NHS
The Dudley Group
NHS Foundation Trust

Quality Report and Account 2019-20

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Quality Report and Account 2019/2020

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

Part 1: Introduction - Chief Executive's statement

During the year, the Trust has continued to strive to provide high quality care and treatment and improve its services. We do this by focusing on providing

- a good patient experience,
- safe care and treatment, and
- a good and effective standard of care.

This quality report describes the quality of care delivered at the Trust over 2019/20, providing an overall account of where we are performing well and where we can make improvements.

Our quality priorities

At the beginning of the report (Part 2) you will find an outline of our priority quality measures and their progress. I am particularly pleased with the steep decline in avoidable pressure ulcers from last and previous years. Three patients developed avoidable category 3 ulcers and no avoidable category 4 ulcers have occurred. We realise that these are three too many and our zero tolerance approach continues. In terms of infection control, while we have had one MRSA bacteraemia case, the first since September 2015, we are under the national target for C. difficile cases arising due to lapses in care. We continue to improve our practice in the other priority areas.

Following consultations with staff, governors, our commissioners and Healthwatch colleagues, we have decided to concentrate our efforts on improving both patient experience and discharge management as our priorities in 2020/21.

The report follows the mandated format with sections on clinical audit, research and development, and data quality. In Part 3 we have included other key quality initiatives and measures, and specific examples of good practice on all of the aspects of quality, which I hope will provide you with a useful picture of what is occurring across the Trust. I am really proud that the care of patients with sepsis has improved significantly. This is testament to our drive for quality of care and to ensure that patients' conditions do not deteriorate unnecessarily (section 3.3.8).

The Care Quality Commission (CQC) visited the Trust in early 2019 and I am pleased to report a number of improvements as well as retention of previous positive ratings since their last assessment. For instance, our end of life services in hospital and community were assessed as Good throughout all five of the CQC categories (Safe, Effective, Caring, Responsive and Well Led) while community caring was seen as Outstanding. Caring in our surgical services was also seen as Outstanding. Critical care was assessed overall as Good. Our urgent and emergency service was seen to have improved overall since the regulator's previous visit in 2018. Unfortunately, our diagnostic imaging service was seen to be Inadequate and so we have a full set of improvement actions in place.

During the year, as well as continually monitoring and striving to improve our own performance, a number of independent reviews of the quality of care at the Trust have been undertaken by outside organisations (see section 2.2.1). This combination of our own and external assessments allows us to assure both patients and ourselves of what we are doing well and the learning we need to take on to further improve and strengthen the care we provide to patients.

I hope the contents show that the Trust does not stand still but is always pursuing a path of improvement.

Measuring quality

This quality account includes many indicators of quality and we have included a number of specific examples of the quality initiatives our skilled, caring and motivated staff are undertaking across the Trust and what patients have said about the care they have received from us. We could not include them all but hopefully these examples, together with the innovation and initiatives that Trust staff have achieved and implemented in the year, give a sense of our quality of care. I would like to make a special mention to all of the staff and departments that have either been nominated, or progressed and gone on to win, both local and national awards (see section 3.4.2).

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

Finally, following the emergence of the COVID-19 situation towards the end of this financial year, 2020/21 will bring a series of demands as we begin the restoration and recovery of services. Staff - with tremendous help and support from the local community - have come together to provide exceptional care and treatment in these unprecedented times. As the coming year progresses, there will be national challenges which require us to achieve a range of performance targets within financial constraints and a focus on restoration of our services, continuing to provide high quality care. In addition, we will continue our work with partners across the Dudley system and further integration of clinical pathways that support and improve health outcomes with the community we serve.

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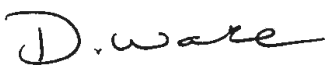
Signed:



Diane Wake
Chief Executive
Date: July 2020

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

2.1 Quality improvement priorities

2.1.1 Summary

The table below provides a summary of the history of our quality priorities over the past four years and outlines the new priorities for 2020/21.

Quality Priority	2016/17	2017/18	2018/19	2019/20	2020/21	Notes
Patient experience Ensure that the percentage of patients who report positively on their experience is better than the national average. Ensure pain control measures improve.	Hospital: 😐 Partially achieved Community: 😐 Partially achieved	Hospital: 😐 Partially achieved Community: 😐 Partially achieved	Hospital: 😐 Partially achieved Community: 😐 Partially achieved	Hospital: 😐 Partially achieved Community: 😐 Partially achieved	**Priority 1**	See page 9 for more information
Pressure ulcers Reduce the occurrence of avoidable pressure ulcers.	Hospital: 😐 Partially achieved Community: 😐 Partially achieved	Hospital: 😐 Partially achieved Community: ☹ Not achieved	Hospital: 😐 Partially achieved Community: ☺ Achieved	Hospital: ☺ Achieved Community: ☺ Achieved		See page 13 for more information
Infection control Reduce our MRSA rate in line with national and local priorities.	☺ Achieved	☺ Achieved	☹ Not achieved	☹ Not achieved		See page 15 for more information
Reduce our Clostridium difficile rate in line with local and national priorities.	☺ Achieved	☺ Achieved	☺ Achieved	☺ Achieved		
Nutrition Ensure there are effective processes in place for nutrition care.	😐 Partially achieved	😐 Partially achieved	😐 Partially achieved	😐 Partially achieved		See page 17 for more information
Hydration Ensure there are effective processes in place for hydration care.						
Medications Ensure effective processes are in place for medicine administration.	☹ Not achieved	☹ Not achieved	☹ Not achieved	☹ Not achieved		See page 20 for more information
Discharge Management **Ensure effective discharge planning systems are in place**			😐 Partially achieved	Hospital: 😐 Partially achieved Community: ☺ Achieved	**Priority 2**	See page 22 for more information
Incident Management **Ensure there is a positive learning culture**			😐 Partially Achieved	😐 Partially Achieved		See page 26 for more information

