Quality Report and Accounts 2010/11

Statement on quality from the Chief Executive

I am delighted to present this, our third, Quality Report and Accounts to share our quality goals and achievements from our hospitals and announce our new quality priorities in particular, for our new Adult Community Services directorate.

Our aim is to provide high quality care for all of our patients, and through this Quality Report and Accounts we will:

- Firstly, define what we use to determine the quality of our patient care, in effect this is asking the following three things:
    - Do patients receive good quality clinical care (clinical effectiveness)?
    - Are patients safe in our hands (patient safety)? and,
    - Does the Trust provide a clean, friendly environment in which patients are happy with the personal care and the treatment they receive (patient experience)?
- Secondly, decide priorities which are designed to achieve meaningful improvements in the standard of care;
- Thirdly, design methods for measuring, documenting and acting on the things which determine the quality of patient care. Furthermore, the Trust provides patient care in the hospital and the community. It strives to provide good quality care in both environments.

At the time of writing we are undergoing a period of massive change in the NHS and just one of those changes is the transfer of adult community services into The Dudley Group.

We hope the Quality Report and Accounts is helping to build a picture of quality measures and priorities we have in place in our local healthcare services. A summary of current and previous priorities can be seen on the table on page 35; 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 targets for 2011/12.

We have spent time this year considering and planning the Trust's five year strategy and have developed our strategic objectives in six key areas – Quality, Innovation, Productivity, Prevention, Patient Experience and Staff Engagement (national QIPP agenda plus our own two local objectives). This has helped us to ensure we will keep quality at the heart of everything we do.

Our aim is to provide the highest quality care to our patients so we believe, through the wide range of measures and checks detailed in this report, the overall quality of care delivered at The Dudley Group of Hospitals is good and in line with that of other similar Trusts both locally and nationally. You will see on pages 62 to 64 we exceed or at least meet all but two of the national standards. For MRSA it is recognised we have a difficult target to meet and we only missed it by one case this year (it is of note that Monitor considers six MRSA cases the ceiling). We still have some of the

lowest infection rates in the region with our C difficile rates reducing by a further 44 cases from last year.

We understand like other hospitals in the West Midlands region we have work to do to ensure our stroke patients spend at least 90 per cent of their time on a dedicated stroke ward. Our failure to meet this target in 2010/11 was a direct result of the massive increase in emergency admissions to Russells Hall Hospital beyond previous years and levels estimated by our commissioners. We continue to re evaluate the use of our beds to help achieve this target. However we are pleased that we exceed the target for ensuring the early scanning of suspected stroke/TiA patients enabling us to treat people more effectively and quickly.

We have recognised there is some way to go to ensuring our patient's experience of our services matches that we would all expect and we still have work to do to ensure we drive down the number of pressure ulcers acquired in hospital. We have the measures in place to ensure we are alerted to any such quality issues early so we may address them before they become an issue.

Our Quality Goals

Our quality goals in relation to the three dimensions of quality as mentioned above (clinical effectiveness, patient experience and safety) are:

- to exceed all internal quality targets, and
- to be recognised as the highest quality service provider by patient groups, staff and other stakeholders

In the past, our progress in improving patient experience based on the national inpatient survey, has been modest. This is unacceptable to our organisation and we are developing a patient experience strategy that clearly demonstrates what we intend to achieve and the methods we will use to improve patient experience. The Commissioning for Quality and Innovation Payment Framework (CQUIN) for patient experience (see page 57) sets out how we will measure ourselves for our host commissioners, NHS Dudley.

Measuring Quality

We have implemented a performance dashboard which, at the click of a mouse, gives senior managers access to real-time data on quality. This is helping to ensure any quality issues are resolved in a timely manner. The dashboard contains both our priority indicators as set out in this report and many other indicators and measures used to monitor quality.

We have also continued to develop and use our Nursing Care Indicator audits as a tool to measure the quality of care we give to patients on our wards. Patient notes tell an important story to the health professionals treating the patient, so it is essential that they are fully completed and give a snapshot of the care given to patients. The audits assess the following areas within patient notes:

- Patient observations

- Pain management
- Manual handling and falls risk assessment
- Tissue viability – prevention of pressure ulcers
- Nutrition assessment and monitoring
- Medications
- Prevention of infection
- ThinkGlucose programme to monitor diabetes

Monitoring our hospital standardised mortality ratio (HSMR) is of utmost importance to us and we are committed to monitoring our rates to ensure they remain consistent with national levels (see page 65 for more detail on HSMR). Other ways in which we measure and monitor quality are detailed from page 51.

I hope you will find useful the information on the quality priorities we have chosen to focus on, the ways in which we assure ourselves of quality of care and a selection of the targets, both national and local, we use to form a picture of quality across the Trust. Overall we consider the Trust has had a good year in providing quality care meeting or exceeding all but two of the national standards and in particular having positive assessment from external organisations such as the Care Quality Commission's unannounced visit, PCT and West Midlands Quality Review Service. We would appreciate any feedback you would like to give us on both the format and content of the account but also the priorities we have chosen. You can either phone the communications team on 01384 244404 or email communications@dgh.nhs.uk

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

Signed:

Paula Clark

Chief Executive Date:

Quality priorities summary

The table below gives a summary of the quality priorities we have used for the last two years and also those we will be working towards next year (2011/12).

Priority	2009/10	2010/11	Priority for 2011/12	Comment	More info
(a)Increase the number of patients who rate their overall care highly (b) Increase of patients who would recommend DGOH services to a friend or relative	√ achieved	*We are improving but there is still work to do* *Slight decrease*	Priority one	Following a slight decrease in the number of patients who would recommend the Dudley Group of Hospitals to a relative or a friend we will retain and refresh our focus on improving the whole patient experience	P38
Reduce avoidable stage three and four acquired pressure ulcers in our hospital and ensure a robust reporting mechanism established in community care settings	N/A	N/A	Priority two - new this year	Our dedicated tissue viability team will ensure systems are robust to prevent and manage pressure ulcers. We aim to reduce current rates by 50%. Community services will be ensuring a robust system for recording is set up and rolled out across the services.	P43
Reduce our MRSA rate in line with national and local priorities	√ achieved	√ achieved	Priority three The two infection control priorities are merged into one.	Trust has sustained investment in our Infection Control Team who have successfully embedded effective systems.	P45
Reduce our Clostridium difficile rate in line with (or better than) local and national priorities	√ achieved	√ achieved			
Increase the number of patients who undergo surgery for hip fracture within 36 hours from admission (where clinically appropriate to do so)	N/A	*New priority*	Priority four	The Trust will continue to drive improvements to all aspects of this priority.	P48
Maintain reduced numbers of cardiac arrest calls	√	√	Not included as a priority	There has been a dramatic improvement from 32 per month in 2008 to around 13 per month by the end of March 2011 and so this issue no longer remains a challenge for the Trust.	P36

Choosing our priorities for 2011/12

In December 2010, we invited more than 40 staff, patients and governors to attend a Listening into Action (LiA) event to ask key questions around quality. LiA is a programme of staff engagement events to encourage staff and stakeholders to become involved in generating ideas to improve patient experience and service efficiency across the Trust (see page 27 for more information on LiA). This event was held to agree our quality priorities for 2011/12.

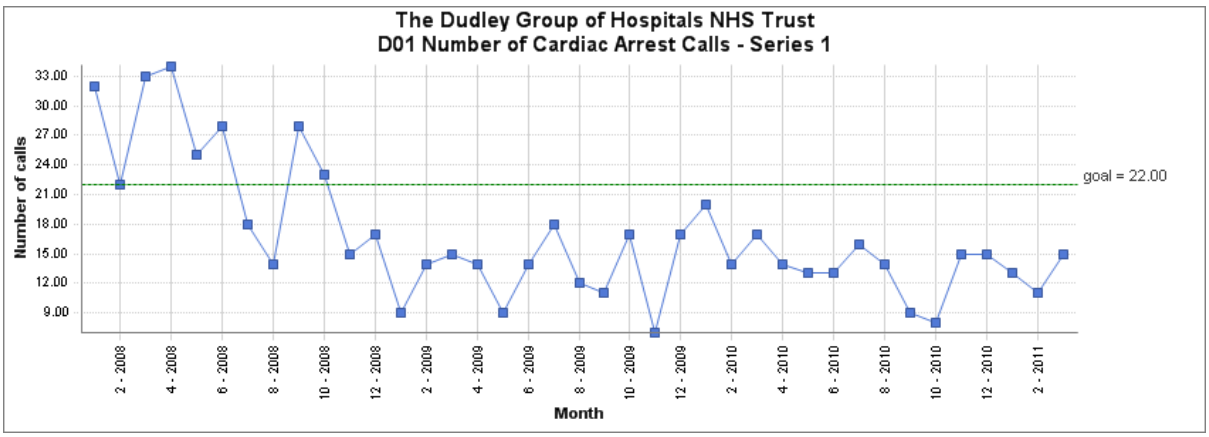
Some other quality priority suggestions raised by our patients, governors and public during the year included:

- Communication between organisations and professionals
- Being treated with dignity and respect
- Staff taking the 'time to care'
- Communication and changes of appointment times

Our Council of Governors also took the time to produce a paper to highlight what they felt 'good quality hospital care' looked like and key areas the Trust could focus on. The paper was part of the work undertaken by the Governors' Service Strategy working group and was used by the Trust in setting its strategy and Annual Plan delivered to Monitor (our independent regulator).

