The Dudley Group NHS
NHS Foundation Trust

Quality Report
2011/12

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Content

PART 3

ANNEX

Part 1: Chief Executive's Statement

I am delighted to introduce this Quality Report, the purpose of which is to give a detailed picture of the quality of care we provide for patients who have visited our hospitals and/or received our services in the community from April 2011 to the end of March 2012.

At the beginning of the year we set ourselves some challenging quality objectives. We wanted to set ourselves on a path to exceed our internally set quality targets by 2014 so that we would be recognised as the highest quality service provider in the region by patient groups, staff and other key stakeholders. We also wanted to ensure we were providing excellent care and services, making patients feel involved, valued and informed.

These objectives linked into both our guiding principle as a healthcare provider and indeed the reason for our existence; to provide high quality care for all of our patients. However, what is high quality care? We believe it is being able to answer 'yes' to the following three questions:

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

2 Patient Safety
Are patients safe in our hands?

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

We are working towards answering these questions positively and being able to demonstrate it transparently. We believe the quality of care is made up of these three elements but they cannot be measured in just one way. Therefore we use a number of measures, all of which add together to give an overall picture of what the organisation is achieving and where it still needs to improve.

In Part two 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 6; more information on each current priority can be found on the page numbers listed in the table. This further information includes progress made to date, as well as our new targets for 2012/13. 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 three we have included other key quality projects and measures and specific examples of good practice on the three elements of quality listed above. Hopefully this will give a rounded view of what is happening across the whole of the Trust.

This is the first Quality Report that covers our new community adult services which joined us last April. Although some parts of the report are divided into hospital and community sections, we have deliberately not included a separate section on the community services. The reason for this is that we take the patient view that services should be seamless and integrated and many of our services cross the hospital and community boundary.

During 2011/12, nationally there has been a requirement to make substantial financial savings and a degree of uncertainty remains regarding the overall structure of the NHS. Despite these challenges, we believe the wide range of measures and checks detailed in this report 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

As you read the report, you will see that we have performed well with our 2011/12 priorities related to patient experience feedback from our community services, inpatient MRSA infections, the time from admission that patients are having their hip operations and the large reduction in the numbers of hospital acquired pressure ulcers. For Clostridium difficile, we unfortunately breached our target but, following intensive work with assistance from outside partners, we have been back onto the individual monthly targets from November 2011 and this continues. We recognise there is some way to go to ensuring our inpatients' experience of our services matches that which we would all expect and we still have work to do to ensure we drive down the number of avoidable pressure ulcers acquired in the community. With regards to 2012/13, we have retained all of the topics from 2011/12 except for the time from admission to having a hip operation, as we are consistently performing well with this. In addition, we have included further priorities relating to nutrition and hydration, issues that we know are important to individual patients as well as local and national patient organisations.

Measuring Quality

The report shows that we are constantly monitoring the quality of our care in a variety of ways. We do this to assure patients and ourselves of where we are doing well and to learn where we need to change practice and improve our services. This year we have re-launched our vision and values to help steer us towards our goal to put the patient first, value our staff and improve customer care. Our new vision "Where People Matter" goes hand in hand with our new values: "Care, Respect and Responsibility" which together form a good basis for high quality care.

Although the report includes facts and figures to measure quality, we have also included a number of specific examples of awards, innovations and initiatives that Trust staff have achieved and put into practice throughout the year.

Recognising that our staff are our greatest asset, we have also started a new Patient and Customer Care Ambassador programme to enhance patient experience by helping to improve staff attitude and behaviour. Our aim is to give our patients, carers, families and visitors the best possible healthcare experience. To spearhead the change more than 30 staff have already completed the programme since it was piloted in October 2011.

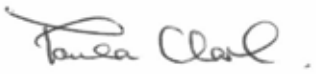
The ambassadors have been handpicked from staff across all wards and departments because they are known for their exemplary behaviour towards patients, their families, visitors and colleagues. They are now in the process of using their own experiences, both good and bad, to come up with a set of customer care standards as a promise to our patients to treat them with courtesy and respect at all times. In addition, while our patients acknowledge staff every day by the many compliments and letters we receive, we have developed a Roll of Honour which we publish on our Intranet which shows our appreciation of staff who give exceptional quality service and encourage others to copy their good customer care approach.

I hope you will find useful the information on the quality priorities which we have chosen to focus on, the ways in which we assure ourselves of our quality of care and a selection of the targets, both national and local.

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 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

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

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 2012/13.

Priority	2009/10	2010/11	2011/12	2012/13	Comments	More info
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 with a slight decrease in another	**Priority 1** **Hospital:** Partially achieved **Community:** √ Achieved	**Priority 1**		P8 – 11
PRESSURE ULCERS Improve systems of reporting and reduce the occurrence of avoidable pressure ulcers	N/A	N/A	**Priority 2** **Hospital:** √ Achieved **Community:** Partially achieved	**Priority 2**		P12 – 14
INFECTION CONTROL Reduce our MRSA rate in line with national and local priorities Reduce our Clostridium Difficile rate in line with (or better than) local and national priorities	√ Achieved	√ Achieved	**Priority 3** √ Achieved x Not achieved	**Priority 3**		P15 – 17
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	**Priority 4** √ Achieved	Not included as a priority	As the target was achieved for two consecutive years this priority has now been replaced for 2012/13	P7 – 8
NUTRITION Increase the number of patients who have a risk assessment regarding their nutritional status within 24 hours of admission	N/A	N/A	N/A	**Priority 4**	A new priority for 2012/13	P18 – 19
HYDRATION Increase the number of patients who have fluid balance charts completed	N/A	N/A	N/A	**Priority 5**	A new priority for 2012/13	P18 – 19
CARDIAC ARRESTS Reduce the numbers of cardiac arrests	√ Achieved	√ Achieved	Not included as a priority	Not included as a priority	There was a dramatic improvement from 32 per month in 2008 to 13 per month by March 2011 and so this issue no longer remained a challenge for the Trust.	N/A

2.1.2 Choosing our Priorities for 2012/13

In February 2012, a 'Listening into Action' (LiA) workshop on the Quality Report, hosted by the Chief Executive and Director of Nursing, was held at Russells Hall Hospital Clinical Education Centre. There was an open invite to Trust Governors, members and representatives from patient groups. Fifty five people attended comprising 24 staff (three of which are Governors), five other Governors (four public, one appointed), 21 Foundation Trust members and five others from the following organisations: Dudley LINk, NHS Dudley, Dudley MBC, Dudley Stroke Association and Dudley Action for Disabled People and Carers (ADC). The purpose of the day was to:

1. Provide an overview of the Trust's quality priorities (2011/12) and how they had progressed so far
2. Look at the quality priorities for 2012/13
3. Consider potential areas beyond 2012/13

Key clinical and non-clinical staff presented short talks on the existing four priorities:

- Patient Experience
- Infection Control
- Pressure Ulcers
- Hip Fractures

In addition, further presentations were made on two new potential priorities (Nutrition and Hydration) for 2012/13.

As the present target related to hip fractures had been achieved (see details across), we have decided to replace that with new topics for 2012/13. Therefore, there are now five areas for improvement for 2012/13 (the three other existing priorities from 2011/12 and the two new priorities). The workshop groups at the LiA event agreed that all five areas for improvement were of importance and so the Trust Board has agreed to have five priority areas in 2012/13.

Priority 4 for 2011/12. 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).

All of the developments for 2011/12 in this area for improvement, which were planned last year, have either been completed or are on-going. This has contributed to very good practice which has resulted in national recognition (see section 3.4.2).

Participants at the 'Listening into Action' workshop event as well as other Trust staff and Governors, have noted the success in achieving this target. For patients admitted between Apr 2011 – Mar 2012 (regional/national provisional figures correct at 8th May 2012):

- National average time to Surgery = 34.25 hours
- Regional average time to Surgery = 35.17 hours
- Trust average time to Surgery = 26.33 hours

The following two tables show the percentage of all of our patients who had hip surgery within 36 hours of admission (Table 1) and the percentage of those patients who had hip surgery within 36 hours of admission when it was clinically appropriate to do so (Table 2). We have shown two tables as some patients on admission are initially not well enough for surgery and need extensive treatment and therefore time to make them well enough for surgery to occur.

Table 1 – All patients having hip fracture surgery (Total: 460 patients of which 89.3 per cent were operated on <=36 hours)

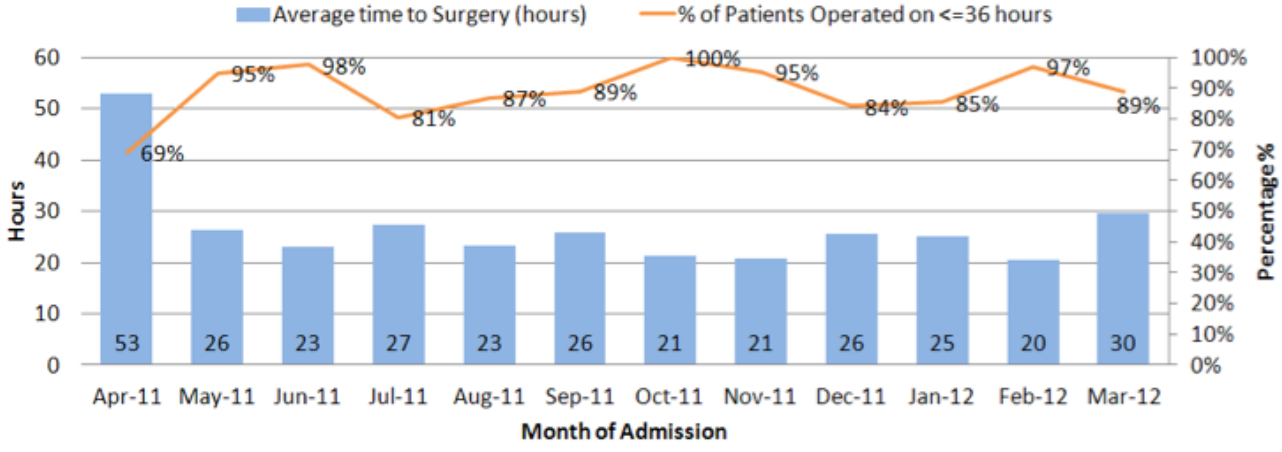
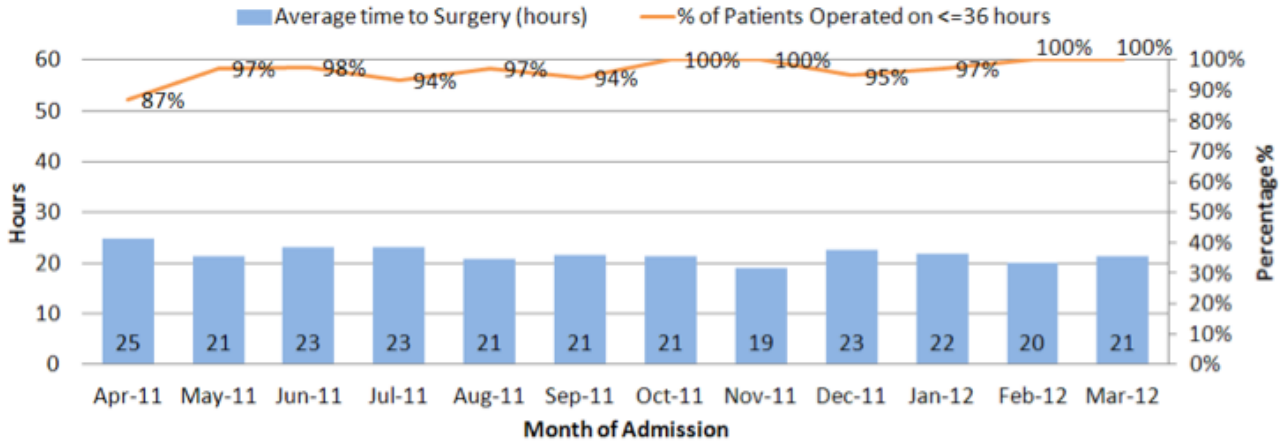


Table 2 – All patients having hip fracture surgery who were clinically well enough on admission for surgery (Total: 424 patients of which 96.9 per cent were operated on <=36 hours)



As Table 2 shows, the target has now been achieved, so we have decided to replace this priority with two new priorities for 2012/13 relating to nutrition and hydration. Already committed to making nutrition and hydration a priority during patients' stay in hospital, the Trust is endeavouring to develop and implement new strategies and monitoring systems to support this vital element of hospital care.

2.1.3 Our Priorities

Existing Priority 2011/12

PATIENT EXPERIENCE (3rd Priority Year)	
Priority 1 2011/12	
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. (b) Show an increase in patients who would recommend The Dudley Group's 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.

Patient Stories:

"Instruction on how to manage my condition was done sensitively and patiently."

"I did not enjoy the food on my recovery. I had very little appetite as the treatment affected my mouth, throat and intestines."

How we measure and record this priority

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 priority is measured against results of the Inpatient Survey which takes place once a year and gives a 'snapshot' of care provided at that moment in time. We also undertake our own 'real-time' surveys to provide us with early identification of any problems throughout the year. We believe that listening to what patients tell us about their experiences is the best way for us to learn and improve.

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

Community
The Trust takes part in the Commissioning for Quality and Innovation (CQUIN) patient experience survey which systematically gathers the views of patients about the care they have recently received in the community. This usually takes place twice a year with the collection of baseline information early in the year and a repeat audit to measure our improvements. More information about the CQUIN scheme is available in section 2.2.4 on page 26.

Developments that occurred in 2011/12

In 2011/12 we refreshed our real-time surveys to improve the way we listen and make changes. Our enthusiastic team of volunteers carry out the surveys with patients in order to offer complete confidentiality. During the 2011/12 year we completed surveys with 1048 inpatients.

We also set up Patient Panels to provide a forum for patients to share their experiences to help us to improve our services. Panels have so far been held on:

- Inpatient mealtimes (November 2011)
- Accessibility (March 2012)

At the first Patient Panel we received feedback on the choice of food available, special dietary requirements, quality and flavour of food and communication relating to mealtimes. This subject has sparked great debate, and patient comments have been instrumental in the Board deciding to undertake a complete root and branch review of the way we deliver inpatient food services.

The Patient Panel on accessibility was well attended in March 2012 with patients sharing their experiences around wheelchair access, parking, hearing and low vision awareness. Action plans for improvement will be shared with the group and we look forward to working together to provide more accessible services.

