust's Mortality Review Committee for wider dissemination. Examples of issues that have been progressed are as follows;

- Senior clinicians all aware of mortality data.
- Identification of all unexpected deaths.
- Importance of documentation of all patient risk factors upon admission.
- Listening to relatives and carers to glean enhanced levels of patient history.
- Identification of inappropriate referrals.
- Contemporaneous note keeping.
- MEWS scores rewritten to emphasise calling for senior review.
- Ensuring pneumonia recorded as the cause of death is done so only under established clinical guidelines.
- Ensuring coding for all co-morbidities, with appropriate coding for bedbound and institutional care.
- Junior doctors, education programme for the documentation of severity scores and adherence to antibiotic guidelines.
- More aggressive microbiological investigation.
- Speed of Chest X-Ray in Accident & Emergency.
- Development of new VTE protocols.
- Ensuring Pulmonary Embolism recorded as the cause of death is done so only under established clinical guidelines.

Addressing QIPP (Quality Innovation Productivity and Prevention)
RWHT is participating as a host organisation in the pilot phase of the QIPP Safe Care Work Stream - Safety Express, from January to June 2011. The aim of the programme is to reduce harm from pressure ulcers, falls, catheter acquired urinary tract infections and blood clots across acute settings and in the community. The Trust is working with partners from across the local health economy to develop systems and processes to address these issues.

Transforming community services
From April 2011 community health services in Wolverhampton will be delivered by RWHT as part of the integration of Wolverhampton City Primary Care Trust Provider Services under Transforming Community Services.

As part of the quality assurance process the Trust has undertaken an investigation into the transaction (due diligence), which incorporated a review of services, finances, assets and operating systems whilst analysing any risks associated with the transaction. Also in line with Monitor's Transactional Manual and Risk Evaluation for Investment Decisions (REID) guidance, the compliance framework requirements were assessed in order for the transaction to take place and Board assurance was given in March 2011. RWHT is required to

register with the Care Quality Commission for the community services to be integrated. Confirmation of its new registration status has been confirmed with no imposed compliance conditions on registration.

To ensure continuity of cover under the National Health Services Litigation Authority (NHSLA) schemes, The Royal Wolverhampton Hospitals NHS Trust has received approval and notification confirming its registration status with the combined community provider services with effect from the 1 April 2011.

It was agreed that the provider services team would develop a stand alone 2010/11 Quality Account document to provide a detailed account of their work over the previous 12 months, however the two organisations have worked together to jointly develop aligned priorities for 2011/12, holding joint engagement events to gather feedback from the local community on their priorities and preferences.

RWHT recognises its responsibilities for ensuring priorities included in the community services Quality Account are actioned and monitored. The Trust will also manage any risks highlighted in the document. The provider services Quality Account will be agreed and signed off by the RWH Trust Board alongside the RWHT Quality Account document.

Supporting our Staff

The Trust recognises that through greater involvement staff are more likely to be actively engaged in developing ways of working and changes which improve the service for patients. Over the past two years the Trust has adopted Listening into Action (LiA) and ChatBack; a staff engagement and empowerment approach, to work hand-in-hand with Staff Side Representatives to connect the right people, develop and embed a highly collaborative style of working, to deliver agreed outcomes for staff, patients and the Trust, that are owned and delivered by the staff themselves. Performance against ChatBack action plans is monitored on a quarterly basis through the Divisional Performance Reviews.

As one of the largest employers in the local community the Trust has a responsibility to recruit a workforce that is representative of the community. Our workforce profile is shown below and is broadly reflective of the community we serve using Wolverhampton census data as an indicator.

	2001 Census	**Workforce 31/03/08**	**Workforce 31/03/09**	**Workforce 31 /03/10**	**Workforce 31/03/11**
Africa	0.29%	1.24%	1.27%	1.45%	1.50%
Asian	0.67%	3.19%	2.88%	3.01%	2.84%
Bangladeshi	0.09%	0.11%	12.00%	0.16%	0.23%
Caribbean	3.85%	3.30%	3.01%	2.90%	2.93%
Chinese	0.36%	0.46%	0.54%	0.55%	0.47%
Indian	12.32%	9.85%	9.94%	10.04%	10.31%
Mixed White	2.37%	0.79%	0.73%	0.76%	0.94%
Other Black	0.35%	2.44%	0.68%	0.67%	0.68%
Other Mixed	0.22%	0.83%	0.15%	0.18%	0.24%

Other/Not Known	0.45%	0.07%	1.87%	1.64%	1.78%
Pakistani	1.24%	1.14%	1.22%	1.39%	1.50%
White	77.79%	76.58%	77.59%	77.26%	76.59%
BME total	26.60%	23.40%	22.40%	22.74%	23.40%

The table below shows the Trust's staff sickness and turnover rates for the past five financial years, showing a steady improvement in both areas.