<u>Reduction in cardiac arrest calls priority</u>

At the above LiA event it was noted that the cardiac arrest project (priority one last year) had been a major success leading to a reduction from 32 cardiac arrest calls per month in 2008 to 13 per month in 2010/11 (see graph below). This had been achieved by identifying those patients at risk, monitoring them carefully and escalating the clinical care to appropriate professionals to prevent cardiac arrest. Actions have included the redesign of observation charts used by nurses, the strengthening of the outreach team of specialist nurses and the setting up of an emergency 24 hour response team, which includes senior medical staff.



It was decided at the event we will concentrate our efforts into maintaining the reduced number of cardiac arrest calls and replace it with a new priority for 2011/12, namely reducing pressure ulcers.

Hospital acquired infections priority

It has been noted that we have made excellent progress in the last few years reducing the number of cases of MRSA and Clostridium difficile (see graphs page 46 and 47). It was agreed by staff and patients at the event that our infection control systems and procedures are now so well established that we could combine reducing the infection rates from both organisms into one priority. However, we remain committed to maintaining and improving the progress made so far.

Patient experience priority

We are committed to improving our whole patient experience and it is felt that in priority one part of our measures is; *patients who rate their overall care highly*, encompasses all of the issues raised at the quality LiA. We recognise all of the above elements have to be in place for patients to feel they have received a good overall level of care (see page 51 for more information on how we review the quality of our services)

Our Priorities

Priority one	**Hospital**	**Community**
	(a) Increase the number of patients who rate their overall care highly from 89.3 per cent in the 2010 national inpatient survey to 91 per cent and **(b) Show an increase in patients who would recommend The Dudley Group of Hospitals services to a friend or relative.**	**Increase the number of patients who rate their overall satisfaction with community services care and treatment from 94 per cent in the 2010/11 CQUIN (Commissioning for Quality and Innovation) patient experience survey to 96 per cent.**

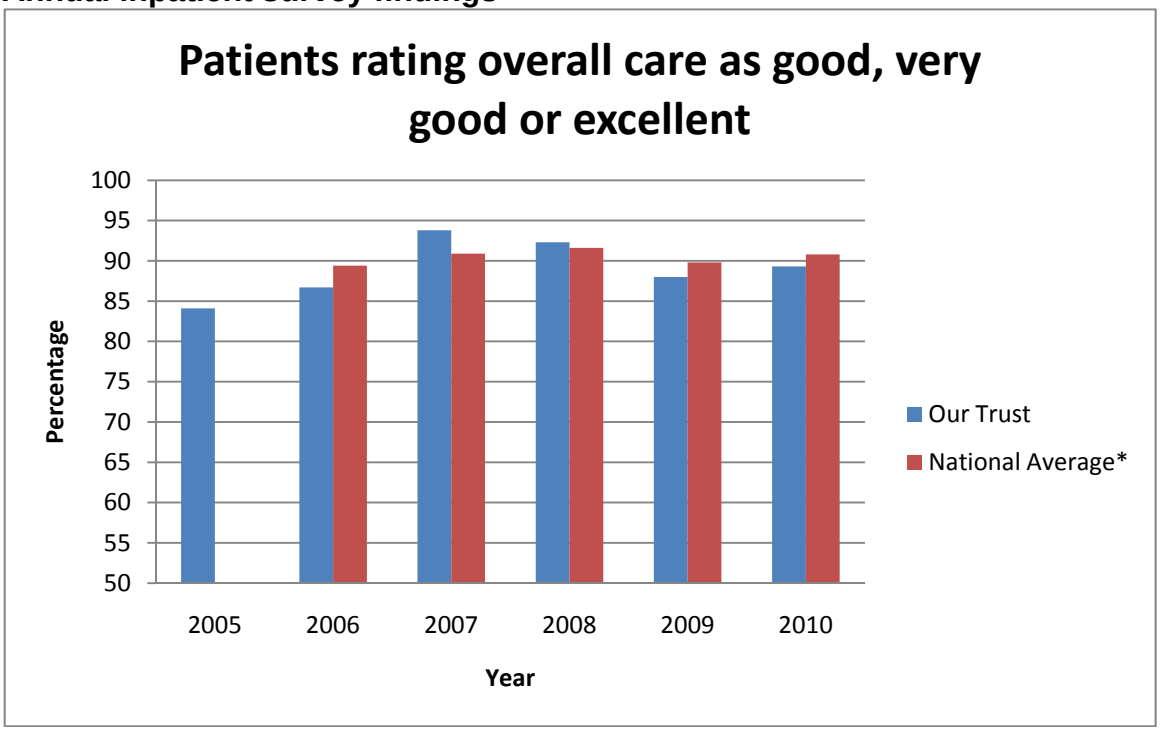
Progress last year (2010/11) (hospital)

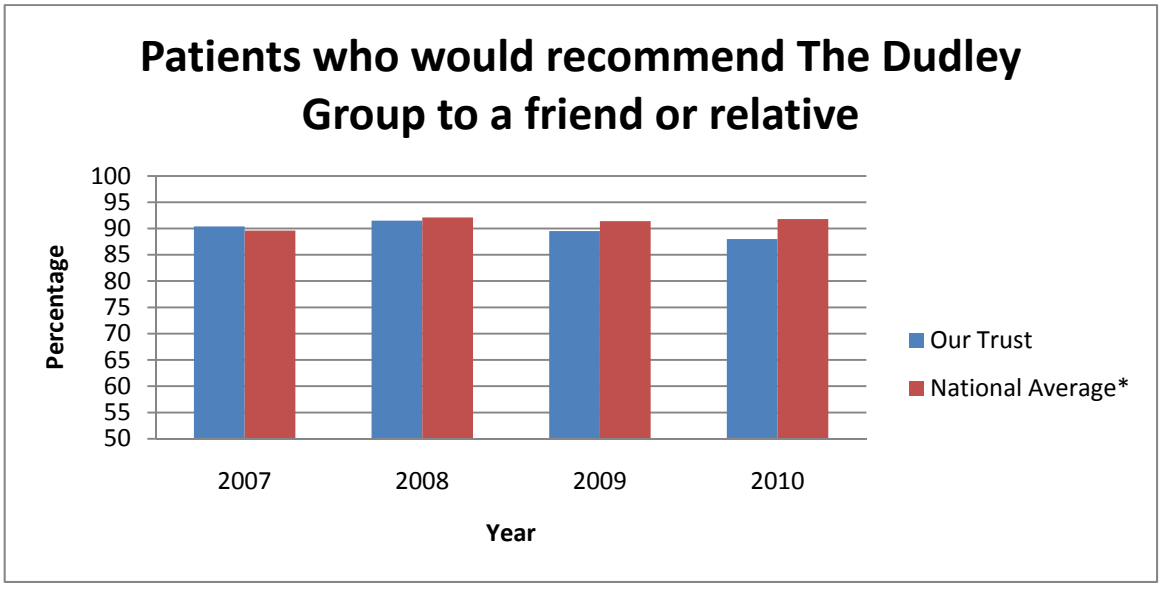
We are really pleased that 89.3 per cent of patients surveyed rated their care highly. We know that when patients come into hospital they expect the clinical care they receive to be of the highest quality. With this priority we are trying to ensure that the overall experience patients have of our services can match this high quality clinical care. We are disappointed to have seen a slight decrease in the number of patients responding positively to the question “would you recommend the hospital to a

friend?" and we need to do more to gain your recommendation. In the 2010 inpatient survey the score was 88 per cent (2009 89.5per cent).

We are keeping this priority for 2011/12 as this is very important to us and to our patients.

Annual inpatient survey findings





*National Average = Picker Institute Europe average. Picker undertake the inpatient survey for around 75 hospital trusts in England

<u>To increase the number of patients who rate their overall care highly from 89.3 per cent to 91 per cent</u>

Patients said:

"I have private healthcare but could not have received a better service."

"This time I was really impressed – thank you – huge improvement."

To show an increase in patients who would recommend The Dudley Group of Hospitals to a friend or relative

Patients said we could improve:

"Keeping patients in the picture if there are any delays."

"Our food."

"The nurses and doctors were really good, but I wasn't given any advice on aftercare."

How we measure and record patient experience (Hospital)

The Trust takes part in the annual National Patient Survey programme which systematically gathers the views of patients about the care they have recently received. This takes place once a year so gives a 'snapshot' of care provided at that moment in time.

We believe that listening to what patients tell us about their experiences is the best way for us to learn and improve. In 2011/12 we are refreshing our real-time surveys to improve the way we listen and make changes. Our enthusiastic team of volunteers will carry out the surveys with patients in order to offer complete confidentiality.

We also measure our patient experience by listening to our Local Involvement Network (LINk) and Health Select Committee, feedback from patient concerns, complaints and compliments as well as feedback posted on NHS Choices.

Developments planned this year (2011/12) (Hospital)

We recognise that by listening to patients, visitors and staff we can improve our services to better meet your expectations.