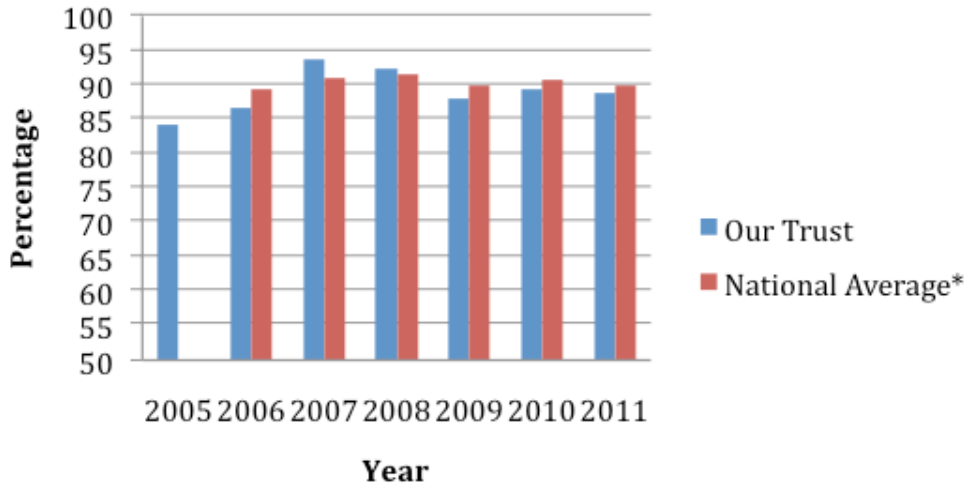
We also introduced a 'Health Hub' in the main reception at Russells Hall Hospital to provide patients, relatives, visitors and carers with as much information as possible to help reduce their potential anxieties and encourage them to be more informed about their care and treatment. During the year we also increased our range of patient information leaflets by 125.

Current status

Hospital
(a) The 2011 national Inpatient Survey results show that the number of patients who rate their overall care highly at The Dudley Group has decreased by 0.6 percent during the course of the year. This is in line with the average of 73 Trusts whose results were available for comparison, showing an average reduction of 0.8 per cent against this question.

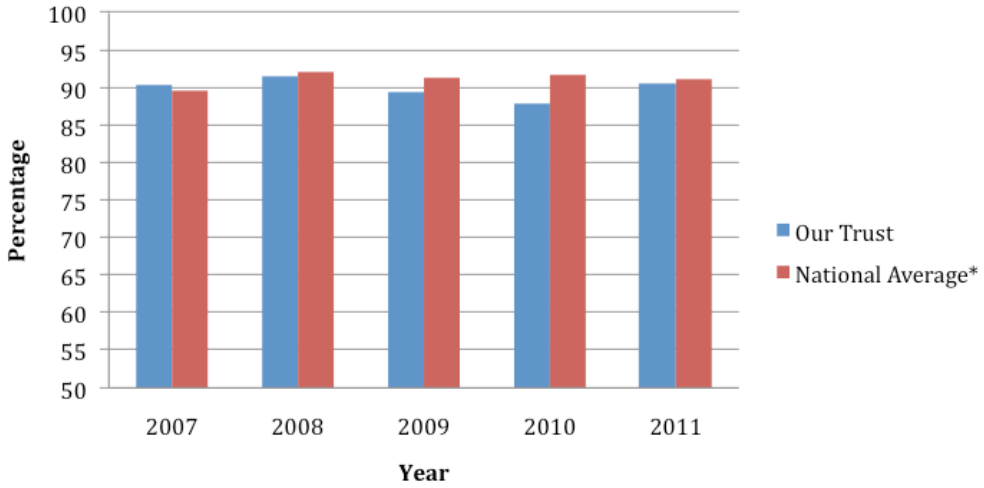
As indicated in the chart below, the results for this question have remained around 90 per cent for the last five years.

Patients rating overall care as good, very good or excellent



(b) In the 2011 National Inpatient Survey the Trust undertook the shorter core questionnaire (rather than the extended questionnaire) to try to encourage more participants to complete the survey. Unfortunately the recommendation question was not included in the core questionnaire; therefore the 'Our Trust' bar in the table below shows the results of our real-time surveys for 2011. Our real-time surveys represent the views of a much larger number of patients than the national survey and show an increase to 90.7 per cent of patients who would recommend the Trust to a friend or relative.

Patients who would recommend the Trust to a friend or relative



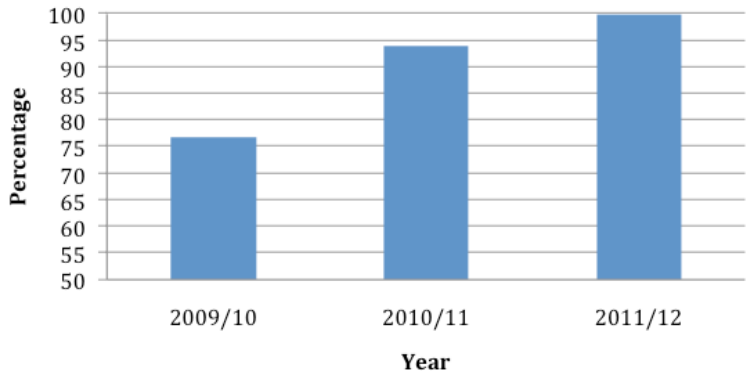
**National Average = Picker Institute Europe average. Picker undertook the inpatient survey for 73 hospital trusts in England in 2011*

Community

In line with the CQUIN requirements, a baseline survey was carried out in quarter two, with a follow up survey in quarter four to check for improvements. The surveys were undertaken with patients receiving care and treatment from the four services dictated by the CQUIN scheme: Continence, Diabetes, Virtual ward and Wound care (leg ulcer).

We are very pleased that patients surveyed are wholly satisfied with the care and treatment received, with the quarter two baseline of 99.56 per cent rising to 100 per cent in quarter four. This is testament to the hard work of community staff during their initial year in the Trust. Results from this and the two previous years are compared on the graph at the top of the next page.

Percentage of patients who are satisfied with the personal care and treatment received from the community services



New Priority 2012/13

PATIENT EXPERIENCE (4th Priority Year)	
Priority 1 2012/13	
Hospital	Community
(a) Increase the number of patients who receive enough assistance to eat their meals from 81 per cent to 85 per cent. (b) Increase the number of patients who receive enough information about ward routines from 57 per cent to 65 per cent.	(a) Increase the number of patients who use their Single Assessment Process folder to monitor their care from 75.3 per cent to 80 per cent. (b) Increase the number of patients who would know how to raise a concern about their care and treatment if they wished to do so from 80.8 per cent to 85 per cent.

Rationale for inclusion

Feedback at the Listening into Action workshop told us that patients and staff think that improving our patient experience is really important and should be retained as a quality priority. In previous years we have focused on overall measures of patient satisfaction and, while this is useful, in 2012/13 we want to try to make improvements to some specific issues that have scores which are lower than we would like.

Measuring this priority in 2012/13

Hospital

This will be measured using our ongoing real-time survey system to ensure we have up to the minute information and an early trigger system to highlight if progress is not being made either Trust-wide or in specific areas. This priority also forms part of our CQUIN scheme for 2012/13.

Community

This will be measured using an annual survey. The questions will be included alongside the existing CQUIN questions and will be asked of patients receiving care from the four services: Continence, Diabetes, Virtual ward, Wound care (leg ulcer).

Developments planned for 2012/13

- Consider feasibility of increasing employed nutritional support workers, continue utilising trained volunteer mealtime assistants, embedding of 15-minutes meal bell alert along with behind the bed boards identifying mealtime assistance requirements
- Introduce bedside folders to inform patients of ward routines
- Raise awareness with patient (or family/carer) of the use of the Single Assessment Process folder to keep them informed of the care provided and as a means of communication
- Ensure PALS leaflets are available for patients, refresh posters in clinic areas advising patients how to complain if they wish to, PALS advice to be documented as part of assessment

Board sponsor:
Denise McMahon, Director of Nursing

Operational lead:
Mandy Green, Communications Manager

Existing Priority 2011/12

PRESSURE ULCERS (1st Priority Year)	
Priority 2 2011/12	
Hospital	Community
Reduce avoidable stage three and four hospital acquired pressure ulcers through the year. This will mean by 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 reliable, accurate data collection system in place. For those patients on a district nurse caseload, avoidable stage three and four community acquired pressure ulcers are reduced through the year.

Patient Stories:

"Even once I was home I couldn't do the things that I usually do because the pressure ulcers were on my feet and I couldn't walk very well. It took a long time to heal."

How we measure and record this priority

Pressure ulcers (also called pressure sores and bed sores) are graded one to four with four being the most serious. It is vital that those treating the sores know what stage it is at and treat accordingly. It is also very important that the stage is recorded and treatment begins as soon as possible to prevent any complications and the problem becoming worse.

When a patient is identified as having a pressure ulcer this is noted on a weekly report on each ward and community service. This information is sent to the tissue viability team which maintains a Trustwide database of the details.

If pressure damage is noted within 72 hours (a time frame agreed by the Strategic Health Authority) of being admitted to hospital then this is considered to have developed before admission. The beginnings of an ulcer can be present but not visible for some time, therefore the patient may have been admitted to hospital already suffering from pressure damage.

Developments that occurred in 2011/12

Last year, we outlined a number of actions we intended to undertake during 2011/12. These have either been completed or are on-going. The key ones include:

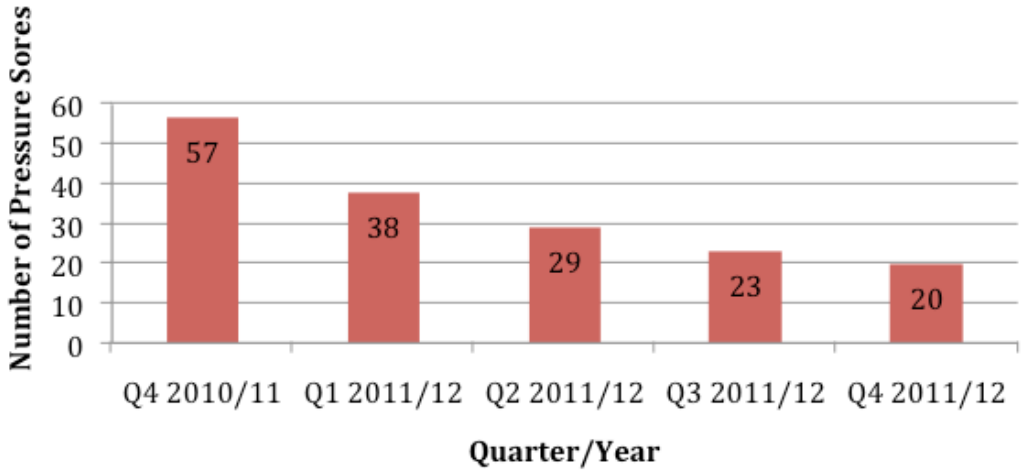
- The 'We love your skin' campaign which ran for three months and helped to raise awareness of pressure ulcer prevention.
- All wards have been issued with pressure ulcer prevention and management documents, which have been in use for over a year now. Compliance of the use of these documents is audited on a weekly basis. All wards are rated individually and there is a robust system in place to address any under achieving areas.
- All stage three and four pressure ulcers are reported as 'Serious Untoward Incidents' and are thoroughly investigated. This is done by a root cause analysis (a way of working out how and why the problem has happened) and from this actions are taken to prevent it happening again.Mandatory and induction training sessions continue for both hospital and community staff and a test has been added to ensure they know how to prevent, treat and manage pressure ulcers.

Current Status

Hospital

The graph below shows the number of stage three and four pressure ulcers that developed in the hospital from the fourth quarter of 2010/11 (January – March). It can be seen that to achieve the target of a reduction of 50 per cent the Trust needs to have reduced the numbers to 28-29 by the fourth quarter of 2011/12. This was achieved by the second quarter of the year.

Number of Stage three/four Pressure Ulcers Developed in Hospital

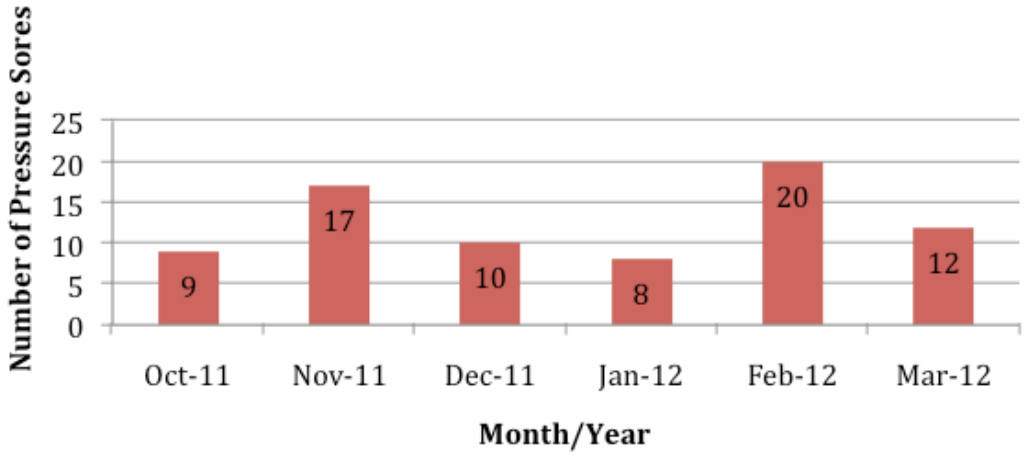


Community

A reliable system of reporting of pressure ulcers was put in place in community services in October 2011. This is now in line with the hospital system with all pressure ulcers being reported within 48 hours of development.

The number of ulcers do not seem to be decreasing (see graph overleaf). However, the new clear reporting system now in place has undoubtedly contributed to increased and more accurate reporting. Now district nurses report all pressure ulcers directly to the tissue viability department, rather than on the computer system which had connectivity problems when the Trust took over the community services.

Number of Grade three/four Pressure Ulcers Developed on District Nurse Caseload



It has also been seen through discussion of root cause analysis reports that there was a lack of knowledge in the community around pressure ulcer staging. This has led to a drive in education around pressure ulcers and again this has probably contributed to more accurate and increased reporting. Although the future cannot be fully predicted, it is probable that the numbers will level off as the new reporting system is used.

New Priority 2012/13

PRESSURE ULCERS (2nd Priority Year)	
Priority 2 2012/13	
Hospital	Community
Reduce avoidable stage three and four hospital acquired pressure ulcers, against activity, so that the number for 2011/12 has been reduced by 50 per cent in 2012/13.	Reduce avoidable stage three and four acquired pressure ulcers that occur on the district nurse caseload through the year, so that the number for the final quarter of 2011/12 has been reduced by 10 per cent at the second quarter of 2012/13 (Jul- Sep) and by 20 per cent at the final quarter of 2012/13 (Jan-Mar).