	06/07	**07/08**	**08/09**	**09/10**	**10/11**
Staff Sickness rate	5.14%	5.10%	4.76%	4.53%	4.69%
Staff Turnover rate	9.66%	10.15%	9.82%	8.76%	7.73%

NHS staff survey

Each year a sample of RWHT staff are randomly selected to take part in the National NHS staff survey. The table below sets out the Trusts results in some key areas over the past five years. The findings of the survey are reported to the Trust Management Team and action plans are formulated annually and monitored throughout the year to address any issues raised.

Question	**06/07**	**07/08**	**08/09**	**09/10**	**10/11**
% staff working in a well structured team environment	35	33	41	39	-
% staff reporting errors, near misses or incidents	93	97	93	93	97
% staff working extra hours	70	66	74	65	67
% staff witnessing potentially harmful errors, near misses or incidents in previous month	41	36	32	35	29
Quality of work life balance (score out of 5*)	3.08	3.12	3.20	3.35	3.39
Staff job satisfaction (score out of 5*)	3.26	3.26	3.42	3.50	3.54
Work pressure felt by staff (score out of 5*)	3.16	3.24	3.10	3.02	2.95
Staff intention to leave jobs (score out of 5*)	2.80	2.97	2.61	2.45	2.43

**where 1 is negative and 5 is positive*

Overall the results show an improving trend across all areas over time, job satisfaction has improved, as has the quality of work life balance, whereas work pressure felt by staff has decreased as has people's intention to leave. Importantly staff are witnessing less potentially harmful errors, near misses or incidents but are continuing to sustain a high level of reporting of any such incidents. Reporting is crucial to ensure lessons are learnt and action taken. Despite these positive trends there is still work to do particularly concerning the number of staff who feel they are working in a well structured team environment.

Preceptorship
RWHT's Preceptorship programme is designed to increase the confidence and competence of newly qualified Nurses, Midwives, Allied Health Professions, and Health Care Scientists during their first year of employment following registration. The 12 month programme is designed to support the transition from student to newly qualified health professional, by supporting learning in everyday practice through a range of learning activities both taught and on line and additional support from work based preceptors. Approximately 110 eligible staff known as preceptees are recruited onto the programme annually.

Each preceptee is issued with a professional portfolio, mapped to KSF outlines and professional regulation requirements to take to appraisals demonstrating evidence of learning. Preceptees attend 'appraisal clinics' with the Preceptorship team to validate their portfolios and managers are alerted to the review periods in support of the accelerated pay progression procedures.

As part of recruitment, and promotion of the Trust as an employer of choice, finalist student nurses are introduced to the programme immediately prior to qualification. This strong preceptorship support is promoted in the Trust's NHS Jobs profile and new video on the recruitment Trust website. The Trust also hosted the National Preceptorship conference on March 31st 2011.

From April 2011 this programme will be rolled out to be available to staff working in community and rehabilitation services. We also hope to secure academic credits at degree and masters levels for successful completion of the programme in 2011.

Internship
The internship programme was launched in 2011 and offers a programme of education and skills updates for seven specifically identified registered nurses who have not had recent acute care/hospital experience. This will help them to gain the experience necessary to be safe, capable and confident nurses. It provides support by offering opportunities for professional growth and autonomy leading to active participation as members of the clinical team. It facilitates talented people getting a foothold in their chosen career and provides opportunities to experienced nurses who are changing specialties to advance their careers.

This paid educational programme is for a three month period and includes classroom lectures, structured computer-based learning, case studies, and clinical experiences incorporating simulations and hands-on technical skill development. On successful completion of the programme the nurses will be eligible for permanent staff nurse posts within the Trust. We will carry out an evaluation of the internship programme in 2011/12.

Supporting our staff to carry out Research and Development
During 2011/11 RWHT set up a new Clinical Lead Management Board Committee providing an opportunity for clinical leads to come together and discuss developments in research and development including how to develop specialty specific research portfolios and plans to expand RWHT's academic partnerships.

