Agenda Item No:

THE ROYAL WOLVERHAMPTON HOSPITALS NHS TRUST

Report to:	Trust Board
Date:	Quarter 1 (1 April to 30 June 2011)
Subject:	Quality & Safety Report
Report by:	Director of Nursing & Midwifery
Author:	Patient Safety Manager
Purpose of Report	To provide the Trust Board with information regarding performance and progress with Trust quality and safety.

Report

The report relates to Quarter 1 (1 April to 30 June 2011) and includes progress of the Trust's campaign to prevent harm and improve patient safety in addition to an organisational overview of incidents, complaints, inquests, and claims. It also provides information on issues that fall outside of the campaign but contribute to the quality and safety agenda.

Review Committee Approval

Approved by the Quality & Safety Committee 2 August 2011.

Recommendation(s)

The Board is asked to note the content of the report.

Contents

1) EXECUTIVE SUMMARY

This report on Quality and Safety includes progress on the Campaign for Preventing Harm, Improving Safety. The report refers to the period Quarter 1 (1 April to 30 June 2011)

Section 2 provides an overview of organisational quality and safety.

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

Section 4 reports on the patient experience.

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

The areas to note regarding progress are as follows:

- Inpatient falls slightly above target in June
- Increase in hospital acquired Grades 2, 3 & 4 pressure ulcers
- %late observations 27-32%
- Cumulative C Diff above cumulative plan
- DRHABS above target in June
- Target for responding to complaints not achieved
- Compliance with Essence of Care standards not achieved

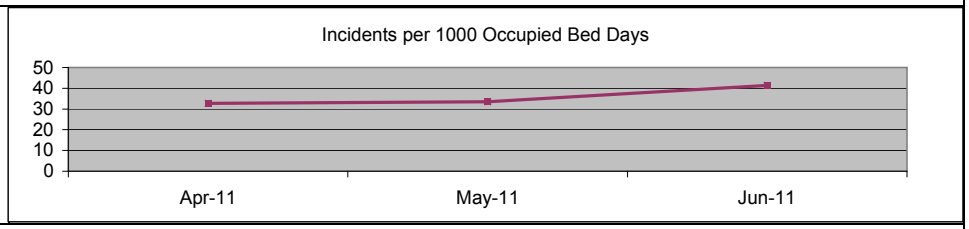
- Reduction in serious complaints
- Reduction in radiology incidents
- MSSA below plan
- VTE compliance significantly improved
- Formal complaints below 1% activity
- Hand hygiene and environmental standards above targets
- Decrease in single sex incidents
- Decrease in staffing incidents
- Decrease in medical administration incidents

2) TRUST SAFETY & QUALITY OVERVIEW

2.1 Incident Rate

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

	Apr-11	May-11	Jun-11
Div 1	310	337	410
Div2	326	341	427
Total	636	678	837
Per 1000obd	**32.7**	**33.5**	**41.4**



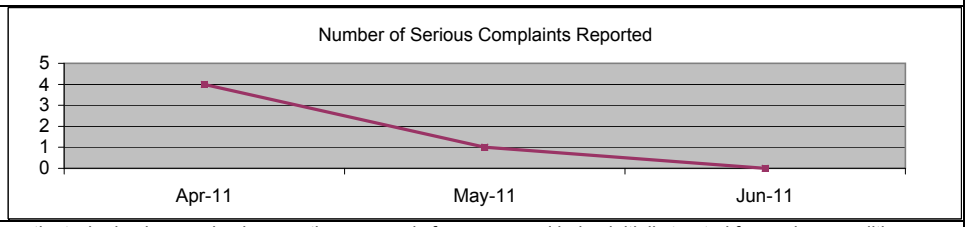
Analysis: The number of incidents reported during Q1 (Apr - Jun 11) has increased by 1.8% from the previous quarter. The majority of incidents are reported by nursing and midwifery staff and the largest category of incidents is patient falls (further information on patient falls in section 3.2).

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

2.2 Serious Complaints

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

	Apr-11	May-11	Jun-11
Div 1	1	0	0
Div2	3	1	0
Corp	0	0	0
Total	4	1	0



Analysis: April - Division1: One complaint graded as amber. This complaint related to a patient who having received a negative prognosis for cancer and being initially treated for a minor condition. **Division 2:** Three complaints graded as amber. The first complaint relates to an elderly patient who attended A/E on several occasions following several falls at home. The patient was not x rayed until the fourth visit to A/E and the x ray showed a broken pelvis. Second complaint relates to a child who suffered from sickle cell disease and sadly passed away. The parents are unhappy with the appropriateness of treatment and the information and guidance received in relation to the management of sickle cell disease. The third complaint involved a patient who attended A/E due to suffering a miscarriage. The patient is unhappy with the level care and compassion shown, that the pain relief given was inadequate, and poor communication, indecision and consideration shown by the clinical staff. **May - Division 2:** One complaint graded as amber. The patient was unhappy with the level of care received when they attended A/E. The patient needed emergency surgery and felt that the clinical staff did not listen to them, the missed diagnosis put their life at risk and there was contradicting communication between A/E & Gynaecology.

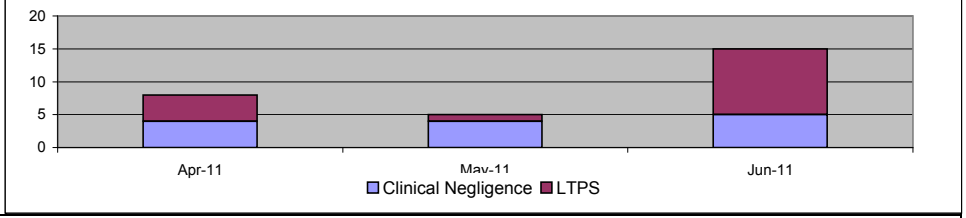
Actions: April - Division 1: Full explanation given in final response - the operation was performed in anticipation of life threatening problems for the patient if not undertaken and also to give the patient a better quality of life. Unfortunately, due to a combination of unforeseen post operative complications this was not the case. The diagnosis of COPD was a pre-existing condition. Apologies made for failing to provide clear communication to the patient. **Division 2**: First complaint-Full explanation given about patients A/E attendances. Patient was referred to the falls prevention team following her second attendance and on subsequent discharges the patient was transferred directly to Bradley Resource Centre. Second complaint - A full chronology of events was included and explained in the final response. The Trust was unable to provide any information relating to the cause of death as they are awaiting the results of the post mortem. The Trust's legal department are aware of this complaint. Third complaint- Importance of adequate analgesia and good communication to be reinforced at the next team meeting to both clinical and nursing staff. Additional nursing staff recruited to the area and each shift has an additional nurse on duty. Complaint to be used as a mechanism for teaching.

May - Division 2: (A/E) Pain relief now being prescribed at triage. The need for prompt pain relief and the appropriate choice of pain relief reiterated to junior doctors at their teaching sessions. Reviewed pathway in relation to administering and monitoring of analgesia if administered to a patient at triage. (Gynaecology) Multi disciplinary review within the department to determine how cases like this should be managed.

2.3 New Litigation

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

	Apr-11	May-11	Jun-11
Clinical Negligence	4	4	5
LTPS	4	1	10
Total New	8	5	15



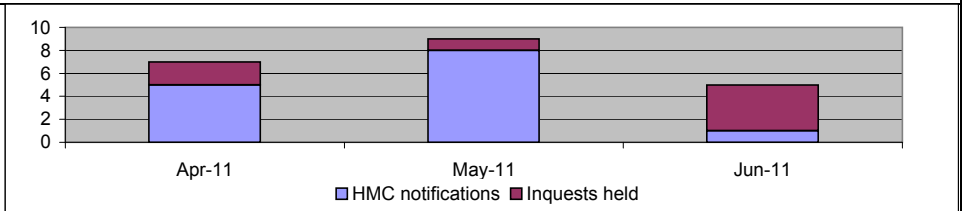
Analysis: During this quarter the clinical negligence claims received relate to diagnosis, treatment and nursing and obstetric care and treatment. LTPS claims relate to needle stick, slip, trips and falls, manual handling and other (yellow waste bin became detached from truck)

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

2.4 Inquests

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

	Apr-11	May-11	Jun-11
HMC notifications	5	8	1
Inquests held	2	1	4
HMC Recommendations	0	0	0
% Recommendations per FCE	0	0	0



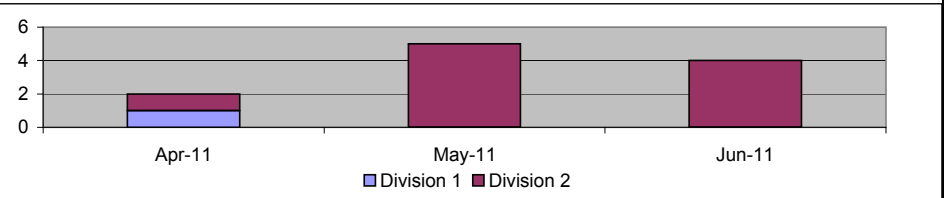
Analysis: During the period 7 inquests were held the verdicts of which are abbreviated as follows: Deceased suffered from carcinoma of the lung and had she been anticoagulated asap after the finding of an pulmonary embolism she would still not have survived the embolism. Deceased had Clostridium difficile infection which was precipitated by the antibiotic therapy used to treat the initial urinary tract infection; had earlier episodes of sepsis, which led to septicaemia and multi-organ failure. Deceased died of myocardial infarction caused by severe coronary artery disease. Deceased died as a result of an acute pulmonary thromboembolism. Deceased as a result of recognised complications of a ruptured acute myocardial infarction. Deceased died despite lengthy treatment for the pelvic abscess. The persistence and spread of lymphoma was suspected; she was started on anti-lymphoma therapy but her condition deteriorated. Deceased died as a result of a subarachnoid haemorrhage and intra-ventricular haemorrhage caused by the rupture of a cerebral artery aneurysm

Actions: No further actions

2.5 Safeguarding Adults Incidents

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

Safeguarding Adults	Apr-11	May-11	Jun-11
Div 1	1	0	0
Div2	1	5	4
Total	2	5	4



Analysis: All locally held data has been cross referenced with that held by Wolverhampton Safeguarding Team to ensure that robust information is available and a centrally held database of all referrals has been established. Since April there are 10 confirmed open safeguarding cases raised by other organisations against the Trust. Six internal investigations have been completed, 2 of which await closure by the Safeguarding team.

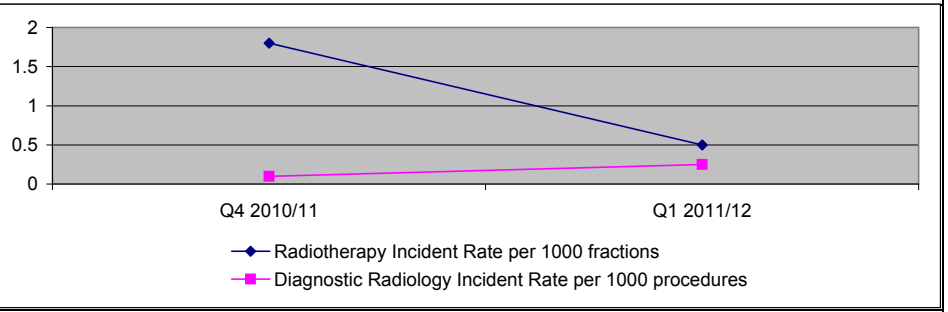
Actions: Performance report detailing all allegations with recommendations following investigation reported to JHSVAC as standing agenda item to disseminate findings

2.7 Radiation Incidents

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

Radiation Incidents	Apr-11	May-11	Jun-11
Radiotherapy	2	1	1
Diagnostic Radiology	5	4	2
Nuclear Medicine	0	0	0
Laser/Non-ionising	0	0	0

Quarterly Rates	Q1
Radiotherapy Incident Rate per 1000 fractions	0.5
Diagnostic Radiology Incident Rate per 1000 procedures	0.25



Analysis: ▪Diagnostic Radiology - 1 radiation incident was externally reported to the Care Quality Commission. The incident involved the incorrect patient being selected on the A&E request system, generating an x-ray request form for the wrong patient, resulting in the incorrect patient being exposed. The Chief Inspector for the CQC queried the training that had been undertaken on the electronic request system, response still awaited from A&E/Clinical Director. The incident is still under investigation and it was discussed that quality of training should be reviewed.
Five of the incidents reported were near misses that were picked up by radiography staff, 2 incidents were due to missing patient ID arm bands and a further 3 due to incorrect information on request cards. Two incidents required a repeat image to be taken, one due to the request card being filled in incorrectly, the second due to a non-erased CR plate being used after an image on another patient had been lost (electronically) resulting in a double exposed plate. The latter incident suggests the need to review procedure for lost images and plate erasure.
▪ Radiotherapy – Of the four incidents that occurred this quarter 2 were near misses and patients were treated correctly. One incident was discovered during treatment and was corrected for. The remaining
▪ Radiology - Approx 50 000 radiological examinations were performed in Radiology this quarter and 12 separate radiation incidents occurred. Incident Rate: 0.25 incidents per 1000 procedures.
▪ Nuclear Medicine – No radiation incidents reported this quarter. Although there have been a number of near misses related to IRMER compliance that are being addressed through a change in job roles and specific staff training. ▪ Lasers/Non-Ionising – There have been no laser incidents reported this quarter. However the annual safety audits highlighted a number of concerns regarding compliance to the Trust's Laser Safety Policy and associated legislation. These concerns have been raised with the Trust's Medical Director and through the Trust's Compliance Committee. A plan is currently in development involving Medical Physics, Governance and the Medical Director to facilitate hospitals managers complying with legislative requirements

Actions: ▪ Diagnostic Radiology: 1. Follow up on incident reported the CQC. Training of staff using electronic requesting to be reviewed. 2. Review of procedure in the case of lost images and plate erasure. ▪ Lasers:1. Follow up on compliance plan for Laser Safety within the Trust.

3) PREVENTING HARM, IMPROVING SAFETY MEASURES

Introduction:

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

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

3.1 Mortality

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

	Apr-10	May-10	Jun-10	Jul-10	Aug-10	Sep-10	Oct-10	Nov-10	Dec-10	Jan-11	Feb-11	Mar-11	Outturn
HSMR	102.6	112.3	93.4	109.8	107.9	94.2	99.9	97.5	106.4	103.4	103.4	95	**102**
Observed Death Rate (56	3.80%	3.70%	3.20%	4.20%	3.80%	3.50%	4.30%	4.00%	5.10%	4.90%	4.50%	3.90%	**4.08%**
Expected Death Rate (56	3.70%	3.30%	3.40%	3.80%	3.50%	3.70%	4.30%	4.10%	4.80%	4.80%	4.30%	4.10%	**3.98%**
No of In Hospital Deaths	155	131	120	148	135	134	148	146	196	186	148	163	**1810**
Expected Deaths	135	122	130	145	133	141	150	154	186	183	151	164	**1793**
Excess Deaths	20	9	-10	3	3	-7	-2	-8	10	3	-3	-1	**17**

Analysis: The year end position shows a HSMR of 102 which is 2 points above the England average, there were 17 excess deaths according to the Dr Foster statistical calculation. The rebased HSMR for 2010/11 is 113. The year end HSMR marks a marked improvement in the end of year position compared to 2008/9 [109] and 2009/10 [116].

Top Diagnostic Groups Contributing to Patient Deaths by Volume

Diagnosis Group	Spells	Observed Deaths	Expected Deaths	Excess Deaths	SMR
Pneumonia	**988**	**254**	**222**	**32**	**114**
Acute Cerebrovascular disease	**765**	**172**	**147**	**25**	**117**
Congestive heart failure nonhypertensive	**502**	**92**	**75**	**17**	**123**
Septicaemia (except in labour)	**211**	**81**	**72**	**10**	**113**

Analysis: The top diagnostic groups contributing to deaths are set out above; There is a rolling programme of clinical case note review and detailed data interrogation, to glean systemic clinical process issues. Recent audits conducted have not revealed any systemic issues.

Alert Status

Cusum Statistical Mortality Alerts

Alert received April 2011 = 0, Alert received March 2011 = 0, 2010-11 Cumulative= 12

Associated Indicators of Mortality

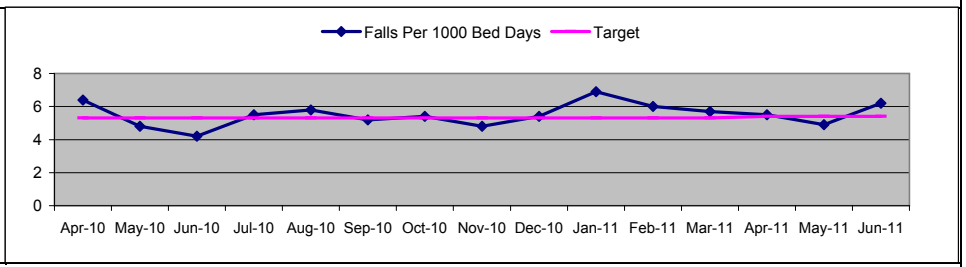
Indicator	Period	Target	Actual	RAG	TREND
Charlson Codes Per Spell (HED)	Apr-Feb 10	Peer Group Average **5.76**	**5.35**		Ý
Palliative Care Deaths Per 1000 Spell (HED)	Apr-Feb 10	Peer Group Average **18**	**13**		Ý
Expected Death Rate (Dr F)	Apr10-Mar11	Peer Group Average [4.1%]	**3.90%**		Ý

Analysis: Apr-Feb 2011, HED ANALYTICS: The indicators here represent non-clinical coding related elements that contribute to the Trust's expected death rate. The Peer Group average is calculated from acute Trusts that have similar populations as set out by the Office of National Statistics. As a result of the targeted work conducted by the coding team improvements have been seen consecutively in January and February 2011, the programme of work is ongoing and further improvements can be expected in subsequent months.