Rationale for inclusion

- Pressure ulcers are difficult to treat and slow to heal and prevention is therefore a priority
- Although the hospital achieved its target in 2011/12, the Trust 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 2012/13

Actions being undertaken to achieve the Trust target include:

- Continue to embed the reliable reporting system with community nursing teams
- Train community staff to know what stage ulcers are at and treat accordingly
- Introduce a revised and improved version of the pressure ulcer prevention and management document
- Undertake a check of the use of the new document described above
- Undertake training of social services carers and carers within residential homes
- Improve the reporting of the incidence of pressure ulcers so that it is done electronically across the Trust rather than on paper as at present

Board Sponsor:
Denise McMahon, Director of Nursing

Operational Lead:
Lisa Turley, Tissue Viability Lead Nurse

Existing Priority 2011/12

INFECTION CONTROL (3rd Priority Year)
Priority 3 2011/12
Reduce our MRSA and Clostridium difficile (C. diff) rates in line with the national and local priorities. MRSA Bacteraemia (blood stream infections) target is no more than two post 48 hour cases; C.diff is no more than 77 post 48 hour cases.

Patient story

"Having C. diff makes you feel dirty and humiliated. You try to be clean but it feels out of control and very immediate. The nurses have been excellent and fastidiously wash their hands and change their aprons."

How we measure and record this priority

MRSA Bacteraemia and C. diff numbers are divided into pre and post 48 hours of admission 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.

When our Pathology laboratory finds a positive result the information is fed into the HCAI (Health Care Acquired Infection) data system, a national data base. From there the data for all Trusts are collated and is sent to the Health Proctection Agency (HPA) for publication.

Developments that occured in 2011/12

Last year we outlined a number of actions we intended to undertake during 2011/12. These have either been completed or are on-going. The key ones include:

- Updating the policy and training for the taking of blood cultures. This has now happened.
- The development of a training video for the taking of blood cultures is nearly complete as are similar videos for aseptic technique, which prevents or minimises the risk of infection during clinical procedures, and cannulation, so making training more accessible.
- Disposable mops have been introduced across all areas of the Trust.
- Taking part in the National Patient Safety Agency (NPSA) prevention of central line infection in Critical Care Unit project and continue the Surgical Site Surveillance of non-mandatory procedures.
- In September 2011 we participated in the fourth national Prevalence Survey on hospital associated infections and the first national antimicrobial use and quality indicators in England. We are currently awaiting feedback to help us to identify target areas to watch in the future and decide on action.

Current Status

We have continued our good work to maintain consistently low levels of MRSA Bacteraemia (two in total). Unfortunately, we have not achieved our Clostridium difficile (C. diff) target this year, with numbers increasing generally across the West Midlands region.

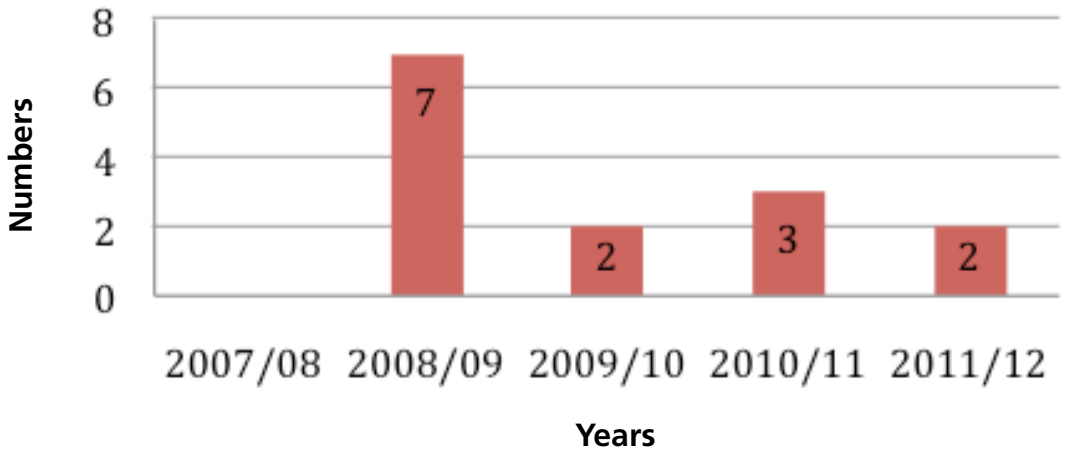
In May 2011, the Trust realised it was in danger of not meeting the C. diff target and so requested support from the Health Protection Agency (HPA), relevant PCT and SHA staff as well as independent

experts. Staff from these agencies investigated the situation and found that all the Trust procedures were appropriate. However, in certain cases these procedures were not always being used. Also in depth assessment (typing) of the strain of each case showed that cross infection was not happening in the hospital. An action plan was put into place and this is now monitored at a weekly meeting.

Actions taken include:
- Increased training
- More timely feedback on investigations of individual cases to the relevant clinicians to prevent reoccurrence
- A widespread awareness campaign

From November 2011, the Trust was back on track with its monthly targets and this continues to be the case up until the end of March 2012. 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 a total of two in 2011/12.

Total MRSA cases per year

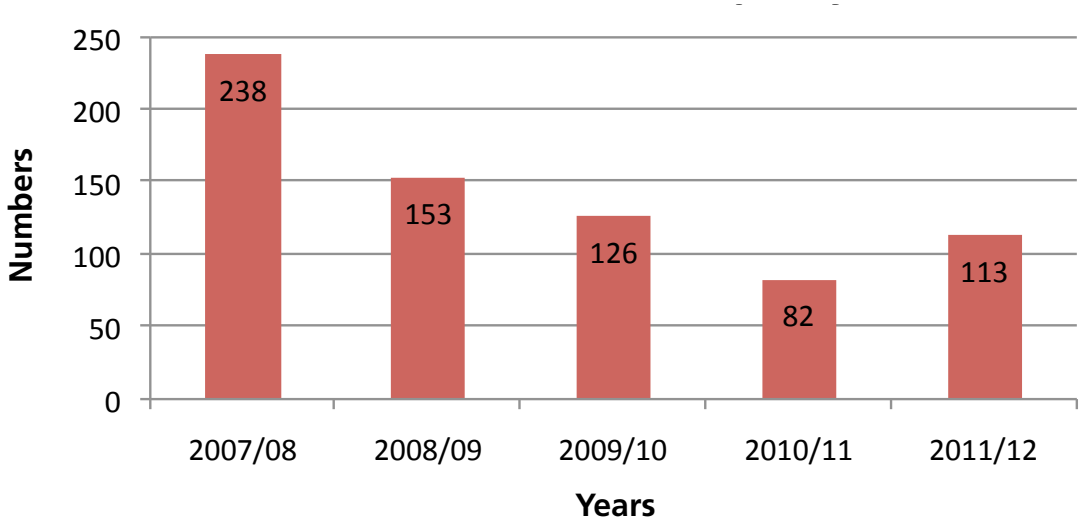


(In 2007/8 there was a total of 30 MRSA cases across the whole of Dudley both Trust and Community but separate post and pre-48 hours cases were not collected until 2008/9)

Current status C. diff

The graph below shows the total number of C. diff cases recorded as occuring more than 48 hours after admission, showing the reduction from a total of 238 in 2007/08 to a total of 113 in 2011/12.

Total C. diff cases per year



Priority for 2012/13

INFECTION CONTROL (4th Priority Year)

Priority 3 2012/13

To reduce our MRSA and Clostridium difficile (C.diff) rates in line with the national and local priorities. MRSA Bacteraemia (blood stream infections) target is no more than 2 post 48 hour cases; C.diff is no more than 77 post 48 hour cases.

Rationale for inclusion

- The drive to reduce healthcare associated infections, which includes MRSA Bacteraemia and C. diff, continues to become more challenging.
- To reduce infection remains a key aim across the NHS
- The Trust is conscious of not reaching the target for C. diff in 2011/12
- Feedback from our patients, staff, community groups and Governors indicates this should remain a target
- The Trust has been set by Department of Health the same targets for 2012/13 as those in 2011/12. This suggests that numbers have already been reduced to the minimal background level for C. diff.

Developments planned for 2012/13

Actions planned to achieve the above aims include:

- Introduce hydrogen peroxide 'fogging' for the environment when patients are discharged to reduce cross contamination
- Improve training support for anti-microbial (drugs that destroy disease-carrying micro-organisms) prescribing
- Review the details of the local cleaning contract in light of new national directives
- Agree competencies for the nursing element of cleaning the environment
- Agree and report competencies of contracted cleaning staff
- Improve information gathering including feedback and changes in practice regarding anti-microbial prescribing, bringing more senior medical input into the root cause analysis process
- Ensure more reliable investigations of individual infection cases with feedback and action plans to prevent or reduce it happening again
- Introduce the new testing algorithm introduced by the Department of Health
- Clarify the reporting regime as outlined by Department of Health guidelines
- The National Patient Safety Agency (NPSA) infection prevention project to be expanded and taken into the surgical and high dependency areas
- Review usage of protein pump inhibitors medication used for patients with stomach problems
- Monitor and record the time it takes to place patients into side rooms once an infection has been identified
- Appointment of an analyst to assist with the management of all the information required to keep an eye on and reduce infection rates
- Monitoring mortality rates when infections are involved

Board sponsor:
Denise McMahon, Nursing Director/Director of Infection Prevention and Control

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

New Priorities 2012/13

NUTRITION (1st Priority Year)

Priority 4 2012/13

Increase the number of patients who have a risk assessment regarding their nutritional status within 24 hours of admission. By September 2012 at least 90 per cent of patients will have the risk assessment completed and this will continue for the rest of the year.

HYDRATION (1st Priority Year)

Priority 5 2012/13

Increase the number of patients who have fluid balance charts fully completed. By September 2012 at least 70 per cent of patients will have a fluid balance chart fully completed and this will rise to at least 90 per cent by the end of the year (March 2013).

How we will measure and record this priority

Every month 10 observation charts are checked at random on every ward as part of the wider Nursing Indicator assessments (in effect, 200 charts are audited in total per month). Each ward and the whole Trust is RAG (Red/Amber/Green) rated with a 'Green' given for a 90 per cent or greater score, an 'Amber' for 89-70 per cent scores and a 'Red' for scores 69 per cent or less.

Rationale for inclusion

- Poor nutrition and hydration leads to poor health, increased and prolonged hospital admissions and increased costs to the NHS. The results of poor nutrition and hydration are well documented and include a) increased risk of infection, b) poor skin integrity, c) delayed wound healing, d) decreased muscle strength, e) depression and f) premature death. Put simply poor nutrition and hydration cause harm.
- A number of national reports, including those from Age UK and the CQC (Care Quality Commission), have questioned the state of practice with nutrition and hydration across hospitals generally.

A strong starting point for good nutritional care is that on admission every patient should be assessed on their nutritional status. The 'Malnutrition Universal Screening Tool' ('MUST'), in use for a number of years at the Trust, has been designed to help identify adults who are underweight and those at risk of malnutrition. It is a quick and simple procedure which enables us to take action and provide appropriate nutritional advice on admission.

In the last year, the importance of MUST has been highlighted by Dudley Council's Health and Adult Social Care Scrutiny Committee (HASC) during its Dignity in Care review of the Trust and by the CQC at one of its inspections.

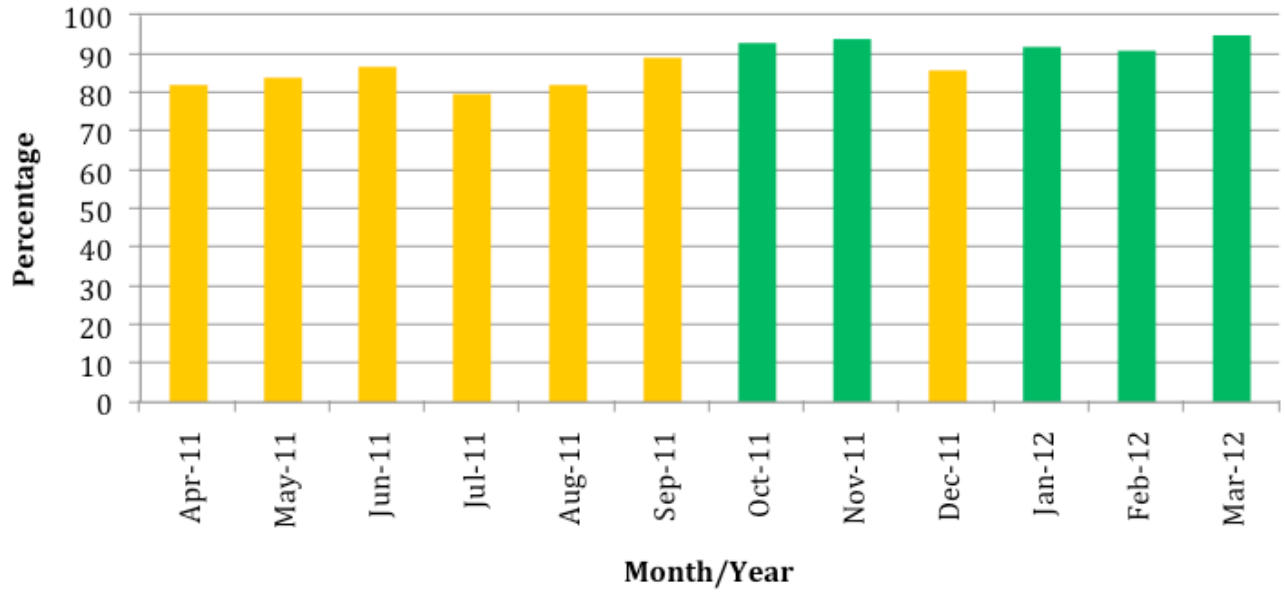
Improving hydration brings well-being and better quality of life for patients and can often mean reduced use of medication and prevention of illness. For the best hydration of the patient, the need for accurate recording of fluid input and output cannot be underestimated.

