The Dudley Group NHS
NHS Foundation Trust

Quality Report 2014/15

WHERE PEOPLE MATTER
dgnhs
FOUNDATION TRUST
www.dudleygroup.nhs.uk

Contents

Throughout this document, there are a number of quotes taken from reviews that patients themselves have posted online on NHS Choices and Patient Opinion.

Part 1: Chief Executive's statement

I am again pleased to introduce the annual Quality Report and Account, where we give a detailed picture of the quality of care provided by our hospital, outpatient centres and adult community services. This report covers the year from April 2014 to the end of March 2015.

Our primary focus is to provide high quality treatment and care for all of our patients. By this, we mean we strive to provide:

- A good patient experience
- Safe care and treatment
- A good and effective standard of care

As in previous years, this report uses these three elements to describe the quality of care at the Trust over the year, providing an overall picture of what the organisation is achieving and where it still needs to improve.

Following on from this introduction, in Part 2 we have outlined our priority quality measures and charted their progress throughout the year. A summary of current and previous priorities can be seen in the table on page 8 as can more details on each priority on the page numbers listed in that table. These details include progress made to date, as well as our new targets for 2015/16. This part of the report also includes sections required by law on such topics as clinical audit, research and development and data quality.

In Part 3 we have included other key quality initiatives and measures, and specific examples of good practice on all of the three elements of quality which hopefully give a rounded view of what is occurring across the Trust as a whole. As we provide both acute and community care, you will see some parts of the report are divided into hospital and community sections for ease of reference.

In terms of independent reviews of the quality of care at the Trust, the key event this year was a visit from the Care Quality Commission (CQC). A CQC inspection team of 40 people assessed the Trust, visiting many wards and departments and talking with a wide variety of staff and patients. This report contains a section (Section 2.2.5) providing the details of that review but, in summary, we were pleased to note that the Trust was rated 'Good' in 30 out of the 38 core services inspected. The majority of the group categories (five out of eight) also received an overall rating of 'Good'. Despite this, the overall rating for the Trust was 'Requires Improvement', which was a disappointment. The Chief Inspector of Hospitals, Professor Sir Mike Richards, believes we are not far off achieving an overall 'Good' rating and he has confidence that we are addressing the issues highlighted by the inspection. It is a credit to all of the staff that the inspection team found much evidence of excellent practice and that patients see them as highly caring with many examples of staff going the extra mile.

As well as the CQC, we are monitored by a variety of other external organisations and agencies (see Section 2.1.1) and, as this report indicates, we are constantly monitoring ourselves in many ways on the quality of our care. This allows us to assure both patients and ourselves of what we are doing well and learn where we need to change practice and improve our services.

Although there is much debate about the usefulness of mortality indicators, I am pleased to be able to report that the Trust has now been consistently within the expected range for the Summary Hospital-level Mortality Indicator (SHMI) the whole of this year and, in fact, constantly from the period commencing October 2012.

Our quality priorities

You will see in Part 2 that we have made excellent progress with the majority of our 2014/15 priorities. I am pleased to report reductions in both healthcare associated infections and pressure ulcers. We have met both our C. difficile and MRSA targets, with this being the first year we have had none of the latter. Whilst we unfortunately had a single stage 4 avoidable pressure ulcer in the hospital, stage 3 avoidable pressure ulcers were reduced by more than 50 per cent from last year. The community had no stage 4 avoidable ulcers, whilst stage 3 avoidable ulcers remained at a low number throughout the year.

Our mortality tracking process includes clinical coding, validation, multidisciplinary specialist audit and, where necessary, senior medical and nursing review led by our Deputy Medical Director. This process is to ensure that each death occurring in hospital is understood and we are responsive to the information we gather from this process. We have met our new target in this regard.

In addition, the assessments that nurses undertake mean that we have met two out of three nutrition and hydration targets. The survey results for patient experience indicate we have also met the connected target regarding patients' perceptions of receiving enough help to eat at meal times. As part of the same survey, we had a target that at least 90 per cent of patients would indicate that their call bells are always answered in a reasonable time but we were unable to reach this target and so further work is required in this area.

Finally, the results of our local annual survey of community patients show that, unfortunately, we have not met the targets we set ourselves. In 2014/15 we introduced the national Friends and Family Test (FFT) into the community. We have included this, along with the inpatient FFT, as a quality priority for 2015/16 in order to allow us to compare ourselves with other providers, both locally and nationally.

With regards to 2015/16, we have retained all of the topics from 2014/15 due to their importance from both a patient and organisational perspective, and to build on the good work already undertaken.

Measuring quality

This report includes a wide range of objective indicators of quality, and we have also included a few specific examples of the many quality initiatives from around the Trust and what patients have said about us. We could not include them all but hopefully the examples, together with awards, innovation and initiatives that Trust staff have achieved and implemented in the year, give a flavour of our quality of care.

A fundamental part of improving quality at the Trust is listening to our patients' experiences. I am especially pleased to report that the Trust is receiving positive and better than national average scores and feedback from our inpatients, mothers on our Maternity Unit and patients being seen in the Emergency Department in the national Friends and Family Test (Section 3.2.2). Our nurses continue to improve the

quality of care they provide as measured by our detailed monthly Nursing Care Indicator assessments (Section 3.3.4). I am also particularly pleased to report that a number of our nurses and midwives from both the hospital and community have won some prestigious national awards, ranging across a number of specialties (Section 3.4.2).

I hope you will find it helpful to see some of the information we use to monitor our quality of care, creating a picture of quality across the Trust.

We would appreciate any feedback you would like to give us on both the format and content of the report but also the priorities we have chosen. You can either telephone the communications team on (01384) 244403 or email communications@dgh.nhs.uk

In addition, we summarise this lengthy report in our annual summary, 'Your Trust', and publish quarterly updates on the progress of our quality priorities on our website www.dudleygroup.nhs.uk

The Trust and its Board of Directors have sought to take all reasonable steps and exercise appropriate due diligence to ensure the accuracy of the data reported. Following these steps, to the best of my knowledge, the information in this document is accurate.

Finally, 2015/16 will be challenging for the Trust as we enter the second year of austerity measures. We will continue to work with patients, commissioners and other stakeholders to deliver further improvements to quality in the context of growing demand for services and developments in healthcare provision generally.

Signed **Date: 21st of May 2015**

Paula Clark
Chief Executive

Part 2: Priorities for improvement and statements of assurance from the Board of Directors

2.1 Quality improvement priorities

2.1.1 Quality priorities summary

The table below gives a summary of the history of our quality priorities and also those we will be working towards in 2015/16.

Priority	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	Notes
Patient experience Increase in the number of patients who report positively on their experience on a number of measures.	Achieved	We improved on one measure but had a slight decrease in another	Hospital: Partially achieved Community: Achieved	Hospital: Achieved Community: Partially achieved	Hospital: Partially achieved Community: Not achieved	Hospital: Partially achieved Community: Partially achieved	Priority 1	See page 10 for more information
Pressure ulcers Improve systems of reporting and reduce the occurrence of avoidable pressure ulcers.	N/A	N/A	Hospital: Achieved Community: Partially achieved	Hospital: Achieved Community: Achieved	Hospital: Partially achieved Community: Achieved	Hospital: Partially achieved Community: Partially achieved	Priority 2	New in 2011/12 See page 14 for more information
Infection control Reduce our MRSA rate in line with national and local priorities.	Achieved	Achieved	Achieved	Achieved	Not achieved	Achieved	Priority 3	See page 19 for more information
Reduce our Clostridium difficile rate in line with local and national priorities.			Not achieved	Achieved	Not achieved	Achieved		
Nutrition Increase the number of patients who have a risk assessment regarding their nutritional status.	N/A	N/A	N/A	Achieved	Partially achieved	Partially achieved	Priority 4	New in 2012/13 See page 22 for more information
Hydration Increase the number of patients who have their fluid balance charts monitored.	N/A	N/A	N/A	Achieved	Achieved	Achieved		New in 2012/13 See page 22 for more information
Mortality Improve reviews of hospital deaths.	N/A	N/A	N/A	N/A	N/A	Achieved	Priority 5	New in 2014/15 See page 26 for more information
Hip operations Increase the number of patients who undergo surgery for hip fracture within 36 hours from admission (where clinically appropriate to do so).	N/A	Achieved	Achieved	N/A	N/A	N/A	N/A	As the target was achieved for two consecutive years this priority was replaced in 2012/13
Cardiac arrests Reduce the numbers of cardiac arrests.	Achieved	Achieved	N/A	N/A	N/A	N/A	N/A	With a decrease from 32 per month in 2008 to 13 per month by 2011 this no longer remained a challenge

2.1.2 Choosing our priorities for 2015/16

The Quality Priorities for 2014/15 covered the following six topics:

Patient Experience	**Infection Control**
Pressure Ulcers	**Nutrition**
Hydration	**Mortality**

These topics were agreed by the Board of Directors due to their importance both from a local perspective (e.g. based on key issues from patient feedback, results from our Nursing Care Indicators, see Section 3.3.4) and a national perspective (e.g. reports from national bodies such as Age UK, CQC etc.). The first five topics (ie. excluding mortality) were initially endorsed by a Listening into Action event on the Quality Report, hosted by the Chief Executive and Director of Nursing, attended by staff, governors, Foundation Trust members and others from the following organisations: Dudley LINK, Dudley Primary Care Trust, Dudley MBC, Dudley Stroke Association and Dudley Action for Disabled People and Carers (ADC). The sixth topic, mortality, was added from the recommendation of an external review of the Trust.

Following consultation with governors, those who attended the Annual Members Meeting, the public generally via an online questionnaire and suggestions from our main commissioner, it has been agreed that the same priority topics will be retained in 2015/16.

All of the topics have a fundamental role in providing good quality patient care. Good patient experience of our services is a core purpose of the Trust. The Trust is committed to minimising healthcare associated infection rates which is a key commissioner and patient expectation. There are national campaigns of zero tolerance to avoidable pressure ulcers and the need to focus on patients' nutrition and hydration. Monitoring mortality indicators is seen as a useful device as they can act as a 'warning sign' or 'smoke-alarm' for potential quality issues.

All of our priorities have named leads who have the responsibility of coordinating the actions aimed at achieving the targets. Every quarter our progress on all the targets is reported to the Clinical Quality, Safety and Patient Experience Committee, the Board of Directors and the Council of Governors. In addition, a summary of the progress is placed on the Trust website.

Outstanding doesn't come close to describing the level of care the midwives give... it was obvious it's more than just a job and they are more than willing to go above and beyond to ensure that mom and baby are happy and safe.

2.1.3 Our priorities

Priority 1 for 2014/15: Patient experience

Patient experience	
Hospital	**Community**
a) Maintain an average score of 8.5* or above throughout the year for patients who report receiving enough assistance to eat their meals.	a) Equal or improve the score of patients who state they were informed who to contact if they were worried about their condition after treatment. (2013/14 was 8.8 out of 10)
b) By the end of the year, at least 90 per cent of patients will report that their call bells are always answered in a reasonable time.	b) Equal or improve the score of patients who state they know how to raise a concern about their care and treatment if they so wished. (2013/14 was 8.3 out of 10)

*Change of scoring system to be consistent with the national surveys. Now out of 10 rather than 100

How the Trust measures and records this priority

Hospital

This priority has been measured using our real-time survey system. A random sample of inpatients is asked to share their experiences by participating in the survey about their stay before they leave hospital. Responses to the surveys are entered directly into a hand-held computer and downloaded straight into our database to provide timely feedback. During 2014/15, 1479 patients participated in the surveys. All surveys are anonymous and results are shared with individual wards enabling them to take action in response to patient comments.

Community

The community priority has been measured using an annual survey. A paper questionnaire was distributed to community patients who were also provided with a freepost envelope to ensure an anonymous response; 571 responses to the survey were received, with question (a) answered by 541 respondents and (b) answered by 532.

Developments that occurred in 2014/15

- Changing and improving the food and drink for our inpatients has been a focus this year with numerous interventions including: new water jugs which are easier to handle, fresh fruit available every day, daily mealtime observations, refreshed training for housekeepers, and increased availability of chips and jacket potatoes. There was also a complete new menu trial conducted on four wards which included tasting sessions and feedback from patients, staff and governors resulting in a new *Chosen by Patients* menu which will be rolled out during 2015.
- Dedicated lead nurse on all wards for mealtimes to ensure enough nursing support during mealtimes.
- New Wellbeing Worker role developed and recruited across the Trust to provide one-to-one care for our most vulnerable patients and, in particular, those living with dementia.
- Dementia Friends campaign and training launched across the Trust, with almost 400 members of staff now signed up.
- Three wards initially trialled a 30 second response time to answering call bells, including information posters displayed to advise patients of what can be expected. This was then rolled out across the Trust.
- Improved highway signage on main roads leading to the Guest Outpatient Centre site.
- Card payment system introduced on parking machines.
- Environmental improvements to the admissions lounge and day case area, including daily newspapers, better signage and a review of seating arrangements.
- Establishment of the Patient Experience Group incorporating representatives from the Clinical Commissioning Group, Healthwatch Dudley and the Council of Governors. The group is chaired by the Chief Executive and reports into the Clinical Quality, Safety and Patient Experience Committee.
- Development and agreement of new reporting style on patient experience to our commissioners.
- Development of a patient experience mobile phone app to be launched in 2015 to provide another platform for patients and the public to share their views.
- Business cards developed to advise patients of how to raise a concern, compliment or complaint and posters refreshed across all sites.
- Regular patient videos or letters presented to Board of Directors each month.

I received a warm welcome from the accompanying nurse and the consultant himself. The consultation left me feeling reassured and comforted, and we even exchanged a few laughs which helped to ease the worry.

Current status: Hospital

Quality priority hospital (a)	Q1	Q2	Q3	Q4	2014/15
a) Maintain an average score of 8.5 or above throughout the year for patients who report receiving enough assistance to eat their meals.	8.5	9.6	9.2	7.04	8.72
Number of patients who felt they sometimes or never got the help they needed	5 (out of 400 surveyed)	2 (out of 440 surveyed)	3 (out of 300 surveyed)	8 (out of 339 surveyed)	18 (out of 1479 surveyed)
Quality priority hospital (b)	**Q1**	**Q2**	**Q3**	**Q4**	**2014/15**
b) By the end of the year at least 90 per cent of patients will report that their call bells were always answered in a reasonable time	85.5%	86%	89%	78.1%	86.75%

We are pleased the Trust has met the target relating to patients' perceptions of receiving enough assistance to eat their meals (target 8.5 with actual score of 8.72). It is disappointing that there was a small number of patients who felt they did not receive enough assistance to eat. When a patient indicates this, the independent person undertaking the survey immediately contacts the nurse in charge who resolves the issue with the patient.

With regards to the call bell target, it is disappointing to see that this has not been met (in 2013/14 the target of 80 per cent was achieved and so the target was made more difficult this year). A system is being implemented to monitor and improve this next year.

Current status: Community

Quality priority community (a)	2013/14	2014/15
a) Equal or improve the score of patients who state they were informed who to contact if they were worried about their condition after treatment.	8.8	8.9 ▲

Quality priority community (b)	2013/14	2014/15
b) Equal or improve the score of patients who state they know how to raise a concern about their care and treatment if they so wished.	8.3	8.1 ▼

The Trust has achieved part (a) of the community priority achieving a higher score to the previous year for the number of people who felt they knew who to contact if they were worried about their condition after treatment in community services. However, priority (b) has seen a slight decrease from 8.3 in 2013/14 to 8.1 in 2014/15 for patients who knew how to raise a concern about their care or treatment.

New priority 1 for 2015/16

Patient experience	
Hospital	**Community**
a) Achieve monthly scores in the inpatients Friends and Family Test (FFT) that are equal to or better than the national average. b) Achieve monthly scores in the outpatients Friends and Family Test that are equal to or better than the national average. *(First planned publication during 2015/16).*	a) Achieve monthly scores in the community Friends and Family Test that are equal to or better than the national average. *(First planned publication May 2015)*

Rationale for inclusion

The hospital and community targets have changed this year to focus on the Friends and Family Test. This is a national measure of patient experience and allows the Trust to benchmark itself against other trusts, both regionally and nationally, on a monthly basis. The Friends and Family Test aims to provide a simple headline metric to drive continuous improvements. It makes sure staff providing the service and the Board of Directors obtain regular feedback from patients on how the services are being received, what is working well and where improvements are needed. The simple survey asks patients if they would recommend the service to a friend or relative and to rate this recommendation from extremely likely to extremely unlikely.

We consistently achieved the hospital priority (a) target set in 2014/15 throughout the year and so chose to identify a different priority where the target can be benchmarked against both local and national results, ultimately aspiring to be in the top 20 per cent of trusts nationwide.

Developments planned for 2015/16

Actions being undertaken to achieve the Trust target include:

- Continue the patient catering developments including the roll out of new *Chosen by Patients* menus.
- Refresh volunteer recruitment to target volunteers into the areas of greatest patient need, including mealtime volunteers.
- Review patient gowns.
- Complete implementation of soft close bins to help make ward areas quieter for patients during the night.
- Review appointment and discharge letters to ensure patients receive information on who to contact if they are worried after treatment and how to raise a concern.
- Launch patient feedback mobile phone app.
- Provide patient and public Wi-Fi access across the three hospital and outpatient centre sites.

Board sponsor: Paula Clark, Chief Executive
Operational lead: Liz Abbiss, Head of Communications and Patient Experience

Priority 2 for 2014/15: Pressure ulcers

Pressure ulcers	
Hospital	**Community**
Ensure that there are no avoidable stage 4 hospital acquired pressure ulcers throughout the year. Ensure that the number of avoidable stage 3 hospital acquired pressure ulcers in 2014/15 does not increase from the number in 2013/14.	Ensure that there are no avoidable stage 4 pressure ulcers acquired throughout the year on the district nurse caseload. Ensure that the number of avoidable stage 3 acquired pressure ulcers on the district nurse caseload in 2014/15 does not increase from the number in 2013/14.

How we measure and record this priority

Pressure ulcers, also called pressure sores or bed sores, are staged one to four with four being the most serious and one being the least. When a patient is identified as having a pressure ulcer, the details are entered into the Trust's incident reporting system to be reviewed by the tissue viability team prior to reporting externally.

If pressure damage is noted within 72 hours of admission to the hospital, and the patient has not been under the care of the community teams or on the district nurse caseload, this is not considered to have developed whilst under the care of the Trust. This time frame is agreed regionally as it is recognised that pressure damage can occur but not be visible immediately.

Developments that occurred in 2014/15

The Trust has updated the pressure ulcer prevention guidelines, taking into account all recent research developments.

Standardised pressure ulcer prevention and management documents are now being used across the hospital and community. The prevention document includes a standardised assessment and treatment record known as a bundle. The SKIN (Surface Keep moving Incontinence Nutrition) bundle is completed by all staff across the Dudley health economy to ensure every aspect of pressure ulcer prevention is addressed at each patient care episode.

The Trust has recognised the importance of continually updating community and social care carers in pressure ulcer prevention and completion of the SKIN bundle document. Training sessions continue for this group of staff across the year on a rolling programme and all sessions are well attended.

In the hospital, each ward has tissue viability co-ordinating link nurses who complete ongoing audits of the SKIN bundle documents to ensure they are completed correctly. There has been an additional audit completed as part of a study programme that revealed some changes were required to these documents to

ensure a standard approach across the Trust. The tissue viability team have started work to ensure these changes are carried out.

The Trust also introduced new static air mattresses to all inpatient beds (excluding maternity and children areas) during 2014/15. This type of mattress is known as a hybrid mattress and combines foam and air cells which makes them suitable for patients who are at a very high risk of developing pressure ulcers. Plug-in specialist mattresses may still be required for a small number of patients; however, because this need has been reduced, we are able to provide patients with this specialist high risk equipment without delay. As a result of the switch, the Trust has made significant cost savings and there was no increase in the number of patients developing stage 3 or 4 pressure ulcers.

The tissue viability team and other senior nurses now see and assess all patients that have been reported to have developed stage 3 or 4 pressure ulcers. This assessment not only helps to verify that the correct type of wound has been identified, but also ensures that a specialist who can make sure the appropriate care is in place has seen the patient.

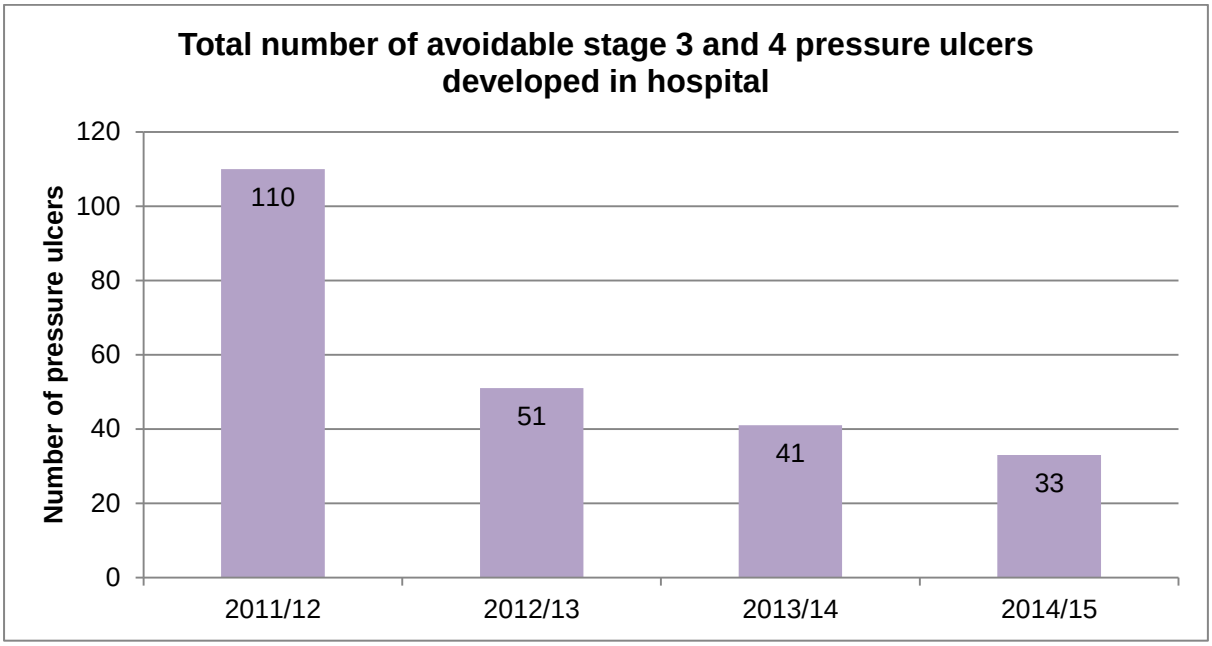
The Trust has employed community tissue viability nurses to focus on the correct use of pressure-relieving equipment in the community. This has, again, involved education and training for community teams and our social care colleagues. These nurses have implemented a new equipment selection flow chart which gives staff more guidance than was available previously. This process involved roadshows to which all staff were invited to collect their guidance and receive a short education session on all equipment available to them.

The team has also developed a good relationship with Dudley MBC's equipment service that supplies different types of pressure reduction equipment to patients at home and in care homes. We have been working with this service to ensure all equipment is tested correctly and fit for purpose and now hold regular meetings to ensure delivery and collection time frames are maintained.

The Trust also has a representative at the national tissue viability group which works closely with NHS England to ensure standards are in place locally. This year the group has worked together to develop a poster which helps nurses with the identification of skin damage.

