The Dudley Group NHS
NHS Foundation Trust

Quality Report 2013/14

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Contents

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

Part 1: Chief Executive's statement

I am again delighted to introduce the annual Quality Report and Account, the purpose of which is to give a detailed picture of the quality of care provided by our hospitals and adult community services. This report covers the year from April 2013 to the end of March 2014.

Our primary aim is to provide high quality 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

In this report we have used these three elements to describe the quality of care at the Trust over the year. We have given an overall picture of what the organisation is achieving and where it still needs to improve.

Following on from this introduction, in Part 2 of this document 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 eight, more information on each priority can be found on the page numbers listed in the table. This includes progress made to date, as well as our new targets for 2014/15. 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 listed above which hopefully give a rounded view of what is occurring across the whole of the Trust. As we are an integrated acute and community care provider, you will see some parts of the report are divided into hospital and community sections for ease of reference or where the priorities are measured differently.

Many of you will know that the Trust was in the spotlight during the year when it was named as one of the 14 chosen to be part of the Sir Bruce Keogh Review. Inclusion was based on having higher than expected mortality indicators for two consecutive years, although the Trust's figure was within the expected range for the HSMR, one of the two key mortality indicators, at the time of the review. Both mortality indicators (SHMI and HSMR) have continued to improve consistently for the Trust and are now within the expected range. It is worth noting that these indicators are not designed or intended to identify 'unnecessary' or 'excess' deaths nor do they measure quality and safety. They are seen to act as a "warning sign" or "smoke-alarm" for potential quality problems, although even this has been disputed recently.

The Keogh investigation looked very broadly and intensely at the quality of care and treatment provided at the Trust. The detailed review considered our performance across five other areas as well as mortality: patient experience, safety, workforce, clinical and operational effectiveness together with leadership and governance. I was pleased that the review team did not find any areas of major concern that warranted further escalation and the Trust was one of only two of the 14 not placed in special

measures. This is testament to the hard work and commitment of all our staff and the pride they take in delivering the best possible care to our patients. As the review has been one of the most far reaching and detailed inspections the Trust has ever experienced, it gives us confidence that we are providing good quality of care whilst recognising the areas where we can do better. Following the review, we established and implemented an action plan for those areas where it was indicated that we could make improvements.

As well as the Keogh Review, we are monitored by a variety of other external organisations and agencies and we are constantly monitoring ourselves on the quality of our care in a variety of ways in order both to assure patients and ourselves of where we are doing well and to learn where we need to change practice and improve our services.

In late March 2014, towards the very end of the year covered by this report, the Trust was visited by the Care Quality Commission as part of its new inspection process and although, at the time of writing, we have not received formal feedback I can assure everyone that we will fully implement any recommendations made. We believe the wide range of measures and checks detailed here indicate that the overall quality of care delivered at The Dudley Group is good and in line with that of other similar Trusts both locally and nationally.

Our quality priorities

You will see in the following pages that we have performed quite well with some of our 2013/14 priorities. The successful priorities relate to positive patient experience feedback of our hospital, further substantially reducing serious pressure ulcers in the hospital and community and some improved nutrition and fluid intake care. However, we acknowledge that all of our targets have not been met. For instance, although we had a reduction in Clostridium Difficile cases from last year, we did not meet the ambitiously set target for the year and we had one case of MRSA bacteraemia a few days prior to the end of the year.

With regards to 2014/15, we have retained all of the topics from 2013/14 due to their importance from both a patient and organisational perspective and due to some of the targets not being met. Following the discussion on mortality indicators above and due to a specific recommendation from the Keogh Review we have added this important topic as a further priority.

Measuring quality

The 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.

I am especially pleased to report that the Trust is receiving positive feedback from our inpatients, mothers on the 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 our midwives won a Royal College of Midwives

Annual Midwifery Award, and we have gained a substantial grant to work with our partners to improve palliative care (Section 3.4.2).

I hope you will find useful this information on the quality priorities we have chosen to focus on, the ways in which we assure ourselves of the quality of care and a selection of the targets, both national and local, we use to form 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 regular Trust newsletter, Your Trust, and publish quarterly updates on the progress with our quality priorities both in the newsletter and on our website.

I can confirm that, to the best of my knowledge, the information contained in this document is accurate.

Signed **Date: 13th of May 2014**

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 2014/15.

Priority	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	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	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	Priority 2	New in 2011/12 See page 15 for more information
Infection control Reduce our MRSA rate in line with national and local priorities.	Achieved	Achieved	Achieved	Achieved	Not achieved	Priority 3	See page 20 for more information
Reduce our Clostridium Difficile rate in line with local and national priorities.			Not achieved	Achieved	Not 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	Priority 4	New in 2012/13 See page 23 for more information
Hydration Increase the number of patients who have their fluid balance charts monitored.	N/A	N/A	N/A	Achieved	Achieved	Priority 5	New in 2012/13 See page 23 for more information
Mortality Improve reviews of hospital deaths.	N/A	N/A	N/A	N/A	N/A	Priority 6	New in 2014/15 See page 28 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	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	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 2014/15

The Quality Account Priorities for 2013/14 covered the following five topics:

Patient Experience

Infection Control

Pressure Ulcers

Nutrition

Hydration

These topics were agreed by the Board of Directors on the basis of their importance both from a local perspective (e.g. based on complaints, results of Nursing Care Indicators (see Section 3.3.4)) and a national perspective (e.g. reports from national bodies e.g. Age UK, CQC findings etc.). These topics were 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).

Patient experience is at the core of why the Trust exists. The Trust is committed to reducing infection rates which is central to providing good patient care and is a key commissioner and patient requirement. There are national campaigns of zero tolerance to pressure ulcers and the need to focus on patients' nutrition and hydration.

It has been agreed that the same priorities will be retained in 2014/15 as they are fundamental to patient care and not all targets were achieved in 2013/14. In addition, the recent Keogh Review suggested that the Trust should include mortality indicators as a further priority and this has been agreed by the governors and Board of Directors.

As well as gaining the governors' views on the priority topics, a questionnaire was devised that has been made available both at a Trust open day and on the Trust website. On the website, the questionnaire was made available to all members of the public, and local statutory and voluntary bodies were informed that their views were also welcome using this process. The responses received generally endorsed the decisions made above.

"To the doctors and consultants – you were superb in your diagnosis and subsequent treatment. I can only thank you all for listening to me and for easing my concerns for my future."

2.1.3 Our priorities

Priority 1 for 2013/14: Patient experience

Patient experience	
Hospital	**Community**
a) Maintain an average score of 85 or above throughout the year for patients who report receiving enough assistance to eat their meals. b) By the end of the year, at least 80 per cent of patients will report that their call bells are always answered in a reasonable time.	a) Increase the number of patients who use their Single Assessment Process folder/Health and Social Care Passport to monitor their care from 49.4 per cent to 80 per cent by the end of the year. b) Increase the number of patients who would know how to raise a concern about their care and treatment if they so wished from 86.8 per cent to 90 per cent by the end of the year.

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 2013/14, 1440 patients participated in the surveys. All surveys are anonymous and results are shared with individual wards enabling them to take action on 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; 668 responses to the survey were received, with question (a) answered by 261 respondents and (b) answered by 615. The reason for the difference in respondents is that not all patients have a Single Assessment Process folder, which is a useful communication document used by all staff from all services that contribute to the care and management of people with long term conditions.

Developments that occurred in 2013/14

- The hospital patient experience quality priority was included in the newly developed Quality Outcome Measures Dashboard, a list of key quality indicators, to give lead nurses and matrons timely feedback.
- Three nutritional support workers were appointed on ward A2 which now means there are two wards with such assistance.
- Investigations into the possibility of introducing a more automated system of ensuring that patients and staff are forewarned about mealtimes rather than the use of hand bells were undertaken; however, current solutions appear cost prohibitive – we will continue to investigate options.
- A recruitment event was held to increase the number of volunteers trained to provide mealtime assistance – 35 volunteers were recruited and are now undergoing induction.
- Details around the welcoming of family members to assist their relatives at mealtime, if they wish to do so, were included in our Welcome to the Ward leaflets.
- Internal reporting processes strengthened where a patient reports not receiving enough assistance to eat.
- A pilot is underway on our surgical wards for a 30 second response time to answering call bells, including information posters displayed to advise patients of what can be expected.
- The final version of the new Health and Social Care Passport to improve information sharing between the patient, carers and health and social care professionals has been agreed and signed off by all stakeholders and printing quotes are being obtained. An information leaflet will accompany the launch of this new document which will replace the Single Assessment Process Folder.
- The annual survey of community services was extended to include a question on reasons for patients choosing not to use the document to monitor their care.

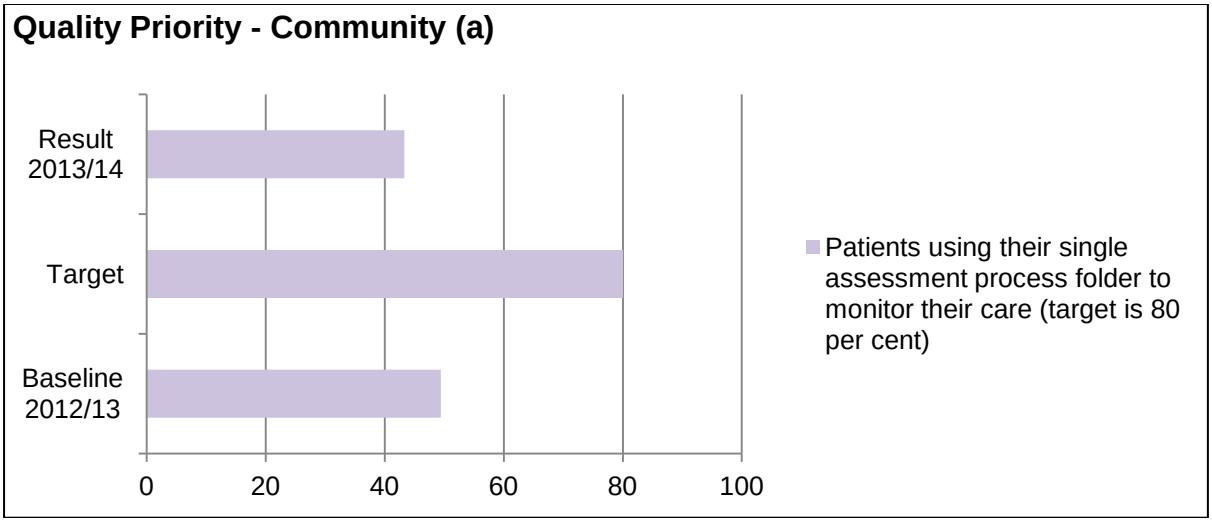
Current status: Hospital

Quality priority hospital (a)	Q1	Q2	Q3	Q4	2013/14
Maintain an average score of 85 or above throughout the year for patients who report receiving enough assistance to eat their meals	77.3	77.6	81.2	91.7	**81.8**
Number of patients who felt that they sometimes or never get the help that they needed	3 (out of 326 surveyed)	9 (out of 429 surveyed)	3 (out of 359 surveyed)	2 (out of 326 surveyed)	**17 (out of 1440 surveyed)**
Quality priority hospital (b)	**Q1**	**Q2**	**Q3**	**Q4**	**2013/14**
By the end of the year at least 80 per cent of patients will report that their call bells are always answered in a reasonable time	89.2	89.1	89.4	86.5	**88.6**

It can be seen that although there has been a recent improvement in the figures, the Trust has not met the target relating to patients' perceptions of receiving enough assistance to eat their meals (target 85 with actual figure of 81.8).

With regards to the call bell target, this has been achieved for the year as a whole.

Current status: Community

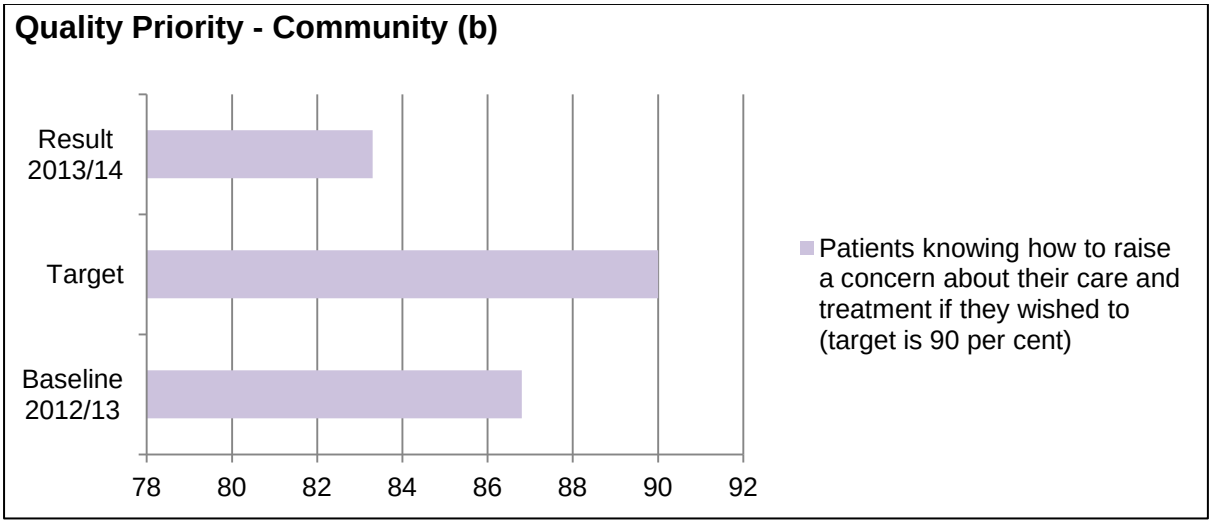


It can be seen on the chart that the Trust did not meet this target in 2013/14.
Of the patients with a Single Assessment Process folder, 88.7 per cent reported that they understood its purpose, but only 43.3 per cent use it to monitor their own care.
In the 2013/14 community survey the Trust asked patients with a Single Assessment Process who did not use it to monitor their own care the reason for this to help understand why improvements were not being made against this target.

The reasons patients stated were:

- They did not feel any need to do this
- They did not know they could
- That the Trust staff do this and staff explain to them what is going on
- That they have physical reasons why they cannot do this e.g. cannot see well enough

For this reason this priority will not be carried forward to 2014/15 as it does not appear to be an important priority for patients.



Of those asked, 83.3 per cent of patients stated that they would know how to raise a concern about their care and treatment if they wished to do so, against a target of 90, and a slight dip in score was seen against the previous year. It is important this priority does not drop further so it will be retained in the 2014/15 priority schedule.

New priority 1 for 2014/15

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*

Rationale for inclusion
The hospital (a) target has seen lower than required scores during the year and we are looking for a more consistent approach to this important aspect of patient care.

Hospital (b) is an important patient experience measure for patients and, therefore, sees a more challenging target set for 2014/15.

The community priorities were chosen following the results of the 2013/14 patient surveys which indicated these areas need improvement.

Developments planned for 2014/15
Actions being undertaken to achieve the Trust target include:

- Continue to recruit volunteer mealtime assistants
- Newly recruited volunteer mealtime assistants to be trained and in place on the wards where needed
- Targeted patient experience surveys to be undertaken with patients requiring mealtime assistance to ensure patients are getting the help they need
- Call bell data included on the new ward huddle board (prominent boards on each ward that include important safety and patient experience information for patients, relatives and staff) to maintain the focus on this important issue and to let staff and patients know how their ward is performing
- Review and further develop the pilot carried out on surgical wards in 2013/14 and roll out to all wards
- Develop postcard-style information to give to patients finishing their treatment advising who to contact if they are worried and how to raise a concern
- Utilise the Single Point of Access (SPA) telephone number for patients to use
- Refresh posters in clinic settings advising patients how to raise concerns
- 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

Board sponsor: Denise McMahon, Director of Nursing
Operational lead: Mandy Green, Deputy Head of Communications and Patient Experience

Priority 2 for 2013/14: Pressure ulcers

Pressure ulcers	
Hospital	**Community**
a) Reduce avoidable stage 4 hospital acquired pressure ulcers so that the number for 2012/13 has been reduced by 50 per cent in 2013/14. b) Reduce avoidable stage 3 hospital acquired pressure ulcers so that the number for 2012/13 has been reduced by 25 per cent in 2013/14.	Reduce avoidable stage 3 and 4 acquired pressure ulcers that occur on the district nurse caseload so that the number for 2012/13 has been reduced by 25 per cent in 2013/14.

How we measure and record this priority

Pressure ulcers, also called pressure sores and bed sores, are staged one to four with four being the most serious. When a patient is identified as having a pressure ulcer, the details are entered into the computer incident reporting system and are reviewed by the Tissue Viability team prior to reporting externally.

If pressure damage is noted within 72 hours of admission, this is not considered to have developed in hospital. This time frame is agreed regionally as it is recognised that pressure damage can occur but not be visible immediately.

Developments that occurred in 2013/14

In April 2013 the Trust changed the tool used to stage the depth of pressure ulcers. The new tool was adapted from the agreed national tool. To publicise the tool, several education sessions took place across the Trust and the Tissue Viability team visited all parts of the hospital with a specially decorated bed. During this tour, the team gave out information about the tool and took the opportunity to raise awareness about all key methods of preventing pressure ulcers.

The pressure ulcer prevention campaign launched in 2012 known as the ‘50 Day Dash’ continued. Some wards have now gone far beyond the initial aim of having 50 pressure ulcer free days, achieving more than 500 days free from avoidable stage 2,3 and 4 pressure ulcers. The relevant wards were recently rewarded for all their hard work with a visit from the chief executive who was full of praise for the staff. Information on the campaign remains visible on the Trust intranet

Certain patients need high specification plug-in alternating air mattresses. This specialised type of equipment is not required on every bed so the Trust ensured that, when needed, the equipment was available as soon as possible. Appreciating that patients were not on this equipment immediately on admission led to the evaluation of a new type of mattress, known as the hybrid mattress, that could be available on every bed. Following work to evaluate several different options, new static air mattresses, which have air cells inside them and are suitable for patients who are at high risk of developing pressure ulcers, have now been introduced and are in-situ on

all inpatient beds (excluding maternity and paediatrics). When plug-in mattresses are required they can be issued within an acceptable time frame because overall demand for this type of equipment has reduced significantly.

Standardised pressure ulcer prevention and management documents are now being used across the hospital and community. The prevention document includes a SKIN (Surface Keep moving Incontinence Nutrition) bundle, which carers complete to ensure every aspect of pressure ulcer prevention is addressed at each patient care episode. Further improvements have been made in the way in which the documents are monitored.

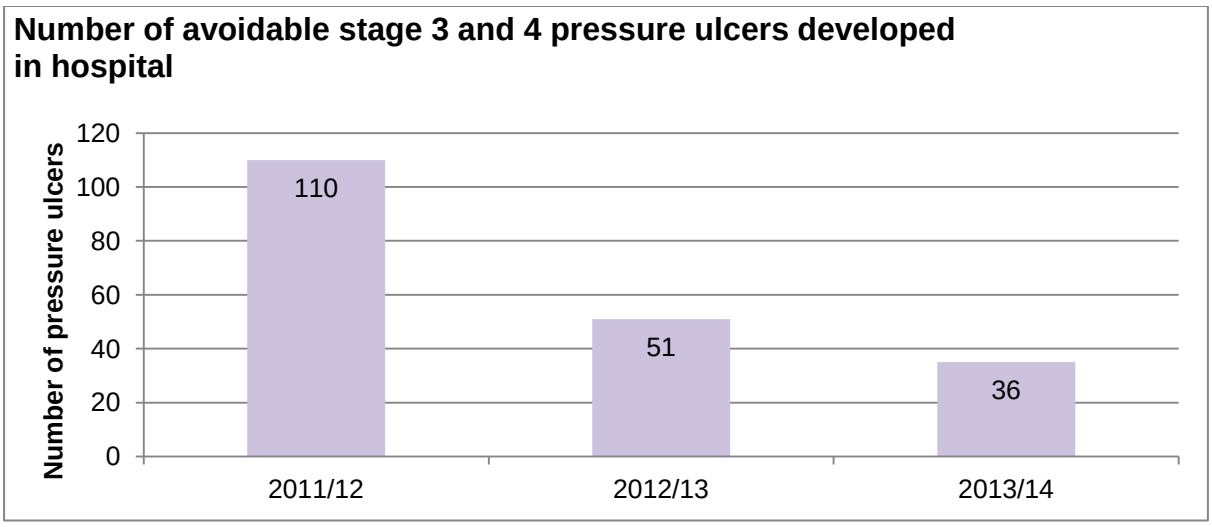
The Trust has recognised the importance of continually updating community carers in pressure ulcer prevention and completion of the SKIN bundle documents. This includes carers in the home and residential home settings. SKIN bundle sessions continue for this group of staff across the year on a rolling programme and all sessions are well attended. The Trust has supported the continued hospital link nurse sessions in which nurses off all wards are kept updated every two weeks.