Current status

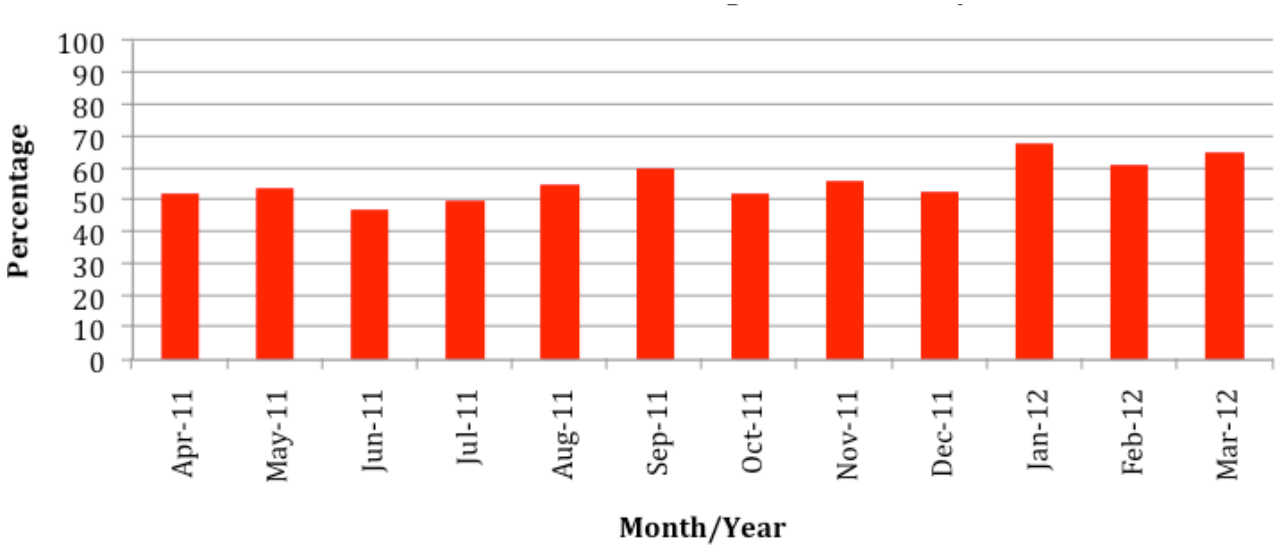
- Patients' needs are constantly assessed and where necessary information on bed boards is available so staff know the nutrition and hydration needs of each patient and can give special care
- The 15 minutes dinner bell prepares patients and staff for meal times
- A wide choice of food is available, including a vegetarian option and foods to meet religious, cultural and dietary needs
- 'Protected Meal Times' has been introduced meaning no interruptions with non-urgent treatments during mealtimes. This results in a more relaxed atmosphere which aids consumption and digestion
- Along with beverages served mid morning, mid afternoon and in the evening, extra snacks and drinks are also available
- A water jug, fruit juices and hot drinks are available to patients so that they stay hydrated and meet the recommended consumption of eight glasses of fluid per day

The graph below shows the overall Trust results for 2011/12:

MUST charts completed on admission 2011/12



Fluid balance charts completed 2011/12



Developments planned for 2012/13

- Nutrition steering group to review indicators quarterly and drive changes from any required action points
- Continue audit of MUST and education to be delivered in targeted areas
- Develop screen saver to promote MUST screening on admission to Trust
- Essence of Care Link nurses re enlisted
- Fluid balance charts redesigned and to be introduced
- New fluid balance charts to include new lunch time evaluation requiring trained nurse signature
- Education package for fluid balance developed to be delivered in all ward areas
- Competency document for fluid balance developed for all staff to sign
- New fluid balance criterion to be included in the Nursing Care Indicator (NCI) audit

Board Sponsor:
Denise McMahon, Director of Nursing

Operational Leads:
Dr S. Cooper, Consultant Gastroenterologist
Sheree Randall, Matron
Karen Broadhouse, Quality Project Lead

2.2 Statements of assurance from the Trust Board

2.2.1 Review of Services

During 2011/12 the Trust provided and/or sub-contracted 59 NHS services. The Trust reviewed all the data available to them on the quality of care in all of these NHS services. The income generated by the NHS services reviewed in 2011/12 represents 99.4 per cent of the total income generated from the provision of NHS services by the Trust for 2011/12.

The above reviews were undertaken in a number of ways. With regards to patient safety, the Trust Executive and Non Executive Directors have been undertaking Patient Safety Leadership Walkrounds (see Section 3.3.2). Also covering patient safety, but including clinincal effectiveness, are the morbidity and mortality reviews undertaken by the Chairman, Chief Executive, Medical Director and the Non Executive Director who is chair of the Audit Committee. External input is provided by the Acting Medical Director of NHS Dudley. These occur on an 18-month rolling programme, covering all services.

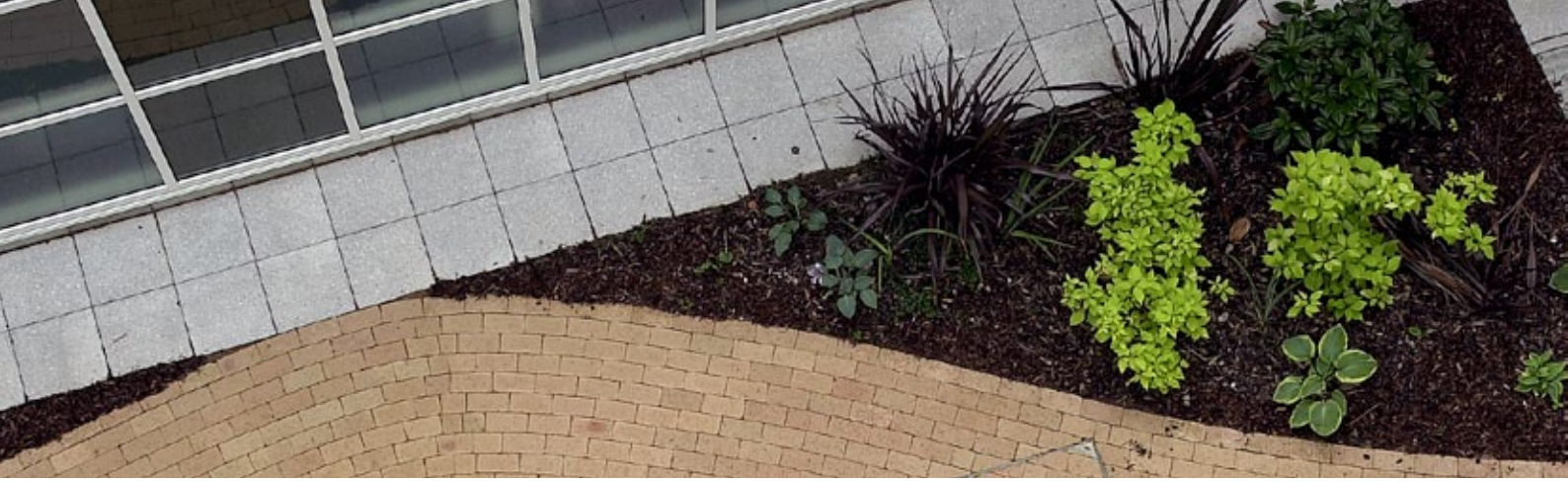
Each service presents information from a variety of sources including:

- Internal audits
- National audits
- Peer review visits
- Activity and outcome figures such as readmission rates, day case rates and standardised mortality rates (see page 38 for more detail on our hospital mortality figures)

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

- Nursing Care Indicators (NCI) – these are monthly reports of key nursing actions and their documentation. The results are published, monitored and reported to Trust Board monthly by the Director of Nursing.
- 'Productive' series – part of our Transformation programme looks at 'releasing time to care' by making work changes in theatres, the wards and the community. This results in clinical staff having more time directly with patients.

- The Outpatient Executive Group – oversees the action plan resulting from the National Outpatient Survey and other key working changes such as changes to clinic templates to help reduce waiting times.
- Ongoing patient surveys that give a basic feel for our patients' experiences in real-time so that we can quickly identify any problems and correct them.
- Patient Panels on specific topics also help us to get to the bottom of any hot topics such as inpatient mealtimes and accessibility. Our next Patient Panel will focus on carers.
- Every other month, senior medical staff attend the Trust Board to provide a report and presentation on performance and quality issues within their specialty areas.
- Every other month, a matron attends the Trust Board 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 electronic dash board is essentially an online centre of vital information for staff. As a result of the information available here staff are able to give the right services and best possible care to patients.
- The Trust works with its local commissioners scrutinising the Trust's quality of care at joint monthly Clinical Quality Review meetings
- This year, the Midlands and East NHS has introduced a Quality Dashboard comparing all Trusts on a number of quality indicators, some of which are discussed in this report. The Trust has taken notice of the contents of this new initiative and has contributed to making the contents more robust.
- External assessments, which included the following key ones this year:
    - NHS Dudley continued its series of Appreciative Enquiry Visits by reviewing the arrangements for pressure ulcer prevention and management at the Trust. NHS Dudley staff were accompanied by patient/public representatives to interview staff and visit 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.
    - In May 2011, the West Midlands Quality Review Service looked at the Trust in conjunction with the local health community on the following services: a) Mental Health b) Learning Disability c) Vulnerable Adults in Acute Hospitals and d) Dementia. The results of the review were positive and an action plan has been drawn up and commenced.
    - In Nov/Dec 2011 a Joint CQC and Ofsted Inspection of safeguarding and looked after children services across the whole of Dudley took place. The Trust was a part of this inspection along with Dudley Metropolitan Borough Council, NHS Dudley and other local organisations. The Trust has drawn up an action plan, which has been approved by the CQC and started to put in place the relevant recommendations made.
    - In mid year, the Health and Adult Social Care Scrutiny Commitee (HASC) of Dudley Metropolitan Borough Council undertook a Dignity in Care Review of the Trust. In conclusion, the review stated: 'Members were impressed by the energy and commitment to Dignity practices'. A number of recommendations were made and the Trust is in the process of putting them in place.
    - The Trust had visits/inspections from the Local Supervisory Authority for Midwives (March 2011) and Clinical Pathology Accreditation (UK) Ltd accredited the Immunology Department (Jun 2011) and Histopathology and Cytology departments (April 2011). With regards to education and training, NHS West Midlands assessed the quality of training of pharmacists. The University of Birmingham College of Medical and Dental Sciences undertook a 'Follow On' Developmental Visit of the Undergraduate Teaching Academy (May 2011) and West Midlands Postgraduate Medical Education and Training Deanery inspected the paediatric department (July 2011), the Chemical Pathology department (Oct 2011) and the nephrology speciality (Jan 2012). NHS Quality Control North West assessed the Aseptic Preparation of Medicines (March 2011). Where recommendations were made, action plans have been put into place.



2.2.2 Participation in National Clinical Audits and Confidential Enquiries

During 2011/12, 43 national clinical audits and four national confidential enquiries covered NHS services that the Trust provides.

During that period the Trust participated in 40 (93 per cent) national clinical audits and four (100 per cent) 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 2011/12, 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 during 2011/12

Name of Audit	Type of Care	Audit Participation	Submitted %
Perinatal mortality (MBRRACE-UK)	Peri-natal	Yes	100%
Neonatal intensive and special care (NNAP)	Neo-natal	Yes	100%
Paediatric pneumonia (British Thoracic Society)	Children	Yes	100%
Paediatric asthma (British Thoracic Society)	Children	Yes	100%
Pain management (College of Emergency Medicine)	Children	Yes	100%
Childhood epilepsy (RCPCH National Childhood Epilepsy Audit)	Children	Yes	100%
Paediatric intensive care (PICANet)	Children	Yes	100%
Diabetes (RCPCH National Paediatric Diabetes Audit)	Children	Yes	100%
Emergency use of oxygen (British Thoracic Society)	Acute Care	Yes	100%
Adult community acquired pneumonia (British Thoracic Society)	Acute Care	Yes	In progress
Non invasive ventilation (British Thoracic Society)	Acute Care	Yes	In progress
Pleural procedures (British Thoracic Society)	Acute Care	Yes	100%
Cardiac Arrest (National Cardiac Arrest Audit)	Acute Care	Yes	100%
Severe sepsis & septic shock (College of Emergency Medicine)	Acute Care	Yes	100%
Adult critical care (ICNARC CMPD)	Acute Care	Yes	100%
Potential donor audit (NHS Blood & Transplant)	Acute Care	Yes	100%
Seizure management (National Audit of Seizure Management)	Acute Care	Yes	70%
Diabetes (National Adult Diabetes Audit)	Long term conditions	Yes	100%

Name of Audit	Type of Care	Audit Participation	Submitted %
Heavy menstrual bleeding (RCOG National audit)	Long term conditions	Yes	100%
Chronic pain (National Pain Audit)	Long term conditions	Yes	100%
Ulcerative colitis & Crohn's disease (UK IBD Audit)	Long term conditions	Yes	100%
Parkinson's disease (National Parkinson's Audit)	Long term conditions	Yes	100%
Adult asthma (British Thoracic Society)	Long term conditions	Yes	100%
Bronchiectasis (British Thoracic Society)	Long term conditions	Yes	100%
Hip, knee and ankle replacements (National Joint Registry)	Elective procedures	Yes	96%
Elective surgery (National PROMs Programme)	Elective procedures	Yes	85.2%
Peripheral vascular surgery (VSGBI Vascular Surgery Database)	Elective procedures	Yes	100%
Carotid interventions (Carotid Intervention Audit)	Elective procedures	Yes	100%
Acute Myocardial Infarction & other ACS (MINAP)	Cardiovascular disease	Yes	100%
Heart failure (Heart Failure Audit)	Cardiovascular disease	Yes	100%
Acute Stroke (SINAP)	Cardiovascular disease	No	
Cardiac arrhythmia (Cardiac Rhythm Management Audit)	Cardiovascular disease	Yes	100%
Renal replacement therapy (Renal Registry)	Renal disease	Yes	100%
Lung cancer (National Lung Cancer Audit)	Cancer	Yes	100%
Bowel cancer (National Bowel Cancer Audit Programme)	Cancer	Yes	100%
Head & neck cancer (DAHNO)	Cancer	Yes	100%
Oesophago-gastric cancer (National O-G Cancer Audit)	Cancer	Yes	100%
Hip fracture (National Hip Fracture Database)	Trauma	Yes	100%
Severe trauma (Trauma Audit & Research Network)	Trauma	Yes	48% (participation commenced Oct 2011)
Bedside transfusion (National Comparative Audit of Blood Transfusion)	Blood transfusion	Yes	100%
Medical use of blood (National Comparative Audit of Blood Transfusion)	Blood transfusion	Yes	1st Stage 60% 2nd stage In progress
Risk factors (National Health promotion in Hospitals Audit)	Health promotion	No	
Care of dying in hospital (NCDAH)	End of life	No	

Table 2. National confidential enquiries that the Trust was eligible to participate in during 2011/12

Name of Enquiry		Enquiry Participation	% of cases submitted
Cardiac arrest procedures	NCEPOD	Yes	100%
*Bariatric Surgery	NCEPOD	Yes	100%
Surgery in Children	NCEPOD	Yes	100%
Peri-operative Care	NCEPOD	Yes	100%

**The Trust does not perform Bariatric Surgery but has participated in the study of patients who have been admitted as an emergency following Bariatric surgery elsewhere.*

As well as the national audits from the Department of Health standard list, in Table 1 above, the Trust has also taken part in these further national audits:

Table 3. Additional National Audits that the Trust has participated in during 2011/12

