The Dudley Group NHS
NHS Foundation Trust

Quality Report 2012/13

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CARE

RESPONSIBILITY

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Throughout the document are a number of quotes from patients, the majority of which are from conversations with independent outside assessors.

PART 1: CHIEF EXECUTIVE'S STATEMENT

I am again delighted to introduce the annual Quality Report and Account, the purpose of which is to give a detailed picture of the quality of care provided by our hospitals and adult community services. This report covers April 2012 to the end of March 2013.

The very core of our work is to provide high quality care for all of our patients.

By this we mean we aim to provide:

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

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

With regards to the report's format, in Part 2 of this document we have outlined our priority quality measures and charted their progress throughout the year. A summary of current and previous priorities can be seen in the table on page six. More information on each 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 2013/14. This part of the report also includes sections required by law on such topics as clinical audit, research and development and data quality.

In Part 3 we have included other key quality initiatives and measures and specific examples of good practice on all three of the elements of quality listed above. These hopefully give a rounded view of what is occurring across the whole of the Trust. Although some parts of the report are divided into hospital and community sections, we have deliberately not included a separate distinct section for community services as we take the patient perspective that services should be seamless and integrated and many of our services cross the hospital and community boundary.

The report indicates that we are constantly monitoring the quality of our care in a variety of ways in order to both assure patients and ourselves of where we are doing well and to learn where we need to change practice and improve our services. 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. This view is based not only on our internal monitoring but, as the report shows, on many outside organisations' reviews of the Trust. I am particularly pleased to report that the main hospital inspectorate, the Care Quality Commission, has visited the Trust on a number of occasions during the year, both announced and unannounced, and after talking to staff and patients and checking a variety of documentation, always found the Trust compliant with its standards.

Our quality objectives

The Trust's strategic objectives for quality, as set out in the 'Annual Forward Plan' dated May 2012, are:

- To exceed all internal quality targets by 2014 and to be recognised as the highest quality service provider in the region by patient groups, staff and other key stakeholders.
- To provide excellent service and care making patients feel involved, valued and informed.

Our quality priorities

You will see in the following pages that we have performed very well in relation to our 2012/13 priorities. In fact, we have achieved or exceeded them all except one. The successful priorities relate to: positive patient experience feedback of our hospital, reducing inpatient MRSA and Clostridium difficile infections, improving the recording of fluid intake and output of patients, improving the assessing of patients' nutritional status and reducing significantly the numbers of both hospital and community acquired pressure ulcers. I am particularly pleased by our 50 per cent reduction in stage three and four pressure sores in the hospital as we also managed to reduce the numbers by half in the previous year. In saying that, we are not complacent, and recognise we need to be working towards further reductions next year. With regards to the patient experience target in the community that was only partially achieved, we realise that we need to improve the implementation and patients' understanding of the Single Assessment Process. With regards to 2013/14, we have retained all of the topics from 2012/13 due to their importance, although we have amended the specific targets dependant on the detailed outcomes in 2012/13.

Measuring quality

Although the report includes a range of objective indicators of quality, we have also included a number of specific examples of quality initiatives at the Trust. We couldn't include them all but hopefully the examples give a flavour of the quality of care, awards, innovation and initiatives that Trust staff have achieved and implemented in the year.

I am especially pleased to report that the Trust is receiving positive feedback from our patients in the new Friends and Family Test (Section 3.2.2). Our nurses continue to improve the quality of care they provide as measured by our detailed monthly Nursing Care Indicator assessments (Section 3.3.4). I am particularly glad to report that one of our nurses has won the prestigious national Ward Sister of the Year award and the skills of our newly appointed Head of Medical Education have been recognised (Section 3.4.2).

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

We would appreciate any feedback you would like to give us on both the format and content of the account and also the priorities we have chosen. You can either phone the communications team on (01384) 244404 or email communications@dgh.nhs.uk

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

Signed:

Paula Clark, Chief Executive Date: 08/05/2013

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 2013/14. (N/A applies to priorities not being in place at that time).

Priority	2009/10	2010/11	2011/12	2012/13	2013/14	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 but had a slight decrease in another	Hospital: Partially Achieved Community: √ Achieved	Priority 1 Hospital: √ Achieved Community: Partially Achieved	Priority 1		8-11
PRESSURE ULCERS Improve systems of reporting and reducing the occurrence of avoidable pressure ulcers	N/A	N/A	Hospital: √ Achieved Community: Partially Achieved	Priority 2 Hospital: √ Achieved Community: √ Achieved	Priority 2		12-15
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	√ Achieved Not Achieved	Priority 3 √ Achieved	Priority 3		15-17
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 √ Achieved	Priority 4		18-22
HYDRATION Increase the number of patients who have fluid balance charts completed	N/A	N/A	N/A	Priority 5 √ Achieved	Priority 5		18-22
HIP OPERATIONS Increase the number of patients who undergo surgery for hip fracture within 36 hours of admission (where clinically appropriate to do so)	N/A	√ Achieved	√ Achieved	N/A	N/A	*As the target was achieved for two consecutive years this priority has now been replaced for 2012/13.*	N/A
CARDIAC ARRESTS Reduce the numbers of cardiac arrests	√ Achieved	√ Achieved	N/A	N/A	N/A	*With a decrease from 32 per month in 2008 to 13 per month by 2011 this issue no longer remained a challenge.*	N/A

2.1.2 Choosing Our Priorities for 2013/14

The Quality Account Priorities for 2012/13 covered the following five topics:

Patient Experience **Infection Control** **Pressure Ulcers**

Nutrition **Hydration**

These topics were agree by the Trust Board on the basis of their importance both from a local perspective (e.g. based on complaints, results of Nursing Indicators (see Section 3.3.4)) and a national perspective (e.g. reports from national bodies e.g. Age Concern, CQC findings etc). These topics were endorsed by a Listening into Action event on the Quality Account, hosted by the Chief Executive and Director of Nursing, at which 55 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, Dudley PCT, Dudley MBC, Dudley Stroke Association and Dudley Action for Disabled People and Carers (ADC).

Two of the above topics (Nutrition/Hydration) were new in 2012/13 with the others rolling over from previous years (Patient Experience/Infection Control have been continual priorities since the commencement of Quality Accounts in 2009/10 and Pressure Ulcers were introduced in 2011/12).

In November 2012, the Trust Board agreed that the existing topics should be retained for 2013/14. This is because Nutrition and Hydration remain important and were new in 2012/13 and so improvement trends over time need to be seen before they are removed as a priority. The other three topics remain important issues both from a local and national perspective. Patient experience is at the core of why the Trust exists; the reduction and maintenance of low infection rates are a key commissioner and patient requirement and there is a national campaign of zero tolerance to pressure ulcers.

As stated above, the five priority topics originated from an event attended by staff, governors, Foundation Trust Members and representatives from local organisations. The retention of the topics was further discussed and agreed at a Governors workshop in November 2012 and at the full Governors meeting in December 2012. Input from members was also canvassed through the Trust members magazine ‘Your Trust’ and from the general public via the Trust website.

> The care, professionalism and willingness to answer questions was excellent.

2.1.3 Our Priorities
Priority 1 for 2012/13

PATIENT EXPERIENCE	
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.

How we measure and record this priority

Hospital

This priority has been measured using our real-time survey system. A random sample of inpatients are asked to share their experiences by participating in the survey about their stay before they leave hospital. Responses to the surveys are inputted directly into a hand-held computer and downloaded straight into our database to provide timely feedback.

During 2012/13 the Trust has continued to develop its real-time survey system resulting in 3063 patients participating, more than double the response rate from the previous year (1286).

All surveys are anonymous and results are shared with individual wards enabling them to take action on patient comments.

Community

The community priority has been measured using an annual survey. A paper questionnaire was distributed to community patients who were also provided with a freepost envelope to ensure an anonymous response. There were 1183 responses to the survey, with question (a) answered by 326 respondents and (b) answered by 1140 – the difference in responses is because not all patients have a Single Assessment Process folder, which is a useful document that acts as a communication tool for staff from all services who contribute to the care and management of people with long-term conditions.

Developments that occurred in 2012/13

Monthly Essence of Care meetings continue to reinforce the need to identify patients who require assistance at mealtimes by utilising the behind the bed boards, red tray system and electronic handover. This has been complemented by a poster campaign to raise awareness of the 15 minute meal bell alert, compliance of which is monitored via mealtime audit. The mealtime audits check usage of the behind the bed boards which share important information around nutritional needs.

Nutrition support workers remain in post on ward A2 since May 2011. During 2012/13 a staffing review discussed adopting the nutrition support worker role more widely; however, it was decided to appoint clinical support workers who could assist patients with additional tasks as well as assisting with nutritional needs.

During 2012/13 we also introduced bespoke welcome leaflets for each ward. The 'Welcome to the Ward' leaflets contain important information such as: visiting times, mealtime routines, uniforms, who's who and ward contact numbers both for relatives and for patients if they have health concerns once they return home.

The leaflets are printed on A5 card to sit on the bedside cabinet where visitors can also read the important information contained within.

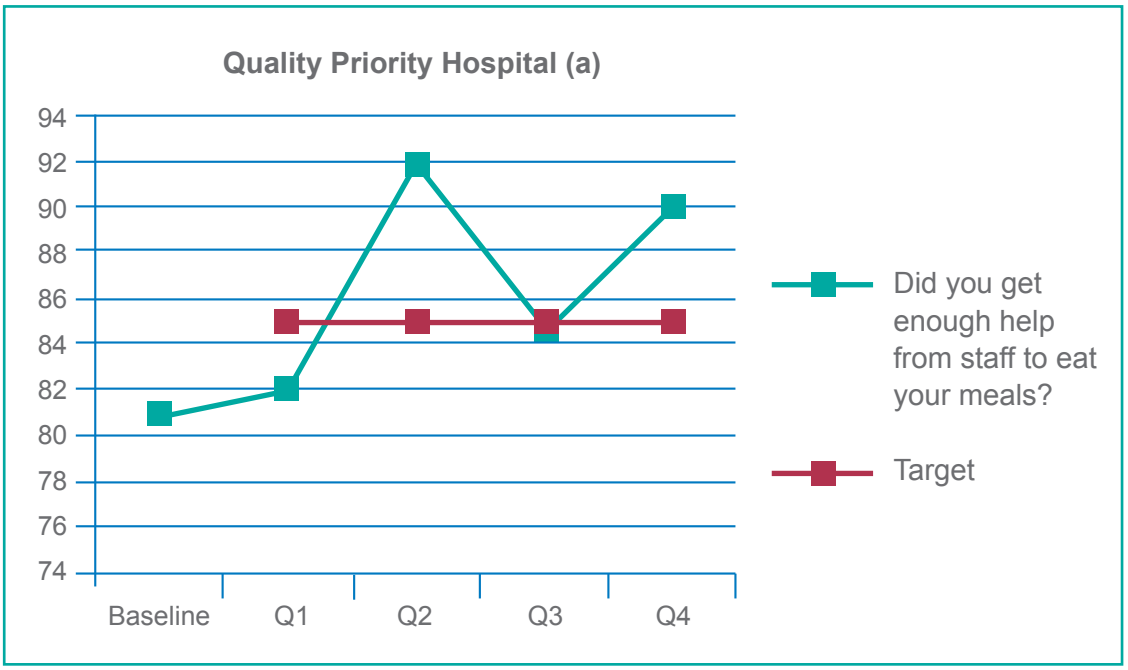
In the community, we have been working with Dudley Council to develop an improved Single Assessment Process folder and this has taken longer to complete than we expected. The document is now almost complete so will be launched in 2013/14.

We have also ensured that PALS leaflets are available for patients, refreshed posters are in clinic areas advising patients how to complain if they wish to and have given PALS advice as part of assessments.

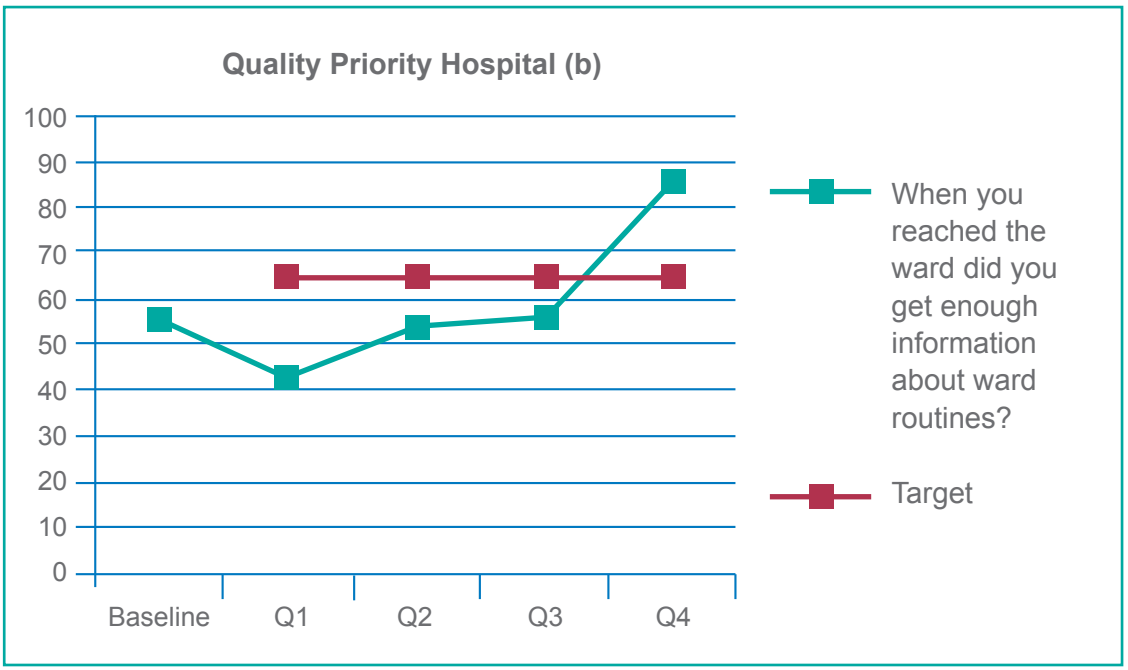
Current status

Hospital

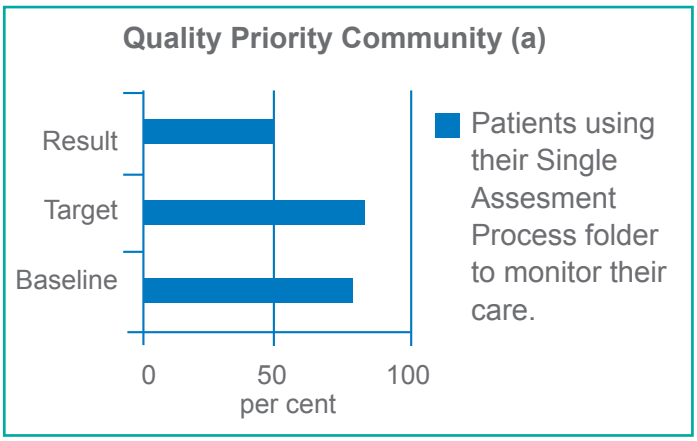
(a) The Trust exceeded its target in quarter two and quarter four achieving a score of 92 and 90 respectively against a target of 85. However, some fluctuation in the score was apparent during the year and, therefore, this priority will be carried forward to 2013/14 to aim for a consistent service.

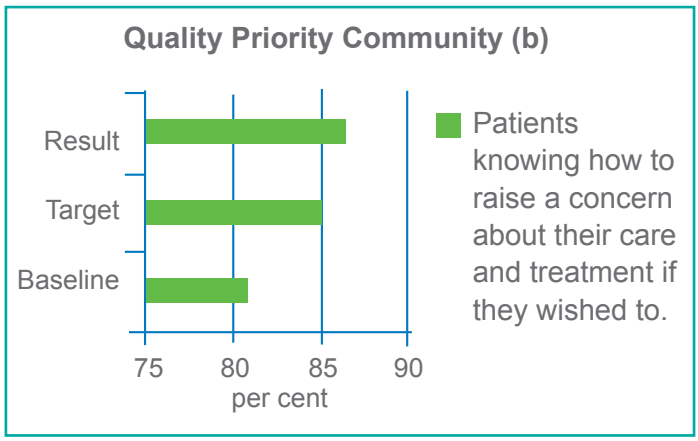


(b) The introduction of the new 'Welcome to the Ward' leaflets in January 2013 has seen this priority being achieved in quarter four with the score rising to 87.2 against a target of 65. We will continue to monitor that leaflets are given out but will remove this as a priority as the actions taken have been successful.



Community





The patient experience quality priority for community has been partially achieved for 2012/13. We are pleased that the number of patients reporting that they would know how to raise a concern about their care and treatment if they wished to do so has risen from 80.8 per cent to 86.8 per cent against a target of 85 per cent. However, the number of patients using their Single Assessment Process folder to monitor their care has dropped from 75.3 per cent in 2011/12 to 49.4 per cent. While this is disappointing, we recognise that finalising the new Single Assessment Process folder and educating patients and families/carers on its use will help us to improve next year.

New Priority 1 for 2013/14

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

Rationale for inclusion

We have retained, and in most cases strengthened, three out of the four patient experience targets from 2012/13. The reason we have carried these forward is because we felt that there was still progress to be made.

The hospital (a) target had seen fluctuation during the year and we are looking for a more consistent approach to this important aspect of patient care. Hospital (b) is a new target for 2013/14 aimed at ensuring timely response to call bells as this is something that patient feedback tells us we could do better.
The community (a) target saw a large decrease in score in 2012/13 so is carried forward with the same target into 2013/14. The newly developed Single Assessment Process folder is being renamed the Health and Social Care Passport; this new name is reflected in the priority above. Community (b) was achieved and is carried forward with a stretched target to ensure that we have processes in place so that patients know how to raise a concern if they wish to.

> I have had good treatment, I couldn't ask for better.
> They tell me everything they are doing.

Developments planned for 2013/14

- Include the hospital patient experience quality priority in the newly developed Quality Outcome Measures Dashboard, which is a list of key quality indicators, to give lead nurses and matrons timely feedback.
- Introduce a more automated system of ensuring that patients and staff are forewarned about mealtimes rather than the use of hand bells, thereby allowing sufficient time for patients and nursing staff to adequately prepare for mealtimes.
- Recruit additional nutrition support workers within the Stroke and Elderly Care Department.
- Increase the number of volunteers trained to provide mealtime assistance.
- Include details in our patient information around the welcoming of family members to assist their relatives at mealtime if they wish to do so.
- Launch the new Health and Social Care Passport, which is a document for information sharing between the patient, carers and health and social care professionals. It will be simpler to follow and will encourage patient and carers to use to monitor their care.
- Produce an information leaflet for existing Single Assessment Process folder holders to explain to them how to use the document to monitor their care.
- Extend the annual survey to try to discover the reason for patients choosing not to use the documents to monitor their care.
- Pilot an improved system of call bell answering on the surgical wards, monitor its impact and roll out to other areas dependant on its success.
- Design and trial new posters giving patients clear information on the call bell system.