3.2 Inpatient Falls

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

	Apr-11	May-11	Jun-11
Target per occupied bed days	<5.4	<5.4	<5.4
Number of falls per occupied bed	5.5	4.9	6.2
Number of falls resulting in serious injury	1	0	0



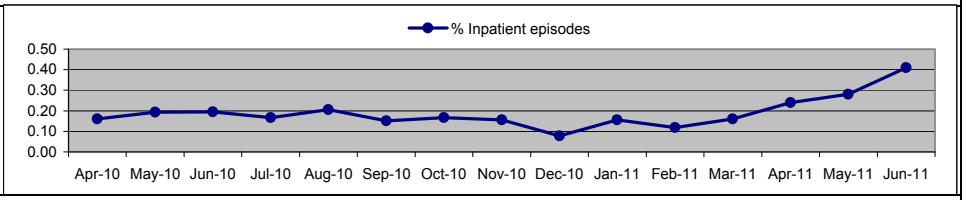
Analysis: A review of the position of last year's falls per OBD has occurred. This has revealed an inaccuracy of reporting and the verified end of year figures was 5.62 per 1,000 OBD not 6.19 per 1,000 OBD. The target set for this year is 5.4 per 1,000 OBD. This is in line with the national average and is based on acute inpatients. A target for West Park Hospital inpatient unit has been set at 7.6 per 1,000 OBD, in recognition of benchmarking with rehabilitation hospitals.
A target of 50% reduction in falls where serious injury occurs has been set across acute inpatient and West Park for 2011/12 against 2010/11 figures. This target is 14 falls with serious injury.
There was one fall resulting in serious injury in April and 7 falls reported that resulted in a patient suffering a moderate injury (2 Apr, 3 May, 2 June).

Actions: A rapid improvement programme commenced on 20th June 2011 in relation to falls. This has initially been targeted on the inpatient areas with the highest rate of falls in 2010/11. The aim of this approach is to ensure all elements in relation to prevention of falls are in place before commencement and to closely monitor outcomes. This approach will be implemented across the remainder of the organisation and a sustainability plan implemented.

3.3 Pressure Ulcers

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

	Apr-11	May-11	Jun-11
Grade 2	27	30	43
Grade 3	1	3	9
Grade 4	0	1	0
Total	28	34	52
%Inpatient Episodes	0.27	0.28	0.41



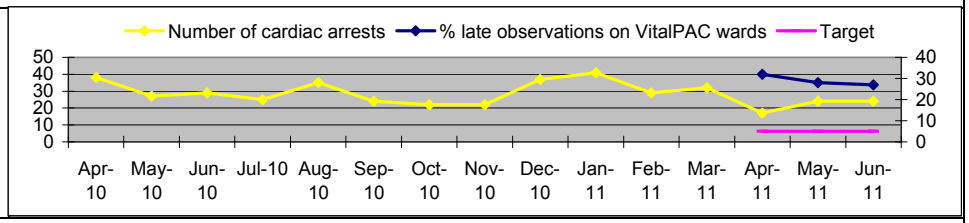
Analysis: Awareness and reporting of pressure ulcers have significantly improved in the inpatient setting following training and support from the Tissue Viability team. Five of the grade 3 pressure ulcers were deteriorating hospital acquired wounds during their inpatient stay. 1 patient with a new hospital acquired pressure ulcer already had grade 4 pressure ulceration in another area which originated from a Care home. Early signs of deterioration were not reported on 7 incidents

Actions: A rapid improvement programme is being planned for 6 wards across the Health economy to commence 12th September 2011 - pressure ulcer awareness week. Training plans to continue on wards. Elearning package to be purchased. Pressure ulcer care package is amended and awaiting final approval to be launched. Patient leaflet awaiting final approval. EPUAP guidance poster for wards designed. Resource package on each ward to be filed in safety folders. Guidance on mattress selection has been sent on global communication. Pressure ulcer policy to be amended with all the stated packages. Any pressure ulcer related serious and untoward incident- the Ward manager will meet with Senior management to discuss the incident. Lessons learnt from RCAs to be cascaded in directorate meetings

3.4 Recognition of the Deteriorating Patient

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

	Apr-11	May-11	Jun-11
Number cardiac arrests	17	24	24
% observations late	32%	28%	27%
Target (late observations)	5%	5%	5%



Analysis: Late observations are defined as observations taken greater than 30 minutes after the protocol and excludes observations where the protocol has been over ridden by a greater time interval. The percentage of late observations is obtained from wards using VitalPAC only. The frequency of required observations is based on the Trust escalation protocol, which is based on NICE guidance. The target is no more than 5% late observations.

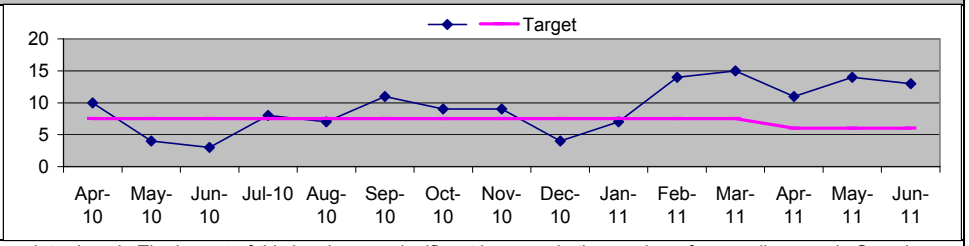
Actions: Late observations are now a key performance indicator for all adult inpatient wards and ward managers are working to improve compliance.

3.5 Healthcare Acquired Infections (HCAIs)

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

3.5.1 Clostridium Difficile - hospital acquired for ages >2 years

	Apr-11	May-11	Jun-11
Number of C Diff	11	14	13
Cum Plan	6	12	18
Cum Actual	11	25	38
Cum Variance	5	13	20

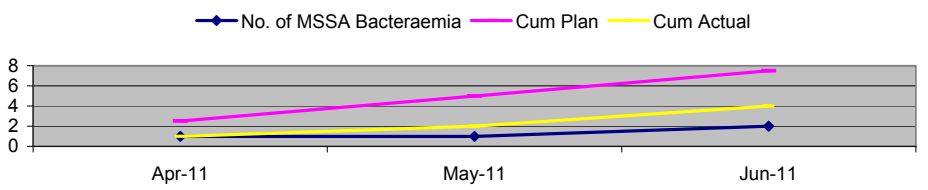


Analysis: At the beginning of February 2011 a more sensitive testing method for *C diff* was introduced. The impact of this has been a significant increase in the number of cases diagnosed. Samples found to be positive using the new method have been retested with the method formerly used in RWHT and less than 60% were found to have been positive using the old method. This ability to better diagnose the disease undoubtedly has been responsible for our apparent poor performance. The intention of using the more sensitive method is that, by being better able to accurately make the diagnosis, patients will receive more appropriate treatment and better targeted infection prevention precautions will eventually lead to fewer infections. Additionally, it must be remembered that the targets were set based on performance that did not include West Park patients, but performance this year does include West Park patients. During Q1 there have been 4 cases attributable to West Park Hospital.

Actions: All wards or clinical areas that have more than a single infection during a 30-day period are investigated; an environmental audit and observation of clinical practices are undertaken. Any appropriate training and other actions put in place and the monitoring continues in the area. The 30-day all-cause mortality in C diff positive patients is also monitored; in comparison with the other Trusts in the Region who also look at this our rate is one of the lowest.

3.5.2 MSSA Bacteraemia

	Apr-11	May-11	Jun-11
No. of MSSA Bacteraemia	1	1	2
Cum Plan	2.5	5	7.5
Cum Actual	1	2	4
Cum Variance	-1.5	-3	-3.5



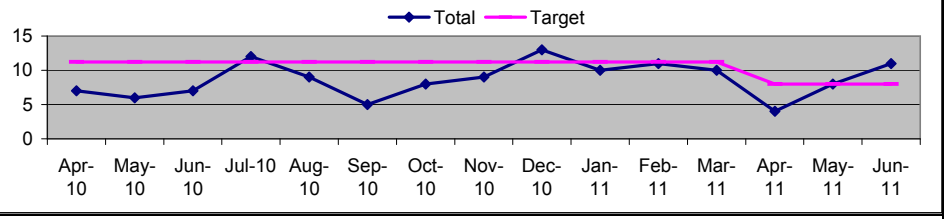
Analysis: This is the lowest number of RWHT-attributable MSSA bacteraemias in a single quarter since this data began to be collected in 2007. One of these bacteraemias was on the Critical Care Unit, and was the first CCU-attributable *Staph. aureus* bacteraemia for more than 2 years. This is a remarkable achievement and is testament to the commitment to avoiding patient harm on the unit. Another was secondary to a surgical site (SSI) infection. One was on the Neonatal Unit and the final case was associated with a Renal line infection.

Actions: A Trust-wide SSI surveillance programme is being planned in order to be able to monitor, understand and reduce the number of these infections. The Renal Physicians and Vascular Surgeons are committed to reducing the number of haemodialysis patient who dialyse via lines, while MSSA screening of those renal patients who have to be managed using lines will identify those who might benefit from MSSA eradication therapy. Clinical practices and the device insertion and management continue to be monitored on the high-risk areas such as CCU and NNU to try to reduce infections associated with these.

3.5.3 Device Related Hospital Acquired Bacteraemias

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

	Apr-11	May-11	Jun-11
Target(monthly)	8	8	8
DRHABS	4	8	11



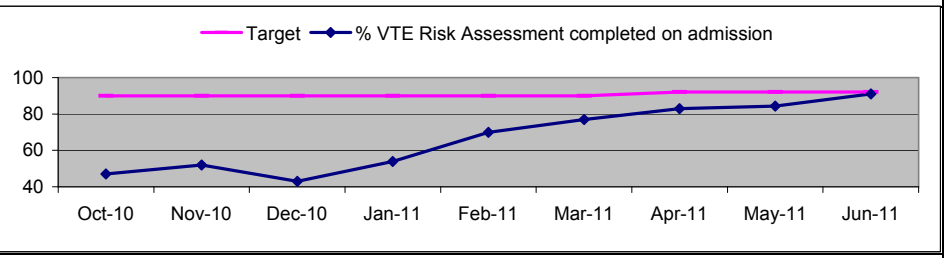
Analysis: Despite April having the lowest total for any month since surveillance for DRHABs began, overall performance for the quarter was only just within target. Lines remain the predominant cause of DRHABs, with 14 in the quarter. Urinary catheters account for a further 6, nephrostomies 2 and ventilator associated pneumonias 1. Haematology / Oncology had for 7 cases, the NNU 5, surgical wards 5, medical wards 4 and the Renal Unit 2.

Actions: Training is ongoing to wards across the Trust, of especial note a new Central Venous Access Course to teach qualified nurses to optimal oncology standards to access central lines. In neonates the use of alcoholic chlorhexidine is to be implemented for skin preparation prior to line insertion, once to move to the new unit is settled. Trials ongoing in renal patients into the use of new antimicrobial patch dressings, and oncology/haematology are considering this also for their most at risk patient groups.

3.6 Venous Thrombo Embolism

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

	Apr-11	May-11	Jun-11
% adult patients with completed VTE risk assessment	83.0%	84.4%	91.0%
Number of patients with hospital acquired VTE	4	7	8
Number of patients with community acquired VTE	tbc	29	28



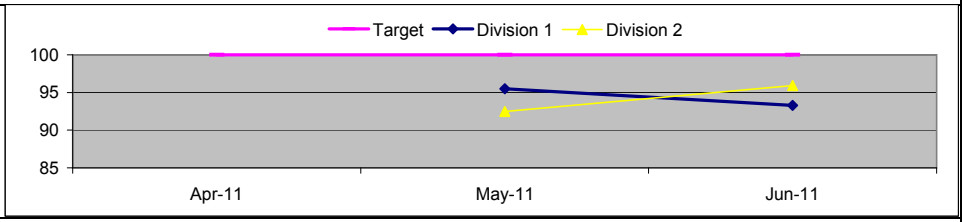
Analysis: Hospital acquired RCAs identified missing doses of anticoagulants or the omission of alternative thromboprophylaxis where medical prophylaxis was contraindicated. The outcomes of 7 RCAs are awaited. Five case notes from June have yet to be reviewed to determine if the VTE was acquired in a care setting.

Actions: Each specialty is presenting the outcomes from the RCA's at their governance meetings and making action plans accordingly. Further to their action plans we have also contacted the appropriate companies re medical devices. Huntliegh have been asked to provide more mechanical compression devices to keep in the medical equipment library and the wards have been encouraged to report any broken equipment ASAP so it can be replaced and shortages of equipment avoided. Extra TED training has been requested in those areas where there are issues.

3.7 Nutrition

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

% adult inpatients with completed MUST	Apr-11	May-11	Jun-11
Division 1	n/a	95.5%	93.3%
Division 2	n/a	92.5%	95.9%
Target	n/a	100	100



Analysis: The completion of MUST is a key performance indicator for all adult inpatient wards and monitoring commenced in May 2011.

Actions: The Nutrition Support Steering Committee has reviewed and consulted on the Trust nutrition screening policy (CP17). Training on nutrition screening has been offered to all wards during July (nutrition focus month). The nutrition sessions on nurse induction and mandatory training will be reviewed when the updated policy has been ratified.

3.8 Clinical Handover

There are many clinical handovers each day and there is national and local evidence that key information is not always communicated. This project will focus on the emergency medical patient and improving clinical handover to ensure that all relevant clinical information is communicated during medical handovers. The measures and targets have yet to be determined.

Analysis:

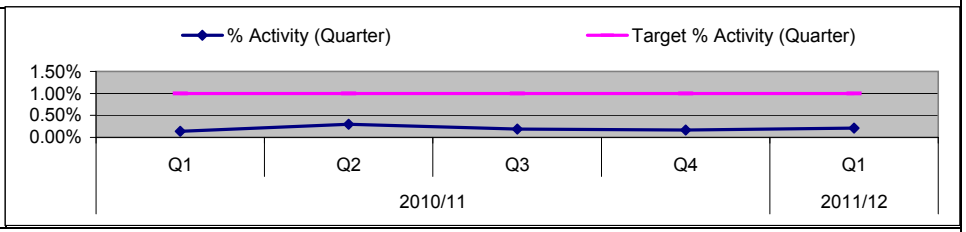
Actions: An application to The Health Foundation has been submitted to take part in their Safer Clinical Systems project. The application, if successful, would secure funding for the life of the Safer Clinical Systems project (2 years). Work has already commenced in identifying an appropriate environment for clinical handover and reviewing the electronic handover tool which has been developed within the medical division.

4) PATIENT EXPERIENCE

4.1 Formal complaints

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

Target	Q2 10/11	Q3 10/11	Q4 10/11	Q1 11/12
1.00%	0.30%	0.19%	0.17%	0.21%



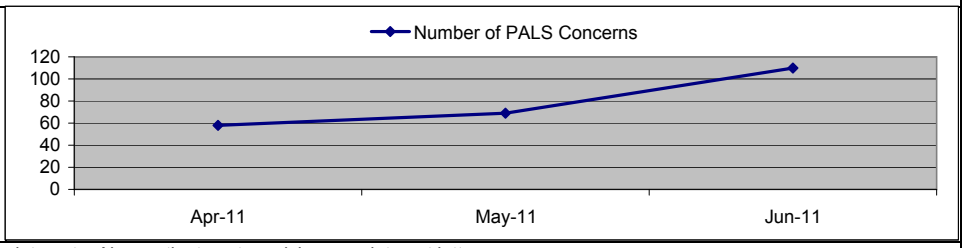
Analysis: 80 complaints were received in Q1 for 11/12 which equates to 0.21% of the Trust's activity.

Actions:

4.2 PALS Concerns

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

Apr-11	May-11	Jun-11
58	69	110



Analysis: The focus of the top 3 themes for PALS relate to cancellation or change of appointments. Also, patients not receiving appointment letters.

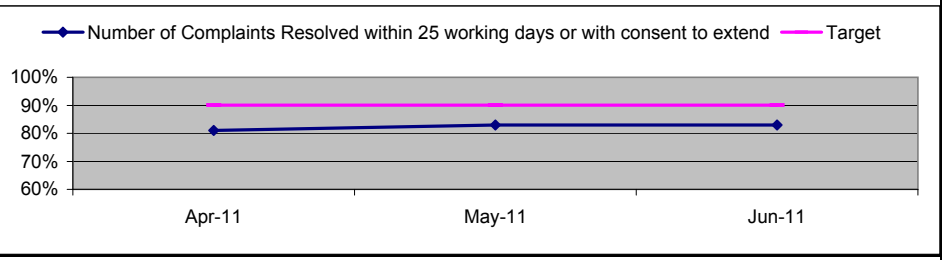
Actions:

4.3 Formal Complaints resolved within 25 days

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

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

Apr-11	May-11	Jun-11
81%	83%	83%



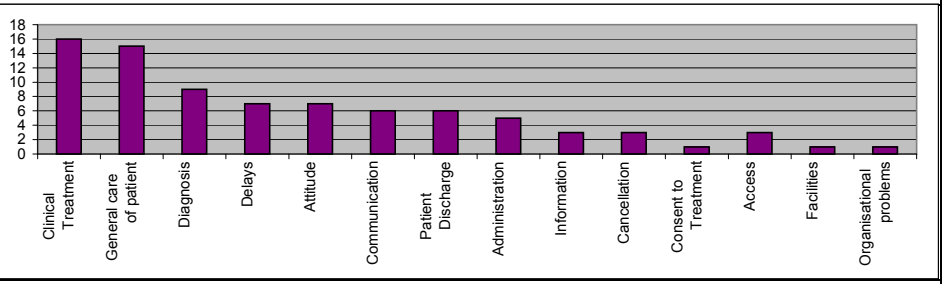
Analysis: Due to timescales for responding to complaints the June figure is only partially complete. The Trust has not achieved its target for responding to complaints in this quarter.

Action: Discussion will be taking place with the Divisional Managers in order to identify the available options for improving the current system. These will include centralising to the PALS/Complaints team the process to obtain consent to breach, also holding weekly PALS/Complaints team meetings to review and monitor the process.