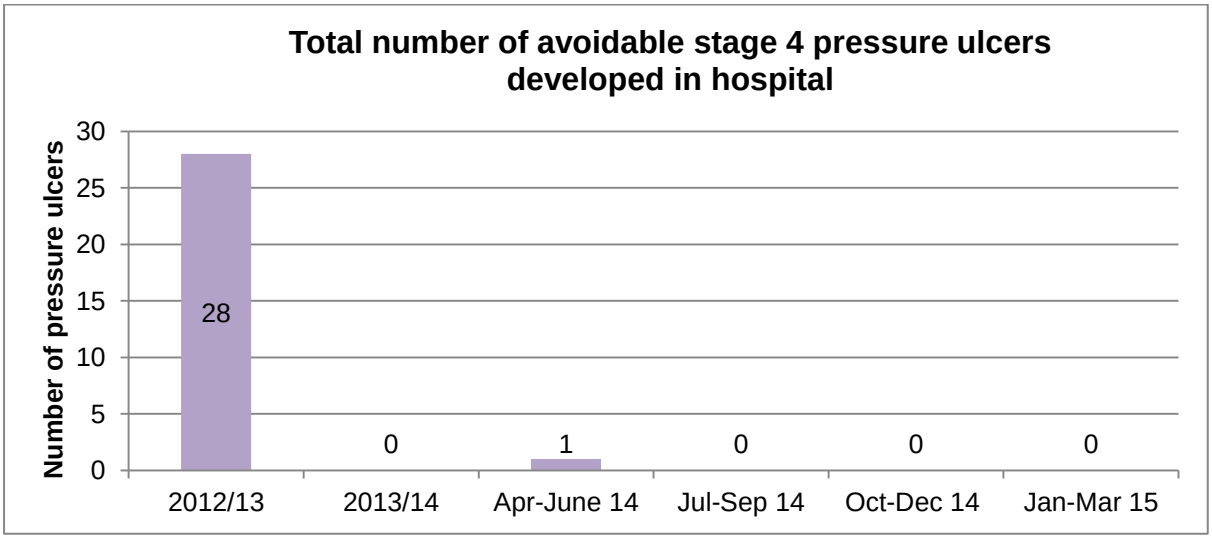
Current status: Hospital

The graph below shows the total number of avoidable stage 3 and 4 pressure ulcers that have developed in the hospital from 2011/12 to the present. It gives an indication of the dramatic fall in numbers due to the hard work of all staff involved. While there were 41 stage 3 and 4 ulcers in 2013/14 these have been reduced to 33 this year.

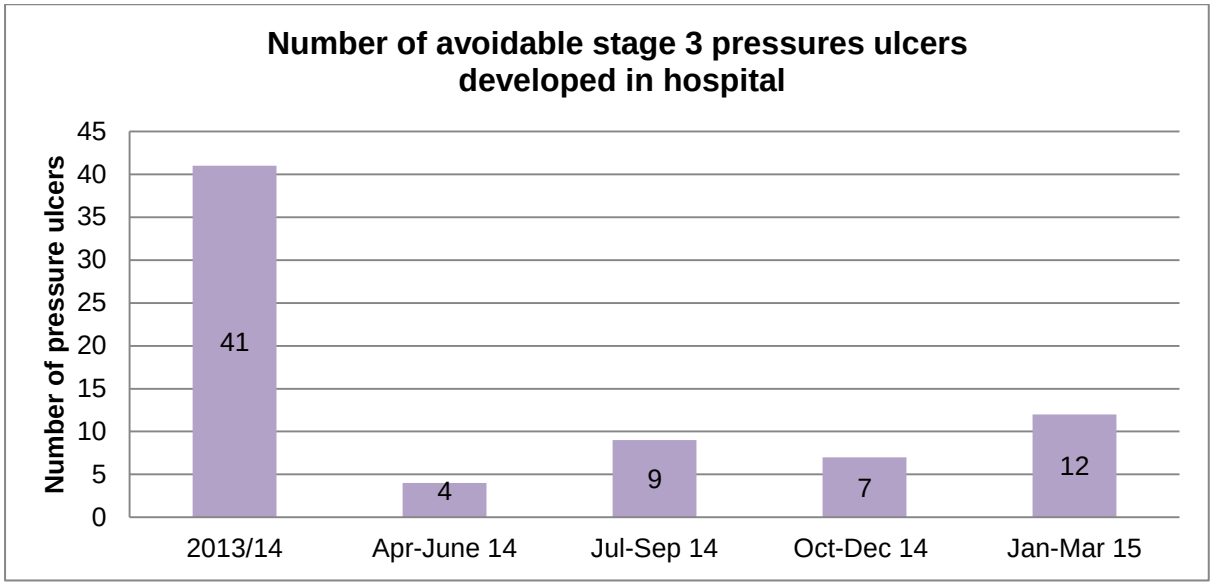


(In the 2013/14 Quality Report we reported a lower number of avoidable stage 3 pressure ulcers (36). Investigations that continued after the year end later found a further five avoidable ulcers)

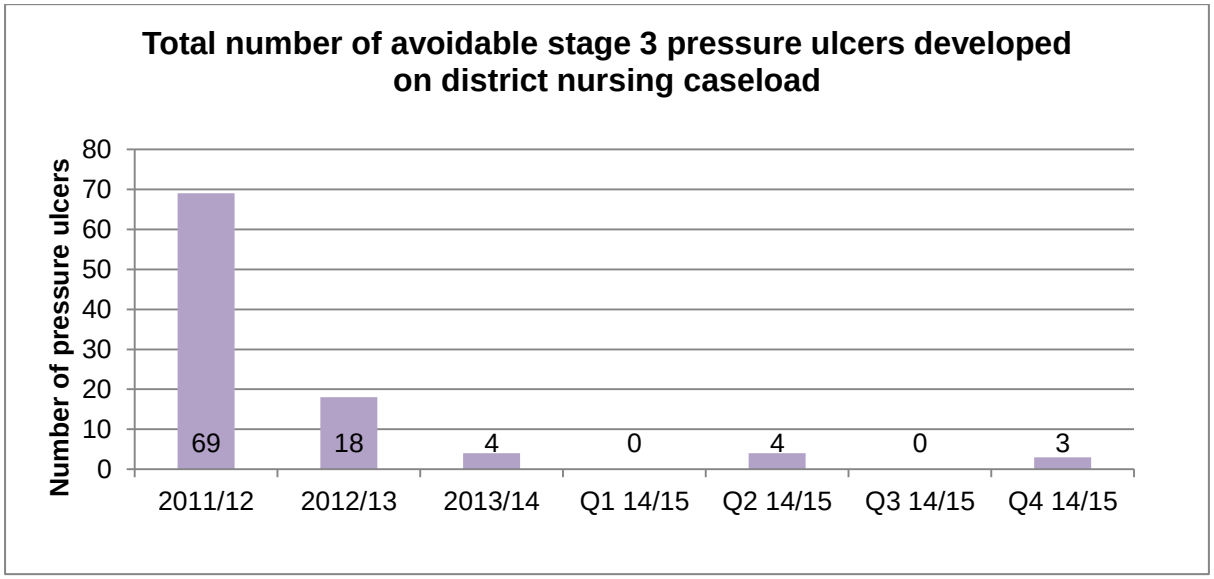
Specifically for avoidable stage 4 hospital acquired pressure ulcers, the target set was that there would not be any. This year there has unfortunately been a single avoidable stage 4 ulcer and so this target has not been achieved.



With regards to avoidable stage 3 hospital acquired pressure ulcers, the target set was that the number in 2014/15 would not increase from the number in 2013/14. In 2013/14 there were 41 avoidable stage 3 ulcers. It can be seen that this year there have been 32 and so this target was achieved.



Current status: Community



(In the 2013/14 Quality Report we reported a lower number of avoidable stage 3 pressure ulcers (3). Investigations that continued after the year end later found a further one avoidable ulcer)

The target of there being no avoidable stage 4 pressure ulcers acquired throughout the year on the district nurse caseload has been achieved. With regard to the avoidable stage 3 acquired pressure ulcer numbers not increasing from the number in 2013/14, this was a difficult target to achieve as there were only four in 2013/14, a dramatic drop from the previous two years.

New priority 2 for 2015/16

Pressure ulcers	
Hospital	**Community**
a) Ensure that there are no avoidable stage 4 hospital acquired pressure ulcers throughout the year.	a) Ensure that there are no avoidable stage 4 pressure ulcers acquired on the district nurse caseload throughout the year.
b) Ensure that the number of avoidable stage 3 hospital acquired pressure ulcers in 2015/16 reduces from the number in 2014/15.	b) Ensure that the number of avoidable stage 3 pressure ulcers acquired on the district nurse caseload in 2015/16 reduces from the number in 2014/15.

Rationale for inclusion

- Pressure ulcers are difficult to treat and slow to heal, and prevention is therefore a priority.
- Although the Trust has continued to reduce the overall number of pressure ulcers, it realises there is still much to do and moving to a zero tolerance approach should be the aim.
- Feedback from our patients, staff, community groups and governors indicates this should remain a target.

Developments planned for 2015/16

Actions being undertaken to achieve the new Trust target include:

- Audits of all pressure relief equipment within residential home care settings to ensure it is maintained and used as per the Trust guidance
- Amend education programmes to include short one hour sessions with a specific focus each month
- Continue to provide regular educational sessions for community and social care staff
- Continue weekly joint (community/hospital) pressure ulcer group meetings to ensure Trust-wide learning
- Update the pressure ulcer prevention document and ensure teams have the required education and support for its continued use
- Agree process for lead nurses to support tissue viability nurses in the verification of stage 3 and 4 pressure ulcers
- Once the verification process has been agreed, the tissue viability team will support specific wards with prevention work through structured ward walks and audits
- Develop a ‘refusal of care’ pathway to ensure patients have a clear understanding of the risks associated with refusing equipment or positioning
- Investigate the use of a new device that can detect possible pressure damage before any redness occurs on the skin
- Continue to work with the regional group to assist the national-level work such as updating and maintaining the national *Stop the Pressure* website.

Board Sponsor: Denise McMahon, Director of Nursing
Operational Lead: Lisa Turley, Tissue Viability Lead Nurse

Priority 3 for 2014/15: Infection control

Infection control	
Reduce our MRSA bacteraemia and Clostridium difficile (C. diff) rates in line with national and local priorities.	
MRSA	**Clostridium difficile**
Have 0 post 48 hour cases of MRSA bacteraemia (blood stream infections).	Have no more than 48 post 48 hour cases of Clostridium difficile.

How we measure and record this priority

Infections are monitored internally, along with other key quality indicators, on the Trust's electronic dashboard (see page 29). In addition, these infections are monitored by our commissioners at quality review meetings

Positive MRSA bacteraemia and C. diff results are also reported onto the national Healthcare Associated Infections data capture system

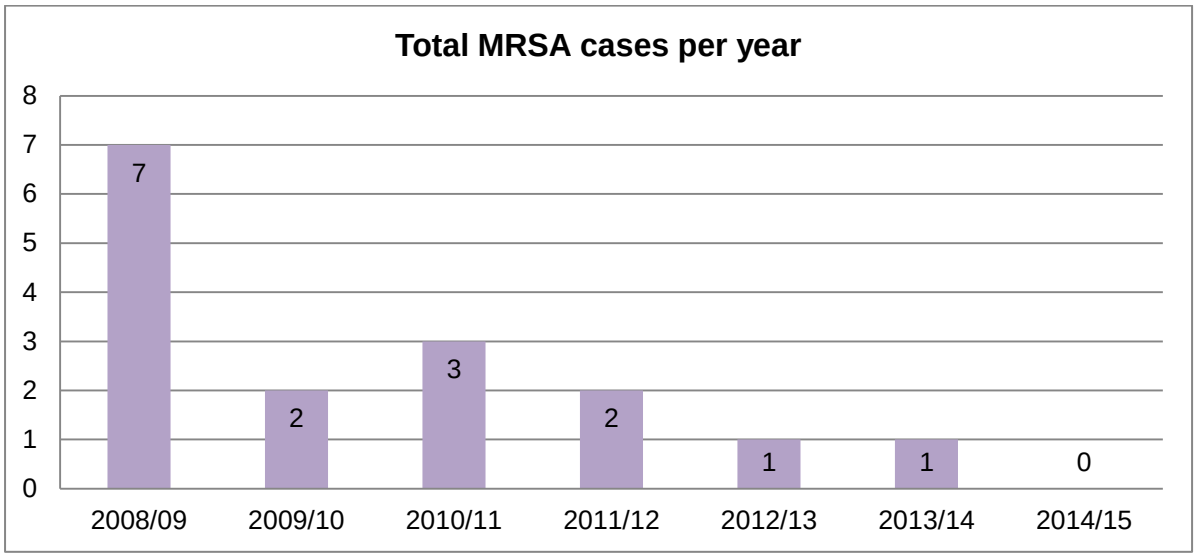
Developments that occurred in 2014/15

- We worked with our hydrogen peroxide vapour fogging contractor to agree a rolling programme of decontamination across all inpatient areas to assist in the prevention of infection
- We provided additional training for staff around the correct procedures for collecting specimens
- We developed education programmes and competencies for infection control that can be utilised across the Trust
- We have worked with our community teams to enhance their knowledge around infection prevention and auditing of practice
- We have worked with our commissioners to agree a process for determining whether or not C. diff cases are avoidable

The community is fortunate to have such a dedicated and expert medical staff working with terminally ill patients in the Georgina Ward.

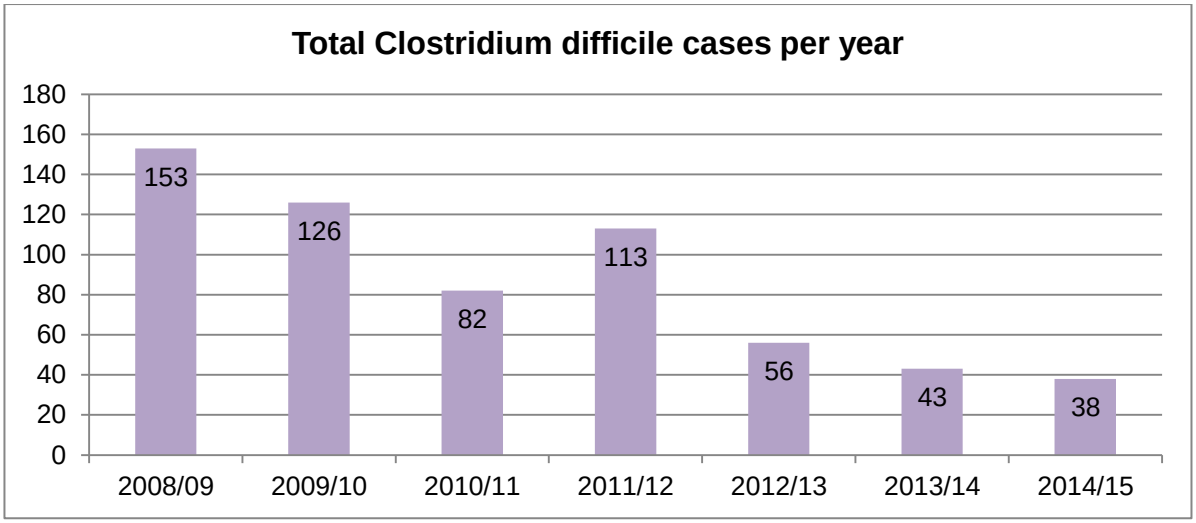
Current status: MRSA

NHS England has set a zero tolerance approach to MRSA bacteraemia. We have successfully reported zero MRSA bacteraemia for 2014/15.



Current status: Clostridium difficile

We have reported a total of 38 cases of C. diff for 2014/15. This rate is well below the threshold set of no more than 48 cases and shows a significant reduction on the previous year. We have achieved this through a continued focus on the clinical management of patients with identified or suspected infection.



New priority 3 for 2015/16

Infection control	
Maintain or reduce our MRSA and Clostridium difficile (C. diff) rates in line with national and local priorities. All cases will undergo a root cause analysis, the results of which will be discussed jointly by the Trust and Dudley Clinical Commissioning Group to agree on any avoidability/lapses in care.	
MRSA	**Clostridium difficile**
Have 0 post 48 hour cases of MRSA bacteraemia (blood stream infections).	Have no more than 29 post 48 hour cases of Clostridium difficile.

Rationale for inclusion

- The Trust and the Council of Governors have indicated that the prevention and control of infections remains a Trust priority.
- NHS England has a zero tolerance of MRSA bacteraemia.
- The Trust has a challenging target set national of 29 C. diff cases for the coming year.

Developments planned for 2015/16

Actions planned to achieve the above aims include:

- Review the current documentation used to monitor intravenous cannulae
- Develop an information leaflet for patients who are identified as C. diff carriers
- Develop protocols for the implementation of faecal transplant for patients who have relapses of C. diff. The purpose of faecal transplant is to provide appropriate bowel flora in the gut after infection with C. diff
- Review and redesign the isolation cards displayed on the rooms of patients with an infection to indicate specific precautions are required
- Plan a focus day – C the Difference – to highlight the importance of all aspects of management for C. diff

Board sponsor: Denise McMahon, Director of Nursing
Operational lead: Dr. E Rees, Director of Infection Prevention and Control

I would like to thank all who attended to me from cleaners to consultant surgeons. The nursing staff on B2 were exceptional and the care I received was second to none.

Priorities 4 and 5 for 2014/15: Nutrition and Hydration

Nutrition
Increase the number of patients who have a weekly risk re-assessment regarding their nutritional status. Throughout the year on average at least 90 per cent of patients will have their weekly risk assessment completed and this will rise to at least 93 per cent by the end of the year (March 2015).

Hydration
Ensure that, on average throughout the year, 93 per cent of patients' fluid balance charts are fully completed and accumulated at lunchtime.

How we measure and record these priorities

Every month 10 observation charts are checked at random on every ward as part of the wider Nursing Care Indicators (NCI) monitoring (see Section 3.3.4). This process includes checking the Malnutrition Universal Screening Tool (MUST) assessment which is a rapid, simple procedure commenced on first contact with the patient and weekly thereafter so that clear guidelines for action can be implemented and appropriate nutritional advice provided.

MUST has been designed to help identify adults who are underweight and at risk of malnutrition, as well as those who are obese. The tool has been in use at the Trust for a number of years. The NCI monitoring also includes checking that recorded fluid input and output of patients is added up both at lunchtime and at the end of the day. The completion rates of each ward are fed back to matrons and lead nurses for action where necessary.

Each ward and the whole Trust is RAG (Red/Amber/Green) rated. Up until 2013/14 'Green' was given for a 90 per cent or greater score, 'Amber/Yellow' for 89-70 per cent scores and 'Red' for scores of 69 per cent or less. Due to the overall improvement in scores across the Trust, from 2013/14 onwards 'Green' is given for a 93 per cent or greater score, 'Amber/Yellow' for 92-75 per cent scores and 'Red' for scores of 74 per cent or less.

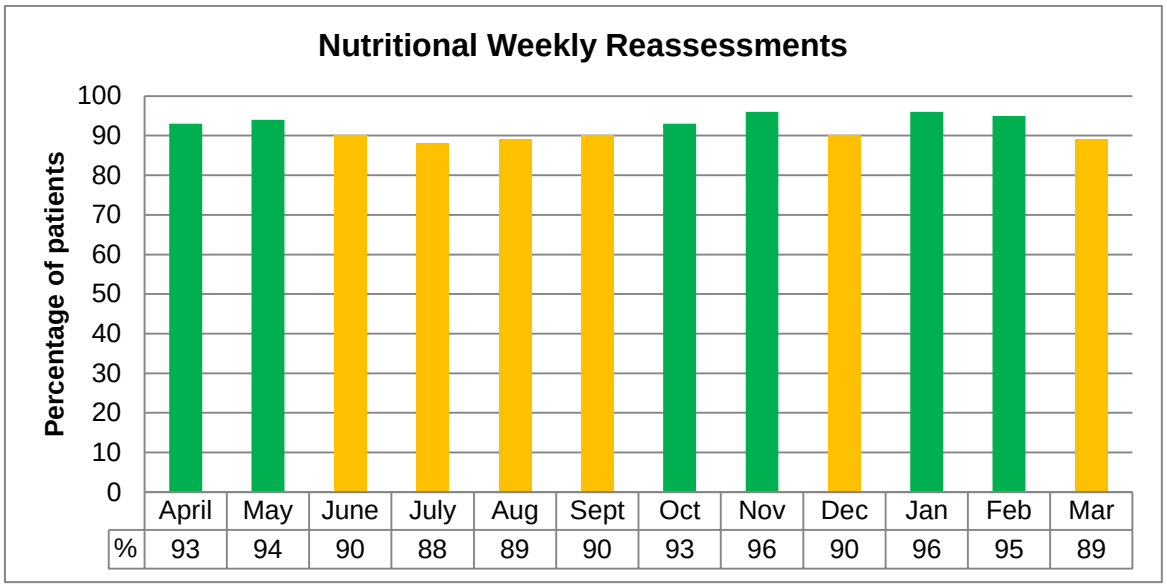
Developments that occurred in 2014/15

- An escalation process has been developed for tracking areas of concern from the mealtime audits
- An electronic based learning package has been identified and we are awaiting verification of compatibility with current Trust IT systems
- Freestanding notices at the entrance of each ward area to denote that Protected Mealtime is taking place have been introduced
- New national descriptors for speech and language therapy in relation to food consistency grading have been rolled out
- New *Chosen by Patients* menus, which have been tried and tested by patients and staff, have been trialled on three wards for future roll out across the Trust
- We participated in International Nutrition and Hydration Week when the importance of a good diet was publicised in a variety of ways across the Trust

Current status: Nutrition

The results of monitoring weekly reassessments indicate that for the whole year the 90 per cent average score was exceeded with 92 per cent being the average (compared to 89 per cent last year) and so the first target was met.

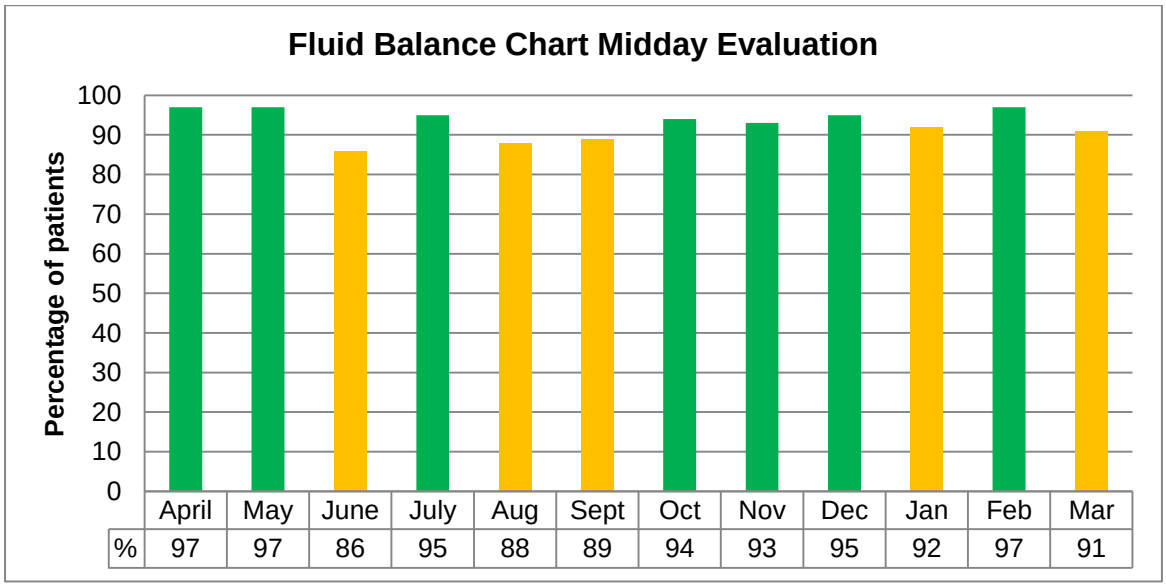
Although scores of 93 per cent or more were achieved in six months during the year, a dip in March meant that the target of 93 per cent or above by the year end was not met.