2.1.2 Choosing our priorities for 2020/21

The quality priorities for 2019/20 covered the following seven topics:

1. Patient experience
2. Infection control
3. Pressure ulcers
4. Nutrition/hydration
5. Medication
6. Discharge management
7. Incident management

These key topics were agreed by the Board of Directors due to their importance both from a local perspective (e.g. based on key issues from patient feedback, both positive and negative) and from a national perspective (e.g. reports from national bodies such as the Health Ombudsman, CQC etc.). The first four topics were agreed five years ago at a collaborative event on the Quality Report, hosted by the chief executive and chief nurse who were in post at the time, attended by staff, governors, Foundation Trust members and others from key outside organisations. These topics have been endorsed in discussions with the Dudley MBC Health and Social Care Scrutiny Committee and Dudley Clinical Commissioning Group. The fifth topic, medication, was added in 2016/17 following a review of patient feedback on their care and treatment.

Following further year-on-year consultations internally; with governors, patients and others who attended the Annual Members Meeting; the public generally via an online questionnaire and our main commissioner, it was agreed in 2018/19 that these topics should be retained with two further topics added - discharge management and incident management. For 2019/20, all of these topics were retained.

To shape priorities for the coming year, a listening event was held in October 2019 to get the views of as many stakeholders as possible. Invited were a variety of Trust staff including nurses, doctors, allied health professionals, and pharmacy and governance staff from both the hospital and community. Colleagues from Dudley CCG were invited as were a number of governors, the chief officer of Healthwatch Dudley and a representative from Dudley MBC.

There was general agreement that the topics should be reduced to enable concentration on two or three. It was agreed the topics should not be either: 1) ‘day to day’ issues that are being monitored for either national or local contracts/requirements (e.g. FFT, MRSA etc) but that these would continue to be monitored for general performance management purposes or 2) topics that had recently improved (e.g. pressure ulcers, MUST scores).

The need to focus on patient experience was considered a priority. The importance of patient flow and effective discharge processes was also seen to be important. The general view was that patient experience was key, particularly in terms of what patients themselves tell us about communication processes. Good listening skills and good patient involvement in their care and treatment plans, for example, were thought to be important issues. It was appreciated however that having specific measurable indicators for such topics may be difficult. A creative thinking event occurred with key staff to suggest a number of specific indicators for these two topics. Suggestions went to the board who agreed the indicators outlined in this report.

2.1.3 Our priorities

Priority 1 of 2019/20: Patient experience
a) Achieve monthly response rates in Friends and Family Test (FFT) for all areas (inpatients, outpatients, maternity, Emergency Department and community) that are equal to or better than the national average. b) Achieve monthly scores in Friends and Family Test (FFT) for all areas (inpatients, outpatients, maternity, Emergency Department and community) that are equal to or better than the national average. c) Improve the overall year score from 2018/19 to 2019/20 for the following question used in our local real-time survey: Were you involved as much as you wanted to be in decisions about your care? d) Improve the overall year score from 2018/19 to 2019/20 for the following question used in our local real-time survey: When you reached the ward, were you given a 'Welcome to Russells Hall Hospital' booklet?

Rationale for inclusion and how we measure and record this priority

- The FFT recommended score and response rates targets have been retained as they remain a national focus, provide valuable benchmarking information and drive improvement to the patient experience. We only saw a slight improvement in the local survey question asked last year and so this has been retained to improve further.
- Our present local survey results show that not all patients are being provided with the hospital welcome booklet that contains useful information for all patients.

The FFT survey provides valuable data to support local actions to improve the patient experience. The NHS Friends and Family Test (FFT) is firmly embedded within the Trust with all patients given the opportunity to complete the survey after each episode of care and treatment in all areas of the organisation. Feedback is captured through a variety of methods (SMS or smartphone app, tablet or kiosk at point of discharge and online once patient is home). The question is also included in the inpatient local surveys and scores are recorded on the internal Friends and Family database. We measure the numbers of responses received against the total number of eligible patients. Our local real time surveys cover the last two items above. We measure this by inviting inpatients who have been given an estimated discharge date and who are expecting to be discharged within 48 hours, to answer these questions. An average of 120 patients are surveyed each month.

Halesowen District Nurses visited my mother following knee replacement surgery. They were unfailingly kind and caring and their visits filled her with confidence and reassurance. Thank you so much for your care.