Board sponsor: Denise McMahon, Director of Nursing

Operational lead: Mandy Green, Deputy Head of Communications and Patient Experience

Priority 2 for 2012/13

PRESSURE ULCERS	
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 community 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).

How we measure and record this priority

Pressure ulcers, also called pressure sores and bed sores, are graded from one to four with four being the most serious. When a patient is identified as having a pressure ulcer the details are entered into the computer incident reporting system and is reviewed by the Tissue Viability team prior to reporting externally.
If pressure damage is noted within 72 hours of admission, this is not considered to have developed in hospital. This time frame is agreed regionally by the Strategic Health Authority. It is recognised that pressure damage can occur but not be visible immediately.

> One thing I really like is the way they respect your privacy.
> They are always closing the curtains when they come to talk to you.

Developments that occurred in 2012/13

A new campaign was launched to follow on from the 'We Love Your Skin' campaign. The '50 Day Dash' was an Olympic themed campaign with the aim to reach 50 days free from pressure ulcers, giving wards a visual representation of their progress. Awards were presented to those wards that were successful, and the race continues, with some wards having reached 150 days pressure ulcer free.

There is now a more robust reporting system for the hospital and community to ensure all pressure ulcers are reported through Datix and verified by a Tissue Viability nurse, although further work continues to ensure that nurses correctly differentiate pressure ulcers from moisture lesions.

In order to ensure the same standard of pressure ulcer prevention across the Trust, a joint pathway has been developed between the hospital and community.

The pressure ulcer prevention and management documents were launched in the community in November 2012. This document includes a skin bundle which is a document completed on a regular basis by nursing staff including all the important components of care to prevent pressure ulcers. SKIN is an acronym which stands for *Surface, Keep Moving, Incontinence* and *Nutrition*. Progress is now underway to audit the correct completion of the documentation and skin bundle.

Skin bundle training has taken place for all the Trust's community nurse and specialist teams. In addition, we have organised this training for both carers in residential homes and home carers. It has been recognised that this needs to continue as a rolling programme of education for all carers.

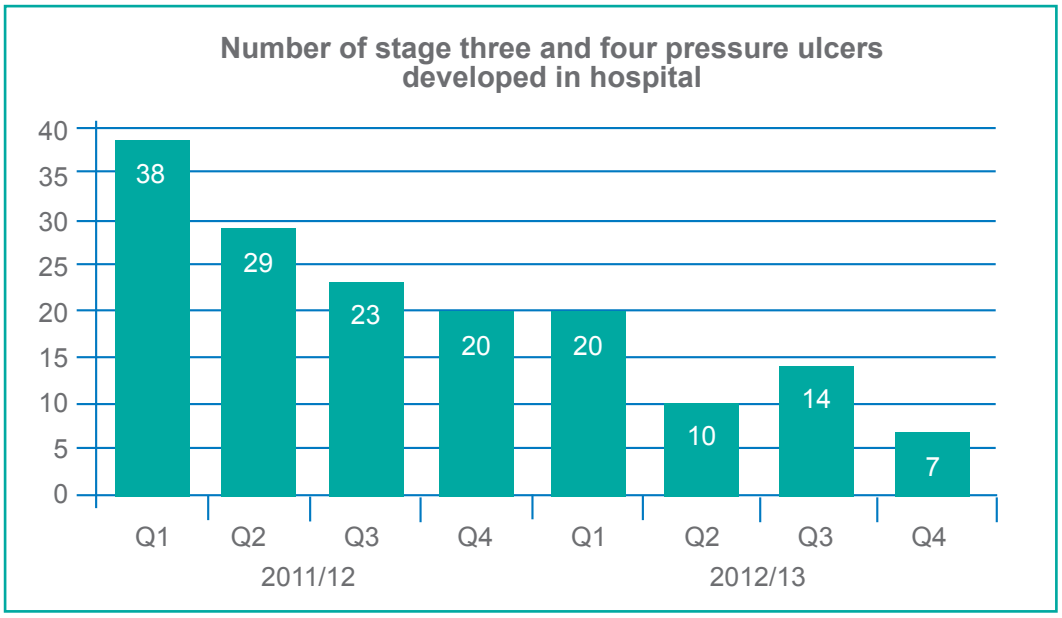
Meetings have taken place with managers of private care agencies as there was some initial resistance to complete this documentation. Initial reservations, however, have since been addressed and plans are in place to initiate their training sessions.

All stage three and four pressure ulcer incidents continue to be discussed and monitored in the pressure ulcer group meetings on a weekly basis, ensuring that lessons are learned to reduce reoccurrence.

Current status

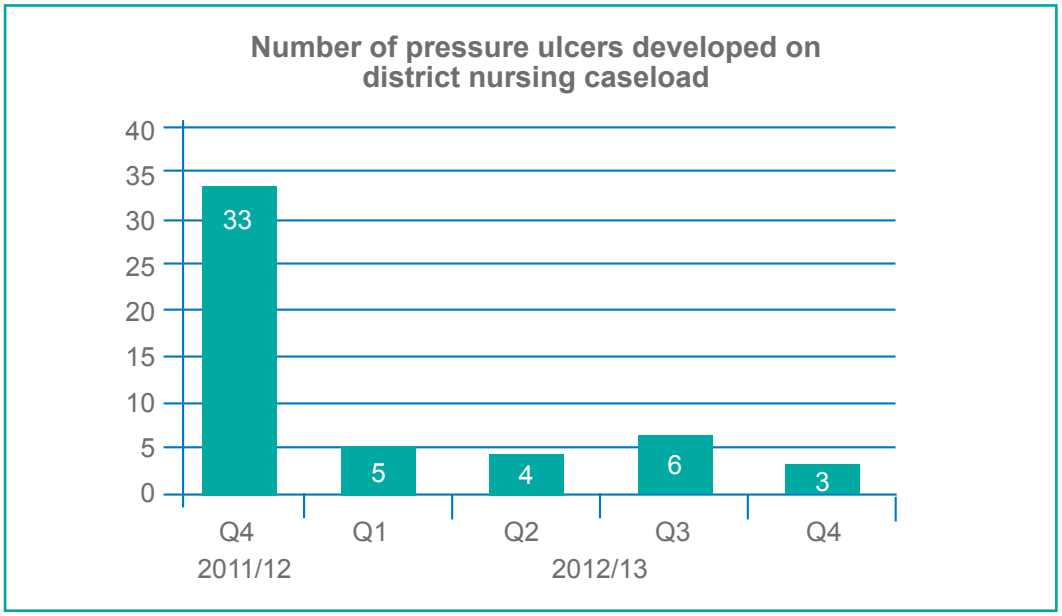
Hospital

The graph below shows the number of stage three and four pressure ulcers that developed in the hospital from the first quarter of 2011/12, including all four quarters of this year (2012/13).



It can be seen that the number of pressure ulcers continues to fall compared to last year. We set ourselves the ambitious target of reducing them by half from last year after successfully reducing them by half from the year before. It can be seen that last year we had 110 of these ulcers but only 51 this year and so we are very pleased to note that we have managed to achieve this ambitious target again due to the efforts of all the staff involved.

Community



The community target of a reduction of 10 per cent in the second quarter from the final quarter of 2011/12 was exceeded considerably with a reduction of over 85 per cent. This means that, in effect, both the half year and end of year targets were met together and in advance.

New Priority 2 for 2013/14

PRESSURE ULCERS	
Hospital	**Community**
Reduce avoidable stage four hospital acquired pressure ulcers so that the number for 2012/13 has been reduced by 50 per cent in 2013/14. Reduce avoidable stage three hospital acquired pressure ulcers so that the number for 2012/13 has been reduced by 25 per cent in 2013/14.	Reduce avoidable stage three and four community acquired pressure ulcers that occur on the district nurse caseload so that the number for 2012/13 has been reduced by 25 per cent in 2013/14.

Rationale for inclusion

- Pressure ulcers are difficult to treat and slow to heal, and prevention is therefore a priority.
- Although the Trust achieved its targets in 2012/13, it realises there is still much to do and moving to a zero tolerance of pressure ulcers in hospital should be the aim.
- Feedback from our patients, staff, community groups and Governors indicates this should remain a target.

> They help me move around and they told me that would help.

Developments planned for 2013/14

Actions being undertaken to achieve the Trust target include:

- Continue to promote the '50 Day Dash' campaign.
- The Tissue Viability team is planning a trolley dash for the hospital to continue the message of zero tolerance, and to highlight the importance of elevating patients heels off the surface with a suggestion box on the day for staff to inform the Trust how we can improve pressure ulcer prevention. This trolley dash will also spread the message of a different staging tool to assess the severity of pressure ulcers.
- Regular equipment sessions have been organised to inform community nursing teams about the correct use of equipment and fault finding.
- Education sessions will continue for all Trust staff.
- The team will continue to work with private care agencies and organise education sessions and updates as required.
- The Tissue Viability team will support nursing homes with the formulation of a mattress selection guide.

Board Sponsor: Denise McMahon, Director of Nursing

Operational Lead: Lisa Turley, Tissue Viability Lead Nurse

Priority 3 for 2012/13

INFECTION CONTROL

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 48hr cases; C. diff is no more than 77 post 48hr cases in 2012/13.

How we measure and record this priority

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

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

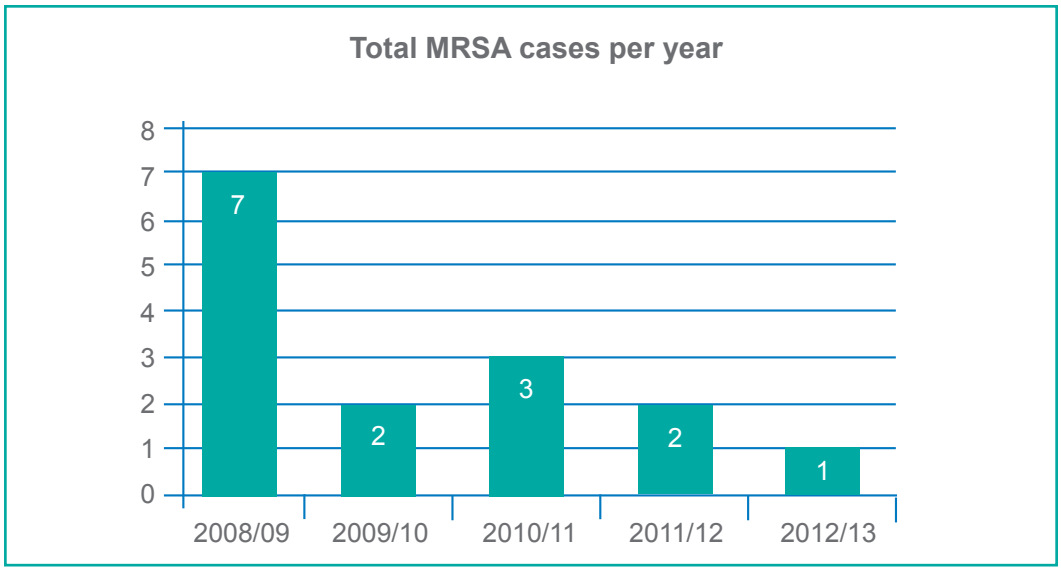
Developments that occurred in 2012/13

- Introduced hydrogen peroxide 'fogging' for the inpatient areas when patients are discharged to reduce cross contamination.
- Improved access to training for antimicrobial (drugs that destroy disease-carrying micro-organisms) prescribing by the development of an online package.
- Agreed competencies for the nursing element of cleaning the environment.
- Agreed and reported competencies of contracted cleaning staff.
- Improved information gathering including feedback and changes in practice regarding anti-microbial prescribing, bringing more senior medical input into the root cause analysis process.
- Introduced the new Department of Health testing algorithm for C. diff.
- Expanded the National Patient Safety Agency (NPSA) infection prevention project into the surgical and high dependency areas.
- Introduced a more systematic process for the usage of protein pump inhibitors medication used for patients with stomach problems.
- Monitored and recorded the time it takes to place patients into side rooms once an infection has been identified.

- Appointed an analyst to assist with the management of all the information required to closely monitor and reduce infection rates.
- Monitored mortality rates when infections are involved.

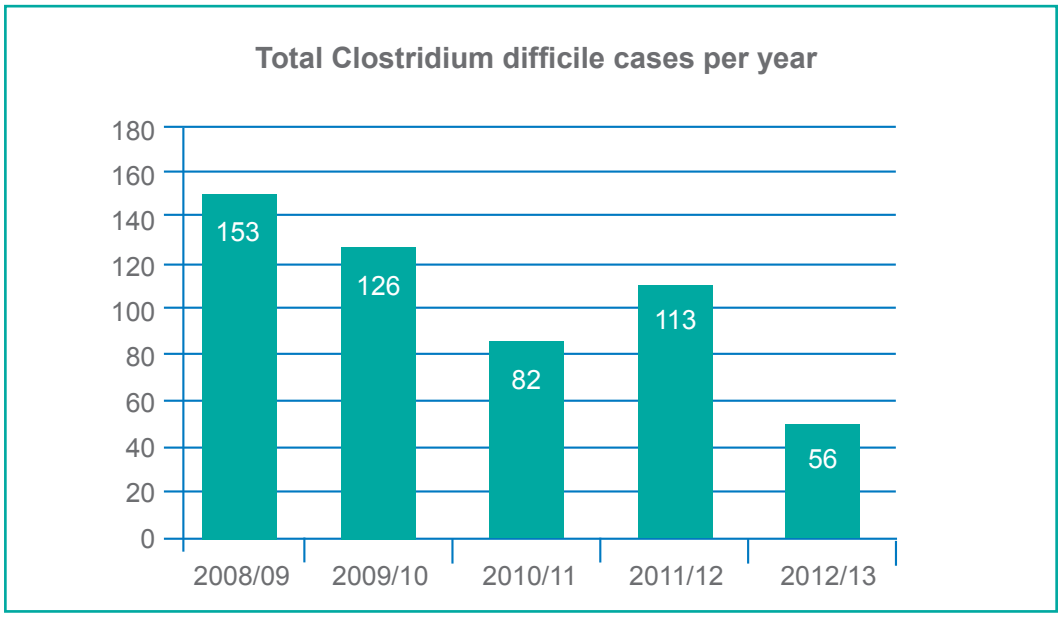
Current status MRSA

We continue our good work to maintain a low level of MRSA Bacteraemia. The graph below shows the continued reduction of MRSA bacteraemia cases (post 48 hr, i.e. patients who acquired it whilst in hospital) from a total of seven in 2008/09 to a total of one in 2012/13.



Current status C. diff

In addition, we have managed to reduce our Clostridium difficile (C. diff) cases both from last year and our previous lowest annual figure (2010/11). This year we have come in under threshold having had 56 in 2012/13. The graph below shows the total number of C. diff cases recorded greater than two days after admission, showing the reduction from a total of 238 in 2007/08 to a total of 56 in 2012/13.



New Priority 3 for 2013/14

INFECTION CONTROL

Reduce our MRSA and Clostridium difficile (C. diff) rates in line with national and local priorities. MRSA Bacteraemia (blood stream infections) target is to have no post 48hr cases; C. diff is no more than 38 post 48hr cases in 2013/14.

Rationale for inclusion

- The drive to reduce healthcare associated infections, which includes MRSA Bacteraemia and C. diff, continues to get more and more challenging.
- The reduction of infection remains a key priority across the NHS.
- Feedback from our patients, staff, community groups and Governors indicates this should remain a target.

Developments planned for 2013/14

Actions planned to achieve the above aims include:

- Continue to develop education programmes and improve the attendance of staff at the relevant sessions.
- Increase the rate of MRSA screening for emergency patients.
- Promote effective antimicrobial prescribing.
- Roll out the availability of the 'fogging' service that contributes to the prevention of cross infection.

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

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

> "They have given me lots of information about what will happen and what other support I can get. I am reading through this."

Priorities 4 and 5 for 2012/13

NUTRITION

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

Increase the number of patients who have their fluid balance charts fully completed.

By September 2012 at least 70 per cent of patients will have their 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 measure and record this priority

Every month 10 observation charts are checked at random on every ward at the Trust as part of the wider Nursing Care Indicators (NCI) monitoring (see Section 3.3.4). This process includes checking the Malnutrition Universal Screening Tool (MUST) assessment which is a rapid, simple and general procedure commenced on first contact with the patient so that clear guidelines for action can be implemented and appropriate nutritional advice provided. The MUST has been designed to help identify adults who are underweight and at risk of malnutrition, as well as those who are obese. Locally, the tool has been in use at the Trust for a number of years. The NCI monitoring also includes checking the recording of fluid input and output of patients. The completion rates of each ward are fed back to the matrons and ward managers for action where necessary. Each ward and the whole Trust is RAG (Red/Amber/Green) rated. In 2012/13 a 'Green' was given for a 90 per cent or greater score, an 'Amber/Yellow' for 89-70 per cent scores and a 'Red' for scores of 69 per cent or less. Due to the overall improvement in scores across the board, for 2013/14 a 'Green' will be given for a 93 per cent or greater score, an 'Amber/Yellow' for 92-75 per cent scores and a 'Red' for scores 74 per cent or less.

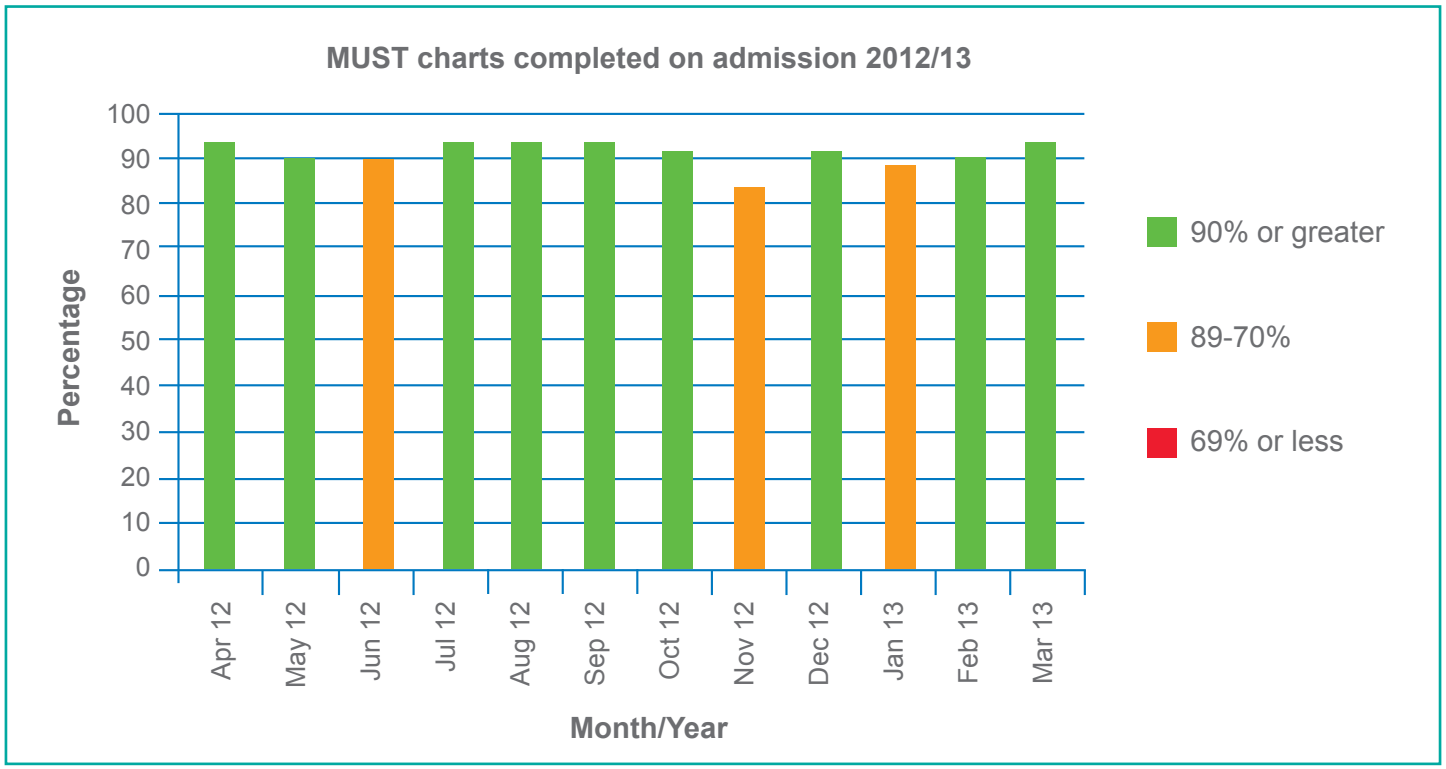
> "I have a physiotherapist who has helped me. I think their kindness and support is brilliant and they've shown me how to change my dressing and everything."