4.4 Formal Complaints trends

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

	Apr-11	May-11	Jun-11
Number of formal complaints	28	29	23



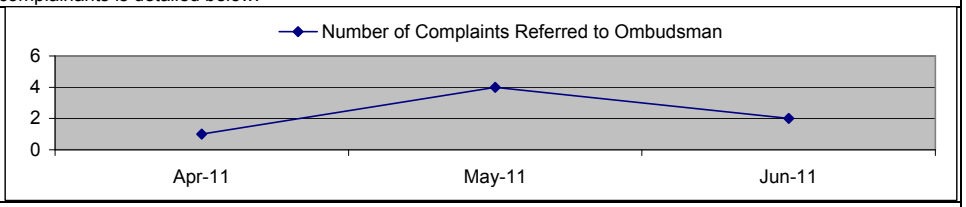
Analysis: The top 3 themes for complaints relate to the clinical aspect of a patients experience - correct treatment received, received in a timely manner, or the correct diagnosis received.

Action:

4.5 Ombudsman

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

	Apr-11	May-11	Jun-11
Number of complaints referred to the PHSO	1	4	2

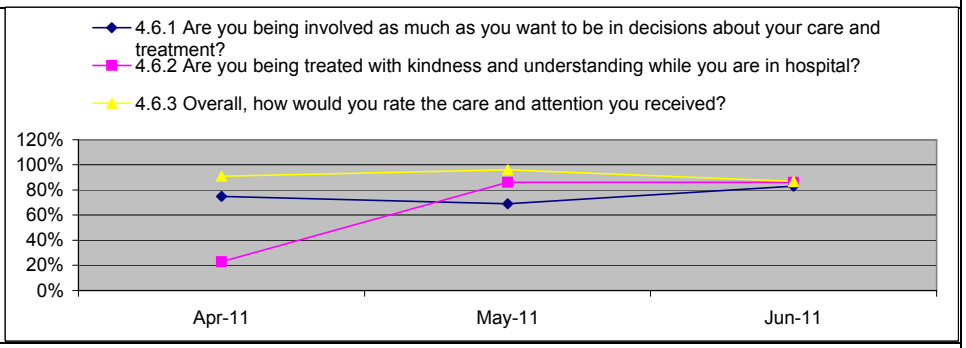


Analysis: In Q1 7 complaints were referred to the PHSO. 1 in April, 4 in May and 2 in June. 2 complaints were closed as the PHSO made the decision not to investigate with no actions or recommendations. Papers were requested for 4 complaints and the appropriate records and additional information have been provided to the PHSO - we await their comments. 1 complaint was referred back to the Trust to see if local resolution can be achieved.

Actions:

4.6 Patient Experience Tracker

	Apr-11	May-11	Jun-11
4.6.1 People that said yes definitely to: Are you being involved as much as you want to be in decisions about your care and treatment?	75%	69%	83%
4.6.2 People that answered yes all of the time to :Are you being treated with kindness and understanding while you are in hospital?	23%	86%	86%
4.6.3 People that answered 'excellent or good to :Overall, how would you rate the care and attention you received?	91%	96%	87%



Analysis: The percentage in April is low for the 'kindness and understanding' question due to an error on the server which was not identified until the end of that survey period. This is the first quarter for this survey and only relates to adult inpatients, excluding ward D22(dementia ward) and Critical Care.

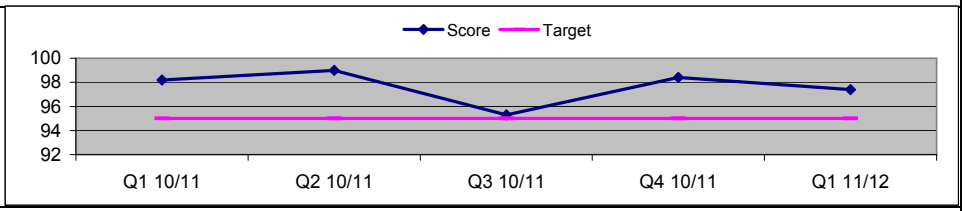
Actions: The survey results are sent to the various wards on a monthly basis to the ward manager and directorate manager for review. This first quarter will be used as a way of establishing a baseline.

5) PATIENT SAFETY AND QUALITY

5.1 Hand Hygiene Practice

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

	2010/11			2011/12
Target	Q2	Q3	Q4	Q1
95%	99.0%	95.3%	98.4%	97.4%



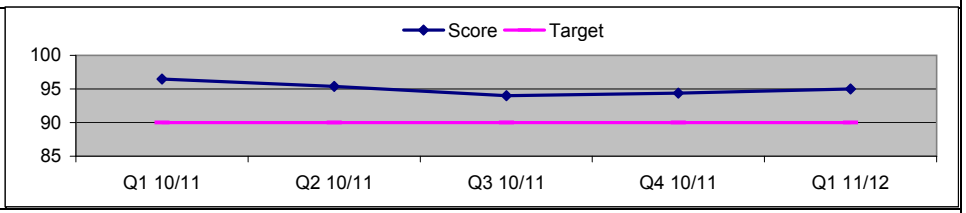
Analysis: 45 out of 63 areas reported 100%. Main areas identified as non-compliant were hand hygiene prior to procedures and after removing gloves, staff wearing nail varnish, medical and AHP staff not bare below the elbow

Actions: All non-compliances were challenged at times of audit, line managers for medical and AHP staff informed of breach of policy

5.2 Environmental standards

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

	2010/11			2011/12
Target	Q2	Q3	Q4	Q1
90%	95.4%	94.0%	94.4%	95.0%



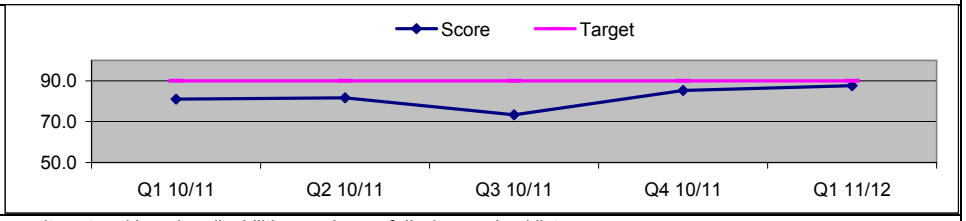
Analysis: 77% of areas scored above 95%, the main issues identified were dust at high/low levels, dusty air vents, floors dusty and gritty in corners, visitors stools not intact and shower curtains needing replacement

Actions: Matrons for low scoring areas have met with domestic supervisors to agree a plan of action and reaudit schedule, the deep clean programme is ongoing, equipment replacement has been ordered, shower curtain replacement programme agreed.

5.3 Essence of Care standards

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

	2010/11			2011/12
Target	Q2	Q3	Q4	Q1
90%	81.7%	73.3%	85.2%	87.6%



Analysis: The principle areas of non-compliance were staff training in relation to mental capacity act and learning disabilities, and use of discharge checklist

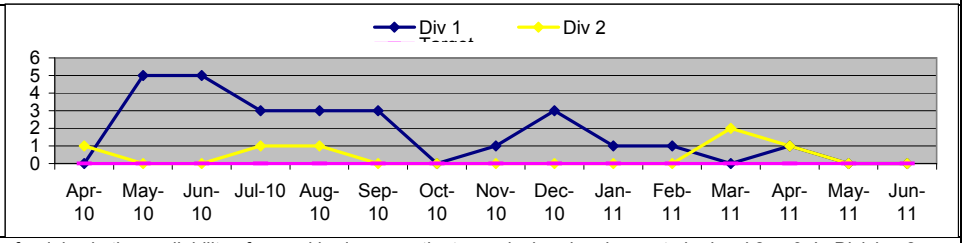
Actions: The essence of care bench marking group has been reformed, with an updated audit programme, the discharge checklist has been revised and relaunched for use in all inpatient areas with an audit of compliance of use to be completed by the end of July

5.4 Single sex accommodation

Patients want care delivered in single sex accommodation. The vast majority of our clinical areas have declared themselves compliant against Department of Health standards for single sex accommodation. A small number of areas are not currently compliant, these include: Deanesly Ward, EAU, Renal Unit and Endoscopy all of which are waiting for building work. Additionally, it is known that ICCU, while making every attempt to segregate men and women, will be unable to achieve this consistently for clinical reasons. The measure below includes the number of incidents in those areas that have declared themselves compliant. We will measure incidents of mixed sex sleeping accommodation.

Number of incidents	Apr-11	May-11	Jun-11
Target	0	0	0
Division 1	1	0	0
Division 2	1	0	0

Definition of Single sex incident: A patient located in a bay with patients of the opposite sex is defined as one incident (e.g in a six bedded bay, 1 incident not 6 incidents)



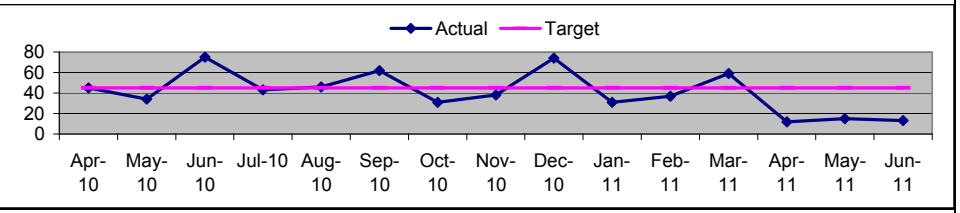
Analysis: In Division 1 there was 1 breach of same sex in ICCU and this was as a result of a delay in the availability of a ward bed once patient was declared no longer to be level 2 or 3. In Division 2 a bedbound female patient was placed in a sideroom situated off a male bay. Whilst patient's privacy was not compromised, this is a breech by DoH definition and awareness amongst staff has been raised.

Actions: At 12.00 capacity meeting patients awaiting transfer from ICCU are discussed and plans put into place to prevent same sex incidents.

5.5 Nursing & Midwifery staffing levels

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

	Apr-11	May-11	Jun-11
Division 1	1	4	4
Division 2	11	11	9
Total	12	15	13
Target	45	45	45



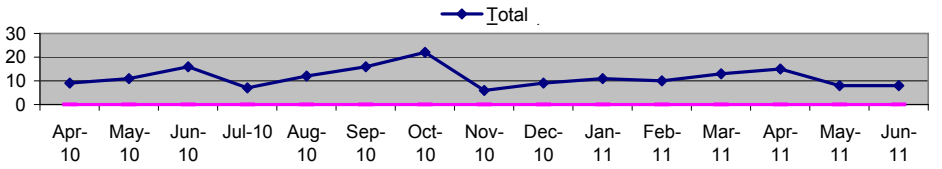
Analysis: In Division 1 there were 9 reported breaches in staffing levels - none of which resulted in patient harm, these incidents were all reported in areas with additional capacity open to support patient flow. In Division 2 breech reports were significantly lower than the same period last year. Staffing was balanced across the medical wards and during this period additional capacity was opened at times. Staffing challenges continue on ward D16 in particular.

Actions: Both the Head and Neck and Cardiac Directorates have drafted operating frameworks which are to be implemented should the empty bay on ward D4 or cardiac catheter lab be requested to be opened to support surge in emergency activity.

5.6 Medication administration incidents

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

	Target	Apr-11	May-11	Jun-11
Division 1	0	10	5	5
Division 2	0	5	3	3
Total	0	15	8	8
Target	0	0	0	0



Analysis: There were 20 nurse drug administration errors in Division 1 non of which resulted in patient harm. In Division 2 there were 11 incidents reported, a number of these were in paeds/NNU. No patient harm was reported as a result of these errors.

Actions: All incidents were dealt with at the time and appropriate action and polices were followed

Agenda Item No:

THE ROYAL WOLVERHAMPTON HOSPITALS NHS TRUST

Report to:	Trust Board
Date:	26 September 2011
Subject:	Quality & Safety Report
Report by:	Director of Nursing & Midwifery
Author:	Patient Safety Manager
Purpose of Report	To provide the Committee with information regarding performance and progress with Trust quality and safety.

Report

This is the first monthly report following the Board's decision to receive the Quality & Safety Report on monthly rather than quarterly basis. The report relates to July 2011 and includes progress of the Trust's campaign to prevent harm and improve patient safety in addition to an organisational overview of incidents, complaints, inquests, and claims. It also provides information on issues that fall outside of the campaign but contribute to the quality and safety agenda.

Review Committee Approval

Approved by the Quality & Safety Committee 6 September 2011

Recommendation(s)

The Trust Board is asked to note the content of the report

Contents

1) EXECUTIVE SUMMARY

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

Section 2 provides an overview of organisational quality and safety.

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

Section 4 reports on the patient experience.

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

The areas to note regarding progress are as follows:

- 3 serious complaints this month
- 3 falls resulting in serious injury
- 25% late observations
- DRHABS above monthly target
- 5 complaints referred to the Ombudsman
- 12 medication administration incidents

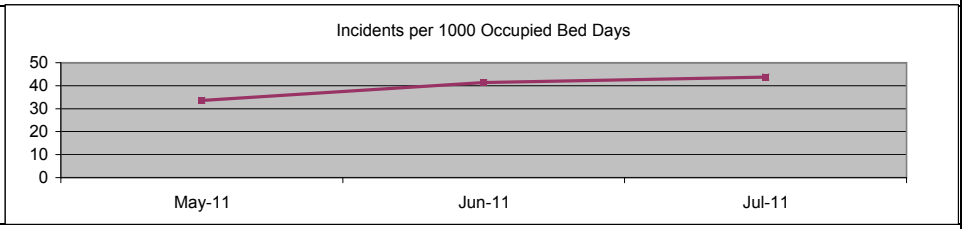
- 11 cardiac arrests this month compared to 24 in each of the previous two months
- Lowest monthly incidence of C Diff since testing method changed but still above target
- VTE risk assessment 94%
- 92% complaints received response within 25 working days
- 97% people rated care and attention excellent or good
- No breaches of single sex accommodation

2) TRUST SAFETY & QUALITY OVERVIEW

2.1 Incident Rate

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

	May-11	Jun-11	**Jul-11**
Div 1	337	410	401
Div2	341	427	458
Total	678	837	859
Per 1000obd	33.5	41.4	**43.7**



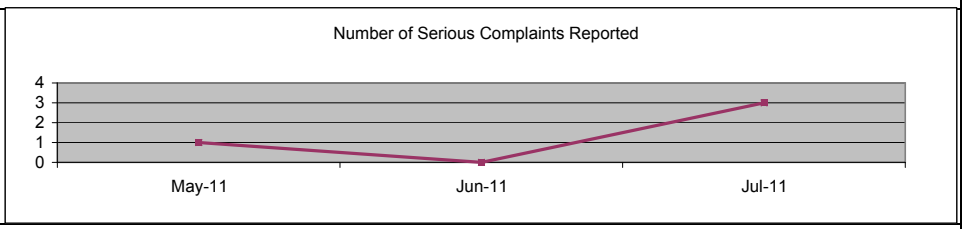
Analysis: The number of incidents reported during July has increased by 2.6% from the previous month. The majority of incidents are reported by nursing and midwifery staff and the largest category of incidents is patient falls (further information on patient falls in section 3.2).

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

2.2 Serious Complaints

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

	May-11	Jun-11	**Jul-11**
Div 1	0	0	1
Div2	1	0	2
Corp	0	0	0
Total	1	0	3



Analysis: Division 1 - One complaint graded as amber. This complaint related to a patient who was admitted to hospital and underwent an operation to remove an aortic aneurism and to replace heart valves. Prior to the operation the patient was able to speak normally. Following surgery the patient found it difficult to speak and her voice was extremely strained and hoarse. The patient feels that the vocal cords were damaged during the operation and were now paralysed. The patient has appointed a firm of solicitors to act on their behalf.

Division 2 - Two complaints graded as amber. The first complaint relates to a patient who was diagnosed with cancer and is under the care of the Chemotherapy Unit and Durnall Unit. The patient was advised to attend A&E as she was feeling unwell and was unhappy with the treatment and care received. The patient's daughter feels that the A&E staff did not act professionally as the doctor and nurse appeared to be having a disagreement in front of the patient. In addition they had concerns about infection prevention as, after taking blood from the patient, they witnessed the A&E Doctor leave traces of the patients blood all over the sink in the cubicle.

The second complaint relates to a patient who attended A&E with their parent having suffered a suspected broken nose after an accident whilst playing football. The A&E doctor said the patient needed to be taken to his GP after approximately a week as there was a lot of swelling to the nose and this needed to go down before anything could be done. The patient did as they were instructed and the GP made a referral to ENT. When the patient attended the ENT appointment the Consultant asked the parent why they had waited so long to see him. The parent explained sequence of events and alleges that the Consultant allegedly informed them that had he seen the patient within 3 weeks of the accident he would have been able to correct his nose. However, because of the time delay, he would be unable to repair the nose until the patient turns 15 years old (patient is 9 yrs old).

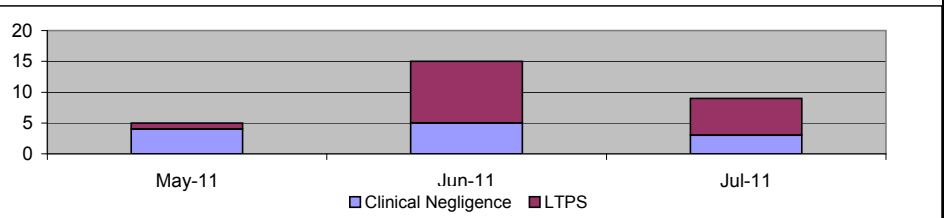
The parent is upset and feels let down as, because she followed the advise of the A&E Doctor, the patient will have to live with a broken nose for many years. If they had received better advice the nose could have been repaired.

Actions: Division 1 - Patient had major cardiac surgery to treat a potentially life threatening condition of aorta and heart. There were no specific anaesthetics problems on the day. The risk of vocal cord injury during cardiac surgery is very small - the symptoms are an unusual event. Advice sought from legal services with regards to final response. **Division 2** - The first complaint is still open as the final response is not due until September. The second complaint - Doctors are aware that patients with suspected nose fractures and obvious deformity should be referred directly to the ENT Clinic as an outpatient. A&E Consultant has reinforced to the examining doctor and other doctors in the department the need for review by the GP within 3 - 4 days.