To make sure that our services are responsive to your needs we are, this year, refreshing real-time survey systems so the views of our patients can quickly be used to make improvements and build upon the information you have already given us. In 2011/12 we are also planning to:

- Improve patient information

- Pilot shared decision-making tools (e.g. leaflets, videos) to help patients make the right decisions about their treatment
- Increase reporting of 'you said, we did' — where patients or relatives have made suggestions for improvements we will tell you what we have been able to do about it
- Further develop our Patient and Public Experience Steering Group to encompass quality of care. The new 'Patient Experience and Quality of Care Steering Group' will be chaired by Non-Executive Director David Bland

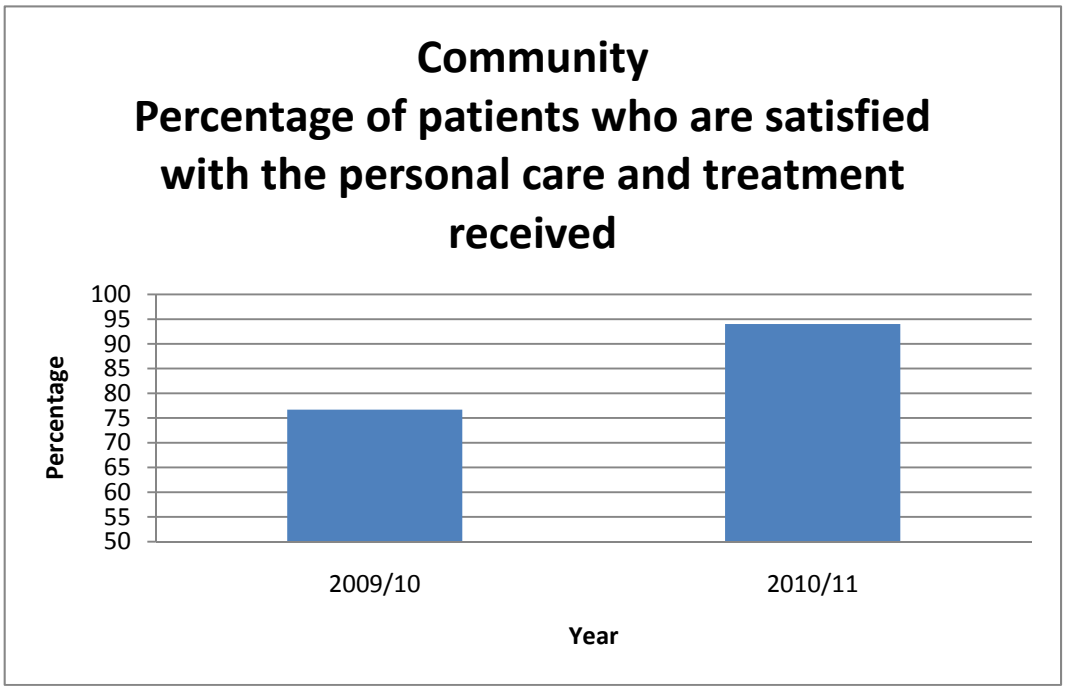
Current status (Community)

We are really pleased 94 per cent of our patients who were surveyed in 2010/11 said that overall they were satisfied with the care and treatment they received from community services. We are trying to ensure the overall experience patients have of our services is continually improved to give the highest standards of care.

The Community services surveyed last year (2010/11) as set by Commissioning for Quality and Innovation (CQUIN) scheme were:

- Wound care/Dermatology
- Diabetes
- Continence
- Chronic Obstructive Pulmonary Disease (COPD)

2010/11 CQUIN survey findings



How we measure and record this priority (Community)

The Trust takes part in the CQUIN (Commissioning for Quality and Innovation) patient experience survey which systematically gathers the views of patients about the care they have recently received in the community. This takes place twice a year with the collection of baseline information early in the year and a repeat audit to measure our improvements.

Developments planned this year (2011/12) (Community)

In 2011/12 we will build on our 2010/11 learning and continue to ask if patients:

- Have been involved in decisions about their care and treatment
- Are given enough time to discuss their condition with healthcare professionals
- Are satisfied overall with our services and any comments they have to help us improve the care we provide

We will use this information to improve our services.

Community services to be surveyed, set by Commissioning for Quality and Innovation (CQUIN) scheme for 2011/12, will be:

- Wound Care/Dermatology
- Diabetes
- Continence
- Early Intervention (Virtual Ward)

We aim to extend our surveys across all of our community services.

Details of how we are progressing with this priority will be reported to our Board of Directors on a quarterly basis as part of our patient experience report.

Board sponsor: Denise McMahon, Director of Nursing

Operational lead: Mandy Green, Communications Manager

Priority two	Hospital	Community
	Reduce avoidable stage three and four hospital acquired pressure ulcers through the year, so that at the final quarter of 2011/12 (Jan-Mar) the number for the last quarter of 2010/11 has been reduced by 50 per cent.	**Ensure there is a robust, accurate data collection system in place and, for those patients on a district nurse caseload, reduce through the year avoidable stage three and four community acquired pressure ulcers.**

Patient story

"I felt dirty when they told me I had pressure ulcers. I know it's not a dirty disease but that's how I felt. It was very depressing. If it wasn't for the nurses here, I wouldn't have known I had them. They saw them straight away and now they're sorting them out for me."

Rationale for inclusion

It was estimated in 2004 that the NHS in the UK spent £1.4-2.1bn treating pressure ulcers. These figures are a conservative estimate. Ninety per cent of this cost is nursing time. Pressure ulcers are difficult to treat and slow to heal and prevention is therefore a priority. Evidence suggests that between four and 10 per cent of patients admitted to UK district hospitals develop a pressure ulcer. In 2008/09 this equalled just over 51,000 pressure ulcers (source HES data).

There is a national campaign for pressure ulcer management. The aim of 'Your skin matters' is no avoidable pressure ulcers in NHS provided care and we decided to embed the campaign (called locally '*We* Love Your Skin') into the Quality Report and Accounts as a key priority. Alongside this national drive to reduce the incidence of pressure ulcers, feedback from our patients, staff and our clinical quality framework confirms this as a priority (CQUINS see page 57).

Current status

We have introduced new robust systems for the monitoring and recording of pressure ulcers followed by the launch of a campaign, '*We* Love Your Skin', to raise awareness across the Trust of the importance of this issue and the correct ways to prevent, record and manage pressure ulcers. Our six Trust Directors featured on the campaign posters and were photographed exposing body parts most prone to pressure ulcers. A competition was also held for staff to guess which body part belonged to which Director, further raising awareness. Once we have established a robust reporting mechanism for community acquired pressure ulcers will ensure this is rolled out across all community services.

This approach has helped to give a very serious issue a high profile and made it evident to staff at all levels just how important this is to patients and therefore to the Trust. The '*We* Love Your Skin' campaign has led to an increase in recording of

pressure ulcers and we expect this to continue as the campaign becomes embedded across the Trust.

At the end of quarter four (Jan – Mar 2011) we had 32 grade three and four pressure ulcers recorded (in the hospital), and we have set out to reduce that figure by at least 50 per cent by the last quarter of 2011/12.

How we measure and record this priority

The Trust has a dedicated Tissue Viability team of senior nurses which offers advice and support to all departments in preventing and managing pressure ulcers. The team also monitor the levels of ulcers across the organisation. There is also a dedicated community based tissue viability specialist.

Pressure ulcers, also called pressure sores and bed sores, are graded one to four with four being the most serious. When a patient is identified as having a pressure ulcer it is reported onto the tissue viability database via a weekly report from all wards to the team.

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 by the Strategic Health Authority. It is recognised that pressure damage can occur but not be visible immediately.

If a patient develops a pressure ulcer stage three or four, or if a pressure ulcer deteriorates to a three or four while the patient is in hospital, the lead nurse will undertake a detailed investigation called a root cause analysis. The results of the investigation are discussed at the weekly pressure ulcer monitoring group. Following the discussion of the results an action plan is agreed and the plan is monitored to ensure we learn lessons from every occurrence and actions are taken to reduce the risk of further pressure ulcers occurring.

Developments planned for this year (2011/12)

Actions being undertaken to achieve the Trust target include:

- Continuing to embed the '*We* Love Your Skin' campaign;
- Working together across community and acute healthcare settings to develop a pressure ulcer pathway to promote effective prevention of pressure ulcers;
- Continuing to ensure mandatory tissue viability training for all nursing staff;
- Promoting the use of the new hospital nursing documents developed by the Tissue Viability team for the prevention and management of pressure ulcers. This includes a chart to record and monitor the number of times a patient is turned and the checks made on the affected area. They were introduced for use throughout the hospital during February 2011;
- Identifying all patients at risk of developing a pressure ulcer and any patients with a pressure ulcer to ensure they have both the pressure ulcer prevention information and the pressure ulcer management information as appropriate;

- Embedding the use of the tissue viability documentation across the Trust through the use of the link nurses on each ward, who have protected time each week to perform this function;
- Updated pressure ulcer prevalence documentation, and improved care planning, to be implemented 1st May 2011 in the community services;
- Regular audits of use of the documentation for pressure ulcers;
- Ensure a robust recording system is set up across community services.

Board Sponsor: Denise McMahon, Director of Nursing

Operational Lead Hospital: Lisa Turley, Tissue Viability Lead Nurse

Operational Lead Community: Gill Weale Tissue Viability Specialist Community Services

Priority three:	**Reduce our MRSA and *Clostridium difficile* rates in line with the national and local priorities. MRSA Bacteraemia (blood stream infections) target is no more than 2 post 48hr cases; *C.diff* is no more than 77 post 48hr cases in 2011/12.**

Progress last year (2010/11)

We have continued our good work to maintain consistently low levels of MRSA Bacteraemia and *C.diff* infections across the Trust. This work together with work with our community colleagues has meant we have seen further reductions in our overall *C.diff* rates, 44 less cases than the previous year and MRSA Bacteraemia rates remain low, see graph over.

Feedback from our patients, staff, community groups, Governors and the national drive to have a zero tolerance to hospital acquired infections has meant we have decided to keep both our MRSA and *C.diff* priorities but to combine them into one priority.

The drive to reduce healthcare associated infections, which includes MRSA Bacteraemia and *C.diff,* continues to get more and more challenging. Where numbers have already been reduced to the minimal background level for that particular organism, the Trust is working to maintain this low rate.

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. The Trust as part of the local health economy has to record both pre and post 48 hours cases.