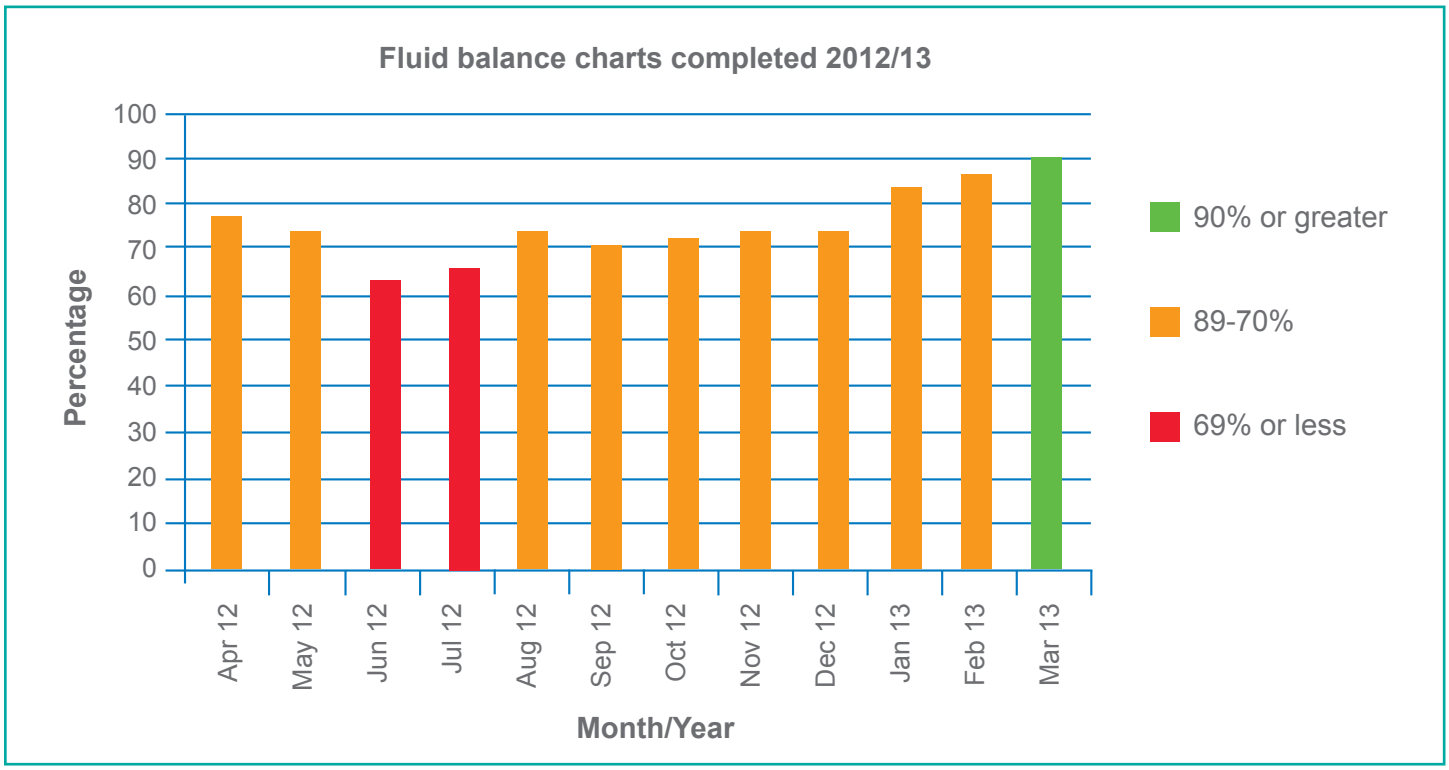
Developments that occurred in 2012/13

- Education sessions on MUST delivered in targeted areas.
- Screensaver developed to promote MUST screening on admission to Trust.
- Essence of Care link nurses re-enlisted.
- Fluid balance charts redesigned and introduced which now include lunch time evaluation requiring a qualified nurse's signature.
- Education package for fluid balance developed and delivered to all ward areas.
- Competency document for fluid balance developed for all staff to sign.
- New fluid balance criteria included in the Nursing Care Indicator (NCI) audit.
- Hand held bells now sounded 15 minutes before each mealtime to indicate the importance of the forthcoming mealtime, the need to get patients ready for the meal and to ensure the feeding of patients is a priority.
- Signs introduced behind every bed to indicate the nutritional needs of patients.
- Introduction of monthly mealtimes audits that include observations and the patient perspective.

Current status

The graphs below show the overall Trust results for 2012/13:





It can be seen that the target of having 90 per cent of patients being risk assessed for their nutritional status was achieved by September 2012. Since that date, there have been two monthly scores (November 2012 and January 2013) that have just dipped below the 90 per cent figure but for the whole of the six months the score has been on average over 90 per cent and so the target was achieved.

With regards to hydration, the 70 per cent completion of fluid balance charts was achieved in September 2012. Following an intensive campaign to improve this figure, it can be seen that the target of 90 per cent was achieved in March 2013.

New Priorities 4 and 5 for 2013/14

NUTRITION

Increase the number of patients who have a weekly risk re-assessment regarding their nutritional status.

Through the year on average at least 90 per cent of patients will have the weekly risk assessment completed and this will rise to at least 93 per cent by the end of the year (March 2014).

Increase the number of patients having a food recording chart and a fluid balance chart in place if the MUST score is one or above.

Through the year on average at least 90 per cent of patients will have the charts in place and this will rise to at least 93 per cent by the end of the year (March 2014).

HYDRATION

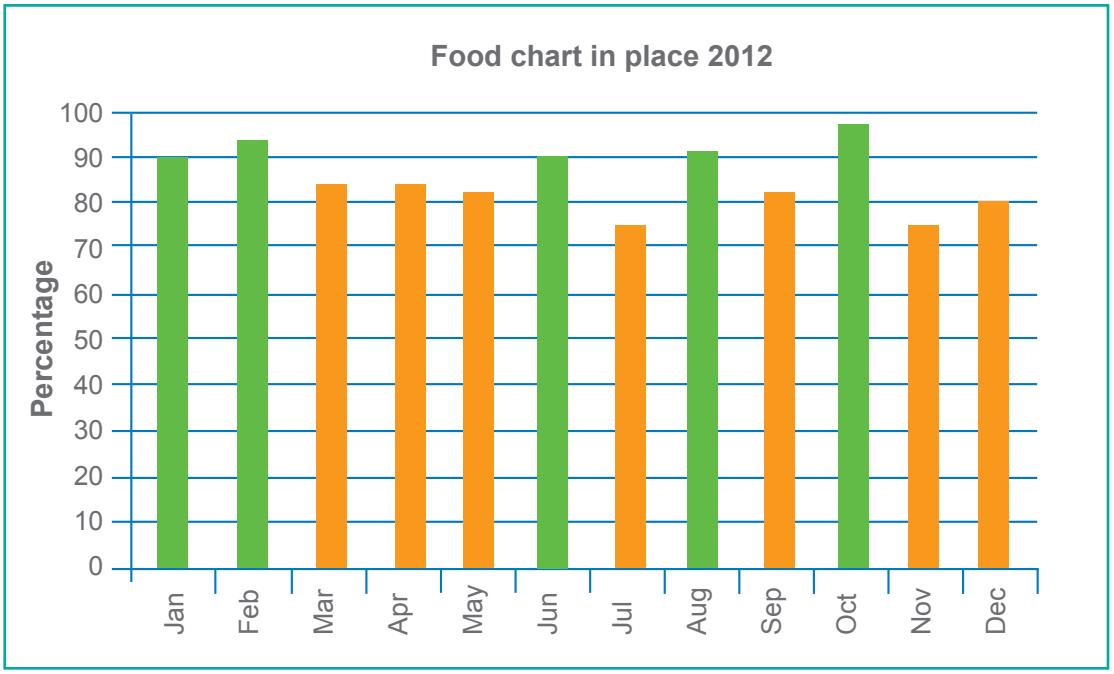
Increase the number of patients who have their fluid balance charts fully completed.

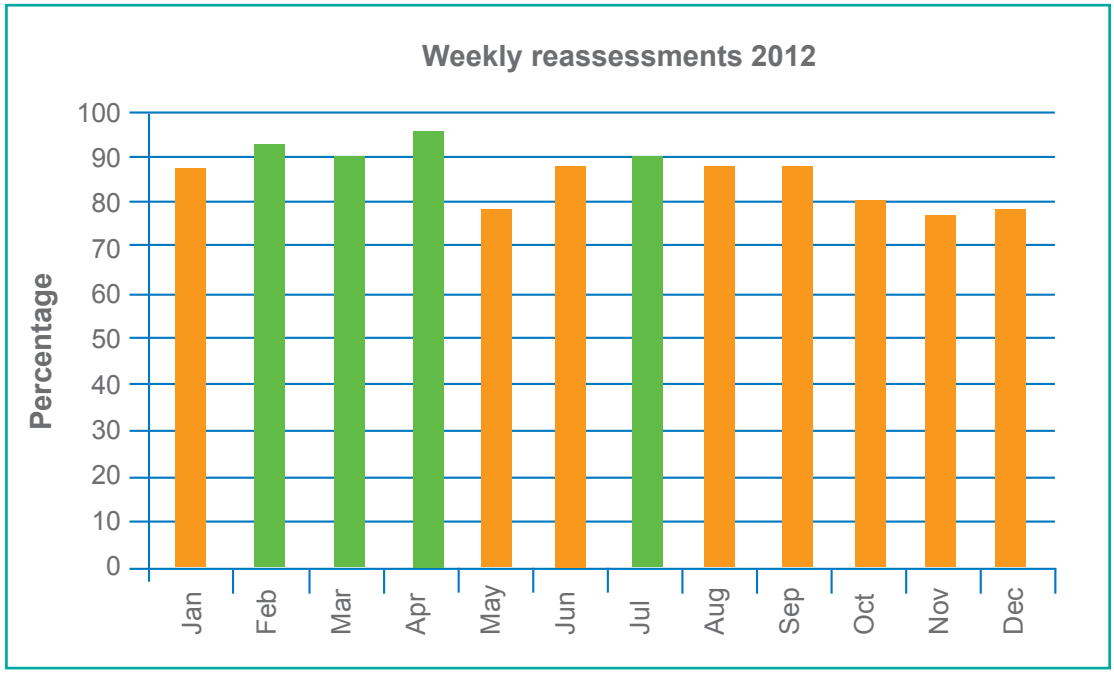
Through the year on average at least 90 per cent of patients will have their charts fully completed and this will rise to at least 93 per cent by the end of the year (March 2014).

Rationale for inclusion

- Poor nutrition and hydration leads to poor health, increased and prolonged hospital admissions and increased costs to the NHS. The consequences of poor nutrition and hydration are well documented and include increased risk of infection, poor skin integrity and delayed wound healing, decreased muscle strength, depression and, sadly, premature death. Put simply, poor nutrition and hydration causes harm.
- A number of national reports from Age UK, the CQC etc have questioned the state of practice on these topics across hospitals generally.

In 2012/13 we ensured that generally MUST assessments are completed within 24 hours of admission. This is a good starting point for effective nutritional care. It is important that these assessments are continued on a weekly basis to monitor that if deterioration occurs appropriate action is taken to counteract this when possible. In addition, the purpose of the MUST assessment is that standard actions (e.g. referral to a dietician) occur, dependant on the score obtained from the assessment. One of the standard actions is that food and fluid recording charts are commenced if the score is more than one. It is thought useful therefore to include these targets to ensure that monitoring continues after admission and to ensure that the correct actions are being taken following assessment. It can be seen from the charts below that considerable work is required to match the 90 and 93 per cent targets set for 2013/14.





> The food is OK and I get vegetarian meals as I had requested.

Dehydration has been shown to increase by two-fold the mortality of patients admitted to hospital with a stroke and to increase the length of hospital stay for patients with community acquired pneumonia. Improving hydration brings well-being and better quality of life for patients. It can allow reduced use of medication and can prevent illness. It is not only good healthcare and dietary practice, but also the right thing to do. For optimal hydration of the patient, the need for accurate recording of fluid input and output cannot be underestimated. Although the Trust made great progress in improving the monitoring of fluid balance in 2012/13, it is appreciated that good scores were only achieved at the end of the year and so it has been decided to continue to target a good performance throughout 2013/14.

Developments planned for 2013/14

- System of monthly mealtime audits to be reviewed to have a more robust system of ensuring appropriate action is taken dependent on the audit results.
- Introduce a more automated system of ensuring that patients and staff are forewarned about mealtimes rather than the use of hand bells.
- Explore the introduction of an e-learning package.
- Develop a strategy for ensuring the importance of nutrition/hydration is a priority issue by such means as further screensavers, articles in newsletters and other appropriate mechanisms.

Board Sponsor: Denise McMahon, Director of Nursing

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

> "I have had enough to eat and drink here and they help me when I need it."

2.2 Statements of Assurance from the Trust Board

2.2.1 Review of Services

During 2012/13 The Dudley Group NHS Foundation Trust provided and/or sub-contracted 59 relevant health services. The Trust has reviewed all the data available to them on the quality of care in all of these relevant health services. The income generated by the relevant health services reviewed in 2012/13 represents 99.4 per cent of the total income generated from the provision of relevant health services by The Dudley Group NHS Foundation Trust for 2012/13.

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 the second element of quality (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 GP Clinical Executive for Quality and Safety from Dudley Clinical Commissioning Group (CCG). These occur on an 18 month rolling programme, covering all services. Each service presents information from a variety of sources including: internal audits, national audits, peer review visits, as well as activity and outcome data such as readmission rates, day case rates and standardised mortality rates (see Sections 2.2.7 and 3.3.6 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 – monthly audits of key nursing interventions and their documentation. The results are published, monitored and reported to Trust Board monthly by the Director of Nursing.
- 'Productive' series, which is the part of our Transformation programme that looks at 'releasing time to care' by making time and productivity changes in theatres, the wards and the community. It results in clinical staff having more time directly with patients.
- Ongoing patient surveys that give a feel for our patients' experiences in real-time so that we can quickly identify and problems and correct them.
- 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 dashboard is essentially an online centre of vital information for staff.
- The Trust works with its local commissioners, scrutinising the Trust's quality of care at joint monthly Clinical Quality Review Meetings.
- The Trust monitors the Midlands and East NHS Acute Trust Quality Dashboard, comparing all the Trusts on a number of quality indicators, some of which are discussed in this report.
- External assessments, which included the following key ones this year:
    - Following a visit on site in June 2012 the Care Quality Commission (CQC) declared the Trust compliant with the regulated activity of terminations of pregnancy. In July 2012, it also reviewed the Trust following a previous inspection to check the progress being made on its cleanliness and infection control standard. It declared the Trust compliant with that standard also. In addition, the CQC undertook a routine unannounced visit in February 2013, and inspectors visited five wards and two departments. The results of that visit were that the Trust is compliant with the following six standards: care and welfare of people who use the services, meeting nutritional needs, management of medicines, supporting workers, assessing and monitoring the quality of service provision and complaints.
    - In July 2012, NHS Dudley undertook an unannounced visit to review our emergency services. An action plan was drawn up which included improving systems of monitoring staffing levels and listening to the concerns of staff, actions which all have been completed.
    - NHS Dudley continued its series of Appreciative Enquiry Visits by reviewing in October 2012 the arrangements for patients who had sustained falls. NHS Dudley staff, which included general practitioners, interviewed staff and visited wards and departments 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 addition, Clinical Pathology Accreditation (UK) Ltd, which is the authority which approves laboratories, visited the following departments: Clinical Biochemistry (Nov 2012), Haematology (December 2012) and Microbiology (December 2012). Action plans have been formulated prior to final approval and the Microbiology Department will be inspected further in July 2013. The Human Tissue Authority (HTA) inspected in March 2012 and the Trust was approved for the procurement and distribution of human tissues and cells. A Cancer Services peer review of the Upper Gastro-Intestinal Department was made (March 2012) and the one key recommended action was implemented. Similar reviews of Acute Oncology and Clinical Chemotherapy took place in March 2013 and results are awaited. With regards to education and training, the University of Birmingham College of Medical and Dental Sciences undertook a visit reviewing Foundation Year Training (November 2012) and West Midlands Postgraduate Medical Education and Training Deanery inspected the Ophthalmology (March 2013), Radiology (November 2012), Maxillofacial (November 2012) and Obstetrics/Gynaecology (March 2012) departments. NHS Quality Control North West assessed the Aseptic Preparation of Medicines (April 2012). Where recommendations were made, action plans have been put into place.