2.3 New Litigation

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

	May-11	Jun-11	**Jul-11**
Clinical Negligence	4	5	3
LTPS	1	10	6
Total New	5	15	9



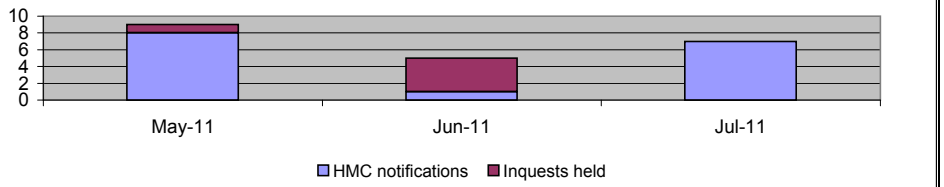
Analysis: Inquest notifications concern, deceased child with multiple medical problems, deceased undergoing surgery for congenital omphalocele, deceased found in peri-arrest situation and oxygen cylinder empty, deceased underwent a bronchoscopy, deceased baby was delivered at the hospital and transferred to Birmingham Children's Hospital, in one inquest notification the coroner is still to state the details. No inquests were held during July.

Actions: No further actions

2.4 Inquests

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

	May-11	Jun-11	**Jul-11**
HMC notifications	8	1	7
Inquests held	1	4	0
HMC Recommendations	0	0	0
% Recommendations per FCE	0	0	0



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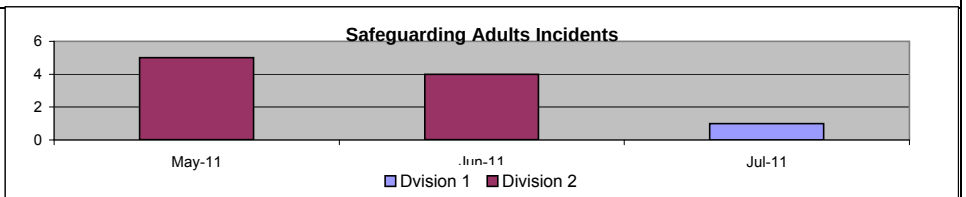
Actions: No further actions

2.5 Safeguarding Adults Incidents

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

Safeguarding Adults	May-11	Jun-11	**Jul-11**
Div 1	0	0	1
Div2	5	4	0
Total	5	4	1



Analysis: One Safeguarding Adult (SA1) referral received in July - alleged neglect by acts of omission relating to pressure damage acquired whilst inpatient on D5. Investigations have been completed on ten of the open eighteen safeguarding referrals alleging neglect by the trust. These are currently with the safeguarding team of the local authority where we await feedback.

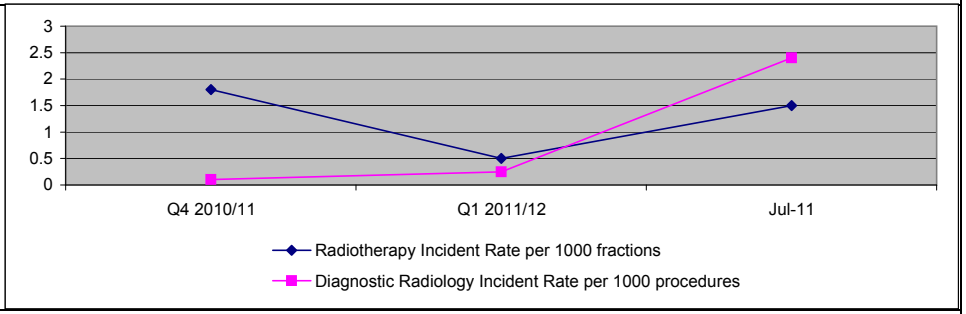
Actions: Investigation commenced on July referral. Each completed investigation has led to an improvement action plan and monitoring by the divisional governance process

2.7 Radiation Incidents

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

Radiation Incidents	May-11	Jun-11	**Jul-11**
Radiotherapy	1	1	4
Diagnostic Radiology	4	2	4
Nuclear Medicine	0	0	not available
Laser/Non-ionising	0	0	not available

Rates	Q1		**Jul-11**
Radiotherapy Incident Rate per 1000 fractions	0.5		1.5
Diagnostic Radiology Incident Rate per 1000 procedures	0.25		2.4



Analysis: ▪ Radiotherapy – None of the incidents in Radiotherapy this month required external reporting. None of the incidents were related and no trends have been identified. All incidents were discussed at the local staff meeting. None of the incidents resulted in patient harm or detriment to treatment. Approx 2600 fractions of radiotherapy were delivered in total this month. Incident Rate 1.5 incidents per 1000#. ▪ Diagnostic Radiology – There were 4 incidents in Radiology this month, none of which required external reporting. The incidents have not been classified by the radiation safety committee. One incident involved missing information on a request card. Two incidents involved the request of x-rays that had already been carried out, one of which resulted in an additional radiation exposure. The other incident involved an exposure of the incorrect site due to inaccurate clinical information. Approx 16500 radiological examinations were carried out this month. Incident rate 2.4 incidents per 1000 procedures. ▪ Nuclear Medicine – information not currently available ▪ Laser/Non-ionising – information not currently available

Actions: The Radiation Safety Committee will discuss these incidents and any further action required at their next meeting.

3) PREVENTING HARM, IMPROVING SAFETY MEASURES

Introduction:

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

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

3.1 Mortality

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

	May-10	Jun-10	Jul-10	Aug-10	Sep-10	Oct-10	Nov-10	Dec-10	Jan-11	Feb-11	Mar-11	Apr-11	May-11
HSMR	112.3	93.4	109.8	107.9	94.2	99.9	97.5	106.4	103.4	103.4	95	91	84
Observed Death Rate (56 CCS	3.70%	3.20%	4.20%	3.80%	3.50%	4.30%	4.00%	5.10%	4.90%	4.50%	3.90%	4.40%	3.50%
Expected Death Rate (56 CCS	3.30%	3.40%	3.80%	3.50%	3.70%	4.30%	4.10%	4.80%	4.80%	4.30%	4.10%	4.80%	4.20%
No of In Hospital Deaths	131	120	148	135	134	148	146	196	186	148	163	125	98
Expected Deaths	122	130	145	133	141	150	154	186	183	151	164	138	117
Excess Deaths	9	-10	3	3	-7	-2	-8	10	3	-3	-1	-15	-19

Analysis: Information currently available from Dr Foster

Top Diagnostic Groups Contributing to Patient Deaths by Volume

Diagnosis Group	Spells	Deaths	%
Pneumonia	**154**	**34**	**22.08%**
Acute Cerebrovascular disease	**158**	**26**	**16.46%**
Urinary Tract Infections	**189**	**11**	**5.82%**
Acute Myocardial Infarction	**183**	**9**	**4.92%**
Congestive Heart Failure, nonhypertensive	**83**	**8**	**9.64%**

Analysis:

Alert Status

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

Actions: A panel of consultants led by a specialist geriatrician are conducting a detailed case note review. This is being complemented by enhanced level data interrogation of the specified HRGs.

Associated Indicators of Mortality

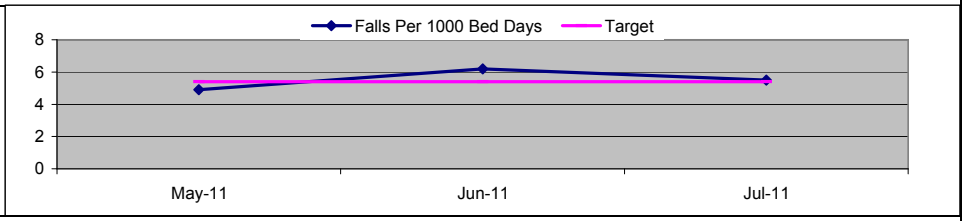
Indicator	Period	Target	Actual	RAG	TREND
Charlson Codes Per Spell (HED)	Apr-May 11	Peer Group Average **5.75**	**5.78**		
Palliative Care Deaths Per 1000 Spell (HED)	Apr-May 11	Peer Group Average **18**	**17**		
Expected Death Rate (Dr F)	Apr-May 11	Peer Group Average [4.8%]	**4.50%**		

Analysis:

3.2 Inpatient Falls

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

	May-11	Jun-11	**Jul-11**
Target per occupied bed days	<5.4	<5.4	<5.4
Number of falls per occupied bed	4.9	6.2	5.5
Number of falls resulting in serious injury	0	0	3



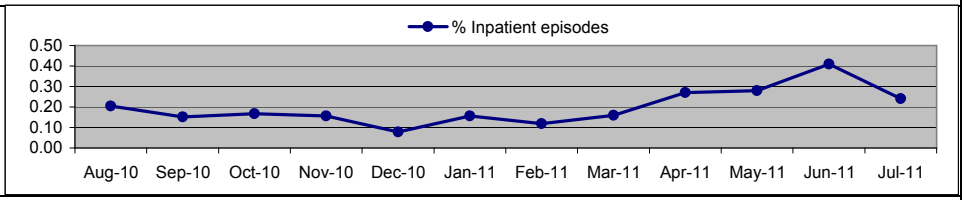
Analysis: This year the trust set a 50% reduction in serious injury as a result of a fall. Across acute and community impatient services the target for the year is 14 . Annual falls with serious injury to date is 4 from April to July 2011.

Actions: Need to continue to embed rapid improvement programme across the six identified ward areas and to enhance communication of the programme trust wide. Planning is underway for phase 2 of the rapid improvement programme across a further five ward areas.

3.3 Pressure Ulcers

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

	May-11	Jun-11	**Jul-11**
Grade 2	30	43	28
Grade 3	3	9	2
Grade 4	1	0	0
Total	34	52	30
%Inpatient Episodes	0.28	0.41	0.24



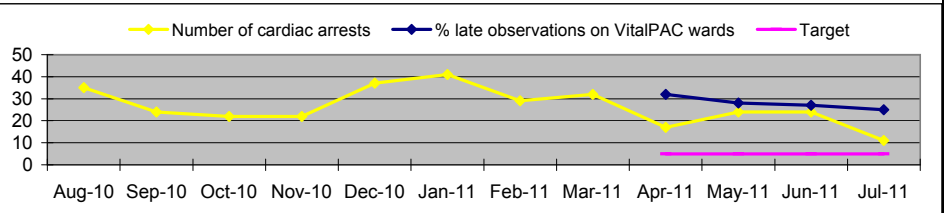
Analysis: Improved identification and reporting of pressure damage since April 11 provides an accurate % of inpatient episodes. Revised national definition of grades of pressure damage has been implemented in the organisation with significant staff training and education provided

Actions: Rapid improvement programme due to commence 3/10/11. Planning currently underway. Eight wards areas across acute and community with the highest incidence of pressure ulcers will undertake the programme initially. There will be a particular focus on positioning and personal care of patients, competencies, training and education and patient/carer education and compliance.

3.4 Recognition of the Deteriorating Patient

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

	May-11	Jun-11	**Jul-11**
Number cardiac arrests	24	24	11
% observations late	28%	27%	25%
Target (late observations)	5%	5%	5%



Analysis: During April to July 2010 there were 119 cardiac arrests, during the same period this year there have been 76 cardiac arrests. Late observations are defined as observations taken greater than 30 minutes after the protocol and excludes observations where the protocol has been over ridden by a greater time interval. The percentage of late observations is obtained from wards using VitalPAC only. The frequency of required observations is based on the Trust escalation protocol, which is based on NICE guidance. The target is no more than 5% late observations; this has been achieved this month by Clinical Haematology Day Case Unit, Durnall, Cardiology Day Ward, & Beynon Day Case Unit.

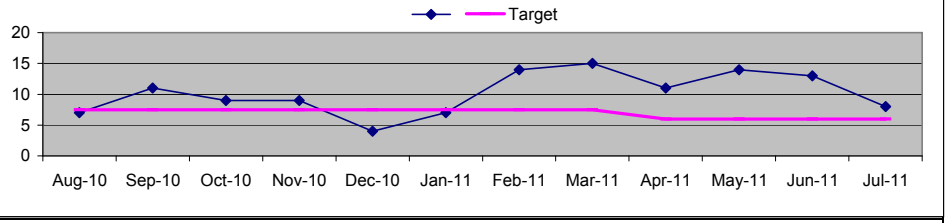
Actions: The percentage of late observations is a key performance indicator for all adult inpatient wards and ward managers are working to improve compliance.

3.5 Healthcare Acquired Infections (HCAIs)

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

3.5.1 Clostridium Difficile - hospital acquired for ages >2 years

	May-11	Jun-11	**Jul-11**
Number of C Diff	14	13	8
Cum Plan	12	18	24
Cum Actual	25	38	46
Cum Variance	13	20	22

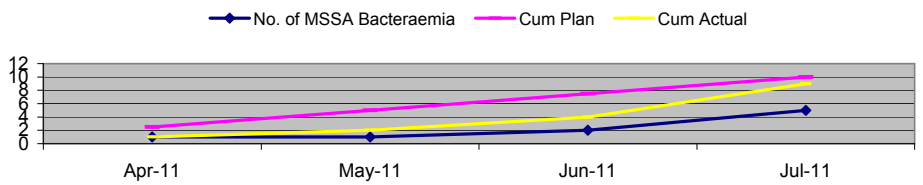


Analysis: The lowest number of cases in a month since the testing method was changed. No ward had more than one case during the month. Performance remains considerably above target.

Actions: C diff Action Plan is being reviewed. New Antimicrobial Prescribing Guidelines have been launched; findings of C diff RCAs have been used in writing these. Deep Clean programme continues, with hydrogen peroxide decontamination available to ensure maximal efficacy against C diff.

3.5.2 MSSA Bacteraemia

	May-11	Jun-11	**Jul-11**
No. of MSSA Bacteraemia	1	2	5
Cum Plan	5	7.5	10
Cum Actual	2	4	9
Cum Variance	-3	-3.5	-0.5



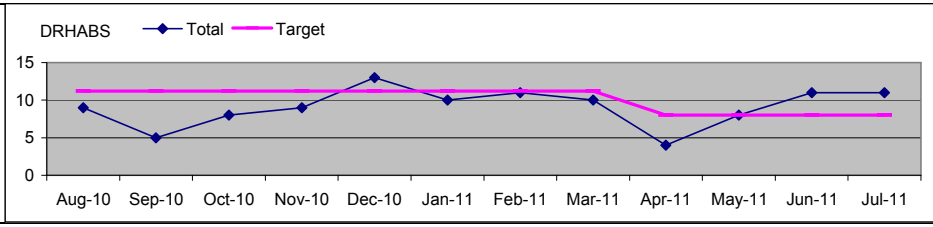
Analysis: Three secondary to intravenous lines, one a renal dialysis line. Others probably secondary to skin soft tissue infections.

Actions: Screening for MSSA of patients who dialyse via lines commenced. ANTT training and DRHAB work ongoing.

3.5.3 Device Related Hospital Acquired Bacteraemias

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

	May-11	Jun-11	**Jul-11**
Target (monthly)	8	8	8
DRHABS	8	11	11



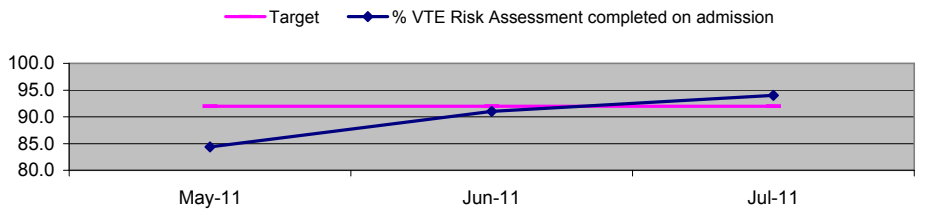
Analysis: 8 line-related and 3 urinary catheter-related bacteraemias.

Actions: A new Central Venous Access Course has commenced for qualified nursing staff. The neonatal unit is now using chlorhexidine for skin decontamination. The Renal Dialysis Unit is screening all patients for MSSA as an additional measure, and is using less viscous locking solution in order to reduce line occlusion. Oncology Haematology and the Renal Specialities are trialling antibacterial patch dressings on their higher risk patients. A monthly newsletter (DRHAB News) has been created to increase staff awareness.

3.6 Venous Thrombo Embolism

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

	May-11	Jun-11	**Jul-11**
% adult patients with completed VTE risk assessment	84.4%	91.0%	94.0%
Number of patients with hospital acquired VTE	7	8	6
Number of patients with community acquired VTE	29	28	35



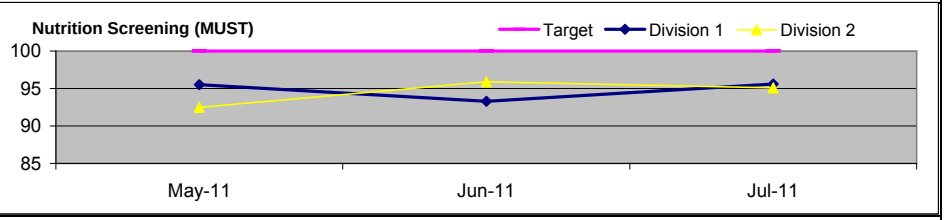
Analysis: Trust compliance with VTE risk assessment was 94% in July. (Local CQUIN target is 92%, national CQUIN target is 90%)

Actions: RCAs commenced on patients identified with VTE to determine if healthcare acquired. Outcomes discussed at Prevention of VTE Group and at Directorate governance meetings.

3.7 Nutrition

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

% adult inpatients with completed MUST	May-11	Jun-11	**Jul-11**
Division 1	95.5%	93.3%	95.6%
Division 2	92.5%	95.9%	95.1%
Target	100	100	100



Analysis: The completion of MUST is a key performance indicator for all adult inpatient wards and monitoring commenced in May 2011.