In 2010/11 the Trust has continued to reduce the *C.diff* post 48 hours cases below the target locally agreed with the PCT. The agreed target was no more than 113 cases and at the end of the year and the Trust recorded only 82.

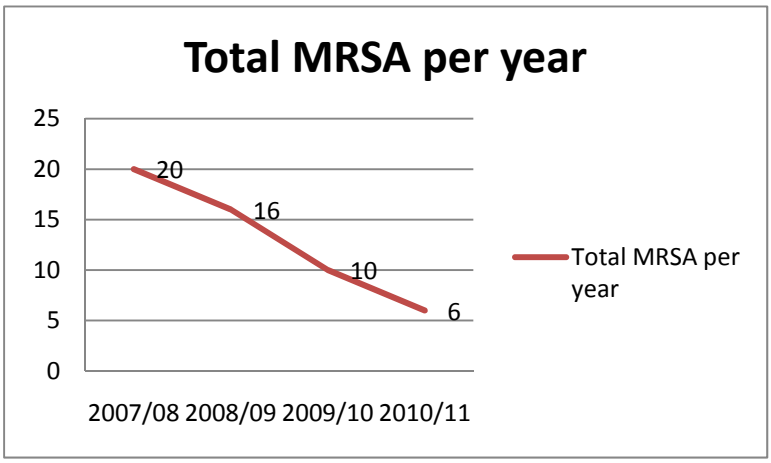
The Trust did not achieve the agreed target of no more than two post 48hr MRSA Bacteraemia cases but missed the target by only one case, total three. All were investigated but no common theme was found. The Trust was disappointed as it had continued to work hard on controlling the rates. There was an agreement with Monitor that our threshold is six post 48 hour cases before they consider formal interventions and so this target was achieved.

How we measure and record this priority

MRSA and C difficile – when our Pathology laboratory has a positive result the information is fed directly into the MESS (Mandatory Enhanced Surveillance System) national database. From here the data for all trusts is collated and sent to the Health Protection Agency (HPA) for publication.

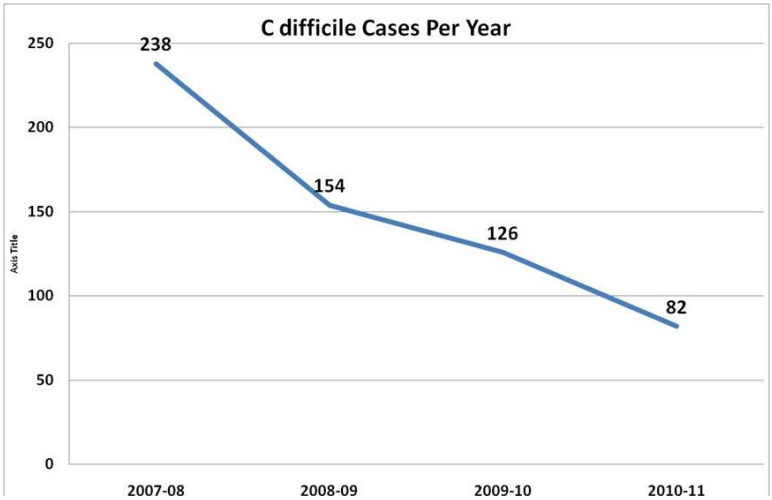
Current status MRSA

The graph below shows the continued reduction of MRSA bacteraemia cases (pre and post 48 hou, i.e. patients who had MRSA before being admitted to hospital and those who acquired it whilst in hospital) from a total of 19 in 2007/08 to a total of six in 2010/11.



Current status *C. diff*

The graph below shows the total number of *C.diff* cases recorded greater than two days after admission, showing the continued reduction from a total of 238 in 2007/08 to a total of 82 in 2010/11.



Developments planned for this year (2011/12)

Our main aims are to reduce our MRSA Bacteraemia rate in line with national and local targets. We will continue to be measured on only the post 48 hours cases and the target again this year is no more than two. This is very challenging and has been recognised by Monitor (our independent regulator), who have again agreed a threshold of six post 48 hours cases before they consider formal interventions. We have already extended our screening programme to include all emergency patients admitted and those planned patients who we screen before they come into hospital for a procedure.

Our second main aim is to reduce our *C.diff* rate in line with national and local targets. The Trust target for 2011/12 is no more than 77 post 48 hours cases.

Actions planned to achieve the above aims:

- Updating the policy and training for the taking of blood cultures;
- Developing training videos in conjunction with Clinical Skills for Aseptic Technique and cannulation;
- Undertaking additional infection control training sessions for special organisms;
- Publicising aims on World Hand Hygiene Day in May 2011;
- Introducing disposable mops for all areas of the Trust;
- Taking part in the National Patient Safety Agency (NPSA) prevention of central line infection in Critical Care Unit project;
- Undertaking the Surgical Site Surveillance of non-mandatory procedures;
- Integrating the Infection Prevention and Control services across all Trust services including acute and community.

Board sponsor: Denise McMahon

Operational lead: Dawn Westmoreland, Consultant Nurse, Infection Prevention & Control

Priority four	**Increase the number of hip fracture patients who undergo hip fracture surgery within 36 hours from admission to the Emergency Department (where clinically appropriate to do so).**

Patient story

"I came in on the Friday and had my operation on the Saturday morning. The standard of nursing care has been better than I expected – you do hear one or two negative things about the hospital in the newspaper and so I didn't expect it to be as good as it was. It's been brilliant."

Current status

Good hip fracture care depends on minimising the delay before the operation. Delays that are not clinically necessary can contribute towards a poorer result for the patient. Russells Hall Hospital was in the top five hospitals out of 193 listed in the National Hip Fracture Database (NHFD) for 2010/11. This achievement by the fracture neck of femur (hip fracture) team recognises the high quality care given to our hip fracture patients.

The NHFD is a joint venture between the British Geriatrics Society and the British Orthopaedic Association, and is designed to facilitate improvements in the quality and cost effectiveness of hip fracture care. The database stores information looking at the performance of different hospitals across the country. Here, our hip fracture practitioners are responsible for keeping the database up-to-date with the support of our data analyst.

The Trust has come a long way in developing its hip fracture services and has a designated Hip Fracture Suite. A dedicated team of nurses look after patients from admission to discharge and the ortho-geriatric team stabilise the patient prior to surgery and support in the management of the patient after surgery. The Consultant Orthogeriatrician runs a falls clinic, since many patients fracture their hip following a fall. Patients also have a dedicated orthopaedic doctor who keeps their families informed of their progress.

Delivering good care for patients with hip fractures is challenging and involves many health professionals. The quality of care varies considerably across the country and this achievement by our hip fracture team translates into high quality care for a vulnerable and frail group of patients.

Progress last year (2010/11)

- Organised a patient experience conference in January 2011at which patients gave an account of their experience alongside the professionals;
- Introduced a dedicated bed manager for Trauma and Orthopaedics to reduce delay of patients waiting for a bed;

- Commenced multidisciplinary team and nurse led discharge to facilitate efficient and effective discharge;
- Trauma co-ordinator who meets relatives within 24 hours of patients' admission;
- Reviewed the integrated care pathway to improve multidisciplinary working;
- Raised awareness of falls risk assessment and purchase of bed and chair alarms to reduce risk of patient falling;
- Introduced bespoke patient menus to aid recovery.

How we measure and record this priority

As soon as a patient is admitted to hospital with a hip fracture, data is submitted to the National Hip Fracture Database (NHFD). This data remains live until the patient has completed all of their care, including any intermediate care and rehabilitation if necessary, following their surgery.

Developments planned for 2011/12

- Implementation of patient group directives to be used by hip practitioners for pain relief and intravenous fluids;
- Development of the enhanced recovery pathway to capture patient experience and enhance the patient journey;
- Reduction of pressure ulcers developed in hospital to help recovery and enable patients to go home as quickly as possible.

Board sponsor: Richard Beeken

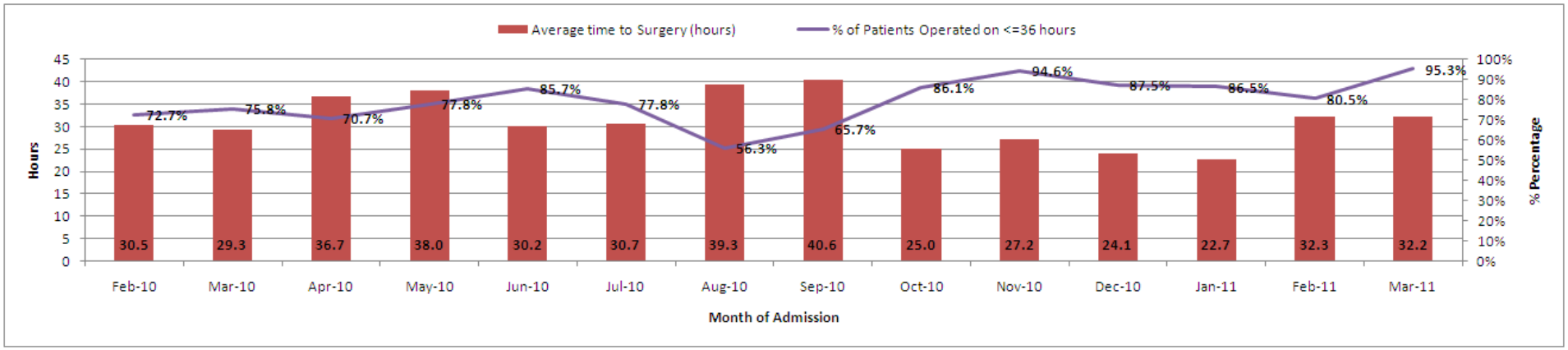
Operational lead: Jennie Muraszewski, General Manager