Name of Audit	Type of Care	Audit Participation
RCPCH Decreased Conscious Level Audit	Children	Yes
National Audit of Services for People with Multiple Sclerosis	Long term condition	Yes
CEM Consultant Sign-off in the ED	Acute care	Yes
Ionising Radiation (Medical Exposure) Regulations (IR(ME)R 200	Radiology	Yes
National Audit of Back Pain by NHS Occupational Services	Health promotion	Yes

The reports of six national clinical audits were reviewed by the provider in 2011/12 and the Trust has taken or intends to take the following actions to improve the quality of healthcare provided:

- Variable rate insulin infusion introduced
- New blood sugar testing and insulin charts introduced
- New Diabetic Ketoacidosis (DKA) and Hyperosmolar Nonketotic Coma (HONK) guidelines produced
- Introduction of falls link nurses in ward areas and link nurse meetings
- Production of falls prevention leaflets for outpatients areas
- Review of the Medical Emergency Team (MET) and cardiac arrest calls to ensure track and triggers are used correctly (in conjunction with new guidance on completion of observations)
- Develop a clear standard of care and treatment for all end of life patients
- Mental health awareness training made mandatory for all clinical staff who come into contact with people with dementia
- Expansion of the Acute Confusion Care Team
- Appointment of a Band 6 Registered Mental Nurse (RMN)
- Updated departmental guidelines in line with national guidance for the management of Paediatric Pneumonia
- Patients' smoking status checked at every review and referral to smoking cessation services offered
- Patients offered Computed Tomography (CT) calcium scoring to assess coronary heart disease risk
- Development of a patient information booklet which explains the importance of cascade screening for early detection and treatment of familial hypercholesterolaemia. This has been developed to improve the screening process and increase the identification of patients with the disease
- Promoting increased use of the patient information booklet which explains familial hypercholesterolaemia and the importance of lifestyle changes and treatment to reduce cholesterol levels

Local Clinical Audit

The reports of 70 completed local clinical audits were reviewed by the Trust in 2011/12 and the Trust has taken, or intends to take, the following actions to improve the quality of healthcare provided:

- New referral form introduced to replace GP referral letter to standardise information relating to patients attending the Emergency Assessment Unit
- New consultant obstetric anaesthetist commenced September 2011
- Consent forms for caesarean sections currently being revised by the consultants
- Changes introduced to medical ward round frequency to ensure all patients are seen by a consultant within 72 hours
- Following carpal tunnel decompression, referral to hand therapy in early post-operative phase to help with the common problems such as scar pain
- Inclusion of information sheets for semi-elective trauma cases in junior doctor induction pack
- Introduction of a standard referral proforma for spinal trauma patients
- Development of specific sleep study parameters that are most predictive of sleep apnea
- Production of guidelines for the management of elderly women with breast cancer
- Provision of training for two additional breast care nurses to deliver quality information at pre-operative assessment
- Increase use of ultrasound for acute surgical admissions
- Pre-operative scoring of the risk factors in cataract surgery to ensure allocation of the theatre slots according to the severity of the risks
- Setting of clearly documented post operative targets in all cases following strabismus surgery
- Introduction of a pharmacist in Post Operative Assessment Clinic (POAC) to achieve 100 per cent improvement in care and documentation
- Further education for prescribers and nursing staff regarding risks of oxygen
- Review of current allocation of audiologists
- Introduction of a structured day case patient journey to resolve excessive pre-operative starvation times and prolonged stay
- Triage staff to inform the lead midwife coordinator when waiting times increase so that extra resource may be provided to deal with women in a timely manner
- Specific fatigue/breathlessness sessions developed by the community Macmillan specialist team
- Arrangement of shadowing opportunities for therapists with the independent living team
- Utilisation of a checklist to identify patients suitable for cardiac resynchronisation therapy (CRT) and as a prompt for evidence-based medication
- Proton Pump Inhibitors (PPI) indication review to be undertaken on and during admission to acute medical ward
- In the elective pre-operative setting, echocardiography requests are to be made at least three weeks prior to operation date to allow adequate allocation of resources

2.2.3 Research and Development

The number of patients receiving NHS services provided or sub-contracted by the Trust in 2011/12 that were recruited during that period to participate in research approved by a research ethics committee was 972. Commercial studies were 6.2 per cent of the total.

The Trust has participated in large multicentre trials in the fields of cancer, cardiology (heart) and musculoskeletal (body movement) medicine, undertaking both academic and commercial studies. The Dermatology Department has also begun commercial research during 2011/12 by taking advantage of the services of a research nurse employed by the Birmingham and Black Country Comprehensive Local Research Network (BBC CLRN) and the Clinical Research Unit's laboratory facilities.

In 2011 a professorship was awarded to Mrs Carmichael, Consultant in Breast Surgery, by the University of Aston for research work relating to breast cancer.

We have three clinical research fellows, one funded by the Trust, another funded by Arthritis Research UK and an oncology (cancer) clinical research fellow funded by BBC CLRN. Two rheumatology staff have also submitted grant applications.

Some of the improvements in clinical practice brought about by participating in clinical trials and other research studies are:

- All newly diagnosed patients with breast cancer are now routinely advised about the beneficial effect of regular exercise in breast cancer management

- Patients suffering from some acute leukaemias and lymphomas are now treated with a chemotherapy treatment whose success is based on the results of clinical trials.
- Patients awaiting joint replacement are advised on exercise and diet before surgery. In some cases weight reduction stops joint pain completely and surgery is not required.

Trust publications, including conference posters, increased to over 100 during the calendar year 2011, the greatest contribution coming from the rheumatology department providing new knowledge on lipids and platelet function in rheumatoid arthritis.

2.2.4 Commissioning for Quality and Innovation Payment (CQUIN) framework

A proportion of the Trust's income in 2011/12 was conditional upon achieving quality improvement and innovation goals agreed between the Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of NHS services, through the Commissioning for Quality and Innovation payment framework. Further details of the agreed goals for 2011/12 and for the following 12 month period are available online at: http://www.monitor-nhsft.gov.uk/sites/all/modules/fckeditor/plugins/ktbrowser/_openTKFile.php?id=3275

This is a quality increase that applies over and above the standard contract. The sum is variable based on 1.5 per cent of our activity outturn and depends on achieving quality improvement and goals. The estimated value in 2011/12 was £3.75m as part of our contracts with Primary Care Trusts (PCTs) for acute and community services, and with specialised services commissioners. We have not yet agreed the final settlement figure for 2011/12 as some targets depend upon information yet to be received. However, for the purpose of the year end accounts, we have assumed 84 per cent achievement of both the PCT and specialised services schemes. This would equal approx £3.15m.

CQUIN report 2011/12

There is one CQUIN (Commissioning for Quality and Innovation) scheme per contract, made up of several goals. Goals for venous-thromboembolism (a blood clot in a vein) and responsiveness to personal needs are nationally determined, and the remainder are locally agreed.

We have rated the CQUIN for 2011/12 on a red amber green (RAG) basis dependent on achievement to date. We will fall short of meeting the goal for hospital patient experience and we have actions in place to ensure the quality of care in this areas is improved and it is a quality priority for 2012/13.

Primary Care Trust CQUIN

Hospital – summary of goals

Goal no.	Description of goal	Quality Domain
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 – Pressure Ulcers	Safety and Effectiveness
4	Medicines Management – Antimicrobial Stewardship	Safety
5	Smoking and Alcohol	Effectiveness
6	Mental Health	Effectiveness and Patient Experience

Community – Summary of goals

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

Specialised Services CQUIN

Hospital – Summary of goals

Goal no.	Description of goal	Quality Domain
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	Screening for Retinopathy of Prematurity in Neonates	Safety and Effectiveness
4	Audit of Neonatal Pathways	Safety and Effectiveness
5	Access to Renal Therapies	Effectiveness and Patient Experience
6	Organs for Transplant	Effectiveness

CQUIN report 2012/13

In 2012/13 the amount the Trust can earn from the CQUIN framework will increase to 2.5 per cent on top of the actual outturn value. The estimated value of this is £6.4m. As well as the mandated goals for venous-thromboembolism and responsiveness to personal needs being continued in 2012/13, there are additional compulsory goals of dementia screening and the NHS Safety Thermometer.

Primary Care Trust CQUIN

Hospital – Summary of goals

Goal no.	Description of goal	Quality Domain
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	Patient Experience – Net Promoter	Patient Experience
4	Dementia screening, risk assessment and referral for specialist services	Safety and Effectiveness
5	NHS Safety Thermometer	Safety and Effectiveness
6	Tissue Viability – Pressure Ulcers	Safety and Effectiveness
7	Medicines Management – Antimicrobial Stewardship	Safety and Effectiveness
8	Alcohol & Smoking – Brief Advice	Safety and Effectiveness

Community – Summary of goals

Goal no.	Description of goal	Quality Domain
1	Patient Experience – Personal needs	Safety, Effectiveness, Patient Experience and Innovation
2	National NHS Safety Thermometer	Safety and Effectiveness
3	Tissue Viability – Pressure Ulcers	Safety and Effectiveness
4	Virtual Ward	Safety, Effectiveness and Patient experience
5	Making Every Contact Count (MECC)	Effectiveness

Specialised Services CQUIN

Hospital – Summary of goals

Goal no.	Description of goal	Quality Domain
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	Dementia screening, risk assessment and referral for specialist services	Safety and Effectiveness
4	NHS Safety Thermometer	Safety and Effectiveness
5	Maintain the improvement from previous CQUINs	Effectiveness
6	Quality Dashboards	Effectiveness

2.2.5 Care Quality Commission (CQC) registration and reviews

The Trust is required to register with the Care Quality Commission and its current registration status is registered without conditions.

The Care Quality Commission has not taken enforcement action against the Trust during 2011/12.

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

Following the January 2011 planned visit to inspect the 16 Essential Standards of Quality and Safety set out by the CQC, (which was noted in last year's Quality Account) we submitted an action plan to the CQC. The CQC revisited the Trust in September 2011 to check the progress of the required actions and these were all found to be successful. A further issue regarding infection control was noted in this second visit and was thought to need improvement and an action plan is now in place.

2.2.6 Quality of data

The Trust submitted records during 2011/12 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 was:

- 99.2 per cent for admitted patient care; National average was 98.87 per cent
- 99.7 per cent for outpatient care; National average was 99 per cent
- 96.4 per cent for accident and emergency care, National average was 93.1 per cent

Which included the patient's valid General Practitioner Registration Code was:

- 100 per cent for admitted patient care; National average was 99.9 per cent
- 100 per cent for outpatient care; National average was 99.7 per cent
- 100 per cent for accident and emergency care. National average was 99.4 per cent

The Trust's Information Governance Assessment Report overall score for 2011/12 was 74 per cent and was graded 'Satisfactory'. The Trust will be taking the following actions to improve data quality:

- Improve the filing and date order of patient case notes
- Ensure electronic discharge summaries are complete and consistent with patient case notes
- Review the system of correcting admission and discharge errors that are made on the patient computerised administration system

The Trust was subject to the Payment by Results clinical coding audit during the reporting period by the Audit Commission and the error rates reported in the latest published audit for that period for diagnoses and treatment coding (clinical coding) were 7.2 per cent for diagnoses and 3 per cent for treatments with a 6.6 per cent error rate overall (the latest national overall figure in 2009/10 was 11 per cent). These results should not be extrapolated further than the Trust-wide and general medicine samples audited.

During 2011/12 there were 16 incidents relating to data loss. These included faxes and letters sent to incorrect and old addresses. Actions taken from these incidents included:

- Controls over faxing information tightened with a new policy widely circulated, posters placed by each machine and publicity distributed throughout the Trust
- Systems introduced to phone relevant departments before and after faxes are sent to check patient information is correct
- Systems put in place for staff to check the latest addresses rather than copying the address on previous letters
- Importance of data security and confidentiality reinforced at Trust induction for new staff
- Incidents publicised to all staff to raise awareness of this issue

Part 3: Other Quality Information

3.1 Introduction

The Trust has a number of different Key Performance Indicators (KPI) reports. These are available and used by a wide variety of staff groups monitoring quality on a day-to-day basis. The main tool for the reporting of the Trust's progress towards its goals is a web-based dashboard, available to all senior managers and clinicians. This dashboard currently contains over 130 targets, grouped under the headings of Quality, Performance, Workforce and Finance. In addition, constant monitoring of different aspects of the quality of care include weekly reports being sent to senior managers and clinicians which include: A&E, Referral to Treatment, Stroke and Cancer targets and monthly reports being sent to all wards, with a breakdown of performance by ward. These are based on Nursing Care Indicators, Ward Utilisation, Adverse Incidents, Governance and Workforce Indicators and Patient Experience scores.

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. Some senior managers have access to the West Midlands SHA comparative performance tables to enable the Trust to compare itself against other Trusts.

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 final section includes general quality measures which have remained the same for 2011/12 as the Trust Board 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.

3.2 Patient Experience

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

This section shows how we gained a picture of patients' views of the Trust and examples of changes made based on those views.

3.2.2 Trustwide Initiatives

a. Real-time surveys

During the 2011/12 year we refreshed our real-time survey system from a paper to an electronic system. Using bespoke inhouse software allows us to have full control over the questions that we include and ensures that changes can take place as and when required.

We endeavour to visit every ward twice per week to listen to patients' experiences and gain their views on the quality of our care. A built in trigger system means that, should a patient raise a concern, we can quickly take action to improve the rest of their stay with us.

b. Patient Panels

Patient Panels were also set up this year to provide patients with a forum to help to make improvements in specific areas by sharing their experiences with us.

By using these forums to focus on specific topics we hope to really get to the bottom on where any issues lie. The aim is to find out what it feels like to be on the receiving end of our services; what is good, what matters most and where opportunities exist for improvements to be made.

We have held two Patient Panels during 2011/12 and aim to continue these forums in 2012/13. For more information on the 2011/12 Patient Panels see page 9.

c. Patient and Customer Care Ambassadors

Recognising that our staff are our greatest asset, we have also started a new Patient and Customer Care Ambassador programme to enhance patient experience by helping to improve staff attitude and behaviour. Our aim is to give our patients, carers, families and visitors the best possible healthcare experience.

More than 30 staff have already completed the programme since it was piloted in October 2011.

d. Patient Stories

Hearing about a patient's experience directly from the patient is a very powerful learning tool for both our Board of Directors and the staff who are providing care. To this end we have started a programme of patient video stories that allow us to hear directly from the patient to learn valuable lessons for improvement.

3.2.3 National Survey Results

In 2011 we took part in two national patient surveys, one for inpatients and one for outpatients. The Trust chose Picker Institue Europe as our independent survey co-ordinator and participants were chosen by randomly selecting 850 patients for each survey from the sample months indicated in the table below.