Additional Quality information

The tables below are designed to provide the reader with additional RWHT performance data

	Indicator	2006/07	2007/08	2008/09	2009/10	2010/11
Organisational approach to quality	Palliative coding (ICD10 coding Z515) Rate (%)	not avail	not avail	8.7	10.8	16.5
	Data completeness – Admitted Patient Care	not avail	not avail	9.1	9.6	9.5
	Data completeness – Out Patient	not avail	not avail	8.6	8.7	9.4

	Indicator	2006/07	2007/08	2008/09	2009/10	2010/11
Preventing people from dying prematurely	Crude mortality per 100 provider spells	3.3	2.8	2.9	2.9	2.9
	Elective Standardised Mortality Ratio (SMR)	94.8	115.6	106	106.1	119.2
	Emergency Standardised Mortality Ratio (SMR)	109	102.5	109.9	116.8	104.5
	Emergency SMR – Stroke	103.7	114.3	104.6	122.9	118.6
	Emergency SMR – Chronic Obstructive Pulmonary Disease (COPD)	110.8	109.3	121.6	151.4	118.7
	Emergency SMR – Myocardial Infarction	90.3	67.6	87.6	85.1	121.2
	Emergency SMR – Fracture Neck of Femur	123.4	110.2	109.8	129.8	99.5
	Emergency SMR – Pneumonia	120.2	131.5	126.6	136.5	115.1
	Emergency SMR – Heart Failure	102.2	105.9	94	109.1	120.1
	Mortality in low risk Healthcare Resource Group (HRG)	116.8	87.2	101	144.1	95.1

	Indicator	2006/07	2007/08	2008/09	2009/10	2010/11
Helping people to recover from episodes of ill health or following injury	% patients discharged to usual place of residence	95.81%	96.29%	96.27%	96.43%	96.47%
	Emergency Readmission in 30 days following other admission	not avail	not avail	not avail	3621	3578
	Emergency Readmission in 30 days following elective admission	not avail	not avail	not avail	1650	1809
	Emergency Readmission in 2 days following other admission	not avail	not avail	not avail	759	766
	Emergency Readmission in 2 days following elective admission	not avail	not avail	not avail	389	442

	Indicator	2006/07	2007/08	2008/09	2009/10	2010/11
Ensuring people have a positive experience of care	Cancer waits – 14 days GP referral to first seen	3728	3889	4570	5420	6061
	Cancer waits – 31 Day Decision to First Definitive Treatment	1576	1469	1445	1808	2100
	Cancer waits – 62 Day Referral to First Definitive Treatment	550.5	587.0	552.5	683.5	808.5
	Cancellation of Elective Surgery for non-clinical reasons	0.26%	0.38%	0.45%	0.45%	0.37%
	A&E - 7 day reattendance	3.90%	3.79%	4.05%	3.37%	3.64%
	A&E - Attenders who leave without being seen	4.44%	4.15%	4.22%	3.53%	4.41%
	A&E - Mean Time to initial assessment (in minutes)	12	11	12	13	13
	A&E - Mean Time to treatment (in minutes)	57	58	59	57	67

	Indicator	2006/07	2007/08	2008/09	2009/10	2010/11
Treating and caring for people in a safe environment and protecting them from avoidable harm	Fracture Neck of Femur operated on in 48 hours	542	630	668	659	613
	Caesarean section rate – Elective	10.53%	10.48%	10.41%	11.14%	9.85%
	Caesarean section rate – Non elective	14.89%	15.55%	13.79%	14.61%	13.67%
	Number of MRSA bacteraemias (RWHT-attributable cases in brackets where data available)	61 (49)	15 (9)	18 (9)	3 (3)	0 (0)
	Number of CDIF infections (RWHT-attributable cases in brackets where data available)	422	225 (121)	171 (80)	151 (80)	144 (80)
	Number of MSSA bacteraemias (RWHT-attributable cases in brackets where data available)	107	101 (57)	74 (34)	63 (38)	71 (35)
	% planned day case converted to Inpatient	9.07%	7.83%	10.28%	10.66%	8.55%
	Day case rate	68.42%	73.90%	72.11%	72.90%	74.25%

How we selected our priorities for 2011/12

We developed a long list of priorities drawing together national requirements such as CQUINs, HIAs, and local information such as PALS and complaints issues, patient surveys and feedback from stakeholders. We then asked staff, Trust Members and stakeholders to review the long list and select their top priorities. The feedback was collated and reviewed and the Trust priorities were chosen based on this feedback.

A Stakeholder event was held to seek the views of a wide and diverse representation of direct users of services examples of attendees included the Local Involvement Network, patients, carers and community representative including those from disability groups and Black and Ethnic Minority groups. Staff at the Trust were also encouraged to review and comment on the Quality Account priorities through the staff bulletin.

RWHT Quality Account priorities long list for 2011/12:

Quality dimension	Priority area	Driver
Patient experience	Delays	HIA priority
	Hospital signage	Local priority/ complaints
	Dementia	Local priority, NICE Guidance
	Real time capture of patient feedback	Equity and Excellence: Liberating the NHS/ CQUIN/ operating framework
	End of life care	HIA priority
Patient safety	Recognising a deteriorating patient	Linked to improving mortality / NICE Guidance
	Blood Clots (VTE)	HIA priority/ CQUIN / Safety Express
	Falls	HIA priority/ CQUIN / Safety Express
	Infection Prevention - devices	Safety Express (Urinary catheters)
	Pressure ulcers	HIA priority/ CQUIN / Safety Express
Clinical effectiveness	Normal births	HIA priority
	Nutrition	HIA priority / CQUIn/Ombudsman complaints/ local priority / Essence of Care /PEAT/CQC/NICE Guidance
	Pain management	Complaints/ national inpatient survey
	Mortality rates	FT application/Monitor, CQC
	Single emergency portal	Local priority

Statements from our partners

Wolverhampton City PCT statement

Partnership working between the PCT and the acute hospital has enabled standards of health care to improve further in Wolverhampton during 2010/11.