Recently the Trust has employed two new nurses to support community nurses through development of guidance and education to continue to improve pressure ulcer prevention.

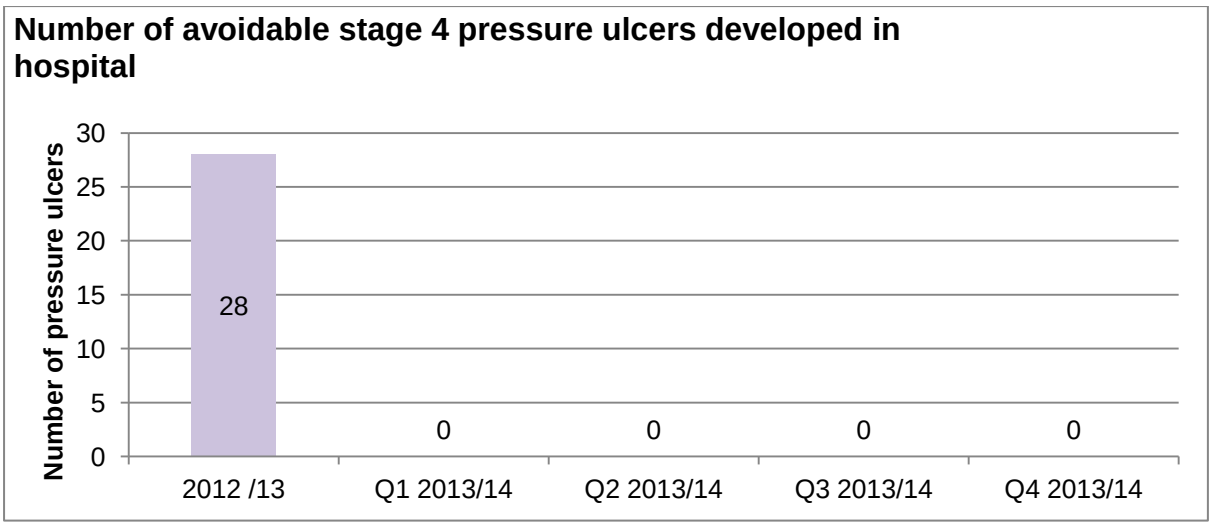
An innovative video campaign was launched during the Christmas period. This was a fun video reminding staff of the ways to reduce the risk of pressure ulcers. The video is available on the Trust intranet for staff to see.

Current status: Hospital

The graph below shows the total number of avoidable stage 3 and 4 pressure ulcers that 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 51 stage 3 and 4 ulcers in 2012/13 these have been reduced to 36 this year.



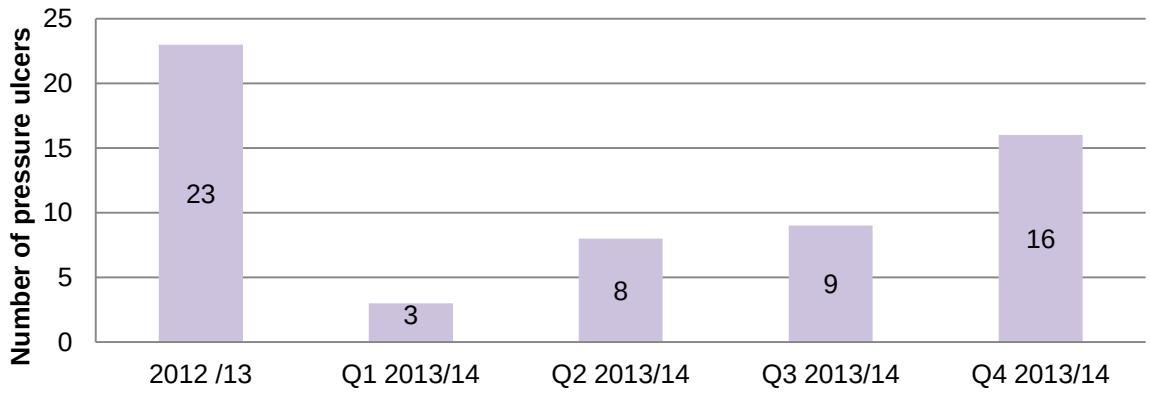
Specifically for avoidable stage 4 hospital acquired pressure ulcers, the target set was that the number for 2012/13 would be reduced by 50 per cent in 2013/14. In 2012/13 there were 28 stage 4 ulcers. This year there have been none of these at all and so the target has been achieved.



I can only sing the praises of the department as nothing was too much trouble and would like to say a big thank you for their dedication and care.

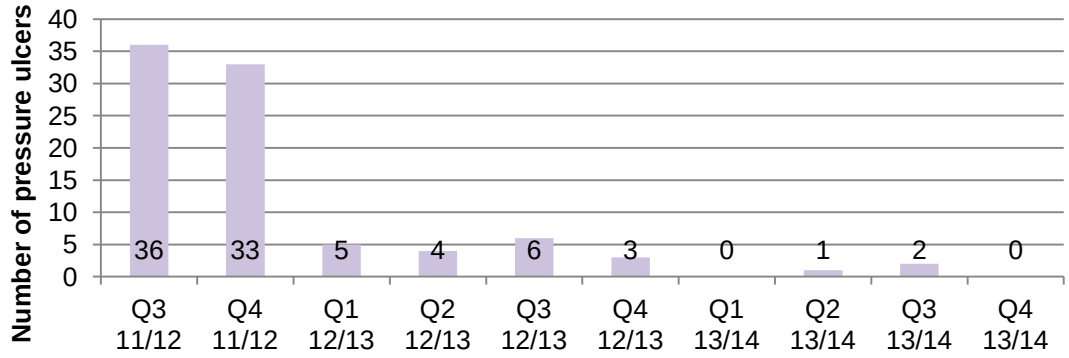
With regards to avoidable stage 3 hospital acquired pressure ulcers, the target set was that the number for 2012/13 would be reduced by 25 per cent in 2013/14. In 2012/13 there were 23 stage 3 ulcers and so to hit the target the Trust should have had fewer than 16. It can be seen that there have been 36 and so this target has unfortunately not been met. This non-achievement should be seen in context of the introduction of a new staging tool and the overall yearly reduction of stage 3 and 4 ulcers from 51 to 36. It is likely that the numbers of stage 3 ulcers have risen as some of these would previously have developed into stage 4.

Number of avoidable stage 3 pressures ulcers developed in hospital



Current status: Community

Total number of avoidable stage 3 and 4 pressure ulcers developed on the district nursing caseload



It can be seen that the district nurse caseload target that avoidable stage 3 and 4 acquired pressure ulcers in 2013/14 would be reduced by 25 per cent from the 2012/13 number has been achieved. In 2012/13 there were 18 ulcers in total and so a reduction of 25 per cent would be to have 13. There have been three in total for the whole year and so the actual reduction has been more than 80 per cent.

New priority 2 for 2014/15

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.

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 numbers in 2013/14, it realises there is still much to do and moving to a zero tolerance of pressure ulcers in hospital should be the aim.
- Feedback from our patients, staff, community groups and governors indicates this should remain a target.

Developments planned for 2014/15

Actions being undertaken to achieve the Trust target include:

- Continue to support hospital staff in the effective use of new mattresses
- Utilise the equipment coordinator to monitor current practice in all wards. This will include checking that SKIN bundles are completed effectively and ensuring patients are all nursed on the appropriate equipment
- Develop and embed the use of a new equipment selection flow chart for the community service supported by education sessions
- Continue weekly meetings with the pressure ulcer group to review any stage 3 or 4 ulcers that may develop while the patient is under the care of the Trust
- The Tissue Viability team will continue to work with private care agencies and organise education sessions and updates as required
- The team will support nursing homes with regular link nurse meetings
- Following the success of a first newsletter sent out to nursing homes, the team intend to send a regular newsletter to update nursing home staff and practice nurses
- Education sessions to continue for all staff with practical sessions
- Play a role in working with national groups to agree standard definitions for wounds that are diabetic foot ulcers or related to circulation problems compared to pressure ulcers

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

Priority 3 for 2013/14: Infection control

Infection control	
Reduce our MRSA and Clostridium difficile (C. diff) rates in line with national and local priorities.	
MRSA	**Clostridium difficile**
Have no post 48 hour cases of MRSA bacteraemia (blood stream infections).	Have no more than 38 post 48 hour cases of Clostridium difficile.

How we measure and record this priority

MRSA bacteraemia and C. diff numbers are divided into pre and post 48 hours cases. Only the post 48 hours cases are attributed to the Trust, meaning the patient acquired it in hospital. Pre 48 hours cases mean the patient was already developing the infection before they were admitted to hospital. As part of the local health economy the Trust has to record both pre and post 48 hours cases.

When our pathology laboratory has a positive result, the information is fed into the MESS (Mandatory Enhanced Surveillance System) national database. From here the data for all trusts is collated and sent to the Public Health England for publication.

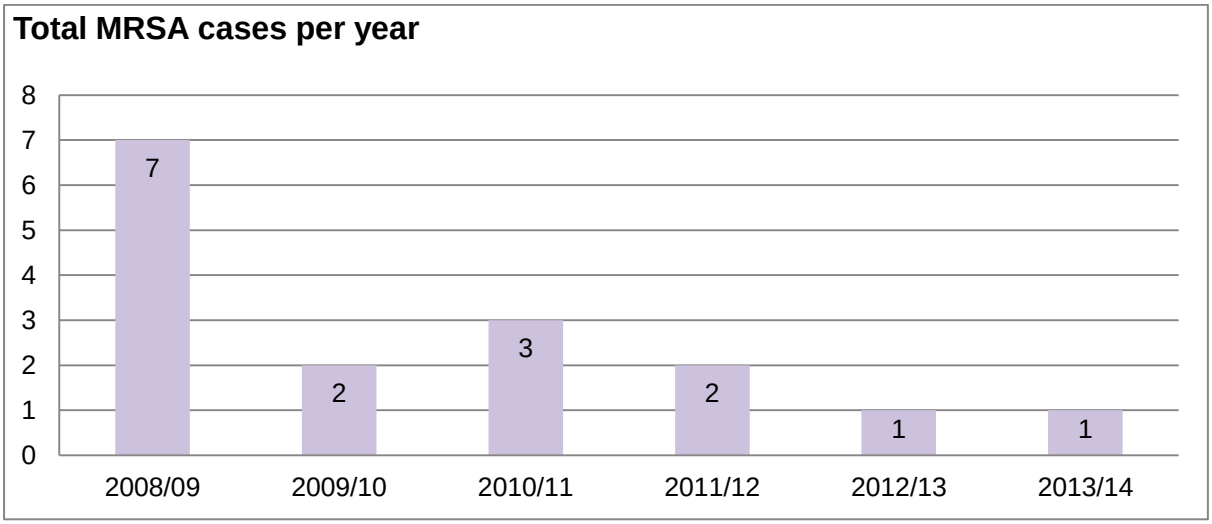
Developments that occurred in 2013/14

- Further education programmes have been developed and there has been improved attendance of staff at the relevant sessions.
- Effective antimicrobial prescribing has been promoted.
- The hydrogen peroxide vapour (HPV) 'fogging' service that contributes to the prevention of cross infection has been rolled out.
- The C. diff care pathway has been revised in line with national guidance to include the use of fidaxomicin (Dificlir), which is associated with lower rates of relapse.
- An Infection Control Nurse has been assigned to the investigation and follow up of patients with C. diff.
- The Trust has participated in primary care educational programme for GPs to improve prescribing of antimicrobials and awareness of C. diff.

"The ward I was in was kept scrupulously clean by the hard working cleaning staff every day."

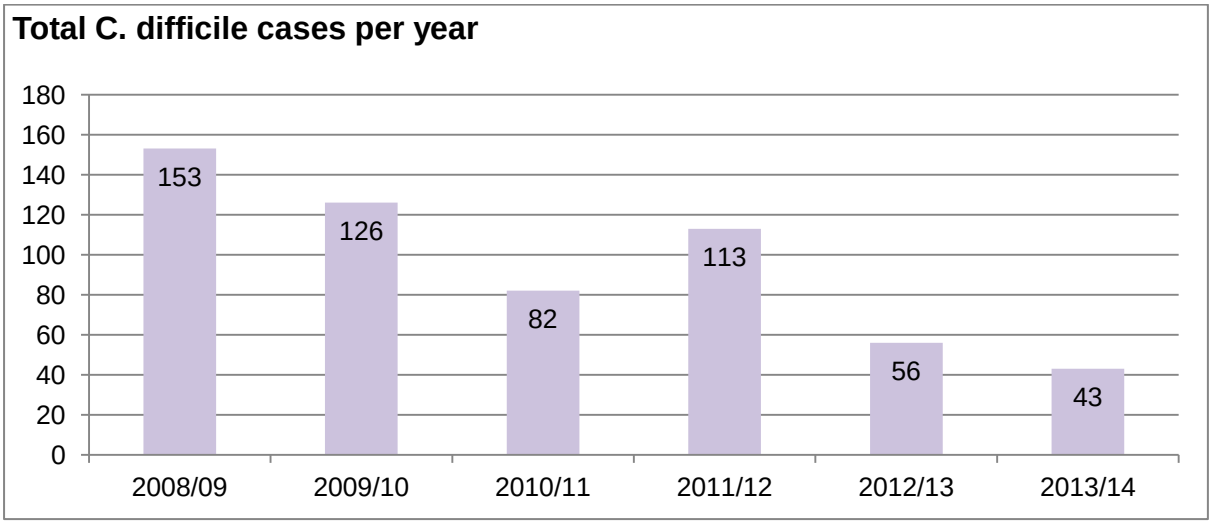
Current status: MRSA

We continue our good work to maintain a low level of MRSA bacteraemia; however, we did not achieve the target of having no cases. The graph below shows the continued reduction of MRSA bacteraemia cases (post 48 hour, i.e. patients who acquired it whilst in hospital) from a total of seven in 2008/9 to the one case this year.



Current status: C. difficile

With regards to C. diff, the target set by the government in 2012/13 was no more than 77 and the Trust achieved this with just 56 in the year. When the Trust was set the target of 38 for this year, it was accepted that this would be challenging and this has proved to be the case. The Trust has had 43 cases in the year and so the target has not been met even though it is the Trust's best performance for six years.



New priority 3 for 2014/15

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

Rationale for inclusion

- The drive to reduce healthcare associated infections, which includes MRSA bacteraemia and C. diff, continues to get more and more challenging.
- The reduction of infection remains a key priority across the NHS.
- The Trust is extremely conscious of its non acheivement of the targets in 2013/14.
- Feedback from our patients, staff, community groups and governors indicates this should remain a target.

Developments planned for 2014/15

Actions planned to achieve the above aims include:

- Working with our hydrogen peroxide vapour (HPV) 'fogging' contractor to agree a rolling programme of decontamination services to assist in the prevention of cross infection
- Providing further training around specimen collection and utilising the specimen checklist relating to C. diff
- Develop further education programmes and competencies that can be utilised across the Trust for Infection Control
- Working with community nursing teams to enhance their knowledge around specimen retrieval, infection prevention and control and data collection.
- Developing an agreement with the principal commissioner (Dudley CCG) on local actions, including an algorithm to differentaite between avoidable and unavoidable cases, based on NHS England's publication: C. diff infection objectives for NHS organisations in 2014/15 and guidance on sanction implementation
- Publish the numbers of avoidable and unavoidable C. diff cases on the Trust website

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

"The staff on the ward were caring and helpful, the ward was spotlessly clean and nothing was too much trouble for the staff."

Priorities 4 and 5 for 2013/14: Nutrition and hydration

Nutrition
a) Increase the number of patients who have a weekly risk re-assessment regarding their nutritional status. Through the year on average at least 90 per cent of patients will have the weekly risk assessment completed and this will rise to at least 93 per cent by the end of the year (March 2014). b) Increase the number of patients having a food recording chart and a fluid balance chart in place if the Malnutrition Universal Screening Tool (MUST) score is 1 or above. Through the year on average at least 90 per cent of patients will have the weekly risk assessment completed and this will rise to at least 93 per cent by the end of the year (March 2014).

Hydration
Increase the number of patients who have their fluid balance charts fully completed. Through the year on average at least 90 per cent of patients will have their charts fully completed and this will rise to at least 93 per cent by the end of the year (March 2014).

How we measure and record these priorities

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

The Malnutrition Universal Screening Tool (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 the recording of fluid input and output of patients. The completion rates of each ward are fed back to the matrons and ward managers for action where necessary.