	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
%	93	94	90	88	89	90	93	96	90	96	95	89

Current status: Hydration

The results of monitoring fluid balance charts completion at midday show that, for the year as a whole, the 93 per cent target has just been met.



	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
%	97	97	86	95	88	89	94	93	95	92	97	91

New priority 4 for 2015/16

Nutrition and Hydration
Ensure that the overall score of the monthly nutrition and hydration audit (made up of 24 items): a) is 90 per cent or above in each of the first three quarters for the Trust as a whole b) has a 'Green' rating (93 per cent or above) in the final quarter for every ward in the hospital

Rationale for inclusion

- To retain the emphasis on nutrition and hydration.
- Two of the specific targets for 2014/15 were met.
- The new target covers all of the 24 items of the nutrition and hydration audit, rather than focusing on just two or three specific issues, and so is more comprehensive.
- The new target also covers every ward separately as well as an overall Trust score. By publishing the results for each ward in the final quarter the situation on each ward will be clear.
- Poor nutrition and hydration leads to poor health, increased and prolonged hospital admissions and increased costs to the NHS. The consequences of poor nutrition and hydration are well documented and include increased risk of infection, poor skin integrity and delayed wound healing, decreased muscle strength, depression and, sadly, premature death. Put simply, poor nutrition and hydration causes harm.

From October 2014, as part of the monitoring of care relating to nutrition and hydration, a more comprehensive audit tool was introduced. This follows the NCI model looking at what is recorded in the nursing notes but also asks patients for their experiences of being offered drinks and choice of food. It also includes observations of the environment, for instance, whether patients have drinks within reach and whether they are placed in an optimal position for eating.

In total, there are 24 elements to the audit and it is undertaken on ten patients on every ward each month. The results up to the end of December 2014 can be seen over the page. It can be seen that there is scope for improvement, particularly in terms of achieving the target we have set ourselves. During late 2014 there have been 13 occasions where wards have scored below the 93 per cent standard required for quarter 4.

I recovered on Ward C6, with very attentive nurses and doctors, well fed and hydrated! A big thanks to all involved in my stay from the consultant to the porters and cleaners

Table of overall results of the nutrition and hydration audits for each ward starting October 2014

Area	Oct 2014	Nov 2014	Dec 2014	Average score
A1 (Discharge Lounge, OPAT, Hot Clinic)	*	*	92	92
A2 (Short Stay Unit)	92	96	94	94
A3 (Frail and Elderly Short stay Unit and Elderly Care)	92	99	98	96
A4 (Acute Stroke)	98	99	98	98
B1 (Orthopaedics)	99	88	99	95
B2 (Hip and Trauma)	97	91	99	96
B3 (Vascular Surgery)	99	97	79	92
B4 (Mixed Colorectal and General Surgery)	99	96	97	97
B5 (Surgical Assessment Unit, Gynaecology Surgery/Admissions and General Surgery)	100	99	100	100
B6 (Ear Nose and Throat, Maxillofacial and Male Plastics	100	97	100	99
C1 (Renal and Endocrinology)	96	91	94	94
C3 (Elderly Care)	100	100	100	100
C4 (Georgina Unit/Oncology)	99	99	100	99
C5 (Respiratory)	99	95	93	96
C6 (Respiratory and GI overflow)	99	94	100	98
C7 (Gastrointestinal Medicine)	92	94	90	92
C8 (Elective Medical Unit, Rheumatology Outpatients, Stroke Rehabilitation and General Rehabilitation)	97	100	98	98
Medical High Dependency Unit	92	89	100	94
Coronary Care Unit	100	100	100	100
Critical Care Unit	+	94	99	97
Emergency Assessment Unit	99	97	96	97
Clinical Decision Unit	92	94	85	90

**Ward A1 was reconfigured in November and so the results from that month and October are not comparable.*
+The Critical Care Unit commenced auditing in November 2014

Developments planned for 2015/16

- New visual display boards will be introduced which comply with national descriptors in relation to food consistency grading to ensure patients get the right consistency of food and therefore correct nutritional input.
- Development of a Nutrition and Hydration Care Bundle, incorporating a flow chart for escalation when intake is poor.
- Monthly multi-agency meal time audits to ensure patients and staff views are heard and real time actions are taken if required.
- Development of Trust standards for nutrition and hydration for inpatients.
- Training for volunteers and non ward-based staff to support meal times.

Board Sponsor: Denise McMahon, Director of Nursing
Operational Leads: Kaye Sheppard, Head of Nursing-Medicine, Jenny Davies, Matron for GI and Renal Services, Rachel Tomkins, Matron for Elderly

Priority 6 for 2014/15: Mortality

Mortality
Ensure that 85 per cent of in-hospital deaths undergo specialist multidisciplinary review within 12 weeks by March 2015.

How we measure and record this priority

The Trust's Mortality Tracking System (MTS) was developed by our Information Team and launched in January 2012. Every patient death is recorded on the MTS and tracked through the following processes: coding, consultant validation, mortality audit and review. Monthly reports will be provided to the Mortality Review Panel and quarterly to the Clinical Quality Safety and Patient Experience Board Committee.

Rationale for inclusion

- Feedback from the Keogh Review in May 2013 indicated that the Trust should consider including mortality as a Quality Priority.
- The Keogh Review highlighted the importance of detailed and systematic case note review as the way forward in learning from hospital deaths and, therefore, the Trust needs to ensure that this is undertaken regularly in all specialities.

Developments that occurred in 2014/15

The Trust has remained within the expected range for the most widely used risk adjusted mortality indicators Hospital Standardised Mortality Ratio (HSMR) and Summary Hospital-level Mortality Indicator (SHMI). It is, therefore, even more important the Trust develops its use of mortality ratios as an indicator to investigate specific areas and respond appropriately where care has not met our high standards. This year data from the Mortality Tracking System has been used to provide information for external assurance to Dudley Clinical Commissioning Group and the Care Quality Commission (CQC). Timely review of deaths is particularly important if the Trust receives mortality outlier alerts from external bodies. We have been able to demonstrate this year that we have current, peer reviewed, quantitative, as well as qualitative, data on all deaths in hospital.

The Mortality Tracking System used to capture and record this data, and on which the target is based was placed in the finals of the prestigious E- Health Insider Awards in October 2014.

I would like to thank the surgeon and his team and all the wonderful nurses on ward B1... Thanks to the staff for all their helpfulness and cheerfulness each time I have had to contact them.

Current status

The Trust achieved an average of 85.6 per cent of in-hospital deaths undergoing specialist multi-disciplinary review within 12 weeks for 2014/2015, meeting our target and greatly improving upon our position at the end of last year in which we only achieved 70.6 per cent. The details by speciality are below:

Meeting 85% target **50% or above but below 85% target** **Below 50%**

Trust Overall	Quality Report 2013/14	Year to Date
	70.6%	85.6%

	% audited within 12 weeks					% audited within 12 weeks			
	Q1	Q2	Q3	YTD*		Q1	Q2	Q3	YTD*
Cardiology	88.9	93.3	73.3	88.7	**Renal**	69.2	88.2	61.5	88.2
Gastroenterology	0	68.4	88.9	74.6	**Haematology**	0	80	62.5	43.3
General Medicine	80.6	79.5	78.8	83.4	**Oncology**	33.3	0	0	29.7
Medical Assessment	91.7	96.7	87	92.3	**Care of the Elderly**	98.6	93.7	97.9	97.8
Orthogeriatrics	100	N/A	97.9	100	**ENT**	50	N/A	.100	66.7
Rehabilitation	100	80	100	94.1	**General Surgery**	90.3	43.7	57.1	69.2
Respiratory	98.2	91.9	84.4	92.9	**Urology**	100	0	40	54.5
Stroke Medicine/Stroke Rehab	91.3	40	79.4	79.3	**Vascular Surgery**	58.3	81.8	81.8	82.7
Diabetes	100	100	100	100	**T&O Rehabilitation**	100	83.3	100	96.2
Endocrinology	100	100	50	88.2	**Trauma and Orthopaedics**	83.3	100	100	96
Neonate	50	100	50	77.8	**Gynaecology**	N/A	100	0	50
Plastic Surgery	N/A	100	N/A	100	**Rheumatology**	N/A	N/A	100	100

**Due to the 12 week target for completion of each audit, the full year position will not be available until 12 weeks after the end of the final quarter which will be 30/06/2015. The year to date calculation shows all audits of deaths in hospital completed within 12 weeks between 01/04/2014 and 31/03/2015 as available.*

New Priority 5 for 2015/16: Mortality

Mortality
Ensure that 90 per cent of in-hospital deaths available for review undergo specialist multidisciplinary review within 12 weeks by March 2016.

Rationale for inclusion

- We believe that all specialities are able to improve beyond the current target of 85 per cent if those audits delayed as a result of issues beyond our control, such as cases referred to the coroner, are taken into account.
- The Trust maintains that timely case note review of deaths provides us with the best source of information regarding patients who died in hospital and the quality of care they received.
- The Trust will be able to respond more effectively internally to make appropriate changes where care falls below the standards we expect and externally to give assurance if as many in hospital deaths as possible are reviewed within 12 weeks.

Developments planned for 2015/16

- Escalated exception reports by specialty to divisional management through to directors
- Development of the Mortality Tracking System with other Trusts
- Additional End of Life Care Audit to be completed where appropriate as part of mortality audits

Board sponsor: Paul Harrison, Medical Director
Operational lead: Teekai Beach, Directorate Manager to Medical Director

2.2 Statements of assurance from the Board of Directors

2.2.1 Review of services

During 2014/15, The Dudley Group NHS Foundation Trust provided and/or sub-contracted 59 relevant health services. The Trust has reviewed all the data available to them on the quality of care in all of these relevant health services. The income generated by the relevant health services reviewed in 2014/15 represents 99.4 per cent of the total income generated from the provision of relevant health services by The Dudley Group NHS Foundation Trust for 2014/15.

The above reviews were undertaken in a number of ways. With regards to patient experience and safety, the Trust executive and non-executive directors continue to undertake Patient Safety Leadership Walkrounds (see section 3.3.2). Morbidity and mortality reviews are undertaken by the Chairman, Chief Executive and Medical Director. External input is provided by Dudley Clinical Commissioning Group (CCG). These occur on an 18-month rolling programme, covering all services. Each service presents information from a variety of sources including: internal audits, national audits, peer review visits, as well as activity and outcome data such as standardised mortality indicator figures.

We also monitor safety, clinical effectiveness and patient experience through a variety of other methods:

- Nursing Care Indicators; monthly audits of key nursing interventions and their documentation. The results are published, monitored and reported to the Board of Directors every other month (see section 3.3.4).
- Ongoing patient surveys that give a ‘feel’ for our patients’ experiences in real time allow us to quickly identify any problems and correct them (see section 3.2.2).
- Every other month, senior medical staff attend the Board of Directors meeting to provide a report and presentation on performance and quality issues within their speciality areas.
- Every other month, a matron attends the Board of Directors meeting to provide a report and presentation on nursing and quality issues across the whole Trust.
- The Trust has an electronic dashboard of indicators for directors, senior managers and clinicians to monitor performance. The dashboard is essentially an online centre of vital information for staff.
- The Trust works with its local commissioners, scrutinising the Trust’s quality of care at joint monthly Clinical Quality Review Meetings.
- External assessments, which included the following key ones this year:
    - In February 2015, Dudley Clinical Commissioning Group undertook an unannounced visit to the Trust’s frail elderly services. The Trust has received a positive report and no actions are required.

- In February 2015, an expert review of the Trust's radiological services was led by the ex-vice president of the Royal College of Radiologists. The conclusion of the review was that the Trust has an excellent department.
- The Clinical Pathology Accreditation (CPA) (UK) Ltd, which was the longstanding body which approved laboratories, visited Haematology in October 2014 and Biochemistry in November 2014. Both maintained accredited status. Cellular Pathology and the Mortuary Services also had a very good inspection in March 2015 and maintained CPA accredited status. They will also be offered accreditation to ISO 15189:2012 Medical Laboratories – Requirements for Quality and Competence once some improvement actions are completed.
- The Human Tissue Authority (HTA) inspected the Trust Mortuary Services in June 2014 and there was a successful outcome.
- In January 2015, the Trust had a JACIE assessment (The Joint Accreditation Committee-ISCT [Europe] & EBMT) and was re-accredited for haematopoietic stem cell (HSC) transplantation. The re-accreditation panel highlighted a well-established quality management system.
- In June 2014, NHS Quality Control North West visited the Trust's aseptic pharmacy unit and concluded that the unit continues to operate to a very high standard, with a well maintained and well documented quality system. The overall risk rating for the unit remains 'Low'.
- The West Midlands Quality Review Service (WMQRS) visited the Trust on three occasions. In April 2014, the service reviewed our Frail Elderly Services from which no major issues of note were found and a number of improvements were implemented. In February 2015, a team reviewed Day Case Surgery and in the following month our services relating to Transfer of Care from Acute Hospital and Intermediate Care were reviewed. At the time of publishing we are still awaiting the final reports from these reviews.
- With regards to education and training, the West Midlands Deanery undertakes a variety of checks on the education of doctors at the Trust. This year the Emergency Medicine services were visited in both May and September 2014. Following some initial concerns in May, the latest visit resulted in a commendation for the improvements made.

Thank you to the doctor who showed me empathy and also the anaesthetist who took time out to discuss everything. Thank you for all information you gave in a professional manner.

2.2.2 Participation in national clinical audits and confidential enquiries

During 2014/15, 32 national clinical audits and four national confidential enquiries covered relevant health services that the Trust provides. During that period, the Trust participated in 100 per cent of the national clinical audits and 100 per cent of the national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that the Trust was eligible to participate in, actually participated in, and for which data collection was completed during 2014/15, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

Table 1

National clinical audits that the Trust was eligible to participate in, actually participated in during 2014/15 and the percentage of the number of registered cases submitted by the terms of the audit

Name of Audit	Type of Care	Participation	Submitted %
ICNARC Case Mix Programme Database	Acute Care	Yes	100%
Adult Community Acquired Pneumonia	Acute Care	Yes	100%
National Emergency Laparotomy Audit	Acute Care	Yes	100%
National Joint Registry	Acute Care	Yes	96%
Pleural Procedures Audit	Acute Care	Yes	100%
TARN Severe Trauma Audit	Acute Care	Yes	51.1%
National Comparative Audit of Blood Transfusion: 2014 Survey of Red Cell Use	Blood & Transplant	Yes	100%
National Comparative Audit of Blood Transfusion: 2014 Blood Use in Sickle Cell Anaemia	Blood & Transplant	Yes	100%
National Bowel Cancer Audit Project	Cancer	Yes	100%
Data for Head and Neck Oncology	Cancer	Yes	100%
National Lung Cancer Audit	Cancer	Yes	100%
National Oesophago-gastric Cancer Audit	Cancer	Yes	100%
National Prostate Cancer Audit	Cancer	Yes	100%
MINAP Acute Coronary Syndrome/Acute Myocardial Infarction Audit	Heart	Yes	100%

Name of Audit	Type of Care	Participation	Submitted %
Cardiac Rhythm Management	Heart	Yes	100%
National Cardiac Arrest Audit	Heart	Yes	100%
National Heart Failure Audit	Heart	Yes	76% to end Jan 2015
National Vascular Registry	Heart	Yes	96%
National Diabetes Foot Care Audit (NDFA)	Long-term Conditions	Yes	100%
National Pregnancy in Diabetes Audit	Long-term Conditions	Yes	100%
National Paediatric Diabetes Audit	Long-term Conditions	Yes	100%
Inflammatory Bowel Disease Audit	Long-term Conditions	Yes	100%
National Chronic Obstructive Pulmonary Disease Audit programme	Long-term Conditions	Yes	100%
Renal Replacement Therapy (Renal Registry)	Long-term Conditions	Yes	100%
Rheumatoid and Early Inflammatory Arthritis	Long-term Conditions	Yes	100%
Mental Health (care in emergency departments)	Mental Health	Yes	100%
Falls and Fragility Fractures Audit Programme	Older People	Yes	100%
Sentinel Stroke National Audit Programme	Older People	Yes	100%
Older people (care in emergency departments)	Older People	Yes	100%
Elective Surgery (National PROMs Programme)	Other	Yes	99%
Epilepsy 12 Audit (Childhood Epilepsy)	Women & Children's Health	Yes	100%
Maternal, Newborn and Infant Clinical Outcome Review Programme	Women & Children's Health	Yes	100%
National Neonatal Audit Programme	Women & Children's Health	Yes	100%
Fitting Child (care in emergency departments)	Women & Children's Health	Yes	100%

Table 2

National confidential enquiries that the Trust was eligible to participate in and actually participated in during 2014/15 and the percentage of the number of registered cases required by the terms of the enquiry

Name of Audit	Type of Care	Participation	Submitted %
Tracheostomy Care	NCEPOD	Yes	100%
Lower Limb Amputations	NCEPOD	Yes	100%
Gastrointestinal Haemorrhage	NCEPOD	Yes	100%
Sepsis	NCEPOD	Yes	Still in progress

NCEPOD: National Confidential Enquiry into Patient Outcome and Death

As well as the national clinical audits in Table 1, from the officially recognised Healthcare Quality Partnership (HQIP) list, the Trust has also taken part in these further national audits:

Table 3

Additional National Clinical Audits that the Trust participated in during 2014/15

Name of Audit	Type of Care	Participation	Submitted %
National Postpartum Haemorrhage Audit	Obstetrics	Yes	100%
First Sprint National Anaesthesia Project (SNAP-1)	Anaesthesia	Yes	100%
BAUS National Nephrectomy Audit Database	Urology	Yes	100%

In the Day Case Unit I was put at ease by the nurses. A further visit from the anaesthetist and the surgeon laid any further worries to rest. Following my surgery the aftercare throughout the rest of the day was excellent and reassuring.

The reports of the following 18 national clinical audits were reviewed in 2014/15:

Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)
College of Emergency Medicine (CEM) Asthma in Children Audit
CEM Paracetamol Overdose Audit
CEM Severe Sepsis Audit
National Anaesthesia Sprint Audit Project (ASAP)
National Audit of Dementia
National Audit of Seizure management in Hospitals (NASH2)
National Bowel Cancer Audit
National Care of the Dying Audit for Hospitals (NCDAH)
National Chronic Obstructive Pulmonary Disease Audit Programme
National Diabetes Inpatient Audit (NaDIA)
National Emergency Laparotomy Audit (NELA)
National Joint Registry
National Lung Cancer Audit
National Oesophago-Gastric Cancer Audit
NCEPOD Lower Limb Amputation: working together
Sentinel Stroke National Audit Programme (SSNAP)
Trauma Audit Research Network (TARN)

From the above reviews, the Trust has taken or intends to take the following actions to improve the quality of healthcare provided:

CEM Severe Sepsis Audit
Audit outcome and recommendations identified for improved management of patients discussed and disseminated to all Emergency Department (ED) staff through the ED Governance Newsletter.

National Care of the Dying Audit for Hospitals (NCDAH)
Planned introduction of a Trust-wide local audit of care of the dying to be included on the annual mandatory audit programme. VOICES bereavement survey has been introduced with results reported to the Patient Experience Group. The End of Life (EOL) workstream is currently reviewing End of Life Care Guidelines working with community, primary care and hospice teams. The Trust's Chaplaincy Service is currently writing a strategy to identify adequate resource for the spiritual needs of the dying patient.

National Audit of Seizure Management (NASH2)
Subsequent recommendations for a sustained improvement include: the development of local guidelines, education of doctors in the assessment and management of epilepsy and introduction of regular departmental audits against NICE guidelines and NASH2 recommendations.

National Anaesthesia Sprint Audit Project (ASAP)
Pathway to be developed in conjunction with the trauma and orthopaedic speciality for provision of pre-operative femoral nerve blockade to all fracture neck of femur patients.

Local clinical audit

The reports of 30 completed local clinical audits were reviewed in 2014/15 and the Trust has taken, or intends to take, the following actions to improve the quality of healthcare provided:

Microbiology
Review and further elaborate the section explaining notification in the meningitis element of the Trust's antimicrobial guidelines. The same is to be included in the meningitis section of the antimicrobial mobile phone app.

Acute Medicine
A senior review of patients in the afternoon with the junior doctor and/or nurse in charge is now routine practice, with a designated specialist registrar on the rota for the afternoon ward round. The Trust is holding a series of training sessions to raise awareness of encephalitis and its management and posters are now displayed in the relevant clinical areas. We will be re-auditing our performance in the future.

With regards to the Sepsis Six, re-audit has shown improved compliance to achieving this within one hour compared to the previous 2010 audit. We will continue education on the Sepsis Six pathway by including it in induction for all new junior doctors rotating to the Trust and encourage the use of the proforma. We will also set up a Trust-wide coordinating group to improve the identification and treatment of sepsis.

Gastrointestinal Medicine
A flow chart showing appropriate management and education on sigmoid volvulus will be rolled out to junior doctors in surgical teaching sessions.

A simple flowchart will be introduced, and available on the The Hub, the Trust's staff intranet, to highlight the indication of a proton-pump inhibitor (PPI) and the appropriate duration of treatment.

The department will introduce rectal administration of Nonsteroidal Anti-inflammatory Drug (NSAID) for all patients undergoing Endoscopic Retrograde Cholangiopancreatography (ERCP).

Stroke Medicine
It was recommended that all patients presenting with atrial fibrillation (AF) should be assessed for stroke risk using CHADS2/CHADVASC score and should be considered for anticoagulation if the bleeding risk is low using the HAS-BLED score, taking into account patients' preferences.

There is now a pathway to identify patients with acute ischaemic stroke undergoing intravenous thrombolysis at Russells Hall Hospital that may potentially benefit from thrombectomy which is performed at the Queen Elizabeth Hospital.

Rheumatology
A database has been created of patients receiving denosumab in hospital on which a serum calcium is recorded both before and after the injection. A patient information

leaflet is now given at the time of injection on which the importance of monitoring serum calcium is highlighted. New Trust guidelines for Acute Hot Joint are currently awaiting ratification.

Anaesthetics
The Trust is now using the West Midlands palliative care document as our guidance on opioid conversion. A Standard Operating Procedure for anaesthetic pre-op clinic/CPET (Cardio Pulmonary Exercise Testing) clinic has been introduces and letters now go to all patients' GPs when anaemia is identified.

Dietetics
A new dysphagia menu has been devised and introduced to the Trust, giving patients a better variety of meals and texture to suit their needs.

District Nursing
For patients requiring IV therapy in the community, 8cm midlines will now be used for IV antibiotics of more than five days.

Intensive Care Medicine
A maximum dose has been added to the electronic prescription for propofol. This ensures that doses greater than 4mg/kg/hr cannot be prescribed and, therefore, given. An advisory has also been developed to prompt clinicians to look for features of propofol infusion syndrome and to consider alternative strategies for sedation.

Paediatrics/Neonates Audit
A simpler flow chart for therapeutic hypothermia has been introduced on the Neonatal Unit. We are ensuring strict adherence to the new therapeutic cooling and referral pathway to help better identify suitable patients for therapeutic hypothermia.