Survey	Sample month	Number of responses
Outpatient survey	April 2011	401 (47.8%)
Inpatient survey	August 2011	443 (52.8%)

What the results of the surveys told us

Outpatient Survey

Things we are good at:
- Patients being given the name of who their appointment would be with
- Easy to find the way to the outpatient department
- Cleanliness of our facilities
- Consistency of seeing the same member of staff in the department
- Patients being told how to take new medications

Areas where improvements could be made:
- Better choice of appointment time
- Being able to find a convenient place to park
- Better explanation of why tests are needed
- Not all staff introduce themselves
- Better information on who to contact if worried about condition or treatment

Inpatient Survey

Things we are good at:
- Time from referral to being admitted
- Not having to share bay with members of the opposite sex
- Plenty of hand wash gels available
- Cleanliness of ward/room
- Privacy when being examined or treated

Areas where improvements could be made:
- Hospital food
- More involvement around discharge from hospital
- More information about what to do/not to do after leaving hospital
- Better patient involvement in decision making

Actions plans have been drawn up to make improvements in the areas identified.

3.2.4 Examples of Specific Patient Experience Initiatives

a. DVD for Hip and Knee Replacement Surgery

The Orthopaedic Department has developed a script for patient information/education to produce a DVD for future patients awaiting hip/knee replacement surgery. The purpose of the DVD is to inform and prepare patients for their planned surgery to improve recovery and reduce both complications and length of hospital stay.

b. Making patients' stays more comfortable

Patient comfort packs containing little essentials to help make stays in hospital more comfortable are being handed out to patients in the Emergency Assessment Unit (EAU). The packs are for people who come into hospital without any toiletries or without any family support. They contain a cleansing wipe, bar of soap, sachet of shampoo, comb/brush, toothbrush and toothpaste and have been introduced as part of the Trust's drive to improve patient experience.

c. Dignity boxes improve patients' comfort

Two clinical support workers have devised a 'dignity box' for patients with continence and mobility problems who visit outpatients by ambulance. The boxes have been produced as part of the staff's National Vocational Qualification (NVQ) level three in health and social care and contain everything a patient with continence problems might need to make their hospital visit more comfortable. Items in the box include body care wipes, pyjamas, a night gown, slippers and pads for bowel and bladder dysfunction. Until now, the department hasn't had a central place to store clothes and equipment and it could be embarrassing and uncomfortable for patients with continence problems to wait while staff collected everything that was needed. The dignity box makes life easier for patients and preserves their dignity and comfort when they visit outpatients.

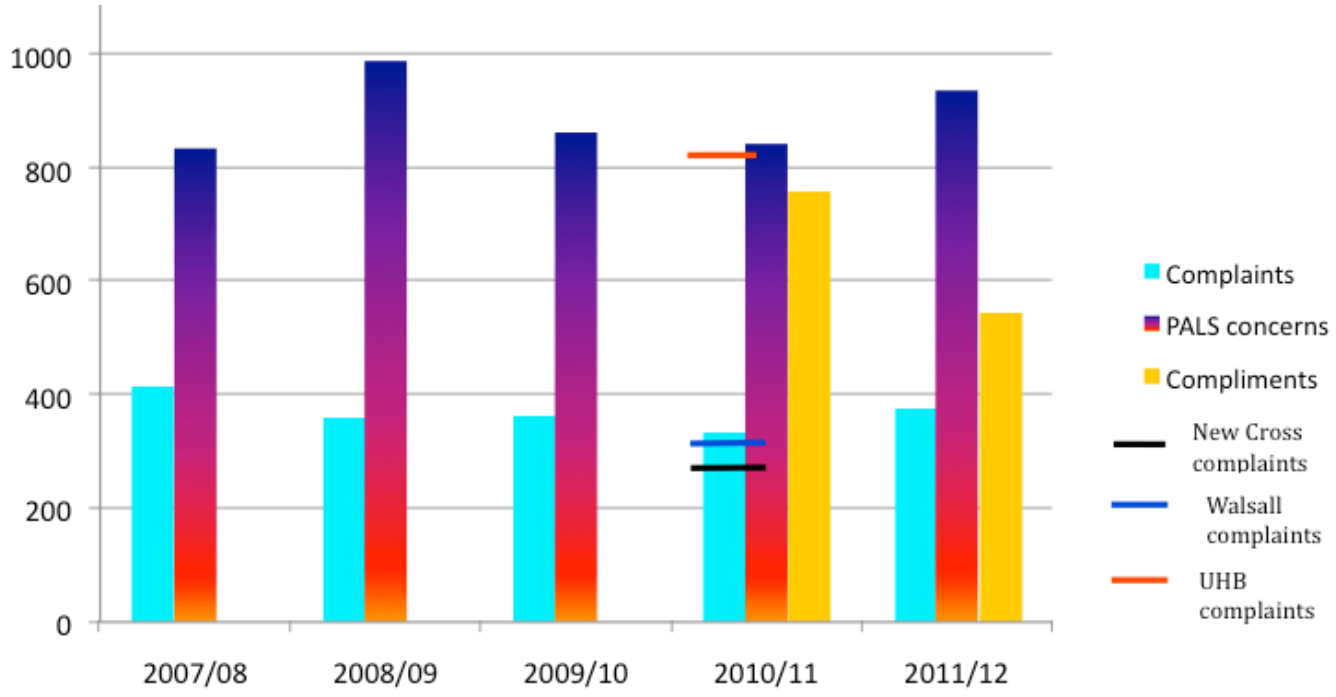
d. Outpatient satisfaction survey of breastcare patients

Patients were asked their views of their clinic visits and had to rate their experience on five subscales. Over 75 per cent of patients were satisfied overall and 95 per cent thought the medical staff warm and friendly. However, patients did not think enough time was spent with them and so the medical staff have stopped the task of dictating notes after each patient so enabling more time with each patient. The satisfaction scores have improved considerably.

3.2.5 Complaints and Compliments

This section contains tables of key complaint information together with examples of changes made as a result of complaints.

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



b) Top 5 Complaints categories

Category	Year end 2010/11	Q1 2011/12	Q2 2011/12	Q3 2011/12	Q4 2011/12	Year end 2011/12
All aspects of clinical treatment	221	70 (70%)	52 (53%)	58 (64%)	58 (64%)	238 (63%)
Attitude of staff	26	10 (10%)	8 (8%)	6 (6%)	12 (13%)	36 (10%)
Communication/ information to patient	23	5 (5%)	10 (10%)	7 (7%)	4 (4%)	26 (7%)
Admission, Discharge and Transfer	24	2 (2%)	5 (5%)	4 (4%)	8 (9%)	19 (5%)
OPD appointment/ cancellation	24	7 (7%)	14 (15%)	5 (5%)	3 (3%)	29 (8%)

c) Percentage of complaints against activity

Activity	Total yr ending 31/3/10	Total yr ending 31/3/11	Q1 2011/12	Q2 2011/12	Q3 2011/12	Q4 2011/12	Total yr ending 31/3/12
Total patient activity	707462	714519	179588	184699	199883	189299	753469
% Complaints against activity	0.05%	0.05%	0.05%	0.05%	0.04%	(0.04%)	(0.05%)

d) Examples of changes implemented as a result of complaints

Emergency, Specialty Medicine & Elderly Care
- Direct line to district nursing service now available
- Review of staffing levels and increased ratio of care support workers and trained staff
- Nurses to check patients every two – four hours to ensure nursing needs (including meals and drinks) are met

Community Services and Integrated Care
- Explanation offered regarding signage in new Health Centre, which is outside of Trust's responsibility
- Failure to attend DNA (Did Not Attend) appointments explained to patient, who was asked to notify department if unable to attend appointments.
- Choose and Book system explained to patient

Surgery & Anaesthetics
- All medical staff reminded to ensure handwriting is legible
- Appointment system under review
- Additional clinics arranged
- New system of prescriptions in operation

Women and Children
- Women to be offered a wheelchair if they have difficulty in walking
- Matron raised awareness of staff attitude and good communication during patient interaction
- All staff reminded to answer call bells promptly
- Discharge checklist reviewed following stillbirth and information regarding community midwife visit now included
- Labelling on doors changed and teddy bear now used for rooms where babies are provided with treatment and care

3.2.6 PEAT Scores

Patient Environment Action Teams (PEAT) is an annual assessment of inpatient healthcare sites in England that have more than 10 beds.

It is carried out in accordance with guidance and includes Trust staff, PFI partners and an external validator. Patient representatives are also involved in the audit which is carried out on a single day once per year.

It is a benchmarking tool to ensure improvements are made in the non-clinical aspects of patient care including environment, food, privacy and dignity.

The assessment results help to highlight areas for improvement and share best practice across healthcare organisations in England.

Comparative PEAT assessment results 2009 to 2011

Year	Site Name	Environment Score	Food Score	Privacy & Dignity Score
2011	Russells Hall Hospital	Excellent	Good	Good
2010	Russells Hall Hospital	Excellent	Good	Good
2009	Russells Hall Hospital	Good	Good	Good

3.2.7 Patient Experience Measures:

	Actual 2007/08	Actual 2008/09	Actual 2009/10	Actual 2010/11	Actual 2011/12
% of patients that would recommend hospital to a relative/ friend	90.4%	91.5%	89.5%	88%	90.7%*
% of patients who would rate their overall care highly	93.8%	92%	88%	89.3%	88.7%
% of patients who felt they were treated with dignity and respect	97.4%	95.9%	94.6%	96%	95.3%

Data from national inpatient surveys conducted for CQC

** Data from our real-time surveys*

3.3 Patient Safety

Are patients safe in our hands?

3.3.1 Introduction

Ensuring patients are safe in hospital is achieved in many different ways from the quality of the training to the quality of equipment purchased. This section includes some examples of the ways we try to prevent things going wrong and what we do on those occasions when things unfortunately do not go to plan.

3.3.2 Patient Safety Walkrounds

For a number of years, the directors of the Trust have formally visited all of the departments to discuss with staff any concerns they have about patient safety in their areas. This year began with a schedule of at least three visits a month and included for the first time community departments, such as audiology, occupational therapy and physiotherapy at Brierley Hill Health and Social Care Centre. As well as making sure that directors get to know what front line staff are saying about patient safety, each visit results in an action plan.

Examples of changes that have happened this year after the walkrounds include:

- Purchase of both more monitoring equipment and beds for parents to sleep alongside children
- Improvements in the co-ordination and management of operating theatres
- Patients notes which were kept in an open carousel in a busy ambulatory care area now stored in a locked cupboard to prevent potential breaches in confidentiality
- Emergency nurses trained in specialised equipment rather than having to ask high dependency unit staff for advice and support. This reduces delays in treatment
- Purchase of further specialist equipment e.g. chairs, commodes, wheelchairs for larger patients
- Improved waste disposal in the renal (kidney) dialysis unit reducing the amount of waste in public areas
- Computer system amended to prevent inappropriate referrals eg between Audiology (hearing) and ENT (Ear, Nose and Throat) clinics
- System put in place to ensure confidentiality of key pad numbers when going into patient homes

3.3.3 Patient Safety Incidents

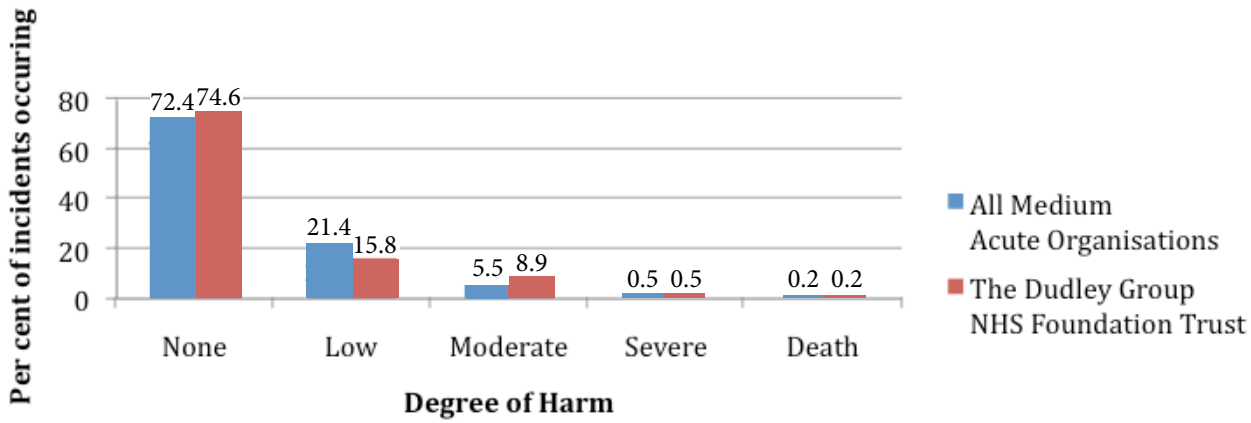
The Trust actively encourages its staff to report incidents, believing that to improve safety it needs to know what problems exist. This reflects the National Patient Safety Agency which has stated:

'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 1 April 2011 to 30 September 2011. Organisations are compared against others of similar size. The Trust is the second highest reporter of 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 Trusts 68 per cent of incidents are reported as no harm (Dudley Group 74.6 per cent) and under 1 per cent as severe harm or death (Dudley Group 0.7 per cent).

Incidents Reported by Degree of Harm for Medium Acute Trusts Organisations in England and Wales (Apr – Sep 2011)



In 2011/12 the Trust had no 'Never Events' (these are a special class of serious incident that generally are preventable). The Trust did have 302 'Serious Incidents' all of which underwent an internal investigation and, when relevant, action plans were initiated and changes made in 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 its occurrence e.g. all child deaths are serious incidents even when this occurs as a result of serious illness or accident prior to admission).

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

- Development of common management protocols for all patients in relation to laparoscopic colorectal surgery to ensure consistency of practice
- Robust method of introducing new guidelines and changes in practice which ensure all midwives are aware of new requirements in care and observations
- Improved monitoring and supervision of patients' wellbeing in the radiology department which includes the employment of a clinical support worker
- Introduction of an improved tracking system for medical photographs to ensure they can be located more easily when required for clinical and legal reasons
- Updated neonatal clinical guidelines which reflect the local Neonatal Network Guidelines
- Review of restraint policy to ensure clear guidance on approved restraint for healthcare settings and increased training on the needs of patients with mental health issues
- Introduction of screensavers on all computers across the Trust with key safety messages to raise awareness amongst staff and to help to prevent reoccurrence

3.3.4 Nursing Care Indicators (NCI)

Every month 10 nursing charts and other documents are checked at random on all general wards and departments at the Trust (in effect, 200 charts are audited in total per month) to ensure that nurses are undertaking activities that patients require and documenting that activity.