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

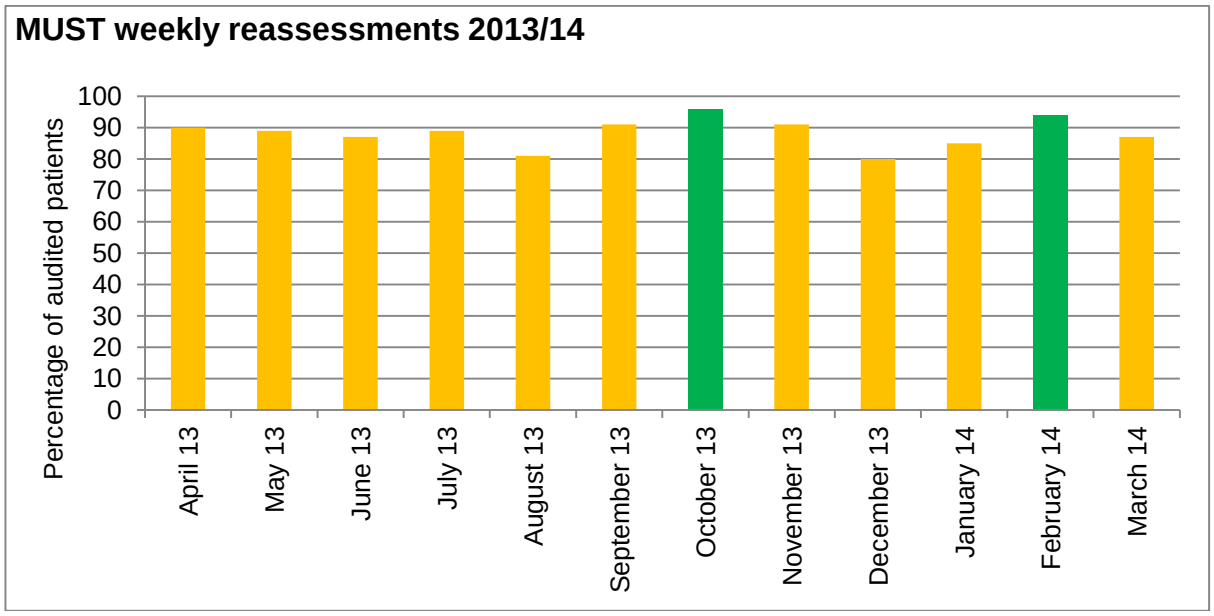
Developments that occurred in 2013/14

- 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
- Free standing notices at the entrance of each ward area to denote Protected Mealtime Service is occurring have been introduced

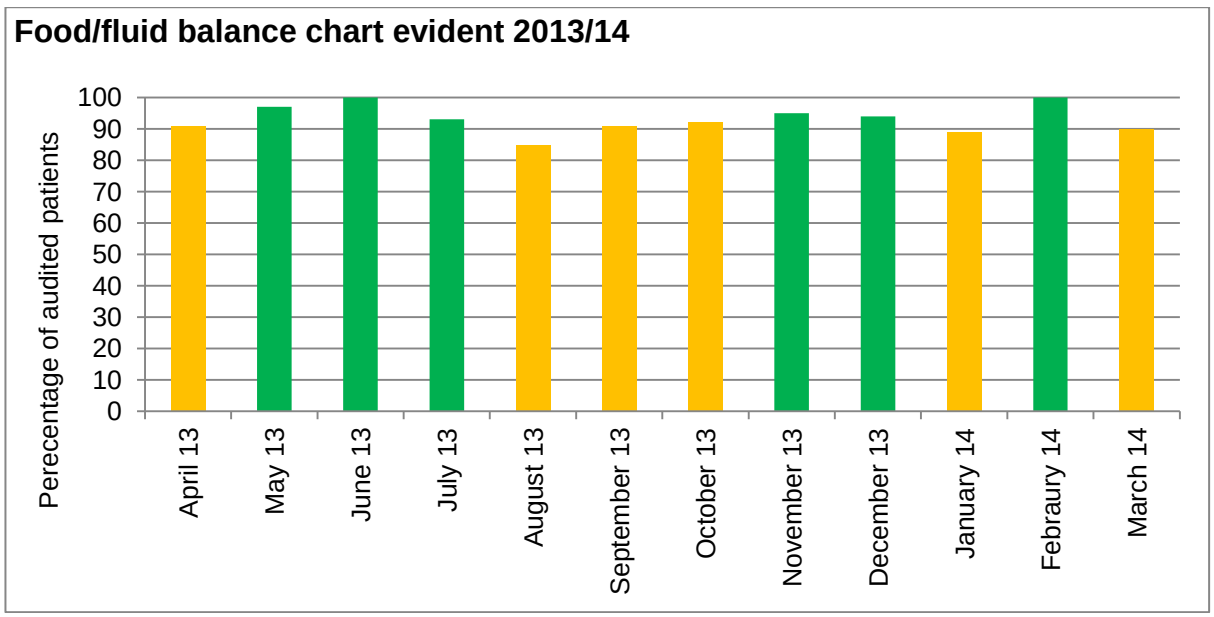
- New national descriptors for speech language therapy in relation to food consistency grading have been rolled out
- Participated in International Nutrition and Hydration week when the importance of a good diet was publicised in a variety of ways across the Trust

Current status: Nutrition

Results for the weekly reassessments of the MUST scores show that although 93 per cent or over was achieved in October and February, unfortunately the average of 90 per cent throughout the year was just missed, with the Trust achieving an average of 89 per cent. In March the figure attained was 87 per cent and so the 93 per cent end of year target was not met.

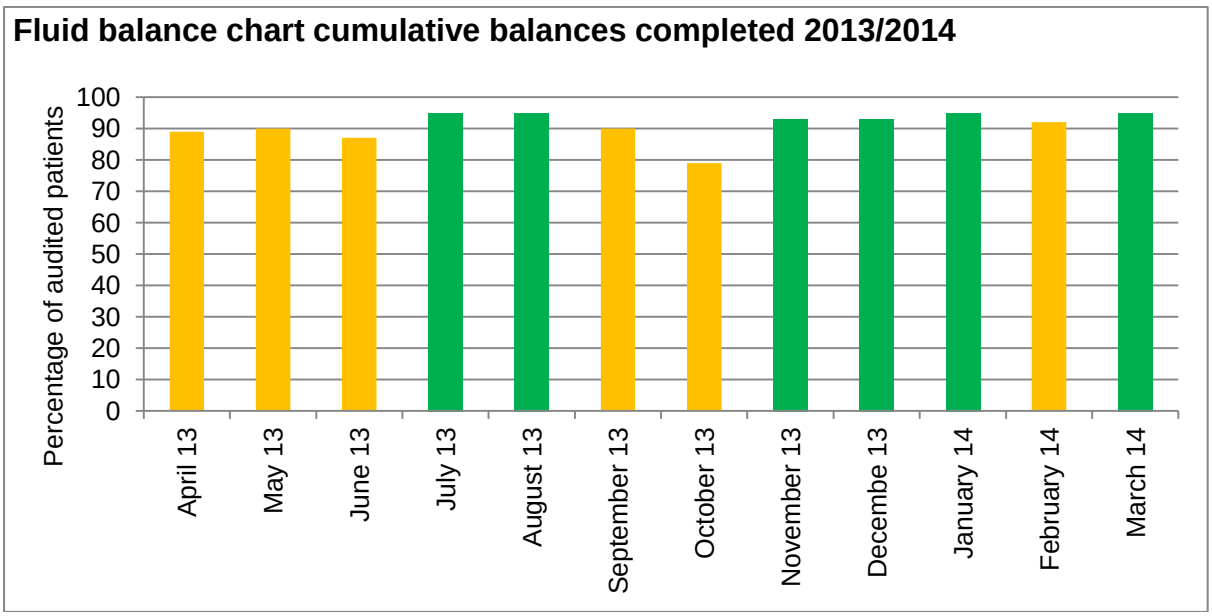


Results for patients identified at risk having both a fluid balance and food monitoring chart in place show that 93 per cent or over was achieved in six of the months and the average of 90 per cent throughout the year has been met (average was 93 per cent). In March 2014 the figure attained was 90 per cent and so the 93 per cent end of year target was not met.



Current status: Hydration

Results for patients having their fluid balance charts completed show that 93 per cent or over was achieved in six of the months and the average of 90 per cent throughout the year has been met (average was 91 per cent). In March the figure attained was 95 per cent and so the 93 per cent end of year target was also met.



New priorities 4 and 5 for 2013/14

Nutrition
Increase the number of patients who have a weekly risk re-assessment regarding their nutritional status. Through the year on average at least 90 per cent of patients will have the 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.

Rationale for inclusion

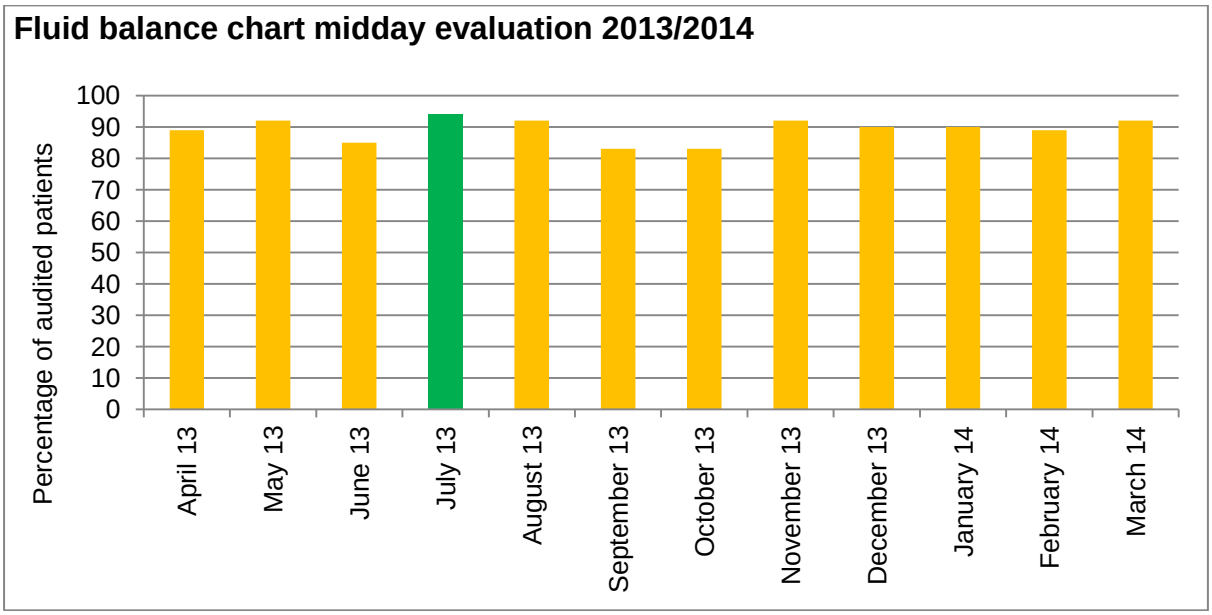
- Not all of our targets on these topics were met last year.
- Poor nutrition and hydration leads to poor health, increased and prolonged hospital admissions and increased costs to the NHS. The consequences of poor nutrition and hydration are well documented and include increased risk of infection, poor skin integrity and delayed wound healing, decreased muscle strength, depression and, sadly, premature death. Put simply poor nutrition and hydration causes harm.
- A number of national reports have questioned the state of practice on these topics across hospitals generally.

As 2013/14 figures show, with regards to undertaking the weekly re-assessments of the MUST we did not achieve the 90 per cent average target (actual figure 89 per cent) or the end of year target of 93 per cent (actual figure 87 per cent). Consequently we are retaining this target for 2014/15. Due to adding in a sixth priority topic this year (Mortality – see section below), and as we achieved an average of 93 per cent in our second nutrition target, we shall just have one nutrition target in 2014/15.

With regards to hydration, we achieved both elements of that target, with nurses ensuring they completed patients' fluid balances at the end of the day. It is important that nurses not only monitor and total the fluid balance at the end of the day but also monitor input and output continually. In order to further improve care, we have decided that the balance should also be calculated and documented at midday. These lunch time evaluations are vital in ensuring that any hydration issues are identified early so interventions and active management can be implemented to halt any deterioration of the patient.

I am sure that the high standard and excellent choice of food provided by the catering staff at Russells Hall Hospital was a major contributor in aiding my recovery.

In 2013/14, the average monthly completion of these midday fluid balances was 89 per cent (see below). The new hydration target for 2014/15 is that this should average 93 per cent.



Developments planned for 2014/15

- The present process of monthly mealtime audits will be reviewed to develop a more robust system of ensuring appropriate action is taken dependant on the audit results.
- A more automated system of ensuring that patients and staff are forewarned about mealtimes rather than relying on the use of the hand bells will be introduced.
- An electronic learning package will be implemented.
- A formalised strategy will be developed to ensure that nutrition and hydration are priority issues.
- All current menus will be reviewed to ensure greater choice for patients.
- All nutrition based policies will be reviewed and amended to ensure they reflect up-to-date practice at the Trust.

Board Sponsor: Denise McMahon, Director of Nursing
Operational Leads: Dr S. Cooper, Consultant Gastroenterologist; Sheree Randall, Matron; Karen Broadhouse, Quality Project Lead

The care I received from every person who I came into contact with was excellent and made me feel important, well informed and cared for at all times.

New 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 will 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 the Clinical Quality Safety and Patient Experience Board Committee. Clinical directorates will also report and be monitored on performance at quarterly reviews.

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 Report 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 specialties.
- A high Summary Hospital-level Mortality Indicator (SHMI) is a trigger for hospitals to investigate and understand where performance may be falling short in specific areas.

Current status
At present, the Trust has an average of 70.6 per cent of in-hospital deaths undergoing specialist multi-disciplinary review within 12 weeks. The details by speciality are below:

Meeting 85% target **At or above Trust average** **Below Trust average**

Specialty	% audited within 12 weeks
Cardiology	80.6
Gastroenterology	65.1
General medicine	64.5
Medical assessment	82
Orthogeriatrics	100
Rehabilitation	70.6
Respiratory	95.5
Stroke medicine	85.9
Diabetes	88.9
Endocrinology	100
Renal	32.1
Rheumatology	100

Specialty	% audited within 12 weeks
Clinical oncology	63.6
Haematology	50
Medical oncology	33.3
Care of the elderly	79.3
ENT	66.7
General surgery	62.8
Urology	30
Vascular surgery	47.4
T&O rehabilitation	100
Trauma and orthopaedics	96.3
Neonates	100
Gynaecology	100

Developments planned for 2014/15

- Directorate mortality and action plans will be reviewed quarterly.
- Monthly mortality meeting will be held by the Medical Director, Information staff and Dudley CCG staff to review:
    - Mortality Indices,
    - Mortality Tracking System Performance
    - Review action plans
    - Provide exception reports where necessary to board.

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 2013/14 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 2013/14 represents 99.1 per cent of the total income generated from the provision of relevant health services by The Dudley Group NHS Foundation Trust for 2013/14.

The above reviews were undertaken in a number of ways. With regards to patient 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 Board of Directors monthly by the director of nursing (see section 3.3.4).
- Ongoing patient surveys that give a 'feel' for our patients' experiences in real time so that we can 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 for monitoring performance. The dashboard is essentially an on-line 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:
    - The Keogh Review occurred in May 2013. Following the review, the Trust was one of two of the 14 hospitals reviewed not to be placed in special measures. A publically available action plan was implemented following the visit (see http://www.nhs.uk/NHSEngland/bruce-keogh-review/Pages/published-reports.aspx).
    - Following an unannounced visit on site, in July 2013 the Care Quality Commission (CQC) declared that the Trust was compliant with the regulated activity of medicines management. As part of its new regime of inspections, the CQC visited the Trust in March 2014 and a formal report is expected in June 2014.

- In February 2013, Dudley Clinical Commissioning Group undertook a visit into the Trust's frail elderly services. The Trust received the final report in May 2014 and is drawing up an action plan based on the report.
- The Clinical Pathology Accreditation (UK) Ltd, which is the authority which approves laboratories, visited the following departments: Microbiology (July 2013) and Immunology (July 2013). Both maintained accredited status.
- In May 2013, NHS Quality Control North West visited the Trust's Aseptic Pharmacy Unit and the conclusion was that the unit continues to operate to a very high standard, utilising a very comprehensive and well documented quality system.
- The West Midlands Quality Review Service (WMQRS) visited the Trust on two occasions. In January 2014 the service reviewed the Care of Critically Ill & Critically Injured Children, and in February 2014 it undertook a formative review of certain elements of the maternity service. The outcome of both reviews found no major issues of note and a number of improvements are in the process of being implemented.
- With regards to education and training, the West Midlands Deanery undertakes a variety of checks on the education of doctors at the Trust. Following previous visits to the paediatric speciality in 2012, the Trust had a follow up visit led by the Postgraduate Dean in April 2013, the result of which was that the programme was approved. A further check in November 2013 had a similar positive outcome and so the next inspection for paediatrics is now due in three years time. In June 2013, an Anaesthetic Department visit had a similar favourable outcome with the programme approved. In February 2014, the Trust had a monitoring visit on its Medical Undergraduate Teaching Academy. The feedback from the visit highlights evidence of good practice and enthusiastic feedback of medical students who gain experience at the Trust.
- In March 2014 the Nursing and Midwifery Council (NMC), which oversees the education of nurses and midwives, undertook a review of the University of Wolverhampton, which the student nurses at the Trust attend. No concerns specific to the Trust were raised.

The care support workers and staff were kind, friendly and helpful and made my recovery a very pleasant experience.

2.2.2 Participation in national clinical audits and confidential enquiries

During 2013/14, 32 national clinical audits and five 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 2013/14, 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 2013/14 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%
Emergency Use of Oxygen	Acute Care	Yes	100%
National Audit of Seizures in Hospitals	Acute Care	Yes	100%
National Emergency Laparotomy Audit	Acute Care	Yes	Ends 2015
National Joint Registry	Acute Care	Yes	97%
Paracetamol Overdose (care provided in Emergency Departments)	Acute Care	Yes	100%
Severe Sepsis & Septic Shock	Acute Care	Yes	100%
TARN Severe Trauma Audit	Acute Care	Yes	81.4%
National Comparative Audit of Blood Transfusion: Audit of the Use of Anti-D	Blood & Transplant	Yes	100%
National Comparative Audit of Blood Transfusion: Audit of Patient Information & Consent		Yes	96%
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%
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	86% to Feb 14
National Vascular Registry	Heart	Yes	96-100%
National Diabetes Inpatient Audit	Long-term Conditions	Yes	100%
National Pregnancy in Diabetes Audit		Yes	Ends 30 Aug 2014
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	Ends May 2014
Renal Replacement Therapy (Renal Registry)	Long-term Conditions	Yes	100%
Rheumatoid and Early Inflammatory Arthritis	Long-term Conditions	Yes	Began Feb 2014
Falls and Fragility Fractures Audit Programme	Older People	Yes	100%
Sentinel Stroke National Audit Programme	Older People	Yes	100%
Elective Surgery (National PROMs Programme)	Other	Yes	96%
Epilepsy 12 Audit (Childhood Epilepsy)	Women & Children's Health	Yes	Ends Oct 2014
Maternal, Newborn and Infant Clinical Outcome Review Programme	Women & Children's Health	Yes	100%
Moderate and severe asthma in children CEM audit	Women & Children's Health	Yes	100%
National Neonatal Audit Programme	Women & Children's Health	Yes	100%
Paediatric Asthma Audit	Women & Children's Health	Yes	100%

Table 2

National confidential enquiries that the Trust was eligible to participate in, actually participated in during 2013/14 and the percentage of the number of registered cases required by the terms of the enquiry

Name of Audit	Type of Care	Participation	Submitted %
Alcohol Related Liver Disease	NCEPOD	Yes	100%
Subarachnoid Haemorrhage	NCEPOD	Yes	100%
Tracheostomy Care	NCEPOD	Yes	100%
Lower Limb Amputations	NCEPOD	Yes	100%
Gastrointestinal Haemorrhage	NCEPOD	Yes	In progress

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

Table 3

Additional National Clinical Audits that the Trust participated in during 2013/14

Name of Audit	Type of Care	Participation	Submitted %
National British Society for Rheumatology Audit on the Management of Gout	Rheumatology	Yes	100%
National Bowel Cancer Mortality Outlier Review	General Surgery	Yes	98%
National Audit Project (NAP5) Accidental Awareness during General Anaesthesia (AAGA)	Anaesthetics	Yes	100%
National Obstetric Anaesthetic Database (NOAD)	Anaesthetics	Yes	100%
NICE-BAD National Audit on Psoriasis	Dermatology	Yes	100%
National Care of the Dying Audit Hospitals (NCDAH) Round 4	Palliative Medicine	Yes	100%
National Prostate Cancer Audit	Urology	Yes	Organisational data submitted

“Any nurse or doctor that I saw introduced themselves and shook my hand. I was made to feel very comfortable and any questions I had were answered clearly.”

The reports of the following 21 national clinical audits were reviewed in 2013/14:

National Lung Cancer Audit
UK Inflammatory Bowel Disease Audit
Paediatric Pneumonia Audit
Adult Community Acquired Pneumonia
Review of Asthma Deaths
National Hip Fracture Database
National Comparative Audit: Blood sample collecting and labelling
National Colorectal Cancer Audit
National Neonatal Audit Programme
Adult Asthma
Emergency Use of Oxygen
National Diabetes Inpatient Audit
National Joint Registry
Renal Colic Audit
National Audit for Dementia
Paediatric Asthma Audit
Adult Bronchiectasis
Non-Invasive Ventilation – Adults
Sentinel Stroke National Audit Programme
National Comparative Audit: Use of blood in adult medical patients
Feverish Children Audit

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

Dementia
Trust pathway/strategy to be formalised. Planned implementation of the Dementia Champions Project and training commenced in March 2014.

Gastroenterology
Appointed a named inflammatory bowel disease (IBD) consultant and regular monthly IBD meetings are undertaken. Set up a transition clinic for IBD with the paediatric team. Planned action is for arrangements to be made for general practitioners to meet with the IBD team.

Neonates
National guidance for retinopathy screening as an inpatient to be used, admission form for retinopathy to be revised to document date and time seen/signed, and neonatal unit staff to input and check accuracy of all data entry onto the computer database.