2.2.2 Participation in National Clinical Audits and Confidential Enquiries

During 2012/13, 41 national clinical audits and five national confidential enquiries covered relevant health services that the Trust provides. During that period the Trust participated in 100 per cent of the national clinical audits and 100 per cent of the national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that the Trust was eligible to participate in, actually participated in, and for which data collection was completed during 2012/13, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

Table 1. National clinical audits that the Trust was eligible to participate in, actually participated in during 2012/13 and the percentage of the number of registered cases submitted by the terms of the audit

Name of Audit	Type of Care	Audit Participation	Submitted %
ICNARC Case Mix Programme Database	Acute care	Yes	100%
National Joint Registry	Acute care	Yes	95%
CEM Renal Colic Audit 2012	Acute care	Yes	100%
Trauma Audit & Research Network Audit (TARN)	Acute care	Yes	85%
BTS Emergency Use of Oxygen Audit	Acute care	Yes	100%
BTS Community Acquired Pneumonia Audit	Acute care	Yes	In progress - ends 31.5.13
BTS Adult NIV Audit	Acute care	Yes	100%
NHS Blood & Transplant Potential Donor Audit	Blood & Transplant	Yes	100%
National Comparative Audit of Blood Transfusion - Audit of the use of Anti-D	Blood & Transplant	Yes	Delayed nationally
National Lung Cancer Audit (LUCADA)	Cancer	Yes	100%
National Bowel Cancer audit Programme (NBOCAP)	Cancer	Yes	100%
Head & Neck Cancer Audit (DAHNO)	Cancer	Yes	100%
National Oesophago-gastric Cancer Audit	Cancer	Yes	100%
ICNARC National Cardiac Arrest Audit	Heart	Yes	100%
VSSGBI National Vascular Database	Heart	Yes	99%
Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)	Heart	Yes	100%
National Heart Failure Audit	Heart	Yes	100%

Name of Audit	Type of Care	Audit Participation	Submitted %
Heart Rhythm Management (pacing/devices)	Heart	Yes	100%
RCPCH National Paediatric Diabetes Audit (NPDA)	Long term conditions	Yes	100%
National Diabetes Inpatient Audit (NaDIA) 2012	Long term conditions	Yes	100%
UK Inflammatory Bowel Disease Audit - biologics	Long term conditions	Yes	Currently 45% running until 2014
National Pain Audit	Long term conditions	Yes	100%
Renal Registry Renal Replacement Therapy Audit	Long term conditions	Yes	100%
BTS Adult Asthma Audit	Long term conditions	Yes	100%
BTS Bronchiectasis Audit	Long term conditions	Yes	100%
National Review of Asthma Deaths (NRAD)	Long term conditions	Yes	100%
National Carotid Interventions Audit	Older people	Yes	97%
National Hip Fracture Database	Older people	Yes	100%
National Parkinson's Audit 2012	Older people	Yes	100%
National Dementia Audit (NAD) 2012	Older people	Yes	100%
CEM Fractured NOF Audit 2012	Older people	Yes	100%
Sentinel Stroke National Audit Programme (SSNAP)	Older people	Yes	In progress – expected 100% May 10th
Hernia/Varicose veins/Hip replacement/Knee replacement	Other	Yes	92% - current published figures
(PICAnet) Paediatric intensive care	Women's & Children's health	Yes	Data collated centrally at BCH
(MBRRACE-UK) Perinatal Mortality	Women's & Children's health	Yes	100%
(NNAP) Neonatal intensive and special care	Women's & Children's health	Yes	100%
BTS Paediatric Pneumonia Audit	Women's & Children's health	Yes	100%
BTS Paediatric Asthma Audit	Women's & Children's health	Yes	100%
RCPCH National Childhood Epilepsy 12 Audit	Women's & Children's health	Yes	Delayed Nationally
RCPCH Child Health (CHR-UK)	Women's & Children's health	Yes	100%
CEM Fever in Children Audit 2012	Women's & Children's health	Yes	100%

Table 2. National confidential enquiries that the Trust was eligible to participate in, actually participated in during 2012/13 and the percentage of the number of registered cases required by the terms of the enquiry.

Name of Enquiry	Type of Care	Audit Participation	Submitted %
Time to Intervene	NCEPOD	Yes	Complete
Bariatric Surgery Study	NCEPOD	Yes	Organisational data only
Alcohol Related Liver Disease Study	NCEPOD	Yes	Complete
Subarachnoid Haemorrhage Study	NCEPOD	Yes	Complete
Tracheostomy Related Complications	NCEPOD	Yes	In progress - Organisational data submitted
Death Following Lower Limb Amputation	NCEPOD	Yes	In progress

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

Table 3. Additional National Clinical Audits that the Trust is participating in during 2012/13.

Name of Audit	Type of Care	Audit Participation	Submitted %
National Audit Project (NAP5) Accidental Awareness During General Anaesthesia	Anaesthetics	Yes	In progress - ends 31.5.13
National Obstetric Anaesthetic Database (NOAD) Anaesthetics	Anaesthetics	Yes	100%
Audit of Blood Sampling and Labelling	Haematology	Yes	Complete
National Insulin Pump Audit	Diabetes & Endocrinology	Yes	100%

> They are very, very good. I get great care 24/7. The nurses are wonderful
> They showed me how to give myself pain relief and told me all about it.
> I just have to push the button and I get what I want.

The reports of 10 national clinical audits were reviewed in 2012/13 and the Trust has taken or intends to take the following actions to improve the quality of healthcare provided:

ICNARC Case Mix Programme Audit

The 2011/12 National ICNARC Case Mix programme report was reviewed. No specific actions were identified from this report as the Trust's practice, as captured in the well-validated audit, is shown as very good. Ongoing changes in practice reflect the critical care unit's continued efforts to stay abreast of best practice as recommended from other sources.

ICNARC National Cardiac Arrest (NCAA) Audit

The audit results show the Trust has maintained the level of cardiac arrest calls without any significant increase in the survival to discharge rates. The Trust continually looks at reducing events further.

National Heart Failure Audit

- Introduction of a new Trust Heart Failure Service
- Employment of new senior Heart Failure nurse
- Outreach to all patients with heart failure in the Trust, especially those that are being cared for by general physicians
- Improvement in the number of heart failure patients referred to the Community Heart Failure Team on discharge

National Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP) Audit

Prescribing for secondary prevention medication is currently at a high level (less than 90 per cent), but slightly lower than the national average so there is a need for the Trust to see whether there is accurate exclusion of all patients with clinical contra-indications from the analysis. It was also identified that coronary angiography rates appear to be lower than the national average. Actions include:

- To educate nurses regarding appropriate coding of medications
- To discuss coronary angiography rates at future QPDT meeting
- To improve communication of findings

BTS Emergency Oxygen Audit

The audit identified that there needs to be changes in the way oxygen prescriptions are recorded; therefore, commencing in May 2013, there will be a pilot of a new system of oxygen prescribing for all patients on Ward C5.

BTS Community Acquired Pneumonia (CAP) Audit

The audit showed low antibiotic compliance with guidelines; therefore, actions have been implemented to improve adherence to the guidelines.

BTS COPD Discharge Audit

Actions include:

- All patients to be assessed for pulmonary rehabilitation
- All patients to have an emergency pack at discharge

BTS Non Invasive Ventilation (NIV) Audit

Actions include:

- Clear indications for the initiation of NIV have been attached to all portable NIV machines

National Bowel Cancer (NBOCAP) Audit

The National Bowel Cancer (NBOCAP) Audit was reviewed and previous weaknesses in the data collection were highlighted. These are to be addressed by involving clinicians more closely, and quarterly meetings are to be introduced to analyse data prior to submission.

National Diabetes Inpatient Audit (NaDIA)

The audit shows that overall there is evidence of continuing improvements in diabetes care across the Trust and nationally the Trust ranks highly on the majority of outcomes. This can be attributed to the impact of the Front Door Diabetes Team and the protocols developed in the Trust as part of the Think Glucose project. The impact that a new systematic approach to skin assessment and management and the Diabetes Foot Team has had on screening and management of diabetic foot disease is also very dramatic. Further work is required to improve on care planning and choice of meals.

Local Clinical Audit

The reports from 25 completed local clinical audits were reviewed in 2012/13 and the Trust has taken, or intends to take, the following actions to improve the quality of healthcare provided:

- Design and construction of an e-learning module on critical incidents and risk reporting
- Introduction of a more comprehensive discharge plan for older and vulnerable patients following elective orthopaedic procedures
- Introduction of hypo boxes for all diabetic patients
- A change of Trust guidance to the use of Novorapid instead of Actrapid in the management of hyperglycaemia in adults with diabetes mellitus
- All doctors and pharmacists to complete the 'Safe use of Insulin' e-learning training module
- All patients undergoing bowel surgery for malignancy not having anti-thrombotic therapy to receive 28 days of enoxaparin post operatively
- Introduction of a new section in the Surgical Assessment Unit (SAU) clerking sheets to include Best Medical Therapy (BMT) checklist
- Introduction of a standardised format for pre and post operative clinical documentation for Pterygium Surgery
- Further develop the Emergency Department (ED) electronic patient record to promote better use of the electronic sedation record
- Introduction of formal training in sedation technique by anaesthetists
- Refinement of the existing proforma for improved documentation of the Non Invasive Ventilation (NIV) pathway
- Development of a generic PowerPoint presentation on Do Not Attempt Resuscitation (DNAR) and Medical Emergency Team (MET) status for junior doctor induction training
- Deliver supplementary NIV teaching sessions for improved recognition of patients unsuitable for NIV
- Introduction of appointments for investigations (e.g. visual fields tests) before consultation with the doctor
- Follow up appointment dates to be issued on the day of the procedure for Ozurdex Injection in patients with Macular Oedema
- Introduction of a yellow card (for easier recognition) with clinic contact telephone numbers
- Ensure improved pain relief is prescribed 30 minutes before Ozurdex Injection Procedure
- Initiation of testing of Procollegen III for the screening for significant liver disease, as there is good evidence that this substantially reduces the number of patients requiring liver biopsy
- Development of a local guideline and implementation of epilepsy teaching sessions for relevant junior doctors
- Formal CTG training introduced by the obstetrician to anaesthetists
- Sign up to phase two of the Transform Programme developed by the National End of Life Care Programme

> Staff are cheerful and help you if you need it.
> They always check to see if I am okay.

2.2.3 Research and Development

The number of patients receiving relevant health services provided or sub-contracted by the Trust in 2012/13 that were recruited during that period to participate in research approved by a research ethics committee was 2591. We were able to recruit 7.1 per cent to commercial studies. This represents an increase in annual recruitment of over 100 per cent compared to 2011/12.

The Dermatology Department has joined cancer, cardiology and musculoskeletal medicine as a research active specialty by taking part in several large multicentre studies during 2012/13, both academic and commercial studies. This success continues to be due to the services of a research nurse employed by the Birmingham & Black Country Comprehensive Local Research Network (BBC CLRN) and the Clinical Research Unit's laboratory facilities. Diabetes and neurology have also started to recruit to academic clinical studies.

The Trust hosts three research fellows, one funded by Arthritis Research UK, another funded by BBC CLRN and one funded by the Trust. Rheumatology staff have submitted three grant applications.

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

- Further use of targeted Systemic Anti-Cancer Therapies, which have less associated toxicity and improved efficacy
- Switching of some Systemic Anti-Cancer Therapies, which were previously given intravenously, to being given subcutaneously which leads to swifter administration (an advantage for patients and staff alike) and a lower side-effect profile
- More targeted use of prophylactic medications to prevent infection

Trust publications, including conference posters, increased to 120 during the calendar year 2012, the largest contribution coming from the Rheumatology Department.

2.2.4 Commissioning for Quality and Innovation Payment (CQUIN) Framework

A proportion of the Trust's income in 2012/13 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 relevant health services, through the Commissioning for Quality and Innovation payment framework. Further details of the agreed goals for 2012/13 and for the following 12 month period are available online at:
https://commissioning.supply2health.nhs.uk/eContracts/Documents/cquin-guidance.pdf

CQUIN is a quality increment that applies over and above the standard contract. The sum is variable based on 2.5 per cent of our activity outturn and conditional on achieving quality improvement and innovation goals. The estimated value in 2012/13 was £6.5m as part of our contracts with PCTs for acute and community services, and with specialised services commissioners. We have not yet agreed the final settlement figure for 2012/13 as some targets are still contingent upon outstanding information. However, for the purpose of the year end accounts, we have assumed 90 per cent achievement of both the PCT and specialised services schemes. This would equate to approx £5.8m. In 2011/12 the payment was £3.56m.

There is one CQUIN scheme per contract, made up of several goals. Goals for venous-thromboembolism, responsiveness to personal needs, dementia and NHS Safety Thermometer are nationally determined, and the remainder are locally agreed. We have rated last year's CQUINS on a red/amber/green basis dependent on achievement to date. We will fall short of meeting the five goals for patient experience, dementia screening, smoking and alcohol, making every contact count and peritoneal dialysis, and we have actions in place to ensure the quality of care in these areas is improved.

Acute

Goal No.	Targets and topics	Quality domain(s) and RAG rating
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 Diagnosis	Safety/Effectiveness
4	NHS Safety Thermometer	Patient Experience/Safety/Effectiveness
5	Medicines Management – Antimicrobial Stewardship	Safety/Effectiveness
6	Alcohol and Smoking	Effectiveness

Community

Goal No.	Targets and topics	Quality domain(s) and RAG rating
1	Improve responsiveness to personal needs of patients	Patient Experience
2	NHS Safety Thermometer	Patient Experience/Safety/Effectiveness
3	Tissue Viability – Pressure Ulcers	Safety/Effectiveness
4	Virtual Ward	Safety/Effectiveness
5	Making Every Contact Count	Effectiveness

Specialist services

Goal No.	Targets and topics	Quality domain(s) and RAG rating
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 Diagnosis	Safety/Effectiveness
4	NHS Safety Thermometer	Patient Experience/Safety/Effectiveness
5	Clinical Dashboards	Safety/Effectiveness
6	Renal Dialysis – Peritoneal Dialysis Therapyy	Effectiveness Patient/Experience
7	Renal Dialysis – Home Haemodialysis Therapy	Effectiveness Patient/Experience
8	Neonates – Pathway for Therapeutic Hypothermia	Safety/Effectiveness
9	Neonates – Discharge Planning	Effectiveness

> They are very helpful and friendly staff
> and they make sure my bell is there. I feel respected.

CQUINS report 2013/14

In 2013/14 the amount the Trust will be able to earn is 2.5 per cent on top of the actual outturn value. The estimated value of this is £6.13m. The nationally mandated CQUIN goals for venous-thromboembolism, dementia screening and the NHS Safety Thermometer will continue and in addition there will be three indicators within the Friends and Family Test.

Acute and community

Goal No.	Targets and topics	Quality domain(s)
1	Friends and Family Test (3 parts)	Patient Experience
2	NHS Safety Thermometer – Pressure Ulcers	Patient Experience/Safety/Effectiveness
3	Dementia screening, risk assessment and referral for specialist services (3 parts)	Safety/Effectiveness/Patient Experience
4	VTE Risk Assessment (2 parts)	Safety
5	Safe and Timely Discharge	Effectiveness
6	Patient Safety Culture	Safety
7	Patient Experience for Learning Disability Patients	Patient Experience
8	Reduction in Fractures as a result of falls	Safety
9	Letters returning to the referring clinician	Effectiveness
10	Choose and Book	Effectiveness
11	Senior Clinician Review	Effectiveness

Specialist services

Goal No.	Targets and topics	Quality domain(s)
1	Friends and Family Test (3 parts)	Patient Experience
2	NHS Safety Thermometer – Pressure Ulcers	Patient Experience/Safety/Effectiveness
3	Dementia screening, risk assessment and referral for specialist services (3 parts)	Safety/Effectiveness/Patient Experience
4	VTE Risk Assessment (2 parts)	Safety
5	Quality Dashboards	Safety/Effectiveness/Innovation
6	Renal dialysis – Renal Patient View	Effectiveness/Innovation/Patient Experience
7	HIV – registration and communication with GPs	Safety/Effectiveness
8	Neonatal Intensive Care – Improved access to breast milk; timely discharge; retinopathy of prematurity	Safety/Effectiveness/Patient Experience

2.2.5 Care Quality Commission (CQC) Registration and Reviews (see also Section 2.2.1)

The Dudley Group NHS Foundation 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 September 2011 visit to review our compliance against the 16 Essential Standards of Quality and Safety set out by the CQC, we submitted an action plan to the CQC for one of the standards. The CQC revisited the Trust in July 2012 to review the progress of the required actions and as these were all complete we were found to be compliant. In addition, the CQC made a further unannounced visit in February 2013 and, again, we were found to be compliant with the standards.

2.2.6 Quality of Data

The Trust submitted records during 2012/13 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:

- 99.7 per cent for admitted patient care; national average was 99.1 per cent
- 99.9 per cent for outpatient care; national average was 99.3 per cent
- 99.1 per cent for accident and emergency care; national average was 94.9 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 99.9 per cent
- 100 per cent for accident and emergency care; national average was 99.7 per cent

The Trust's Information Governance Assessment Report overall score for 2012/13 was 78 per cent and was graded 'Green'.

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

Accident and Emergency
Investigations: 8.4 per cent Treatments: 15.9 per cent

Paediatric Emergency
Primary Diagnosis: 10 per cent Secondary Diagnosis: 7.4 per cent Primary Procedure: 0 per cent
Secondary Procedure: 0 per cent

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

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

- Crib sheets have been produced to remind reception staff to thoroughly check patient demographic details
- Manual processes have been reviewed and standardised for the input of documents into patient case notes/hand held notes and for ensuring postal addresses are accurate, complete and checked against the hospital main computer system if previously using stand alone systems
- A review of training has taken place so face to face sessions as well as computer based training are now organised

2.2.7 Core Set of Quality Indicators

This is the first year that all Trusts have been mandated to include this section which includes a stipulated number of measures. Due to the time it takes central bodies to collate and publish some of the data, not all of it is up to date and sometimes comparative figures are not available at all (N/A). It should also be appreciated that some of the 'Highest' and 'Lowest' performing trusts on some of the data may not be directly comparable to an acute general hospital e.g. specialist eye or orthopaedic hospitals that have very specific patient groups.