Developments that occurred in 2019/20

- Increased the availability of the Friends and Family survey online app and promoted widely.
- Refreshed the Friends and Family Test survey cards.
- Continued to hold Feedback Fridays weekly.
- Expanded FFT survey via SMS to include children and maternity specialty areas.
- Increased the number of listening events and focus groups.
- Implemented a publicity drive about the welcome booklets. Examined data and information in more detail to identify teams that are performing well and share best practice.
- Carried out a review of the current process, including how the local survey is deployed across all teams and the current methods of data collection.
- Community services have hosted 'Lunch and Learn' sessions to identify trends and learning.
- Increased patient experience volunteers to carry out ward visits and promote the Friends and Family Test.

Current status

Family and Friends Test

a) Response Rate Update April 2019 – March 2020

Inpatient		A&E	Antenatal	Birth			Postnatal Ward	Postnatal Community	Community		Out-patients
11	1	12	-	7	4	-	-	-	11	1	-

(Where national response rate data is not available, this has been calculated internally using 12 months of NHS England raw data from February 2018 to January 2019).

For April 2019 – March 2020 (47 areas were published) the Trust is achieving the performance indicator on 41 occasions where the percentage response rate score is equal to or better than the national average percentage response rate. The areas not achieving the performance indicator are maternity birth. No national comparative data was published for response rates for maternity antenatal, maternity postnatal ward, maternity postnatal community and outpatients.

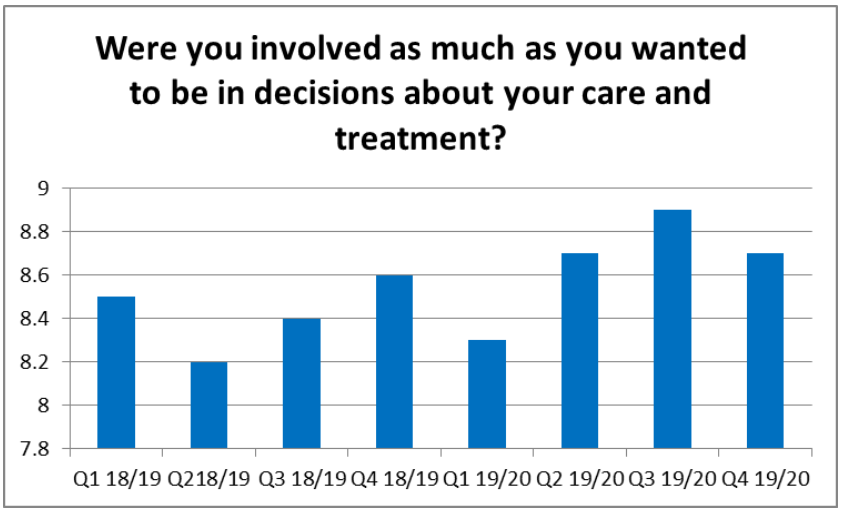
b) Percentage Recommended Update April 2019 - March 2020

Inpatient	A&E		Antenatal			Birth		Postnatal Ward			Postnatal Community			Community	Outpatients	
12	12	7	4	-	7	4	-	4	7	-	8	3	-	12	1	11

(Where national response rate data is not available, this has been calculated internally using 12 months of NHS England raw data from February 2018 to January 2019).

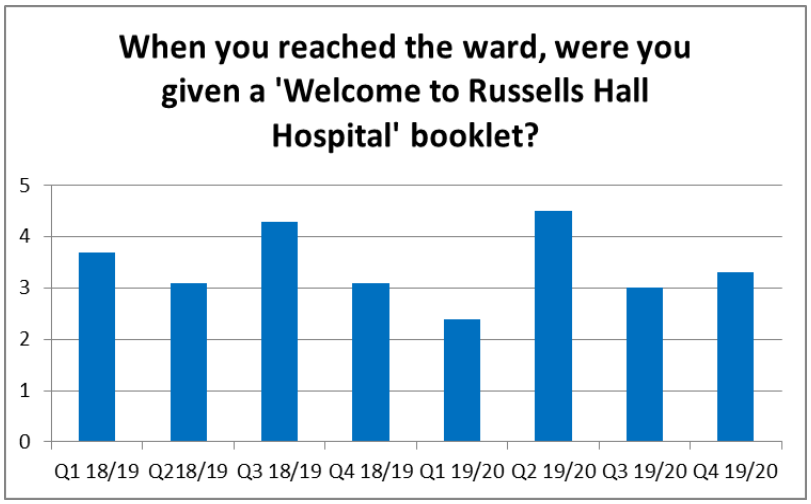
For April 2019 – March 2020 (92 areas have been published) the Trust achieved the performance indicator on 27 occasions where the score is equal to or better than the national average percentage recommended. The areas that are not achieving the performance indicator are inpatients, A&E, community, maternity postnatal ward and outpatients.

c) **Improve the overall year score from 2018/19 to 2019/20 for the following question used in our local real time survey: Were you involved as much as you wanted to be in decisions about your care?**



The scores at the end of each quarter are shown and the 2019/20 full year score was 8.6 in comparison to 8.4 in 2018/2019. This priority has been achieved for the whole year.

d) **Improve the overall year score from 2018/19 to 2019/20 for the following question used in our local real time survey: When you reached the ward, were you given a 'Welcome to Russells Hall Hospital' booklet?**



The scores at the end of each quarter are shown and the 2019/20 full year score was 3.3 in comparison to 3.5 in 2018/2019. This priority has not been achieved for the whole year.