The hospital is committed to delivering top class services for patients and prides itself on consistently maintaining low infection rates, reporting and investigating incidents within specified timescales by seeking to identify root causes and opportunity to improve patient safety.

Through continued partnership working the PCT is confident that the hospital will improve in each of the areas identified during 2011/12, including patient experience, patient safety and clinical effectiveness. This document clearly demonstrates a culture and willingness to identify, review and improve standards of healthcare provided by the hospital. The PCT has routinely monitored the progress of the hospital during 2010/11 through a series of quality review meetings and quality visits and by setting CQUINs. These will continue to take place and together the PCT and hospital will be able drive standards of healthcare to higher levels. The goals identified for the coming year are supported and the PCT is confident that improvements will be made in each of the priority areas.

Throughout this year the PCT has been able to assure the Professional Executive Committee and Trust Board of the ongoing improvements made in healthcare standards, which is due to this hospitals commitment to ensuring that quality is central to their service provision.

Wolverhampton LINk statement

Overall, this seems to be a positive account of the quality being achieved by the Royal Wolverhampton Hospitals NHS Trust and the Trust should be congratulated on the improvements it has made.

Wolverhampton LINk has welcomed the relationship that it has developed with the RWHT Board and key staff members during 2010 – 2011.

The use of jargon contained within your quality account is as bad now as in previous years. As mentioned in last year's feedback, where jargon is used within the document it is hoped that a final version will be developed for the public giving explanations of abbreviations used.

The report covers a number of valuable areas and brief comments on these are set out below.

PRIORITY 1: Delays The focus on reducing the number of outpatient appointments rescheduled and cancelled is well received; members have fed-back to us about the stress and inconvenience that cancelled and rescheduled appointments can cause.
The actions for 2011/12 are welcomed and we would appreciate involvement in this area. The LINk is particularly keen to ensure that special care is taken into account where carers are involved and the impact that rearranging appointments can have on them.

PRIORITY 2: Medication Side Effect Information The LINks soon to be completed audit carried out in the Discharge Lounge highlights areas for improvement regarding patient

information on discharge, we therefore welcome the inclusion of increasing the number of patients who are informed of side effects of medication before discharge and would be keen to work with RWHT on this.

PRIORITY 3: Reduction in Healthcare acquired pressure ulcers We are concerned that pressure ulcers are on the increase at a time when patient stays are typically much shorter, prevention of pressure ulcers is something that should be high on the agenda of nurse training.

PRIORITY 4: Nutrition Wolverhampton LINk have be pleased to have the opportunity to work alongside RWHT regarding improving inpatient nutrition and look forward to being involved in the progression of this work during 2011 - 2012

Our Priorities for Quality Improvement for 2011/12 We would welcome the opportunity to become involved in the process of monitoring the priorities for quality improvement for 2011/12.

Wolverhampton City Council Health Overview and Scrutiny Committee statement

Members of the Health Scrutiny Panel agreed that based on the knowledge of the Royal Wolverhampton Hospital Trust, the report presented is an accurate reflection of the range and quality of healthcare services provided.

The information appears to be consistent with previous reports and updates during the year considered by this Panel.

The Panel welcomes the continued strong focus on improving the quality of care at all stages of the patient's journey and the issues listed as priorities for improvement within the City of Wolverhampton during 2011/12.

As agreed at the meeting on 09/06/11

1. A further progress report to be submitted to the panel, on achieving an increase in the number of patients being informed of the side effects of their medication prior to discharge, including details of the mechanism for recording such information.

2. A report from the Chief Executive of the RWHT in connection with concerns highlighting the difficulties experienced by patients, attempting to respond to appointment letters which requires them to register a password first in order to have their enquiries dealt with.

Giving your views

We welcome your feedback on this Quality Account and your suggestions for the content of future reports. We can be contacted by writing or by e mail and hope that you will choose The Royal Wolverhampton Hospitals NHS Trust for your future healthcare needs.

Please send your comments to:

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The Royal Wolverhampton Hospitals NHS Trust
New Cross Hospital
Wolverhampton WV10 0QP
Or telephone 01902 695333
Or email: rwh-tr.yourcomments@nhs.net