A new Paediatric Assessment Unit proforma with sections to record the date and time is now within the medical notes. Staff have also been reminded of the importance of documenting the time the patient is seen. A re-audit over a longer period of time will take place in the next audit year and will include a wider range of staff.

All staff very friendly and helpful. The procedure was carried out by my consultant who explained the procedure and put me at ease. Her and her staff were very reassuring and helped me relax.

Obstetrics and Gynaecology
Abdominal sacrocolpopexy patients are now pre-assessed to review appropriateness for laparoscopic surgery.

A programme for updated training sessions on infant feeding is now in place. The Specialist Midwife will now be contacted via bleep when required to attend the Children's Ward and a process is also now in place for staff on the Children's Ward to contact a Maternity Infant Feeding Assistant (MIFA) to provide support when required.

Midwifery staffing figures are submitted monthly and shortfalls are now monitored at the monthly manager meetings. A monthly report is presented at the manager meeting to outline the number of incidents in relation to staffing shortfalls and escalation within the Maternity Unit.

Lead midwives now complete a DATIX incident report if a community midwife is unable to support a home birth. Work will be done to further recruit and establish competence for four whole time equivalent support workers.

Ophthalmology
All new prescribers to the department now have a training meeting with a non-medical prescriber regarding prescription form completion and an annual presentation of findings at the doctors' audit meeting will take place.

Pharmacy
Access to all antimicrobial guidelines has been significantly improved with the introduction of the new mobile phone app. Both sets of guidelines are now constantly being updated, with memos sent out to highlight any significant changes.

Handy hints card have also been made for healthcare professionals, these include the sepsis criteria, signs of organ dysfunction, the Sepsis Six and the antibiotic guidelines for treating sepsis.

Podiatric Surgery
Bleeding risk and contraindications to compression stockings and dalteparin have all been incorporated into one deep vein thrombosis (DVT) assessment tool. This includes the blood test requirements as a tick list and the discussion of stopping hormone replacement therapy or the combined oral contraceptive pill as part of the DVT assessment process.

Trauma & Orthopaedics
A new proforma will now be used by the on-call post-take team and put in the notes or inpatient referral.

A proforma will be developed for patients needing an MRI scan for suspected Cauda Equina Syndrome.

2.2.3 Research and development

The number of patients receiving health services provided or sub-contracted by the Trust in 2014/15, that were recruited during that period to participate in research approved by a research ethics committee, was 1913.

Our performance data is reported nationally and a copy can be found on the Trust's website under Research and Development: www.dudleygroup.nhs.uk/research

In last year's Quality Report we predicted that dermatology and endocrinology would grow in importance in terms of research. In autumn 2014, the dermatology research team won a national prize for the success of their commercial work, recruiting to time and target and delivering high quality research data. Dermatology's commercial research income now provides sufficient funding for the Trust to have recruited a senior dermatology research nurse in May 2014. During the same period, more diabetes studies have started, with an equivalent increase in research nurse time.

This year's success story is the opening of several academic studies in the Stroke, Anaesthetics and Critical Care Departments. This has been made possible by successfully bidding for Clinical Research Network: West Midlands funding for additional research nurse time. The Trust is also participating in an important regional vascular surgery trial. Musculoskeletal clinical disciplines and cardiology continue to recruit well to commercial trials. The reorganisation of cancer services and increasing number of very selective, targeted treatment has reduced participation in oncology studies; commercial cancer studies are still undertaken.

The Trust continues to host several research fellows and PhD students from local universities. Two researchers based in rheumatology are currently writing up their doctoral theses.

Trust publications for the calendar year 2014, including conference posters, stand at 202, an increase of approximately 100 per cent on 2013, possibly due to improved methods of collecting and recording these publications.

In the field of haematology, the interim results of a recently closed multicentre Hodgkin's disease study have shown that the introduction of centrally funded PET (Positron Emission Tomography) scans for younger patients is an effective prognostic tool. Scan results indicate to clinicians when to escalate treatment, after which 75 per cent of the patients have improved, progression free survival.

Dudley dermatology patients' participation in clinical trials has helped to secure the UK marketing authorisation and NICE approval for the use of existing drugs to treat psoriasis.

2.2.4 Commissioning for Quality and Innovation (CQUIN) payment framework

What are CQUINs and what do they mean for the Trust?

The CQUIN payment framework was introduced in 2009 to make a proportion of providers' income conditional on demonstrating improvements in quality and innovation in specified areas of care. Whether the Trust receives its CQUIN payments is dependent on achieving certain quality measures.

This means that some of the Trust's income is conditional on achieving certain targets that are agreed between the Trust and our commissioners (Dudley Clinical Commissioning Group and NHS England).

A proportion of the Trust's income in 2014/15 was conditional upon achieving quality improvement and innovation goals agreed between the Trust and any person or body it entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation (CQUIN) payment framework. Further details of the agreed goals for 2014/15 and for the following 12 month period are available online at:

http://www.england.nhs.uk/nhs-standard-contract/

CQUIN is a quality increment that applies over and above the standard contract. The sum is variable based on 2.5 per cent of our activity outturn and conditional on achieving quality improvement and innovation goals.

The value of CQUIN in 2014/15 is £6.14m forming part of our contracts with clinical commissioning groups and specialised services commissioners. Each CQUIN scheme consists of one or more goals for achievement by agreed milestones. A total of 11 CQUIN schemes were agreed for 2014/15 with a combination of locally agreed goals and two schemes, Dementia and Friends and Family Test, which are nationally determined.

At the end of the financial year we have achieved, or it is forecasted that we will achieve, the majority of the indicators. Validation of data for pressure ulcer prevalence for Quarter 4 is still in progress but the indication given is that the target has been achieved. Similarly, Patient Safety Culture is anticipated to be achieved but the final quarter report still requires sign off by the commissioners.

Mitigating actions have been put in place to ensure the quality of care is improved in those areas where goals are partially achieved.

The 'Letters returned to the referring clinician' CQUIN scheme was reviewed in February 2015 as it was identified as unachievable for reasons outside the control of both the Trust and Dudley CCG. A decision was reached to allocate the financial value associated with the this CQUIN proportionally across all remaining schemes.

The final settlement figure for 2014/15 has not yet been agreed as some targets, as indicated above, are contingent upon outstanding information and actions. However, for the purpose of the year-end accounts, we are assuming this will equate to an estimated 85 per cent, which is approximately £5.22m, based on secured and

expected income. In the previous financial year 2013/14, the final settlement figure based on achievement of CQUIN schemes was £5.1m.

The CQUINs for 2014/15 have been rated on a RAG (red/amber/green) basis dependent on achievement to date as detailed in the tables below:

CQUINs 2014/15

Acute and community 2014/15

Goal No.	CQUIN targets and topics	Quality domains and RAG rating
1	Friends and Family Test (6 parts)	Patient experience
2	Dementia and Delirium (3 parts)	Patient experience Safety/Effectiveness
3	NHS Safety Thermometer – Pressure Ulcers (Acute and Community)	Safety/Effectiveness Patient experience
4	Culture of Learning	Safety/Effectiveness Patient experience
5	Safeguarding	Safety
6	Patient Experience for Learning Disability Patients	Patient experience
7	Letters returning to the referring clinician*	Effectiveness
8	Patient Safety Culture	Safety/Effectiveness

**See explanation in text above*

Specialised services 2014/15

Goal No.	CQUIN targets and topics	Quality domains and RAG rating
1	Friends and Family Test (6 parts)	Patient Experience
2	Dementia and Delirium (3 parts)	Patient Experience Safety/Effectiveness
3	Quality Dashboards	Safety/Effectiveness
4	Renal Dialysis – Shared Haemodialysis Care	Patient Experience Effectiveness
5	Neonatal Intensive Care – Total Parenteral Nutrition	Safety/Effectiveness

Key Achieved = Partially Achieved =

Throughout my trips to visit the Ophthalmology Department I was always treated with the utmost care and dignity by all of the nurses and staff, who always had a smile and a kind word for you no matter how busy they were.

CQUINs 2015/16

In 2015/16, the amount the Trust is able to earn is 2.5 per cent on top of the actual outturn value. The estimated value of this is approximately £6.3m.

Acute and community 2015/16

Goal No.	CQUIN targets and topics	Quality domains
1	Physical Health: Acute Kidney Injury	Safety Effectiveness
2	Physical Health: Sepsis	Safety Effectiveness
3	Mental Health: Dementia	Patient Experience Effectiveness
4	Urgent and Emergency Care - Improving recording of diagnosis in A&E	Safety Effectiveness
5	Wellbeing of frequent service users	Effectiveness
6	Cancer Survivorship	Patient Experience Effectiveness
7	Discharge summary letters	Effectiveness
8	Advanced Nurse Practitioner development	Safety Effectiveness

Specialised services 2015/16

Goal No.	CQUIN targets and topics	Quality domains
1	HIV: Reducing unnecessary CD4 monitoring	Safety Effectiveness
2	Renal: EGFR monitoring system	Effectiveness
3	Right Care Right Place: improved outpatient new to follow-up rates	Effectiveness

2.2.5 Care Quality Commission (CQC) registration and reviews

The Dudley Group NHS Foundation Trust is required to register with the Care Quality Commission (CQC) and its current registration status is registered without conditions.

The Care Quality Commission has not taken enforcement action against the Trust during 2014/15. The Trust has not participated in any special reviews or investigations by the Care Quality Commission during the reporting period. On the 26th and 27th March 2014 a team from the CQC inspected the Trust and also returned on a number of unannounced visits in the following two weeks. Both a summary and full report of that inspection has been published and is available from www.cqc.org.uk/provider/RNA

The Trust was rated 'Good' in 30 out of the 38 core services inspected. The majority of the group categories (five out of eight) received an overall rating of 'Good'. Despite this, the overall rating for the Trust was 'Requires Improvement' (see below):

Our ratings for Russells Hall Hospital (including Corbett and Dudley Guest)

	Safe	Effective	Caring	Responsive	Well-led	Overall
Accident and emergency	Good	Not rated	Good	Requires improvement	Requires improvement	Requires improvement
Medical care	Good	Good	Good	Good	Good	Good
Surgery	Good	Good	Good	Good	Good	Good
Critical care	Requires improvement	Good	Good	Requires improvement	Good	Requires improvement
Maternity & family planning	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement
Children & young people	Good	Good	Good	Good	Good	Good
End of life care	Requires improvement	Good	Good	Good	Good	Good
Outpatients	Good	Not rated	Good	Requires improvement	Good	Good
Overall	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement

Our ratings for Dudley Group NHS Foundation Trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Overall trust	Requires improvement	Good	Good	Requires improvement	Good	Requires improvement

Notes

1. We are currently not confident that we are collecting sufficient evidence to rate effectiveness for both Accident & Emergency and Outpatients.
2. The rating for overall trust for the well-led key question is different for the rating for well-led for the location. This reflects the inspection team's view of strong leadership from the executive team, trust board and the chief executive.

Chief Inspector of Hospitals, Professor Sir Mike Richards, believes we are not far off achieving an overall ‘Good’ rating and has confidence that we are addressing the issues highlighted by the inspection.

He noted the following key findings:

- The Trust’s staff are seen as highly caring by many of the patients spoken to and staff were praised for ‘going the extra mile’.
- The Trust’s leadership team is seen as highly effective by staff; and is recognised to be clearly in touch with the experience of patients and the work of the staff.
- Staff value The Dudley Group as a place to work and a team spirit is clearly evident.
- The Trust has responded well to the Keogh Review in 2013.
- There are a number of areas of good practice in the Trust, which should be encouraged. Staff feel able to develop their own ideas and have confidence that the Trust will support them.
- The Emergency Department (A&E) is busy and overstretched. There remains challenges in the flow of patients, but much of this relates to flow across the rest of the hospital. Only a small proportion relates to the Emergency Department itself.
- The Trust does not always follow its own policy in relation to DNACPR (do not attempt resuscitation) notices.
- The ophthalmology clinics require review to ensure that all patients are followed up as required and that there is capacity for these clinics.
- The Trust must review its capacity in phlebotomy clinics as this is seen as insufficient.

The Trust has already taken action to improve many areas of concern, including:

- Phlebotomy (blood testing) provision has been expanded to offer more choice about where and when patients can have a blood test. Patients can now have a blood test at one of our hospital or outpatient sites Monday to Friday, 8am until 7.30pm, as well 8am until 10am on Saturday morning.
- Awareness raising across all staff regarding the correct process for DNACPR. A recent audit of documentation shows that the recording of such decisions has improved.

2.2.6 Quality of data

The Trust submitted records during 2014/15 to the Secondary Uses Service (SUS) for inclusion in the Hospital Episode Statistics (HES) which are included in the latest published data.

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

	The Dudley Group	National average
Admitted patient care	99.8%	99.1%
Outpatient care	99.8%	99.3%
Accident and Emergency care	99.0%	95.1%

The percentage of records in the published data which included the patient's valid General Practitioner Registration Code

	The Dudley Group	National average
Admitted patient care	100%	99.9%
Outpatient care	100%	99.9%
Accident and Emergency care	100%	99.2%

All above Trust figures are for April 2014 to Feb 2015 with national figures to Dec 2014

The Trust's Information Governance Assessment Report overall score for 2014/15 was 78 per cent and was graded 'Green'.

The Trust was not subject to the Payment by Results clinical coding audit during 2014/15 by the Audit Commission.

During 2014/15, the Trust has been required to report one data protection incident to the Information Commissioner's Office, when a letter sent out to a patient had further letters attached to it in error.

The Trust will be taking the following actions to improve data quality:

To continually emphasise the importance of information governance, the Trust's mandatory eLearning training programme on the topic has been further supported by face-to-face training sessions which are more accessible to a wider Trust audience.

To reinforce the training the Trust's Caldicott Guardian who leads on confidentiality and safeguarding is championing an Information Governance Lesson of the Week bulletin on the Trust's intranet – the Hub – which will inform staff of best practice and lessons learnt.

2.2.7 Core set of mandatory indicators

All trusts are required to include comparative information and data on a core set of nationally-used indicators. The tables include the two most recent sets of nationally-published comparative data as well as, where available, more up-to-date Trust figures. It should be appreciated that some of the 'Highest' and 'Lowest' performing trusts may not be directly comparable to an acute general hospital, for example, specialist eye or orthopaedic hospitals have very specific patient groups and so generally do not include emergency patients or those with multiple long-term conditions.

Mortality			
Topic and detailed indicators	**Immediate reporting period: Jul 2013 – June 2014**	**Previous reporting period: Apr 2013 – March 2014**	**Statements**
Summary Hospital-level Mortality Indicator (SHMI) value and banding	**Value** Trust 1.04 National average 1 Highest 1.20 Lowest 0.54 **Banding** Trust 2 National average 2 Highest 1 Lowest 3	**Value** Trust 1.07 National average 1 Highest 1.20 Lowest 0.54 **Banding** Trust 2 National average 2 Highest 1 Lowest 3	The Trust considers that this data is as described for the following reasons: • The Trust is pleased to note that the Trust's SHMI values are within the expected range The Trust has taken the following action to improve this indicator and so the quality of its services by: • Continuing to improve reviews of all mortality (see new Quality Priority). There is evidence that the Trust's SHMI is reducing
Percentage of patient deaths with palliative care coded at either diagnosis or specialty level (Context indicator)	Trust 27.1% National average 24.95% Highest 49% Lowest 7.4%	Trust 26.2% National Average 23.94% Highest 48.5% Lowest 6.4%	The Trust considers that this data is as described for the following reasons: • There is a very robust system in place to check accuracy of palliative care coding The Trust has taken the following actions to improve this percentage, and so the quality of its services by: • Ensuring this percentage will always be accurate and reflect actual palliative care.

Patient Reported Outcome Measures (PROMS)					
Topic and detailed indicators	**Immediate reporting period: 2013/14 Provisional**		**Previous reporting period: 2012/13 Final**		**Statements**
Groin Hernia Surgery	Trust	0.04	Trust	0.07	The Trust considers that this data is as described for the following reasons: • using feedback data (from HSCIC) we are very pleased with the outcomes that patient report. Patients who said that their problems are better now when compared to before their operation: • Groin hernia: 95% *(national = 94%),* • Hip replacement: 98% *(national = 95%),* • Knee replacement: 88% *(national = 89%),* • Varicose veins: 93% *(national = 89%)* The Trust has taken the following actions to improve these scores, and so the quality of its services by: • ensuring the Trust regularly monitors and audits the pre and postoperative healthcare of all patients. Surgical operative outcomes are consistently of high quality and safety, with excellent patient satisfaction for these procedures.
	National average	0.09	National average	0.09	
	Highest	0.14	Highest	0.15	
	Lowest	0.01	Lowest	0.01	
Varicose Vein Surgery	Trust	0.03	Trust	0.05	
	National average	0.09	National average	0.09	
	Highest	0.15	Highest	0.18	
	Lowest	0.02	Lowest	0.01	
Hip Replacement Surgery	Trust	0.41	Trust	0.44	
	National average	0.44	National average	0.44	
	Highest	0.55	Highest	0.54	
	Lowest	0.34	Lowest	0.32	
Knee Replacement Surgery	Trust	0.31	Trust	0.32	
	National average	0.32	National average	0.32	
	Highest	0.42	Highest	0.42	
	Lowest	0.22	Lowest	0.21	

In the above table the higher the score, the higher the average patient health gain

Readmissions					
Topic and detailed indicators	**Immediate reporting period: 2011/12**		**Previous reporting period: 2010/11**		**Statements**
% readmitted within 28 days **Aged 0-15**	Trust	9.09	Trust	9.34	The Trust considers that this data is as described for the following reasons: • since the national published figures (see across) are historical, we have looked at our latest locally available (pre-published) data. This indicates recent improvements (Aged 16 and over: 2012/13 10.2%, 2013/14 9.9%) (Age 0-15: 2012/13 10.3%, 2013/14 9.7%) The Trust intends to take the following actions to improve this percentage, and so the quality of its services by: • undertaking a review of the model of care that supports seven day services • further improving discharge processes • investing into community teams to support the concept of care closer to home • supporting the development of a discharge to assess model with community partners
	National average	10.15	National average	10.15	
	Highest	NA*	Highest	NA*	
	Lowest	NA*	Lowest	NA*	
% readmitted within 28 days **Aged 16 and over**	Trust	11.62	Trust	11.55	
	National average	11.45	National average	11.42	
	Highest	NA*	Highest	NA*	
	Lowest	NA*	Lowest	NA*	

**comparative figures not available*

Responsiveness to inpatients' personal needs					
Topic and detailed indicators	**Immediate reporting period: 2013/14**		**Previous reporting period: 2012/13**		**Statements**
Average score from a selection of questions from the National Inpatient Survey measuring patient experience **(Score out of 100)**	Trust	66.5	Trust	64.9	The Trust considers that this data is as described for the following reasons: • the Trust notes that it is only slightly lower than the national average and is making year on year improvements, The Trust intends to take the following actions to improve this score, and so the quality of its services by: • ensuring the Trust continues to ask these questions as part of the real-time surveys, and ensure actions are taken through the 'You said we did' plans and monitor performance and seek assurance on progress through the Patient Experience Group
	National average	68.7	National average	68.1	
	Highest	84.2	Highest	84.2	
	Lowest	54.4	Lowest	57.4	

Staff views					
Topic and detailed indicators	**Immediate reporting period: 2014**		**Previous reporting period: 2013**		**Statements**
Percentage of staff who would recommend the Trust to friends or family needing care	Trust	72%	Trust	66%	The Trust considers that this data is as described for the following reasons: • the Trust is pleased to see an increase in the percentage of staff who would recommend the Trust as a place to receive treatment. The Trust intends to take/has taken the following actions to improve this percentage, and so the quality of its services by: • multidisciplinary groups focusing on action planning for improvements. • communicating with and supporting managers to understand their data broken down by division and area and take actions where necessary. • involving and communicating with staff though adopting the Listening in Action programme. This has covered a wide range of topics and new areas are being agreed for 2015/16.
	National average	67%	National average	64%	
	Highest	89%	Highest	89%	
	Lowest	38%	Lowest	40%	

Venous Thromboembolism (VTE)					
Topic and detailed indicators	**Immediate reporting period: Q3 Oct – Dec 2014**		**Previous reporting period: Q2 Jul - Sep 2014**		**Statements**
Percentage of admitted patients risk-assessed for Venous Thromboembolism	Trust	95%	Trust	95.2%	The Trust considers that this data is as described for the following reasons: • the Trust is pleased to note that it is similar to the national average in undertaking these risk assessments. The Trust intends to take the following actions to improve this percentage, and so the quality of its services by: • continuing the educational sessions with each junior doctor intake • continuing with a variety of promotional activities to staff and patients
	National average	96%	National average	96%	
	Highest	100%	Highest	100%	
	Lowest	81%	Lowest	86.4%	

Infection control					
Topic and detailed indicators	**Immediate reporting period: 2013/14**		**Previous reporting period: 2012/13**		**Statements**
Rate of Clostridium difficile per 100,000 bed days amongst patients aged 2 or over	Trust	19.3	Trust	23.9	The Trust considers that this data is as described for the following reasons: • the Trust acknowledges it needs to improve its rate and has done so in 2014/12 having had 38 cases, compared to 43 the previous year (see page 19), making the most recent (pre-published) rate 17.3 The Trust intends to take/has taken the following actions to improve this rate, and so the quality of its services by: • the process for reviewing individual C. diff cases is continuing and has developed further to enable particular themes to be identified • The antimicrobial guidelines are functioning well on the smart phone app and this has enabled guidelines to be updated easily. Recently the CCG has undertaken to adopt this method of publication for their primary care prescribing guidelines • Treatment protocols for c. diff continue to be updated to ensure they reflect current evidence-based practice.
	National average	14.7	National average	17.3	
	Highest	37.1	Highest	30.6	
	Lowest	0	Lowest	0	

Clinical incidents					
Topic and detailed indicators	**Immediate reporting period: Apr 2014 – Sept 2014**		**Previous reporting period: Oct 2013 – Mar 2014**		**Statements**
Rate of patient safety incidents **(incidents reported per 1000 bed days)** **(Comparison is with 140 acute Trusts)**	Trust	41.93 (number 5022)	Trust	44.6 (number 5495)	The Trust considers that this data is as described for the following reasons: • as organisations that report more incidents usually have a better and more effective safety culture, the Trust is pleased to note it has higher than average reporting rates and its severe incidents are less than the national average. The Trust has taken the following actions to improve this rate and the numbers and percentages, and so the quality of its services by: • continual raising of awareness of what constitutes as an incident and how to report and continual improvement of quality investigations and learning using improved report templates.
	Average	35.9	Average	33.3	
	Highest	74.96	Highest	74.9	
	Lowest	0.24	Lowest	5.8	
Percentage of patient safety incidents resulting in severe harm or death	Trust	0% (number 0)	Trust	<0.1% (number 3)	
	National average	0.5%	National average	0.7%	

Part 3: Other quality information

3.1 Introduction

The Trust has a number Key Performance Indicator (KPI) reports which are available and used by a variety of staff groups to monitor quality on a day-to-day basis. The main repository for the reporting of the Trust's key performance measures is a web based dashboard, which is available to all senior managers and clinicians and currently contains over 130 measures, grouped under the headings of Quality, Performance, Workforce and Finance.

In addition, constant monitoring of a variety of aspects of quality of care include weekly reports sent to senior managers and clinicians which include the Emergency Department, Referral to Treatment and stroke and cancer targets. Monthly reports which include a breakdown of performance by ward based on Nursing Care Indicators, ward utilisation, adverse incidents, governance and workforce indicators, and patient experience scores are also sent to all wards. In becoming more transparent, each ward now displays its quality comparative data on a large information board (Patient Safety Huddle Boards) for staff, patients and their visitors.