New priority 1 for 2020/21: Patient experience

1. Improve the way we communicate and engage with patients.

   a) 'Do staff treating and examining you introduce themselves?' (National baseline Maternity 2019 99%, Children 2018 93% with the aim being 95% overall).

   b) 'Have you been told what is going to happen to you today (tests etc)?' (Local survey baseline 59% with suggested improvement to 95%)
   (At present, the first question is not part of the local survey but will be added.)

   c) Hold a quarterly forum/focus group with each prioritising two key planned actions and undertaking those actions and measuring the success.

d) Hold the newly developed Citizen Panel at least quarterly (this may be more frequent depending on the views of the attendees at the first meeting).

e) Establish a group of Expert Volunteers to ensure we raise the patient voice so that services are delivered compassionately.

2. Ensure all complaints are responded to in accordance with the Trust complaints and concerns policy. Action plans will be shared for review and learning so that patients and other professionals can see change being made.

a) Improve the percentage of complaints responded to within the internal timeframe of 30 working days (current figure 23%).

Rationale for inclusion

- Providing the best possible patient experience means getting the fundamentals right, making sure our patients feel safe and well-cared for, that they have trust and confidence in the staff caring for them and that they receive excellent quality care in a clean and pleasant environment.
- Having assessed the outcome of the National Inpatient Survey, it was decided to include a new target for a topic where we did not perform as well as other questions.

How we measure and record this priority

- Our local real time surveys cover the first two items above. We measure this by inviting inpatients who have been given an estimated discharge date and who are expecting to be discharged within 48 hours, to answer these questions. An average of 120 patients are surveyed each month.
- We will keep records of when the forum/focus groups, Citizen Panel and Expert Volunteers meet.
- Our complaints database contains a number of recorded dates such as the date the complaint was received and the date of response.

Developments planned for 2020/21

- We will raise the profile of our 'what matters to you' campaign across the Trust and via social media channels. This campaign aims to raise the profile of patient experience across the Trust, capture feedback and share successes. This will be done by using a wide range of mechanisms and reporting on the activity to facilitate organisational learning and improvement in order to achieve the objectives highlighted in the Patient Experience Strategy. There is a communications plan in place for the launch of the campaign.
- The Trust will be developing a 'Patient Panel' to give patients, carers and members of the public the opportunity to have their say on how our services are run and to provide us with feedback on our current service provision and proposals for service redesign and future developments.
- We will be recruiting Patient Voice Volunteers to give patients the opportunity to actively participate in surveys and other health-related activities, give ideas and opinions on how health services can be improved by being part of focus group discussions and workshops, and to use their experiences of health services, as a patient or a carer, to inform and influence the delivery, planning and quality of services we provide. The Patient Voice Volunteers will also represent the interests and views of local patients and carers in the Dudley borough with the overall aim of improving the experiences of people who use our services.
- We will be introducing Patient Reported Experience Measures Survey (PREMs) into the organisation to ensure that more efficient and effective systems are in place to engage with patients and carers to provide feedback on their care. PREMS are used to understand service users' views

on their experience while receiving care, rather than the outcome of that care. This aims to achieve a way of surveying patients using a standard set of questions to capture, understand and use service experience in a consistent way, linked to CQC care standards and cross referencing the findings with the Friends and Family Test as an overall satisfaction score.

Board sponsor: Mary Sexton, chief nurse. **Operational lead:** Jill Faulkner, head of patient experience

The staff in C6 ward could not have done enough for me! The care and attention I received was very thorough and the whole process was explained succinctly and professionally. Thank you very much team, I am on the mend.

Priority 2 of 2019/20: Pressure ulcers	
Hospital	**Community**
a) Ensure that there are no avoidable category 4 hospital acquired pressure ulcers throughout the year. b) Ensure that the number of avoidable category 3 hospital acquired pressure ulcers in 2019/20 reduces from the number in 2018/19 by at least 10 per cent.	a) Ensure that there are no avoidable category 4 pressure ulcers acquired on the district nurse caseload throughout the year. b) Ensure that the number of avoidable category 3 pressure ulcers acquired on the district nurse caseload in 2019/20 reduces from the number in 2018/19 by at least 10 per cent.

Rationale for inclusion

- Pressure ulcers remain a significant healthcare problem despite the knowledge that pressure ulcers are largely preventable.
- Avoidable pressure ulcers are a key indicator of the quality and experience of patient care.
- Feedback from our patients, staff, community groups and governors indicates this should remain a target.

How we measure and record this priority

In order to reduce the incidence of pressure ulcer development, it is important that we measure the incidence and identify the contributing trends and themes.

- When potential pressure damage is identified, the details are entered into the Trust's incident reporting system. Depending on the category of damage, the incidents are reviewed by the lead nurse, matron or the tissue viability team to confirm the category and provide advice and support to the patient's care provider.
- Root cause analysis (RCA) investigation is performed for all acquired pressure ulcers of category 3 and above including Suspected Deep Tissue Injury to allow for a systematic evaluation of the contributing factors.