Paediatrics
An asthma leaflet has been introduced for parents and a special sheet generated to ensure proper documented discharge planning for every patient. Increased awareness for paediatric nurse colleagues to check and document inhaler and spacer technique, and for relevant medical staff to request chest X-rays only where needed and prescribe antibiotics only where necessary. Further education for junior

doctors on feverish children introduced onto teaching programme and guidelines to be established for investigations. A further proposed action is to develop an advice leaflet for parents.

Respiratory Medicine
Inhaler technique to be checked with all adult asthma patients prior to discharge. All patients to be prescribed oral steroids within four hours and smoking cessation to be discussed with all patients. All bronchiectasis patients to have blood tests for aspergillus and immunoglobulins and all patients to have yearly sputum culture and to be referred for active cycle breathing techniques (ACBT). A successful pilot carried out on respiratory ward of oxygen prescription in drug charts. The new drug chart now has a dedicated space for oxygen prescribing. All patients have a treatment plan in place if Non-Invasive Ventilation (NIV) fails.

Diabetes
Several key initiatives have improved our performance. There has been a significant improvement in examination and management of foot problems, and we are now a leading example of good practice in this area having a featured case study on NHS England. Improvement in the number of patients seen by the diabetes team in the first 24 hours, and in how aware the staff are about diabetes.

Orthopaedics
Actions are to continue good practices for robust pre-operative checks and patient selection and to ensure that mechanisms are in place for identifying and using tried and tested prostheses with a good track record.

Haematology
It is planned to develop a Trust-wide policy for written consent for blood transfusion, to audit local practice around transfusion and treatment for anaemia, and to include advice for clinicians regarding underweight adult dosing in blood transfusion training sessions and in the transfusion policy. In addition, a zero tolerance awareness campaign to be repeated in the Trust. Other actions planned to include the implementation of e-phlebotomy, to introduce the ‘two-sample’ approach and the blood bank request form to be re-designed to reflect acceptance criteria.

Local clinical audit

The reports of 92 completed local clinical audits were reviewed in 2013/14 and the Trust has taken, or intends to take, the following actions to improve the quality of healthcare provided:

Haematology
Ward/department resource folder developed to improve staff knowledge of thromboprophylaxis and anticoagulation.

Pharmacy
Screensavers introduced onto hospital intranet and email/text messages sent to junior doctors as reminders of timely completion of prescriptions for take home medications.

Surgery
Improving communication channels in the decision-making for calling second emergency theatre team. Flow chart displayed within relevant clinical areas.

Anaesthetics/Critical Care
Re-audit showed improved critical care nurses' knowledge relating to airway management following the introduction of an educational programme. Education session introduced for anaesthesia trainees and consultants on how to perform low flow anaesthesia safely and effectively. Electronic patient record on ITU updated to encourage compliance with antimicrobial guidelines.

Clinical Biochemistry
Patients considered for bariatric surgery are now given information on the need for lifelong follow up and vitamin supplementation, and are asked to sign to confirm they agree to this. Clinic patients who do not attend are contacted to find out why and are offered support to encourage them to attend.

Neurology
For Parkinson's patients, *Get It On Time* medication campaign launched. Screensaver uploaded onto the Trust intranet. Posters displayed on notice boards and information packs disseminated to all areas.

Emergency Department
Repeat attendees are identified and patient alerts or individual management plans allocated as necessary. Case notes of all patients who do not wait to be seen are reviewed by a consultant.

Infection Control
Increased publicity of timely notification of suspected bacterial meningitis or meningococcal septicaemia to Public Health.

Maternity
Visual aids on Postpartum Haemorrhage (PPH) displayed on labour wards and obstetric theatres. Current guidance on pregnancy of unknown location reviewed as findings suggested that repeat βHCG (beta subunit of human chorionic gonadotropin) did not show any benefit to the clinical diagnosis. Conservative management is an acceptable alternative.

Neonates
A new proforma has been introduced which documents neonatal abstinence observations including the hepatitis status and the referral to social services. Babies are now referred to social services as soon as a diagnosis is identified.

Orthopaedics
All major post-operative cases are reviewed on day one following the operation, and all handover is now done electronically. Introduction of a kidney protection care bundle and AKI (Acute Kidney Injury) management guidelines have been added to junior doctor induction packs.

Urology
Quick and easy access clinic introduced in urology with 92 per cent of patients discharged the same day and inpatient admission avoided.

2.2.3 Research and development

The number of patients receiving NHS services provided or sub-contracted by the Trust in 2013/14 that were recruited during that period to participate in research approved by a Research Ethics Committee was 2284. Of these, 262 were recruited to commercial studies. While overall recruitment reduced by three per cent compared to 2012/13 (2591), accrual to commercial studies, generally acknowledged as being more complex, increased to 11.4 per cent (7.1 per cent in 2012/13), representing a growth in commercial income.

The Trust has always been strong in research activity centred in the cancer, cardiology and musculoskeletal clinical disciplines. This has not only continued but increased further during this financial year, recruiting to both NHS National Institute for Health Research (NIHR) adopted studies and commercial clinical trials.

Dermatology and endocrinology are relatively new to clinical research in Dudley, but both had great successes and will become large research centres over the course of the next financial year. The Research and Development Department continues to monitor and support progress to enable the specialties to reach their full research potential. Trust publications for the calendar year 2013, including conference posters, stand at 107.

NIHR portfolio adopted research activity can also be found within acute medicine, gastroenterology, HIV medicine, maternity, neurology, stroke, urology, breast and vascular surgery. There are plans to increase activity in all of these and other specialties.

The Trust hosts three research fellows and several PhD students, funded predominantly by Arthritis Research UK and Birmingham & Black Country Comprehensive Local Research Network (BBC CLRN).

The Trust ran publicity events at two sites on International Clinical Trials Day, 20th May 2013, with the assistance of staff from BBC CLRN. The ‘OK to ask’ campaign continues to be publicised within the Trust via posters, slots on the Health Hub in Russells Hall Hospital and stalls at Trust member open days.

Staff in orthopaedics and diabetes have worked together to produce a Trust-wide system that generates its own individually tailored patient information sheets for diabetic patients who are undergoing elective orthopaedic surgery. This is an excellent example of collaborative multi-disciplinary working that resolves a long recognised clinical issue.

The Myeloma XI trial, providing treatment pathways for patients with multiple myeloma, and the TEAMM study, seeking to establish the best use of antibiotics in myeloma patients who are at high risk from septic death, demonstrate selection of research studies that will benefit current and future patients.

Participation in the ROSE study, an observational study of rivaroxaban running parallel to our clinical practice, is an example of best practice when introducing a new therapy. The haematology specialty network, which comprises all trusts offering this service within BBC CLRN, was recently awarded most improved specialty by the NIHR. This was largely attributed to the significant number of participants recruited here at The Dudley Group.

2.2.4 Commissioning for Quality and Innovation (CQUIN) payment framework

A proportion of the Trust's income in 2013/14 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 payment framework. Further details of the agreed goals for 2013/14 and for the following 12 month period are available online at:

http://www.england.nhs.uk/wp-content/uploads/2014/02/sc-cquin-guid.pdf

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 estimated value in 2013/14 was £6.1m as part of our contracts with clinical commissioning groups for acute and community services, and with Specialised Services commissioners. We have not yet agreed the final settlement figure for 2013/14 as some targets are still contingent upon outstanding information. However, for the purpose of the year end accounts, we have assumed 81% per cent achievement of both Dudley CCG and Specialised Services schemes. This would equate to approx £4.9m. In 2012/13 the payment was £5.4m.

There is one CQUIN scheme per contract, made up of several goals. Goals for the Friends & Family Test, venous-thromboembolism, dementia and NHS Safety Thermometer (Pressure Ulcers) are nationally determined, and the remainder is locally agreed. We have rated last year's CQUINs on a red/amber/green basis dependent on achievement to date. At the time of reporting, we are expecting to fall short of fully meeting the goals for Friends and Family (part 2: increased response rate), Pressure Ulcers, Reduction in Fractures as a result of Falls, Letters returned to the referring Clinician and Senior Clinician Review. In all cases, the goals have been at least partially achieved. We have actions in place to ensure the quality of care in these areas is improved.

Acute and community 2013/14

Goal No.	CQUIN targets and topics	Quality domains and RAG rating
1	Friends and Family Test (3 parts)	**Patient experience**
2	NHS Safety Thermometer – Pressure Ulcers	**Patient experience** **Safety** **Effectiveness**
3	Dementia screening, risk assessment and referral for specialist services (3 parts)	**Safety** **Effectiveness** **Patient experience**
4	VTE risk assessment (2 parts)	**Safety**
5	Safe and timely discharge	**Effectiveness**

Goal No.	CQUIN targets and topics	Quality domains and RAG rating
6	Patient safety culture	**Safety** **Effectiveness**
7	Patient experience for learning disability patients	**Patient experience**
8	Reduction in fractures as a result of falls	**Safety** **Effectiveness**
9	Letters returning to the referring clinician	**Effectiveness**
10	Choose and Book	**Effectiveness**
11	Senior clinician review	**Effectiveness**

Specialised services 2013/14

Goal No.	CQUIN targets and topics	Quality domains and RAG rating
1	Friends and Family Test (3 parts)	**Patient experience**
2	NHS Safety Thermometer – Pressure Ulcers	**Patient experience** **Safety** **Effectiveness**
3	Dementia screening, risk assessment and referral for specialist services (3 parts)	**Safety** **Effectiveness** **Patient experience**
4	VTE risk assessment (2 parts)	**Safety**
5	Quality dashboards	**Safety** **Effectiveness** **Innovation**
6	Renal dialysis – Renal patient view	**Effectiveness** **Innovation** **Patient experience**
7	HIV – registration and communication with GPs	**Safety** **Effectiveness**
8	Neonatal Intensive Care – Improved access to breast milk	**Safety** **Effectiveness**
9	Neonatal Intensive Care – Simple discharge pathway	**Effectiveness**
10	Neonatal Intensive Care – Retinopathy of prematurity	**Safety** **Effectiveness**

CQUIN report 2014/15

In 2014/15 the amount the Trust will be able to earn is 2.5 per cent on top of the actual outturn value. The estimated value of this is approximately £6.4m. The nationally mandated CQUIN goals for the Friends & Family Test, dementia screening and the NHS Safety Thermometer will continue.

Acute and community

Goal No.	CQUIN targets and topics	Quality domains
1	Friends and Family Test (4 parts)	Patient experience
2	NHS Safety Thermometer – Pressure Ulcers (Acute and Community)	Patient experience Safety Effectiveness
3	Dementia and Delirium (3 parts)	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

Specialised services

Goal No.	CQUIN targets and topics	Quality domains
1	Friends and Family Test (4 parts)	Patient Experience
2	NHS Safety Thermometer – Pressure Ulcers	Patient Experience Safety Effectiveness
3	Dementia and Delirium (3 parts)	Safety Effectiveness Patient Experience
4	Quality Dashboards	Safety Effectiveness Innovation
5	Renal Dialysis – Shared Haemodialysis Care	Patient Experience Effectiveness
6	Neonatal Intensive Care – Total Parenteral Nutrition	Safety 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 and its current registration status is registered without conditions.

Following an unannounced visit on site, in July 2013 the Care Quality Commission (CQC) declared the Trust compliant with the regulated activity of medicines management.

The Care Quality Commission has not taken enforcement action against the Trust during 2013/14.

The Trust has not participated in any special reviews or investigations by the Care Quality Commission during the reporting period.

The Trust awaits the results of the CQC inspection undertaken in late March 2014.

2.2.6 Quality of data

The Trust submitted records during 2013/14 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	99.7%	99.1%
Outpatient care	99.9%	99.3%
Accident and Emergency care	99.2%	95.8%

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%	99.1%

All above figures are for April 2013 to February 2014

The Trust's Information Governance Assessment Report overall score for 2013/14 was 79 per cent and was graded 'Satisfactory'.

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

Accident and Emergency

	The Dudley Group	National average
Investigations	10.6%	24.8%
Treatments	23.6%	33%

Paediatric Emergency

	The Dudley Group	National average
Primary diagnosis	10%	11.2%
Secondary diagnosis	7.4%	15.3%
Primary procedure	0%	11.8%
Secondary procedure	0%	16%

In the above tables the lower the figure the better the result.

These results should not be extrapolated further than the Accident and Emergency and Paediatric Emergency samples audited.

During 2013/14 there were eight data protection incidents logged on the Information Commissioner's incident reporting site. Actions taken from these incidents included:

- Fax audit being undertaken to reduce the number of faxes being used across the Trust
- Systems put in place for staff to ensure the Electronic Staff Record has up to date address information
- Importance of data security and confidentiality reinforced for community staff
- Mandatory training enforced
- Managers reminded monthly via mandatory training reports of their staff training compliance

2.2.7 Core set of mandatory indicators

This is the second year that all trusts have been mandated to insert this section which includes a stipulated number of measures. 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 e.g. specialist eye or orthopaedic hospitals that have very specific patient groups and which generally do not include emergency patients or those with multiple long-term conditions.

Mortality			
Topic and detailed indicators	**Immediate reporting period: October 2012 – September 2013**	**Previous reporting period: July 2012 – June 2013**	**Statements**
Summary Hospital-level Mortality Indictor (SHMI) value and banding	**Value** Trust 1.11 National average 1 Highest 1.18 Lowest 0.63 **Banding** Trust 2 National average 2 Highest 1 Lowest 3	**Value** Trust 1.13 National average 1 Highest 1.16 Lowest 0.63 **Banding** Trust 1 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 latest SHMI value is within the expected range The Trust has taken the following action to improve this value 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 25.3% National average 21.2% Highest 44.9% Lowest 2.7%	Trust 23.74% National Average 16.51% Highest 42.6% Lowest 3%	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 these percentages, 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: 2012/13 Provisional**		**Previous reporting period: 2011/12 finalised**		**Statements**
Groin Hernia Surgery	Trust	0.08	Trust	0.05	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%, Hip replacement: 94%, Knee replacement: 87%, Varicose veins: 94%) 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	0.16	Highest	0.14	
	Lowest	0.02	Lowest	0.00	
Varicose Vein Surgery	Trust	0.05	Trust	0.12	
	National average	0.09	National average	0.10	
	Highest	0.18	Highest	0.17	
	Lowest	0.02	Lowest	0.05	
Hip Replacement Surgery	Trust	0.44	Trust	0.40	
	National average	0.44	National average	0.42	
	Highest	0.54	Highest	0.50	
	Lowest	0.32	Lowest	0.31	
Knee Replacement Surgery	Trust	0.32	Trust	0.32	
	National average	0.32	National average	0.30	
	Highest	0.35	Highest	0.39	
	Lowest	0.16	Lowest	0.18	

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 National average Highest Lowest	9.09 10.15 NA* NA*	Trust National average Highest Lowest	9.34 10.15 NA* NA*	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 reduce this percentage, and so the quality of its services by: • consultant review of all medical referrals in Emergency department • extended consultant cover in assessment areas of the Trust • CCG investment into community nursing teams to avoid admissions and readmissions • better information and support around discharge via the discharge facilitator service
% readmitted within 28 days **Aged 16 and over**	Trust National average Highest Lowest	11.62 11.45 NA* NA*	Trust National average Highest Lowest	11.55 11.42 NA* NA*	

**comparative figures not available*

Responsiveness to inpatients' personal needs					
Topic and detailed indicators	**Immediate reporting period: 2012/13**		**Previous reporting period: 2011/12**		**Statements**
Average score from a selection of questions from the National Inpatient Survey measuring patient experience **(Score out of 100)**	Trust National average Highest Lowest	64.9 68.1 84.4 57.4	Trust National average Highest Lowest	63.8 67.4 85.0 56.5	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, with the 2013/14 (pre-published) figure being 66.6 The Trust intends to take/has taken 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, but it will look to restructure its real-time surveys to enable results to be attributed to and acted upon at ward level.

Staff views					
Topic and detailed indicators	**Immediate reporting period: 2013** *(published Feb 2014)*		**Previous reporting period: 2012**		**Statements**
Percentage of staff who would recommend the Trust to friends or family needing care	Trust	66%	Trust	61%	The Trust considers that this data is as described for the following reasons: the Trust is pleased to see an increase in the number 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 score, and so the quality of its services by: • multi-disciplinary groups focusing on action planning for improvements. • communicating with and supporting managers to understand their data broken down by directorate and area and take actions where necessary. The Trust involves and communicates with staff though adopting the Listening in Action programmes. This has covered a wide range of topics and new areas are being agreed for 2014/15.
	National average	64%	National average	60%	
	Highest	89%	Highest	86%	
	Lowest	40%	Lowest	35%	

Venous Thromboembolism (VTE)					
Topic and detailed indicators	**Immediate reporting period: Q3 Oct - Dec 2013**		**Previous reporting period: Q2 Jul - Sep 2013**		**Statements**
Percentage of admitted patients risk-assessed for Venous Thromboembolism	Trust	94.4%	Trust	95.07%	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 assessment, with the 2013/14 (pre-published) figure being 95.2%. 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 • implementing the use of technology to assist in the recording of the risk assessments
	National average	95.8%	National average	95.69%	
	Highest	100%	Highest	100%	
	Lowest	77.7%	Lowest	81.7%	

Infection control					
Topic and detailed indicators	**Immediate reporting period: 2012/13**		**Previous reporting period: 2011/12**		**Statements**
Rate of Clostridium difficile per 100,000 bed days amongst patients aged 2 or over	Trust	23.9	Trust	44.8	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 2013/14 having had 43 cases compared to 56 the previous year (see section 2.1.3), making the most recent (pre-published) rate 18.2 The Trust intends to take/has taken the following actions to improve this rate, and so the quality of its services by: • having an ongoing process to learn from individual cases to reduce the risk of further incidents • releasing a smartphone app so that all medical staff can have the correct antimicrobial guidelines available immediately on their mobile telephones • having intensive HPV (hydrogen peroxide vapour) cleaning to supplement traditional cleaning methods • revising treatment methods to include new drugs and having an associated video e-learning package for this
	National average	17.3	National average	21.8	
	Highest	30.6	Highest	51.6	
	Lowest	0	Lowest	0	

Clinical incidents					
Topic and detailed indicators	**Immediate reporting period Apr 2013 – Sept 2013**		**Previous reporting period: Oct 2012 – March 2013**		**Statements**
Rate of patient safety incidents **(incidents reported per 100 admissions)** **(Comparison is to 46 medium acute Trusts)**	Trust	9.02	Trust	8.8	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 continues to encourage staff to report all levels of incidents including near misses with the 2013/14 (pre-published) rate being 9.34 and percentage of severe harm or death being 0.3%). The Trust has taken the following actions to improve this rate, 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	7.23	Average	7.6	
	Highest	14.49	Highest	16.7	
	Lowest	3.54	Lowest	1.68	
Percentage of patient safety incidents resulting in severe harm or death	Trust	0.3%	Trust	0.3%	
	National average	0.7%	National average	0.63%	

Part 3: Other quality information

3.1 Introduction

The Trust has a number of different Key Performance Indicators (KPI) reports which are available and used by a wide variety of staff groups monitoring 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 the quality of care include weekly reports being sent to senior managers and clinicians which include the Emergency Department, Referral to Treatment, stroke and cancer targets. Monthly reports are also sent to all wards, 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. 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 CHKS Ltd, which is 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 2011/12 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.

"The ward ran like clockwork, with all the staff cooperating in the care of the patients. The nurses were exceptional and nothing was too much trouble."

Patient Experience

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 consideration of our Members' views as expressed through our Council of Governors.

3.2.2 Trust-wide initiatives

We gather feedback via, for example:

- The Friends and Family Test
- 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 – e.g. food

Below are examples of some of the numbers of feedback we have received this year (2013/14) and more detailed information about some of the methods. These methods alone show more than 20,000 opportunities for us to listen to our patients' views.