The initial themes looked at are:
- Patient observations (temperature, pulse, respirations etc)
- Pain management
- Manual handling and falls risk assessment
- Tissue viability – prevention of pressure ulcers
- Nutrition assessment and monitoring
- Medications and Prevention of infection.

In October 2011, the themes were expanded to include: ThinkGlucose programme to monitor diabetes and Bowel assessments.

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 with a 'Green' given for a 90 per cent or greater score, an 'Amber' for 89-70 per cent scores and a 'Red' for scores 69 per cent or less.

In the last year all aspects of care have improved across the Trust as shown below.

Average Trustwide scores for each NCI theme

Criterion	Patient Observations	Pain	Manual Handling	Tissue Viability	Nutrition	Medications	Infection Control
2010	77%	70%	71%	86%	68%	92%	95%
2011	83%	80%	79%	93%	77%	94%	97%
Difference	↑6%	↑10%	↑8%	↑7%	↑9%	↑2%	↑2%

The system has been expanded into the maternity, neonatal and paediatric units from 1st January 2012.

3.3.5 'Harm Free' Care and NHS Safety Thermometer

This year the Trust has signed up to 'Harm Free' care, a project being rolled out nationally to help teams eliminate four types of harm:
- Pressure ulcers
- Falls
- Urinary tract infections (in patients with a catheter)
- Venous thromboembolisms

Building on our existing improvements, 'Harm Free' care (meaning the absence of the above harms) can be measured using the NHS Safety Thermometer, so called as it provides a 'temperature check' on harm. This initiative will be reported on fully in next year's report.

3.3.6 Mortality

The different indices of mortality measure 'excess deaths' in different ways and the Trust now monitors the three most used figures:

1. SHMI (Summary Hospital Mortality Indicator)
2. RAMI (Risk Adjusted Mortality Index)
3. HSMR (Hospital Standardised Mortality Ratio)

At present, the Trust's SHMI is not outside the expected range.

To date, all internal investigations of outlier (off track) alerts generated from HSMR figures have confirmed no patient care problems and all alerts have been closed by the Care Quality Commission, which oversees these.

Recognising that whatever indices are used nationally, all mortality should be audited, the Trust continues to develop its internal mortality monitoring process. This includes monthly presentations to the Chairman, Chief Executive and Medical Director.

From 1st January 2012 a new database developed in-house is being used to ensure that the system of monitoring all deaths is undertaken in a more effective way. The Policy for Monitoring Inpatient Deaths has been changed, which will give more helpful and meaningful reporting in the future. This should also help individual departments to identify any patterns/problems more easily.

The Trust is also part of the new West Midlands Mortality Group where knowledge and experience is shared.

3.3.7 Examples of Specific Patient Safety Initiatives

a. Important change to barium enema requesting

We have changed the way barium (a liquid that coats the inside of the bowel to help gain a clear X-ray) enemas are requested both from our own staff and GPs to reduce the risk of harm from oral bowel cleansing solutions. Following a rapid response alert from the National Patient Safety Agency, all referring clinicians must ensure the patient is properly assessed to make certain it is clinically safe to undertake bowel preparation for a barium enema. The standard general X-ray request form has been replaced by a new Barium Enema Request form which includes a checklist that the clinician is asked to complete to ensure the patient is suitable for bowel preparation.

b. Red Stop Stickers help deliver high standards for infection control

Prolonged courses of antibiotics can cause increased risk of Clostridium difficile infections, increased resistance to antibiotics and increased risk of developing an allergy to the antibiotic.

Red stickers (to stop a course of antibiotics being prescribed) have been issued to all staff who don't include a date of duration and date of review on prescription charts when giving patients courses of antibiotics. The five-day red stop sticker initiative was part of our ongoing commitment to deliver high standards of infection control. Antibiotics need to be prescribed responsibly, appropriately and safely and the red stickers will remind prescribers to include all the relevant information on the prescription charts.

c. Protocol for care post-laparoscopic surgery

In response to a National Patient Safety Agency (NPSA) national alert the Trust produced a detailed protocol for care post-laparoscopic (key hole) surgery. For this type of surgery, there is an under-recognised risk that complications can remain undiagnosed until a life threatening condition such as circulatory collapse or septic shock develop. A multidisciplinary team produced clear standards for care post- abdominal, urological and gynaecological procedures.

These included:
- Expected observations
- Discharge criteria
- Information given on discharge
- Actions to take if patients telephoned later with problems

d. Purchase of and training in safer intravenous medicine equipment

Device models differ in their dials and settings which can lead to inaccurate measurement. This year the Trust has standardised intravenous infusion devices on a single model which includes enhanced safety features. A Trust-wide user training programme was put in place which teaches the safe operation of all ambulatory (portable) syringe drivers.

3.3.8 Patient Safety Measures:

	Actual 2007/08	Actual 2008/09	Actual 2009/10	Actual 2010/11	Actual 2011/12
Patients with MRSA infection/1,000 bed days*	N/A	0.07	0.04	0.01	0.01
Patients with C.diff infection/1,000 bed days*	1.45	0.97	0.9	0.51	0.70
Number of cases of Venous Thromboembolism (VTE) presenting within three months of hospital admission	49	48	48	35	143**

**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 the HPA website due to Trust calculations using the 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 recognized 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, this year we have seen an increase in figures, but would stress that this is down to better identification of cases.*

3.4 Clinical Effectiveness

Do patients receive a good standard of clinical care?

3.4.1 Introduction

This section includes the various initiatives happening at the Trust to make sure patients receive a good standard of care and where we stand out compared to other organisations.

3.4.2 Examples of Awards received for Clinical Care

a. NHS Diabetes Care QiC (Quality in Care) award – Best emergency or inpatient care initiative

This award recognises the importance of providing specialised, tailored and safe care to people with diabetes while in hospital. The Trust's initiative 'ThinkGlucose' won this award. The project aims were:

- Increasing awareness of diabetes in inpatients.
- Specialists seen quickly with an early discharge/ follow-up plan to reduce the length of stay.
- Reducing prescription errors and improving patient care through updated guidelines.

The Trust achieved these aims with a reduction in insulin prescription errors, a drop in referrals to the wrong departments and an improvement in hypoglycaemia (low blood sugar) management. ThinkGlucose was seen to be a clear success, resulting in improved outcomes for patients with diabetes.

b. Wound Academy (Molnlycke) Scholarships

The Trust's Diabetes Foot Team was awarded a Highly Commended Team Award for its 'Putting Feet First' initiative, which provides foot education for patients and health care professionals. The team, comprising three podiatrists, focused on the care of wounds in the diabetic foot across primary and secondary care.

c. Fracture neck of femur service – high quality care recognized

The National Hip Fracture 2011 Report has praised the Trust as an example of good practice and for the high standard of care we give our patients.

The report said the Hip Fracture Suite's specialised service has delivered big reductions in long stay patients (from 34 to 23 days) and a steadily rising proportion of patients discharged directly home (from 50 per cent to 64 per cent).

In the same report Russells Hall Hospital has been the top performing among all the West Midland hospitals in the last three quarters of 2011.

d. Chronic Obstructive Pulmonary Disease (COPD)

The Chronic Obstructive Pulmonary Disease Local Enhanced Service (COPD LES) in Dudley won the 'Best Respiratory Initiative' at the National Vision Awards 2011.

The award was presented by Gyles Brandreth to community and hospital staff who attended on behalf of the Dudley Respiratory Group, at The International Convention Centre Birmingham in November 2011.

The COPD LES provides full training and support materials for all healthcare professionals from primary and secondary care, a comprehensive review for all patients with COPD in primary care, standby medication prescribed in both primary and secondary care and encouragement of self management by patients. The judges commented that the COPD LES was 'far reaching and had excellent engagement'.

e. Committed to Excellence Awards

These local awards, sponsored by the Trust's business partners, are now in their fifth year and recognise what staff do, day in day out, to give patients the very best care. One category is the Excellence in Patient Care award which was won this year by Amy Virdee, Clinical Support Worker on Ward C7. Amy has worked for The Dudley Group for more than 20 years and is gentle, caring, considerate and dedicated to her patients. She has very high standards and always encourages and challenges fellow staff to give excellent care.

3.4.3 Examples of Innovation

a. Gastric balloon used to facilitate life-saving surgery

For the first time in the Trust, a consultant gastroenterologist has inserted a gastric balloon to help a patient lose weight so he can receive life-saving heart surgery. The patient was being prepared for a gastric by-pass operation when a routine echocardiogram (heart ultrasound) revealed there was an aneurysm of the ascending aorta (a widening of the artery). Surgeons agreed the risk to the patient was too high for surgery unless he reduced weight significantly. The balloon was inserted as an endoscopic procedure and enabled the patient to lose eight stone. Once the gastric balloon was removed, surgery to repair the aneurysm was undertaken successfully a few days later.

b. National spotlight for bariatric surgery scoring system

Staff in the Biochemistry Department have developed a scoring system for the selection of patients who would benefit most from undergoing bariatric surgery. It has taken three years to develop and perfect the scoring system, which has recently been published nationally in the British Journal of Diabetes and Vascular Disease. The DUBASCO (Dudley Bariatric Surgery Comorbidity Score) identifies those patients who would benefit most from undergoing bariatric surgery (i.e. likely to develop diabetes, urgent need for surgery) but who may not necessarily be the heaviest.

c. Vertebroplasty available for patients with vertebral compression fractures

The Trust now offers a vertebroplasty (vertebral cement augmentation) service to patients with osteoporotic, traumatic vertebral compression fractures with persistent pain beyond six weeks. The multidisciplinary vertebral cement augmentation service provides appropriate patients with interventional (surgical and other) procedures in line with current best evidence and practice guidance. Each patient is assessed meticulously by a multidisciplinary team to provide an advanced

interventional service alongside a holistic approach to provide the ideal environment for improving patients' quality of life.

d. Fat gene test developed by biomedical scientist

A Senior Research Biomedical Scientist at the Trust has developed a quick method of identifying a gene mutation that has been linked to obesity. Patients attending the weight management clinic at Russells Hall Hospital will be invited to take part in a research study to find out if they have a gene mutation – commonly known as the fat gene. People with this gene mutation are on average 3.0 kg (6.6 pounds) heavier than those without it. People who would test positive for the gene may at least have some explanation as to why they tend to put on weight and may realise that they need to eat less and do more activity than others. This work has resulted in a prize at the Biomedical Science Congress which was held in Birmingham in September 2011.

e. Community Heart Failure Specialist Service

The Heart Failure Team has become one of the pilot sites for the British Heart Foundation (BHF) Intravenous Diuretics project. The aim is to improve the care of patients suffering with Heart Failure by delivering injectable diuretics in the home. The aim is to allow patients to be cared for and die at home preventing unnecessary admission to hospital.

3.4.4 Examples of Specific Clinical Effectiveness Initiatives

a. Dudley breast screening goes digital

A state-of-the-art digital screening unit now provides clearer, instant images to improve the diagnosis of breast cancer. Dudley Breast Screening Service's new unit opened in Sedgley and moves around sites across the borough as part of a three-yearly screening programme. The quality of images and the ability to digitally manipulate them on the computer screen makes it much more efficient than traditional films.

b. Open access service for sleep apnoea

We have now started an open access sleep apnoea (sleep disorder) assessment service for any patient who suffers from excessive snoring and or daytime sleepiness. Patients have two nights of Overnight Oximetry, an Epworth Sleepiness Scale questionnaire and Spirometry (breath measurement) is undertaken.

The results of these tests are then reviewed by a respiratory physician who then decides on an appropriate course of action. This new service increases the number of people we can see, reduces length of waiting time and speeds up the assessment and treatment.

c. Multi Disciplinary Team voice clinic aids rapid diagnosis for hoarse voice patients

The Ear, Nose and Throat (ENT) service has developed a multidisciplinary voice clinic with Speech and Language Therapy (SLT) to aid quicker diagnosis, treatment and resolution of symptoms for voice patients.

Voice patients are examined using a flexible nasendoscopy to see the larynx. Both patient and therapist can see internal images and this instant visual feedback helps direct their therapy and the patient also receives a resolution more quickly. The benefits of the clinic include earlier decision making and earlier treatment means less intervention. Another benefit is that patients with more complicated conditions receive input from both Ear, Nose and Throat (ENT) and Speech and Language Therapy (SLT) services.

d. Enhanced Recovery Programme

A number of specialties, including urology, general surgery and orthopaedics, have started this programme which is about improving patient outcomes and speeding up a patient's recovery after surgery. The Enhanced Recovery programme

focuses on making sure that patients take part in their own recovery process and aims to make sure that patients always receive evidence based care at the right time. The programme includes improved pre-operative assessment, planning and preparation before admission, and aims to reduce the physical stress of the operation. It also provides a structured approach to surgery from admission through to after surgery (peri-operative) management, including pain relief and early movement.