MORTALITY			
Topic and detailed indicators	**Immediate Reporting Period: Oct 2011- Sept 2012**	**Previous Reporting Period: July 2011-June 2012**	**Statements**
Summary Hospital-level Mortality Indicator (SHMI) value and banding	*Value* Trust: 1.042 National Av: 1 Highest: 1.21 Lowest: 0.68 *Banding* Trust: 2 Average: 2 Highest: 1 Lowest: 3	*Value* Trust: 1.036 National Av: 1 Highest: 1.26 Lowest: 0.71 Banding Trust: 2 Average: 2 Highest: 1 Lowest: 3	The Trust considers that this data is as described for the following reasons: -The Trust acknowledges that its SHMI is within the expected range. The Trust has taken the following action to improve this indicator and so the quality of its services by: -Monitoring our hospital deaths in detail and thoroughly investigating each case.
Percentage of admitted patients whose treatment included palliative care	Trust: 1.1% National Av: 1.07% Highest: 3.2% Lowest: 0%	Trust: 0.9% National Av: 1.0% Highest: 3.3% Lowest: 0%	The Trust considers that this data is as described for the following reasons: -The Trust acknowledges that these percentages are within the expected range. The Trust has taken the following actions to improve these percentages, and so the quality of its services by: -Working closely with the specialist palliative care team. -Improving access to the expertise of the palliative care team and recording their input accurately.
Percentage of admitted patients whose deaths were included in the SHMI and whose treatment included palliative care (Context indicator)	Trust: 25.1% National Av: 19.2% Highest: 43.3% Lowest: 0.2%	Trust: 21.65% National Av: 18.4% Highest: 46.3% Lowest: 0.3%	

PROMS – PATIENT REPORTED OUTCOME MEASURES			
Topic and detailed indicators	**Immediate Reporting Period: 2011/12 Provisional**	**Previous Reporting Period: 2010/11 Finalised**	**Statements**
Groin Hernia Surgery (Adjusted Health Gain)	Trust: 0.046 National Av: 0.087 Highest: 0.143 Lowest: -0.002	Trust: 0.069 National Av: 0.085 Highest: 0.156 Lowest:-0.020	The Trust considers that this data is as described for the following reasons: -The Trust acknowledges the results vary across the four procedures; for Groin Hernia surgery it is below average, for Varicose Vein surgery it is above average and for Hip and Knee replacements it is in the region of the national average. With regards to Groin Hernia we have noted that 94% of patients said that their problems are better now when compared to before the operation and 87% of patients describe the results of their operation as excellent, very good or good. The Trust has taken the following actions to improve these scores, and so the quality of its services by: -The Trust regularly monitors and audits the pre- and postoperative healthcare of all patients. Surgical operative outcomes are consistently of high quality and safety, with excellent patient satisfaction for these procedures. The health gains that PROMs measure are of a more generic nature and are not exclusively linked to secondary healthcare provision and will need the consideration of a health economy-wide group to influence, comprising GPs, community services, social services, welfare benefit services and Public Health.
Varicose Vein Surgery (Adjusted Health Gain)	Trust: 0.123 National Av: 0.094 Highest: 0.167 Lowest: 0.047	Trust: 0.097 National Av: 0.091 Highest: 0.155 Lowest: -0.007	
Hip Replacement Surgery (Adjusted Health Gain)	Trust: 0.398 National Av: 0.416 Highest: 0.532 Lowest: 0.306	Trust: 0.381 National Av: 0.405 Highest: 0.503 Lowest: 0.264	
Knee Replacement Surgery (Adjusted Health Gain)	Trust: 0.302 National Av: 0.313 Highest: 0.385 Lowest: 0.180	Trust: 0.311 National Av: 0.299 Highest: 0.407 Lowest: 0.176	

READMISSIONS			
Topic and detailed indicators	**Immediate Reporting Period: 2010/11**	**Previous Reporting Period: 2009/10**	**Statements**
Percentage readmitted within 28 days Ages 0-14	Trust: 9.34% National Av: 10.15% Highest: N/A Lowest: N/A	Trust: 8.88% National Av: 10.18% Highest: N/A Lowest: N/A	The Trust considers that this data is as described for the following reasons: -Since the national published figures (across) are considerably historical, we have looked at our recent data and in 2012/13 the overall Trust average for all ages groups is 6.2% which compares to our peer group of similar hospitals of 6% (from CHKS). -The Trust is in the top 10% of Trusts within the Midlands & East SHA cluster for low readmissions to the same specialty. The Trust intends to take the following actions to reduce this percentage, and so the quality of its services by: -Continuing to develop its Paediatric Assessment Unit service. Rapid senior assessment for potential paediatric emergency admissions is undertaken and the principle of more senior and rapid assessment, will reduce admissions and readmissions -Continuing to expand and develop the Acute Medicine and Acute Surgery service by employing more senior decision makers in the initial assessment units, for longer, some unnecessary/avoidable admissions are prevented -Continuing to develop the community virtual ward service. More proactive, risk based management of virtual ward patients is already having an effect on avoidable admission reduction -Working with CCG and primary care practitioners to improve the medical and nursing support to local nursing homes. The Local Enhanced Services for nursing homes and Emergency Nursing Practictioner service will work to appropriately manage “frequent attenders” and avoid hospital admission and readmission -A flag is being developed in our patient administration system to identify patients who are at risk of being readmitted to aid staff decision making about alternative care pathways and care settings
Percentage readmitted within 28 days Ages 15 and over	Trust: 11.55% National Av: 11.42% Highest: N/A Lowest: N/A	Trust: 10.94% National Av: 11.16% Highest: N/A Lowest: N/A	

RESPONSIVENESS TO INPATIENTS' PERSONAL NEEDS			
Topic and detailed indicators	**Immediate Reporting Period: 2012**	**Previous Reporting Period: 2011**	**Statements**
Average score (out of 100) from the five patient experience questions included in the national patient experience CQUIN	Trust: 64.9 National Av: 68.1 Highest: 84.4 Lowest: 57.4	Trust: 63.8 National Av: 67.4 Highest: 85 Lowest: 56.5	The Trust considers that this data is as described for the following reasons: -The Trust notes that is only slightly lower than the national average. The Trust intends to take/has taken the following actions to improve this score, and so the quality of its services by: -Asking these same five questions as part of our real-time surveys to enable results to be attributed to and acted upon at ward level. During 2012/13 more than 3000 patients have given us their feedback via our real-time surveys.

STAFF VIEWS			
Topic and detailed indicators	**Immediate Reporting Period: 2012**	**Previous Reporting Period: 2011**	**Statements**
Percentage of staff who would recommend the Trust to friends or family needing care (Acute Trusts)	Trust: 61% National Av: 60% Highest: 86% Lowest: 35%	Trust: 67% National Av: 62% Highest: 89% Lowest: 33%	The Trust considers that this data is as described for the following reasons: -Whilst there is a small decline compared to the results of the 2011 survey, the latest score of 61% is in line with the national average for Acute Trusts. The Trust intends to take/has taken the following actions to improve this percentage score, and so the quality of its services by: -Commencing focus groups led by Executive Directors following the publication of the staff survey results at which staff are asked about areas of engagement. -Making sure the breakdown of directorate results are made available for directorate leads and line managers. -Involving and communicating with staff through adopting the Listening into Action programme which has covered a wide range of topics.

VENOUS THROMBOEMBOLISM (VTE)			
Topic and detailed indicators	**Immediate Reporting Period: Q3 Oct-Dec 2012**	**Previous Reporting Period: Q2 Jul-Sep 2012**	**Statements**
Percentage of admitted patients risk-assessed for Venous Thromboembolism	Trust: 94.8% National Av: 94.2% Highest: 100% Lowest: 83.3%	Trust: 95.9% National Av: 93.9% Highest: 100% Lowest: 80.9%	The Trust considers that this data is as described for the following reasons: -The Trust is pleased to note that it is above the national average in undertaking these risk assessments due to, in particular, the work of a dedicated specialist nursing team and the promotional work they undertake on this important topic. The Trust intends to take the following actions to improve this percentage, and so the quality of its services by: -Continuing the educational sessions with each junior doctor intake -Continuing with a variety of promotional activities to staff and patients -Implementing the use of technology to assist in the recording of the risk assessments

INFECTION CONTROL			
Topic and detailed indicators	**Immediate Reporting Period: 2011/12**	**Previous Reporting Period: 2010/11**	**Statements**
The rate of Clostridium difficile per 100,000 bed days amongst patients aged two or over	Trust: 44.8% National Av: 21.8% Highest: 51.6% Lowest: 0	Trust: 32.1% National Av: 29.6% Highest: 71.8% Lowest: 0	The Trust considers that this data is as described for the following reasons: -The Trust acknowledges it needs to improve its rate and has done so this year (2012/13) (please see Section 2.1.3 which shows a reduction by more than 50% from 2011/12). The Trust intends to take/has taken the following actions to improve this rate, and so the quality of its services by: -Reviewing in detail all cases to see what lessons can be learned to prevent further cases -Further promoting effective antimicrobial prescribing -Introducing more intensive cleaning methods and expanding their use -Improving the guidance to clinicians on the prevention and treatment of C.diff

CLINICAL INCIDENTS			
Topic and detailed indicators	**Immediate Reporting Period: Apr 12 – Sep 12**	**Previous Reporting Period: Oct 11 – Mar 12**	**Statements**
Rate of patient safety incidents (incidents reported per 100 admissions compared to 49 medium acute Trusts)	Trust: 7.5 Average: 6.7 Highest: 14.3 Lowest: 3	Trust: 8.1 Average: 6.7 Highest: 10.2 Lowest: 2.1	The Trust considers that this data is as described for the following reasons: -As organisations that report more incidents usually have a better and more effective safety culture, the Trust is pleased to note it has higher than average reporting rates. The Trust has taken the following actions to improve this rate, and so the quality of its services by: -Continual raising of awareness of what constitutes as an incident and how to report. -Continual improvement of quality investigations and learning. -Reviewing the severity coding of all incidents to ensure accuracy and consistency of reporting. -Ensuring actions are taken to reduce any repetition of similar incidents.
Percentage of patient safety incidents resulting in severe harm or death	Trust: 1% National Av: 0.8%	Trust: 1.2% National Av: 0.8%	

Patient safety incidents resulting in severe harm or death

This year is the first time that this indicator has been required to be included within the Quality Report alongside comparative data provided, where possible, from the Health and Social Care Information Centre. The National Reporting and Learning Service (NRLS) was established in 2003. The system enables patient safety incident reports to be submitted to a national database on a voluntary basis designed to promote learning. It is mandatory for NHS trusts in England to report all serious patient safety incidents to the Care Quality Commission as part of the Care Quality Commission registration process. To avoid duplication of reporting, all incidents resulting in death or severe harm should be reported to the NRLS who then report them to the Care Quality Commission. Although it is not mandatory, it is common practice for NHS Trusts to report patient safety incidents under the NRLS's voluntary arrangements.

As there is not a nationally established and regulated approach to reporting and categorising patient safety incidents, different trusts may choose to apply different approaches and guidance to reporting, categorisation and validation of patient safety incidents. The approach taken to determine the classification of each incident, such as those 'resulting in severe harm or death', will often rely on clinical judgement. This judgement may, acceptably, differ between professionals. In addition, the classification of the impact of an incident may be subject to a potentially lengthy investigation which may result in the classification being changed. This change may not be reported externally and the data held by a trust may not be the same as that held by the NRLS. Therefore, it may be difficult to explain the differences between the data reported by the trusts as this may not be comparable.

> I felt comfortable complaining.
> I told them what they did wrong and they got better.

PART 3 OTHER QUALITY INFORMATION

3.1 Introduction

The Trust has a number of different Key Performance Indicators (KPI) reports which are available and used by a wide variety of staff groups monitoring quality on a day-to-day basis. The main repository for the reporting of the Trust's key performance measures is a web based dashboard, which is available to all senior managers and clinicians and currently contains over 130 measures, grouped under the headings of Quality, Performance, Workforce and Finance. In addition, constant monitoring of a variety of aspects of the quality of care include weekly reports being sent to senior managers and clinicians which include the A&E, Referral to Treatment, Stroke and Cancer targets. Monthly reports are also sent to all wards, which include a breakdown of performance by ward based on Nursing Care Indicators, ward utilisation, adverse incidents, governance and workforce indicators and patient experience scores.

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 benchmark 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 fourth 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.

PATIENT EXPERIENCE

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

3.2.1 Introduction

This section includes the various methods of gaining a picture of patients' views of the Trust and examples of changes made based on those views.

3.2.2 Trust-wide Initiatives

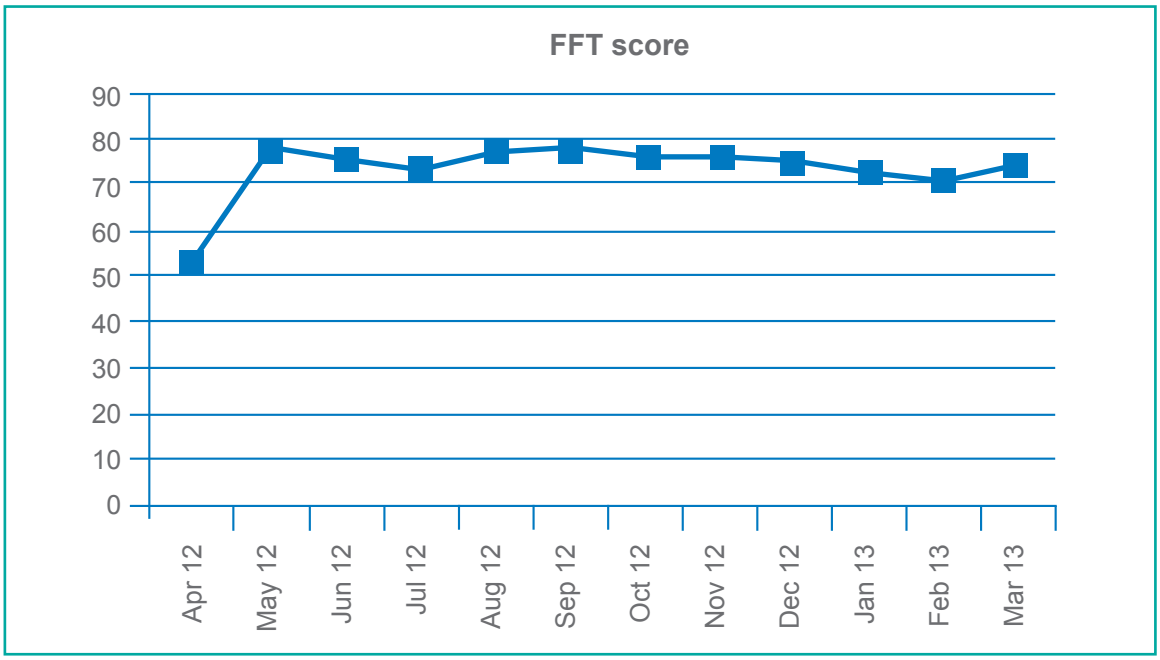
a) Friends and Family Test

We have been running the Friends and Family Test (FFT) on our wards since April 2012, asking all inpatients when leaving the ward whether they would recommend the service they had received to a friend or family member in their hour of need. Patients were asked to rate us on a scale of 0-10 and offer suggestions where they think improvements could be made.

"How likely are you to recommend our service to friends and family if they needed similar care or treatment?"

Average FFT score for 2012/13	Average % of patients completing the FFT
73	21%

Actual monthly FFT score 2012/13



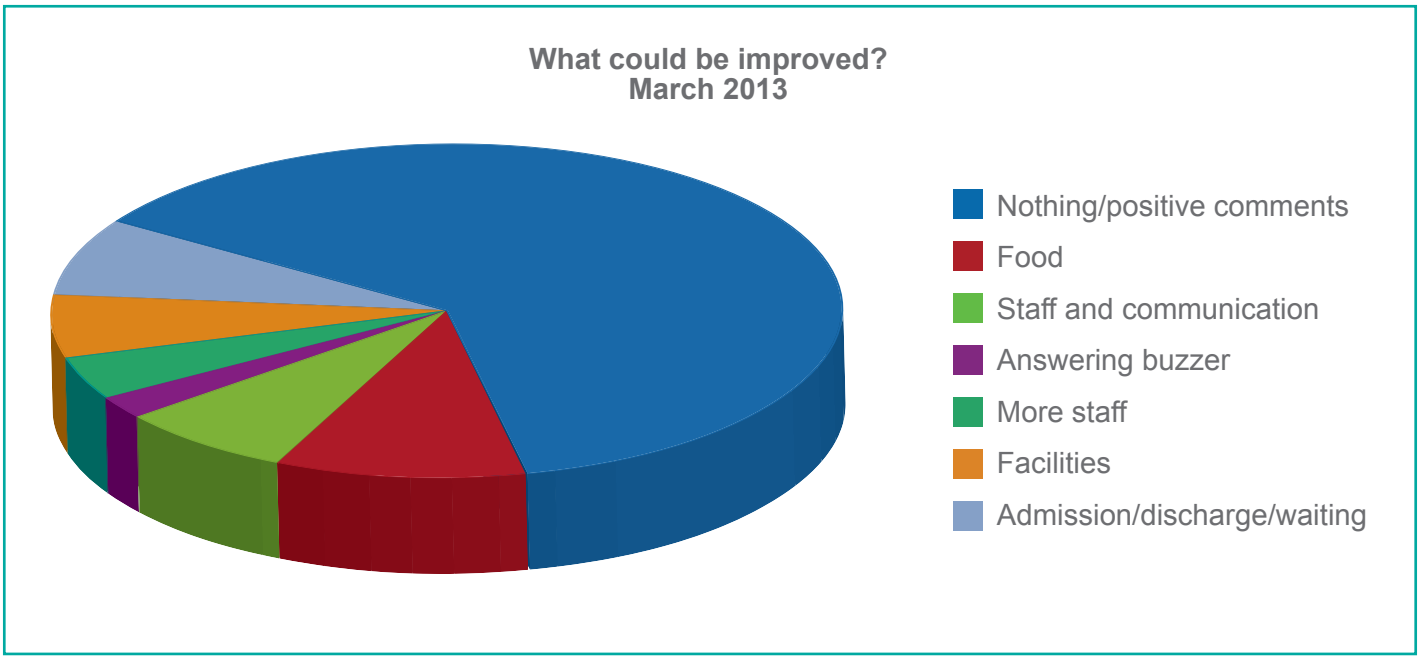
We are pleased that patients have been rating our services highly with scores mainly in the 70s, and we are using their comments to make improvements.

What have patients told us so far?

Around 70 per cent of the comments we have received from patients completing the Friends and Family Test are positive. It is really great for our staff to hear such positive feedback to know that they are providing a good service.

However, there is always room for improvement and the chart below shows the most requested items for improvement during March 2013, food is a common response from an average of 14 per cent of patients during the year (12 per cent in the chart below for March).

All feedback from patients is shared with the wards to help them to make improvements locally, as well as bigger issues being tackled on a Trust-wide basis.



From April 2013 all UK hospitals will be using the Friends and Family Test for inpatients and those patients who have visited A&E as part of a national roll out programme. Patients will be invited to respond to FFT question by choosing one of six options, ranging from 'extremely likely' to 'extremely unlikely' (for 2012/13 we used a 0-10 scale).

The Friends and Family Test is one way we gather patient feedback to help us drive improvements in services.

b) Real-time surveys

During 2012/13 our real-time surveys have gone from strength to strength gaining important feedback from patients in a timely manner. This allows us to react quickly to any issues and to use patient views in our service improvement planning.

An example of surveys undertaken during the year are shown below, these range from large-scale Trust-wide surveys to smaller departmental surveys:

Survey	Responses
Inpatient survey	3069
Discharge survey	780
Outpatient survey	529
Eye Clinic survey	37
Maternity environment survey	67

c) Patient stories

We have continued using patient stories during 2012/13 to enable the patient voice to be heard at the highest level. Stories have been heard at Board meetings and used for service development planning and training purposes.

d) Community volunteers – making our patients smile

During 2012/13 the Trust has worked with the Kissing it Better charity to invite community volunteers and groups into the hospital to entertain our patients. Entertainment has included:

- Gospel singers
- Face painting, hand massage, manicures and make up from Dudley College beauty students
- Regular visits from Buster the dog (and his owner Anthea) from Pets as Therapy

It is a pleasure to see the reaction of patients and staff to these activities; smiles, tears of joy and happiness, laughter and conversation. Priceless! We cannot thank the volunteers enough for their time and effort given to brighten our patients' days.