Current status

National Hip Fracture Database Summary (1st February 2010- 31st March 2011) Time to Surgery Analysis (patient operation performed only)

-	Indicator	Month Patient Admitted														
		Feb-10	Mar-10	Apr-10	May-10	Jun-10	Jul-10	Aug-10	Sep-10	Oct-10	Nov-10	Dec-10	Jan-11	Feb-11	Mar-11	Grand Total
Operated Patients Only	Total No. of Patients Admitted	35	36	43	36	36	36	32	36	37	37	49	40	41	43	**537**
	No. of Patients Operated	33	33	41	36	35	36	32	35	36	37	48	37	41	43	**523**
	Average time to Surgery (hours)	**30.5**	**29.3**	**36.7**	**38.0**	**30.2**	**30.7**	**39.3**	**40.6**	**25.0**	**27.2**	**24.1**	**22.7**	**32.3**	**32.2**	**31.2**
	No. of Patients Operated on within 36 hours	24	25	29	28	30	28	18	23	31	35	42	32	33	41	**419**
	% of Patients Operated on within 36 hours	**72.7 %**	**75.8 %**	**70.7 %**	**77.8 %**	**85.7 %**	**77.8 %**	**56.3 %**	**65.7 %**	**86.1 %**	**94.6 %**	**87.5 %**	**86.5 %**	**80.5 %**	**95.3 %**	**80.1 %**

Source: NHFD - Hip Fracture Patients. Data correct to: 12/04/2011. Date of Admission (1st - 31st Mar 2011). Data is correct at the time of publication



Review of services

During 2010/11 The Dudley Group of Hospitals NHS Foundation Trust provided and/or sub-contracted 38 NHS services. The Trust reviewed all the data available to them on the quality of care in all of these NHS services.

The above reviews were undertaken in a number of ways. With regards to patient safety, the Trust Executive and Non Executive Directors undertake weekly Patient Safety Leadership Walkrounds. When relevant, actions plans are developed after the walkround, with an overall picture of issues raised by staff, discussed at the Trust wide Patient Safety Group meetings. These commenced in January 2009 and remain ongoing and a regular schedule is in place.

Also covering patient safety, but including the second element of quality (effectiveness), are the morbidity and mortality reviews undertaken by the Chairman, Chief Executive, Medical Director and Non Executive Director who is chair of the Audit Committee. External review is provided by the Acting Medical Director of NHS Dudley. 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 readmission rates, day case rates and standardised mortality rates (see page 65 for more detail on our hospital mortality figures).

Following consultation with our patients last year and the results of our national patient surveys, conducted by the Care Quality Commission, we also monitor safety, clinical effectiveness and patient experience through a variety of methods:

- Senior nurse walk rounds – conducted weekly unannounced visits by the Director of Nursing or one of her senior team to check key nursing care standards. Our Governors observe, talk to relatives, patients and staff and provide feedback on the rounds;
- Nursing care indicators – monthly audits of key nursing interventions and their documentation. The results are published, monitored and reported to Trust Board monthly by the Director of Nursing;
- Productive ward series – part of our Transformation programme, looks at 'releasing time to care' by making time and productivity changes. It allows clinical staff to have more time directly with patients;
- The Outpatient Management Board – oversees the action plan arising out of the national outpatient survey and other key operational changes such as changes to clinic templates to help reduce waiting times;
- Smiley face surveys – real-time patient surveys that give a basic feel for our patients' experience's of the services;
- External assessments including:
    - Retaining our NHS Litigation Authority Level One and achieving Level One for maternity services;
    - Nursing and Midwifery Council review of our training for students received a 'good' rating;

- NHS Dudley commenced a series of Appreciative Enquiry Visits beginning with reviewing the nutrition arrangements at the Trust. NHS Dudley staff were accompanied by patient/public representatives and they interviewed staff and visited wards to look at practice and talk with patients. The results of the visit were very positive and an action plan was drawn up for the minor points of concern raised.
- October 2010, the West Midlands Quality Review Service assessed the Urgent Care, Critical Care, Vascular and Stroke and TIA services of the whole of Dudley as part of a regional peer review. The results of the review were generally positive although a number of concerns about the local associated mental health services, the use of trolleys for patients in the Emergency Assessment Unit and some staffing levels were noted. The Trust has taken action to rectify the issues under its direct control and working with partner organisations on other areas.

The income generated by the NHS services reviewed in 2010/11 represents 99.4 per cent of the total income generated from the provision of NHS services by The Dudley Group of Hospitals NHS Foundation Trust for 2010/11.

Participation in national clinical audits and confidential enquiries

During 2010/11, 45 national clinical audits and seven national confidential enquiries covered NHS services the Trust provides.

During that period the Trust participated in 40 (89 per cent) national clinical audits and seven (100 per cent) national confidential enquiries of the national clinical audits and national confidential enquiries, in which it was eligible to participate.

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

National Clinical Audits (Department of Health List)

TITLE	Lead	Eligible (Y/N)	Participate (Y/N)	% Submitted
Perinatal and Neonatal				
Centre for Maternal and Child Enquiries (CMACE): Perinatal mortality	J Edwards	Y	Y	100
National Neonatal Audit (NNAP)	Dr S Mahadevan	Y	Y	100
Children				
Paediatric Pneumonia	Dr R Mudgal	Y	Y	99
Paediatric Asthma	Dr R Mudgal	Y	Y	100
Paediatric Fever	Mr N Stockdale/Dr T Kippax	Y	Y	100
Childhood Epilepsy	Dr A Sharma	Y	Y	*

TITLE	Lead	Eligible (Y/N)	Participate (Y/N)	% Submitted
Diabetes (RCPH National Paediatric Diabetes Audit)	Dr A Mohite	Y	Y	100
Acute Care				
Emergency Use of Oxygen		Y	N	
Adult community acquired pneumonia	Dr M Chaudri	Y	Y	67
Adult NIV (Non Invasive Ventilation)	Dr M Chaudri	Y	Y	100
Pleural Procedures		Y	N	
Cardiac Arrest	Dr P Innes	Y	Y	100
Vital Signs in Majors	Mr R Paw	Y	Y	100
Adult Critical Care Unit ICNARC (Intensive Care National audit & Research Centre)	Dr J Sonksen	Y	Y	100
Potential Donor Audit (NHS Blood & Transplant)	Dr J Sonksen	Y	Y	100
Long Term Conditions				
National Diabetes Audit (NDA)	Dr H Siddique	Y	Y	100
Heavy Menstrual Bleeding	Dr H Morsi	Y	Y	100
Chronic Pain	Dr H Mutagi	Y	Y	100
Ulcerative colitis and Crohn's Disease (National IBD Audit)	Dr S Cooper	Y	Y	100
Parkinson's Disease	Dr S Duja	Y	Y	100
European COPD audit	Dr M Chaudri	Y	Y	52
Adult Asthma		Y	N	
Bronchiectasis		Y	N	
Elective Procedures				
National Joint Registry: hip, knee and ankle replacements	R Rai	Y	Y	100
Hip replacements PROMS (Patient Outcome Reported Measures)	K Holmes	Y	Y	92
Knee replacements (PROMS)	K Holmes	Y	Y	91
Hernia (PROMS)	K Holmes	Y	Y	47
Varicose Veins (PROMS)	K Holmes	Y	Y	52
National Vascular Database	Mrs S Shiralker	Y	Y	20
Carotid Interventions	Mrs S Shiralker	Y	Y	94
Cardiovascular Disease				
Familial Hypercholesterolaemia	Dr M Labib/ L Higginson	Y	Y	100
Myocardial Infarction National Audit Programme (MINAP)	Dr J Martins	Y	Y	100

TITLE	Lead	Eligible (Y/N)	Participate (Y/N)	% Submitted
Heart Failure Audit	Dr J Martins	Y	Y	100
Stroke Care (National Sentinel Stroke Audit)	Dr AK Banerjee	Y	Y	100
Renal disease				
Renal Registry: renal replacement therapy	Dr KA Shivakumar/ B Capewell	Y	Y	100
Patient Transport	J Pain/B Capewell	Y	Y	100
Renal Colic	Dr R Blayney	Y	Y	100
Cancer				
National Lung Cancer Audit (LCA)	H Coyle	Y	Y	96
National Bowel Cancer Audit Programme (NBOCAP): bowel cancer	H Coyle	Y	Y	100
Data for Head and Neck Oncology (DAHNO)	Dr C Brammer	Y	Y	100
Trauma				
National Hip Fracture Database (NHFD)	Mr S Quraishi	Y	Y	100
Trauma Audit & Research Network (TARN): severe trauma		Y	N	
National Falls and Bone Health Audit	Dr A Michael	Y	Y	98
Blood Transfusion				
Use of Platelets	Dr C Taylor	Y	Y	100
O neg blood use	Dr C Taylor	Y	Y	100

*Commences May 2011 and the Trust has registered.