Method	Number
Friends and Family Test – Inpatient	7391
Friends and Family Test – Emergency Department	8100
Friends and Family Test – Maternity	1559
NHS Choices/Patient Opinion	229
Community Services surveys	668

Method	Number
Real-time – inpatient	1440
Real-time – EAU	42
Outpatient surveys	708
Surveys of carers of people with dementia	145
Discharge surveys	303

a) Friends and Family Test (FFT)

The Friends and Family Test aims to provide a simple headline metric to drive continuous improvements. It makes sure that staff providing the service and the Board of Directors receives regular feedback from patients on how the services are being received, what is working well and where improvements are needed.

All inpatient and Emergency Department providers in the UK were required to participate in the Friends and Family Test from 1st April 2013 (inpatients started in April 2012 in Dudley) with maternity services starting in October 2013. Results are published on NHS Choices as: normal, better or worse than others. Friends and Family Test scores are also updated in our wards/departments each month for patients to see.

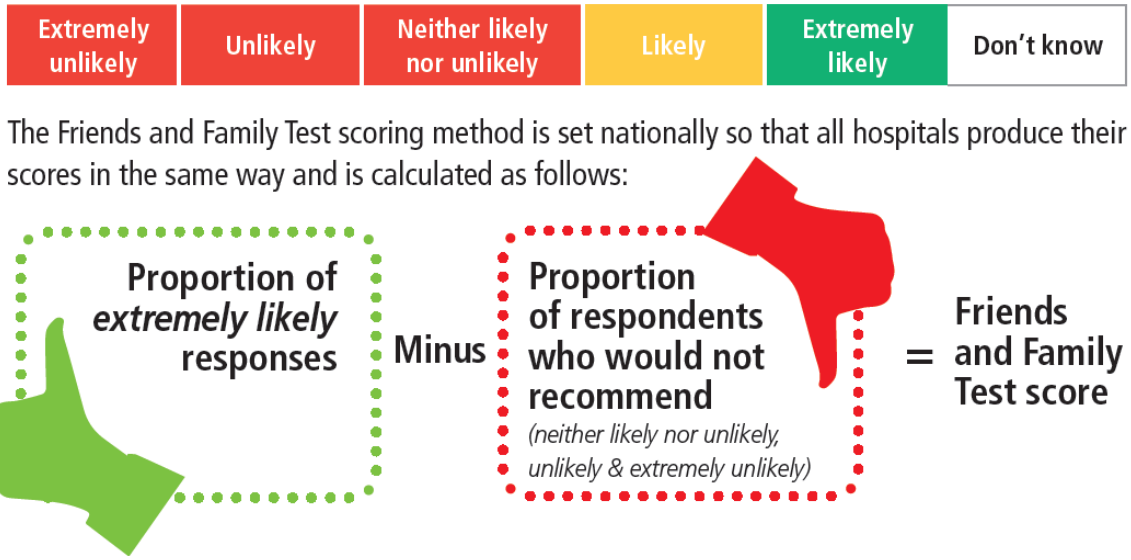
- The Test asks a simple question "How likely are you to recommend (ED/Hospital/Maternity service) to friends and family if they needed similar care or treatment?"
- This is followed up with a question asking "Was there anything that could be improved?"

For inpatients the question is asked at discharge via a confidential postcard. ED patients who are not admitted are either given a postcard or a token (to post into collection boxes).

For maternity the question is asked a number of times during the woman's progression through her pregnancy, birth and postnatal care. The survey is given at the following times:

1	36 week antenatal appointment
2 and 3	At discharge following birth (birth and postnatal ward)
4	At discharge from community postnatal service

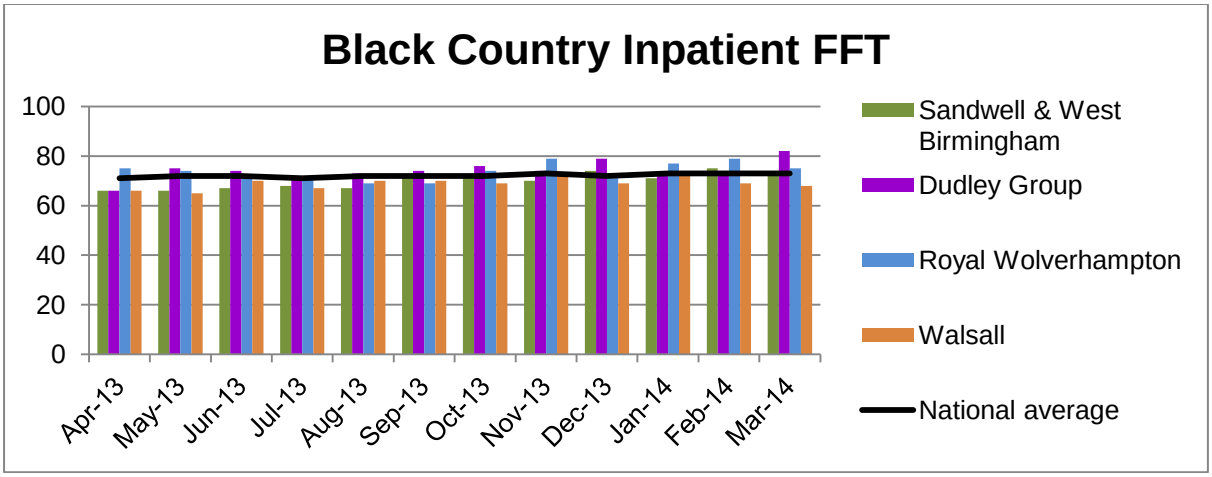
There is a requirement to achieve a 20 per cent response rate for inpatients and ED and 15 per cent for maternity.

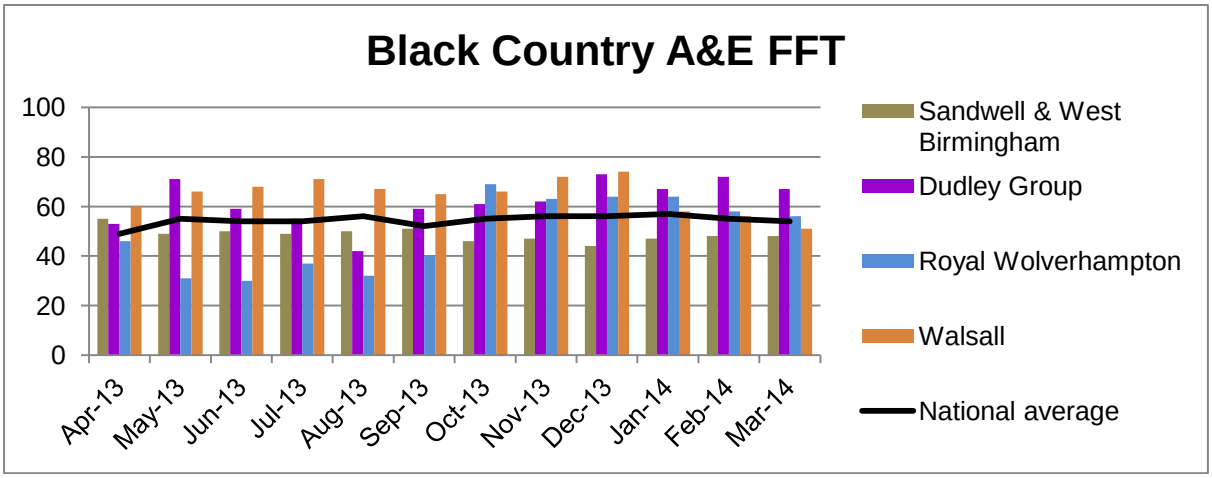


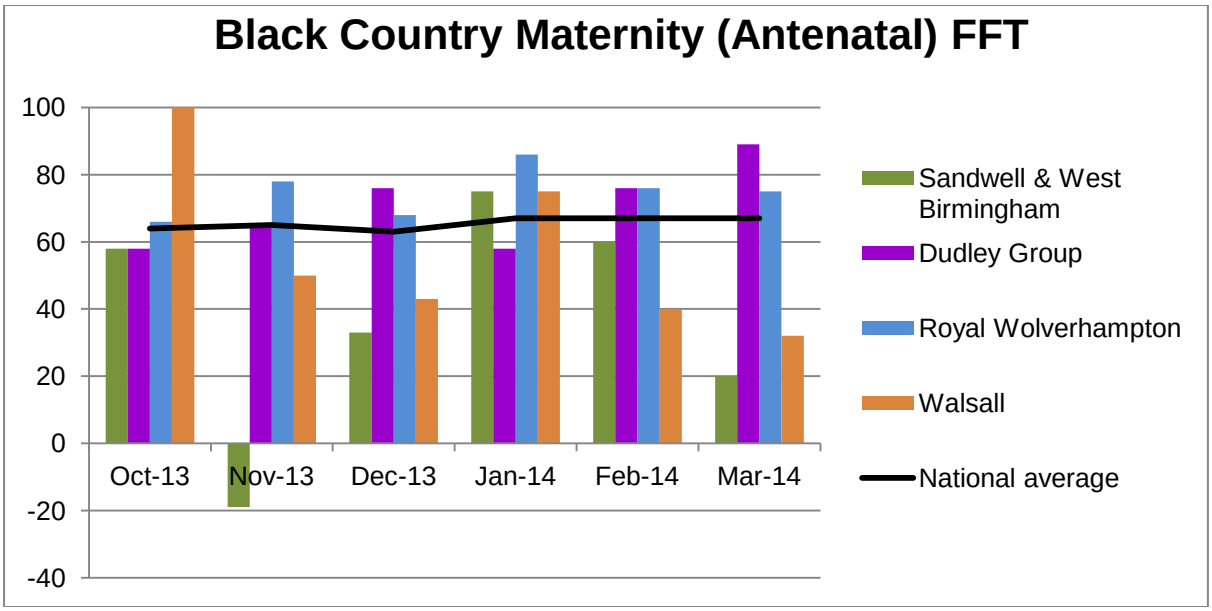
Likely and *don't know* answers are not included in the score. Scores can range from -100 to +100

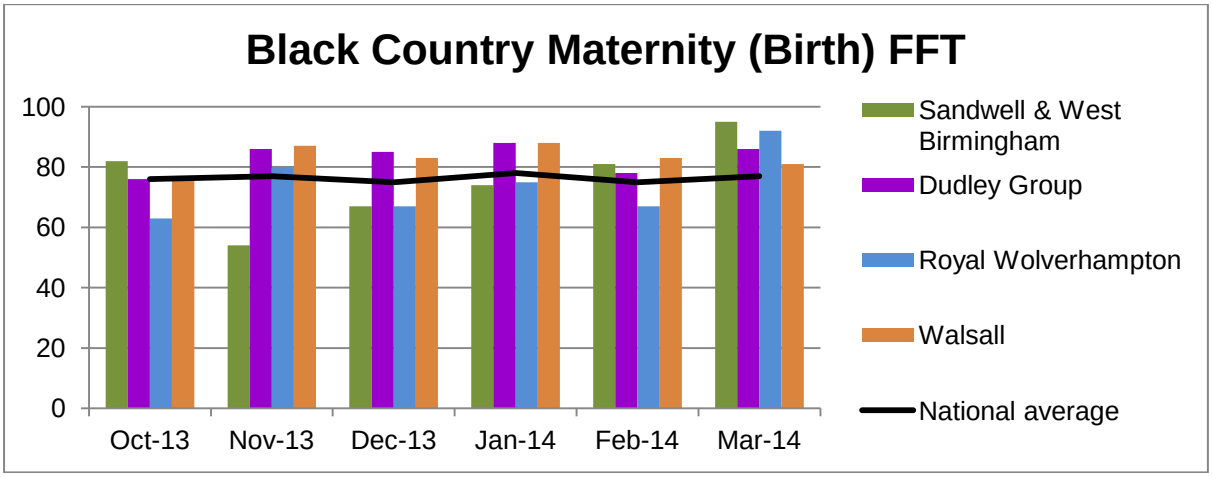
The charts below show our scores for 2013/14 which indicate, for the majority of months, the Trust was above the national average and a high scorer in the Black Country region.

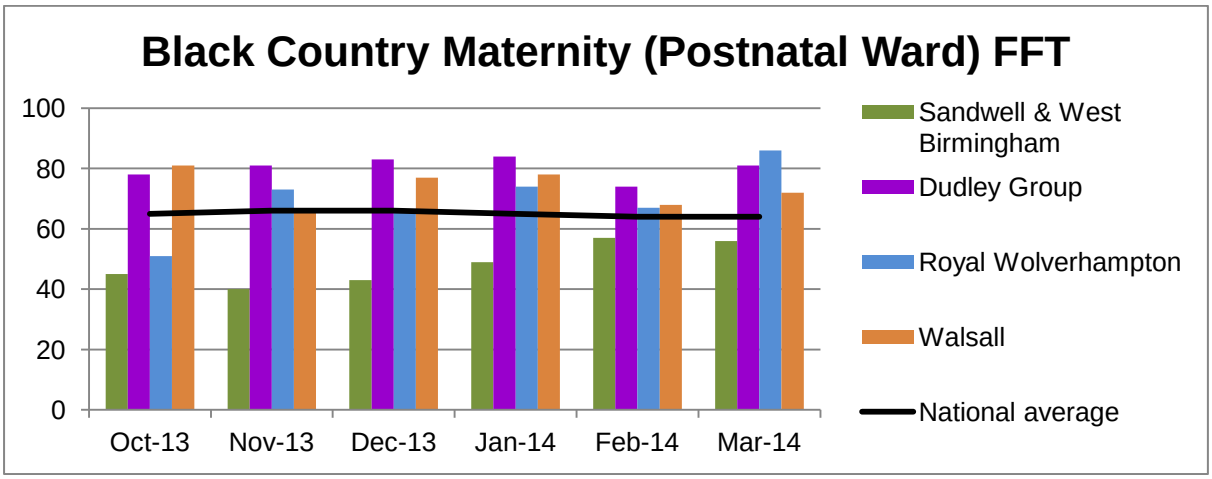
In 2014/15 we are expecting to see the Friends and Family Test rolled out to staff, outpatients, community and day case.

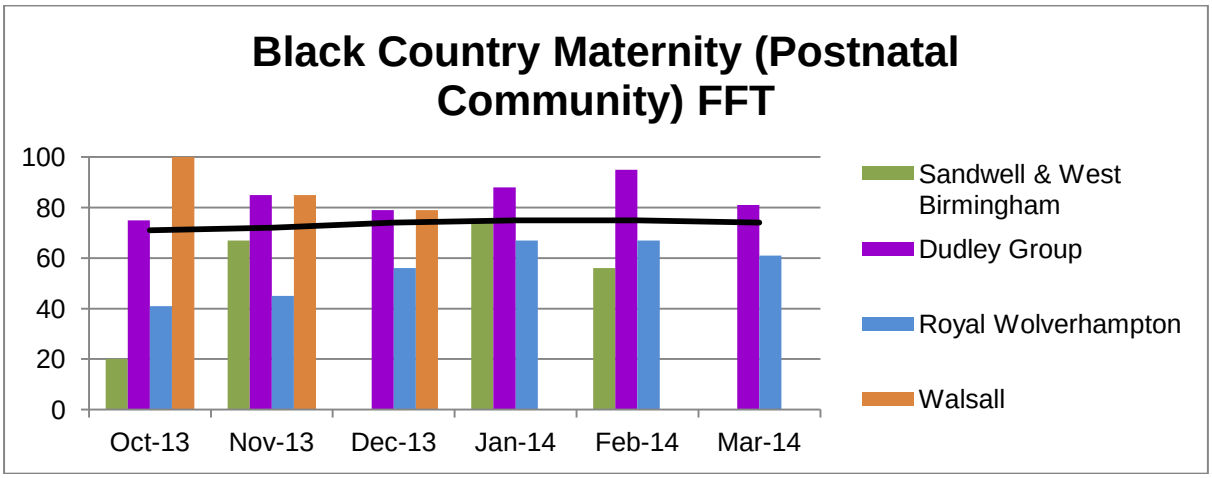












In December and March Sandwell had fewer than the required responses and so data was not published.

From January to March, Walsall did not report any data.

b) Real-time surveys

During 2013/14, 1,440 patients participated in our real-time surveys. This number has decreased compared to last year as more resource has been directed towards implementation and running of the Friends and Family Test and targeted surveys on inpatient meals to help inform our menu review. The real-time surveys work well alongside the Friends and Family Test and these are reported in a combined report to wards and specialties allowing them to use important feedback from patients in a timely manner. This allows us to react quickly to any issues and to use patient views in our service improvement planning.

c) Patient stories

We have continued using patient stories during 2013/14 to enable the patient voice to be heard at the highest level. Stories have been heard at Board meetings and used for service development planning and training purposes.

> **Excellent care and treatment from arrival through to discharge with friendly re-assuring nurses before, wonderful, skilful surgery, followed by delightful aftercare, including tea and toast.**

3.2.3 National survey results

In 2013/14 the results of three national patient surveys were published: inpatients, cancer and maternity.

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	Sample month	Trust response rate	National average response rate
Inpatient survey (published April 2014)	July 2013	50%	49%
Cancer survey (published August 2013)	September to November 2012	66%	64%
Maternity survey (published December 2013)	February 2013	37%	46%

What the results of the surveys told us

Inpatient Survey
The survey told us that we are 'About the Same' as other trusts in all 10 sections of the survey: 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 and overall views and experiences.

Areas where improvements could be made:

- Inpatient meals

Cancer services
Compared to last year, the results of 20 questions showed an improvement and 11 showed no change; however, 27 had deteriorated.

Things we are good at:

- Enabling patients to take part in cancer research

Areas where improvements could be made:

- Provision of information on getting financial help
- Patients being given the name of the clinical nurse specialist in charge of their care
- Patients being given a choice of treatments and being more involved in decision making

Maternity
In the three survey sections we scored 'about the same' as other trusts in two sections (labour and birth and staff) and 'better' than other trusts in care in hospital after the birth.

Things we are good at:

- Partner or companion able to be involved as much as they wanted
- Women being spoken to in a way they could understand

Areas where improvements could be made:

- Staff introducing themselves

Below are some examples of actions taken as a result of patient feedback:

Inpatients	
You Said	**We Did / Doing**
The food needs to improve.	Complete menu review underway. Change of bread to Hovis. Change in some meat products. Sandwich trial undertaken – new fillings. Patient taste sessions being set up to test proposed new menu.
It is too noisy at night.	Proposal to change to soft close bins being scoped. Some staff on individual wards have been reminded to be quiet. Campaign being drawn up regarding quiet night times. Switch off times for TVs agreed and put onto night time site coordinator's schedules.
Extra drinks needed.	Drinks rounds increased on wards where this was requested. Volunteers visit wards to help refill water jugs.
It would be good to have a hot meal on the discharge lounge before you go home.	Hot meals introduced to the discharge lounge.
The cups are too small for a good cup of tea/coffee.	Cups replaced with mugs.
Can sometimes take a while to answer call bells if staff are busy.	Surgical wards are trialling a new call bell answering process.

Emergency Department	
You Said	**We Did / Doing**
Relatives' room was tired and shabby.	Room redecorated and new furniture purchased.
Need more staff.	More funding acquired for nurses. Staffing reviewed daily by lead nurse.
The waiting room is very uncomfortable.	Seating has been moved around to try and improve the waiting area and patient flow. Quotes for new seating requested from charitable funds. Bariatric seating being sourced. Vending machines checked daily to check stock and availability.
Waiting time too long when you have a clinic appointment.	Receptionists instructed to advise patients of waiting time when they book in. Any delays over 15 minutes to be reported to the nurse in charge.
Extra wheelchairs needed.	This was a Trust-wide issue and so 60 additional wheelchairs procured.