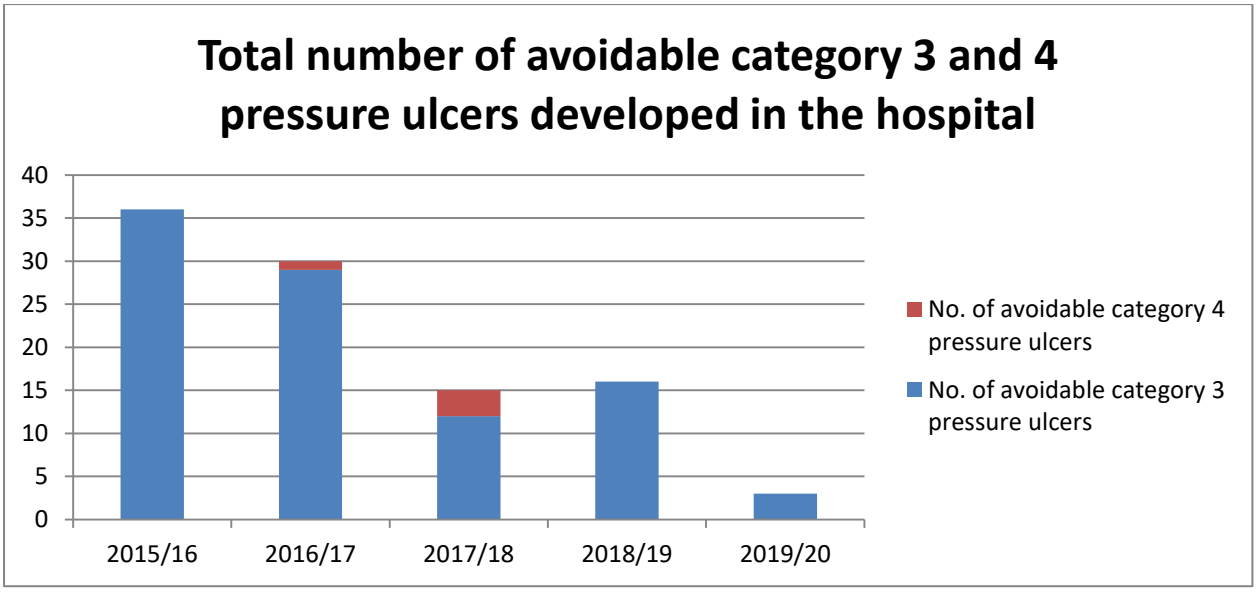
- The duty of candour process ensures that we inform patients and relatives if there have been mistakes in their care that have led to significant harm.

Developments that occurred in 2019/20

- Development of e-learning for all staff.
- Undertook joint working with industrial partners to ensure staff are competent and confident to use treatments and therapies appropriately for the prevention and management of pressure ulcers.
- Fully implemented the NHSi strategy: Pressure ulcers refined definition and measurement to ensure accuracy of reporting.
- Delivered three educational events including 'Pressure ulcers – learning from incidents'. 'Documentation, report writing and fact finding' and 'Complexities of wound healing'.
- Delivered a Trust wide study day 'Coroners Court Experience - is your documentation good enough' sponsored event.
- Delivered the international 'Stop the Pressure' campaign.
- Reported category 2 pressure damage with the aim to reduce the incidents of category 2 pressure damage.
- Reported 'moisture lesions' with an aim to ensure that continence is managed appropriately and reduced.
- Reviewed patient information leaflets and relevant policies for accuracy and update.
- Implemented national guidelines on the prevention and management of skin damage associated with the wearing of PPE during unprecedented COVID-19 period.