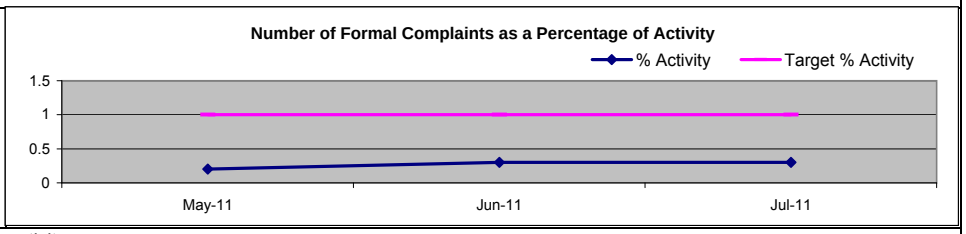
Actions: Protected mealtimes are being re-enforced on 5 pilot wards, with ongoing work through the nutrition action team meetings. Ongoing work with education team & members of Nutrition Steering Committee re frequency & content of mandatory training on nutrition. Nutrition content of nurse induction changing from next month to be more extensive, with nurse & dietician lead sessions.

4) PATIENT EXPERIENCE

4.1 Formal complaints

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

Target	May-11	Jun-11	**Jul-11**
1.00%	0.2%	0.3%	0.3%



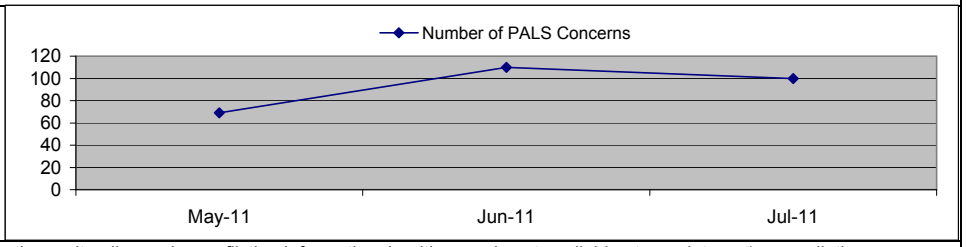
Analysis: 36 complaints were received in July 2011 which equates to 0.3% of the Trust's activity.

Actions: The Trust has achieved its target therefore there are no actions to be taken.

4.2 PALS Concerns

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

May-11	Jun-11	**Jul-11**
69	110	100



Analysis: The focus of the top 3 themes for PALS relate to information (regarding diagnostic results, diagnosis, conflicting information, health records not available at appointment), cancellation or change of appointments and general care of patients (poor communication with patient/relative).

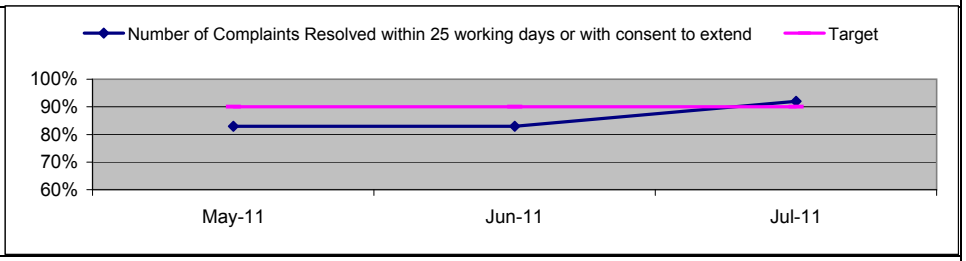
Actions: Themes will continue to be monitored.

4.3 Formal Complaints resolved within 25 days

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

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

May-11	Jun-11	**Jul-11**
83%	83%	92%



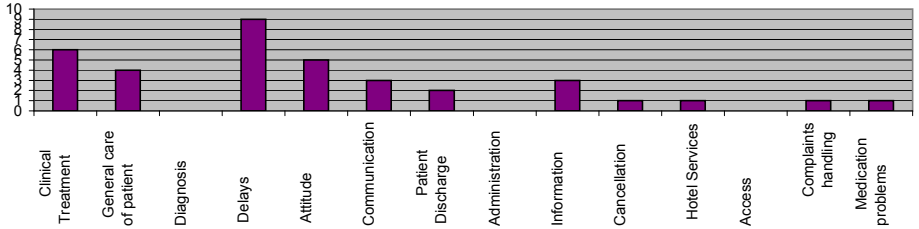
Analysis: The Trust has achieved its target for responding to complaints this month.

Action: The PALS and Complaints team have now centralised the process for obtaining consent to breach. This will be monitored on a weekly basis over the next few months in order to assess its effectiveness.

4.4 Formal Complaints trends

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

	May-11	Jun-11	**Jul-11**
Number of formal complaints	29	23	36



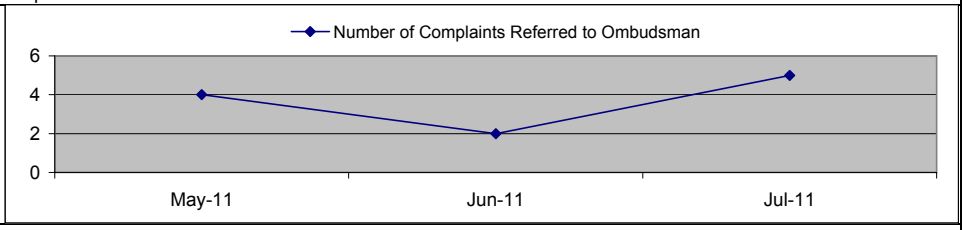
Analysis: The top 3 themes for complaints are delays (i.e. appointments or receiving diagnostic results), clinical treatment and attitude.

Action: The PALS themes are discussed at the Patient Experience Forum and further live feedback is gained by the Leadership Safety Walkabout

4.5 Ombudsman

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

	May-11	Jun-11	**Jul-11**
Number of complaints referred to the PHSO	4	2	5

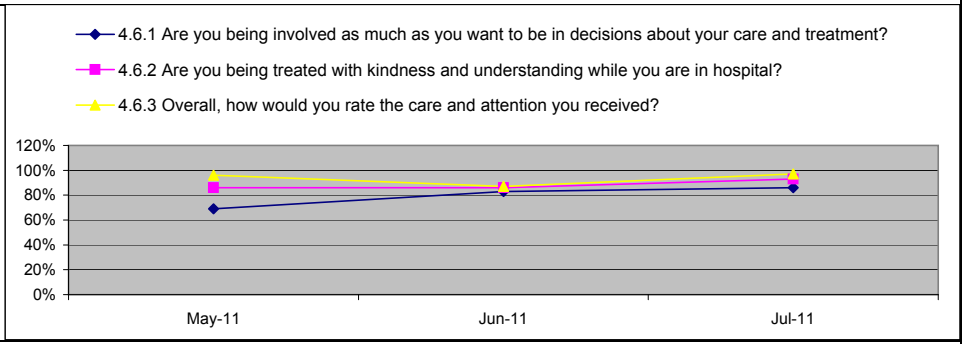


Analysis: In July 5 complaints were referred to the PHSO.

Actions: 1 complaint was closed as the PHSO made the decision not to investigate with no actions or recommendations. Papers were requested for the remaining 4 complaints and the appropriate records and additional information have been provided to the PHSO - we await their comments.

4.6 Patient Experience Tracker

	May-11	Jun-11	**Jul-11**
4.6.1 People that said yes definitely to: Are you being involved as much as you want to be in decisions about your care and treatment?	69%	83%	86%
4.6.2 People that answered yes all of the time to :Are you being treated with kindness and understanding while you are in hospital?	86%	86%	93%
4.6.3 People that answered 'excellent or good to :Overall, how would you rate the care and attention you received?	96%	87%	97%



Analysis: July is the fourth month in which the patient surveys have been carried out. The system is working well, the number of patient's being surveyed is increasing (from 301 in month 1 to 709 in month 4) and the surveys are being well received. Satisfaction levels are improving against all three of the selected questions.

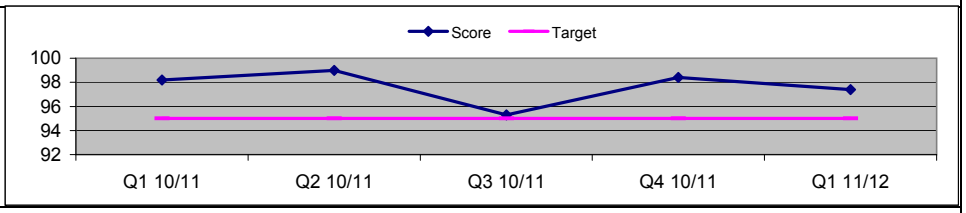
Actions: Surveys will continue to be carried out on adult inpatient wards and work is underway to roll out the survey to EAU from 1 September 2011

5) PATIENT SAFETY AND QUALITY

5.1 Hand Hygiene Practice

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

	2010/11			2011/12
Target	Q2	Q3	Q4	Q1
95%	99.0%	95.3%	98.4%	97.4%



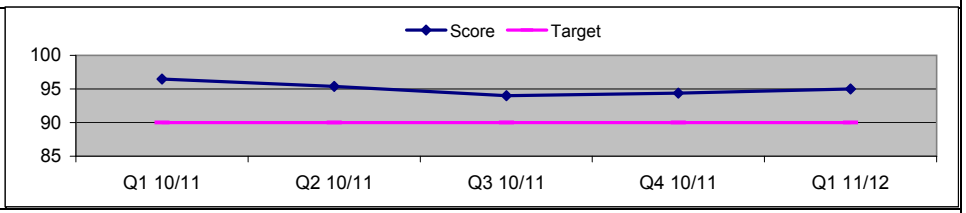
Analysis: Information reported quarterly

Actions:

5.2 Environmental standards

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

	2010/11			2011/12
Target	Q2	Q3	Q4	Q1
90%	95.4%	94.0%	94.4%	95.0%



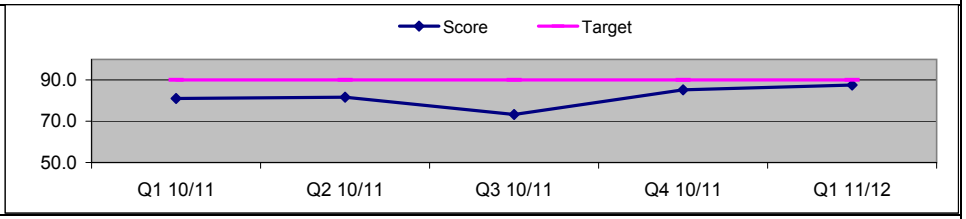
Analysis: Information reported quarterly

Actions:

5.3 Essence of Care standards

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

	2010/11			2011/12
Target	Q2	Q3	Q4	Q1
90%	81.7%	73.3%	85.2%	87.6%



Analysis: Information reported quarterly

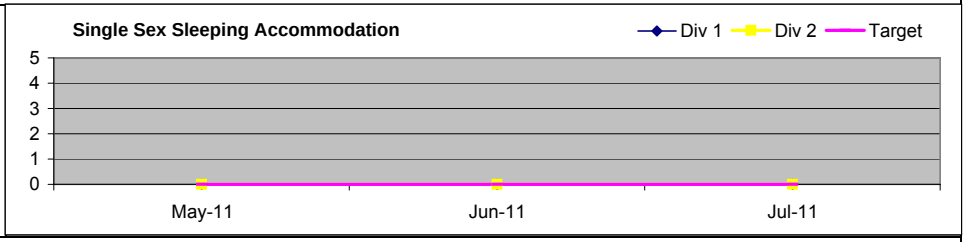
Actions:

5.4 Single sex accommodation

Patients want care delivered in single sex accommodation. The vast majority of our clinical areas have declared themselves compliant against Department of Health standards for single sex accommodation. A small number of areas are not currently compliant, these include: Deanesly Ward, EAU, Renal Unit and Endoscopy all of which are waiting for building work. Additionally, it is known that ICCU, while making every attempt to segregate men and women, will be unable to achieve this consistently for clinical reasons. The measure below includes the number of incidents in those areas that have declared themselves compliant. We will measure incidents of mixed sex sleeping accommodation.

Number of incidents	May-11	Jun-11	**Jul-11**
Division 1	0	0	0
Division 2	0	0	0
Target	0	0	0

Definition of Single sex incident: A patient located in a bay with patients of the opposite sex is defined as one incident (e.g in a six bedded bay, 1 incident not 6 incidents)



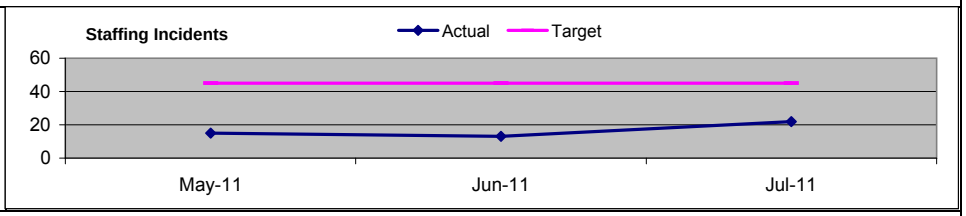
Analysis: No incidents in July where single sex standards were not met.

Actions: Continue with current strategies.

5.5 Nursing & Midwifery staffing levels

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

	May-11	Jun-11	**Jul-11**
Division 1	4	4	11
Division 2	11	9	11
Total	15	13	22
Target	45	45	45



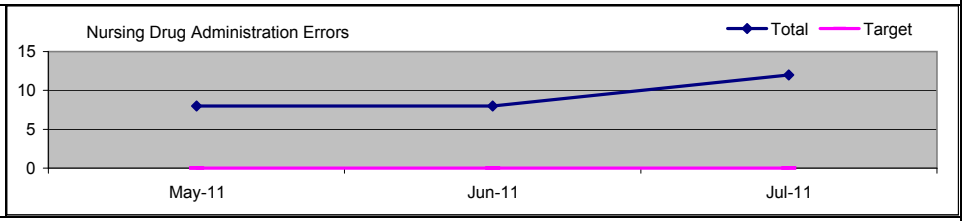
Analysis: No incidents resulting in patient harm.

Actions: Ongoing monitoring of the impact of staffing levels.

5.6 Medication administration incidents

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

	May-11	Jun-11	**Jul-11**
Division 1	5	5	8
Division 2	3	3	4
Total	8	8	12
Target	0	0	0



Analysis: Division 1 - 3 Cardiology ward, 3 D3 ward, 1 D1 ward, 1 D6 – no harm as a result of these errors
Division 2 - 1 acute medicine, 2 gastro, 1 paeds, 3 incidents graded green, 1 yellow - none of which resulted in patient harm.

Actions: Staff managed in accordance with drug error management policy.

Trust Dashboard: July 2011

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

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

Trends:

↔ No change
↑ Improvement on previous month
↓ Deterioration on previous month

				Surgical Division							Emergency, Medical & Community Service Division									
							Surgical Services Group						Rehab & Amb Medical Group			Medical Group				
	Target	Tolerance	Data Source	Diagnostics Service Group	Theatres/ ICCU Service Group	Cardio-thoracic/ Cardiology Service Group	General Surgery/ Urology	Ortho-paedics	Obs & Gynae	Ophthal-mology/ Head & Neck Services Group	Children's Services Group	Adult Community Services Group	Elderly Care & Stroke	Rehab (West Park)	Neurology / Rheuma-tology / Dermatology	Renal & Diabetes	Resp & Gastro	Emergency Services Group	Therapies & Pharmacy Group	Oncology & Haema-tology Group
Patient Experience																				
Patient complaints as a percentage of activity	<0.5%	Green = <0.5, Red = 0.5+	Nina Dunmore	G 0%	R 0.5%↑	G 0.2%↓	G 0.3% ↓	G 0.3% ↑	G 0.2% ↓	R 0.7% ↓	G 0%	G 0%	0.06% ↓	G 0%	G 0%	G 0%↔	G 0.09%↓	G 0.06% ↓	G 0%	G 0.07%↔
New investigations accepted by Ombudsman	0	Green = 0,Amber = 1,Red = >1	Nina Dunmore	G↔	G↔	G↔	G↔	G↔	G ↔	G↔	G↔	G↔	G↔	G↔	G↔	G ↔	G↔	G↔	G↔	G↔
Percentage patients who rated overall satisfaction good/excellent	90%	Green = >90,Amber = 80-89, Red = <80	Nina Dunmore	N/A	N/A	100%↔	99%↑	100%↑	91% ↓	90%↑	N/A	N/A	100%↑	N/A	N/A	98%↑	98%↑	N/A	N/A	95% ↓
Patient Safety																				
Number of red incidents	0	Green = 0,Amber = 1,Red = >1	Sukhy Khunkhuna	G ↔	G ↔	G ↔	G ↔	G ↑	G ↔	G ↔	A ↔	G ↔	G ↔	G ↔	G ↔	G ↔	G ↑	G ↔	G ↔	G ↔
Number of operational red risks	0	Green = 0,Amber = 1,Red = >1	Sukhy Khunkhuna	A ↔	G ↔	G ↔	G ↔	G ↔	G ↔	G ↔	G ↔	G ↔	G ↔	G ↔	G ↔	A ↔	G ↔	G ↔	G ↔	G ↔
Number of inpatient falls *RAG= tolerance multiplied by the number of inpatient wards	0	*Green = 0,Amber = 1-4 Red = 4+	Sukhy Khunkhuna	G 0 ↔	A 1 ↓	A 9 ↓	A 11 ↓	A 5 ↑	A 4 ↓	G 0 ↑	G 0 ↔	G 0 ↔	R 24 ↓	R 27↑	A 1 ↓	R 12 ↑	R 21 ↓	A 15 ↓	A 2 ↑	A 5 ↔
Number of healthcare acquired pressure ulcers acquired/deteriorated (Grade 2, 3 & 4) * RAG= tolerance multiplied by the number of inpatient wards reporting	0	*Green = 0,Red = 1+	Sukhy Khunkhuna	G 0 ↔	R 5 ↑	R 3 ↓	R 4 ↑	R 3 ↑	G 0 ↑	R 5 ↓	G 0 ↑	R 30 ↓	R 2 ↑	R 3 ↓	G 0 ↑	R 5 ↓	R 4 ↑	R 1 ↑	G 0 ↔	R 1 ↔
Percentage completed inpatient MUST assessments	100	Green = 100,Amber = 75-99 Red = <75	Rose Baker Zena Young		G	G ↑	A 80%↑	A 94% ↓	G ↔	G ↑	G	N/A	A 98.8% ↑	A 98%	N/A	A 95% ↑	A 93.6%↑	A 80%		G 0 ↔
MSSA bacteraemia	–	Green = 0,Amber = 1,Red = >1	Mike Cooper	G	G	A ↓	A ↓	G ↔	G ↔	G ↔	G	G	G ↑	G	G	A ↔	A ↓	G	G	A ↔
Clostridium Difficile - hospital acquired for ages >2 years	–	Green = 0,Amber = 1-2 Red = >2	Mike Cooper	G	A 1	G ↔	A 2 ↑	A 1 ↓	G ↔	G ↑	G	G	A 2 ↓	G	A 1	G ↑	A 1 ↑	G	G	G ↑
Device related bacteraemias	–	Green = 0,Amber = 1,Red = >1	Mike Cooper	G		A ↓	R 3 ↑	G ↔	G ↔	G ↔	G	G	G ↔	G	G	Derm G ↑	G ↑	G	G	
Device related bacteraemias (Haem/Onc, ICCU, Renal, Neonates)	–	Green = 0,Amber = 1- 2 Red = >2	Mike Cooper		A 2						Neonates					Renal A 2 ↓				R 3 ↑
Percentage VTE risk assessments assessed on admitting ward (VitalPAC wards only represented by Directorate, excludes maternity & low risk cohorts)	90%	Green = 90%+, Amber = 70-89% Red = <70%	Jayne Lawrence		A 76.2%	A 82.6%	R 66.6% ↓	A 85.7% ↑	A 71.5% ↑				A 87.3% ↓			A 70% ↑	R 48%↓	R 68.9%↑		A 78.3↑
Activity																				
Number of cancelled/rescheduled outpatient appointments	–	Reduction of 40% in year	Lesley Taff	N/A	N/A	39 ↑	242 ↑	1268 ↓	314 ↓	534 ↑	120	N/A	107 ↓	N/A	267	29 ↑	116 ↑	N/A	N/A	785 ↓
Length of stay (elective)	3.06	Green = <3.06 Amber = 3.07-3.19 Red = >3.20	Lesley Taff	N/A	N/A	R 6.8 ↔	R 3.7 ↓	R 3.8 ↑	G 2.7 ↔	G 1.1 ↔	G 1.2 ↑	N/A	N/A	N/A	R 5 ↔	G 0.9 ↑	4.2	N/A	N/A	R 7.5 ↓
Length of stay (non elective)	3.15	Green = <3.15 Amber = 3.16-3.24 Red = >3.25	Lesley Taff	N/A	N/A	R 8.1 ↑	R 4.5 ↓	R 5.9 ↑	G 1.1 ↔	R 4.3 ↔	G 0.7 ↑	N/A	R 3.4 ↑	N/A	R 5.25	R 3.3 ↓	N/A	N/A	N/A	R 7.5 ↓
Activity against contract	2%	Green = 2% Amber = 2-5% Red = >5%	Lesley Taff	N/A		R 12.6% ↓	G 1.01% ↑	R 7.55% ↓	A 2.29% ↑	A 3.65% ↑	G 1.79% ↑	N/A	R -20.86% ↓	N/A	A 2.44%	A 2.52% ↑	R 8.51 ↑	N/A	N/A	R 8.6% ↑
Percentage of emergency readmissions within 30 days	4.19%	Green = <4.19% Amber = 4.20-5% Red = >5%	Lesley Taff	N/A	N/A	G 1.15% ↓	G 1.72% ↑	G 0.66% ↑	G 0.38% ↑	G 0.32% ↑	G 0%↔	N/A	G 0%↔	N/A	G 0%↔	G 0%↔	G 0%↔	N/A	N/A	G 0%↔
Number of cancelled operations on day of surgery for non medical reasons	0	Green = 0 Amber = </= 4 Red = >/=5	Lesley Taff			R 11 ↓	R 11 ↓	A 1 ↑	R 5 ↓	A 4 ↑										
Outpatient DNA Rate (New)	<7%	<7% = Green, 7%-10% = Amber >10% = Red	Lesley Taff	0.0%		A 9.3% ↑	A 7.1% ↔	A 8.5% ↓	R 10.6% ↓	R 10.6% ↑	R 12% ↑	N/A	A 6.5% ↑	N/A	R 10.2%	R 10.1% ↑	R 11.1% ↑	N/A	A 9.8%	G 4% ↑
Outpatient DNA Rate (Review)	<7%	<7% = Green, 7%-10% = Amber >10% = Red	Lesley Taff	0.0%		G 5.1% ↓	A 8.3% ↓	R 11% ↓	R 11.3% ↓	R12.6% ↓	R 14.1% ↓	N/A	A 9.7% ↑	N/A	R 12.0%	R 11.3% ↑	R 12.8% ↓	N/A	R 13.7%	A 9.3% ↓
Human Resources																				
Sickness absence	<4%	Green = <4%,Amber = 4.1 - 5.9 Red = >6%	Lesley Taff	G 3.7%	A 4.97%	A 5.15% ↓	R 8.6% ↓	A 5.27% ↑	A 5.36% ↓	A 5.52% ↓	R 8.64% ↓	N/A	G 1.62% ↑	N/A	A 4.64%	A 5.02% ↓	A 4.71% ↑	A 5.35% ↑	G 3.87%	R 6.9% ↓
Percentage of trained nursing vacancies per funded establishment			Lesley Taff	N/A	0.40%	1.8% ↓	0.9% ↓	3.3% ↓	0.23% ↑	1.8% ↓	3.6% ↓	N/A	2.4% ↑	N/A	0% ↔	2.6% ↓	1.3% ↑	2.9% ↑	N/A	0.6% ↑
Percentage of medical training grades vacancies per funded establishment			Lesley Taff	N/A	0.00%	0% ↔	0.79% ↑	0% ↔	0% ↔	0% ↔	0.8% ↑	N/A	1.7% ↔	N/A	1.8% ↓	0% ↑	1.7% ↑	2.2% ↓	N/A	0% ↔
Staff feedback (Chat Back results to be reported in September 2011)			Caroline Marshal																	
Finance																				
Pay budget (ward pay budget only, represented by Directorate)	In balance	Green = Yes, Amber = Agreed Red = No	Alison Reynolds		R ↑	R ↑	R ↑	R ↑	R ↑	R ↑	R ↓	G ↑	R ↑	R ↓		R ↓	R ↑	R ↓		R ↑
WTE budgeted against actual (ward WTE only, represented by Directorate)	In balance	Green=variance < 5% Amber=variance 5-10% Red=variance >10%	Alison Reynolds		G 1.1% ↑	G 3.8% ↑	G 0.2% ↑	G (3.9)% ↓	G 0.3% ↑	G (1.7)% ↓	G 3.6%↔	R 19.86% ↑	A (6.6)% ↓	R (26.4)%↑		A 7.7% ↑	G 2.3% ↓	G 3.3% ↑		G 1.3% ↑

Trust Dashboard: August 2011

Directorates with any indicator that is red on 3 occasions during any 3 month rolling period is required to submit an exception report on the third occasion (denoted by a red box with a black border).

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

Trends:

↔ No change
↑ Improvement on previous month
↓ Deterioration on previous month

				Surgical Division							Emergency, Medical & Community Service Division									
						Surgical Services Group					Rehab & Amb Medical Group					Medical Group				
	Target	Tolerance	Data Source	Diagnostics Service Group	Theatres/ ICCU Service Group	Cardio-thoracic/ Cardiology Service Group	General Surgery/ Urology	Ortho-paedics	Obs & Gynae	Ophthal-mology/ Head & Neck Services Group	Children's Services Group	Adult Community Services Group	Elderly Care & Stroke	Rehab (West Park)	Neurology / Rheuma-tology / Dermatology	Renal & Diabetes	Resp & Gastro	Emergency Services Group	Therapies & Pharmacy Group	Oncology & Haema-tology Group
Patient Experience																				
Patient complaints as a percentage of activity	<0.5%	Green = <0.5, Red = 0.5+	Nina Dunmore	G 0% ↔	N/A	G 0% ↑	G 0.2% ↑	G 0.4% ↓	G 0.2% ↔	G 0.3% ↑	G 0.2% ↓	G 0% ↔	G 0% ↑	G 0% ↔	G 0% ↔	G 0.03% ↓	G 0.7% ↑	G 0.05% ↑	G 0% ↔	G 0% ↑
New investigations accepted by Ombudsman	0	Green = 0,Amber = 1,Red = >1	Nina Dunmore	G ↔	G ↔	G ↔	G ↔	G ↔	G ↔	G ↔	G ↔	G ↔	G ↔	G ↔	G ↔	G ↔	G ↔	G ↔	G ↔	G ↔
Percentage patients who rated overall satisfaction good/excellent	90%	Green = >90,Amber = 80-89, Red = <80	Nina Dunmore			100% ↔	98% ↓	95% ↓	95% ↑	100% ↑			96% ↓			92% ↓	97% ↓			93% ↓
Patient Safety																				
Number of red incidents	0	Green = 0,Amber = 1,Red = >1	Sukhy Khunkhuna	G ↔	G ↔	G ↔	G ↔	G ↔	G ↔	G ↔	G ↑	G ↔	G ↔	G ↔	G ↔	G ↔	G ↔	G ↔	G ↔	G ↔
Number of operational red risks	0	Green = 0,Amber = 1,Red = >1	Sukhy Khunkhuna	A ↔	G ↔	G ↔	G ↔	G ↔	G ↔	G ↔	G ↔	G ↔	G ↔	G ↔	G ↔	A ↔	G ↔	G ↔	G ↔	G ↔
Number of inpatient falls *RAG= tolerance multiplied by the number of inpatient wards	0	*Green = 0,Amber = 1-4 Red = 4+	Sukhy Khunkhuna	G 0 ↔	G 0 ↑	R 5 ↓	A 10 ↓	A 7↓	G 0 ↑	G 0 ↔	G 0 ↔	A 3↓	R 24 ↔	R 25 ↑	G 0 ↑	R 15 ↓	R 26 ↓	R 28 ↓	A 1 ↑	A 2 ↑
Number of healthcare acquired pressure ulcers acquired/deteriorated (Grade 2, 3 & 4) * RAG= tolerance multiplied by the number of inpatient wards reporting	0	*Green = 0,Red = 1+	Sukhy Khunkhuna	G 0 ↔	R 10 ↓	R 3 ↔	R 6 ↓	R 2 ↑	G 0 ↔	G 0 ↑	G 0 ↔	R 26 ↑	R 3 ↓	R 6 ↓	G 0 ↔	R 3 ↑	R 6 ↑	R 4 ↓	G 0 ↔	G 0 ↑
Percentage completed inpatient MUST assessments	100	Green = 100,Amber = 75-99 Red = <75	Rose Baker Zena Young		G ↔	G ↔	A 96% ↑	A 90% ↓	G 0 ↔	G 0 ↔	G ↔	N/A	A ↔	G ↑	G	G ↑	A 92% ↓	A 95% ↑		G ↔
MSSA bacteraemia	–	Green = 0,Amber = 1,Red = >1	Mike Cooper	G ↔	A ↓	A ↔	G ↑	G ↔	G ↔	G ↔	A ↓	G ↔	G ↔	G ↔	G ↔	A ↔	R 2 ↓	G ↔	G ↔	G ↑
Clostridium Difficile - hospital acquired for ages >2 years	–	Green = 0,Amber = 1-2 Red = >2	Mike Cooper	G ↔	A 1 ↔	A 2 ↓	A 2 ↔	A 1 ↔	G ↔	G ↔	G ↔	G ↔	A 1 ↑	A 1 ↓	G ↑	R 2 ↓	R 5 ↓	R 2 ↓		A 1 ↓
Device related bacteraemias	–	Green = 0,Amber = 1,Red = >1	Mike Cooper	G ↔		G ↑	R 3 ↔	G ↔	G ↔	G ↔		G ↔	G ↔	G ↔	G ↔		R 2 ↓	G ↔	G ↔	
Device related bacteraemias (Haem/Onc, ICCU, Renal, Neonates)	–	Green = 0,Amber = 1- 2 Red = >2	Mike Cooper		A 2 ↔						G ↔					A 1 ↑				G ↑
Percentage VTE risk assessments assessed on admitting ward (VitalPAC wards only represented by Directorate, excludes maternity & low risk cohorts)	90%	Green = 90%+, Amber = 70-89% Red = <70%	Jayne Lawrence		G 94.8%↑	R 60.3%↓	A 78.3% ↑	A 79.7%↓	Gynae R 53%↓	G 92.8%			A 87.5%↑			R 66.7% ↑	A 80%↑	A 78.5% ↑		G 95.5%↑
Activity																				
Number of cancelled/rescheduled outpatient appointments	–	Reduction of 40% in year	Lesley Taff	N/A	N/A	512 ↓	287 ↓	209 ↑	34 ↑	114 ↑	46 ↑	N/A	16 ↑	N/A	242 ↑	47 ↓	34 ↑	N/A	N/A	583 ↑
Length of stay (elective)	3.06	Green = <3.06 Amber = 3.07-3.19 Red = >3.20	Lesley Taff	N/A	N/A	R 7 ↓	R 3.7 ↔	R 3.8 ↔	G 2.7 ↔	G 0.9 ↑	G 1.5 ↓				0.15	1	4.4			4.1
Length of stay (non elective)	3.15	Green = <3.15 Amber = 3.16-3.24 Red = >3.25	Lesley Taff	N/A	N/A	R 8.8 ↑	R 4.3 ↑	R 5.9 ↔	G 1.1 ↔	R 4.4 ↓	0.8				9.7	3.5	3.3			5.8
Activity against contract	2%	Green = 2% Amber = 2-5% Red = >5%	Lesley Taff	N/A		R 10.5% ↑	G 0.9% ↑	G 0.9% ↑	R 5.8% ↓	G 2% ↑	G 1.2% ↑	N/A	R -25.6% ↓	N/A	G 0.03% ↑	G 1.5% ↑	R 7.8% ↑	N/A	N/A	R 8.2% ↑
Percentage of emergency readmissions within 30 days	4.19%	Green = <4.19% Amber = 4.20-5% Red = >5%	Lesley Taff	N/A	N/A	G 0% ↑	G 1.7% ↑	G 1.8% ↓	G 2.9% ↓	G 0.6% ↓	G 0% ↔	N/A	G 0% ↔	N/A	G 0.8% ↓	G 0% ↔	G 0% ↔	N/A	N/A	G 0.1% ↓
Number of cancelled operations on day of surgery for non medical reasons	0	Green = 0 Amber = </= 4 Red = >/=5	Lesley Taff			R 6 ↑	R 8 ↑	A 4 ↓	G 0 ↑	A 3 ↑										
Outpatient DNA Rate (New)	<7%	<7% = Green, 7%-10% = Amber >10% = Red	Lesley Taff	G 1.4% ↓		A 8.2% ↑	A 7.6% ↓	R 10.3% ↓	A 9.1% ↑	R 12.1% ↓	R 16.2% ↓	N/A	G 4% ↑	N/A	R 10.9% ↓	R 10.6% ↓	R 13% ↓	N/A	R 10.9% ↓	G 4.5% ↓
Outpatient DNA Rate (Review)	<7%	<7% = Green, 7%-10% = Amber >10% = Red	Lesley Taff	G 0% ↔		A 9.6% ↓	A 9.5% ↑	R 10.5%↑	A 8.6% ↑	A 8.4% ↑	R 13.4% ↑	N/A	A 8.2% ↑	N/A	R 14% ↓	R 13.2% ↓	R 12% ↑	N/A	R 13.5%↑	A 5% ↑
Human Resources																				
Sickness absence	<4%	Green = <4%,Amber = 4.1 - 5.9 Red = >6%	Lesley Taff	A 4.8% ↓	A 4.3% ↑	A 4.7% ↑	R 10.6%↑	R 6.2%↑	A 5.9% ↑	G 3.8% ↑	A 5.17% ↑	N/A	G 3.34% ↓	N/A	R 7.73% ↓	R 7.59% ↓	G 3.6% ↑	G 3.9% ↑	G 3.8% ↑	A 5.4% ↑
Percentage of trained nursing vacancies per funded establishment			Lesley Taff	N/A	0.3% ↑	1.0% ↑	0.4% ↑	2.0% ↑	0.5% ↓	1.8% ↔	3.2% ↑	N/A	2.4% ↔	N/A	0% ↔	2.6% ↔	0.2% ↓	2.9% ↔	N/A	0% ↑
Percentage of medical training grades vacancies per funded establishment			Lesley Taff	N/A	0% ↔	0% ↔	0.79% ↔	0.8% ↓	0.4% ↓	0% ↔	0.8% ↔	N/A	0% ↑	N/A	0% ↑	0% ↔	1.7% ↔	2.2% ↔	N/A	0% ↔
Staff feedback - % of staff witnessing a potentially harmful error, near miss or incident			Caroline Marshal	Radiology 25% Pathology 28%	36%	17%	36%	46%	11%	21%	31%	33%	Elderly 45% Stroke 47%	22%	Neurology only 0%	Renal 43% Diabetes 50%	Resp 24% Gastro 30%	50%	40%	45%
Staff feedback - % satisfied with the quality of care they give to patients/service users			Caroline Marshal	Radiology 87% Pathology 96%	86%	86%	89%	86%	73%	91%	87%	63%	Elderly 76% Stroke 74%	92%	100%	Renal 93% Diabetes 90%	Resp 86% Gatsro 93%	84%	94%	86%
Staff feedback - % recommending the Trust as a place for friends/relatives to receive treatment			Caroline Marshal	Radiology 63% Pathology 83%	71%	85%	76%	72%	82%	76%	73%	53%	Elderly 86% Stroke 72%	86%	78%	Renal 64% Diabetes 60%	Resp 81% Gastro 77%	77%	80%	86%
Finance																				
Pay budget (ward pay budget only, represented by Directorate)	In balance	Green = Yes, Amber = Agreed Red = No	Alison Reynolds		R ↑	R ↑	R ↑	R ↓	R ↑	R ↓	R ↓	G ↓	R ↑	R ↑		R ↑	R ↑	R ↓		R ↓
WTE budgeted against actual (ward WTE only, represented by Directorate)	In balance	Green=variance < 5% Amber=variance 5-10% Red=variance >10%	Alison Reynolds		3.66	3.05	3.06	4.22	0.45	2.57	9.23	1.06	(8.27)	(11.68)		(5.03)	(4.84)	9.52		3.45

The Royal Wolverhampton Hospitals NHS Trust

The completion of this report is prompted by the existence of red alerts in the Quality & Safety Dashboard indicators on 3 occasions in any rolling 3 month period and is submitted by the Directorate/Group Management to the Trust Board.