To compare ourselves against other trusts, we use Healthcare Evaluation Data (HED) – a leading UK provider of comparative healthcare information – as a business intelligence monitoring tool.

The following three sections of this report provide an overview, with both statistics and examples, of the quality of care at the Trust, using the three elements of quality as outlined in the initial Chief Executive's statement:

Patient Experience
Does the Trust provide a clean, friendly environment in which patients are satisfied with the personal care and treatment they receive?

Patient Safety
Are patients safe in our hands?

Clinical Effectiveness
Do patients receive a good standard of clinical care?

The fourth section includes general quality measures which have remained the same for 2014/15 as the Board of Directors and our stakeholders believe these take into consideration both national and local targets which will be important to patients and give a further perspective of the Trust's quality of care.

A1 ward is exceptional on all levels... All of the staff and I mean every single one of them are brilliant! Caring, kind, considerate I could go on and on. No one wants to be in hospital but this ward and team make it so much better. Thank you so much all of you.

3.2 Does the Trust provide a clean, friendly environment in which patients are satisfied with the personal care and treatment they receive?

3.2.1 Introduction

The Trust values and welcomes all feedback to help us ensure we meet the needs and expectations of our patients, their families and carers, our staff and our stakeholders. As a Foundation Trust we are also legally obliged to take into consideration the views of our members as expressed through our Council of Governors.

3.2.2 Trust-wide initiatives

We gather feedback in a number of ways, including:

- The Friends and Family Test (FFT)
- Real-time surveys (face-to-face surveys)
- NHS Choices/Patient Opinion (online)
- National surveys
- Comment cards
- Complaints, concerns and compliments
- Patient Safety Leadership Walkrounds
- Targeted surveys on specific topics such as food and bereavement

Below are some examples of the quantity of feedback we received during the year (2014/15) and more detailed information about some of the methods. These methods alone highlight more than 21,000 opportunities for us to listen to our patients' views.

Method	Total
FFT – Inpatient	**7,179**
FFT – Emergency Department	**10,096**
FFT – Maternity	**3,500**
FFT – Community	**594***
FFT – Day Case	**1,277***
FFT – Outpatients	**1,672***
Mystery patient programme	**87**

Method	Total
Real-time surveys – inpatient	**1,479**
NHS Choices/Patient Opinion	**278**
Community Services surveys	**1,103**
Surveys of carers of people with dementia	**141**
Discharge surveys	**212**
Bereavement Surveys	**154**
National surveys	**748**

**To qualify for CQUIN payment (see page 39) we chose to implement the FFT in outpatients, community and day case early. The total responses for these areas will therefore differ from those reported to NHS England.*

a) Real-time surveys

During 2014/15, 1,479 patients participated in our real-time surveys. Real-time surveys work well alongside the Friends and Family Test and the results of these surveys are reported in a combined report to wards and specialties, allowing them to use important feedback from patients in a timely manner. The data from these surveys also allows us to react quickly to any issues and to use patient views in our service improvement planning.

b) Patient stories

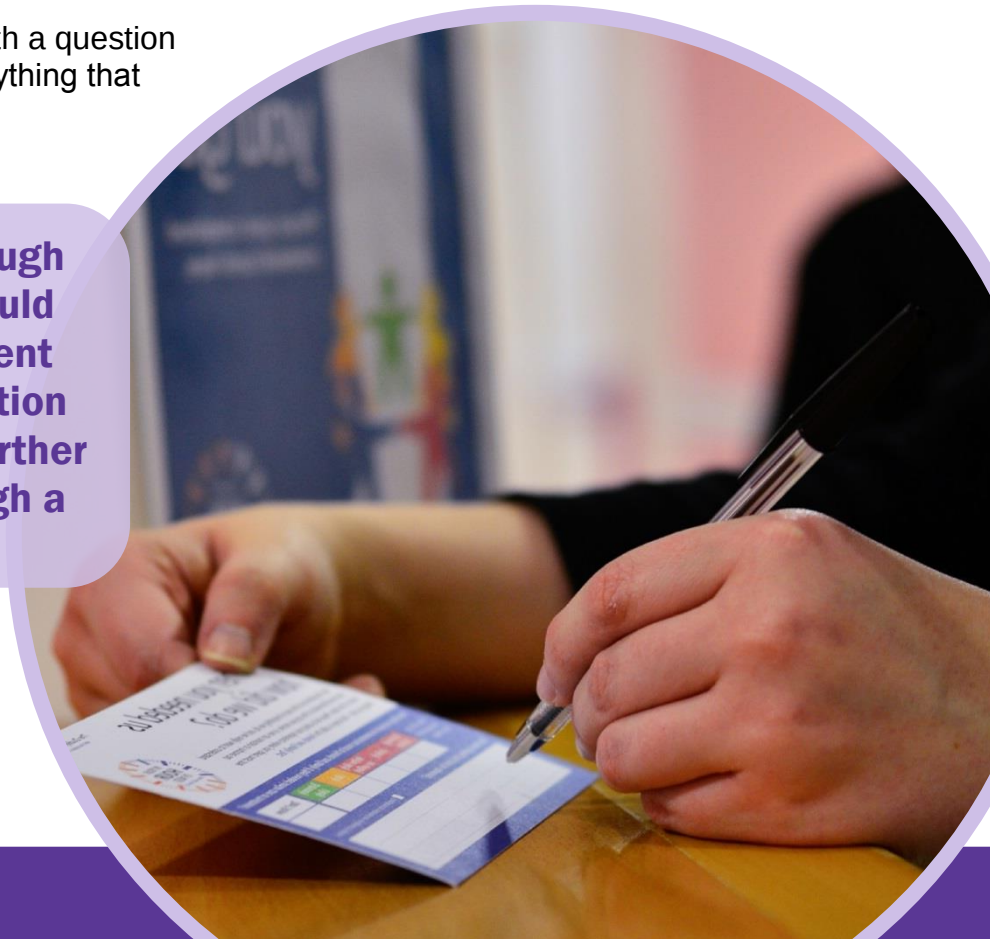
The continued use of patient stories at Board of Directors meetings during 2014/15 enables the patient voice to be heard at the highest level. Stories have been heard at Board of Directors meetings and used for service development planning and training purposes.

c) Friends and Family Test (FFT)

All inpatient and Emergency Department providers in the UK were required to participate in the Friends and Family Test from 1st April 2013 (the Trust introduced inpatient FFT in April 2012) with maternity services starting in October 2013, and further roll out into community, day case and outpatient areas during 2014/15. Results are published on NHS Choices as: normal, better or worse than others. Friends and Family Test scores are also displayed in our wards/departments and updated monthly for patients to see on 'huddle boards'.

- The test asks patients to answer a simple question "How likely are you to recommend (the particular service or department) to friends and family if they needed similar care or treatment?" with answers ranging from extremely likely to extremely unlikely.
- This is followed up with a question asking "Was there anything that could be improved?"

Thank you for caring enough to think about what I would need after my appointment with you, finding information that I could use to seek further support, to get me through a very difficult time.



This table shows our FFT scores for 2014/15 which indicates, for the majority of months, the Trust was above the national average and a high scorer in the Black Country region. For inpatients and maternity postnatal (community) we are proud to be above the national average for the whole year:

Inpatients	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Jan-15	Jan-15	Feb-15	Mar-15
Sandwell & West Birmingham	74	74	70	73	76	95	96	96	94	94	95	96
Dudley Group	82	86	85	81	82	96	96	97	97	97	98	98
Royal Wolverhampton	74	75	80	74	72	89	93	92	94	94	90	86
Walsall	68	68	72	71	70	87	92	94	96	96	93	95
National average	74	74	74	74	74	93	94	95	94	94	95	95

Accident & Emergency	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
Sandwell & West Birmingham	32	49	48	47	49	78	79	79	79	78	78	82
Dudley Group	64	53	57	70	71	84	85	88	75	94	91	92
Royal Wolverhampton	74	52	52	47	52	80	82	83	81	85	85	83
Walsall	52	49	54	45	46	92	90	94	92	90	86	86
National average	55	54	53	53	57	86	87	87	86	88	88	87

Maternity Antenatal	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
Sandwell & West Birmingham		67	55	45		90	78	63	83			
Dudley Group	64	80	78	79	66	97	98	97	100	98	99	100
Royal Wolverhampton	71	82	60	75	40	100					80	
Walsall	31	40	40	39	50	70	92	90	93		86	96
National average	65	67	67	62	66	95	95	96	96	95	95	95

Maternity Birth	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
Sandwell & West Birmingham	60	33	64	100								
Dudley Group	62	85	83	90	94	100	98	100	99	99	97	99
Royal Wolverhampton	72	91	98	100	97	100	100	100	100	100	100	99
Walsall	79	76	90	85	88	97	87	96	100	98	100	100
National average	76	77	77	77	77	95	95	97	97	97	97	97

Maternity Postnatal Ward	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
Sandwell & West Birmingham	57	62	61	68	58	94	94	97	96	95	98	92
Dudley Group	57	85	79	87	94	100	98	100	98	99	99	99
Royal Wolverhampton	66	95	75	55	81	100	96	91	91	88	88	81
Walsall	63	74	73	74	68	90	95	94	98	98	97	98
National average	64	65	67	65	65	91	91	93	93	93	93	98

Maternity Postnatal Community	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
Sandwell & West Birmingham			70	71		100	99	92	98	84	96	97
Dudley Group	86	90	85	85	85	100	100	100	100	100	100	100
Royal Wolverhampton	67	70	100				100	98		94	92	100
Walsall	90	76	91	67	74	95	97	100	97	100	97	100
National average	77	77	77	75	76	96	96	97	98	97	98	98

The national scoring for FFT changed in September 2014 to be a percentage instead of a net promoter score.

Any gaps in data are a result of not enough responses - less than 5 and the data is not displayed.

3.2.3 National survey results

In 2014/15, the results of three national patient surveys were published: inpatients, cancer and emergency department.

Participants for all national surveys are selected against the sampling guidance issued. For the national surveys, 850 patients were selected to receive a survey from the sample months indicated in the table below:

Survey name	Survey sample month	Trust response rate	National Average response rate
2014 Cancer Patient Experience	Sept – Nov 2013	62%	64%
2014 A&E	Jan - Mar 2014	33%	34%
2014 Adult inpatient	June - Aug 2014	47%	47%
2014 Children's and Young Peoples Inpatient	*July – Aug 2014*	*Not yet available**	*Not yet available**
2014 Neonatal: wave two	Apr – Sept 2014	37.4%	37.6%

*Response rate and national comparators published by the CQC not available at time of publication.

What the results of the surveys told us

2014 Cancer Patient Experience
We were delighted by the news that we were the most improved trust in England for cancer patient experience in the National Cancer Patient Experience Survey out of 153 trusts that took part.

We always strive to offer our patients the best possible experience whilst in our care, and this fantastic achievement is testament to the hard work of our specialist cancer teams over the past year. Our teams have been working hard with Macmillan Cancer Support over the past few years to make improvements to patient experience and it is rewarding to see this work recognised.

Compared to 2013 results:

- 53 questions out of 62 show an improved score from previous year
- four questions score same as previous year
- five questions show a slightly worse score

Areas where improvements could be made:

- Provision of information on getting financial help and the impact cancer can have on work and education
- Patients being given a choice of treatments and being more involved in decision making
- Patients being advised of the Cancer Clinical Nurse Specialist (CNS) in charge of their care

2014 A&E survey
The survey asks questions covering 34 different sections including: arrival at emergency department, doctors, nurses, care and treatment, tests and overall experience. In six out of the 34 sections the Trust was worse than other trusts nationally with all other sections being about the same as other emergency departments.

Areas where improvements could be made:

- Waiting times
- Access to food and drink in the department
- Being told what warning signals to look out for once returned home

2014 Adult inpatient survey
The national survey results are published in comparison with all trusts nationally and uses an analysis technique called the 'expected range' to determine whether the Trust has performed 'about the same', 'better' or 'worse' than others.

The 2014 survey told us that we are 'about the same' in all eleven section scores:

- the Emergency Department
- waiting list and planned admissions
- waiting to get to a bed on a ward
- the hospital and ward
- doctors
- nurses
- care and treatment
- operations and procedures
- leaving hospital
- overall views and experiences
- overall experience

Areas where improvements could be made:

- Inpatient meals
- Communication of what to expect during an operation or procedure

2014 Neonatal survey
The Trust chose to take part in the national neonatal survey which asked 43 questions covering the seven following areas:

- Before your baby was born
- Your baby's admission to neonatal care
- Staff on the neonatal unit
- Your involvement in your baby's care
- Environment and facilities
- Information and support for parents
- Leaving the neonatal unit

For the majority of questions, the Trust was on a par with the national average.

Areas where improvements could be made:

- Better written information for parents
- Better communication between staff and parents
- More support for breastfeeding mothers

I wanted to write and say a huge thank you to all the staff on ward C5 at Russells Hall Hospital, my nan was here for the last three weeks of her life and we wouldn't have gotten better treatment if she had been in a private hospital.

We use feedback from national and local surveys to improve patient experience. Below are some examples of actions taken as a result of patient feedback:

Inpatients	
You Said	**We Did / Doing**
More information about ward routines in needed	Welcome to the ward booklets are given to all new patients. A new system has also been put in place to ensure all transferred patients receive a copy of the ward booklet.
Better information about discharge processes is needed	All discharge information is being updated and ward clerks have received training on how to access this information. Additional training of ward staff has taken place and a new patient information leaflet has been launched to support the launch of *Home for Lunch*.
Improved information about waiting for surgery is needed	Letters to patients have been reviewed to now include advice that even though they may be called to their appointment early in the day, they may not be seen in order of arrival. The day room on ward B2 has been comfortably furnished. Patients now receive a phone call the day before their planned surgery when they are advised to bring in reading materials or a hobby activity to undertake should they need to wait.

Cancer	
You Said	**We Did / Doing**
More information is needed around getting financial help	We are working with the Dudley Citizens Advice Bureau and Macmillan Cancer Support, to help patients to identify and claim benefits they are entitled to.
More information about treatments and options is needed	We are reviewing and improving our information. We have also purchased some information stands to improve the availability of cancer information.
I do not know who my Cancer Clinical Nurse Specialist (CNS) is	Additional information will be produced and made available for all patients explaining the CNS/key worker role

Emergency Department	
You Said	**We Did / Doing**
Reduce ambulance handover times	To help reduce the length of time taken to hand over patients to ED from ambulances, we have had a staff nurse and clinical support worker on the ambulance triage team since June 2014. Their work is supported by a Hospital Ambulance Liaison Officer (HALO) from WMAS to ensure timely hand over of care even at times of high demand.
Ensure effective communication between patients, their families and GPs	We aim to ensure all staff involved in an patient's care communicate with one another to avoid contradictions. We have regular patient review meetings with all staff involved in the care of a patient and have introduced a more robust handover procedure. All staff are now aware of safe discharge procedures including assessing the home/family situation. Any patient with issues in these areas are referred to our welfare nurse or the IMPACT team. Advice leaflets containing information about who to contact after discharge are given to patients, as well as a discharge letter to give to their GP.

3.2.4 Examples of specific patient experience initiatives

a) Meeting the needs of patients with learning disabilities

The Trust launched its Learning Disability Strategy in March 2014. The key principle behind the strategy is to ensure that all staff listen to and provide care and treatment appropriately and effectively to people with learning disabilities. One of the practical ways this is demonstrated is by holding patient meetings where people with learning disabilities and their carers are invited to attend. They are an opportunity for this group of patients and their carers to express their hospital experiences and have an input into our patient experience surveys such as the Friends and Family Test, enabling their views to be included in any improvements that need to be made and the future planning of hospital services. The meetings have been well attended, with people talking about what did and didn't work when they used the hospital.

All staff were extremely responsive to all of the learning disability nurse's suggestions ensuring our time at Russells Hall was stress free. Please continue this wonderful and very necessary service.

A health toolkit, developed by Keele University, has also been launched at the Trust to support communication with and gain feedback from patients when they and their carers use our services. Whilst the toolkit is designed for patients with a learning disability, it is also hugely beneficial to use with patients living with dementia, and with those for whom English is not their first language.

b) Macmillan Link Nurse

In November 2014 the Trust's Macmillan Palliative Care Educator won a prestigious Macmillan Excellence Award for her inspirational work supporting healthcare professionals to deliver high quality palliative care for people affected by cancer in Dudley. The award was for improving the coordination and integration of services across the borough which has improved the experiences and outcomes of people affected by cancer.

The Palliative Care Educator has trained and educated more than 70 healthcare professionals across Dudley to become Palliative Care Champions, who then share their new skills and expertise with their colleagues to ensure a high standard of care for patients.

The post has made a huge difference to patients as the support given has helped to give existing staff more confidence. Staff now feel more comfortable having difficult, but important, conversations with patients and carers and are better skilled to support their colleagues, both clinical and non-clinical, to understand how to give the best possible care at the end of life.

c) Food Improvements
As part of our commitment to improve nutrition and hydration, we are introducing a new *Chosen by Patients* menu. We asked patients which dishes they enjoyed on our current menu and what they would like to see offered in the future. Using this information, our dietitians created a new menu that we are now trialling on four of our wards.

Patients on our Medical High Dependency Unit (MHDU) and general surgery, respiratory and children's wards are given a choice of meals from our new menu at lunch and dinner and, during an initial trial period, were asked to give us their feedback.

The feedback we received on the new menu from patients, staff and governors has helped us develop a new menu which we hope will improve patients' experiences of food. Since trialling the new menus, we have received overwhelmingly positive feedback from patients. Just a few of the comments we have received so far include:

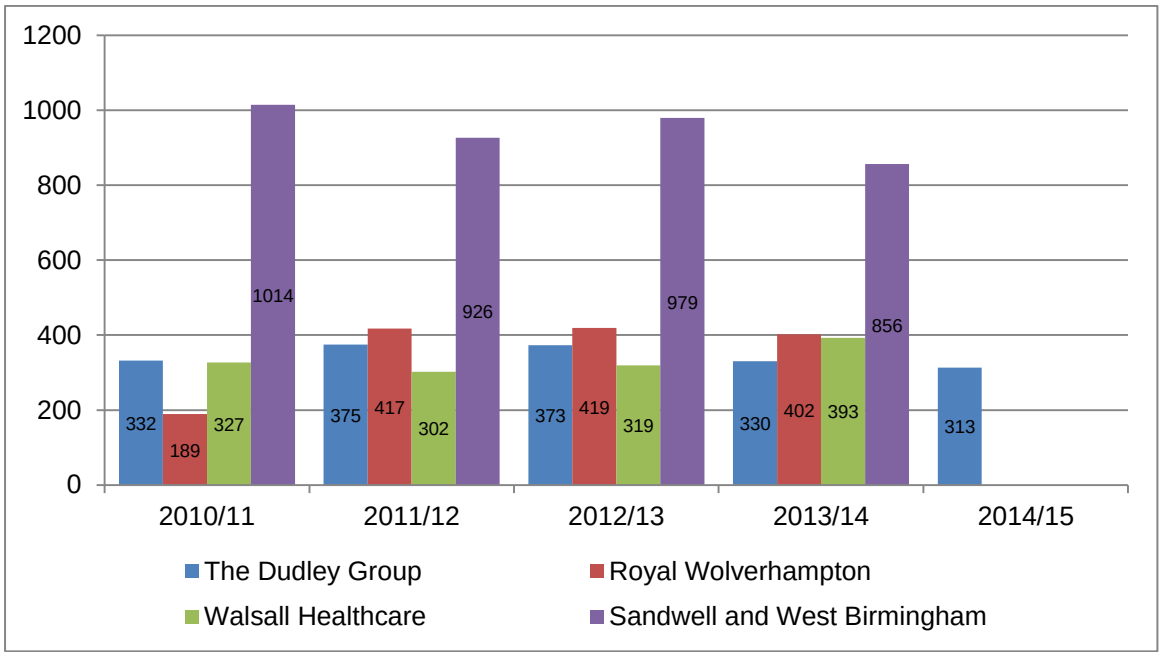
- "I was absolutely grateful for the amount and how fabulous the meals have been. Perfect – five star!"
- "Quite a varied menu – a definite improvement on my last visit to hospital."
- "Excellent to have a menu choice, especially same day prior to serving."

We also recruited 73 Nutrition Support Volunteers in September 2014 to help patients with their nutrition and hydration needs. The volunteers provide mealtime assistance by making drinks, helping with feeding, assisting with menu selection, encouraging eating and drinking and changing drinking water for patients. To make sure our patients receive the very best care and support during their stay, Nutrition Support Volunteers receive in-depth training provided by our nursing staff, dietitians and speech and language therapists.

3.2.5 Complaints, concerns and compliments

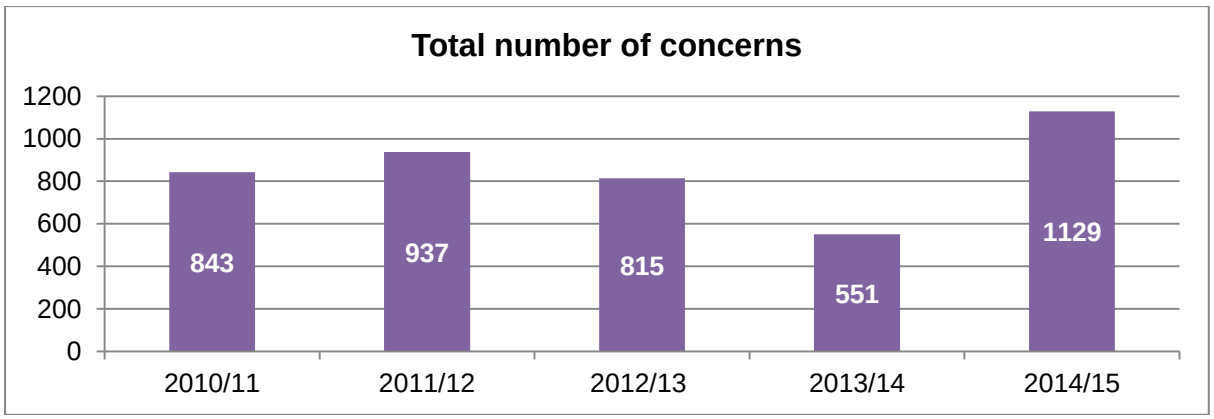
a) Total number of complaints, PALS concerns and compliments

Complaints
The graph below shows the total number of complaints received by the Trust over a number a years, alongside how we compare to neighbouring trusts. It can be seen that the number of complaints at the Trust has been reducing for the past four years.