As well as the national audits tabled above, from the Department of Health list, the Trust has also taken part in these further national audits:

National Clinical Audits (Other)

TITLE	Lead	Eligible (Y/N)	Participate (Y/N)	% Submitted
Pain in children (College of Emergency Medicine)	Dr T Kippax	Y	Y	100
Adult Asthma (College of Emergency Medicine)	Mr I Dukes	Y	Y	100
National Mastectomy and Breast Reconstruction Audit	Mr M Ali	Y	Y	100
National Oesophago-gastric Cancer Audit	Mr J Dmitrewski/ H Coyle	Y	Y	100
Royal College of Physicians Continence Care Audit	Dr S Duja	Y	Y	100
National Audit of Dementia: dementia care	Dr A McGrath	Y	Y	100

National Confidential Enquiries

The reports of eight national clinical audits were reviewed by the provider in 2010/11 and the Trust has taken, or intends to take, the following actions to improve the quality of healthcare provided:

- Commence a seven day per week rapid access clinic for high risk Transient Ischaemic Attack patients;

Title	Lead/Contact	Participated Yes/No	% Submitted
NCEPOD (National Confidential Enquiry into Patient Outcome & Death): Perioperative Care	Dr N Fisher/A Dufill	Y	100
NCEPOD: Cardiac Arrests	A Duffill	Y	Ongoing
NCEPOD: Surgery In Children	A Duffill	Y	Ongoing
NCEPOD: Parenteral Nutrition	A Duffill	Y	52
NCEPOD: Elective/Emergency Surgery in the Elderly	A Duffill	Y	94
CMACE; (Centre for Maternal & Child Enquiries); Stillbirths	J Edwards	Y	100
CMACE; Neonatal Deaths	J Edwards	Y	100

- Appointed a further Stroke consultant;
- Seven day per week consultant ward rounds for Stroke;
- Number of beds allocated to dementia patients to be increased for more effective care and overall observation;
- Continue and enhance the dementia care training for clinical staff;
- Extend service for dementia patients into EAU this will prevent unnecessary admission and distress to patients;
- Increase in dedicated slots in the memory screening clinic for a more accurate diagnosis and therefore more appropriate care;
- Integrated working and education with community services for continence care;
- Agreement on continence lead for elderly care;
- Appointment of continence nurse;
- Introduction of the Diabetes Outreach Team;
- Job plans altered for consultants, registrars and trainees in diabetology specialty;
- Improved education of clinical staff in the importance of diabetes management;
- Developed and implemented a minimum notification criteria in the emergency department to refer potential donors so staff can identify and refer these to the Specialist Nurse Team;
- Improved referral for potential donors to Specialist Nurse Team;

- For patients who have had a fall, telephone triage criteria put into place for appropriate referral; those with high risk are seen in the consultant-led falls clinic and those with low risk are seen in the community;
- The consultant-led falls clinic provides full cardiological, neurological, gait and osteoporosis assessment;
- Pain scoring of all children with limb injuries at triage in the Emergency Department and specific analgesia proforma attached to notes;
- Improved training of all medical and nursing staff in the Emergency Department on the British Thoracic Society and College of Emergency Medicine guidelines on asthma.

The reports of 139 local clinical audits were reviewed by the provider in 2010/11 and the Trust has taken, or intends to take, the following actions to improve the quality of healthcare provided:

- Pathologists issuing interim reports when delays are likely due to additional testing to ensure any necessary treatment occurs in a timely manner;
- All paediatric forearm fractures, within agreed criteria, to be treated with removable casts and to ask Emergency Department to take over the management of such patients. The outcome is that now Emergency Department treat such cases using the set guidelines so leading to a reduction in unnecessary visits to the fracture clinic, which benefits the patient;
- Improved use of high cost antifungals for haematology/oncology patients;
- Reduction in pre-operative testing in Orthognathic Surgery;
- Improved training of junior doctors with regards to intra and inter hospital transfers of critically ill patients;
- Reduction in duplication of documentation with regards to pre-assessment and anaesthetic charts;
- Protected CT and ultrasound scanning slots during working weekdays for emergency surgical admissions reducing delays in diagnosis and treatment;
- Improved updated blood transfusion records;
- Introduction of in-house database for biologics in rheumatology;
- Introduction of Chloraprep for skin preparation for invasive procedures in neonatal unit to reduce risk of infection;
- Improved junior doctor clerking when assessing for urinary tract infection in children;
- More timely system for senior doctor review of women in obstetric day assessment unit ;
- Clear guidelines on the use of Bortezomib (Velcade) in Haematology;
- Standardisation of Dexamethasone and biphosphonare treatment for multiple myeloma;

- Development of a self-medication policy as part of the 'ThinkGlucose' campaign;
- All stroke care nurses trained in performing swallowing assessments;
- Reassessment of distal radius fracture fixation policy in Orthopaedics;
- Review of working patterns of anaesthetists to reduce the risk of delays in undertaking elective caesarean sections;
- Urethral rather than tympanic route used for the recording of temperature of all patients in Intensive Care unit.

Research and Development

The Trust participates in large multicentre trials in the fields of cancer, cardiology and musculoskeletal medicine, undertaking both academic and commercial studies. The provision of a dedicated laboratory in the Clinical Research Unit has been instrumental in facilitating participation in commercial research, providing specimen storage and centrifuges for sample preparation.

Recruitment can be broken down into interventional and observational studies. During the year 364 patients were recruited into interventional and 794 into observational studies. Approximately six per cent of these subjects were recruited into commercial studies.

The Trust is co-sponsor of TRACE RA, a large multi-centre placebo-controlled clinical trial, with a target recruitment of 3,808 subjects, investigating the use of statins in patients with rheumatoid arthritis (RA). The Trust also hosts two Arthritis Research Campaign clinical research fellows. One researcher is investigating lipid profiles; the other is designing an educational intervention to reduce cardiovascular disease in RA sufferers.

The number of patients receiving NHS services provided or sub-contracted by the Trust in 2010/11 that were recruited during that period to participate in research approved by a research ethics committee, was 1,158.

Commissioning for Quality and Innovation Payment Framework (CQUIN) framework

A proportion of the Trust's income in 2010/11was directly related to this framework and is valued at £3.36m as part of our PCT contract and a further £172k is achieved via our specialised services contract. The sum is variable based on 1.5% of our activity outturn and conditional on achieving quality improvement and innovation goals. These are agreed between the Trust and any person or body they have a contract, agreement or arrangement with for the provision of NHS services through the Commissioning for Quality and Innovation Payment Framework. We haven't yet agreed the final settlement figure as some targets are still contingent upon outstanding information. However, for the purpose of the year end accounts, we assumed 75% achievement for the PCT schemes and 100% achievement for specialised services. This would equate to approx £2.7m.

Further details of the agreed goals for 2010/11 and for the following 12 month period are available electronically at http://www.dgoh.nhs.uk/quality/cquins

CQUINS report 2010/11 (Hospital)

Summary of goals

Goal no.	Description of goal	Quality Domain(s)
1	Reduce avoidable death, disability and chronic ill health from Venous-thromboembolism (VTE)	Safety
2	Improve responsiveness to personal needs of patients	Patient Experience
3	Missed doses	Safety
4	Warfarin prescribing medicines acute	Safety
5	Smoking acute	Safety Effectiveness
6	ThinkGlucose	Safety Effectiveness Patient Experience
7	Tissue viability	Safety Effectiveness
8	Dementia pathway	Effectiveness
9	Breastfeeding	Effectiveness
10	End of life care Advance Care Planning (ACP) enables patient choice and preferences, improves patient experience and quality of care	Experience Effectiveness

We have rated last year's CQUINS on a red amber green basis dependent on whether we achieved the target set with the PCT. We fell short of meeting the two for tissue viability and patient experience and we have actions in place to ensure the quality of care in these areas is improved and, in fact, both are quality priorities for this year.

CQUINS report 2011/12 (Hospital)

Summary of goals

Goal no.	Description of goal	Quality Domain(s)
1	Reduce avoidable death, disability and chronic ill health from Venous-thromboembolism (VTE)	Safety
2	Improve responsiveness to personal needs of patients	Patient Experience
3	Tissue viability – reduce the incidence of grade three & four hospital/community acquired pressure ulcers	Safety Effectiveness
4	Antimicrobial stewardship – reduce the incidence of healthcare associated infections	Safety Effectiveness
5	To improve the health of the population by ensuring that all patients who smoke and drink at harmful levels are identified and provided with brief advice by trained staff.	Safety Effectiveness
6	Mental Health – psychiatric liaison team set up, reviewed and improved	Safety Effectiveness Patient experience

CQUINS for 2011/12 (Community)

Summary of goals

Goal no.	Description of goal	Quality Domain(s)
1	Improve responsiveness to personal needs of patients	Patient experience
2	To deliver shared pressure ulcer care across acute and community services	Safety Effectiveness
3	Joint care planning for stroke patients	Safety Effectiveness Patient experience
4	Ensure patients are successfully maintained out of hospital in their own home by the virtual ward service	Safety Effectiveness Patient experience

Care Quality Commission (CQC)

The Dudley Group of Hospitals is required to register with the Care Quality Commission and our current registration status is 'licensed' with no conditions attached to registration.

The Care Quality Commission has not taken enforcement action with The Dudley Group of Hospitals during 2010/11.

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

In January 2011 we had a planned visit to review our compliance against the 16 Essential Standards of Quality and Safety set out by the CQC. Assessors visited various parts of Russells Hall Hospital and Corbett Outpatients Centre to check our compliance to the standards. Overall the report was very positive about our services highlighting just six minor concerns and one moderate concern with the standards. To ensure we make the necessary improvements, we have submitted our action plan to the CQC who will monitor our progress against it.

Quality of data

The Dudley Group of Hospitals NHS Foundation Trust submitted records during 2010/11 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 (based on April – January 2011 SUS data):

According to the NHS Information Centre's Data Quality Dashboard reports, the Trust's average data quality for all fields was 99.5% of which:

The following included the patient's valid NHS number:

- 99.4% for admitted patient care; National average was 98.4%
- 99.8% for outpatient care; National average was 98.8%
- 97.6% for accident and emergency care, National average was 91.6%

The following included the patient's valid General Medical Practice Code:

- 100% for admitted patient care; National average was 99.8%
- 100% for outpatient care; National average was 99.7%
- 100% for accident and emergency care. National average was 99.7%

The Trust Information Governance Assessment Report overall score for 2010/11 was 52 per cent and was graded red – not satisfactory, which indicated that not all of the level two requirements were achieved; however, improvement plans are in place to ensure the key requirements are achieved as soon as possible, and the Trust expects to have reached a satisfactory score by October 2011.