Maternity	
You Said	**We Did / Doing**
Clearer signs needed so that the correct room can be recognised.	A new poster will be designed for the entrance of the department.
Waiting times in the clinic can be long, without any explanation.	Lead midwife/clinic coordinator to regularly update women on the waiting times. Information board to be kept updated.
Food could be better.	Maternity unit included on food survey to help inform menu review.
Fathers to be able to stay overnight, comfortable seating needed.	Partners are able to stay overnight if women are in single room. We are purchasing more guest beds for this purpose.

Cancer	
You Said	**We Did / Doing**
More information was needed around getting financial help	We are working with the Dudley Citizens Advice Bureau who, in partnership with Macmillan Cancer Support, help patients in identifying and assisting them to claim benefits they are entitled to.
More information about treatments and options were needed	We are reviewing and improving our information. We have also purchased some information stands to improve the availability of cancer information.
Can I bring a friend or relative to my appointment?	We have included information in our letters to patients advising that they can bring a friend or relative to their appointment.

3.2.4 Examples of specific patient experience initiatives

a) Sensory room on the Children's Ward

The new sensory room features a cushioned floor and is filled with specialist toys and equipment. It can be used by children on the ward and their families under the supervision of one of the ward's play specialists. It has been funded entirely by donations from the local community following an appeal organised by play specialists Linda Taylor, Ruth Russell, Julie Dale and Mary Williams.

The room is an invaluable addition to the hospital's provision for patients with additional learning needs. Linda Taylor has indicated that we have always catered very well for most of our children but realised that we had very little that was specifically targeted towards our patients with more complex play needs. Even though it was our patients with additional needs that we initially had in mind for the room, it will be incredibly beneficial to all the children. It is ideal for sensory development but also gives all children a lovely place to relax or just spend some time quietly under supervision.

The Cbeebies *Waybuloo characters Yojojo and De Li joined patients and staff on the Children's Ward to mark the grand opening of the brand new sensory room.*

b) Community volunteers (in partnership with Dudley College)

During 2013/14, patients at Russells Hall Hospital have been able to take advantage of the skills of Dudley College students who visit the hospital to offer free hair and beauty treatments. Since September the students have visited different wards each week helping lots of patients to feel better and look good.

The students, who are all training for a career in the hair and beauty industry, offer complimentary treatments making a huge difference to people who are in hospital and away from family and loved ones. Through their visits to the hospital students gain confidence and build on their communication skills as well as obtaining assessment opportunities when appropriate. It gives a win-win feel-good factor to everyone involved.

c) Schwartz Centre Rounds

The Trust has started a series of events called Schwartz Centre Rounds. These were originally pioneered in America, but have been championed in England by the Kings Fund and are now overseen by the Point of Care Foundation, both of which pioneer innovation in healthcare.

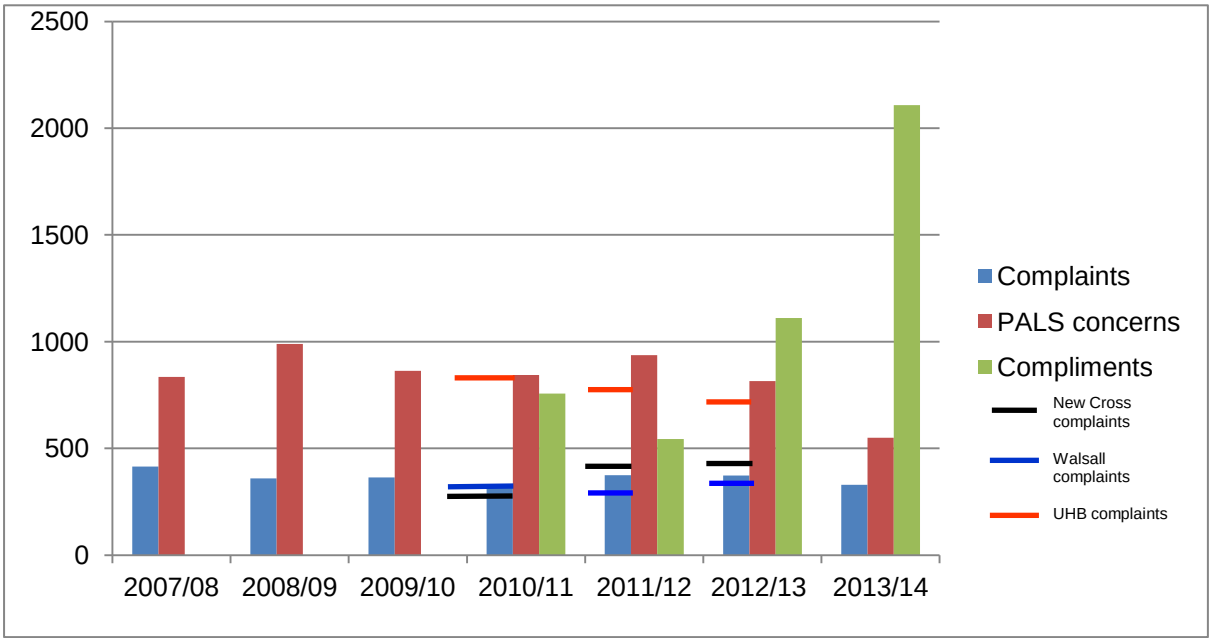
These meetings offer an emotionally safe space for staff to explore the human impact of caring. During a Schwartz Centre Round, a patient case study is presented by a team of clinicians who describe the care and treatment provided to the patient with particular reference to the human impact it had on the patient and staff. This leads into a facilitated open discussion for others to offer their own reflections.
The experience of staff who have taken part mirrors what the Kings Fund identified in a national evaluation, that:

- Individual participants report benefits for themselves,
- Participants report benefits for their day-to-day care of patients,
- Rounds are seen as a source of support in providing day-to-day patient care,
- Participants report that team work is strengthened,
- There have been small but significant changes in the hospital culture.

3.2.5 Complaints, concerns and compliments

This summary contains three sets of tables showing a) the total number of complaints, concerns raised with the Patient Advice and Liaison Service (PALS) and compliments received during the year, compared to both previous years and where possible compared with local trusts b) the types of complaints and concerns this year c) the percentage of complaints compared to the total number of patients visiting the Trust and a further section d) some examples of changes in practice made from complaints and concerns.

a) Total numbers of complaints (with local trust benchmarks), PALS concerns and compliments

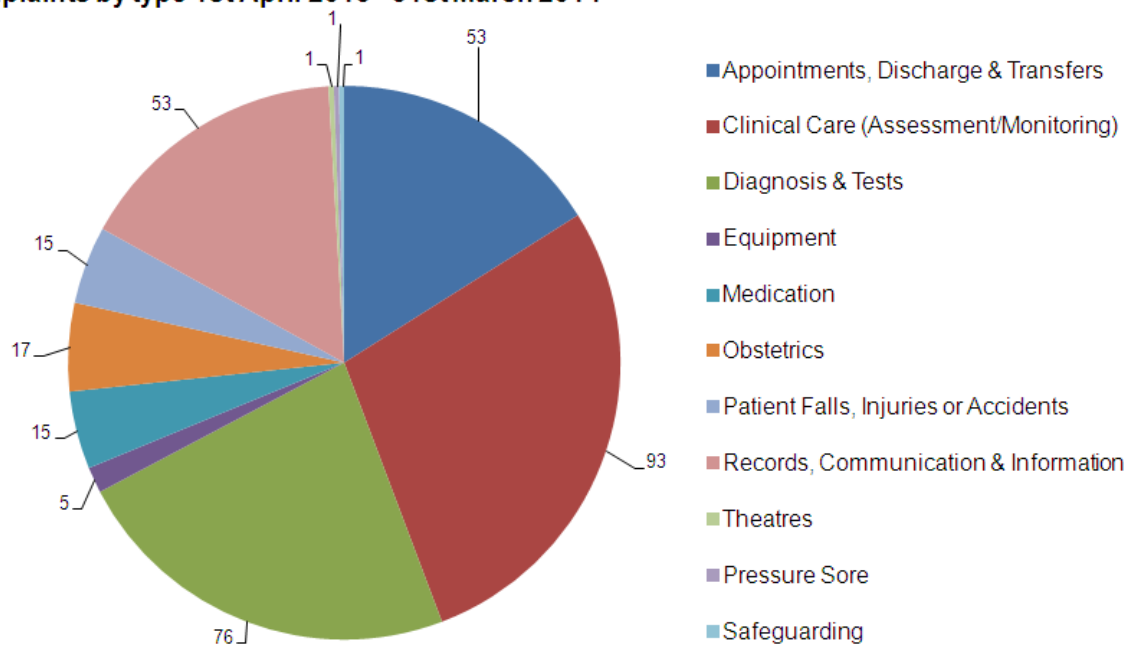


It can be seen that the number of concerns and complaints has reduced from last year. The Trust has introduced an improved system of recording the compliments received and so this will account for some of the increase this year.

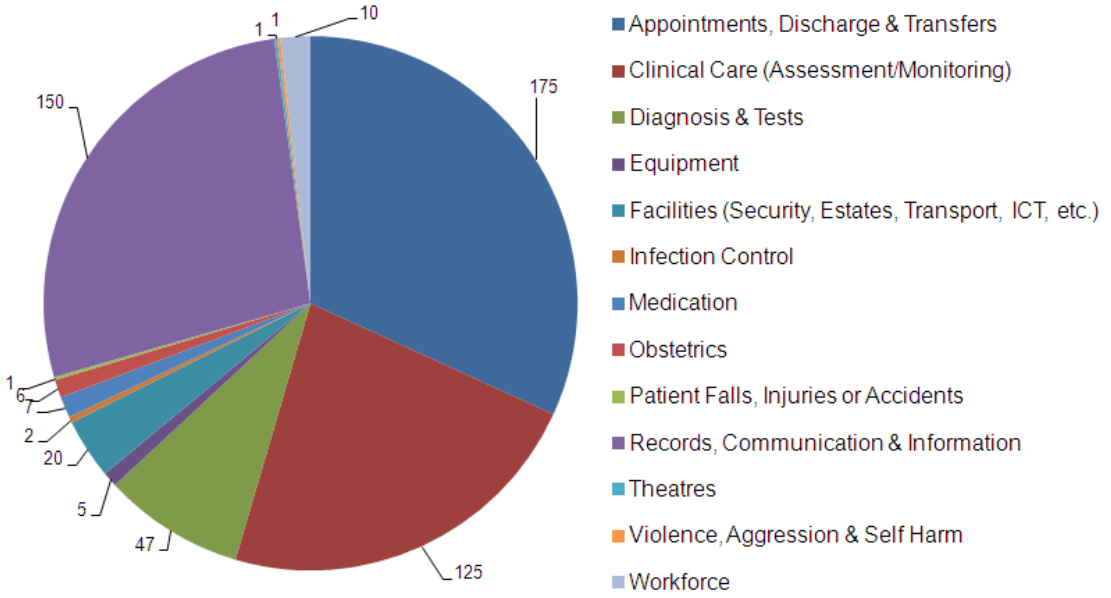
At all times I felt that we were being actively listened to, treated with respect and given appropriate information and choices.

b) Types of complaints and concerns throughout the year

Complaints by type 1st April 2013 - 31st March 2014



Concerns by type 1st April 2013 - 31st March 2014



c) Percentage of complaints against activity

Activity	Total for 2012/13	Total Q1 ending 30/6/13	Total Q2 ending 30/9/13	Total Q3 ending 31/12/13	Total Q4 ending 31/3/14	Total for 2013/14
Total patient activity	735,247	185,113	181,539	186,084	181,503	**734,239**
Complaints against activity	**0.05%**	**0.05%**	**0.04%**	**0.04%**	**0.04%**	**0.04%**

d) Examples of changes in practice from complaints and concerns from departments across the Trust

Summary of complaint	Actions Taken
Trust-wide General	The chief executive invited previous and ongoing complainants to Listening into Action meetings, held in December 2013 and March 2014, to listen to their experiences. Following feedback received during the first meeting, an immediate change was to offer new complainants a meeting to discuss their concerns prior to the commencement of an investigation.
Ambulatory Medicine Complainant was dissatisfied with 'insensitive' correspondence	Department will formally invite patients to research projects at the time they attend clinic; furthermore, letters have been amended to take into account comments regarding 'insensitivity'.
Community Pharmacy Patient was concerned that her own supply of drugs for her allergy was used in Emergency Department (ED)	Patient was supplied with adequate replacement on discharge. However, following discussion between consultants and pharmacy it was agreed to increase current 'fixed order' level to ensure more than double the previous level is held in stock. Also, additional drugs were added to ED stock list to ensure a supply is always in the cupboard ready for use.
Diagnostics Whilst patient was being X-rayed following a hip operation, patient got out of wheelchair and fell sustaining bruising.	Staff now emphasise the need for patients to remain seated until asked or given assistance to move or mobilise to reduce a reoccurrence of this incident.
Emergency Department Patient discharged from department (ED) with a cannula still in situ.	The individual caring for the patient was an agency nurse. This incident was taken into account when a decision was made not to use this nurse again and staff agency was informed.
Emergency Department Patient attended Emergency Department (ED) with symptoms of DVT but not all appropriate tests completed.	Doctors will educate colleagues about the importance of considering the possibility of DVT even in younger patients with minimum risk factors.

Summary of complaint	Actions Taken
Specialty Medicine Due to religious beliefs patient unhappy to be seen by male technician. This led to a wait of two hours to be seen by a female technician.	Information leaflets will be revised and a new 'alert' placed on local booking system so that when department informed that a patient always requires staff of a specific gender it is recorded on the system.
Specialty Medicine Relatives concerned about care and communication in ward.	Apology offered for the lack of empathy from staff. Palliative care team will work with ward staff to provide further training on end of life care. Communication between staff and relatives was discussed during a ward meeting.
Surgery & Anaesthetics Patient should be monitored every six months but had waited longer (eye clinic).	New clinics have been set up to help alleviate the situation. (patient sent 'soon' appointment).
Surgery & Anaesthetics Patient concerned he was on Surgical Admission Unit for too long and not kept informed or offered food	Laminated signs erected in the bays and side rooms to explain to patients why they are kept 'nil by mouth' but advising them to ask nursing staff if they are unsure. Theatre 'team briefs' will also enable staff to offer appropriate refreshments if long delays expected.
Surgery & Anaesthetics Relative concerned about long wait for patient in admissions area when attended as day case. Also unhappy with general pre-operative arrangements.	Family met by the deputy matron on the day and she offered her apologies. Advised that a new 'team brief' was introduced in theatres to discuss lists and need to keep patients better informed of any delays.
Trauma, Orthopaedics & Plastics Daughter concerned about poor communication on ward. Patient was due appointment at another Trust but this was cancelled as ambulance was not booked.	Lead nurse advised ward staff that they must inform the ward clerk at all times when they need to arrange transport.
Women & Children (Maternity & Gynaecology) Delay in treatment in maternity resulted in baby being born in an inappropriate place. Also communication issues raised.	Explanation provided regarding urgency of treatment, staff did as much as they could to assist afterwards. Staff will be reminded of the importance of effective communication and appropriate behaviour in stressful situations.

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

In May 2013, 17 patient assessors joined hospital staff to undertake an assessment of the quality of our non-clinical services and buildings. These reviews are called Patient-Led Assessments of the Care Environment (PLACE). This is a new assessment that replaces the previous annual PEAT (Patient Environment Action Team) system.

The assessments are patient-led to ensure that the patient voice is given the highest priority. Assessors visited different parts of the hospital (inpatient wards, outpatient clinics etc.) and scored Russells Hall Hospital against 150 standards covering:

- Cleanliness
- The condition of the buildings and fixtures (inside and out)
- The quality and availability of food and drinks
- How well the environment protects people's privacy and dignity

We were delighted that we scored higher than the national average in three of the four above topics.

	Cleanliness	Food	Privacy, dignity and wellbeing	Condition, appearance and maintenance
Russells Hall Hospital	97.87%	78.36%	90.92%	90.46%
National Average	95.75%	85.41%	88.90%	88.78%

We scored slightly lower than the national average for food and hydration (78.36 per cent against the national average of 85.41 per cent) and this is something we are already committed to improving. We have already held some tasting sessions with public and patients and plan to hold more to help us make our decision about what elements of food provision we need to improve. We are also analysing patient feedback on a weekly basis and making improvements and menu changes on the basis of their comments.

Examples of the comments made by patient assessors on the day:

"Sometimes these things are just about 'ticking boxes' but this has been much more than that – everyone has taken it really seriously and I feel like we've done what we came to do properly."

"The day gave me an insight into things from a different perspective. I was looking at things from a completely different angle, and looking out for things I wouldn't normally notice. I'd say interesting and informative sums up the whole day for me."

"I think we all found exactly what we were expecting to find: a hospital that cares and really does consider its patients and their relatives."

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 reported six breaches of same-sex accommodation due to a small number of recovering patients on the Intensive Care Unit waiting for beds on general wards.

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 1309 patients who responded to this question, the number whose perception was that they shared a room/bay with members of the opposite sex was 36 (3 per cent). 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	Comparison with other trusts 2013
Patients who agreed that the hospital room or ward was clean	87%	87%	88%	8.7	8.8	9.0	About the same
Patients who would rate their overall care highly	79%	76%	74%	7.4			About the same
Rating of overall experience of care (on a scale of 1-10)					7.6	7.7	
Patients who felt they were treated with dignity and respect	89%	86%	86%	8.6	8.7	8.6	About the same

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).

The doctor who treated me was thorough and professional and treated me with respect and dignity.

Patient Safety

3.3 Are patients safe in our hands?

3.3.1 Introduction

The Trust ensures the safety of its patients is a mina 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 take 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

These Patient Safety Leadership Walkrounds consist of directors hearing first hand the safety concerns of frontline staff and governors listening to patients and any concerns they may have.

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, governors and a scribe from the governance team.

The team observes practice by being shown around the ward/department by one of the 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 the 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:

- A dedicated acute confusion team is now in place on a ward to ensure the allocation of specialist skilled nursing staff to provide additional support to patients with dementia or an episode of acute confusion. There has been an observed reduction in number of falls on the unit since its introduction.
- Relocation of the drug preparation/treatment room nearer to the inpatient area has improved response times for patient medication including analgesia.
- Addition of five pieces of vital signs monitoring equipment provided for a ward which has enhanced the safety and quality of care for patients.
- Patients waiting in the discharge lounge were previously not given the option of hot meals. A choice of a hot meal is now available.
- Ward previously had no equipment to accommodate overnight stays of patients' relatives/carers. Four reclining chairs are now available on the ward for relatives to stay overnight, if required.
- Additional weighing scales that have a stable base and a facility to hold on to for balance were acquired for a department to improve patient safety.
- A six-month trial of the relocation of the delivery suite has been successful and has now become permanent.
- Visiting hours for the Neonatal Unit were extended.