HIGH LEVEL INDICATOR ESCALATION REPORT TO TRUST BOARD (26 September 2011)

Report from: Directorate/Group	Critical Care Services Group
Report prepared by: Name, Job Title	Marion Washer, Group Manager and Beverley Morgan, Matron

Description of indicator:	Number of complaints	Number of Healthcare acquired pressure ulcers	Pay budget ward only (in balance)
Indicator tolerance:	Green= <0.5 , Red= 0.5+	Green =0 Red = 1+	Green = yes Amber = agreed Red = NO
Period of alert: (i.e. Jun, Jul, Aug 2011)	July 2011	July & Aug 2011	July & Aug 2011
Reason/s for alert:	Complaints 0.5%	5 (Jul), 10 (Aug) incidents of pressure ulcers	Pay budget overspent
Impact: Describe impact on patients, care services, quality or safety components. Describe any links to complaints, incidents, KPI, CQUINs, litigation (where known) or other external drivers	The only trend the directorate has is complaints from patients who are expected to wait long hours for their surgery. ICCU complaints are predominantly centred around withdrawal of organ support and bereavement	All ICCU patients are clinically compromised and are often immobile. These patients require optimum pressure relieving mattresses and devices to assist in the prevention of pressure ulcers. Clinically compromised patients who require multiple organ support and high doses of inotropic drugs are nationally recognised as at high risk of developing pressure ulcers. Grade 3and 4 pressure ulcer acquisition during critical illness is linked high mortality rates.	No approval to be overspent in the wards within CCS. The main reason for overspend is because incremental drift for 2011/12 was not funded. No impact upon patient quality and safety
Actions needed or taken to address: Please identify where completed or a timescale for completion and who by.	There has been a directorate review of information leaflets to patients and verbal communication to patients on the day of surgery and at pre assessment. New patient information leaflets are in the	27 new pressure relieving packages approved by Trust – to be ordered by Procurement imminently. Electronic chairs have been ordered from trust funds to assist in the mobility of level	Incremental drift pressure identified to year end = (£52,385) Nursing blue prints are appropriate for activity levels Cannot recover this lack of funding

	process of being produced. Staging of admission times has been introduced where possible	2 patients.	
Assurance/Monitoring: Please identify monitoring arrangements in place to sustain improvements	Reported by Datix, Monthly monitoring through KPIs, and reviewed by the directorate as part of the governance framework	Reported by Datix, weekly monitoring through KPIs and quality audits.	Monthly budget and financial forecasting meetings conducted monthly
Residual or ongoing risks: Consider reputation of the organisation, Patient experience/outcomes, Clinical, Financial or Corporate risk **Include Risk Grade**	The directorate has a proactive approach to patient complaints, aiming to resolve issues promptly. There is a triumvirate approach within the directorate to manage all complaints promptly and where possible informally	Critically ill patients as identified above will remain at high risk of pressure ulcer acquisition	Continued of financial imbalance if incremental drift not funded. Patient care will not affected

The Royal Wolverhampton Hospitals NHS Trust

The completion of this report is prompted by the existence of red alerts in the Quality & Safety Dashboard indicators on 3 occasions in any rolling 3 month period and is submitted by the Directorate/Group Management to the Trust Board.

HIGH LEVEL INDICATOR ESCALATION REPORT TO TRUST BOARD (26 September 2011)

Report from: Directorate/Group	Cardiothoracic Directorate
Report prepared by: Name, Job Title	Directorate Management and Matron

Description of indicator:	Number of healthcare acquired pressure ulcers	Pay budget (ward only)	Length of stay (elective)	Length of stay (non elective)	Activity against contract	Number of cancelled operations on day of surgery for non medical reasons
Indicator tolerance:	Green = 0 Red = >1	R1	Green = <3.06 Amber = 3.07-3.19 Red = >3.20	Green = <3.15 Amber = 3.16-3.24 Red = >3.25	Green = 2% Amber = 2-5% Red = >5%	Green = 0 Amber = </= 4 Red = >/=5
Period of alert: (i.e. Jun, Jul, Aug 2011)	June – Aug 2011	July, Aug 2011	Aug 2011	Aug 2011	Aug 2011	Aug 2011
Reason/s for alert:	CTW PU Grade 1 and 2 May 3 June 3 July 3	Pay spend not in balance	R7	R8.8	R10.5%	R6
Impact: Describe impact on patients, care services, quality or safety components. Describe any links to complaints, incidents, KPI, CQUINs, litigation (where known) or other external drivers	All pressure ulcer acquisition were reported on Datix and KPI Incidents discussed at Directorate meeting via Matron KPI Nil complaints regarding pressure ulcers Review of incidents identified common	No impact on patient care etc.	Assuming this is a combined length of stay with Cardiology and Cardiothoracic, the Group will always show red alert as patients requiring open heart surgery will not have a length of stay <4 days.	Assuming this is a combined length of stay with Cardiology and Cardiothoracic, the Group will always show red alert as patients requiring open heart surgery will not have a length of stay <4 days.	The ongoing underperformance in cardiac activity is largely related to an 8% increase in contract levels for 2011-12 . Waiting times remain constant at between 8-10 weeks for cardiac surgery.	2 cardiac cases overran. 2 x lack of ICCU beds 1 x more urgent cases 1 x lack of surgical assistant Inevitable impact on any patient when their pre-arranged surgery is

	factors for pressure ulcer - long term thoracic cases on wall suction, post op cardiac cases on high dose inotropes on ICCU				Underperformance in elective cardiology work is largely due to consultant annual leave during August. Waiting times for PCI have increased to 9-10 weeks.	cancelled. But some cancellations are due to safety ie. unsafe for surgeon to electively operate for a period >14 hours
Actions needed or taken to address: Please identify where completed or a timescale for completion and who by.	Ward Manager has facilitated training via the Tissue Viability Team which commenced in July – due to holiday season further sessions are planned Ward to be trialling the new care bundle which incorporates "comfort rounds" Increase awareness of staff regarding the reporting of incidents Quality rounds continue regarding the utilisation of TV documentation Spot checks ongoing regarding risk assessment tools and appropriate equipment utilisation Weekly prevalence Ward Manager and Clinical Lead discussing way forward for thoracic cases ie returning from theatre with	PID completed looking at options to bring pay spend back into balance. Kate Middlemiss & Hayley Flavell – submitted to Division 02.09.11	To readjust the targets accordingly or provide split data for Cardiology and Cardiothoracic so that they can be monitored accordingly against a true picture. No actions taken at this stage. Cardiothoracic surgery has one of the lowest length of stays in the country and cannot be reduced further with 98% bed occupancy.	To readjust the targets accordingly or provide split data for Cardiology and Cardiothoracic so that they can be monitored accordingly against a true picture. No actions taken at this stage. Cardiothoracic surgery has one of the lowest length of stays in the country and cannot be reduced further with 98% bed occupancy.	Report on cardiac surgery activity analysis, recovery plan and financial implications already submitted to Divisional Manager (8.9.11). PCI – elective activity – normal lists have resumed and waiting times will reduce gradually over the next 2 months back to approx. 6 weeks	All appropriate actions are taken to avoid patient cancellation at the time.

	THOPAZ insitu (budgetary indications) TV link nurses					
Assurance/Monitoring: Please identify monitoring arrangements in place to sustain improvements	Datix Weekly prevalence Quality rounds Ward KPI Spot checks Matron rounds	Via financial recovery plans PIDs and Divisional monitoring arrangements	Length of stay monitored monthly by Directorate via its own internally developed performance report, attached for information.	Length of stay monitored monthly by Directorate via its own internally developed performance report, attached for information.	All activity closely monitored at Directorate and Divisional level.	RCA's completed on all patients and reviewed at COO's weekly Performance Meeting's
Residual or ongoing risks: Consider reputation of the organisation, Patient experience/outcomes, Clinical, Financial or Corporate risk **Include Risk Grade**	Nature of patients condition ie thoracic cases on wall suction, long term cardiac cases on high dose inotropes C2 minor (short term injury, less than a month to resolve, unsatisfactory experience)	Ongoing risk that budget will be out of balance due to unfunded incremental drift and high levels of maternity leave experienced on Cardiothoracic Ward.	None known.	None known	Financial risk of not achieving contract income levels – Red.	Ongoing risk of further cancellations due to lack of ICCU beds, and appropriately trained theatre staff. Amber

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HIGH LEVEL INDICATOR ESCALATION REPORT TO TRUST BOARD (26 September 2011)

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

Description of indicator:	Hospital Acquired Pressure Ulcers	Device Related Bacteraemia	VTE Risk Assessments	Length of Stay (Elective & Non Elective)	Cancelled Operations (Non Medical Reasons)	Sickness Absence	Pay Budget
Indicator tolerance:	Green = 0 Red = 1+	Green = 0 Red = 1+	Green = 90%+ Amber = 70-89% Red = <70%	<u>Elective</u> Green = <3.06 Amber = 3.07-3.19 Red = >3.20 <u>Non-Elective</u> Green = <3.15 Amber = 3.16-3.24 Red = >3.25	Green = 0 Amber = -/=4 Red = >/=5	Green = <4% Amber = 4.1 – 5.5% Red = >6%	Green = in balance Amber = not in balance but agreed Red = not in balance
Period of alert: (i.e. Jun, Jul, Aug 2011)	June & July 2011	June & July 2011	June & July 2011	June & July 2011	July 2011	June & July 2011	June & July 2011
Reason/s for alert:	3 HAPU in June & 4 HAPU in July	1 on D2 2 on Vascular	66.6% in July Dashboard	Elective LOS – 3.7 Non-Elective LOS – 4.5	11 cancelled ops in July 2011 3 x Consultant Sick 2 ran out of theatre time 5 Complication 1 No bed	8.6% in July	Budget not in balance

Impact: Describe impact on patients, care services, quality or safety components. Describe any links to complaints, incidents, KPI, CQUINs, litigation (where known) or other external drivers	KPI, CQUIN High reporting of non-availability of pressure mattresses.	KPI	Reports received by Directorate indicate Gen Surg 84% & Urology 90%	Dr Foster National Peer Comparison (Q1 2009-10 to Q4 2010 – 11) indicates the following Expected LOS for General Surgery El – 3.6 Non-El - 5	All patients readmitted within 28 days RCA's undertaken for all – no trends identified	KPI – HR & Matron Quality & Safety in relation to patient care. Retention of staff	9 trained & 1 untrained staff on maternity leave. Impact of 'other' leave
Actions needed or taken to address: Please identify where completed or a timescale for completion and who by.	Trust wide introduction of 'safe hands' tags on pressure mattresses. Trial of 'forget me not' chart	Full RCAs undertaken for all cases. No trends of change in practice identified	Discrepancy being investigated	Review currently being undertaken of all planned day cases who stay overnight	RCAs to be undertaken for all cases. All cancellations to be authorised at Divisional level	Monthly sickness workshops to support staff. Non-clinical phased return to work where appropriate	Weekly monitoring of bank usage v's blue print by Matron and Head of Nursing
Assurance/Monitoring: Please identify monitoring arrangements in place to sustain improvements	Weekly pressure ulcer prevalence monitoring Safety Briefings Datix review and audit to be presented to Clinical Governance Meeting	Monthly KPIs RCA's undertaken Antibiotic Prescribing Sticker auditing			Weekly monitoring and reporting internally and externally via Sit Reps	Monthly sickness workshops Application of Sickness policy Stress Risk Assessments Incident of staffing levels below agreed blue print (KPI)	See above Monthly KPIs Monthly Budget review meetings (Directorate) and Monthly Financial Performance Meetings (Division)
Residual or ongoing risks: Consider reputation of the organisation, Patient experience/outcomes, Clinical, Financial or Corporate risk **Include Risk Grade**	Documented on Directorate & Divisional Risk Register						Documented on Directorate Risk Register re Number of maternity leaves

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HIGH LEVEL INDICATOR ESCALATION REPORT TO TRUST BOARD (26 September 2011)

Report from: Directorate/Group	Trauma & Orthopaedic Directorate
Report prepared by: Name, Job Title	Helen Read Directorate Manager

Description of indicator:	**Number of HCA pressure ulcers acquired/deteriorated**	**Length of stay elective**	**Length of stay non elective**	**OPD DNA rate review**	**Ward Pay Budget**
Indicator tolerance:	Green=0, Amber=1 Red=>1	Green 3.06, Amber 3.07 – 3.19 Red>3.20	Green = <3.15 Amber = 3.16- 3.24 Red = >3.25	<7% = Green, 7%-10% = Amber, >10% = Red	Green = Yes, Amber = Agreed Red = No
Period of alert: (i.e. Jun, Jul, Aug 2011)	July, Aug 2011	July, Aug 2011	July, Aug 2011	July, Aug 2011	July, Aug 2011
Reason/s for alert:	3 reported	3.8	5.9	11%	Overspent
Impact: Describe impact on patients, care services, quality or safety components. Describe any links to complaints, incidents, KPI, CQUINs, litigation (where known) or other external drivers	Increase in reported incidents. Pressure ulcers can lead to a delay in discharge and complications such as infection.	HED data shows that National average LOS for T&O electives is 3.66 days and in the West Midlands 3.72 days. Patients are discharged when medically fit and able to safely mobilise.	HED data shows that national average LOS for T&O emergency admissions is 7.73 nationally and 7.52 in the West Midlands. LOS for #NoF at RWHT is the lowest in the West Midlands at 10.94, West Midlands figures is 14.74.	Loss of income to the Trust because of patients failing to attend appointments.	Overspend relates to use of bank staff to fill shifts left vacant due to short term and long term sickness. Use of bank necessary to keep ward staffing at safe levels and protect patient care.
Actions needed or taken to address: Please identify where completed or a timescale for completion and who by.	1.Training package to be revisited and staff identified who require training. 2.Training to be arranged with the TV	Enhanced recovery measures in place to reduce LOS for upper limb and ACL surgery. Pilot for joint replacement underway.	Our LOS is already lower than national average and our LOS for #NoF is the lowest in the West Midlands. Patients discharged at	Introduction of the out-patient waiting list system is anticipated in October which should address DNA rate.	All bank shifts requested reviewed by Matron and approved to ensure essential. Sickness policy followed

	nurse. 3. Matron/Ward Manager to meet with TVN team re care pathway and incorporating pressure ulcer package. 4. All pressure ulcers to be photographed at identification and on any deterioration. 5. All grade 2,3,4 ulcers to be reported on datix within 4 hours. 6. All grade 3 and 4 ulcers and any non healing wounds to be referred to TVN.		the earliest safest opportunity.		with all staff.
Assurance/Monitoring: Please identify monitoring arrangements in place to sustain improvements	Reported by Datix, monitored at Governance Meetings and by matron when working clinically.	HED data.	HED data.	COO report.	On going review of shift allocation by matron. Review of budget reports monthly. Sickness reviews.
Residual or ongoing risks: Consider reputation of the organisation, Patient experience/outcomes, Clinical, Financial or Corporate risk **Include Risk Grade**	Risk Grade: C3	LOS needs to reduce further to cope with additional capacity currently being put through the T&O beds. Risk Grade B2	Trust parameter set considerably lower than national expectations therefore will continue to breach unless re-adjusted for specialty. Risk Grade A1 (graded A1 as will certainly breach target but not considered a clinical risk)	Dependent on roll out of OWL. Risk grade D3	Overspend on pay will continue to be a risk due to sickness. Risk grade B3

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HIGH LEVEL INDICATOR ESCALATION REPORT TO TRUST BOARD (26 September 2011)

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

Description of indicator:	Pay budget
Indicator tolerance:	Red
Period of alert: (i.e. Jun, Jul, Aug 2011)	June, July, August 2011
Reason/s for alert:	Overspending on pay budgets in the months stated
Impact: Describe impact on patients, care services, quality or safety components. Describe any links to complaints, incidents, KPI, CQUINs, litigation (where known) or other external drivers	Impact on financial position of the Trust.
Actions needed or taken to address: Please identify where completed or a timescale for completion and who by.	Review all ward budgets with accountant and HoM to ensure that the minimum staffing levels exist. Management of all sickness and maternity leave as appropriate with HR support. Review of staffing levels will be considered within the MLU b/case.
Assurance/Monitoring: Please identify monitoring arrangements in place to sustain improvements	Financial position and over-performance income
Residual or ongoing risks: Consider reputation of the organisation, Patient experience/outcomes, Clinical, Financial or Corporate risk **Include Risk Grade**	Staff are required due to increase in activity levels – risks to patient care, safety, patient experience if not available

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HIGH LEVEL INDICATOR ESCALATION REPORT TO TRUST BOARD (26 September 2011)

Report from: Directorate/Group	Ophthalmology / Head & Neck / Audiology / Speech & Language Therapy / Community & Special Care Dental Services / Patient Services
Report prepared by: Name, Job Title	Zena Dalton Group Manager

Description of indicator:	Number of healthcare acquired pressure ulcers acquired/deteriorated (Grade 2, 3 & 4) * RAG= tolerance multiplied by the number of inpatient wards reporting	Length of stay (non elective)	Outpatient DNA Rate (New)	Pay budget (ward pay budget only, represented by Directorate)		
Indicator tolerance:	*Green = 0,Red = 1+	Green = <3.15 Amber = 3.16-3.24 Red = >3.25	<7% = Green, 7%-10% = Amber, >10% = Red	In balance Green = Yes, Amber = Agreed Red = No		
Period of alert: (i.e. Jun, Jul, Aug 2011)	July 2011	July, Aug 2011	July, Aug 2011	July 2011		
Reason/s for alert:	July Score 5 Aug none to report	LoS 4.3	DNA rate 10.6	D4 Ward pay budget overspent		
Impact: Describe impact on patients, care services, quality or safety components. Describe any links to complaints, incidents, KPI, CQUINs, litigation (where known) or other external drivers	Delayed recovery period and discharge	Patients in hospital appropriate LoS	Capacity	Medical demand outstripping capacity, opening of unfunded 6 bedded bay		
Actions needed or taken to address: Please identify where completed or a	Discussed at local level with ward team, all sores	None	Newtons review underway in MAX FAX and ENT,	Discussed at divisional governance		

timescale for completion and who by.	reported on Datix. All sores inherited from other specialities		Ophthalmology currently 10% amber	decision made not to open bay		
Assurance/Monitoring: Please identify monitoring arrangements in place to sustain improvements	All sores graded 1 or 2. Patients are assessed when moved to the D4 ward. Incidents are completed and reported on Datix. Non of the sores reported are an omission of nursing care on D4	Patient LoS reviewed by surgical team and directorate. Due to facial trauma LoS per individual can be lengthy.	Directorate packs	Bay is opened when ever medical demand outstrips capacity. Request made to medicine to include opening of bay in their winter plan if they wish to continue using it.		
Residual or ongoing risks: Consider reputation of the organisation, Patient experience/outcomes, Clinical, Financial or Corporate risk **Include Risk Grade**	Continue to actively assess patients on admission to the ward and report finding on datix	Continue to review	Reduced capacity / sunk costs	Medicine continue to use this unfunded 6 bedded bay.		