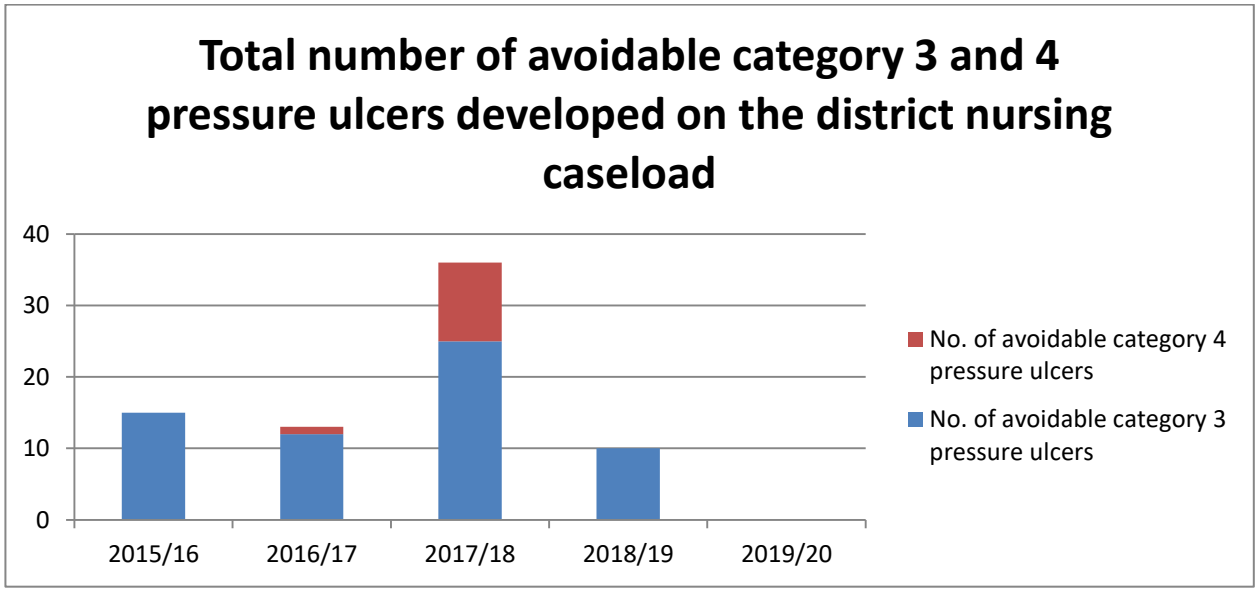
Current status: Hospital

The graph below shows the total number of avoidable category 3 and 4 pressure ulcers that have developed in the hospital from 2015/16 to present. It gives an indication of the fall in numbers due to the hard work of all staff involved. For the full year 2019/20, there have only been three avoidable category 3 ulcers and there have been zero avoidable stage 4 pressure ulcers and so this priority has been achieved.



Current status: Community

Both targets have been achieved this year as there have been no avoidable category 3 or 4 pressure ulcers acquired throughout the year on the district nurse caseload (see graph below).



Board Sponsor: Mary Sexton, chief nurse. **Operational Leads:** Deputy chief nurse Carol Love-Mecrow, divisional chief nurses Julie Pain and Jenny Bree, tissue viability lead nurse Gill Hiskett.

Priority 3 of 2019/20: Infection control	
Maintain or reduce our MRSA and Clostridium difficile (C. diff) rates in line with national and local priorities. All cases will undergo a root cause analysis, the results of which will be discussed jointly by the Trust and Dudley CCG to agree on any avoidability/lapses in care.	
MRSA	**Clostridium difficile**
Have 0 post 48 hour cases of MRSA bacteraemia (blood stream infections).	Have no more than 49 hospital onset healthcare associated (HOHA) cases detected two or more days after admission or community onset healthcare associated (COHA) cases that occur in the community when the patient has been an inpatient in the Trust in the previous four weeks.

Rationale for inclusion and how we measure and record this priority

- The Trust and Council of Governors have indicated that the prevention and control of infections remains a Trust priority.
- NHS England has a zero tolerance of MRSA bacteraemia.
- The Trust has a challenging nationally-set target of no more than 49 C. diff cases for the coming year.

Infections are monitored internally, along with other key quality indicators, on the Trust's electronic dashboard (see section 3.1). In addition, these infections are monitored by our commissioners at quality review meetings. Positive MRSA bacteraemia and C. diff results are reported on the national Healthcare Associated Infections data capture system.

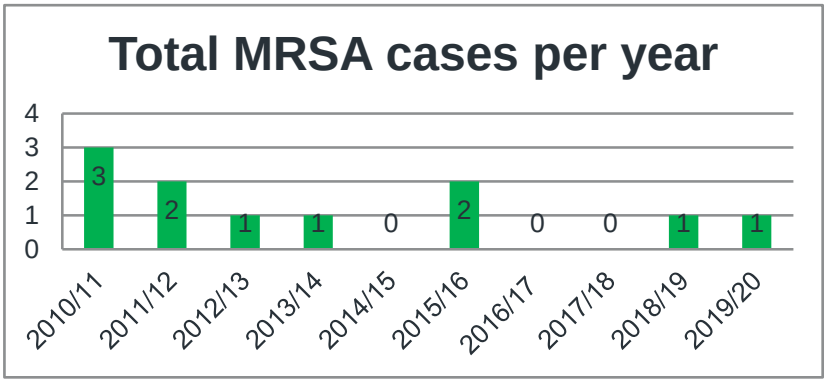
Developments that occurred in 2019/20

- Participated in National Infection Prevention and Control week.
- Participated in WHO Clean Your Hands campaign.
- Contributed to Health Economy Programme to reduce gram negative blood stream infections.
- Took part in Antimicrobial Stewardship Awareness week.
- Reviewed the antimicrobial policy and included clinical teams in the membership of the antimicrobial steering group.
- Monitored compliance with MRSA screening and action plans.
- Commenced divisional reports at Infection Prevention and Control Group.
- Ensured ongoing compliance with mandatory training key performance indicators.

Current status: MRSA

NHS England has set a zero tolerance approach to MRSA bacteraemia. There has been one Trust assigned MRSA bacteraemia in this period. The case has undergone a root cause analysis (RCA) utilising the national tool.

The cause was believed to be a contaminant. The outcomes of the RCA were presented and discussed at a multidisciplinary meeting chaired by the CEO and including representatives from the Dudley Office of Public Health and Dudley CCG. Learning outcomes and actions were identified and shared at ward level via staff meeting/huddle board and with the wider Trust through divisional meetings and the infection prevention group.