These activities have been so successful that we plan to develop this initiative during 2013/14.

e) I am the patient experience video

We also wanted to express to staff how each and every one of them contributes to a good experience for our patients. With staff from a variety of roles we produced a motivating and uplifting video to promote good patient experience and raise awareness of the Trust's vision "Where People Matter".

The video can be viewed on our website www.dudleygroup.nhs.uk

Examples of actions taken as a result of patient feedback

Inpatient mealtimes

Following patient feedback from our surveys, patient panel and also our Friends and Family Test, we have been reviewing the way we deliver our inpatient meal service.

In January 2013 we visited the supplier of an alternative food system called 'Steamplicity'. Following this we have run a Steamplicity trial on one of our wards. We have also held taste tests for our Governors, patient panel members and also for staff to sample the food.

We are gathering as much feedback as possible to help us in our decision-making process around how we can improve our mealtime service.

Accessibility

Feedback from patients has also informed us that we could make improvements around accessibility. With patients' help we have drawn up an action plan and have, so far, ordered 30 more wheelchairs for main reception at Russells Hall Hospital and worked on our hearing loops system (including a number of portable hearing loops that departments can access as and when needed).

Information

Patients told us that they didn't always receive enough information about the ward they were staying on. During the year our 'Welcome to the Ward' booklets were launched giving useful information to patients and relatives relating to visiting and meal times, contact numbers and general ward routines.

3.2.3 National Survey Results

In 2012 we took part in two national patient surveys, one for inpatients and one for Accident and Emergency patients. The Trust chose Picker Institute Europe as our independent survey coordinator and participants were selected against the sampling guidance issued. For the national surveys 850 patients were selected to partake in a survey from the sample months indicated in the table below.

A further 1000 participants were selected to partake in the Accident and Emergency survey as part of a national pilot offering the survey in an online format.

Survey	Sample month	Response rate	National average response rate
Inpatient survey	July 2012	51.7%	48%
A&E survey (including online pilot)	March 2012	33%	33.7%

What the results of the surveys told us

Inpatient survey

Things we are good at:

- Having all of the necessary information relating to the patients' condition/illness
- Answering patients' queries about the operation or procedure
- Privacy when being examined or treated
- Availability of hand gel for use by patients and visitors

Areas where improvements could be made:

- Inpatient meals
- Information about condition in A&E
- The wait to get a bed on the ward
- Information about condition or treatment

A&E survey

Things we are good at:

- Staff not talking in front of patients as if they weren't there
- Explaining results of tests in an understandable way
- Advising when normal activities such as driving or working can be resumed

Areas where improvements could be made:

- Length of time to first speak with a nurse or doctor
- Length of time to be examined by a nurse or doctor

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

> My neighbours speak highly of this hospital.
> It has been as good as I expected.

3.2.4 Examples of Specific Patient Experience Initiatives

a) Kidney dialysis patients access tests online

Patients can now keep track of their treatment and test results from the comfort of their homes, or even while on holiday abroad. A new computer system, called Renal PatientView is more convenient, can save time and will also allow patients to have more control and involvement in their care.

It means they will no longer have to wait for an appointment or travel to hospital to get the latest news about their progress or advice on any worries. Important personal details are easily available to doctors outside the Trust using the patients login details if a patient is taken ill away from home. “Renal PatientView will allow them to see their results as soon as they become available and enable them to monitor their progress,” says Helen Perkins, Renal Unit, Lead Nurse. “It allows them to manage their information, be better informed on their results and medications and attend their appointments armed with more knowledge about their treatment.”

b) Assessment of patients prior to surgery

A number of changes in the surgical pre-assessment process have taken place this year resulting in improvements in the quality of care and patient feedback. Both staff, ensuring that patients are fully assessed for their surgery, and patients themselves, knowing what to expect, have been shown to reduce the risk of complications leading to quicker recovery and a better outcome for the patient.

The depth of the pre-assessment is now based on each patient’s graded risk so ensuring that more time is spent with those at greater risk. Cancellations prior to surgery have also been radically reduced. A survey of 115 patients between September-November 2012, has shown a high satisfaction with the new system with 98 per cent indicating they were as involved as much as they wanted to be in decisions about their care and treatment, 90 per cent definitely happy with the care they received from the pre-assessment service and the same number agreeing that they had received enough information about their operation and anaesthetic.

c) Rheumatology outpatients survey

This year the Rheumatology Department repeated a survey of outpatients it had previously undertaken in 2008. Approximately 550 patients attending the clinic during January 2013 completed the questionnaire. Overall, the majority of patients reported excellent levels in the quality of care received and in their experience of the clinic.

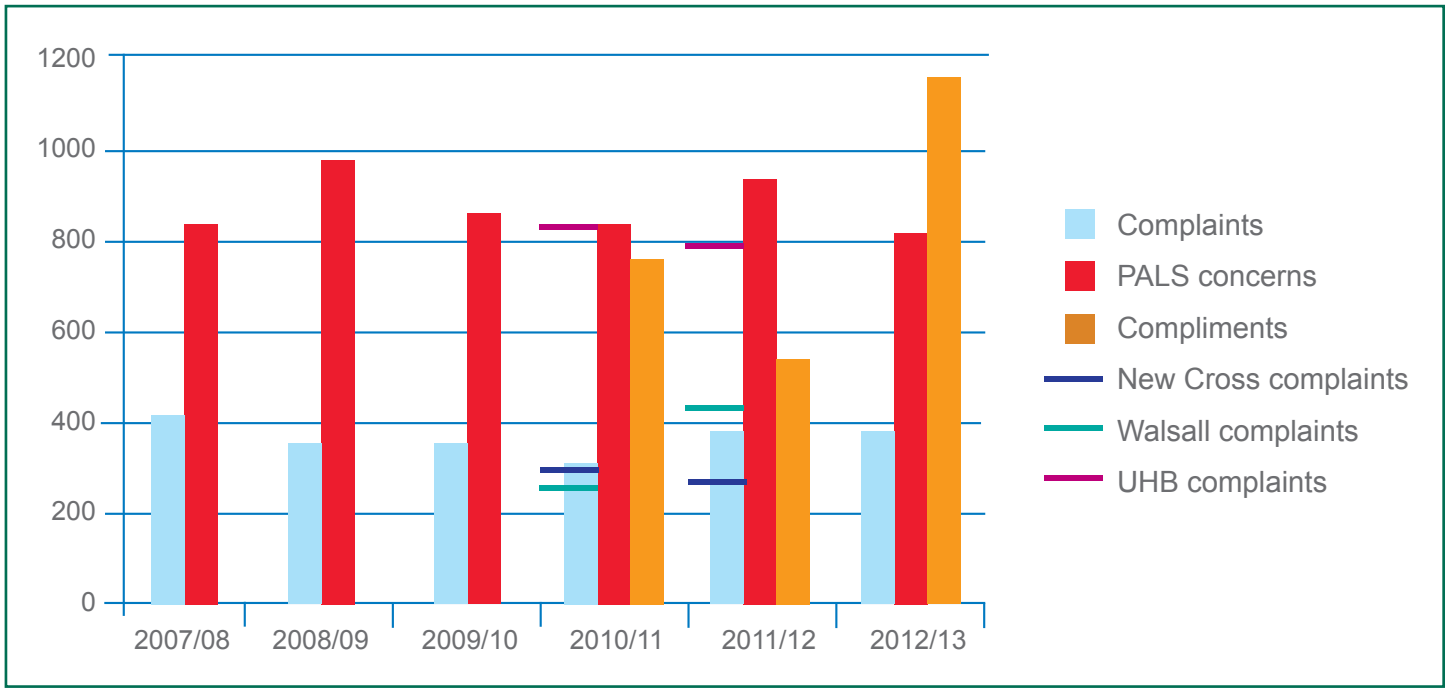
For instance, 89 per cent of patients thought they were definitely involved as much as they wanted to be in the clinical decisions being made (Yes to some extent – 6 per cent, Unanswered – 4 per cent, No – 0 per cent) and 91 per cent had complete confidence and trust in the examining/treating doctor/nurse (Yes to some extent – 3 per cent, Unanswered – 6 per cent, No – 0 per cent). When asked to rate on a scale of 0 – 10 how likely is it that you would recommend this service to family and friends? (10= very likely, 0= not at all) 93 per cent rated the service at ≥ 8 (56 per cent =10; 16 per cent=9; 21 per cent=8) and only one (0.2 per cent) patient rated the service at < 5.

There were areas for improvement: Although 80 per cent of patients were seen within 30 minutes of their appointment (41 per cent on time) and there had been a 50 per cent reduction of patients waiting more than an hour compared to 2008, the department is looking to see how it can increase these numbers as well as reducing rescheduling of appointments which had occurred in 15 per cent of cases.

3.2.5 Complaints and Compliments

This summary contains three tables showing a) the total number of complaints, concerns raised with the patient and liaison service and compliments during the year, compared to both previous years and where possible compared with local trusts b) the total and top five types of complaints this year compared to last year c) the percentage of complaints compared to the total number of patients visiting the Trust and d) some examples of changes in practice made from complaints.

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



b) Total number and five main types of complaints

Categroy	Year end 2011/12	Q1 2012/13	Q2 2012/13	Q3 2012/13	Q4 2012/13	Year end 2012/13
TOTAL	375	75	101	108	89	373
All aspects of clinical treatment	238 (63%)	51	86	88	74	299 (80%)
Attitude of staff	36 (10%)	8	1	2	4	14 (4%)
Communication /information to patient	26 (7%)	2	4	8	4	18 (5%)
Admission, Discharge & Transfer	19 (5%)	1	1	4	2	8 (2%)
OPD appointment delay/cancellation	29 (8%)	6	5	3	3	17 (5%)

c) Percentage of complaints against activity

ACTIVITY	Total year ending 31/3/11	Total year ending 31/3/12	Total year ending 31/3/13
Total patient activity	714519	753469	735247
% Complaints against activity	0.05%	0.05%	0.05%

d) Examples of changes in practice from complaints

Emergency, Specialty Medicine and Elderly Care

- Medical staff to check if ongoing psychiatric medication is continued to be prescribed during hospital admission.
- Review of mandatory training undertaken relating to care of a vulnerable adult.
- Patients sitting in GP area to be reassessed if their condition deteriorates.
- Information regarding Hickman lines being updated and will be available for patients very soon.
- Aftercare information to be provided on discharge.
- Measures put into place to reduce capacity, with some activity moved outside of the hospital, which has subsequently reduced waiting times within the Oncology unit.
- A record of telephone calls made directly to the district nurse team for those discharges that are complex is now maintained to ensure appropriate information has been communicated in a timely manner.
- The Emergency Assessment Unit (EAU) discharge process is being reviewed to improve communication between staff and family members.
- The EAU is reviewing the availability of senior nursing staff and posters advising patients and relatives to speak to a member of the nursing staff if they have any concerns whilst awaiting assessment and the provision of information booklets explaining the systems in operation within the area.
- Review of seating within the Emergency Department is being undertaken.

Women and Children

- Posters to be developed to inform women of staff to be approached regarding waiting times in the Maternity Outpatients Department.
- Process to be changed so that women are informed of all results, whether normal or abnormal. The leaflet will be changed to reflect this.
- Process for contacting the rapid response team in the event of a child death made available to all staff.
- Additional information added to bereavement box which contains information for the parents of a child who dies on the ward now available to staff.
- In the event of a child death, staff will arrange transport home for relatives and carers, if required.
- All community midwives to ensure women make an appointment at their local community phlebotomy service for their blood sugar tests to prevent any delays occurring.
- Re-develop gastro-oesophageal reflux (GOR) guidelines and design a GOR patient advice leaflet
- Information leaflets to be reviewed and additions made regarding water birth.
- Community midwives are to give advice about age parameters for water in labour/birth.
- Midwives to encourage women to administer their own Enoxoparin whilst an inpatient to build confidence before being discharged.
- A surrogate policy to be produced.

Diagnostics

- MRI scan appointment letter amended to include additional information for patients.
- Senior clinical midwife manager to discuss ethnic origin codes for postnatal newborn screening to avoid any confusion.
- Review of service enabled sonographers to add extra women onto their lists.
- Patients who have common variable immunodeficiency disorders require long-term replacement treatment with immunoglobulins. It is recognised that home therapy minimises hospital attendance for infusions and a business plan was submitted to the PCT in January 2013 and approved by the HENIG (Dudley Health Economy NICE Implementation Group) and forwarded to the commissioning team. Once agreed, the Trust is to start the process of training and transfer to home care.

Surgery and Anaesthetics

- Portering staff to make ad hoc deliveries if urgent notes are required in clinic.
- Staff to offer pain relief medication before commencing mobilisation.
- Review practice of instructing patients to be nil by mouth prior to surgery and divide lists into AM/PM to minimise time patients are without diet and fluids.

Ambulatory Medicine

- An inpatient care plan is currently being developed as well as a dialysis prescription that will help in communication between specialities and subsequently improve the patient journey.

Trauma, Orthopaedics and Plastics

- Patients with metal on metal hips will be monitored and provided with appropriate guidelines regarding their management.

3.2.6 PEAT Scores

Patient Environment Action Team (PEAT) is an annual assessment of inpatient healthcare sites in England. It is carried out in accordance with guidance and the team is made up of 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 and 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 2009-2012:

Year	Site Name	Environmental Score	Food Score Score	Privacy and Dignity Score
2012	Russells Hall Hospital	Excellent	Good	Good
2011	Russells Hall Hospital	Excellent	Good	Good
2010	Russells Hall Hospital	Excellent	Good	Good
2009	Russells Hall Hospital	Good	Good	Good

> The compassion the ward staff showed to my sister and I during mother's final hours was nothing short of extraordinary.

From 2013 the way the assessment is carried out is changing. The assessments will be patient-led to ensure that the patient voice is given the highest priority and patient assessors will make up at least 50 per cent of the assessment team. Training will be given to the team of volunteer patient assessors who will be made up from members of our local community. The following elements will be assessed:

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

3.2.7 Same Sex Accommodation

We are compliant with the Government's requirement to eliminate mixed-sex accommodation. Sharing with members of the opposite sex only occurs when clinically necessary (for example where patients need specialist equipment such as in the critical care unit), or when patients actively choose to share (for instance in the renal dialysis unit). During the year the Trust reported no breaches of same sex accommodation. Patient perception is also measured by asking patients whether they shared a room or bay with members of the opposite sex when they were admitted to hospital as part of our real-time survey programme. Of the 3069 inpatients asked, the number whose perception was that they shared a room/bay with members of the opposite sex was 73 (2%).

3.2.8 Patient Experience Measures:

	Actual 2008/09	Actual 2009/10	Actual 2010/11	Actual 2011/12	Actual 2012/13	Comparison with other Trusts 2012/13
Patients who agreed that the hospital room or ward was clean	87%	87%	88%	8.7	8.8	About the same
Patients who would rate their overall care highly	79%	76%	74%	7.4		About the same
Rating of overall experience of care (on scale 1-10)					7.6	
Patients who felt they were treated with dignity and respect	89%	86%	86%	8.6	8.7	About the same

Data from national inpatient surveys conducted for CQC – initially scores expressed as percentages but from 2011/12 scores reported out of 10 (previously this table was compiled from raw data scores).

There has been a change to these three measures this year. The first measure above is new this year. Previously we published the score for 'Patients that would recommend the hospital to a relative/friend', in this table, however, due to the introduction of the mandatory 'Friends and Family' test this year (see Section 3.2.2) this would have been a duplication and so it has been removed from here. In addition, the wording of the second question has changed in this year's national survey, hence we are unable to make a direct comparison with previous years' scores.

PATIENT SAFETY
3.3 Are patients safe in our hands?

3.3.1 Introduction

Ensuring patient safety is undertaken in many diverse ways from the quality of the training staff receive 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 Directors Walkrounds

These Patient Safety Leadership Walkrounds consist of directors hearing first hand the safety concerns of front line staff.

All wards, therapy and community departments are visited throughout the year by an executive team. The team consists of, as a minimum, one Executive Director, one Non Executive Director and a Senior Clinician (i.e. nurse).

The team observes practice by being shown around the ward by a ward representative who also provides a verbal summary of the ward activity, specialty and ways of working. It meets informally with ward/clinical representatives to discuss the staff members' areas of concern related to patient safety issues. In response a report and action plan is produced to address areas of concern identified. Some actions taken from these visits include:

- The purchase of further specialist equipment e.g. medical monitoring equipment, chairs, commodes, wheelchairs for overweight patients.
- Introduction of training of junior doctors in relation to timely prescriptions of medication to take home.
- Completion of minor works for example: blinds, shelving etc.
- Process put in place for volunteers to locate and return wheelchairs to main reception for use by patients.
- Introduction of an additional Oncology outreach service from the Brierley Hill clinic.
- Further development and introduction of training programmes to increase healthcare professionals' knowledge and skills within specialties.
- Review of visiting times to ensure patient safety during drug administration.

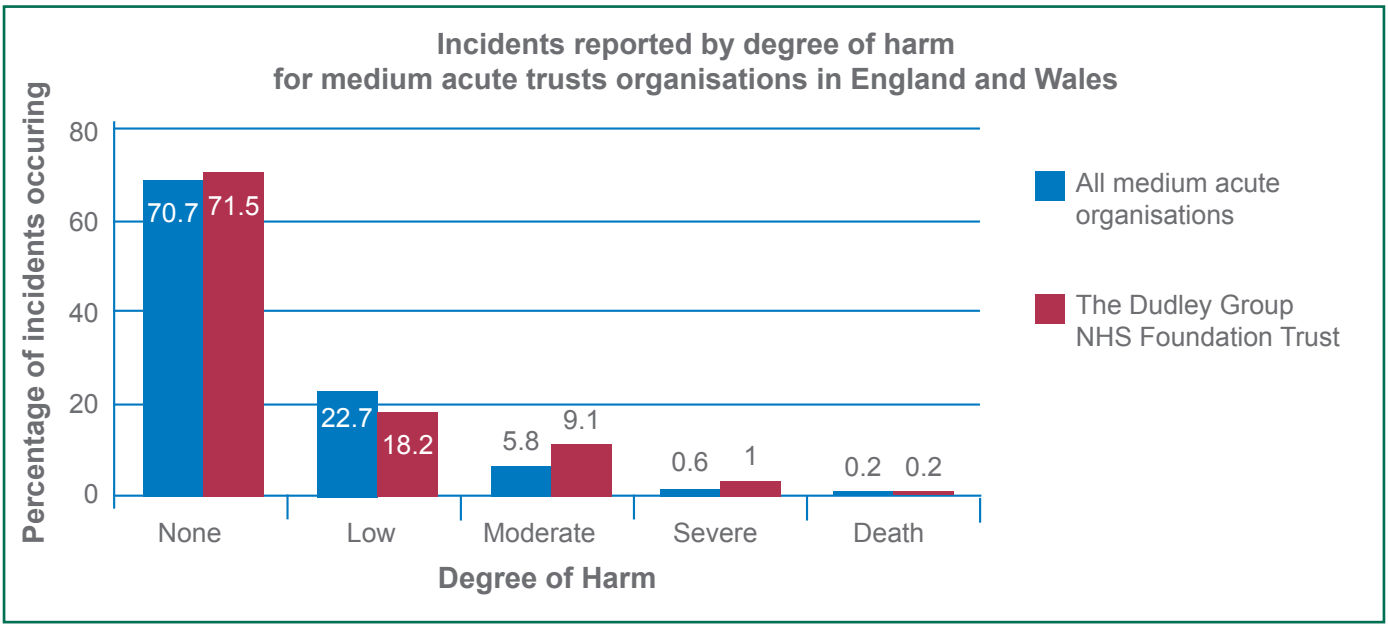
3.3.3 Incident Management

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

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

The latest national comparative figures available are for the period 1 October 2011 to 31 March 2012. Organisations are compared against others of similar size. The Trust is the twelfth 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 (the Trust 71.5 per cent) and just under 1 per cent as severe harm or death (Trust 1.2 per cent)



During the period April 2012 to the end of March 2013, incidents resulting in severe harm and death have accounted for 0.14 per cent and 0.1 per cent respectively of the total incidents reported. In the same period the Trust has had one 'Never Event' (these are a special class of serious incident that generally are preventable) which resulted in no patient harm. It did have 162 serious incidents all of which underwent an internal investigation and, when relevant, action plans were initiated and changes made to practice ('Serious Incidents' are a nationally agreed set of incidents which may not necessarily have resulted from error but need investigating to check the circumstances of their occurrence).