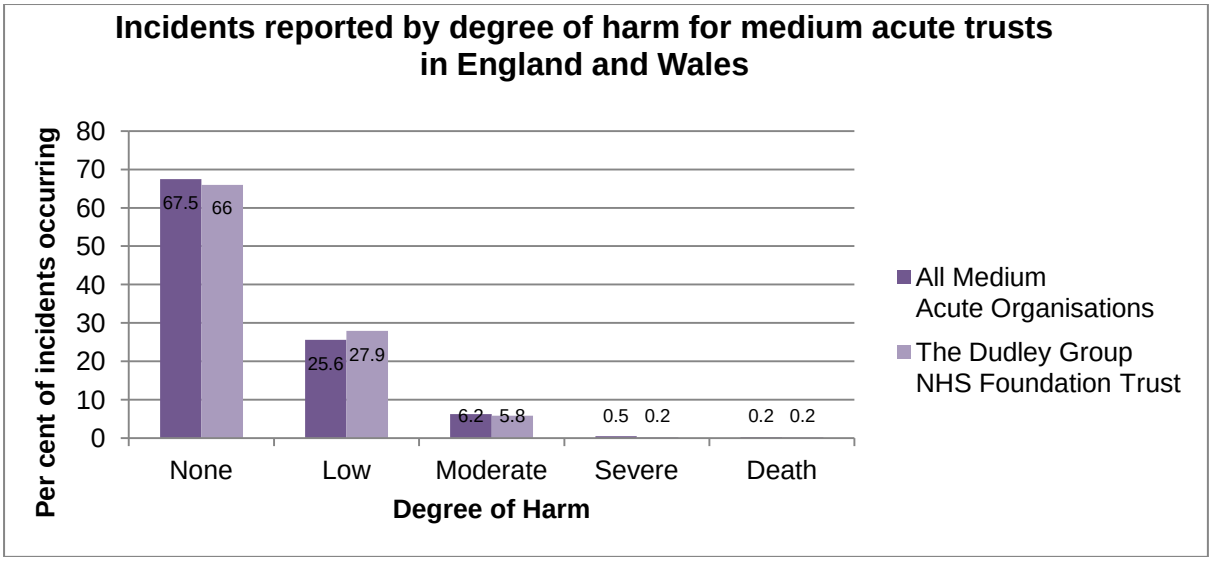
3.3.3 Incident management

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 2013 to 30th September 2013. Organisations are compared against others of similar size. The Trust is the seventh highest reporter of all incidents in its class of medium size acute 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 is similar to other medium sized trusts. Nationally across all medium sized acute trusts, 67.5 per cent of incidents are reported as no harm (the Trust 66 per cent) and 0.7 per cent as severe harm or death (Trust 0.3 per cent).



During the period beginning April 2013 to the end of March 2014, 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 147 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 in practice in response to the above incidents have been:

- Bespoke falls assessment developed to meet the needs of renal dialysis patients
- Dedicated urology ward
- Purchase of additional bed/chair alarms to help prevent patient falls
- Formalised guideline around the frequency of patient vital signs recording

- Introduction of a medicines link nurse practitioner to improve education for all staff
- Trust-wide radiology handover form introduced to ensure sign off from named nurse before patient leaves the ward
- All handwritten X-ray requests to be in block capitals
- Red/Amber/Green criteria introduced for Ophthalmology follow up patients to allocate appointments according to clinical urgency
- All patients now weighed on admission to the Emergency Assessment Unit to ensure accuracy of medication dosages
- Patient discharge checklist proforma implemented
- Use of name stamps for doctors and nurses to clearly identify prescribers on medication sheets
- Standard operating procedure implemented for community staff in regard to safe storage of Trust equipment at the end of working shift or whilst off duty
- Introduction of a new oxygen therapy prescription form
- Review of throat pack flow chart and policy within theatres

3.3.4 Nursing Care Indicators

Every month 10 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 (approximately 430 records are audited per month). The purpose is to ensure nursing staff are undertaking risk assessments, performing activities that patients require and are accurately documenting what has taken place.

The themes looked at are patient observations, pain management, manual handling, tissue viability, medications, documentation, privacy and dignity (community only), nutrition, infection control, Think Glucose, bowels and fluid balance. As can be seen in the table below, the Trust now assesses 12 criteria in hospital and eight in the community. Within community services, there are currently four variations of the audit tool and in hospital there are six in order to capture the practice for specialist areas.

Community results
The table below shows the end-of-year results for each of the criteria assessed by the community teams. During 2013, a review has been undertaken and the questions within each of the individual criteria have been 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%
Difference 2012 - 13	=	↑1%	=	↑2%	↓1%	=	=	↑1%

Inpatient results
During 2013, a slight amendment has been made to the audit questions with the inclusion of the resuscitation trolley checks to the patient observation criterion. Results continue to show improvements with the largest in the fluid balance theme with an increase of 14 per cent on previously reported results. Improvements can be seen in 10 out of the 11 criteria that are assessed.

Criterion	Patient Observations	Pain	Manual Handling	Tissue Viability	Medications	Documentation	Nutrition	Infection Control	Think Glucose	Bowels	Fluid Balances
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%
Difference 2012-13	↑6%	↑7%	↑6%	=	↑3%	↑2%	↑7%	↑3%	↑11%	↑6%	↑14%

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 is being adopted across all of the NHS.

Each month, on a set day, an assessment is undertaken which has covered on average 650 inpatients (with exceptions being day case patients, those attending for renal dialysis and well babies) and 620 patients being cared for in the community. The assessment consists of interviews with the patients, accessing the patient's bedside nursing documentation and, when required, examining the main health record.

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

We aim to reduce these rates to zero percent. Some examples of actions being taken as a result of the assessments are shown below:

- Introduction of a new formal escalation process for less than average results
- Implementation of intentional rounding throughout the Trust (a process of each patient being seen by a member of staff at set times which is documented) as a patient safety measure to improve patient to nurse contact and reduce the prevalence of falls
- Implementation of a systematic process of documenting the care of patients with a urinary catheter bundle to monitor the correct use of indwelling urinary catheters

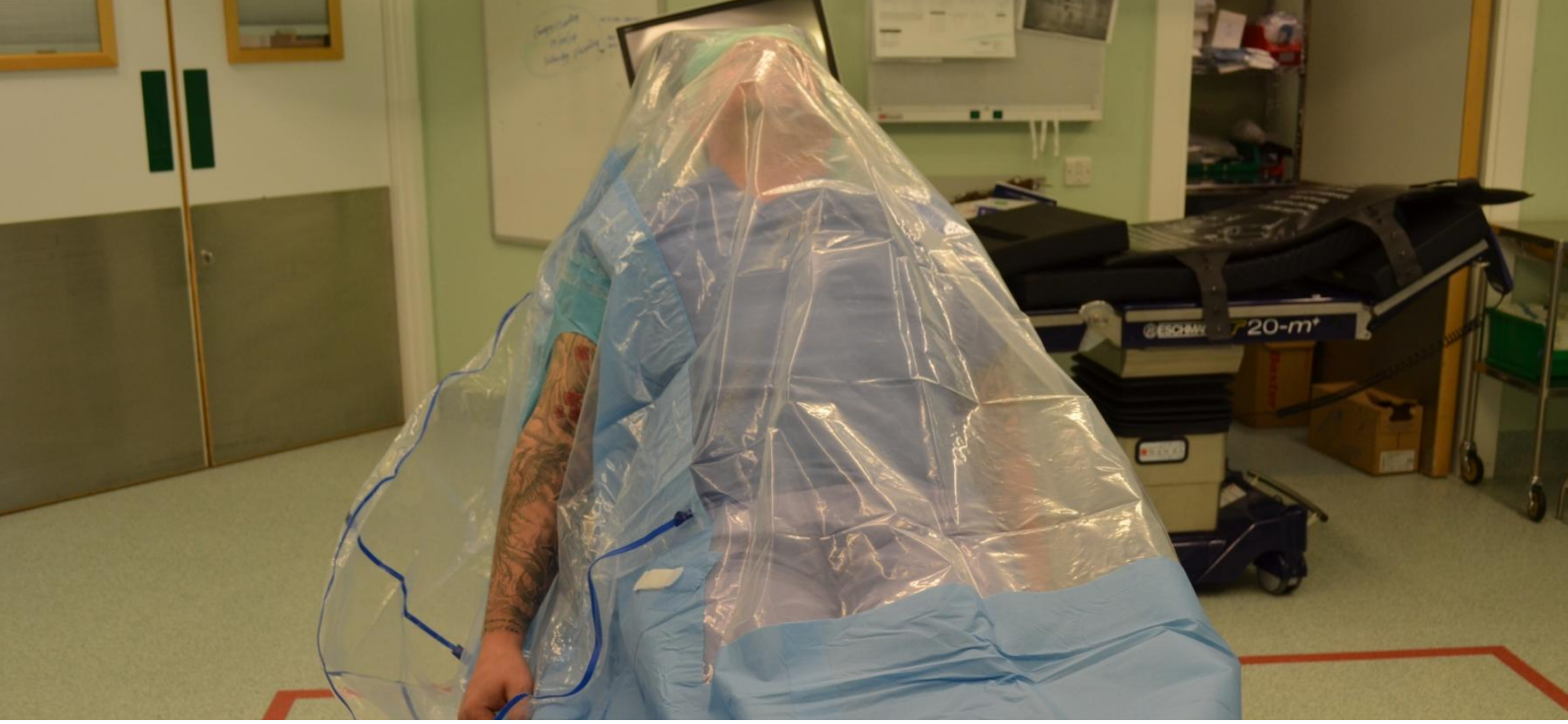
3.3.6 Examples of specific patient safety initiatives

a) Hypo boxes in wards and departments

All wards and other clinical areas now have a hypo box containing all that is needed for the prompt and appropriate treatment of hypoglycaemic episodes experienced by patients. Hypoglycaemia should be treated as a medical emergency because a patient could become unconscious. The standardised hypo boxes will enable staff to quickly treat the diabetic emergency.

As well as selection of glucose products, the hypo boxes contain a patient record book to record patient details and treatment. The boxes are kept in an easily accessible and standard place on every ward and contain a variety of glucose products to be given immediately a patient is having a hypoglycaemic episode. A laminated copy of the clinical guidelines reminds staff how to treat such events.

> **We received nothing but absolute care, consideration and smiling faces, helpful beyond duty.**



c) Beach chair shoulder drape with patient safety window

A new innovative product designed by Dr Nahla Farid, Consultant Anaesthetist at the Trust, is now being manufactured and is available for trusts across the country. For shoulder operations, the patient needs to be in a sitting position and, in the past, all of the patient has been covered by normal opaque drapes except for the affected shoulder and arm. This made it difficult for the theatre team and, in particular, the anaesthetist to continually observe the position of the head and neck of the patient. A change in position of the head and neck could potentially introduce a risk to patients in terms of physical injury. The new drape allows a complete view of the patient's position so substantially reducing the risk of non-recognition of any movement. The drape is less expensive than the existing drapes and is now being used successfully in the Trust.

b) Electronic referral to the eye department for rapid consultation and management

The department, together with a number of general practitioners, is piloting a new system whereby all urgent referrals are made electronically using a template which is easy to complete and which contains all the information required to make an assessment on priority. The previous telephone and fax referral system had a number of problems such as telephone messages being time consuming with the referring doctor often needing to wait to find the appropriate member of staff to accept the call. The content of telephone conversations cannot be audited while faxes are generally hand-written and the print on arrival can be illegible. They may not contain all the necessary information to make an informed decision on urgency, and they are subject to potential practical issues such as problems with ink and paper. These issues can result in delays in treatment and a less-than-quality service.

With the new system, all urgent referrals are made by email using a form which is easy to complete and which contains all the information required to make an assessment on priority. The incoming email results in a senior member of staff with an alarm device being notified immediately so the patient with an urgent eye problem can be assessed immediately, and treated more efficiently and effectively in the right place at the right time. It is planned to extend the system to all general practitioners (GPs) in Dudley.

3.3.7 Patient safety measures

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

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) 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.*

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) The Mom2Mom breastfeeding support project gained a Royal College of Midwives Annual Midwifery Awards

The project, which encourages support from family members, was announced as the winner of the JOHNSON'S® Baby Award for Evidence into Practice**.** The Mom2Mom support project's main aim is to encourage Dudley's new mums to choose breastfeeding with the support of their own mothers.

Project lead Lucy Johnson said, "We were finding that so many of our mums-to-be were worried about the idea of breastfeeding and were considering using formula milk instead. The idea of experienced mothers passing on their knowledge to new mums isn't a new one, but we found that lots of new grandparents were apprehensive about offering advice in case they suggested the wrong thing. We introduced Mom2Mom workshops to teach grandparents-to-be how to best support their daughters once they give birth and to keep them up to date with current best practice."

b) Improving palliative care

The Trust is thrilled to be one of the few trusts taking part in the Specialist Care at Home pilot to improve palliative care for our patients. In collaboration with Dudley CCG and Mary Stevens Hospice, we have been awarded £250,000 from Macmillan Cancer Support for an innovative pilot to improve palliative care for patients in a home setting. By working with our partners we can make a real difference to improving end of life care for our patients. In addition, the Trust has signed up for Phase 2 of the transforming end of life care in acute hospitals, which is part of the national end of life care programme. Again, we are working collaboratively with our partners in primary care, hospice and social care to ensure we all improve the quality of patient, family and carer experience, general decision making, planning and communication, education and training for our workforce across all settings.

3.4.3 Examples of innovation

a) Action Health

A pioneering exercise programme called Action Health has started this year at Russells Hall Hospital in conjunction with the cardiac rehabilitation charity Action Heart and Macmillan Cancer Support, which provided a grant of £35,000 for the service to Professor Carmichael. Action Heart, with its specialist gym, commenced in 1978 and now looks after more than 700 patients at any one time. The 12-week programme provides tailored individual advice for patients and helps them incorporate physical activity into their lives. Research has shown that being active during and after treatment can help recovery and the long-term health of cancer patients.

Catherine Bytheway, one of the first patients to take part said, “It was a good opportunity to do something really positive after a not so positive situation – I got to take control of myself again. I would recommend it to anyone being treated for cancer. I felt so much more motivated compared to when I tried exercising on my own.”

Another patient has said, “Having learnt of the benefits of being active after having cancer, I decided to take up the offer of 12 weeks’ free gym membership. I am now on my seventh week. I don’t find it easy to make the effort but the feeling of achievement, well-being and knowing that I am improving my chances for a healthier life, more than compensates for the work it takes.”

b) Flexible endoscopic therapy for Zenker’s diverticulum

Gastroenterology consultant Dr Sauid Ishaq has launched a treatment to cure a rare illness which has transformed the life of 75-year-old Roy Bradley. At the hospital, six patients have so far benefited from the treatment which relieves a condition that makes it hard to swallow.

Dr Ishaq, said, “We are very excited because we are the only centre in the country to offer this procedure, which is called flexible endoscopic therapy for Zenker’s diverticulum.”

The procedure, which lasts 20 to 30 minutes under a short-acting sedative, provides an answer for patients who would not be well enough for surgery under general anaesthetic. It involves using an argon beam to melt the wall of a pouch, vaporising surrounding tissue so that food can go straight down the gullet.

Mr Bradley said, “I was having a heck of a job swallowing food and it caused me a lot of problems and embarrassment. I’ve got coronary heart disease, which meant there would be danger if I had an anaesthetic for surgery. Now I don’t have any embarrassing moments and I’m enjoying what seems like a new lease of life.”

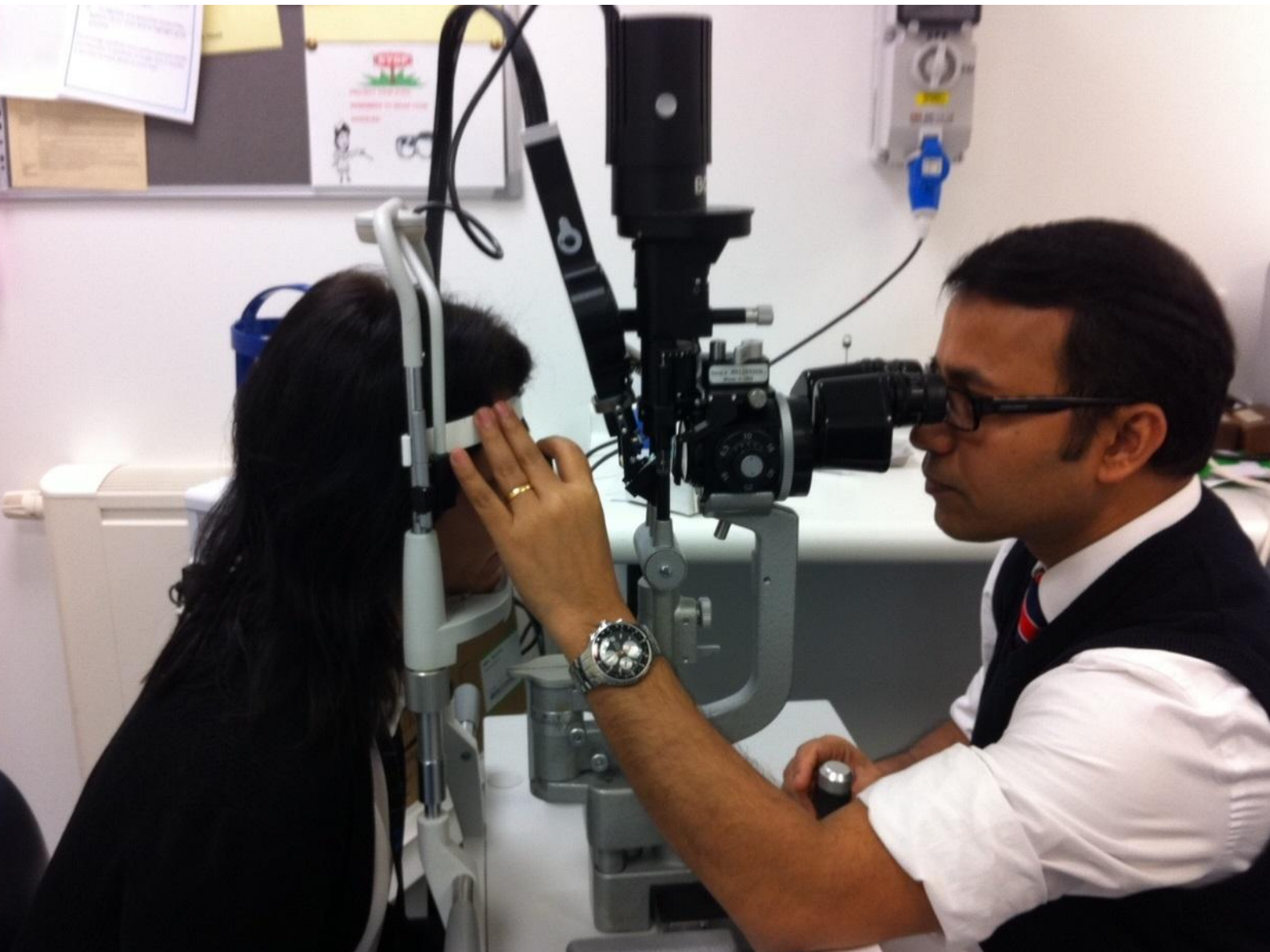
> **I cannot speak too highly of the treatment I received. The surgeon inspired the greatest confidence in me despite the obvious risks.**

c) Innovative glaucoma treatments

Consultant Ophthalmologist, and the glaucoma lead at the Trust, Mr Akash Raj has started to build a world-class glaucoma service. Since February 2014, 20 patients with glaucoma have benefitted from Micropulse Laser Trabeculoplasty, a new procedure only available at four sites across the country, including Russells Hall Hospital (and the only centre in the entire Midlands area). This allows glaucoma patients who either cannot tolerate eye drops or who have an allergy to them, or want independence from eye drops, to be effectively treated and either delaying or reducing the need for eye surgery.

In addition, in September 2013, Mr Raj began using iStents glaucoma tubes as an alternative to conventional surgery, with this technique being performed at only a handful of other centres in the UK. This procedure is less invasive and has fewer complications than surgery and is the smallest human implant available in the world.

Mr Raj has initiated a Glaucoma Support Group for the Dudley and the Black Country to help and support glaucoma patients in the region with providing all round information on glaucoma and involving them in the better glaucoma care movement. He has also started the Dudley Eye (Glaucoma) Charity appeal to help maintain and continually improve the world-class glaucoma service that Russells Hall Hospital can now provide.



3.4.4 Examples of specific clinical effectiveness initiatives

a) Cardiac Rehabilitation and Prevention Programme

This year the Department of Health published the national Cardiovascular Diseases Outcomes Strategy in which the local collaborative programme between the Trust and Action Heart was praised as ‘cutting edge’.