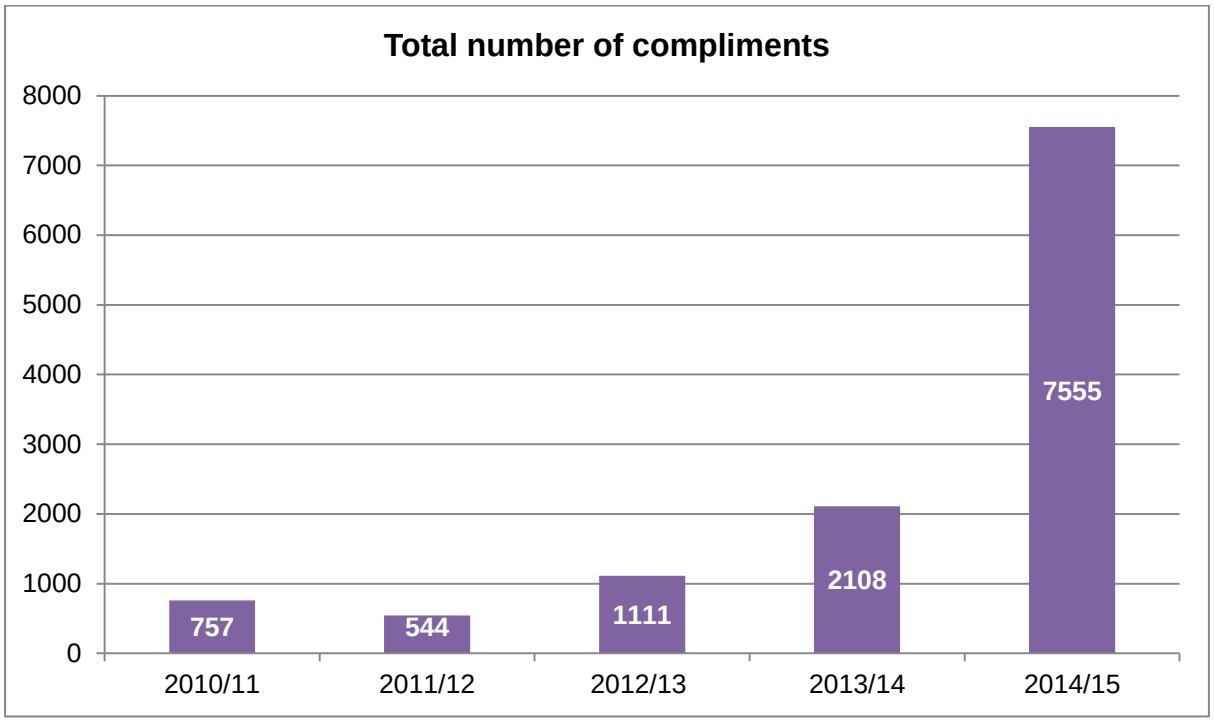
Concerns
The graph below shows the total number of concerns raised with the Patient Advice and Liaison Service (PALS). The number of PALS concerns has increased since last year; however, over the last five years, the number of concerns has fluctuated.

During 2014/15, the PALS team was re-established as a separate team to the Complaints Department, although it still retains strong links to ensure patients receive a seamless service. This change explains the difference in PALS figures from last year with 2013/14 seeing a decrease due to a different method of recording concerns during that period.



Compliments
The graph below shows the total number of compliments received during the year compared with previous years.

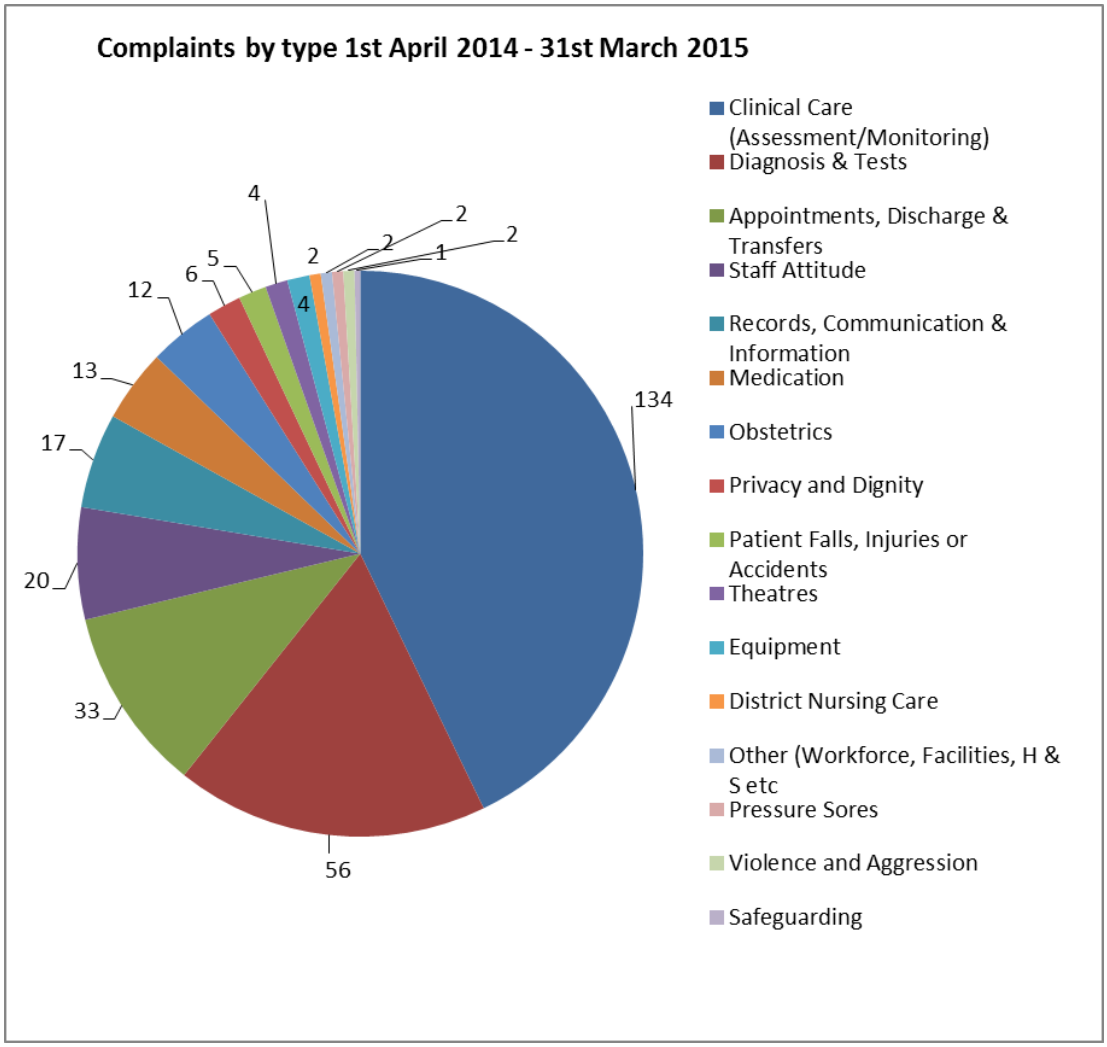
The Trust introduced an improved system of recording the number of compliments received in 2013/14 and so this will account for some of the large increase this year. It is very pleasing to see how many patients take the time to tell us of their good experiences, with 7,555 compliments in 2014/15.



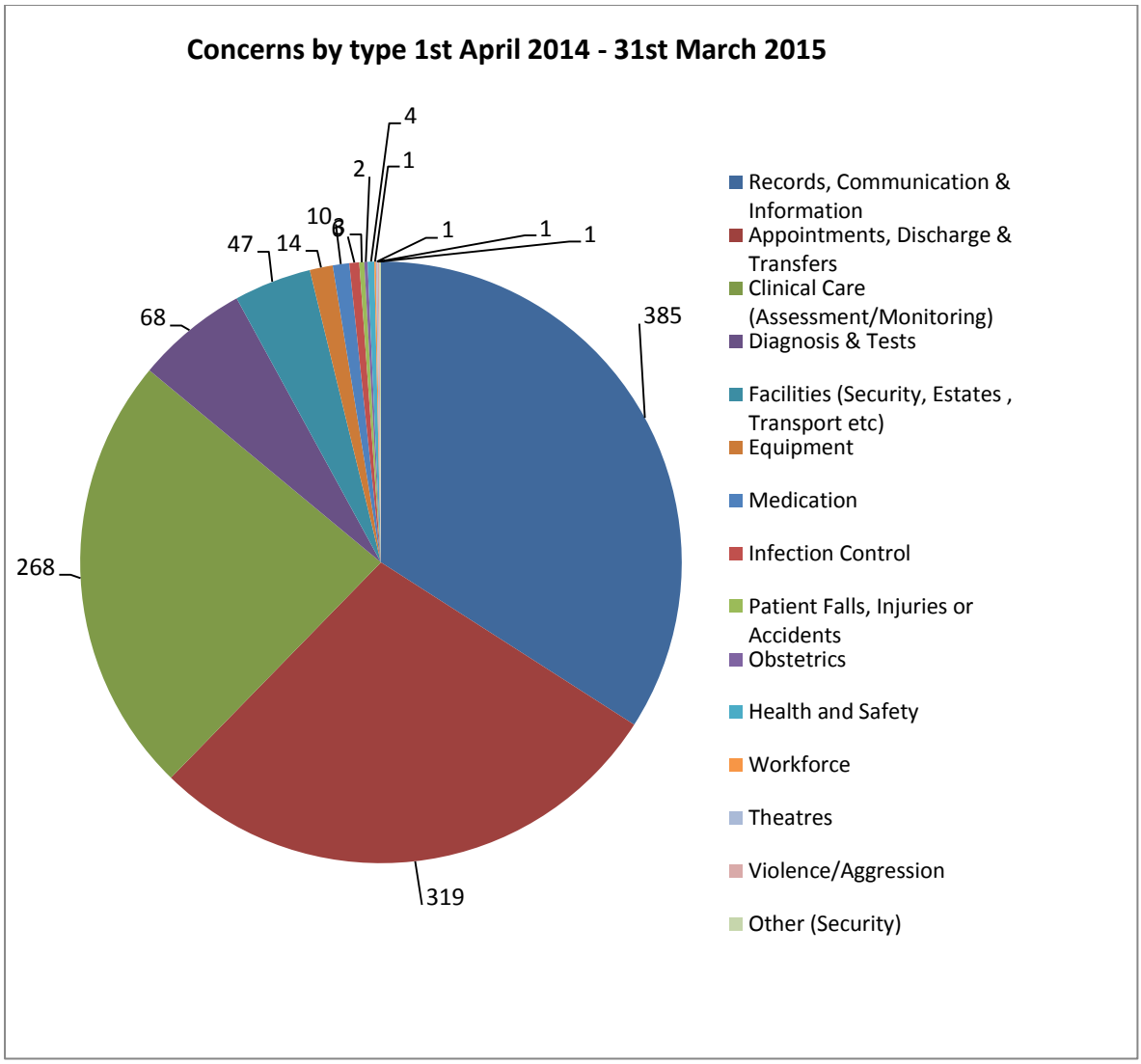
b) Types of complaints and PALS concerns throughout the year

The pie charts below show the types of complaints and concerns received during the year

Although there has been a fall in the overall number of complaints, the types of complaints we receive remain similar from year to year, reflecting the importance that patients place on effective and timely treatment from caring staff, with good communication skills. Some examples of actions taken and changes in practice following complaints and concerns are listed in section d).



Like complaint categories, the types of concerns raised remain similar year on year, reflecting the importance patients place on records, communication and information, closely followed by appointments, discharge and transfers. These top concerns are consistent with the types of comments made through other patient feedback methods.



c) Percentage of complaints against activity

The table below shows the percentage of complaints against total patient activity for each quarter in 2014/15 and for the year as a whole. As can be seen from the table, the percentage of complaints against activity has remained low and the same as 2013/14.

Activity	Total for 2013/14	Total Q1 ending 30/6/14	Total Q2 ending 30/9/14	Total Q3 ending 31/12/14	Total Q4 ending 31/3/15	Total for 2014/15
Total patient activity	734,239	181,132	187,117	184,687	183,574	**736,510**
Complaints against activity	0.04%	0.03%	0.05%	0.03%	0.05%	**0.04%**

d) Examples of actions taken and changes in practice made in response to complaints and concerns

Type of complaint or concern	Example of actions taken	Examples of changes in practice
Clinical Care, Diagnosis and Tests	• Initial X-ray examination performed was reviewed by a senior radiologist and even with the benefit of hindsight a stress fracture diagnosed some weeks later was not visible on the X-ray. A delay in diagnosing the fracture was acknowledged but explanation provided regarding difficulty diagnosing such fractures on initial X-rays. •Consultant met with patient and explained results of tests in some detail, which patient was happy with. • Consultants discussed question of use of compression stockings after aortic aneurysm surgery with team to ensure they are aware why compression stockings are not used after this type of surgery. • Staff reminded to inform parents when tests are sent to specialist hospitals, which might delay results being received. • Staff encouraged to use calculators to calculate drug dosages rather than mobile telephones as using these can give a poor impression. • Deputy matron recruited to older people's mental health team to implement and train new patient support team.	• A business case to increase urology medical staffing establishment was approved and an additional consultant, registrar grade and Senior House Officer grade doctors were appointed. • Mattress use paperwork reviewed and updated to include instruction to users to treat the chart as a guide only and use it in conjunction with other decision making processes. • All patients with a moisture lesion or red area on their skin are now placed on a two hourly skin assessment. • Wellbeing Workers introduced. • Mattresses on trolleys upgraded to provide pressure relief. • Electronic handovers introduced to ensure all information is available for both day and night staff. • Senior nurses now available during visiting hours to meet with relatives. • Two care workers released from night duties to act as 'floating' staff to ensure buzzers are answered within 30-second target. • Paediatric leaflets reviewed to highlight clinic structure. • Experienced care workers allocated to work with qualified staff at front triage and in ambulance triage area. • Patient flow co-ordinator introduced to aid qualified staff in monitoring patient waiting times.

Type of complaint	Example of actions taken	Examples of changes in practice
Records and Communication	• Advised patient he needed to be seen in clinic before going to theatre for procedure. • Staff asked to ensure patients understand what they have been told and to use non-clinical terminology. • Trust's newsletter contains information for GPs, particularly relating to ED attendances • A number of senior nursing staff have visited Mary Stevens Hospice to discuss care for the terminal patient. More nursing staff will go in future and this will be rolled out to other wards, including elderly care wards.	• Huddle boards introduced to improve staff communication. • Communication folder introduced to enable patients and families to raise questions and request meetings if staff not immediately available. • Letter of attendance formulated and available at reception for patients who require proof of attendance. • Patients with rapid access clinic appointments now receive a telephone call as well as a letter to confirm receipt of appointment. • Leaflet provided by reception staff when patients present following GP referral.
Obstetrics	• Telephone operators given emergency numbers for all local areas and these are readily available for pregnant women who contact the hospital. • Matron met with midwife concerned and asked her to reflect on contents of complaint letter, her behaviour towards her patient during her admission and to consider how improvements to her practice and approach can be made to prevent a recurrence. • Consultant reiterated to junior medical staff during meetings and teaching sessions the importance of good communication and of ensuring all patients are provided with full and easily understood explanations during consultations. • Reinforced with staff they should continue to emphasise all risks associated with procedure and continue to give written information.	• Reviewed information leaflet and statistics, post advice leaflet, service guideline (which is based on best national recommendations and practice. • Developed a letter that parents can give to doctors when attending ED departments. • Implemented access to the appropriate member of staff for advice for a number of hours following the clinic session ending. • Parents given information on SANDS (a stillbirth and neonatal death charity) who offer emotional support for parents who have suffered the loss of a baby. • Patients now provided with a comfort pack, blankets and pillows following admission from the day assessment unit.

3.2.6 Patient-led Assessments of the Care Environment (PLACE)

Patient-led Assessments of the Care Environment (PLACE) is the new system for assessing the quality of the hospital inpatient environment which replaced Patient Environment Action Team (PEAT) inspections from April 2013.

All trusts are required to undertake these inspections annually to a prescribed timescale. Patient assessors make up at least 50 per cent of the assessment team with the remainder being Trust and Summit Healthcare Staff.

The inspection covers ward and non-ward areas to assess:

- Cleanliness
- The condition of the buildings and fixtures (inside and out)
- How well the building meets the needs of those who use it, e.g. signage
- The quality and availability of food and drinks
- How well the environment protects people's privacy and dignity

	Cleanliness	Food & Hydration	Privacy, Dignity & Wellbeing	Condition, Appearance & Maintenance
2014 scores	**99.69%**	**84.28%***	**90.96%***	**97.04%**
2014 national average	97.25%	89.79%	87.73%	91.97%
2013 scores	97.87%	78.36%*	90.92%*	90.46%
Variance from national average	▲ +2.44%	▼ -5.51%	▲ +3.23%	▲ +5.07%
Variance from 2013 scores	▲ +1.82%	▲ +5.92%	▲ +0.04%	▲ +6.58%

**Due to changes in the assessment methodology and scoring, the 2014 results for Food and Hydration and Privacy, Dignity and Wellbeing are not directly comparable to the 2013 results.*

We were delighted that we scored higher than the national average in three of the four above topics and all of our scores have improved on our own 2013/14 scores.

Big thumbs up to everyone one on ward C8. Thank you so much for your kindness, expertise and for going above and beyond the call of duty.

3.2.7 Single-sex accommodation

We are compliant with the government's requirement to eliminate mixed-sex accommodation. Sharing with members of the opposite sex only occurs when clinically necessary (for example where patients need specialist equipment such as in the Critical Care Unit), or when patients actively choose to share (for instance in the Renal Dialysis Unit). During the year the Trust has not reported any breaches of same-sex accommodation.

As part of our real-time survey programme, patient perception is also measured by asking patients whether they shared a room or bay with members of the opposite sex when they were admitted to hospital. Of the 1,211 patients who responded to this question, 59 (less than five per cent) had the perception that they shared a room/bay with members of the opposite sex was. This excludes emergency areas.

3.2.8 Patient experience measures

	Actual 2008/09	Actual 2009/10	Actual 2010/11	Actual 2011/12	Actual 2012/13	Actual 2013/14	Actual 2014/15	Comparison with other trusts 2014
Patients who agreed that the hospital room or ward was clean	87%	87%	88%	8.7	8.8	9.0	**8.9**	**7.9-9.7***
Patients who would rate their overall care highly**	79%	76%	74%	7.4				**7.2-9.2***
Rating of overall experience of care (on a scale of 1-10)**					7.6	7.7	**7.8**	
Patients who felt they were treated with dignity and respect	89%	86%	86%	8.6	8.7	8.6	**8.7**	**8.2-9.8***

The above data is from national inpatient surveys conducted for CQC.

Scores were initially expressed as percentages but from 2011 scores are reported out of 10 (previously this table was compiled from raw data scores).

** National range lowest to highest score.*

***The way this question was asked changed in 2011/12 and so figures are not directly comparable.*

Patient Safety

3.3 Are patients safe in our hands?

3.3.1 Introduction

The Trust ensures the safety of its patients is a main priority in a number of ways, from the quality of the training staff receive, to the standard of equipment purchased. This section includes some examples of the preventative action the Trust takes to help keep patients safe and what is done on those occasions when things do not go to plan.

3.3.2 Patient Safety Leadership Walkrounds

All wards, therapy and community departments are visited throughout the year by a team consisting of, as a minimum, an executive director, a non-executive director, a governor and a scribe from the governance team.

The team observes practice by being shown around the ward or department by a member of staff who also provides a verbal summary of the ward activity, specialty and ways of working. The team then meets informally with staff to discuss any issues of concern related to patient safety, while governors talk to patients about their experiences of the care they are receiving. A report and action plan is produced to address areas of concern identified. Some actions taken from these visits include:

- New seating has been purchased for Genitourinary medicine (GUM) outpatient area.
- A new intercom system has been fitted for patients attending the Renal Dialysis Unit out of hours. The reception desk is not manned and ward staff were unaware patients were waiting outside trying to gain access. The system allows ward staff to open doors remotely. The Renal Dialysis Unit has extended its service hours to include late evening sessions.
- Coaxial TV aerials have been pinned back to the walls to reduce the risk of trips.
- Following a service review, regular meetings were scheduled with the Trust's non-emergency patient transport providers Ambuline. The service provides transport for patients attending clinics, outpatients or those being discharged. Previously reported delays and extended patient waits for transport have improved following the introduction of these meetings. From 1st April 2015 the Trust's non-emergency patient transport is to be provided by NSL. We hope to continue these meetings with our new provider in the coming year.
- Repairs were made to seating in the Cardiology Unit.
- A dedicated triage area has been developed on our oncology ward, C4.
- A rehabilitation chair has been introduced into critical care. This will enable ventilated patients to be sat out of bed. In addition, new dignity screens have been fitted in our Surgical High Dependency Unit to allow for greater privacy and dignity.
- A new central console monitoring unit has been purchased for the Coronary Care Unit which is currently waiting installation. It will provide the latest high specification monitoring of cardiac patients within the department.

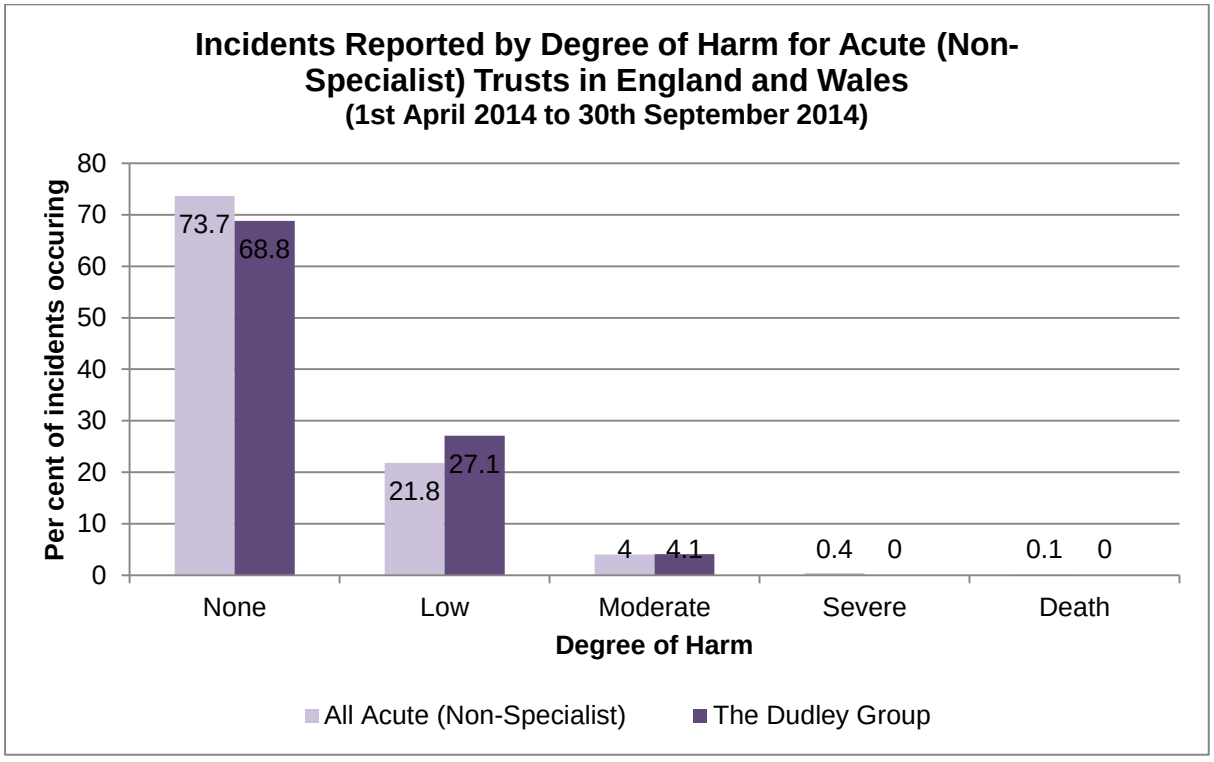
3.3.3 Incident management

The Trust actively encourages its staff to report incidents believing that, to improve safety, it first needs to know what problems exist. This reflects the National Patient Safety Organisation which has stated:

''Organisations that report more incidents usually have a better and more effective safety culture. You can't learn and improve if you don't know what the problems are.''