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

- Development of a new procedure for theatre staff and anaesthetists when throat packs are used
- Implementation of the paediatric Early Warning Score in the Paediatric Department
- Use of fax machines limited to essential use to ensure more robust process to reduce breaches in confidentiality
- Purchase of medical equipment e.g. bed chair alarms and increase the number of patients these are used with
- Development and introduction of a more systematic consistent approach for fluid management and prevention and management of falls
- Implementation of formal Clinician Led Ward Rounds
- Development of care pathways to support clinical practice

> All involved in looking after me were very sensitive to my situation, very polite, very attentive and above all professional. The ward felt like a well oiled machine, I could not have wished for a better experience.

3.3.4 Nursing Care Indicators

Every month 10 nursing records and other documents are checked at random in all general wards and departments at the hospital and in every nursing team in the community (in effect, approximately 400 records 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 were: patient observations (temperature, pulse, respirations etc), pain management, manual handling and falls risk assessment, prevention of pressure ulcers, nutrition assessment and monitoring, medications and prevention of infection. Further themes have been added or amended: a) in September 2011, 'ThinkGlucose' programme to monitor diabetes, documentation and bowel function assessments were added and b) in July 2012, fluid balance was added and the infection control section amended.

The completion rates of each ward and team are fed back to the matrons and ward managers for action where necessary. Each ward/team and the whole hospital and community service is RAG (Red/Amber/Green) rated with initially a 'Green' given for a 90 per cent or greater score, an 'Amber/Yellow' 89-70 per cent scores and a 'Red' for scores of 69 per cent or less. Due to overall general improvements in scores, it has recently been agreed to make the criteria stricter in that, for example a 'Green' score will only be given for 93 per cent and above. This change will be adopted into next year's Quality Account results.

Hospital results

The table below shows the end of calendar year position for each of the criteria assessed and changes from year to year. In 2012 we have improvements in seven of the 11 criterion. Infection control figures (*) show a fall, however, the questions for this assessment have been totally changed in July 2012 and so a direct comparison with 2011 is not possible.

Criterion	Patient Observations	Pain	Manual Handling	Tissue Viability	Nutrition	Medications	Infection Control	Think glucose	Documentation	Bowels	Fluid Balance
2010	77%	70%	71%	86%	68%	92%	95%				
2011	83%	80%	79%	93%	77%	94%	97%	53%	88%	78%	
Difference	↑6%	↑10%	↑8%	↑7%	↑9%	↑2%	↑2%				
2012	86%	88%	85%	95%	82%	94%	91%	79%	88%	81%	77%
Difference	↑3%	↑8%	↑6%	↑2%	↑5%	=	*	↑26%	=	↑3%	

Community results

The table below shows the end of calendar year position and changes from last year for Community Services for each of the criteria assessed. In 2012 we have improved in three of the nine criterion (Manual Handling, Tissue Viability and Infection Control). During October and November 2012 a more systematic approach to assessing skin care and making correct care and treatment decisions was introduced which will have helped increase the score on Tissue Viability. Due to the high levels of compliance the details of all of the indicators are being reviewed to set higher performance targets so ensuring the highest possible standards of care.

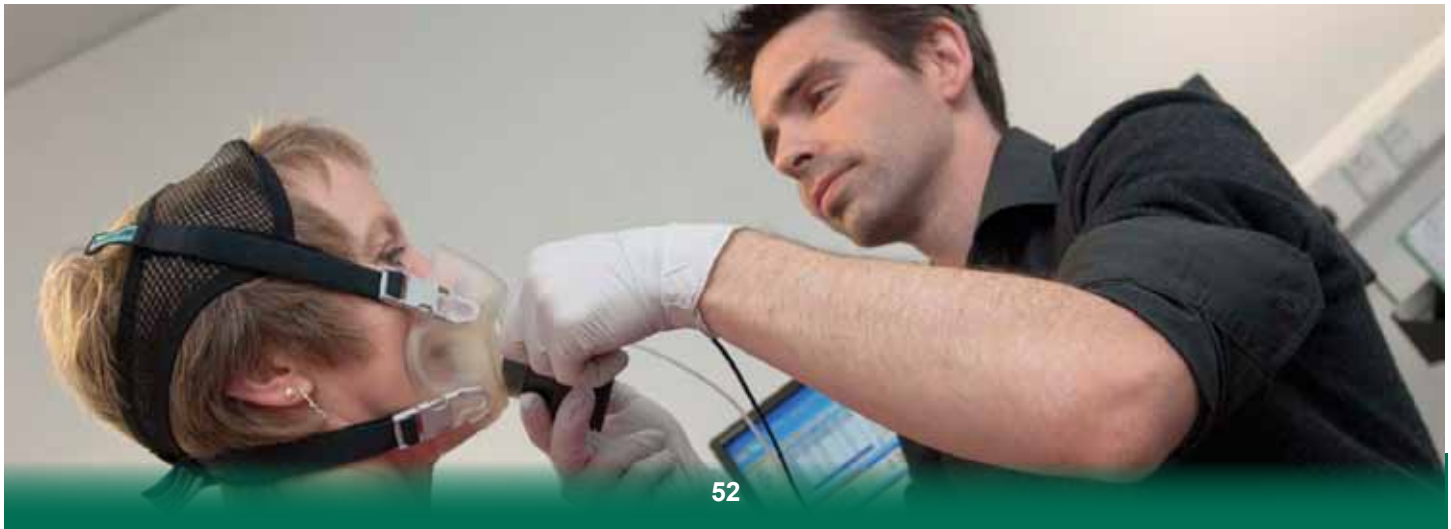
Criterion	Patient Observations	Pain	Manual Handling	Tissue Viability	Nutrition	Medications	Infection Control	Documentation	Privacy and Dignity
2011	97%	98%	94%	95%	97%	99%	97%	98%	99%
2012	97%	98%	97%	97%	97%	99%	98%	98%	99%
Difference	=	=	↑3%	↑2%	=	=	↑1%	=	=

3.3.5 'Harm Free' Care and the NHS Safety Thermometer

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

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

The Trust regularly monitors its performance on these measures and looks to ensure incremental improvements over time.



We aim to reduce these rates to zero per cent. Some examples of actions being taken as a result of the assessments:

- Continue to ensure staff are trained and updated by the Tissue Viability nurse and Link Nurses in the definition and recognition of pressure ulcers
- Enact a verification system to ensure that pressure ulcers are being correctly assessed and recorded
- Adopt a new 'falls bundle' (a clear systematic approach to assessing patients for the risk of falls and putting into place appropriate preventative measures) which is being trialled on a specific ward for later roll out and implementation in all clinical areas
- Ensure staff are aware of the new definition for new VTEs to improve accurate recording

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: SHMI (Summary Hospital Mortality Indicator), RAMI (Risk Adjusted Mortality Index) and HSMR (Hospital Standardised Mortality Ratio) via Healthcare Evaluation Data (HED), a system that allows us to monitor, compare and evaluate hospital performance. The Trust is not presently an outlier on the new nationally mandated SHMI (see Section 2.2.7).

To date, all internal investigations of outlier 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 has a systematic internal mortality monitoring process, which includes monthly presentations to the Chairman, Chief Executive and Medical Director.

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

3.3.7 Examples of Specific Patient Safety Initiatives

a) Gold standard service to cut infection risk

Upgrade work is now complete on a new suite with four of the latest decontamination machines for cleaning equipment used in the Gastroenterology (GI) Department. It uses advanced technology to clean and disinfect endoscopes used to investigate small and large intestines, take biopsies and even treat some digestive disorders. The cleaning process ensures that dirty and clean scopes are separated at all times and advanced technology speeds up the cleaning process, providing doctors with an almost instant supply of decontaminated instruments. The new facility ensures that the Trust remains fully accredited in terms of quality legislation, both now and for the foreseeable future. "We have a good system for decontaminating GI scopes," says Kerry Castle, GI Lead Nurse, "but the new suite is gold standard. It is a major advance and increases reliability. This will be of significant benefit to the 10,000 patients we see every year." The new suite is part of a project to rebuild the Trust's decontamination facilities and ensures that all flexible endoscopes in the Trust are decontaminated to the same standard.

> The service received was fantastic.
> I was put at ease and well cared for and well informed.

b) Improved education and working between junior doctors and pharmacists

In August 2012 the Trust became a pilot site for the 'Better Training Better Care' (BTBC) initiative co-ordinated by the country's lead body in training, Health Education England (HEE). There were only 15 Trusts (and only two in the West Midlands) which were successful in getting funds to become a pilot. The purpose of this patient safety initiative at Dudley is improved education and working between pharmacists and junior doctors to ensure that patients, especially those with complex medicine requirements, receive correct medication. Training sessions with pharmacists and juniors together consist of simulated scenarios using dummy drug charts which aim at timely, accurate and effective prescribing so reducing the risk of medication errors and ensuring that patients stay in hospital is not lengthened by inappropriate medication. In a visit to the hospital, Patrick Mitchell, Director of National Programmes for HEE, said, "Post Francis, the need for professional groups, like here in Dudley, to work closer across professional boundaries to promote safe care and share training opportunities is crucial. The behavioural change here is as important, if not more so, than the training itself."

3.3.8 Patient Safety Measures:

	Actual 2008/09	Actual 2009/10	Actual 2010/11	Actual 2011/12	Actual 2012/13
Patients with MRSA infection/1,000 bed days*	0.07	0.04	0.01	0.01	0.01
Never events – events that should not happen whilst in hospital Source: adverse incidents database	0	0	0	0	1
Number of cases of deep vein thrombosis (DVT) presenting within three months of hospital admission	48	48	35	143**	117**

*Data source: numerator data taken from infection control data system and denominator from the occupied bed statistics in patient administration system. NB the MRSA figure may differ from data available on Public Health England (PHE) website due to different calculation methods and Trust calculations using most current Trust bed data.

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

There has been a change to these three measures this year. The measure 'Patients with C. diff infection/1,000 bed days' has been removed as it is now part of the mandatory measures that all trusts have to report on (see Section 2.27). The measure on Never Events has been added to replace this as it is an important patient safety issue.

CLINICAL EFFECTIVENESS

3.4 Do patients receive a good standard of clinical care?

3.4.1 Introduction

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

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

a) Nursing Standard Annual Awards 2013 - Ward Sister of the year award

Sara Davis from Ward C8 was presented with the above award in March 2013 for initiating a variety of improvements. These included: increasing staff morale and the scores of the nursing care indicators, reducing the number of complaints, serious incidents and sickness levels, ensuring staff training is up to date and improving working relationships with colleagues in other disciplines. A member of Sara's team said, "Sara has completely altered the ward to make the patient journey the priority here and she cares about her staff just as much."

b) Recognising Excellence in Medical Education (REME) Teaching Award for the academic year 2011-12

At a prize giving ceremony held at the University of Birmingham Medical School in December 2012 the above award was presented to Dr A Whallett, Consultant Rheumatologist. REME is a student-led, medical school endorsed organisation that aims to identify teachers who have contributed significantly toward medical education. All students are invited to provide nominations and feedback, all of which is entirely on a voluntary basis. All nominations are reviewed, and winners chosen on the basis of number of nominations and the comments received. Dr Whallett was one of only 11 individuals given this award.

3.4.3 Examples of Innovation

a) State of the art facilities for interventional radiology and endovascular investigation and treatment

This £1.5m development was opened in March 2012 and allows surgical and radiological teams to perform elective and emergency endovascular aortic aneurysm repairs and in the last 12 months, 68 patients from across the Black Country have benefited from this minimally invasive technique to treat what is a life threatening condition. The suite comprises state of the art equipment enabling real time three dimensional imaging and allows complex vascular and other interventions to be performed to the highest standards of precision and patient safety whilst ensuring the lowest possible patient radiation dose. In addition to the vascular work, the suite is used for conventional interventional radiology techniques and is also now being used to undertake other major interventions such as vertebroplasty, an imaging guided technique that brings together a multidisciplinary team to treat painful spinal collapse of various causes.

b) Community Adult Continence Service

The Community Adult Continence Service has been involved in a number of collaborative partnerships to ensure that the patient is seen speedily by the correct expert as close to home as possible. For instance, a clear process is in place for all male patients with lower urinary tract systems so, dependent on the severity of their symptoms, they are seen and treated by the appropriate experts either in the community or in the hospital. This reduces unnecessary visits to the hospital and allows those with the appropriate symptoms to be seen quicker at the hospital. This has come about due to partnership working between the community clinical nurse specialist, hospital care (Urology service), GPs (Wychbury Medical Centre) and pharmaceutical advisors. Local services from, for example, Wolverhampton and Birmingham have all approached the clinical nurse specialist (CNS) on setting up such a service.

Similar innovative work for those patients with constipation has also been developed. For this service the clinical nurse specialist has worked with the hospital (Gastroenterology) and Worcester St practice. One outcome has been more effective prescribing and the reduction in the use of unnecessary laxatives. Shropshire Trust has approached the CNS for advice in setting up a similar service. The next initiative being developed is looking at more appropriate use of aids for bladder and bowel dysfunction in the hospital.

c) Outpatient Parenteral Antibiotic Team (OPAT)

In the past, patients requiring intravenous antibiotics always had to come into hospital for their therapy but from January 2012 a joint service between the hospital and community commenced. Patients are now assessed in hospital and then discharged for the community nurses to administer the intravenous antibiotics. Patients sometimes return to hospital for a review in a specialist clinic. The service was initially started for patients with cellulitis but then extended to those with complex urinary tract infections, including pyelonephritis. A further service for those with diabetic foot problems was also commenced in October 2012 and there are plans to extend this service. During 2012 over 150 patients were successfully treated in the community setting either in the patient's own home or in the community clinic at Brierley Hill Health and Social Care Centre. This is estimated to have saved over 1,385 bed days, increasing capacity within the hospital for more appropriate patients whilst providing excellent care for patients nearer to home. A survey of the patients treated found they were all satisfied with the service, rating it at 9.2 on a scale of one to 10.

3.4.4 Examples of Specific Clinical Effectiveness Initiatives

a) Abdominal Aortic Aneurysm Screening Service

A new Abdominal Aortic Aneurysm (AAA) Screening Service based at Russells Hall Hospital has screened 4140 men across the Black Country since the programme started in April 2012. The programme is part of a national roll out, which invites all men registered with a GP in the Black Country, who will turn 65 in the financial year. In addition, men over 65 years may self-refer by phoning the office. Posters have been distributed to all GP practices and health centres in the Black Country for display and local newspaper articles on the programme have been published.

Screening takes place five days a week at clinics and GP practices in Walsall, Wolverhampton and Dudley, and all scans are uploaded to our secure picture archive at Russells Hall Hospital. "No individual has to travel more than a few minutes. We've made sure we are screening people on their doorsteps," said Mr Rajiv Pathak, Consultant Vascular Surgeon and Black Country AAA Screening Programme Director. Mr Pathak said the large majority of men (98 per cent) will have a normal result with no aneurysm. A small aneurysm means the aorta is between 3cm and 5.4cm wide and if detected will continue to be monitored with a regular scan. To date, we have detected small aneurysms in 42 men. A large aneurysm is over 5.5cm wide and, if one is detected, the patient will be referred to a consultant for treatment. "Only a few aneurysms will be large enough to require urgent treatment and cause a risk to a person's health," said Mr Pathak. We have detected 12 patients so far who have required referral to a consultant for treatment.

Patient Story:

Roger Davies from Woodsetton says he would not be alive today if he had not attended a routine scan for an abdominal aortic aneurysm as part of the national screening programme. The father of two had no idea he had an aneurysm in his abdomen let alone one measuring 10.5cm, the largest found so far on the programme. “I am so relieved I went for the scan – if it had burst, it would have killed me,” said Mr Davies.

Father of three Tom Walker (pictured left with his wife Sue) from Wednesfield described his 7.5cm aneurysm as a “ticking time bomb”. Following his routine scan, he had a complex four-hour operation at Russells Hall Hospital. Mr Walker said, “I would definitely do the test. It was the best 20 minutes I’ve ever spent. It saved my life.”

b) Hyper Acute Stroke Ward

At Russells Hall Hospital the aim is to get the patient to our specialist acute stroke ward within four hours of arrival at our Emergency Department (ED). This increases the chance of a full recovery. The 12-bedded Hyper Acute Stroke Ward provides continuous monitoring and therapy. Ongoing care is provided at the 28-bedded stroke ward. For patients who arrive at hospital very quickly, and have a certain type of stroke, we provide 24/7 thrombolysis with a clot busting drug to reopen blocked blood vessels. If a stroke is confirmed prior to arrival, the ambulance crew will phone ahead to alert the specialist team who, in turn, pre-warn staff that a scan is required. We have machines that monitor real time blood flow from the heart as 40 per cent of strokes in people under the age of 55 are related to the heart. In addition, we use specialist equipment that goes into the throat to provide images of the heart to help in the diagnosis of the cause of the stroke. Following discharge from hospital, hospital staff work with the community Early Support Discharge team to provide further rehabilitation if needed.

Patient Story:

Stanley Pearce from Kinver received care at Russells Hall Hospital.

He said, “I was in A&E with my daughter when I suddenly felt the room sliding and the feeling had gone out of my left leg. My arm was flinging everywhere. A doctor knew straight away I was having a stroke.”
“It was very frightening and you think the worst, but I was on the ward within two hours of it happening.
“The drugs were given to me really quickly and I got the feeling back in my leg and arm. It was brilliant. I was so frightened but the staff were ace. They saved my life.”