The programme has an open policy with respect to eligibility, accepting patients from across the cardiac diagnostic range, resulting in the team accommodating patients with pre-existing conditions/co-morbidities such as stroke, diabetes, transient ischaemic attack (mini stroke), chronic kidney disease, peripheral artery disease and rheumatoid arthritis. This collaboration means, for example, that there is a clear process with the mini stroke service, providing a 12-week exercise and lifestyle programme for this group of patients who had previously received little structured support. In addition, Action Heart and the Trust support a borough-wide exercise referral scheme for patients at high risk of developing cardiovascular disease, receiving referrals from all of Dudley’s general practitioners and hospital consultants.

b) Ambulatory Emergency Care (AEC)

AEC is a new approach to delivering safe, effective and efficient care for a significant proportion of our emergency adult patients. This new service means patients are seen, treated and allowed to go home on the same day, so avoiding an overnight admission to hospital. Working this way offers better patient experience and also ensures that those patients who do need admission are also treated more effectively with better access to beds.

A pilot began in November 2013 and initially saw more than 1000 patients. A total of 66 per cent of these patients were seen, treated and discharged the same day. The patients are seen quickly by a senior doctor who devises a plan of care and requests same day diagnostic tests, specialist referrals and follow-up appointments, if necessary. This enables the patient to return home and remain ambulant whilst in receipt of our care. Both patients’ and staff experience of receiving and delivering care in this way has been extremely positive. The team continues to monitor this and action any recommendations made through patient and staff feedback.

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
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%	6.9%^* Vs 5.9
Number of cardiac arrests Source: Logged switchboard calls	397	250	170	145	119	126	158
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%	0.7%^ Vs 0.87%

^April 2013 to January 2014 for Trust/April 2013 to December 2013 for Peer

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

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	Target 2013/14	National 2013/4	Trust 2013/14	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%	**90%**	**91.4%***	**93.95%**	☺
Maximum time of 18 weeks from point of referral to treatment (non-admitted patients)	99.1%	99.2%	99.2%	99.5%	**95%**	**96.9%***	**99.18%**	☺
Maximum time of 18 weeks from point of referral to treatment (incomplete pathways)	N/A	N/A	N/A	98.1%	**92%**	**94.1%***	**96.74%**	☺
A&E: Percentage of patients admitted, transferred or discharged within 4 hours of arrival	98.1%	98.8%	97.27%	95.4%	**95%**	**95.7%**	**93.74%**	☹
A maximum wait of 62 days from urgent referral to treatment of all cancers	86.5%	87%	88%	88.7%	**85%**	**86.5%^**	**89%**	☺
All cancers: 62 day wait for first treatment from consultant screening service	N/A	99.6%	96.6%	99.4%	**90%**	**94.9%^**	**99.6%**	☺
All cancers: 31 day wait for second or subsequent treatment: surgery	N/A	99.6%	99.6%	99.2%	**94%**	**97.4%^**	**100%**	☺
All cancers: 31 day wait for second or subsequent treatment: anti-cancer drug treatments	N/A	100%	100%	100%	**98%**	**99.7%^**	**100%**	☺
A maximum wait of 31 days from diagnosis to start of treatment for all cancers	99.3%	99.8%	99.7%	99.5%	**96%**	**98.4%^**	**99.9%**	☺
Two week maximum wait for urgent suspected cancer referrals from GP to first outpatient appointment	98%	96.8%	97.2%	96.2%	**93%**	**95.4%^**	**97.5%**	☺
Two week maximum wait for symptomatic breast patients	69%	98.2%	99%	98.1%	**93%**	**95.1%^**	**98.2%**	☺
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	☺
Data Completeness for community services: Referral to treatment information	N/A	N/A	N/A	97.3%	**50%**	**+**	**98.4%#**	☺
Data Completeness for community services: Referral information	N/A	N/A	N/A	65.6%	**50%**	**+**	**64.6%#**	☺
Data Completeness for community services: Treatment activity information	N/A	N/A	N/A	99.1%	**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

☺ = Achieved target
☹ = Not achieved target
Latest monthly figure for March 2014

* applies only from April 2013 to February 2014 as full year figures are not currently available
^applies only from April 2013 to December 2013 as full year figures are not currently available

3.6 Glossary of terms

AAA	Abdominal Aortic Aneurysm
A&E	Accident and Emergency (also known as ED)
ADC	Action for Disabled People and Carers
BAD	British Association of Dermatologists
Bed Days	Unit used to calculate the availability and use of beds over time
BBC CRLN	Birmingham and Black Country Comprehensive Local Research Network
BHF	British Heart Foundation
CCG	Clinical Commissioning Group
C. difficile	Clostridium difficile (C. diff)
CNS	Clinical Nurse Specialist
CQC	Care Quality Commission
COPD LES	Chronic Obstructive Pulmonary Disease Local Enhance Services
CHKS Ltd	A national company that works with Trusts and provides healthcare intelligence and quality improvement services
CQUIN	Commissioning for Quality and Innovation payment framework
CEM	College of Emergency Medicine
DVD	Optical disc storage format
DVT	Deep Vein Thrombosis
EAU	Emergency Assessment Unit
ENT	Ear, Nose and Throat
ED	Emergency Department (also known as A&E)
FCE	Full Consultant Episode (measure of a stay in hospital)
Foundation Trust	Not-for-profit, public benefit corporations which are part of the NHS and were created to devolve more decision-making from central government to local organisations and communities
GP	General Practitioner
HASC	Health and Adult Social Care Scrutiny Committee
HAT	Healthcare Acquired Thrombosis
HED	Healthcare Evaluation Data
HES	Hospital Episode Statistics
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
LINK	Local Involvement Network
MBC	Metropolitan Borough Council

MINAP	Myocardial Ischaemia National Audit Project
Monitor	Independent regulator of NHS Foundation Trusts
MRSA	Meticillin-resistant *Staphylococcus aureus*
MESS	Mandatory Enhanced Surveillance System
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
NHS	National Health Service
NNAP	National Neonatal Audit Programme
NOF	Neck of Femur
NPSA	National Patient Safety Agency
NIV	Non Invasive Ventilation
NVQ	National Vocational Qualification
OSC	Overview and Scrutiny Committee
PALS	Patient Advice and Liaison Service
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
SUS	Secondary Uses Service
SLT	Speech and Language Therapy
TARN	Trauma Audit and Research Network
TEAMM	Tackling Early Morbidity and Mortality in Myeloma
VTE	Venous Thromboembolism

Annex

Comment from Dudley MBC Overview and Scrutiny Committee (received 24/04/2014)

The committee welcomes the opportunity to respond to this consultation as the responsible body for local authority health scrutiny.

Members had occasion to assess delivery against leading priorities identified in the previous Quality Account consultation in February 2014.

Inconsistent compliance regards fluid balance charting remains a concern for the committee. Members will explore this and other key issues underlined across the improvement priorities through follow-up committee's Dignity in Care Review action plan in 2014/15.

The committee acknowledges the view that the existing topics are still key care issues of importance to patients and the public and so should remain priorities going into 2014/15. Consistent baseline reporting will enable local scrutineers to better identify with rates of improvement across themes. In addition, members would support proposals to consider mortality as a future priority particularly in the light of recent Keogh Review experiences.

On urgent care, The Dudley Group NHS Foundation Trust has demonstrated strong partnership working with the CCG enabling a comprehensive, robust and inclusive clinical and patient-led approach to the design of the service. Activity assumptions based on the opening of the Urgent Care Centre being built into the CCG's contract with The Dudley Group NHS Foundation Trust for 2014 until 2016 was particularly welcomed.

Members look forward to The Dudley Group NHS Foundation Trust input on the service model for the triage/streaming element of the urgent care centre and the proposed premises solution as the service specification and procurement framework takes shape in 2014/15.

Comment from the Dudley Health and Wellbeing Board (received 28/04/2014)

Health and Wellbeing Boards came into force in April 2013 as part of the Health and Social Care Act 2012. As system leader for the health and care sector, the Board needs to be confident that quality assurance processes are in place and robust across the system. Dudley's Health and Wellbeing Board welcomes the opportunity to comment on The Dudley Group NHS Foundation Trust's annual quality account and is encouraged that Dudley's Clinical Commissioning Group as lead commissioner, the Health Scrutiny Committee and Healthwatch Dudley will also be commenting.

Some Board members had the opportunity to comment during a recent CQC Inspection of the Trust and welcomed the opportunity to participate and make known their views through that process.

The Board is encouraged by the improvements in patient experience supported by the Friends and Family Test and notes some of the innovative work in this area. However, there is still further work to do to embed. The Health Scrutiny Committee will be focusing on hospital patient experience during 2014 and the Board hopes that the Trust will commit to implement any recommendations.

It is heartening to see that levels of infection, specifically for MRSA and Clostridium difficile (C. diff) show a reducing trend; however, the Trust remains above the national average for C. diff and should endeavour to maintain or reduce further on 2013/14 levels, and take a holistic approach to infection control.

The Board notes the significant amount of work undergone to improve hospital mortality as a result of the Keogh Review and supports the Trust's decision to continue mortality reduction as a priority for 2014/15.

The Board acknowledges the improvements that have been made during 2013/14 and that the report demonstrates that the Trust is committed to continuous improvement of quality across the broad spectrum of patient experience, clinical effectiveness and safety. The Board hopes that the Trust will continue to work with partners to make further quality improvements during 2014/15.

Comment from the Dudley Clinical Commissioning Group (received 29/04/2014)

The CCG note this report outlines the continued focus on the delivery of high quality care by the Trust.

The CCG has previously stated its commitment to reducing avoidable mortality and is pleased to note the Trust's continued focus on this key area. In 2013 the Trust was one of 14 hospitals nationally where concerns were raised regarding the mortality indicators over the preceding two year period and subsequently a review was undertaken, led by the NHS England Medical Director, Sir Bruce Keogh. The CCG participated in this review which resulted in a wide range of recommendations for improvement including improving aspects of the patient experience and increased investment in front-line staff. The Trust actively participated in the review, was very receptive to the need for improvement, and has subsequently made significant progress during the year in implementing the recommendations made.

The Trust is to be commended for having consistently received positive feedback from patients through the national *"Friends and Family Test"* however, there are other areas the CCG would like to see more rapid improvement such reducing the number of patients with hospital acquired pressure ulcers and continued improvements in reducing *C difficile* and MRSA infections.

The Trust did not meet the national A&E waiting time target to admit or discharge 95 per cent of attenders within four hours. Historically, the Trust has been very successful in meeting this target so it is regrettable that this was not achieved in 2013/14. However, Dudley CCG has recently carried out a major public consultation on the redesign of urgent care across the borough with the support of both the Trust and Dudley Health and Wellbeing Board. This will result in the establishment of a new Urgent Care Centre at Russells Hall Hospital by the end of this financial year, which will enable 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. In the meantime, we are reinvesting resources non-recurrently into the hospital to assist in resolving their performance.

Finally, the CCG will work with the Trust in ensuring that evidence of on-going progress is made throughout the year. This is vital for the interests of the patient population of Dudley and will also continue to hold the Trust to account constructively and assertedly for its future performance.

Paul Maubach
Chief Accountable Officer

Comment from the Trust's Council of Governors (received 22/04/2014)

The Trust's Quality Account is presented against a background of continuing change and financial pressures in the NHS. The 2012 Health and Social Care Act came into force on 1st April 2013 heralding a major re-organisation of the NHS in England, and strict 4 per cent annual efficiency gains continue to be required of all trusts. At the same time, the age profile of the population, and hence the healthcare needs, increase proportionately. Both factors are having, and will continue to have, a significant effect on services and how they are delivered. It is also against this background that actions to satisfy the findings of the Francis Reports which required a rigorous focus on patient care and safety have been implemented.

Governors fully support the Chief Executive's Statement in Section 1 of this report and note, in particular, comments on the Keogh Review rationale and outcomes in which the Trust mortality rates were found to be within the expected range.

Governors have been kept fully up to date with actions following that review. We are pleased to note the increased focus on patient experience and safety which has had many strands including, for example, a revised complaints process, and re-organisation of the complaints and PALS provision in consultation with stakeholders.

Governors now take part in Patient Safety Leadership Walkrounds with directors and will be members of a new Patient Experience Group which reports to the Board. Governors note the successful involvement of the Trust in many clinical audits and research trials.

Governors meet many patients, members of the public and community groups each year and gain 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, reflecting the improved Friends and Family Test scores achieved by the Trust. On occasion, there are less positive views about communication, food and parking.

Pressure on services has increased further in 2013/14 particularly in the Emergency Department. In common with many trusts, failure to consistently meet the four hour target has been of concern for some time. Measures are in place to improve this situation and governors have strongly supported the proposed relocation of the walk-in centre and primary care out-of-hours service at the Dudley Borough Walk-in Centre to form an Urgent Care Centre at Russells Hall Hospital during 2014/15. This should result in a more appropriate service for all patients and a reduction in waiting and treatment times.

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 influence choices. While detail is given in section 2 of this report, of the 2013/14 priorities governors are pleased to note the success in reducing the number to zero of avoidable stage 4 pressure ulcers developed in the hospital. The failure to achieve the avoidable stage 3 pressure ulcer target in the hospital is disappointing.

In addition, governors are pleased to see that the community target for the reduction in avoidable pressure ulcers has been met. Governors also note that one of the two hospital patient experience targets was achieved and neither of the two community patient experience targets were met. Further focus will be required to achieve the new patient experience targets in 2014/15. Governors note the further work undertaken on the new Health and Social Care Passport and look forward to implementation during 2014/15. With regard to infection control, governors recognise that the C. diff target set by the Department of Health was extremely challenging. It was not achieved, though some assurance can be taken that there were fewer cases than in 2012/13. The Council of Governors has agreed the continuation of all 2013/14 Quality Priorities into 2014/15 together with mortality as a new priority as recommended by the Keogh Review.

Governors recognise their increased responsibilities following the introduction of the 2012 Health and Social Care Act, the outcomes of the Francis enquiries and the Trust's Keogh Review. The Council of Governors has carried out its own development review and in consultation with the Board of Directors has put in place a future role for governors in which their increased needs for information and assurance can be met in order to hold the Board of Directors to account through its non-executive directors.

In common with other acute trusts, the Trust operates under increasing pressure. The increasingly complex demands of an ageing population and efficiency gains have to be met while protecting the quality of services and care and safety of patients. That staff, especially in stressful and pressured situations on the front line, demonstrate such high levels of care and commitment is to be commended. On behalf of patients, carers and the public, governors wish to place on record their recognition and appreciation of the commitment and excellent work done by staff at all levels in the organisation.

Comment from Healthwatch Dudley (received 24/04/2014)

Healthwatch Dudley recognises the good work undertaken within the Dudley Group, which is highlighted in the performance measures and patient views in the annual Quality Report and Account for 2013/14.

In the relatively short time it has been in existence, Healthwatch Dudley has been able to capture many views from local people about their experience of Dudley Group NHS Foundation Trust services. Healthwatch Dudley representatives are pleased to have been invited to meetings and events following the Keogh Review and Care Quality Commission inspection.

The team has been reassured by actions already taken to improve patient outcomes and experiences and an invitation has been accepted to become a member of the newly-established Patient Experience Group. The team also welcomes opportunities to undertake 'Enter and View' visits to service areas as a critical friend and staff and valuable volunteers will continue to be involved in all patient and wider public engagement events, to ensure the voices of local people are heard and responded to.

In a number of instances marked progress was made against the Quality Priority targets set for 2013/14. Nevertheless, some targets were partially rather than fully achieved by the end of the year.

Healthwatch Dudley welcomes the opportunity to work with The Dudley Group to ensure that the views of local people are taken into account, to improve patient experience across all areas of the Trust.

NB: Healthwatch Dudley is unable to comment on number of patients using their Single Assessment Process Folder/Health and Social Care Passport or the number of patients that know how to raise concerns about their care and treatment. We look forward to seeing this data in the final report.

Statement of directors' responsibilities in respect of the quality report 2013/14

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 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 2013/14*;

- 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 2013 to June 2014
    - papers relating to quality reported to the Board over the period April 2013 to June 2014
    - feedback from commissioners dated 29/04/2014
    - feedback from governors dated 22/04/2014
    - feedback from the local Healthwatch organisation dated 24/04/2014
    - the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 31/04/2014
    - national patient survey conducted between September 2013 and January 2014
    - national staff survey conducted between September and December 2013
    - the head of internal audit's annual opinion over the trust's control environment dated 31/03/2014
    - CQC quality and risk profiles dated 21/10/2013 and 13/03/2014

- the quality report presents a balanced picture of the NHS foundation trust's performance over the period covered;

- the performance information 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/sites/all/modules/fckeditor/plugins/ktbrowser/_openTKFile.php?id=3275).

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: 13th of May 2014**

John Edwards
Chairman

Signed **Date: 13th of May 2014**

Paula Clark
Chief Executive

Independent Assurance Report to the Council of Governors of The Dudley Group NHS Foundation Trust on the Annual Quality Report

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 2014 (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 2014, 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 2014 subject to limited assurance consist of the national priority indicators as mandated by Monitor:

- 62 day standard for cancer treatment; and
- Clostridium Difficile

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 2013 to March 2014;
    - Papers relating to quality reported to the board over the period April 2013 to March 2014;
    - Feedback from the Commissioners dated 29/04/2014;
    - Feedback from local Healthwatch organisations dated 24/04/2014;
    - The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 31/04/2014;
    - The latest national patient survey dated 2013;
    - The latest national staff survey dated 2013;

- Care Quality Commission Intelligence Monitoring Profiles dated 21/10/2013 and 13/03/2014;
- The Head of Internal Audit's annual opinion over the Trust's control environment dated 31/03/2013; 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 within 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.
- 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 governance over quality or non-mandated indicators which have been determined locally by The Dudley Group NHS Foundation Trust.

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 2014:

- 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 2013/14; 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
22 May 2014

This leaflet can be made available in large print, audio version and in other languages, please call 0800 0730510

ਜੇਕਰ ਇਹ ਲੀਫ਼ਲੈੱਟ (ਛੋਟਾ ਇਸ਼ਤਿਹਾਰ) ਤੁਸੀਂ ਆਪਣੀ ਭਾਸ਼ਾ (ਪੰਜਾਬੀ) ਵਿੱਚ ਲੈਣਾ ਚਾਹੁੰਦੇ ਹੋ ਤਾਂ ਕ੍ਰਿਪਾ ਕਰ ਕੇ ਪੇਸ਼ੰਟ ਇੱਨਫ਼ਰਮੇਸ਼ਨ ਕੋ-ਆੱਰਡੀਨੇਟਰ ਨਾਲ **0800 0730510** ਟੈਲੀਫ਼ੋਨ ਨੰਬਰ ਤੇ ਸੰਪਰਕ ਕਰੋ।

यदि आपको यह दस्तावेज़ आपनी भाषा में चाहिये तो पेशन्ट इनफरमेशन को-आरडीनेटर को टैलीफ़ोन नम्बर **0800 0730510** पर फोन करें।

જો તમને આ પત્રિકા તમારી પોતાની ભાષા (ગુજરાતી)માં જોઈતી હોય, તો કૃપા કરીને પેશન્ટ ઈન્ફોર્મેશન કો-ઓર્ડિનેટરનો **0800 0730510** પર સંપર્ક કરો.

আপনি যদি এই প্রচারপত্রটি আপনার নিজের ভাষায় পেতে চান, তাহলে দয়া করে পেশেন্ট ইনফরমেশন কো-অর্ডিনেটারের সাথে **0800 0730510** এই নম্বরে যোগাযোগ করুন।

أذا كنت ترغب هذه الوريقة مترجمة بلغتك الاصلية (اللغة العربية) , فرجاء أتصل بمنسق المعلومات للمريض **Information Co-ordinator** على التلفون **0800 0730510**

حسب ضرورت اس لیف لٹ کو اپنی زبان (اُردو) میں حاصل کرنے کے لئے براہ مہربانی ٹیلیفون نمبر **0800 0730510** پر پیشنٹ انفرمیشن کو-اورڈینیٹر (مریضوں کے لئے معلومات کی فراہمی کے سلسلے میں افسر) کے ساتھ رابطہ قائم کریں۔