Current status: Clostridium difficile

The Trust reports all cases of Clostridium difficile toxin positive disease identified in the hospital laboratory. Changes to the reporting for the 2019/20 year were made to align the UK definitions with international descriptions of disease, however, with regards to the quality priority there are two groups:

- **Hospital onset healthcare associated (HOHA)**: detected in the hospital two or more days after admission
- **Community onset healthcare associated (COHA)**: cases that occur in the community or within two days of hospital admission when the patient had been an inpatient in the Trust reporting the case, within the previous four weeks.

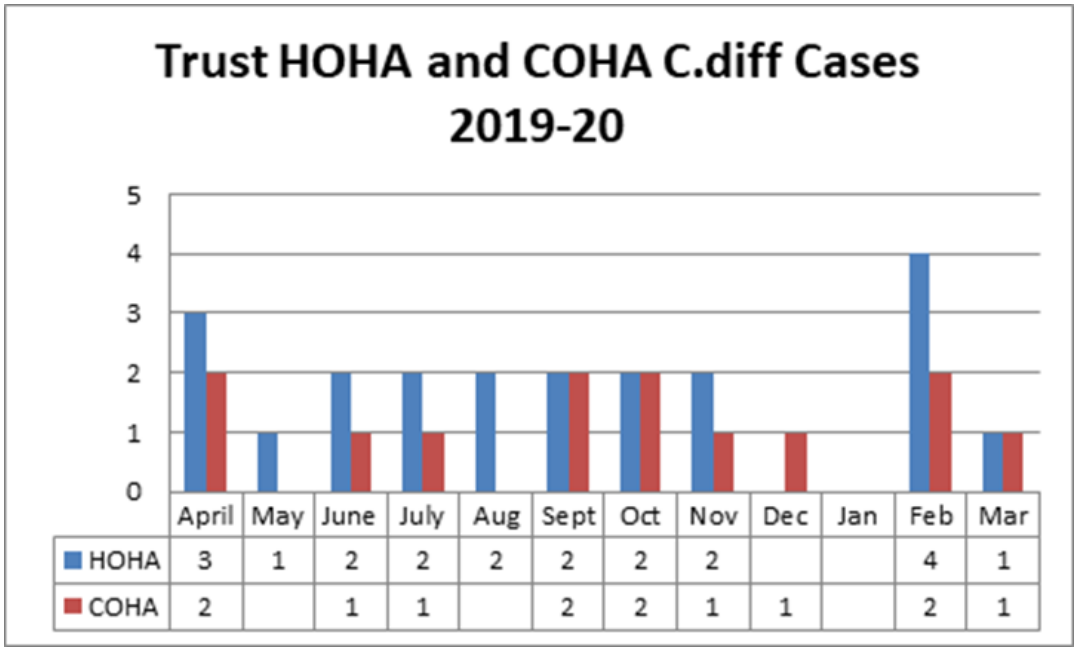
Over the whole year, the number of cases that occurred were:

- 21 hospital onset healthcare associated (HOHA)
- 13 community onset healthcare associated (COHA)

The cases were discussed across the health economy using the national apportionment tool. Themes for the issues identified were antimicrobial stewardship, environmental issues and mandatory training. In order to address issues clinical teams were required to develop action plans which were then monitored locally and via reports submitted by divisions to the Infection Prevention and Control Group.

Of the 34 cases, 18* are where a lapse in care was identified. This means that the threshold of no more than 49 cases has been achieved. (*at the time of writing RCA panel meetings were suspended due to COVID-19 work pressures. There are two HOHA RCAs awaiting review).

The table below demonstrates the number of Clostridium difficile positive cases identified at the Trust for this reporting period.



	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
HOHA	3	1	2	2	2	2	2	2			4	1
COHA	2		1	1		2	2	1	1		2	1

Board sponsor: Mary Sexton, chief nurse, **operational leads:** Director of infection prevention and control Dr Elizabeth Rees, infection prevention and control lead nurse Emma Fulloway.

Priority 4 of 2019/20: Nutrition and hydration

a) At least 95 per cent of acute patients will receive a nutritional assessment within 24 hours of admission to the hospital using the nationally recognised MUST (Malnutrition Universal Screening Tool).
b) With regards to supported mealtimes, 95 per cent of all of the monthly audits will have a positive response to the following three questions:
1) Has all non-essential activity stopped?
2) Is there a nominated qualified nurse overseeing the mealtime?
3) Is there a nominated person to support all patients identified as requiring assistance?

Rationale for inclusion and how we measure and record this priority

- With regards to the MUST target in the hospital, this was not achieved in 2018/19 and so it is retained due to the importance of undertaking a systematic nutritional assessment of all patients who are admitted.
- Supported mealtimes are periods of time over lunch and tea when all non-urgent clinical activity stops. This ensures patients are able to eat their meals in a calm and relaxed environment without unnecessary interruption. It allows nursing staff to monitor and help patients to meet their nutritional

needs which helps to ensure patients don't become malnourished. The newly appointed nutrition nurse has noticed that this system is not universally adopted throughout the hospital.