The latest national comparative figures available are for the period 1st April 2014 to 30th September 2014. Organisations are compared against other acute (non-specialist) trusts. The Trust is the 28th highest reporter of all incidents of the 140 acute (non-specialist) trusts.

With regards to the impact of the reported incidents, it can be seen from the graph below (for the same period stated above) that the Trust reports a similar proportion of incidents to comparable trusts. Nationally, across all medium-sized acute trusts, 73.7 per cent of incidents are reported as no harm (the Trust reported 68.8 per cent) and 0.5 per cent as severe harm or death (the Trust reported 0 per cent).



During the 2014/15 financial year, the Trust has had one Never Event (a special class of serious incident that are generally preventable) which resulted in no patient harm. It had 268 serious incidents*, all of which underwent an internal investigation and, when relevant, action plans were initiated and changes made to practice

**Serious incidents are a nationally-agreed set of incidents which may not necessarily have resulted from error but need investigating to check the circumstances of their occurrence*

Some examples of changes made to practice in response to the above incidents have been:

- Introduction of the Sign and Stamp initiative which requires all medication prescribers to stamp/print their name as well as sign so that the identity of the prescriber is clear
- Review and re-launch of the Think Glucose training programme to ensure staff on wards that do not commonly look after patients with diabetes are aware of their responsibilities when caring for such patients
- Identification of an alternative supplier of bariatric equipment
- Full review of neonatal resuscitation guidelines
- Development of a pre- and post-procedure checklist (adapted WHO Surgical Safety Checklist process) for all invasive procedures, however minor, to be used across the whole organisation to ensure increased patient safety
- Implementation of a double checking system for any procedures when a guide wire is used to have assurance of complete removal of the wire
- Introduction of an additional validation check before releasing pathology results
- Development and introduction of a clinical skills training and competency assessment for nursing staff for the collection and labelling of blood samples
- Ensuring all district nurse referrals for equipment are now followed up with a telephone call to reduce the risk of delayed equipment

I saw the psychologist, the physiotherapist and the pain specialist and they were all superb. They clearly gel together and combine their specialties to enable them to diagnose the problem and recommend an overall approach to treatment.

3.3.4 Nursing Care Indicators

Every month, ten nursing records and the supportive documentation are checked at random in all general inpatient areas and specialist departments at the hospital, and in every nursing team in the community. A total of approximately 430 records are audited each month. The purpose of this audit is to ensure nursing staff are undertaking risk assessments, performing activities that patients require and accurately documenting what has taken place.

Following a review of the audit questions and the results being obtained, the audit template has been changed. From September 2014, the hospital audits were abridged, with the community process due to be changed from April 2015. Within the hospital, the previous themes assessed were: patient observations, pain management, manual handling, tissue viability, medications, documentation, nutrition, infection control, 'Think Glucose', bowels and fluid balance. The Trust decided to concentrate on six criteria: patient observations, manual handling, falls, tissue viability, nutrition and medications. The elements no longer included in the Nursing Care Indicator audits are now managed by the relevant specialist teams in the hospital, for example, Think Glucose is now managed by the diabetes team.

As can be seen in the tables below, the Trust now assesses eight criteria in the community and six in hospital. To allow us to capture practice for specialist areas, there are two variations of the audit tool in the community, and five variations in hospital.

Community results

The table below shows the year-end results for each of the criteria assessed by the community teams. During 2014, a review was undertaken and the questions within each of the individual criteria were amended slightly. Community results are very stable with little fluctuation month on month.

Criterion	Patient Observations	Pain	Manual Handling	Tissue Viability	Medications	Documentation	Privacy and Dignity	Nutrition
2011	97%	98%	94%	95%	99%	98%	99%	97%
2012	97%	98%	97%	97%	99%	98%	99%	97%
2013	97%	99%	97%	99%	98%	98%	99%	98%
2014	99%	99%	97%	100%	98%	97%	99%	99%
Difference from 2013 to 2014	▲2%	=	=	▲1%	=	▼1%	=	▲1%

Inpatient results

During 2014, a slight amendment has been made to the audit questions with a new criterion of 'Falls' added. The questions for this criterion had previously been included within the Manual Handling section. By looking at each of these areas separately, the Trust is able to focus on specific patient safety initiatives. Results continue to show improvements, with the largest in the patient observation theme (an increase of four per cent from the previous year). The largest improvement over the five years reported can be seen in Nutrition (an increase from 68 to 92 per cent).

Criterion	Patient Observations	Pain	Manual Handling	Tissue Viability	Medications	Documentation	Nutrition	Infection Control	Think Glucose	Bowels	Fluid Balances	Falls
2010	77%	70%	71%	86%	92%		68%	95%				
2011	83%	80%	79%	93%	94%	88%	77%	97%	53%	78%		
2012	86%	88%	85%	95%	94%	88%	82%	91%	79%	81%	77%	
2013	92%	95%	91%	95%	97%	90%	89%	94%	90%	87%	91%	
2014	96%		93%	97%	99%		92%					94%
Difference from 2013 to 2014	▲4%		▲2%	▲2%	▲2%		▲3%					

I am so grateful to the attentive care that all the staff gave us at a scary and worrying time.

The nurses were also brilliant including the lovely lady in the plaster clinic who fitted me with my boot and also the staff in the ultra sound department who did my scan.

3.3.5 Harm Free Care and NHS Safety Thermometer

The NHS Safety Thermometer has been developed as a 'temperature check' on four key harm events – pressure ulcers, falls that cause harm, urinary tract infections in patients with a catheter and new venous thromboemboli. It is a mechanism to aid progress towards harm free care and has been adopted across the whole of the NHS.

Each month, on a set day, an assessment is undertaken consisting of interviews with patients, accessing the patient's bedside nursing documentation and, when required, examining the main health record. On average, 650 adult inpatients (excluding day case patients and those attending for renal dialysis) and 620 patients being cared for in the community are assessed every month.

There are national trials of a paediatric and young person's safety thermometer and a maternity safety thermometer and the Trust is taking part in these trials.

The Trust regularly monitors its performance and, although direct comparisons need to be made with caution, it is pleasing to note its harm events fall below the national averages.

Some examples of actions being taken as a result of the assessments include:

- An ongoing formal escalation process for less than average results
- A formal review and upgrade of the intentional rounding throughout the Trust (a process of each patient being seen by a member of staff at set times which is documented) has been undertaken as a patient safety measure to improve patient to nurse contact and reduce the prevalence of falls.
- Catheter care bundles have been introduced and are now embedded within the organisation. Monitoring for compliance is undertaken by annual spot check audits.

I was looked after by support workers and nursing staff with care, consideration, dignity and nothing was too much for them to do.

3.3.6 Examples of specific patient safety initiatives

a) Simulation Centre

In December 2014, a new state-of-the-art simulation centre was officially opened by the Vice Dean of Birmingham Medical School, Professor Kate Thomas.

The Ron Grimley Undergraduate Simulation Centre at Russells Hall Hospital has been designed to offer a training environment as close to real life as possible, complete with mannequins, which mimic 'real' patient illnesses and responses to treatment. The area is made up of a fully functional two-bedded ward area which can also be adapted to become an operating theatre, complete with a working anaesthetic machine and piped oxygen, medical air and suction gases. The facility also boasts an echocardiogram simulator and a state of the art virtual fibrescope that allows anaesthetists to practise the skill of fibreoptic intubation.

Controlling the facility from behind the scenes is a team of simulation trainers who can replicate a variety of scenarios from a control room next to the simulation suite. They can control the mannequins' behaviours and replicate any number of medical conditions and clinical observations. The facility also has full audio and video recording, enabling staff and students to watch their sessions back afterwards and discuss their experience with training staff.

The area is already being used by medical students and foundation year doctors as part of their training programmes, and a training pilot with final year operating department practitioners and anaesthetic trainees also took place earlier during the year. A programme for final year nursing students and student operating department practitioners has just been developed, and the facility will be extended to multidisciplinary staff in the near future.

b) Mortality Tracking System

One technique we use to ensure patient safety is to systematically review the care and treatment of all patients who have died in the hospital to see if any lessons can be learned for the effective care and treatment of future patients. To allow us to do this in a timely and efficient manner, we have developed a web-based application. The systems, which captures information about deaths as soon as they are recorded, was shortlisted and placed in the finals of a top national award for the use of Information Technology to improve patient safety.

The Mortality Tracking System (MTS) solution allows all information and documentation surrounding each individual death to be readily accessible from one place so that it is ready for review and audit by clinical staff. The system also automatically sends emails to senior staff informing them of the number of deaths ready for review, completed, or escalated for further investigation.

c) Hip A.I.D (Assess, Investigate and Diagnose)

This project was launched in February 2015 and aims to enhance our service to all patients with possible hip fractures. Many of these patients are frail or elderly so it is important that the correct specialised treatment and care starts immediately, both for the general wellbeing of the patient, and to ensure that they are fit for surgery (which should occur as soon as possible after admission).

With regards to the latter point, in the last Falls and Fragility Fracture Audit Programme (FFFAP) National Hip Fracture Database Annual Report 2014, 83.2 per cent of patients at the Trust had surgery on the day of or day after admission (in all of the West Midlands hospitals this ranged from 84.7 per cent down to 40.5 per cent with over half of hospitals less than 70 per cent). The Trust realised, however, that it could do better to ensure patients were admitted to the orthopaedic ward as quickly as possible.

This project comprises of ambulance staff phoning ahead to the Emergency Department to inform them that a patient with a possible hip fracture is on the way. The specialist hip fracture practitioner then meets the patient on arrival, allowing the patient to be assessed immediately and, if the patient does not have any comorbidities (e.g. stroke), the patient is transferred immediately to the Radiology Department for an X-ray where a hip fracture is diagnosed. The patient is then taken directly to the orthopaedic ward (Ward B2) where orthopaedic nurses can begin the necessary care, and where specialist medical staff are based to treat the patient. Any delays such as waiting in the Emergency Department are avoided with patient safety being maintained at all times.

3.3.7 Patient safety measures

	Actual 2008/09	Actual 2009/10	Actual 2010/11	Actual 2011/12	Actual 2012/13	Actual 2013/14	Actual 2014/15
Patients with MRSA infection per 1000 bed days*	0.07	0.04	0.01	0.009	0.005	0.004	0
Never events – events that should not happen whilst in hospital Source: adverse incidents database	0	0	0	0	1	1	1
Number of cases of deep vein thrombosis presenting within three months of hospital admission	48	48	35	143**	117**	116**	102**

Due to the small rates of MRSA infections, figures are now expressed to three decimal places.

**Data source: Numerator data taken from infection control data system and denominator from the occupied bed statistics in patient administration system.*

NB: MRSA figure may differ from data available on HPA website due to different calculation methods and Trust calculations using most current Trust bed data.

***Previous data collection of Hospital Acquired Thrombosis (HAT) was identified through clinical codes alone. We found that this information was not always a true reflection for a variety of reasons including the fact that the available clinical codes for thrombosis are confusing and, in practice, misleading. Also, a majority of deep vein thrombosis (DVT) cases do not require readmission to hospital which results in further inaccuracies in data collection. To improve the accuracy of our data collection we now review all diagnostic tests for DVTs and pulmonary embolism (PE), cross referencing positive tests with past admissions. This methodology is only undertaken by relatively few hospitals as it is labour intensive, but is recognised as giving a more accurate figure for HAT. As a further check, we receive notification from the bereavement officer if PE was identified as the primary cause of death. As a result of amending our methods of identifying HAT, 2011/12 saw an increase in figures. As stated, this is down to better identification of cases.*

Everyone had so much patience and took time to answer my somewhat silly questions... They made me feel really relaxed and I went off to sleep feeling really happy to be in such good hands.

Clinical effectiveness

3.4 Do patients receive a good standard of clinical care?

3.4.1 Introduction

This section includes the various initiatives occurring at the Trust to ensure patients receive a good standard of care and examples of where we excel compared to other organisations.

3.4.2 Examples of awards received related to improving the quality of care

a) Frenulotomy service

The Trust's frenulotomy service. which cares for babies with ankyloglossia or tongue-tie, scooped a 'Highly Commended' certificate for its work and came runner up in the All Party Parliamentary Group Maternity (APPGM) Services Awards 2014 in the category of 'Most Effective Multidisciplinary Team'. The team was rewarded for its work in developing and offering the frenulotomy service to improve feeding for babies with tongue-tie and breastfeeding rates.

Head of Midwifery, Steph Mansell, said, "The frenulotomy service we offer at Russells Hall Hospital is unique and I am very proud of all the staff who have worked really hard to provide better maternity services for woman and babies in our community. This recognition is well deserved by everyone in the team."

Members of the team attended the awards ceremony at the House of Commons. The APPGM, which is serviced by the National Childbirth Trust charity, is a cross-party group that aims to highlight maternity issues within Parliament and bring together health professionals, service users and politicians.

b) Queen's Nurse

District Nurse Team Leader for OPAT (Outpatient Antimicrobial Therapy) Kate Owen was given the prestigious title of Queen's Nurse by the community nursing charity The Queen's Nursing Institute (QNI). The title is not an award for past service, but indicates a commitment to high standards of patient care, learning and leadership. Kate was presented with a badge and certificate by Jane Cummings, Chief Nursing Officer for England, at a ceremony at the Royal Garden Hotel in London

Crystal Oldman, Chief Executive of the QNI said, "Congratulations are due to Kate for her success. Community nurses operate in an ever more challenging world and our role is to support them as effectively as we can. The Queen's Nurse title is a key part of this and we would encourage other community nurses to apply."

c) National award for tissue viability

Clinical nurse specialist and lead nurse for tissue viability Lisa Turley received a national award for her presentation on the Trust's move to static air mattresses. She was presented with the only award of The Wounds UK Annual Conference – the Wounds UK Award of Excellence – for her paper on the Trust-wide changeover to the new mattresses. Her paper covered the move to static air mattresses from start to finish, covering the whole process from the initial decision making, training and planning, to the implementation, benefits for patients and cost savings.

Lisa said, "It's really nice to be recognised and to help you realise you've actually done a good job – it's a real confidence boost."

Rob Yates, Publishing Director of the WoundsGroup, said, "The judges felt that the quality of the work undertaken and the clear, positive health economic impact it demonstrated, was worthy of special mention and ultimately marked it out as a clear winner."

3.4.3 Examples of innovation

a) Ensuring radiological expertise is always available

With the national shortage of consultant radiologists and specialist medical staff with the expertise to interpret complex radiological investigations and suggest the appropriate treatment of patients, the Trust has taken the innovative step of obtaining that expertise using recent technological developments.

When emergencies occur, for example in the middle of the night, the tests are undertaken and the results sent electronically to London and onto Australia. The results are then interpreted and reported back in a 'follow the sun' manner. This ensures that the results of the tests are being interpreted and reported by consultants who are awake and alert, and not by on-call staff being woken up who may have worked throughout the previous day and are due to work the next day.

The expert interpretations and suggested treatments are returned electronically in a timely manner. The new system also means that reporting is done by dedicated specialists in that type of test. It also means that our own staff work efficiently as they are well rested and, therefore, more productive (not sleep deprived) and the service is provided in a cost effective manner. The effectiveness of the service is constantly monitored with a guaranteed turnaround time.

b) New equipment allowing improved assessment of surgical patients

A brand new machine that tests how well the body responds to exercise has been installed at Russells Hall Hospital to help consultants predict how well a patient will cope with surgery. This state-of-the-art Cardio Pulmonary Exercise Testing (CPET) machine evaluates how the heart, lungs and muscle simultaneously respond to exercise, mimicking the physiological stress on the body that surgery causes. The CPET machine tests are performed on a stationary bike and, as the patient cycles, consultants measure how much air they breathe, how much oxygen they require and how fast and efficiently their heart beats.

Adrian Jennings, consultant anaesthetist, said, “We are now able to accurately risk assess patients undergoing surgery. This is useful for clinicians as we can better direct care to each patient’s individual needs, for example, the type of anaesthetic and the type of postoperative care. Moreover, it is useful for patients who can better understand their surgical risk and make better informed decisions about their treatment opinions. In some cases, we may be able to optimise patients’ fitness further before they embark on surgery.”

In addition, the Trust has acquired a thrombelastography machine for theatres. This device allows clinicians to assess the clotting of blood in patients who are bleeding heavily, or have an underlying bleeding propensity. We can detect blood clotting problems more quickly and identify the cause. This allows treatment, usually blood transfusion, to be directed in an individualised way, ensuring patients only receive the minimum amount of blood products necessary. This reduces transfusion risk, allows blood clotting to be optimised and is cost effective.

c) Outdoor exercise

The Trust, Action Heart and Dudley MBC achieved a UK first when an outdoor gym facility was installed at Russells Hall Hospital in May 2014. The grand opening was attended by an international delegation from Portugal and has generated many enquiries within the UK.

The outdoor gym is to be used as a demonstration site for patients, stepping down from exercise rehabilitation, to be able to maintain their commitment to physical activity via one of the eight outdoor gyms that are strategically located in parks within Dudley Borough.

The Trust also hopes to lead the way in highlighting the importance of physical activity in good health by encouraging staff to use the outdoor gym (and other physical activities on site) and becoming appropriate role models for their patients.

3.4.4 Examples of specific clinical effectiveness initiatives

a) Cardiology One Stop Clinic

The Trust's Cardiology Department had a long-standing rapid access clinic for patients with chest pain who needed to be seen quickly as well as the usual outpatient (OPD) clinics. With the rising number of referrals and increasing waiting times, and with some patients being referred inappropriately to one of the two types of clinic, the department developed a one-stop clinic which helps to ensure that all patients receive a streamlined personalised effective service appropriate to their individual needs.

In collaboration with our GP colleagues, all patients are now referred into one place. The referral requires certain standard detailed information on the patient's condition, and all patients (except those with chest pain in order to avoid referral delay) to have had a heart trace undertaken (electrocardiogram – ECG). The referral information and the ECG trace allows specialist staff at the hospital to assess the best course of action:

1) Giving advice and guidance to the GP who will continue to see the patient
2) Arrange further open access investigations with specialist advice, with the results reported back to the GP
3) Ask the patient to attend the one stop clinic where a rapid assessment will be made and all necessary, non-invasive investigations will be carried out on the same day so that a plan of care can be put into place straightaway. On this pathway, priority is given to cardiac sounding chest pain, with other urgent referrals seen in two weeks or sooner if necessary
4) If the patient has a known previous or existing condition and there is no immediate concern, then a usual OPD clinic appointment is made.

This new system has resulted in a considerable drop in waiting times, improved access for those patients that need it and a more effective service overall.

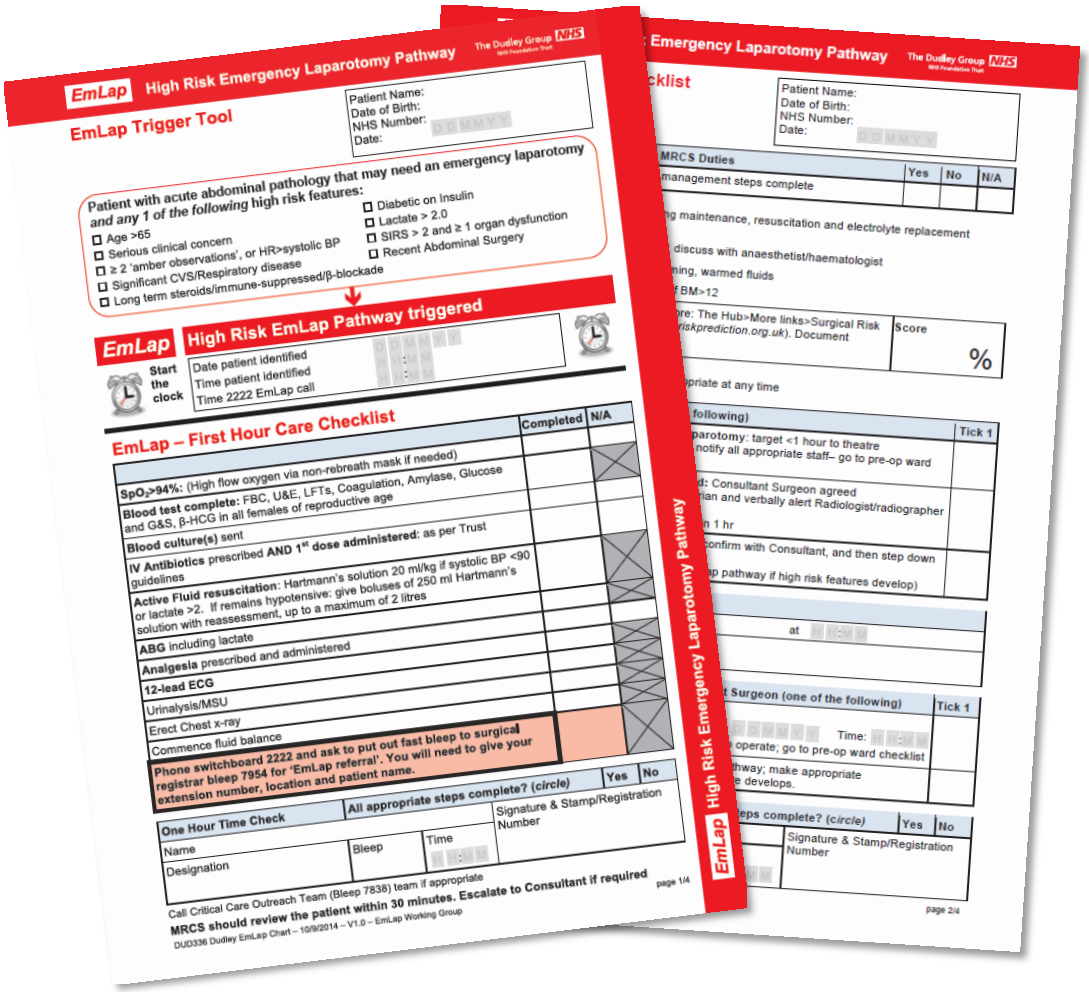
I have been in the Children's Ward twice in the last month... The care for both my son and myself was brilliant - nothing too much trouble for him or a timely hug or cup of tea for me.

b) Emergency Laparotomy Pathway (EmLap)

Patients who develop severe intra-abdominal problems can become very ill quickly; where this is due to a problem which can be corrected by surgery, many of these will need to undergo an emergency laparotomy. An emergency laparotomy is a high-risk surgical procedure that involves making an incision to provide access to the abdominal cavity, allowing the problem to be fully diagnosed and, where possible, corrected.

The longer the time between patients needing such an operation and it being carried out, the worse the outcome for the patient. Research indicates that patients who undergo an emergency laparotomy have more than a 10 per cent risk of dying within 30 days of their operation. For patients over 80 years old, the risk rises to more than 30 per cent. Many other patients will suffer post-operative complications, and have a prolonged hospital stay. However, reports do reveal a wide variation in care and outcomes, with mortality rates of up to 40 per cent. Some of this difference is related to the time between symptoms starting and the operation being performed.

To improve patient outcomes after an emergency laparotomy, an evidence based quality improvement care bundle known as the EmLap Pathway has been developed. The bundle enables prompt identification, assessment, resuscitation and operation. It also identifies how staff can ensure the most effective escalation of care so these high risk patients are cared for by the right people, in the right place at the right time. Other hospitals recently commencing such a scheme have shown a reduction in 30 day mortality by up to 50 per cent.