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HIGH LEVEL INDICATOR ESCALATION REPORT TO TRUST BOARD (26 September 2011)

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

Description of indicator:	Ward Pay Budget
Indicator tolerance:	Red
Period of alert: (i.e. Jun, Jul, Aug 2011)	July , Aug 2011
Reason/s for alert:	Red rating
Impact: Describe impact on patients, care services, quality or safety components. Describe any links to complaints, incidents, KPI, CQUINs, litigation (where known) or other external drivers	Overspending on budget
Actions needed or taken to address: Please identify where completed or a timescale for completion and who by.	A finance recovery plan has been drawn up and agreed with the Management accountants and agreed by the Divisional Manager
Assurance/Monitoring: Please identify monitoring arrangements in place to sustain improvements	Monthly budget reports
Residual or ongoing risks: Consider reputation of the organisation, Patient experience/outcomes, Clinical, Financial or Corporate risk **Include Risk Grade**	It will take a few months to get the budget back in line but the overall Directorate position is at a break even position at end of July 2011

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HIGH LEVEL INDICATOR ESCALATION REPORT TO TRUST BOARD (26 September 2011)

Report from: Directorate/Group	Rehab & Ambulatory Medical Group
Report prepared by: Name, Job Title	Wendy Worth, Group Manager

Description of indicator:	Number of inpatient falls	Number of healthcare acquired pressure ulcers acquired/deteriorated (Grade 2, 3 & 4)	Pay budget (ward pay budget only, represented by Directorate)
Indicator tolerance:	Green = 0,Amber = 1-4, Red = 4+	Green = 0,Red = 1+	Green = Yes, Amber = Agreed Red = No
Period of alert: (i.e. Jun, Jul, Aug 2011)	Jul, Aug 2011	Jul, Aug 2011	Jul, Aug 2011
Reason/s for alert:	Red in Elderly Care & Stroke Increase in falls within Stroke ward	Red in Elderly Care & Stroke 6 pressure ulcers identified in July /august 2011	Red in Elderly Care & Stroke, Rehab (West Park) Overspending position
Impact: Describe impact on patients, care services, quality or safety components. Describe any links to complaints, incidents, KPI, CQUINs, litigation (where known) or other external drivers	Risk of serious injury from falling in patient group who may have cognitive defects and are physically impaired due to brain injury. Additional issues as elderly greater potential for serious injury following fall	Poor patient experience potential for safeguarding referral , increased length of stay and patient discomfort Risk high due to the nature of injury and inability to control environment prior to admission to hospital post fall./injury	No impact on quality of care to patients, risk is to ongoing financial position of the group
Actions needed or taken to address: Please identify where completed or a timescale for completion and who by.	ASU and D8 partaking in falls rapid improvement event . Raising awareness within ward staff in line with Rapid improvement philosophy. Appropriate use of falls care bundle and observational skills. Escalation of interventions by team to assure safety Team leaders and ward manager to instil best care . MDT exploration of interventions to best meet the needs of the client group	Increased vigilance on pressure risk assessment and subsequent care delivery Completion of pressure care documentation , Comfort rounds to assure regular repositioning and patient compliance Safety brief to ensure adequate communication . Regular re assessment and care planning to prevent detraction of skin integrity.	Recovery plan in place and agreed within Division 2

	Share good practice and interventions. Repeat fallers to have increased intervention		
Assurance/Monitoring: Please identify monitoring arrangements in place to sustain improvements	Weekly monitoring of progress. Ward manager to check compliance with policy and RIE measures. Safety briefs to alert staff	Daily reporting of skin condition of patients ward manager to ensure daily skin, inspections and review documentation and communication of individual needs . Take action when skin integrity may be compromise in proactive approach to ensure any pressure damage is eliminated	Monthly performance review within Division
Residual or ongoing risks: Consider reputation of the organisation, Patient experience/outcomes, Clinical, Financial or Corporate risk **Include Risk Grade**	*Patient group risk will remain high despite intervention patients often forget abilities and with cognitive damage potential will remain*	Continued risk due to fragile patient group	Revised forecast agreed within Division

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HIGH LEVEL INDICATOR ESCALATION REPORT TO TRUST BOARD (26 September 2011)

Report from: Directorate/Group	Renal & Diabetes
Report prepared by: Name, Job Title	Dean Gritton – Group Manager Sharon Reilly – Matron for Renal and Diabetes

Description of indicator:	Number of Healthcare acquired pressure ulcers.	Number of in patient falls	Out patient DNA New	Out patient DNA Review	Pay budget (ward pay budget only)
Indicator tolerance:	Green = 0 Red = 1	Green = 0 Red = 1	<7% Green 7%-10% Amber >10% Red	7% Green 7%-10% Amber >10% Red	In Balance: Green=Yes; Amber=Agreed; Red=No
Period of alert: (i.e. Jun, Jul, Aug 2011)	July 2011	July 2011	July, Aug 2011	July, Aug 2011	July, Aug 2011
Reason/s for alert:	R3↑	R15↓	Diabetes 13.0% (Red) and renal 6.7% (green)	Diabetes 14.8% (Red) and renal 10.4% (red)	Overspending position
Impact: Describe impact on patients, care services, quality or safety components. Describe any links to complaints, incidents, KPI, CQUINs, litigation (where known) or other external drivers	Poor patient experience and outcome.	Poor patient experience and outcome.	Potential loss of income and insufficient use of capacity.	Potential loss of income and insufficient use of capacity	No impact on quality of care to patients; risk is to ongoing financial position of the Group
Actions needed or taken to address: Please identify where completed or a timescale for completion and who by.	Datix entries completed for all falls. RCA's completed for all falls resulting in serious injury. Falls Care bundle implemented for all 'at risk' patients. Monitoring of staff training and completion of falls management competencies for nurses	Tissue Viability team have revised nursing documentation to improve record keeping. Agreed pilot of new documentation on D15 & D16. Monitoring of staff training and completion of TV competencies for nurses	The work undertaken in Diabetes with Newtons reduced the DNA rate. The increase in August is considered temporary.	The work undertaken in Diabetes with Newtons reduced the DNA rate. The increase in August is considered temporary.	Action plan in place to reduce overspending position; plan agreed with Division. Weekly reviews with Procurement in terms of outstanding CIP.

Assurance/Monitoring: Please identify monitoring arrangements in place to sustain improvements	Nursing KPIs Datix incident reporting RCAs for falls resulting in serious injury Safety briefings PSAG boards Individual patient risk assessment Presented at Directorate Governance meetings to agree lessons learnt / action required	Nursing KPIs Datix incident reporting RCAs for Grade 3/4 pressure ulcers Safety briefings PSAG boards Individual patient risk assessment Presented at Directorate Governance meetings to agree lessons learnt / action required	The DNA rates will be monitored monthly. The actions implemented by Newtons in terms of reminders will also be monitored.	The DNA rates will be monitored monthly. The actions implemented by Newtons in terms of reminders will also be monitored.	Weekly review of bank nursing requests with Matron; monthly Budget Surgery with all budget holders to ensure ongoing delivery of action plan; monthly performance review with Division
Residual or ongoing risks: Consider reputation of the organisation, Patient experience/outcomes, Clinical, Financial or Corporate risk **Include Risk Grade**	Ongoing risk due to client group: Diabetes / vascular dementia, etc	Ongoing risk for unavoidable ulcers due to client group/multiple co morbidities/complex patient problems.	Potential loss of income	Potential loss of income	Revised forecast agreed with Division

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HIGH LEVEL INDICATOR ESCALATION REPORT TO TRUST BOARD (26 September 2011)

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

Description of indicator:	Number of in patient falls	Number of health care acquired pressure ulcers	Out patient DNA New	Out patient DNA Review	Pay budget
Indicator tolerance:	0	0	<7% Green 7%-10% Amber >10% Red	7% Green 7%-10% Amber >10% Red	In Balance: Green=Yes; Amber=Agreed; Red=No
Period of alert: (i.e. Jun, Jul, Aug 2011)	July, Aug 2011	July, Aug 2011	July, Aug 2011	July, Aug 2011	July, Aug 2011
Reason/s for alert:	R 26 ↓	R 6↑	R10.6↓	R12↑	Overspending position
Impact: Describe impact on patients, care services, quality or safety components. Describe any links to complaints, incidents, KPI, CQUINs, litigation (where known) or other external drivers	Potential for serious injury to occur. Leading to poor experience and increase length of stay.	Poor patient experience, potential for poor outcome.	Potential loss of income and insufficient use of capacity.	Potential loss of income and insufficient use of capacity	No impact on quality of care to patients; risk is to ongoing financial position of the Group
Actions needed or taken to address: Please identify where completed or a timescale for completion and who by.	Datix entries completed for all falls. RCA's completed for all falls resulting in serious injury. Falls care bundles completed for all patient assessed as being at risk. RIE taking place currently on D18.	RCA's completed for all Grade 3/4 pressure ulcers. Through July and August all RCA's have found ulcers to be unavoidable.	Following the work undertaken in conjunction with Newtons the DNA rates in August fell below 10% for the first time in 12 months.	Following the work undertaken in conjunction with Newtons the DNA rates in August fell below 10% for the first time in 12 months.	Financial recovery plan in place to reduce overspending position; plan agreed with Division

Assurance/Monitoring Please identify monitoring arrangements in place to sustain improvements	Safety Briefings now occurring in all wards and departments. Patient Status Board identifies at risk patients. Risk assessments undertaken when ward area deemed exceptional risk and additional staffing put in place if required.	Pressure Ulcers/Tissue Viability risk form part of safety briefing and electronic handover. Full action plan re training in place for D18 and D20. RCA's/findings are discussed at local directorate governance meetings.	The Directorate will continue to monitor rates and ensure all the agreed actions are implemented daily	The Directorate will continue to monitor rates and ensure all the agreed actions are implemented daily	Weekly review of bank nursing requests with Matron; monthly Budget Surgery with all budget holders to ensure ongoing delivery of action plan; monthly performance review with Division. Meetings with Procurement in terms of CIP
Residual or ongoing risks: Consider reputation of the organisation, Patient experience/outcomes, Clinical, Financial or Corporate risk **Include Risk Grade**	Ongoing risk due to client group on D18, remains on directorate risk register.	Ongoing risk for unavoidable ulcers due to client group/multiple co morbidities/complex patient problems.	Potential loss of income	Potential loss of income	Revised forecast agreed with Division

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HIGH LEVEL INDICATOR ESCALATION REPORT TO TRUST BOARD (26 September 2011)

Report from: Directorate/Group	Emergency Services Group
Report prepared by: Name, Job Title	Jane McKiernan, Group Manager

Description of indicator:	Percentage VTE risk assessments assessed on admitting ward	Pay budget (ward pay budget only, represented by Directorate)
Indicator tolerance:	Green = 90%+, Amber = 70-89%, Red = <70%	Green = Yes, Amber = Agreed Red = No
Period of alert: (i.e. Jun, Jul, Aug 2011)	Jul, Aug 2011	Jul, Aug 2011
Reason/s for alert:		Incremental drift
Impact: Describe impact on patients, care services, quality or safety components. Describe any links to complaints, incidents, KPI, CQUINs, litigation (where known) or other external drivers	Risk of DVT or PE is increased with consequential impact on health and delayed length of stay	Actions to achieve balance will impact on patient i.e delay on recruitment, use of bank staff.
Actions needed or taken to address: Please identify where completed or a timescale for completion and who by.	Acute physicians have instigated VTE check with each patient on their ward rounds (day time). Nursing staff to remind junior docs of requirement to complete out of hours. Work with VTE nurses to identify non compliance	Temp delay on recruitment Use Bank 2 nurses where possible rather than qualified
Assurance/Monitoring: Please identify monitoring arrangements in place to sustain improvements	Monitoring through Governance	Monitoring through Business meetings
Residual or ongoing risks: Consider reputation of the organisation, Patient experience/outcomes, Clinical, Financial or Corporate risk **Include Risk Grade**	Ongoing risk associated with transient nature of medical workforce particularly out of hours.	Ongoing risk associated with reduced workforce and use of temporary/inconsistent staff who require greater supervision and lack training.

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HIGH LEVEL INDICATOR ESCALATION REPORT TO TRUST BOARD (26 September 2011)

Report from: Directorate/Group	Cancer Services
Report prepared by: Name, Job Title	Maurice Hakkak – Group Manager Amanda Watts – Matron for Cancer Services

Description of indicator:	Number of Healthcare acquired pressure ulcers.	Number of device related bacteraemias.	Length of stay (elective)	Length of stay (non-elective)	Activity against contract	Pay budget (ward pay budget only)
Indicator tolerance:	Green = 0 Red = 1	Green = 0 Red = 1	Green = <3.06 Amber = 3.07 – 3.19 Red = > 3.20	Green = <3.15 Amber = 3.16 – 3.24 Red = >3.25	Green=2%; Amber=2-5%; red>5%	In Balance: Green=Yes; Amber=Agreed; Red=No
Period of alert: (i.e. Jun, Jul, Aug 2011)	July 2011	July 2011	July, Aug 2011	July, Aug 2011	July, Aug 2011	July, Aug 2011
Reason/s for alert:	6 pressure sores identified from May – July 2011	R 3↑ 2 line infections on CHU and 1 on Durnall Unit.	R 7.5↓	R 7.5↓	Activity 8.6% over performing	Overspending position
Impact: Describe impact on patients, care services, quality or safety components. Describe any links to complaints, incidents, KPI, CQUINs, litigation (where known) or other external drivers	Care compromised Poor patient experience and outcome.	Patient infected ↑LOS. Hickman line on some occasions has to be removed.	Haematology patients can stay on CHU for many weeks whilst we are preparing them for bone marrow transplants. Patients on Deanesly Ward are having complex treatments, investigations and symptom control management. These patients usually have complex discharges.	Patients in Directorate require complex investigations, treatments / symptom control. These patients may have complex discharge arrangements. Newer treatments are giving rise to more complex problems requiring management as an inpatient.	Staffing levels being managed to accommodate this level of activity; has contributed in part to the ward budget over-spend	No impact on quality of care to patients; risk is to ongoing financial position of the Group

Actions needed or taken to address: Please identify where completed or a timescale for completion and who by.	RCA completed for 1 x grade 4 pressure sore. Action plan in place. Bespoke training arranged with Tissue Viability Team re: use of dressings and full completion of documentation. Need for regular assessment of pressure areas reiterated to nursing teams.	RCA's completed in all cases. Use of silver coated lines for high risk patients. Patient education augmented. Working across Directorate to ensure compliance with hand hygiene.	Haematology have a weekly MDT meeting. Regular case conferences take place on both wards. Discharge plans are started immediately on admission.	Peer Review of 3rd and 4th line treatments commence 3rd October 2011.	Weekly review of nursing off-duties; development of plans to move much of this work into the community	Action plan in place to reduce overspending position; year end forecast now improved by £150k; plan agreed with Division
Assurance/Monitoring: Please identify monitoring arrangements in place to sustain improvements	Band 7 taking daily report for every patient re: pressure areas; findings reported to Matron.	Reports sent to Matron on a monthly basis from Mike Cooper. Themes reviewed in all cases.	LOS figures completed on a weekly basis. Consultant Led Acute Oncology reviews to commence 3rd October 2011 in line with agreed expansion. Will be supplemented by new team working arrangements and ward rounds.	LOS figures completed on a weekly basis. Consultant Led Acute Oncology reviews to commence 3rd October 2011 in line with agreed expansion. Will be supplemented by new team working arrangements and ward rounds.	Over-performance levels unlikely to change materially in-year	Weekly review of bank nursing requests with Matron; monthly Budget Surgery with all budget holders to ensure ongoing delivery of action plan; monthly performance review with Division
Residual or ongoing risks: Consider reputation of the organisation, Patient experience/outcomes, Clinical, Financial or Corporate risk **Include Risk Grade**	Continued high risk due to patients, underlying condition – policies and practice (as above in place to mitigate). Risk added to risk register	Risk will continue due to the proportion of our patients who have a line core part of their treatment. On risk register.	LOS likely to remain above average for this cohort of patients.	LOS likely to remain above average for this cohort of patients.	Indication of more patients benefiting from treatment; likely to positively affect patient outcomes	Revised forecast agreed with Division