The Dudley Group of Hospitals NHS Foundation Trust was not subject to a Payment by Results clinical coding audit during 2010/11 by the Audit Commission because only Trust's within the bottom 30 in terms of auditing performance from the previous year (2009/10) had an audit.

The Trust's next scheduled audit will be between August 2011 and March 2012.

During 2010/11 there were two incidents involving personal data. The first involved a set of patient notes being delivered to the wrong health centre. The information was never in the public domain and the Trust reviewed its policy on the transportation of health records. In the second case, a member of the public received incorrectly addressed patient letters intended for a GP practice. Outgoing mail is now subject to an audit programme of regular sampling of letters.

Quality overview – performance against selected quality indicators

The Trust has a number of different Key Performance Indicators (KPI) reports and dashboards 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 indicators and measures is a web based dashboard. This is available to all senior managers, matrons and clinicians and currently contains over 130 indicators, grouped into the domains of Quality, Performance, Workforce and Finance.

The dashboard displays the performance of the indicators by month, quarter and year to date and the majority of them have historic data going back three years or more. There are also charts showing current financial year performance and trend line graphs to help the users see the current performance of each of the indicators. There are weekly and daily sections as well as views which just show the CQC, Monitor, CQUIN and PCT contractual measures.

Separate to this, a weekly e-mail is sent to senior managers and clinicians which include the A&E, Referral To Treatment, Stroke and Cancer targets.

Further, on a monthly basis Ward Performance Reports are 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.

A monthly report also goes to the Trust's Finance and Performance meeting and management executive meeting showing the Trust's performance against CQUIN, Monitor and CQC targets. A Performance Management report is also submitted to NHS Dudley containing performance against all national and locally set KPI's. The Trust also uses CHKS Ltd, who is a leading UK provider of comparative healthcare information, as a Business Intelligence monitoring tool. Some senior managers have access to the West Midlands SHA comparative performance tables to enable the Trust to benchmark itself against other trusts.

Our quality indicators have remained the same for 2011/12 as the Board and our stakeholders believe these take into consideration both national and local targets which will be important to patients and give a good overall view of the Trust's quality of care.

The tables below and overleaf cover the three dimensions of quality and reflect our quality priorities, topics we know are important to patients and those targets we are measured on locally and nationally.

Patient experience metrics:

	Actual 2007/08	Actual 2008/09	Actual 2009/10	Actual 2010/11	National Average 2010/11	Target 2011/12
% of patients that would recommend hospital to a relative/ friend**	90.4%	91.5%	89.5%	88%	91.8%	95%
% of patients who would rate their overall care highly**	93.8%	92%	88%	89.3%	90.8%	91%
% of patients who spent less than 4 hours waiting in A&E (national target)	98.1%	95.9%	98.1%*	98.8%*	96.9% West Midlands only	95%***
% of patients who felt they were treated with dignity and respect**	97.4%	95.9%	94.6%	96%	95.6%	N/A

*Dudley health economy mapped figure Data source:

**Data from national inpatient surveys conducted for CQC

National Average = Picker Institute Europe average. Picker undertake the inpatient survey for around 75 hospital trusts in England

*** A&E 4 hour wait target was 98% for Quarter one of 2010/11 and 95% for Quarter 2 to 4.

Safety measures:

	Actual 2007/08	Actual 2008/09	Actual 2009/10	Actual 2010/11
Patients with MRSA infection/1,000 bed days*	N/A	0.07	0.04	0.01
Patients with C difficile infection/1,000 bed days*	1.45	0.97	0.9	0.51
Number of cases of Deep Vein Thrombosis presenting within three months of hospital admission Source: Patient Administration System	49	48	48	35

*Data source: Numerator data taken from infection control data system and denominator from the occupied bed statistics in patient administration system. *NB MRSA/C difficile figures may differ from data available on HPA website due to different calculation methods and Trust calculations using most current Trust bed data.*

Clinical outcome measures reported:

	Actual 2007/08	Actual 2008/09	Actual 2009/10	Actual 2010/11
Trust Readmission Rate for Surgery Vs Peer group West Midlands SHA Source: CHKS Signpost	4.6% Vs 4.1%	3.9%* Vs 4.3%	4.1% Vs 4.2%	4.4% Vs 4.7%
Number of cardiac arrests Source: logged switchboard calls	397	250	170	145
Never events – events that should not happen whilst in hospital Source: adverse incidents database	0	0	0	0

*3.8 per cent for 2008/09 in the 2009/10 report was April 2008 to February 2009 only

Our performance against key national priorities and National Core Standards

National targets and regulatory requirements	Actual 2007/08	Actual 2008/09	Actual 2009/10	Actual 2010/11	Target 2011/12
The Trust has fully met the CQC core standards, and national targets	24/24	23/24	23/24	N/A	N/A
A maximum two-week wait for standard Rapid Access Chest Pain Clinics	99.98%	99.89%**	99.90%	99.64% 99.88% West Mids SHA Apr-Dec	95%
Genito-urinary medicine – percentage of patients offered an appointment within 48 hours	N/A	99.59%	99.83%	99.66% 99.9% West Mids SHA Apr-Dec	98%
Percentage of patients who have operations cancelled for non-clinical reason to be offered another date within 28 days	100%	100%	100%	100% 97.9% West Mids SHA Apr-Dec	98.5%
Clostridium difficile year on year reduction	N/A	154*	126	81 N/A West Mids SHA	No more than 77 No more than 126 Monitor Target
MRSA – maintaining the annual number of MRSA bloodstream infections as per the PCT contract	N/A	16 (only seven of which were post 48hrs)	10 (only two of which were post 48 hrs)	3 N/A West Mids SHA	No more than 2 No more than 6 Monitor Target
National targets and regulatory requirements cont.	**Actual 2007/08**	**Actual 2008/09**	**Actual 2009/10**	**Actual 2010/11**	**Target 2011/12**

Screening all elective in-patients for MRSA	N/A	N/A	100%	100% Apr-Mar	100%
Stroke patients spending 90% of their time on stroke unit	N/A	N/A	N/A	68.30% 67.87% West Mids SHA Apr-Jan	80% by the end of Mar 2011
Suspected stroke/TiA scanned < 24hrs of presentation	N/A	N/A	N/A	76.11% 47.66% West Mids SHA Apr-Jan	60%
Maximum time of 18 weeks from point of referral to treatment (admitted patients)	N/A	92.4%	95.8%	97.03% 93.37% West Mids SHA Apr-Jan	95%
Maximum time of 18 weeks from point of referral to treatment (non-admitted patients)	N/A	96.15%	99.1%	99.25% Apr-Jan 98.04% West Mids SHA Apr-Jan	90%
Two week maximum wait for urgent suspected cancer referrals from GP to first outpatient appointment	100%	100%	98%	96.8% 94.97% West Mids SHA Apr-Feb	93%
A maximum wait of 31 days from decision to treat to start of treatment for all cancers	100%	100%	99.3%	99.8% 98.68% West Mids SHA Apr-Feb	96%
A maximum wait of 62 days from urgent referral to treatment of all cancers	100%	99.9%	86.5%	87% 85.53% West Mids SHA Apr-Feb	85%
Proportion of women receiving cervical cancer screening test results within two weeks	90%	90%	32.12%***	98.60% Data Not available West Mids SHA	98%
Percentage of patients waiting five weeks or less for diagnostic tests	N/A	99.73%	99.58%	98.34% Apr-Mar Data Not available West Mids SHA	100%

All figures are final year end data for 2010/11 unless stated otherwise.

N/A applies to targets not in place at that time.

*The outcome of verification of year end data for 2009/10 was confirmed after publication of the 2008/09 report which stated a figure of 152

**The outcome of verification of year end data for 2009/10 was confirmed after publication of the 2008/09 report which stated a figure of 99.98 per cent

*** There was a print error in last year's Quality Report and Accounts stating this figure was 97%, this was the quarter 4 figure. The reason the per cent is now less is due to the year end figure being inserted. The low figure is due to a national increase in women coming forward for screening following a very high profile celebrity death from cervical cancer.

Hospital Standardised Mortality Ratio

We are committed to ensuring the best possible outcome for our patients at The Dudley Group of Hospitals and were disappointed with the mortality ratio of 115.5 assigned to us by Dr Foster for 2009/10. Our internal monitoring systems, which include audits, mortality and morbidity reviews and detailed reviews in areas where mortality alerts have been generated, have not raised any concerns. The Trust also works with CHKS, an external independent organisation that provides comparative performance data in a number of areas, including mortality.

CHKS use a similar but alternative methodology to calculate mortality risk called the Risk Adjusted Mortality Index (RAMI). Using an additional analysis methodology helps us to identify and investigate areas that may be of concern. The RAMI position for the same period as Dr Fosters data was 91, and for the current year to date is 88. These figures will be adjusted as part of a rebasing process, but we are not anticipating our final RAMI to raise concerns.

Using CHKS has given the Trust additional reassurance around mortality performance. Indeed mortality alerts raised via the Care Quality Commission (CQC) give us further reassurance as our responses have required no additional investigation due to the robustness of our processes. Additionally our published response to Dr Foster Good Hospital Guide evidencing our robust methodology was supported by NHS Dudley and acknowledged by the Strategic Health Authority, Monitor and the CQC.