Clifford Palmer (pictured right) was also admitted to the Hyper Acute Stroke Ward. His son Wayne said, “The care at Russells Hall Hospital has been phenomenal, especially how fast he had thrombolysis. I’m over the moon for dad.”

c) Blood Borne Virus Service

From December 2012 the community clinical nurse specialists have introduced a new treatment for patients with hepatitis C, a potentially serious disorder. The drug telaprevir, used in combination with pegylated interferon and ribavirin, has during trials improved the clearance rates of hepatitis C by a further 20 per cent for genotype 1 patients. Currently the first eight patients who require weekly monitoring to detect possible severe side effects have had excellent results and any side effects have been well managed in conjunction with the dermatology team. We have high hopes that those who have previously experienced treatment failures will go on to be successfully treated with this additional therapy. The final results will not be known for 18 months when treatment and follow up are complete. The team of staff have worked closely to involve Pharmacy and Microbiology to ensure safe and efficient patient care is delivered in a timely fashion. It is hoped that once this group of patients has been safely managed through the first few months of treatment, further patients will be able to start on this new therapy.

3.4.5 Clinical Effectiveness Measures:

Categroy	Actual 2007/08	Actual 2008/09	Actual 2009/10	Actual 2010/11	Actual 2011/12	Actual 2012/13
Trust Readmission Rate for Surgery Vs Peer group West Midlands SHA Source: CHKS Insight	4.6% Vs 4.1%	3.9%* Vs 4.3%	4.1% Vs 4.2%	4.4% Vs 4.7%	5.6% Vs 5.0%	5.7%^ Vs 5.2%
Number of cardiac arrests Source: logged switchboard calls	397	250	170	145	119	126
% of elective admissions where the planned procedure was not carried out (not patient decision) Vs Peer group West Midlands SHA Source: CHKS Insight	N/A	2.0 Vs 1.6	1.4 Vs 1.6	1.4 Vs 1.3	0.67% Vs 1.1%	0.57%^ Vs 0.86%

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

^To end of January 2013

N/A = Data Not Available

There has been a change to these three measures this year. The measure ‘Never Events’ has now been given its more appropriate categorisation and moved to Patient Safety (see Section 3.3.8) so the Trust has added a new clinical effectiveness measure of when planned procedures are not undertaken. The reduction of cardiac arrests indicates success in identifying patients at risk, monitoring them carefully and escalating the clinical care to appropriate professionals to prevent cardiac arrest.

3.5 Our performance against Key National Priorities across the domains of the NHS Outcomes Framework

National targets and regulatory requirements	Trust 2008/09	Trust 2009/10	Trust 2010/11	Trust 2011/12	National 2012/13	Target 2012/13	Trust 2012/13	Target Achieved/ Not Achieved
1. Preventing People from Dying Prematurely								
A maximum wait of 31 days from diagnosis to start of treatment for all cancers	100%	99.3%	99.8%	99.7%	98.3%*	96%	99.5%	☺
All cancers: 31 day wait for second or subsequent treatment: surgery	N/A	N/A	99.6%	99.6%	97.1%*	94%	99.2%	☺
All cancers: 31 day wait for second or subsequent treatment: anti-cancer drug treatments	N/A	N/A	100%	100%	99.6%*	98%	100%	☺
A maximum wait of 62 days from urgent referral to treatment of all cancers	99.9%	86.5%	87%	88%	86.3%*	85%	88.7%	☺
All cancers: 62 day wait for first treatment from consultant screening service	N/A	N/A	99.6%	96.6%	94.9%*	90%	99.4%	☺
3. Helping people to recover from episodes of ill health or following injury								
Maximum time of 18 weeks from point of referral to treatment (admitted patients)	92.4%	95.8%	97.03%	95.7%	92.4%	90%	96.1%	☺
Maximum time of 18 weeks from point of referral to treatment (non-admitted patients)	96.15%	99.1%	99.2%	99.2%	97.6%	95%	99.5%	☺
Maximum time of 18 weeks from point of referral to treatment (incomplete pathways)	N/A	N/A	N/A	N/A	94.2%	92%	98.1%	☺

National targets and regulatory requirements	Trust 2008/09	Trust 2009/10	Trust 2010/11	Trust 2011/12	National 2012/13	Target 2012/13	Trust 2012/13	Target Achieved/ Not Achieved
4. Ensuring people have a positive experience of care								
A/E: Percentage of patients admitted, transferred or discharged within 4 hours of arrival	95.9%	98.1%	98.8%	97.27%	95.8%	95%	95.4%	☺
Two week maximum wait for urgent suspected cancer referrals from GP to first outpatient appointment	100%	98%	96.8%	97.2%	95.7%*	93%	96.2%	☺
Two week maximum wait for symptomatic breast patients	N/A	69%	98.2%	99%	95.7%*	93%	98.1%	☺
5. Treating and caring for people in a safe environment and protecting them from avoidable harm								
MRSA – number of post 48hour bacteraemia infections	7	2	3	2	–	No more than 2	1	☺
Data Completeness for community services: Referral to treatment information	N/A	N/A	N/A	N/A	+	50%	97.3%	☺
Data Completeness for community services: Referral information	N/A	N/A	N/A	N/A	+	50%	65.6%	☺
Data Completeness for community services: Treatment activity information	N/A	N/A	N/A	N/A	+	50%	99.1%	☺
Certification against compliance with requirements regarding access to healthcare for people with a learning disability	N/A	N/A	N/A	Compliant	–	Compliant	Compliant	☺

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

☺ = Achieved target ☹ = Not achieved target

– Applies to National figures not being appropriate

* = Quarter 4 figures as full year figures are not currently available

+ = National figures not available

3.6 Glossary of Terms

AAA	Abdominal Aortic Aneurysm
A & E	Accident and Emergency
ADC	Action for Disabled People and Carers
Bed Days	Unit used to calculate the availability and use of beds over time
BBC CLRN	Birmingham and Black Country Comprehensive Local Research Network
BHF	British Heart Foundation
BTS	British Thoracic Society
CCG	Clinical Commissioning Group
C. diff	Clostridium difficile
CNS	Clinical Nurse Specialist
CQC	Care Quality Commission
COPD LES	Chronic Obstructive Pulmonary Disease Local Enhance Services
CHKS Ltd	A national company that works with Trusts and provides healthcare intelligence and quality improvement services
CQUIN	Commissioning for Quality and Innovation payment framework
CEM	College of Emergency Medicine
DAHNO	Data for Head and Neck Oncology
DUBASCO	Dudley Bariatric Surgery Co-morbidity Score
DVD	Optical disc storage format
EAU	Emergency Assessment Unit
ENT	Ear, Nose and Throat
ED	Emergency Department
FCE	Full Consultant Episode (measure of a stay in hospital)
Foundation Trust	Not-for-profit, public benefit corporations which are part of the NHS and were created to devolve more decision-making from central government to local organisations and communities
GP	General Practitioner
HASC	Health and Adult Social Care Scrutiny Committee
HAT	Healthcare Acquired Thrombosis
HED	Healthcare Evaluation Data
HES	Hospital Episode Statistics
HPA	Health Protection Agency
HQIP	Healthcare Quality Improvement Partnership
HSMR	Hospital Standardised Mortality Ratios
HTA	Human Tissue Authority
IBD	Irritable Bowel Disease

ICNARC CMPD	Intensive Care National Audit & Research Centre Case Mix Programme Database
LINK	Local Involvement Network
MUST	Malnutrition Universal Screening Tool
MBC	Metropolitan Borough Council
MBRRACE-UK	Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries in the UK
MINAP	Myocardial Ischaemia National Audit Project
Monitor	Independent regulator of NHS Foundation Trusts
MRSA	Meticillin-Resistant Staphylococcus Aureus
MESS	Mandatory Enhanced Surveillance System
MUST	Malnutrition Universal Screening Tool
NCEPOD	National Confidential Enquiry into Patient Outcome and Death
NCI	Nursing Care Indicator
NICE	National Institute for Health and Clinical Excellence
NHS	National Health Service
NNAP	National Neonatal Audit Programme
NOF	Neck of Femur
NPSA	National Patient Safety Agency
NIV	Non Invasive Ventilation
NVQ	National Vocational Qualification
OSC	Overview and Scrutiny Committee
Ofsted	Office for Standards in Education, Children's Services and Skills
PALS	Patient Advice and Liaison Service
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
REME	Recognising Excellence in Medical Education
RAMI	Risk Adjusted Mortality Index
SHMI	Summary Hospital Mortality Indicator
SINAP	Stroke Improvement Audit Programme
SKIN	Surface, Keep Moving, Incontinence and Nutrition
SUS	Secondary Uses Service
SLT	Speech and Language Therapy
VCF	Vertebral Compression Fractures
VSGBI	Vascular Society of Great Britain and Ireland
VTE	Venous Thromboembolism

ANNEX

Comment from Dudley Clinical Commissioning Group (received 07/05/2013)

Dudley Clinical Commissioning Group acknowledges that this report demonstrates that The Dudley Group NHS Foundation Trust continues to place quality improvement at the forefront of their service delivery. The 2013/14 priorities reflect the continued commitment to patient experience, quality of care, nutrition, hydration, prevention of pressure ulcers, and infection prevention.

The further improvement in healthcare associated infections demonstrates that much has been achieved. The Clinical Commissioning Group continues to encourage the Trust to further reduce and prevent HCAI through implementing improvement plans, and this clearly sets out HCAI as a continued priority.

Mortality remains a focus of the Trust, with monthly meetings attended by the Chief Executive, Chairman, Clinical Director, along with active participation by Board member representatives from the Clinical Commissioning Group. This allows detailed assessment of specialties and identifies any themes or areas for improvement.

The current and planned patient outcome measures of both the Trust and the Clinical Commissioning Group allow assessment, monitoring, and informed judgements and decisions about the quality of healthcare services provided to local patients.

Dudley Clinical Commissioning Group supports the contents and aims of this Quality Account, and looks forward to working closely with The Dudley Group NHS Foundation Trust to ensure that they achieve high quality outcomes and provide a quality experience to their patients.

Comment from the Trust's Council of Governors (received 26/04/2013)

The Trust has presented the Quality Accounts against a challenging background leading up to a major reorganisation of the National Health Service in England on 1st April 2013. The improvements in 2012/13 were achieved against a background of a stringent 4 per cent efficiency target which will continue into the foreseeable future.

Following the Francis Report, there has been an intense focus on the quality of care and safety of patients, both nationally and locally, highlighting the need for caring and compassionate staff.

The Governors fully support the aims and objectives defined in the Statement from the Chief Executive in Part 1 of the report.

There has been an increased pressure on services provided by the Trust particularly in the Emergency Department (in common with many areas of the country) with patients requiring to be admitted as emergencies to Russells Hall Hospital.

The process used to identify the quality priorities was wide ranging and provided a valuable opportunity for Governors, patients, staff, members, and patient representative groups to consider and influence the choices.

Governors recognise and appreciate the significant improvements made by the Trust in many areas in 2012/13, particularly the effective action taken to reduce the incidence of pressure ulcers, post 48 hour MRSA bacteraemia and Clostridium Difficile. Hydration and nutrition are crucial to the health and wellbeing of patients and the Council of Governors notes the systematic processes that have been implemented to ensure that the needs of patients are being met. Further work is required to improve the use of the Single Assessment Process folder.

Trust performance against most national standards has been good and nearly all targets have been met. However, inpatient experience can be improved and remains a priority for further improvement in 2013/14. Whilst the new national Friends and Family Test has resulted in ratings for hospital services of over 70 per cent, there is clearly room for improvement and patients have made many positive suggestions.

Governors have met with many members of the Trust and public, including ex-patients, during the year to gain feedback about the Trust's services and patient experience. This information is fed back into the Trust.

The Trust has informed the Council of Governors that in 2012/13, its Summary Hospital Mortality Indicator is within the expected range and it has monitored hospital deaths in detail and has investigated each case. The Council notes that the Trust also uses the Risk Adjusted Mortality Index and the Hospital Standardised Mortality Ratio, supported by a systematic internal mortality monitoring process.

Governors acknowledge that the Quality Accounts provide a significant quantity of information about the care provided to patients and the range of methods used by the Trust to monitor the safety of patient care, clinical effectiveness and the patient experience. The Council of Governors notes the statements of assurance from the Board which describe an extensive quantity of internal and external practices, audits and assessments which are positive, together with the numerous external assessments that have been undertaken including those carried out

by the Care Quality Commission. Following the inspection by the Care Quality Commission in February 2013, it has stated that the Trust is compliant with the standards inspected.

Governors have been able to question Executive and Non-executive Directors in detail within committee meetings to gain assurance about the quality of services in the Trust, and about patient safety and experience. The outputs from committee meetings are reported to the Council of Governors.

Governors wish to place on record their appreciation of the excellent work done by staff especially on the 'front-line', often in stressful or pressurised circumstances.

It is pleasing to note that there has also been an increase in the membership of the Trust. This has been assisted by holding 'Open Days' for the public and members which have addressed areas of interest such as diabetes. These 'Open Days' have all been well supported.

An enhanced Council of Governors committee structure was implemented in early 2012 in anticipation of the changes being brought forward by the Health and Social Care Act 2012. The effectiveness of the Council and its committee structure is reviewed annually.

An excellent working relationship has been established between the Trust Board (and other staff) and the Council of Governors where there is a full and open sharing of information and co-operation. This has greatly assisted the Council of Governors to fulfil its role within the Trust. The Trust policy of 'full openness and transparency' in all areas, both positive and negative, has also greatly assisted the Council of Governors in its governance role.

While receiving significant assurance about performance and standards from the Board, auditors, together with inspection visits and reviews, Governors will continue to discuss with the Board the need for further direct measures of assurance. From Spring 2013 governors will take part in Director's Patient Safety Walkrounds and have the opportunity to talk to inpatients directly while experiencing services.

Governors are very aware of their increased accountability under the Health and Social Care Act 2012. Governors will continue to seek a full understanding of the information provided by the Board against a background of the changed structure and shape of the NHS, and the number of bodies which will have authority and/or influence in its management, especially in the areas of quality and quality oversight and the influence of the Francis Report.

Comment from Healthwatch Dudley (received 26/04/2013)
Healthwatch Dudley is a new organisation that began operating on 1 April 2013. We acknowledge receipt of The Dudley Group NHS Foundation Trust's annual Quality Report and Account for 2012/13. However, bearing in mind that we are a new organisation and the report covers a period of time when we were not in existence, our ability to comment on its contents in the way that we would like is constrained. Nevertheless, we welcome the improvements that have been made to services cited in the report and are mindful of the need to focus on improvement in services where gaps or weaknesses have been identified. More specifically, with regard to the targets identified for action to improve particular services in 2013/14 we look forward to commenting on the progress made towards achieving them in the annual Quality Report and Account for 2013/14. In future, Healthwatch Dudley will expect to develop a more in-depth response to matters raised in the report and include evidence that draws on our knowledge and understanding of the experiences and views of citizens including patients and carers that are used to support our submission.

Comment from the Dudley MBC Health and Adult Social Care Scrutiny Committee (received 24/04/2013)
Our Committee is responsible for health scrutiny and engages respective Quality Accounts as a useful device for considering operational improvement across the sector. They also present an opportunity to ensure priorities are representative of the quality of services provided; and cover areas of importance across Dudley's communities. We are encouraged to see evidence indicating staff increasingly involved in supporting patients at mealtimes; along with data suggesting patients now having access to more information about services on ward arrival - these are among a number patient experience priorities we have collaborated on arising from our 2011/12 dignity in care review.

The favourable trend in MUST assessments signals improved nutritional practice. On hydration, however, year end compliance for fluid balance disguises a variable performance throughout the year - we will wish to remain watchful on this care issue in 2013/14.

Strengthening the Single Assessment Process across patient pathways will further promote effective monitoring of care needs. This coupled with a greater awareness amongst patients, carers and families on how to raise concerns about care and treatment may also result in even better outcomes and experiences.

We commend the achievement of reducing hospital acquired pressure ulcers by 50 per cent and exceeding quarterly community targets; we will be keen to see this good practice implemented consistently across all services for long-term success.

Practically, in terms of the document's future development, greater use of case studies and stronger performance base-lining would be welcomed with the aim enabling the public and scrutiny bodies to better identify with patterns and trends over time.

The Committee welcomes the opportunity to comment on the Trust's QA; and overall supports the direction of travel endorsed by the Council of Governors for priorities going into 2013/14.

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 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 2012/13;
- 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 2012 to June 2013
- Papers relating to Quality reported to the Board over the period April 2012 to June 2013
- Feedback from the commissioners dated 07/05/2013
- Feedback from Governors dated 26/04/2013
- Feedback from the Local Healthwatch organsation dated 26/04/2013
- The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 23/04/2013
- The national patient survey June 2012
- The national staff survey conducted between September and December 2012
- The Head of Internal Audit's annual opinion over the Trust's control environment dated 31/03/2013
- CQC quality and risk profiles dated 28/2/2013, 31/1/2013 and 30/11/2012

- the Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered;
- the performance information reported in the Quality Report is reliable and accurate;
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice;
-the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and the Quality Report has been prepared in accordance with Monitor's annual reporting guidance (which incorporates the Quality Accounts regulations) (published at www.monitor-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/sites/all/modules/fckeditor/plugins/ktbrowser/_openTKFile.php?id=3275)).

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

By order of the Board

Chairman Date 08/05/2013

Chief Executive Date 08/05/2013

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 2013 (the "Quality Report") and certain performance indicators contained therein.

Scope and subject matter

The indicators for the year ended 31 March 2013 subject to limited assurance consist of the national priority indicators as mandated by Monitor:

- C. Difficile
- 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 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 2012 to March 2013;
    - Papers relating to Quality reported to the Board over the period April 2012 to March 2013;
    - Feedback from the Commissioners dated May 2013;
    - Feedback from local Healthwatch organisations dated April 2013;
    - The Trust's 2012/13 complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated March 2013;
    - Action Plan and Management Response to 2011/12 recommendations (March 2013);
    - Networking Session Draft Notes (November 2012);
    - Full Council of Governors Final Minutes (November 2012) and Draft Minutes (February 2013);
    - Copy of project plan/ outline of approach to Quality Report Production (November 2012);
    - The national patient survey results 2012;
    - The national staff survey result 2012;
    - Care Quality Commission quality and risk profiles dated December 2012, February 2013 and March 2013; and
    - The Head of Internal Audit's annual opinion over the Trust's control environment for the year ending 31/03/2013.

- 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 for external assurance on Quality Reports.

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

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

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 2013, 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.

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;
- Analytical procedures
- Limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation;
- Comparing the content requirements of the *NHS Foundation Trust Annual Reporting Manual* to the categories reported in the Quality Report; and
- Reading the documents.

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

Limitations

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

The absence of a significant body of established practice on which to draw allows for the selection of different but acceptable measurement techniques which can result in materially different measurements and can 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 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 2013:

- 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 for external assurance on Quality Reports; and
- the indicators in the Quality Report subject to limited assurance have not been reasonably stated in all material respects in accordance with the *NHS Foundation Trust Annual Reporting Manual*.

Deloitte LLP
Chartered Accountants
Birmingham, United Kingdom
23 May 2013

The Dudley Group NHS
NHS Foundation Trust