3.4.5 Clinical Effectiveness Measures:

	Actual 2007/08	Actual 2008/09	Actual 2009/10	Actual 2010/11	Actual 2011/12
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%	5.6% Vs 5.0%
Number of cardiac arrests Source: logged switchboard calls	397	250	170	145	119
Never events – events that should not happen whilst in hospital Source: adverse incidents database	0	0	0	0	0

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

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

National targets and regulatory requirements	Trust 2007/08	Trust 2008/09	Trust 2009/10	Trust 2010/11	Trust 2011/12	National 2011/12	Target 2011/12	Trend/Comparison/ Target		
1. Preventing People from Dying Prematurely										
A maximum wait of 31 days from diagnosis to start of treatment for all cancers	100%	100%	99.3%	99.8%	99.7%	98.41%**	96%	↓	☺	☺
All cancers: 31 day wait for second or subsequent treatment: surgery	N/A	N/A	N/A	99.6%	99.6%	97.58%**	94%	↔	☺	☺
All cancers: 31 day wait for second or subsequent treatment: anti-cancer drug treatments	N/A	N/A	N/A	100%	100%	99.74%**	98%	↔	☺	☺
A maximum wait of 62 days from urgent referral to treatment of all cancers	100%	99.9%	86.5%	87%	88%	87.3%**	85%	↑	☺	☺
All cancers: 62 day wait for first treatment from consultant screening service	N/A	N/A	N/A	99.6%	96.6%	93.51%**	90%	↔	☺	☺
Proportion of high risk TIA patients investigated and treated within 24 hours of first contact with a health professional	N/A	N/A	N/A	76.11%	72.18%	70.19%**	60%	↓	☺	☺
3. Helping people to recover from episodes of ill health or following injury										
A maximum two-week wait for standard Rapid Access Chest Pain Clinics	99.98%	99.89%	99.90%	99.64%	99.89%	99.86%**	95%	↑	☺	☺
Genito-urinary medicine – percentage of patients offered an appointment within 48 hours	N/A	99.59%	99.83%	99.66%	99.18%	N/A	98%	↓	N/A	☺
Stroke patients spending 90% of their time on stroke unit	N/A	N/A	N/A	68.30%	76.8%	80.97%**	80%	↑	☹	☹
Maximum time of 18 weeks from point of referral to treatment (admitted patients)	N/A	92.4%	95.8%	97.03%	95.7%	90.83%*	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	99.2%	97.3%*	90%	↓	☺	☺
Referral to treatment times for admitted patients	N/A	N/A	N/A	19.8 weeks	19 weeks	N/A	23 weeks	↑	N/A	☺
Referral to treatment times for non-admitted patients	N/A	N/A	N/A	12.1 weeks	9.6 weeks	N/A	18.3 weeks	↑	N/A	☺

4. Ensuring that people have a positive experience of care										
A/E: Percentage of patients admitted, transferred or discharged within 4 hours of arrival	98.1%	95.9%	98.1%	98.8%	97.27%	97.13%#	95%			
Percentage of patients who have operations cancelled for non-clinical reason to be offered another date within 28 days	100%	100%	100%	100%	100%	96.14%**	98.5%			
Two week maximum wait for urgent suspected cancer referrals from GP to first outpatient appointment	100%	100%	98%	96.8%	97.2%	95.77%**	93%			
Two week maximum wait for symptomatic breast patients	N/A	N/A	69%	98.2%	99%	95.61%**	93%			
Percentage of patients waiting five weeks or less for diagnostic tests	N/A	99.73%	99.58%	98.34%	95.25%	98.27%*	100%			
Proportion of women receiving cervical cancer screening test results within two weeks	90%	90%	32.12%+	98.60%	99.9%	N/A	98%		N/A	
Mixed sex accommodation breach rate per 1000 FCEs	N/A	N/A	N/A	N/A	0	0.84***	0	N/A		
5. Treating and caring for people in a safe environment and protecting them from avoidable harm										
Clostridium difficile year on year reduction	N/A	154	126	81	113	N/A	No more than 77		N/A	
MRSA – number of post 48hour bacteraemia infections	N/A	7	2	3	2	N/A	No more than 2		N/A	
Screening all elective in-patients for MRSA	N/A	N/A	100%	100%	100%	100%**	100%			
Certification against compliance with requirements regarding access to healthcare for people with a learning disability	In 2011/12 the Trust is compliant									

+The low figure for 09/10 is due to a national increase in women coming forward for screening following a very high profile celebrity death from cervical cancer.

N/A = Not available or not applicable **Figures are up to end of Feb 2012* ***Figures are up to end of Dec 2011*

****Figures are up to end of Oct 2011* *#Figures are up to end of Sep 2011*

KEY

Trend = Present position compared to last year 2010/11
Target = Position compared to allocated target
Comparison = Position compared to national figure

 = Improvement
= Deterioration
 *= Same*

 *= Better than target/national figure*

 *= Worse than target/national figure*

3.6 Glossary of Terms

A & E	Accident and Emergency (also ED – Emergency Dept.)
ADC	Action for Disabled People and Carers
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
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
C. diff	Clostridium difficile
CQUIN	Commissioning for Quality and Innovation payment framework
CEM	College of Emergency Medicine
DAHNO	Data for Head and Neck Oncology
DNA	Did Not Attend
DUBASCO	Dudley Bariatric Surgery Co-morbidity Score
DVD	Optical disc storage format
DVT	Deep Vein Thrombosis
EAU	Emergency Assessment Unit
ENT	Ear, Nose and Throat
ED	Emergency Department (also Accident and Emergency Dept.)
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 Select Committee
HAT	Hospital Acquired Thrombosis
HCAI	Healthcare Acquired Infection
HES	Hospital Episode Statistics
HPA	Health Protection Agency
HQIP	Healthcare Quality Improvement Partnership
HSMR	Hospital Standardised Mortality Ratios
IBD	Irritable Bowel Disease
ICNARC CMPD	Intensive Care National Audit & Research Centre Case Mix Programme Database
KPI	Key Performance Indicator
LiA	Listening in Action
LINk	Local Involvement Network
MBC	Metropolitan Borough Council
MBRRACE-UK	Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries in the UK
MET	Medical Emergency Team
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 Scoring Tool
NCEPOD	National Confidential Enquiry into Patient Outcome and Death
NCI	Nursing Care Indicator
NCDAH	National Care of the Dying Audit in Hospitals
NICE	National Institute for Health and Clinical Excellence
NHS	National Health Service
NNAP	National Neonatal Audit Programme
NPSA	National Patient Safety Agency
NVQ	National Vocational Qualification
Ofsted	Office for Standards in Education, Children's Services and Skills
PALS	Patient Advice and Liaison Service
PE	Pulmonary Embolism
PEAT	Patient Environment Action Teams
PFI	Private Finance Initiative
PROMs	Patient Reported Outcome Measures
PCT	Primary Care Trust
RAG	Red/Amber/Green
RCOG	Royal college of Obstetricians and Gynaecologists
RCPCH	Royal College of Paediatrics and Child Health
RAMI	Risk Adjusted Mortality Index
SHA	Strategic Health Authority
SHMI	Summary Hospital Mortality Indicator
SINAP	Stroke Improvement Audit Programme
SUS	Secondary Uses Service
SLT	Speech and Language Therapy
VSGBI	Vascular Society of Great Britain and Ireland
VTE	Venous Thromboembolism

ANNEX

Comment from Dudley Clinical Commissioning Group

Commissioners continue to work closely with The Dudley Group Foundation Trust and recognise the commitment to quality demonstrated in this report. It is acknowledged that the Trust has sought to ensure that quality improvement has remained very much at the forefront of service provision in 2011/12 and has clearly set out equally challenging aims for 2012/13.

The Trust has recognised that whilst much has been done to reduce Health Care Associated Infection, there remains much to be further implemented, and commissioners welcome the strategies now in place to support the reduction in Clostridium difficile infection rates, including learning from best practice, the introduction of dual testing processes, and a commitment to support colleagues across the Health economy to support further reductions in other infection rates.

Similarly, the Clinical Commissioning Group recognise the learning implemented by the Trust in seeking a reduction in hospital mortality, implementing electronic patient notes across the Accident & Emergency service, and look forward to continuing to work with colleagues in providing support to further safety and effectiveness strategies across health care.

Comment from Dudley Local Involvement Network

Dudley LINk is pleased to contribute to this report for another year.

Patient Experience

Receiving feedback from our community through Service Watch, LINk has received observations about our hospitals from patients, their family members and carers. The majority of who give positive comments and rate our hospitals good or very good. Some examples of comments received are:

- Excellent – Couldn't fault it in any way – all the staff were really good
- Directions in the hospital have improved immensely; staff were caring, direct and to the point. Trying to work hard under the pressure of the number of people
- This totally professional team made me totally relaxed. They looked after me 100% Bless them all; what would have been a very stressful time turned out to be a very positive experience!! Please relate my comments to them – they deserve it 110%

On feeding these comments back to the hospitals we know that the comments of our community have been taken into account in identifying areas where services can be improved.

Pressure Ulcers

We know that the prevention and treatment of pressure ulcers are of concern to people and we are pleased to see that this is again being prioritised for both patients in our hospitals and also for those in our community who are susceptible to this condition.

Infection Control

Last year our hospitals made good inroads into reducing MRSA and Clostridium difficile rates. We know that staff have worked hard to reduce these rates but we also remind our community (as we did last year) of the importance of hand hygiene when visiting our hospitals.

Nutrition and Hydration

Some of the less favourable comments made to us by our community relate to these two issues and so it is good to see these being prioritised this year.

We also approve that New Patient Forum Groups have been formed and that hospital food is one of the topics being discussed by them. We recognise the importance that has been placed on improving nutrition and hygiene in line with recommendations.

Comment from the Dudley MBC Health and Adult Social Care Scrutiny Committee

The Committee reviewed the progress of the Trust against the 2011/12 quality improvement priorities at its last meeting of the municipal year held on 28th March 2012. This also provided the opportunity to comment on the priorities developed for 2012/13.

The considerable reduction in hospital acquired pressure ulcers was noted. Members welcomed the continued focus on nutrition as a quality improvement area, in the light of it's 2011/12 Dignity in Care Review, along with the introduction of a 24 hour 'nutritional assessment' target for new admissions. The Committee would want assurance that the appointment of nutritional workers would help realise this target across services and a resultant improvement in patient hydration and overall meal time experience. It was also felt consideration should be given to the inclusion of performance indicators on this theme in future quality reports to assist in quantifying improvement and evaluating trends.

The Committee was also encouraged by the Trust's participation in the 'Safety Thermometer' initiative as it provided a real opportunity to secure even greater reductions in pressure ulcers acquired whilst in hospital and whilst on the community district nurse caseload; the Committee will be monitoring this issue through scrutiny of the Trust's patient experience strategy in 2012/13.

Overall, the Committee agreed that planned priorities for improvement going into 2012/13 were representative of the quality of services provided and covered areas of importance to local communities.

Comment from the Trust's Council of Governors

The Council of Governors continues to acknowledge the Trust Board's commitment to robust clinical governance and supports its aim to achieve a continuous improvement in the quality of services, both clinical and non-clinical. The Council accepts that substantial progress has been made, especially through the Transformation Programme, although there are a number of issues where improvements still need to be achieved.

The Council notes the positive actions being taken to reduce the rates of MRSA and C. diff infections and support the Trusts own view that even one case is one too many. Governors received regular updates and slide presentations on the work being done to reduce hospital acquired infection rates and is assured that significant progress has been made in this area.

The Council has expressed some concerns over the 'inpatient experience' satisfaction levels, but again is supportive of the work being instigated by the Trust to achieve improvements. Surveys used in gathering the information capture only a limited number of patient views when compared to the total number of patients seen in a full year so it is pleasing that governors have taken part in ward walk-rounds taking the opportunity to speak to patients on a one-to-one basis. Governors participated in the Quality Priority Listening Event held in February and are fully supportive of the Trust's intention to prioritise and take steps to achieve improvements in the areas of nutrition and hydration as part of its work in 2012/13.

It is important to understand that the role of the Council is that of 'secondary governance' with the Trust Board responsible for 'primary governance'. The Trust Board and the Council have worked together in an open and transparent way. Without this it would be difficult to influence Trust strategy positively. The Council acknowledges that to achieve this the Board has consulted with Governors on a wide range of issues during the year either through the Council's own committee structure, consultative papers or direct at the meeting of the full Council. These consultations have provided an essential route by which the Governors can ensure the Trust's membership's views are brought to the board's attention. A good example is the paper written by a governor highlighting the rights of all patients to receive good quality hospital care. Supported by the Council it set 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.

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 as a whole. Despite this positive aspect the Council had concerns about its own effectiveness and outside consultants were appointed to carry out an in-depth review; the results of which were in the main reflective of the Council's own views. The Council played an important role working alongside the Trust's Board in reviewing, and where required, amending, the Trust Constitution and fully supports the reduction in numbers of Governors from 39 to 25. This review, along with a restructuring of the Council of Governors own committee structure, has enabled the Council to be more effective in carrying out its duties.

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 as amended 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 2011/12;

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 2011 to June 2012
- Papers relating to Quality reported to the Board over the period April 2011 to June 2012
- Feedback from the commissioners dated 02/05/2012
- Feedback from Governors dated 26/04/2012
- Feedback from LINks dated 26/04/2012
- The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 01/04/2012
- The National Patient Survey 24/04/2012
- The National Staff Survey March 2012
- The Head of Internal Audits annual opinion over the Trusts control environment dated 31/03/12

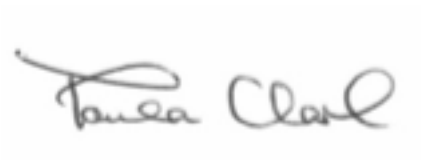
• CQC quality and risk profiles dated Apr/Jun/Jul/Aug/Oct/Dec 2011 and Feb/Mar 2012

o the Quality Report presents a balanced picture of the NHS Foundation Trust's performance over the period covered;
o 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.
o 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
o the Quality Report has been prepared in accordance with Monitor's annual reporting guidance (which incorporates the Quality Accounts regulations) (published at www.monitor-nhsft.gov.uk/annualreportingmanual) as well as the standards to support data quality for the preparation of the Quality Report (available at www.monitor-nhsft.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

Date 15/05/2012 Chairman



Date 15/05/2012 Chief Executive

Independent Auditor's Assurance Report to the Council of Governors of the Dudley Group NHS Foundation Trust on the Annual 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 2012 (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 2012, to enable the Council of Governors to demonstrate that it has discharged its 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 save where terms are expressly agreed and with our prior consent in writing.

Scope and subject matter

The indicators for the year ended 31 March 2012 subject to limited assurance consist of the national priority indicators as mandated by Monitor:

- MRSA
- 62 day cancer waits

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 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 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 2011 to March 2012;
    - Papers relating to Quality reported to the Board over the period April 2011 to March 2012;
    - Feedback from the Commissioners dated 2 May 2012;
    - Feedback from LINks dated 26 April 2012;
    - Feedback from the Council of Governors dated 26 April 2012;
    - The Trust's 2011/12 complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009;
    - The national patient survey 2011/12;
    - The 2011/12 local patient experience report. Due to the timings of our work we have reviewed quarters one, two and three for 2011/12;

- The national staff survey 2011/12;
- Care Quality Commission quality and risk profiles dated February 2012; and
- The Head of Internal Audit's annual opinion over the Trust's control environment for the year ending 31/03/12.

- 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 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.

We read the other information contained in the Quality Report and consider whether it is materially inconsistent with the documents specified within the detailed guidance. We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with those documents (collectively the "documents"). Our responsibilities do not extend to any other information.

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

Assurance work performed

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

- Evaluating the design and implementation of the key processes and controls for managing and reporting the indicators;
- Making enquiries of management;
- Testing key management controls;
- Limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation;
- Comparing the content requirements of the *NHS Foundation Trust Annual Reporting Manual* to the categories reported in the Quality Report; and
- Reading the documents.

A limited assurance engagement is 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

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 impact 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 thereof, 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 nature, form and content required of Quality Reports are determined by DH/Monitor. This may result in the omission of information relevant to other users, for example for the purpose of comparing the results of different NHS Foundation Trusts. In addition, 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 2012:

- 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 the detailed guidance; 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* and the six dimensions of data quality set out in the *Detailed Guidance for External Assurance on Quality Reports.*

Deloitte LLP
Chartered Accountants
Birmingham
24th May 2012