3.4.5 Clinical effectiveness measures

	Actual 2007/08	Actual 2008/09	Actual 2009/10	Actual 2010/11	Actual 2011/12	Actual 2012/13	Actual 2013/14#	Actual 2014/15
Trust readmission rate for surgery Vs Peer group West Midlands SHA Source: CHKS Insight	4.6% Vs 4.1%	3.9% Vs 4.3%	4.1% Vs 4.2%	4.4% Vs 4.7%	5.6% Vs 5.0%	6.1% Vs 6.8%	6.4%* Vs 7.1%	6.7%^* Vs 7.2%
Number of cardiac arrests Source: Logged switchboard calls	397	250	170	145	119	126	158	189
Elective admissions where the planned procedure was not carried out (not patient decision) Vs Peer group West Midlands area Source: CHKS insight	N/A	2.0% Vs 1.6%	1.4% Vs 1.6%	1.4% Vs 1.3%	0.67% Vs 1.1%	0.68% Vs 1.2%	0.75% Vs 0.8%	0.86%^ Vs 0.9%

^April 2014 to November 2014. NOTE: DGNHSFT no longer contract to CHKS Ltd for benchmarking information. The date range used is the latest included by CHKS from HES Data. These measures will not be available in the 2015/16 report.

**Specialties included in the surgical directorate changed during 2013/14 which has affected the figures compared to previous years and the peer group.*

#The percentage rates for 2013/14 are for the full year and so are different to the partial year figures printed in last year's report.

I would like to thank the consultant and his team for the excellent care I received. All his team were kind and respectful. The treatment and care was exceptional.

3.5 Our performance against key national priorities across the domains of the NHS outcomes framework

National targets and regulatory requirements	Trust 2009/10	Trust 2010/11	Trust 2011/12	Trust 2012/13	Trust 2013/14	Target 2014/15	National 2014/15	Trust 2014/15	Target Achieved/ Not Achieved
1. Access									
Maximum time of 18 weeks from point of referral to treatment (admitted patients)	95.8%	97.03%	95.7%	96.1%	93.95%	**90%**	**88.6%**	**91.59%**	☺
Maximum time of 18 weeks from point of referral to treatment (non-admitted patients)	99.1%	99.2%	99.2%	99.5%	99.18%	**95%**	**95.4%**	**98.71%**	☺
Maximum time of 18 weeks from point of referral to treatment (incomplete pathways)	N/A	N/A	N/A	98.1%	96.74%	**92%**	**93.2%**	**95.43%**	☺
A&E: Percentage of patients admitted, transferred or discharged within 4 hours of arrival	98.1%	98.8%	97.27%	95.4%	93.74%	**95%**	**93.6%**	**94.68%**	☹
A maximum wait of 62 days from urgent referral to treatment of all cancers	86.5%	87%	88%	88.7%	89%	**85%**	**83.4%**	**85.6%**	☺
All cancers: 62 day wait for first treatment from national screening service	N/A	99.6%	96.6%	99.4%	99.6%	**90%**	**93.2%**	**97.3%**	☺
All cancers: 31 day wait for second or subsequent treatment: surgery	N/A	99.6%	99.6%	99.2%	100%	**94%**	**95.7%**	**99.6%**	☺
All cancers: 31 day wait for second or subsequent treatment: anti-cancer drug treatments	N/A	100%	100%	100%	100%	**98%**	**99.6%**	**100%**	☺
A maximum wait of 31 days from diagnosis to start of treatment for all cancers	99.3%	99.8%	99.7%	99.5%	99.9%	**96%**	**97.7%**	**99.7%**	☺
Two week maximum wait for urgent suspected cancer referrals from GP to first outpatient appointment	98%	96.8%	97.2%	96.2%	97.5%	**93%**	**94.2%**	**97.1%**	☺
Two week maximum wait for symptomatic breast patients	69%	98.2%	99%	98.1%	98.2%	**93%**	**93.3%**	**96%**	☺
2. Outcomes									
Certification against compliance with requirements regarding access to healthcare for people with a learning disability	N/A	N/A	Compliant	Compliant	Compliant	Compliant	-	Compliant	☺
Data Completeness for community services: Referral to treatment information#	N/A	N/A	N/A	97.3%	98.4%	**50%**	**+**	**99.6%**	☺
Data Completeness for community services: Referral information#	N/A	N/A	N/A	65.6%	64.6%	**50%**	**+**	**90.7%**	☺
Data Completeness for community services: Treatment activity information#	N/A	N/A	N/A	99.1%	100%	**50%**	**+**	**100%**	☺

N/A applies to targets not in place at that time
– applies to national figures not being appropriate
+ applies to national figures not available

☺ = Target achieved
☹ = Target not achieved
Latest monthly figure for March of the financial year

3.6 Glossary of terms

A&E	Accident and Emergency (also known as ED)
AAA	Abdominal Aortic Aneurysm
ADC	Action for Disabled People and Carers
BBC CRLN	Birmingham and Black Country Comprehensive Local Research Network
Bed Days	Unit used to calculate the availability and use of beds over time
BHF	British Heart Foundation
C. diff	Clostridium difficile (C. difficile)
CCG	Clinical Commissioning Group
CD4	Glycoprotein found on the service of immune cells
CEM	College of Emergency Medicine
CHKS Ltd	A national company that works with trusts and provides healthcare intelligence and quality improvement services
CNS	Clinical Nurse Specialist
COPD LES	Chronic Obstructive Pulmonary Disease Local Enhanced Services
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation payment framework
DATIX	Company name of incident management system
DVD	Optical disc storage format
DVT	Deep Vein Thrombosis
EAU	Emergency Assessment Unit
EBMT	European Society for Blood and Marrow Transplantation
ED	Emergency Department (also known as A&E)
EGFR	Epidermal Growth Factor Receptor
ENT	Ear, Nose and Throat
ERCP	Endoscopic Retrograde Cholangio-Pancreatography
FCE	Full Consultant Episode (measure of a stay in hospital)
GP	General Practitioner
HASC	Health and Adult Social Care Scrutiny Committee
HAT	Healthcare Acquired Thrombosis
HCA	Healthcare Associated Infections
HDU	High Dependency Unit
HED	Healthcare Evaluation Data
HES	Hospital Episode Statistics
HIV	Human Immunodeficiency Virus
HQIP	Healthcare Quality Improvement Partnership
HSCIC	Health and Social Care Information Centre
HSMR	Hospital Standardised Mortality Ratio
HTA	Human Tissue Authority

IBD	Irritable Bowel Disease
ICNARC	Intensive Care National Audit & Research Centre
ISCT	International Society for Cellular Therapy
LINK	Local Involvement Network
MBC	Metropolitan Borough Council
MESS	Mandatory Enhanced Surveillance System
MINAP	Myocardial Ischaemia National Audit Project
Monitor	Independent regulator of NHS Foundation Trusts
MRI	Magnetic Resonance Imaging
MRSA	Meticillin-resistant *Staphylococcus aureus*
MUST	Malnutrition Universal Screening Tool
NCEPOD	National Confidential Enquiry into Patient Outcome and Death
NCI	Nursing Care Indicator
NICE	National Institute for Health and Care Excellence
NIHR	NHS National Institute for Health Research
NIV	Non Invasive Ventilation
NNAP	National Neonatal Audit Programme
NOF	Neck of Femur
NPSA	National Patient Safety Agency
NSL	The Trust's non-emergency patient transport provider from 01/04/2015
NVQ	National Vocational Qualification
OSC	Overview and Scrutiny Committee
PEAT	Patient Environment Action Teams
PFI	Private Finance Initiative
PROMs	Patient Reported Outcome Measures
RAG	Red/Amber/Green
ROSE	Rivaroxaban Observational Safety Evaluation
SHMI	Summary Hospital-level Mortality Indicator
SKIN	Surface, Keep Moving, Incontinence and Nutrition
SLT	Speech and Language Therapy
SUS	Secondary Uses Service
TARN	Trauma Audit and Research Network
TEAMM	Tackling Early Morbidity and Mortality in Myeloma
VTE	Venous Thromboembolism
WHO	World Health Organisation
WMAS	West Midlands Ambulance Service

Annex

Comment from Dudley MBC Overview and Scrutiny Committee (received 8/04/2015)

The Committee has a role in ensuring the effective planning, development and delivery of quality services across Dudley's patient population by holding system leaders accountable for their performance.

Members recently had occasion to review outcomes against 2014/15 priorities initially consulted on early 2014/15 along with improvement areas moving into 2015/16 and welcomed the opportunity to participate and express strong views through this process. Resultant issues and findings will be factored into the development of the committee's 2015/16 work plan.

The Committee is heartened by sustained commitment to patient experience supported by implementation of recommendations associated with the Committee's previous Dignity In Care review, Healthwatch collaboration and success in the outcomes of Friends and Family Test measures.

Continued focus on mortality tracking with the use of an associated innovative information technology tool and establishing zero tolerance approaches to pressure ulcers is also welcomed; members support the Trust's decision to continue mortality and pressure ulcer reduction as distinct priorities.

The document clearly demonstrates an organisation committed to continuous improvement across patient experience, clinical effectiveness and safety and overall the Trust should be commended on the range of improvements attained throughout 2014/15.

The Committee will remain watchful to ensure the Trust will continues maximise opportunities with system partners to secure further improvements for Dudley communities during 2015/16.

Comment from the Dudley Clinical Commissioning Group (received 2/4/2015)

The CCG is pleased to note the continued focus on quality by the Trust and there are many areas of improvement and good practice to be noted.

The work the Trust has done to gather patient experience data and the development of a patient experience 'app' to be launched in 2015 is commendable as this will provide another platform for patients and the public to share their views. The business cards and posters developed by the Trust to advise patients / public how to raise a concern, compliment or complaint is reassuring. The Trust is to be commended for having consistently received positive feedback from patients through the national "Friends and Family Test".

The CCG has undertaken two unannounced visits to the Trust's clinical areas, one in August 2014, when the visiting team found some areas of concern, which they told the Trust about and which have been dealt with promptly. A further visit was done in March 2015 and the visiting team concluded that no immediate patient safety risks were found, in fact the visiting team observed a range of good practice and passionate and interested staff entirely focused on giving the best possible care to patients.

The Trust has in place a robust mortality tracking system to enable each specialty to review in-hospital deaths. Most specialities are doing well with standard set by the Trust, however several are not and this is a cause of concern to the CCG although it must be noted that the Trust is not an outlier against national mortality indicators.

The Trust has worked hard to improve its performance against the A&E four-hour standard and is one of the best performing Trusts nationally in this area. In March 2015, a new Urgent Care Centre opened at Russells Hall Hospital. This was following a major public consultation by Dudley CCG regarding the redesign of urgent care across the borough with the support of both the Trust and Dudley Health and Wellbeing Board. This new facility is enabling the Trust to provide significant advancements in service and better co-ordinated care with the rest of the local health and social care system in Dudley.

The work on ensuring timely and accurate electronic discharge letters is on-going, following problems in December 2014; however, the Trust is making progress to remedy the situation working closely with GP members of the CCG.

The Trust is taking a significant amount of posts out of the organisation, the CCG has requested quality impact assessments for these from the Trust - at the time of writing this commentary none have been received. The CCG has been assured, however, that a robust process is in place to mitigate any risks to quality, led by the Trust Medical Director and Nurse Director.

The CCG and Trust use a broad range of objective indicators of quality, which together with wider intelligence is proving to be a robust system to assure the wider public of the quality of services. In reading this account the Trust appears to be very hospital centric - the CCG would like to see a greater emphasis on community provision, population focused services and outcomes based measures including further work on Patient Reported Outcome Measures.

Finally, the CCG will work with the Trust in ensuring that the people of Dudley are able to access services of the highest quality that are evidence based and ensure seamless care without organisational boundaries.

Paul Maubach

Chief Executive Officer

Comment from the Trust's Council of Governors (received 2/04/2015)

Governors have worked with the Trust and held the non-executive directors to account for the performance of the Board during a year of financial austerity with further financial pressures in the NHS and increasing demands on Trust services. We note the successful involvement of the Trust in many clinical audits and research trials, and the success of both hospital and community nurses and midwives in winning national awards.

Governors fully support the Chief Executive's Statement in Section 1 of this report and note, in particular, positive comments on the outcomes of the March 2014 Care Quality Commission inspection, the excellent progress with the majority of the Trust's 2014/15 Quality Priorities and the emphasis on quality of care and patient experience.

Governors have further embedded their involvement in Trust governance activity including Ward Walk Rounds with Trust directors and membership of Trust working groups for Patient Experience and for Quality and Safety, both of which report directly to Board Committees. Governors regularly meet executive and non-executive directors both in Council Committee meetings and in update/discussion sessions. Governors are kept well informed by the Board about all aspects of Trust activity and performance.

We are pleased to note the effectiveness of listening to patients as a fundamental part of improving quality at the Trust. A great deal of patient feedback is acquired and analysed carefully. Formal feedback is very positive. Improvements embedded made during the year include a revised complaints process, and re-organisation of the complaints and PALS provision. Trials of new patient food menus have been well-received. It should be noted that wards and staff receive numerous compliments, verbal and written, every year and that hospital inspectors found staff to be very caring.

Governors have met many patients, members of the public and community groups during the year and gained direct feedback about the quality of services and patient experience. Governors find that users' views of clinical treatment and the care provided by our nurses, doctors and other staff is very positive. This is reflected in the above average Friends and Family Test scores achieved by the Trust compared to national benchmarks.

In common with many trusts, failure to meet the A&E four hour target had been of concern for some time. It is very pleasing to note that measures to improve the flow of patients through the hospital have been very effective. The Trust has achieved among the best outcomes nationally in recent months and were very close to achieving the national target of 95 per cent in 2014/15. Governors have strongly supported the development of the new Urgent Care Centre at Russells Hall Hospital scheduled to open in April 2015. This should result in a more appropriate service for all patients and a reduction in waiting and treatment times.

Governors have also seen excellent working with our commissioners and other partners to ensure we continue to improve health services across Dudley. This includes projects such as working with the Dudley Clinical Commissioning Group and Dudley Metropolitan Borough Council to develop integrated care teams.

The process used to ratify the Trust's choice of Quality Priorities gives a wide range of patients, members, governors, staff and other interest groups the opportunity to be involved and to influence choice of priorities. While detail is given in section 2 of this report of the 2014/15 priorities, governors are pleased to note excellent progress and particularly the success in meeting targets for Infection Control, Nutrition, Hydration and Mortality. The Priority target measures for in-hospital call bell answering times and the slight decline in the community performance concerning patient awareness of raising concerns is disappointing. Governors are very pleased to see that the continued focus on pressure ulcers has resulted

in a commendable and dramatic decrease in avoidable pressure ulcers in hospital and the maintenance of very low numbers in the community. Equally the success of the continued focus on reducing hospital associated infections is notable. Commendably, the Trust has met all other key national priority targets.

During 2014/15 the Council of Governors carried out its own annual development review and in consultation with the Board of Directors reviewed the responsibilities of its committees. These will change somewhat in 2015/16 to give further emphasis to patient experience, the quality and safety of services and a renewed focus on membership engagement. These changes will ensure that governors have the information and assurance they need to hold the non-executive directors to account for the performance of the Board of Directors. Governors will maintain their focus on Trust governance and strategic direction.

In summary, the Trust operates under increasing pressure. The growing demands of an ageing population and efficiency measures have to be met while protecting the quality of services and care and safety of patients. That all staff demonstrate such high levels of care and commitment is to be commended. On behalf of patients, carers and the public, governors again wish to place on record their recognition and enormous appreciation of the commitment and excellent work done by staff at all levels in the Trust.

Comment from Healthwatch Dudley (received 2/4/2015)

Healthwatch Dudley can see that The Dudley Group NHS Foundation Trust has worked hard to meet quality improvement priorities as highlighted in the summary of their 2014/15 annual quality accounts.

We can see that progress has been made with capturing patient experiences and there have been a number of developments on the Patient Experience Group. Whilst we can see that the patient experience priority, with strands within the hospital and the community have not been fully achieved, we feel reassured that the Trust is committed to listening to the experiences of patients to improve services. It is important to us that driving improvement in these areas continues across the whole Trust looking forward.

Healthwatch Dudley feels that it is important for the Trust to continue to have a positive relationship with our organisation. This will help ensure that the views of patients and local people are listened to and taken into account, to improve patient experience across all areas of operation.

In 2015/16 we are looking forward to the introduction and development of services including:

- A review of appointment and discharge letters to ensure that patients receive information about who to contact if they are worried after treatment and how to raise a concern. We would welcome an opportunity to review this area in detail.
- The development and introduction of a new patient experience feedback app.
- Helping patients and hospital visitors to be better connected through the introduction of Wi-Fi across the sites.

Jayne Emery

Healthwatch Dudley Chief Officer

Statement of directors' responsibilities in respect of the quality report 2014/15

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year.

Monitor has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation trust boards should put in place to support the data quality for the preparation of the quality report.

In preparing the Quality Report, directors are required to take steps to satisfy themselves that:

- the content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2014/15 and supporting guidance;
- the content of the Quality Report is not inconsistent with internal and external sources of information including:
    - board minutes and papers for the period April 2014 to March 2015
    - papers relating to Quality reported to the board over the period April 2014 to March 2015
    - feedback from commissioners dated 2/4/2015
    - feedback from governors dated 2/4/2015
    - feedback from the local Healthwatch organisation dated 2/4/2015
    - feedback from Overview and Scrutiny Committee dated 8/4/2015
    - the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 28/4/2015
    - the latest national patient survey sampling patients from July 2014
    - the latest national staff survey dated 2014
    - the Head of Internal Audit's annual opinion over the trust's control environment dated 31/3/2015
    - CQC Intelligent Monitoring Report dated December 2014
- the Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered;
- the performance information reported in the Quality Report is reliable and accurate;

- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice;

- the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and

- the Quality Report has been prepared in accordance with Monitor's annual reporting guidance (which incorporates the Quality Accounts regulations) (published at www.monitor.gov.uk/annualreportingmanual) as well as the standards to support data quality for the preparation of the Quality Report (available at www.monitor.gov.uk/annualreportingmanual).

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Report.

By order of the board

Signed **Date: 12th of May 2015**

David Badger
Chairman

Signed **Date: 12th of May 2015**

Paula Clark
Chief Executive

Independent Auditor's Report to the Council of Governors of The Dudley Group NHS Foundation Trust on the Quality Report

We have been engaged by the council of governors of The Dudley Group NHS Foundation Trust to perform an independent assurance engagement in respect of The Dudley Group NHS Foundation Trust's quality report for the year ended 31 March 2015 (the 'Quality Report') and certain performance indicators contained therein.

This report, including the conclusion, has been prepared solely for the council of governors of The Dudley Group NHS Foundation Trust as a body, to assist the council of governors in reporting The Dudley Group NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2015, to enable the council of governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body and The Dudley Group NHS Foundation Trust for our work or this report, except where terms are expressly agreed and with our prior consent in writing.

Scope and subject matter
The indicators for the year ended 31 March 2015 subject to limited assurance consist of the national priority indicators as mandated by Monitor:

- 18 week referral to treatment – incomplete pathway; and
- Maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers.

We refer to these national priority indicators collectively as the 'indicators'.

Respective responsibilities of the directors and auditors
The directors are responsible for the content and the preparation of the quality report in accordance with the criteria set out in the 'NHS foundation trust annual reporting manual' issued by Monitor.

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- the quality report is not prepared in all material respects in line with the criteria set out in the 'NHS foundation trust annual reporting manual';
- the quality report is not consistent in all material respects with the sources specified below:
    - board minutes for the period April 2014 to March 2015;
    - papers relating to quality reported to the board over the period April 2014 to March 2015;
    - feedback from Commissioners, dated 02/04/2015;
    - feedback from governors, dated 02/04/2015;
    - feedback from local Healthwatch organisations, dated 02/04/2015;
    - feedback from Overview and Scrutiny Committee, dated 08/04/2015;
    - the Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 28/04/2015;
    - the national patient survey, dated 2014;
    - the national staff survey, dated 2014;
    - Care Quality Commission Intelligent Monitoring Report dated December 2014;

- the Head of Internal Audit's annual opinion over the Trust's control environment dated 31/03/2015; and
- any other information included in our review.

- the indicators in the quality report identified as having been the subject of limited assurance in the quality report are not reasonably stated in all material respects in accordance with the 'NHS foundation trust annual reporting manual' and the six dimensions of data quality set out in the 'Detailed guidance for external assurance on quality reports'.

We read the quality report and consider whether it addresses the content requirements of the '*NHS foundation trust annual reporting manual,* and consider the implications for our report if we become aware of any material omissions.

We read the other information contained in the quality report and consider whether it is materially inconsistent with the documents listed above and specified in the detailed guidance for external assurance on Quality Reports.

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with those documents (collectively the 'documents'). Our responsibilities do not extend to any other information.

We are in compliance with the applicable independence and competency requirements of the Institute of Chartered Accountants in England and Wales (ICAEW) Code of Ethics. Our team comprised assurance practitioners and relevant subject matter experts.

Assurance work performed
We conducted this limited assurance engagement in accordance with International Standard on Assurance Engagements 3000 (Revised) – 'Assurance Engagements other than Audits or Reviews of Historical Financial Information' issued by the International Auditing and Assurance Standards Board ('ISAE 3000'). Our limited assurance procedures included:

- Evaluating the design and implementation of the key processes and controls for managing and reporting the indicators;
- Making enquiries of management;
- Testing key management controls;
- Limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation;
- Comparing the content requirements of the 'NHS foundation trust annual reporting manual' to the categories reported in the quality report; and
- Reading the documents.

A limited assurance engagement is smaller in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

Limitations
Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different, but acceptable measurement techniques which can result in materially different measurements and can affect comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision of these

criteria, may change over time. It is important to read the quality report in the context of the criteria set out in the 'NHS foundation trust annual reporting manual'.

The scope of our assurance work has not included testing of indicators other than the two selected mandated indicators, or consideration of quality governance.

Conclusion
Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2015:

- the quality report is not prepared in all material respects in line with the criteria set out in the 'NHS foundation trust annual reporting manual';

- the quality report is not consistent in all material respects with the sources specified in Monitor's Detailed Guidance for External Assurance on Quality Reports 2014/15; and

- the indicators in the quality report subject to limited assurance have not been reasonably stated in all material respects in accordance with the 'NHS foundation trust annual reporting manual'.

Deloitte LLP
Chartered Accountants
Birmingham
21 May 2015

This leaflet can be made available in large print, audio version and in other languages, please call 0800 073 0510.

للحصول على هذه النشرة بحجم أكبر، وعلى شكل إصدار صوتي و بلغات أخرى، الرجاء الاتصال بالرقم 08000730510.

此宣传单可提供大字版本、音频版本和其它语言版本，请拨打电话：0800 073 0510。

Ulotka dostępna jest również w dużym druku, wersji audio lub w innym języku. W tym celu zadzwoń pod numer 0800 073 0510.

ਇਹ ਪਰਚਾ ਵੱਡੇ ਅੱਖਰਾਂ, ਬੋਲ ਕੇ ਰੀਕਾਰਡ ਕੀਤਾ ਹੋਇਆ ਅਤੇ ਦੂਸਰੀਆਂ ਭਾਸ਼ਾਵਾਂ ਵਿਚ ਵੀ ਪ੍ਰਾਪਤ ਹੋ ਸਕਦਾ ਹੈ, 0800 073 0510 ਤੇ ਫੋਨ ਕਰੋ ਜੀ।

Aceasta brosura poate fi pusa la dispozitie tiparita cu caractere mari, versiune audio sau in alte limbi, pentru acest lucru va rugam sunati la 0800 073 0510.

یہ کتابچہ آپ کو بڑے حروف کی لکھائی ، سمعی صورت اور دیگر زبانوں میں مہیا کیا جا سکتا ہے۔برائے مہربانی فون نمبر 08000730510پر رابطہ کریں۔