The Trust is not alone in having a retrospective increase in Dr Foster's mortality ratio applied to our performance. The government has also raised concerns over the inherent difficulties associated with Risk Adjusted Mortality modelling and its suitability for comparing organisational performance.

As a consequence a new measure, Summary Hospital-level Mortality Indicator (SHMI) is due to be introduced in April 2011 to address these issues and provide a single standard across the country. Even with this standard measure the government's steering group has said that:

> *"While it is acknowledged that variation in quality of care is likely to have an adverse impact on the number of avoidable deaths, it cannot be assumed that a high SHMI – or any other summary level indicator – of deaths is necessarily the result of poor quality of care"*

ANNEX

Comment from NHS Dudley (received 29/04/2011)

NHS Dudley is pleased to provide a supporting statement for The Dudley Group of Hospitals NHS Foundation Trust Quality Report and Accounts for 2010/11. We have carefully reviewed the contents of this report and believe the content is a true and accurate reflection of the performance information recorded by the Trust. As such we are happy to endorse it.

We applaud the work done within the Trust to improve the recognition of deteriorating condition of patients and the associated reduction of cardiac arrests. This represents an important contribution to patient safety.

Following the transfer of some community services into the new Dudley Group of Hospitals NHS Foundation Trust, we value the alignment of the Trust's priorities and goals across both hospital and community services going forwards to 2011/12.

We share the Trust's concern about the number of patients developing pressure ulcers and are extremely pleased to see this as a priority for significant improvement this year.

We also shared the Trust's disappointment with the Hospital Mortality rate published by Dr Foster this year and continue to work closely with Trust colleagues to review and monitor deaths in hospital.

Finally we welcome a strengthened focus on listening to patients and improving patient experience in 2011/12.

Comment from Dudley Local Involvement Network (received 20/04/2011)

Dudley Local Involvement Network (LINk) welcomes the opportunity to contribute to the Quality Report and Accounts.

We work across Dudley Borough to listen to the community and hear their experiences and comments about the services that they receive. We therefore share the concern expressed by Chief Executive Paula Clark regarding her disappointment that levels of patient experience has not improved as much as the Trust would like. In addition to being consulted about Quality Priorities on an ongoing basis being represented on the Trust's Patient and Public Experience Steering Group and being involved in the quality priority Listening into Action event, LINk has enabled the voice of Dudley residents to be heard and, whilst we also hear from people whose expectations of the services they have received have not been met, we must also remember the many people in Dudley who cannot compliment our hospitals and the staff enough.

As the Trust has now taken on board some of our community services it is good to see that when setting their priorities for the coming year these services have been taken into account.

The priorities this year will be important to the people of Dudley. We know that they want to be satisfied with the quality of the service that they receive; we know that the possibility of acquiring a pressure ulcer is a concern to people; we know that people

really do worry about catching MRSA and C-diff whilst in hospital; we know that the trust has a good record in operating swiftly on hip fractures and that we want this to continue

All of these priorities are important and LINk will work hard with Dudley residents and The Dudley Group of Hospitals NHS Foundation Trust to ensure that they are maintained.

Comment from the Overview and Scrutiny Committee (received 14/04/2011)

The quality priorities were considered at the OSC (Overview and Scrutiny Committee) meeting held on the 6th April 2011. Unfortunately, due to the proximity to year end processing and other constraints, the OSC was unable to provide a supporting narrative this year. However the Committee agreed to develop subsequent work plans to incorporate the Quality Report and Accounts issues to support year round dialogue to ensure relevance amongst Dudley's communities is maintained.

Comment from the Trust's Council of Governors (received 07/04/2011)

The Council of Governors acknowledges the progress made by the Trust during the last 12 months and in particular the involvement of, or consultation with, Governors on several occasions. It also acknowledges the transparency and co-operation received from the Trust Board and senior staff, without which it would be difficult to function effectively e.g. influencing in a positive way the strategy of the Trust.

Governors have been regularly informed about the Trust Transformation programme including receipt of a number of slide presentations followed by question and answer sessions. This has ensured the Trust was made aware of the views of the Trust Membership with opportunity given for suggestions to be considered. A number of suggestions have been put forward by Governors which have been incorporated into the Transformation programme. These have been made in writing, paper, verbally or by participation in the Listening into Action (LiA) group sessions which have resulted in changes in the way the Trust operates. The LiA events are proving to be a successful means of communication of good ideas from the Trust staff working on the front line, and although specifically designed for staff, have been a useful tool for Governors when they have been invited to attend, such as the Quality LiA.

Governors wrote a paper highlighting the right of our patients to receive 'good quality hospital care'. Supported by the Council of Governors it sets out some expectations for quality:

- Good clinical care
- An efficient service which includes – prompt responses and a good use of resources
- The provision and availability of suitable food
- A friendly welcoming environment in which patients and visitors feel important and cared for
- A clean hospital and a quiet, peaceful environment, especially at night

- Good communications – between staff, patients, visitors and any other appropriate persons

The list is by no means exhaustive, but Governors are alerted to patients' views by their own experiences in hospital, talking to Trust Members and by taking part in unannounced senior nursing staff 'ward assessment visits', which give Governors the chance to obtain up-to-date views of our patients about their experience whilst in hospital. On the whole patients find the medical and nursing care to be very good although, inevitably, there are some instances where we get things wrong. Patients welcome the opportunity to be able to talk with Governors during these visits. Items brought to the attention of Governors are discussed at both the Service Strategy Sub Committee and full Council of Governors.

Cleanliness and patient safety is a top priority for everyone so it is extremely pleasing to note the major strides forward in reducing instances of MRSA and C Diff. The Council of Governors receives regular updates and presentations throughout the year showing the progress.

Governors feel they have used their roles in a positive way to influence the strategy of the Trust and will continue to do so despite the major changes that lie ahead for the NHS, acute hospitals and Foundation Trust Governors alike.

Statement of directors' responsibilities in respect of the quality report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 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 foundation trust boards should put in place to support the data quality for the preparation of the quality report.

In preparing the quality report, directors are required to take steps to satisfy themselves that:

- The content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2010-11;
- 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 2010 to June 2011
    - Papers relating to Quality reported to the Board over the period April 2010 to June 2011
    - Feedback from the commissioners dated 20th April 2011
    - Feedback from governors dated 7th April 2011
    - Feedback from LINks dated 20th April 2011
    - The Trusts complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 23rd May 2011

- The national patient survey 7th April 2011
- The national staff survey 16th March 2011
- The Head of Internal Audits annual opinion over the trusts control environment dated 24th May 2011
- CQC quality and risk profiles dated Jan '10, Sept '10, Oct '10, Nov '10, Dec '10, Feb '11, March '11

The Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered. The performance information reported in the Quality Report is reliable and accurate. There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice.

The data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed 106 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.monitornhsft.gov.uk/annual reporting manual) as well as the standards to support data quality for the preparation of the Quality Report (available at www.monitornhsft.gov.uk/annualreportingmanual)).

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

By order of the Board

NB: sign and date in any colour ink except black

Date 26th May 2011 Chairman

Date 26th May 2011 Chief Executive

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

We have been engaged by the Council of Governors of The Dudley Group of Hospitals NHS Foundation Trust to perform an independent assurance engagement in respect of the content of

The Dudley Group of Hospitals NHS Foundation Trust's Quality Report for the year ended 31 March 201 I (the "Quality Report").

This report, including the conclusion, has been prepared solely for the Council of Governors of The Dudley Group of Hospitals NHS Foundation Trust as a body, to assist the Council of Governors in reporting The Dudley Group of Hospitals 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 20 II , to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the Quality Report. 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 of Hospitals NHS Foundation Trust for our work or this report save where terms are expressly agreed and with our prior consent in writing.

Scope and subject matter

We read the Quality Report and considered whether it addresses the content requirements of the NHS Foundation Trust Annual Reporting Manual, and considered the implications for our report if we became aware of any material omissions.

Respective responsibilities of the Directors and auditors

The Directors are responsible for the content and preparation of the Quality Report in accordance with the criteria set out in the NHS Foundation Trust Annual Reporting Manual 20 I 0111 issued by the Independent Regulator of NHS Foundation Trusts ("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 content of the Quality Report is not in accordance with the *NHS Foundation Trust Annual Reporting Manual* or is inconsistent with the documents.

We read the other information contained in the Quality Report and considered whether it is materially inconsistent with:

- Board minutes for the period April 201 0 to March 20II.
- Papers relating to Quality reported to the Board over the period April 20 I 0 to March 20II.
- Feedback from the Commissioners dated *29/04/20 II.*
- Feedback from the Council of Governors dated *07/04/2011.*
- Feedback from LINKS dated *20/04/20 II*
- The Trust's 2010111 complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009. (Due to the timing of our work we have reviewed Quarter I (June 20I0), 2 (September 20I0) and 3 (December 20I0) for 2010/11).
- The 20I0 national patient survey and local patient survey dated *31/03/20* II.
- The 20I0 national staff survey.
- The Head of Internal Audit's annual opinion over the Trust's control environment dated *31 /03/20* II.
- Care Quality Commission quality and risk profiles dated March 20 II.

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

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 lnformation' issued by the International Auditing and Assurance Standards Board (,ISAE 3000'). Our limited assurance procedures included:

- Making enquiries of management.
- 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 less 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

It is important to read the Quality Report in the context of the criteria set out in the NHS Foundation Trust Annual Reporting Manual.

Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 3 I March 20II, the content of the Quality Report is not in accordance with the NHS Foundation Trust Annual Reporting Manual.

Deloitte LLP

Chartered Accountants

Birmingham

I June 20II