- Feedback from our patients, staff, community groups and governors indicates this should remain a target.

As part of the monitoring of care relating to nutrition and hydration, a comprehensive audit tool was introduced in 2014. This follows the quality indicator model (see section 3.3.5) and involves auditors checking what is recorded in the nursing notes and asking patients about their experience of being offered drinks and a choice of food. It also includes observations of the environment, for instance whether patients have drinks within reach and whether patients are placed in an optimal position for eating. In total, there are 24 elements to the audit and it is undertaken on 10 patients on every ward each month. The MUST score is also audited as part of the Quality Indicator monitoring.

Developments that occurred in 2019/20

The focus on nutrition and hydration in 2019/20 has focused on five areas:

1. **Increasing staff engagement and awareness**

- Celebratory events such as Nutrition and Hydration Week. This included Trust-wide patient tea parties to increase patient calories in an exciting way, and a host of other events.

- 'MUST is a MUST' trolley dashes which involved visiting areas to 'test and teach' within nutrition hydration competitions.
- Meal Time Matters week where ward areas identified what they thought made the best hospital meal time, including the best board competition.
- Dysphagia awareness day organised with the learning disability team and speech and language team to increase awareness of providing safe nutrition to patients with swallowing difficulties.
- 'Meal time think tank' was completed, this involved clinical support workers, therapy workers and catering teams coming together to strengthen relationships and bring together individual improvement ideas.
- Meal time engagement video filmed in Trust and used in education.
- Healthcare Hero nominations completed when excellent nutrition and hydration practice was seen. The frailty ward was nominated for brilliant individualised meal time observation and patient feedback.
- Launch of the 'best served cold' initiative to increase awareness of individualised dietary supplement provision (flavours and temperature).
- Increased Trust intranet presence by redesigning the nutrition and hydration page and showing screensavers.

2. **Increased education on nutrition and hydration, specifically on the malnutrition universal screening tool**

- E-learning for health on nutrition and hydration easily accessible to all staff.
- Intensive face to face education delivered to developing areas.
- Student nurses, graduate qualified nurses and clinical support workers on a rolling education programme.
- Specialist nutrition nurse and qualified nurse one to one teaching provided to developing ward areas.

3. **Audit**

- Daily deep dive audits completed in areas by specialist nurses, invaluable information gathered to encourage improvement.
- Ward areas increased frequency of audits when underperforming.
- Multidisciplinary Trust-wide meal time audit completed to gather intelligence around baseline themes. This has helped to provide improvement goals for the future.
- Multidisciplinary nutrition task and finish group created.

4. **Food and drink provision**

- Improved patient menu and new meal trolleys introduced throughout the Trust.
- New dysphagia menu developed in line with international descriptors.
- Finger foods added to special menu to help with increasing food intake for patients with dementia/learning disabilities and those with a small appetite.
- Provision of snacks trialled on three ward areas.

5. **New ways of working**

- Pat slide scales trialled in admission areas.
- Volunteers assisting at meal times piloted in one area for four weeks, which is currently under review.

Current status: Nutrition/hydration

a) At least 95 per cent of acute patients will receive a nutritional assessment within 24 hours of admission to the hospital using the nationally recognised MUST (Malnutrition Universal Screening Tool).

Financial Quarter	Percentage
Q1	92.9%
Q2	95.3%
Q3	96.4%
Q4	96.6%
Full year 2019/20	94.4%

- With regards to the MUST result, we have just missed the target of 95 per cent but improved from last year (90 per cent). In a data audit exercise at the end of the year, we discovered a software programming error which meant the score should have been 94.7 per cent. This error has been rectified going forward. In quarter four the ward areas had additional challenges with the COVID-19 response which may have negatively affected the March 2020 results.

b) With regards to supported mealtimes, 95 per cent of all of the monthly audits will have a positive response to the following three questions:

1) Has all non-essential activity stopped?

Financial Quarter	Percentage
Q1	98.0%
Q2	100%
Q3	100%
Q4	96.6%
Full year 2019/20	98.7%

2) Is there a nominated qualified nurse overseeing the mealtime?

Financial Quarter	Percentage
Q1	90.0%
Q2	94.7%
Q3	83.6%
Q4	88.1%
Full Year 2019/20	89.1%

3) Is there a nominated person to support all patients identified as requiring assistance?

Financial Quarter	Percentage
Q1 2019/20	100%
Q2 2019/20	98.2%
Q3 2019/20	100%
Q4	100%
Full Year 2019/20	99.5%

We are pleased to note that we achieved two of the three targets above. Qualified nurse presence at meal times is essential to provide oversight of adequate nutrition and hydration. The target of 95 per cent has not been met this year and so a Trust-wide meal time development plan has been completed to achieve this in 2020/21.

Board sponsor: Mary Sexton, chief nurse **operational leads:** Jenny Bree and Julie Pain, divisional chief nurses, matron Sheree Randall, matron Debra Vasey and Trust nutrition lead Izzie Gibson.

Priority 5 of 2019/20: Medications

a) All patients who have a known potential to have an adverse reaction or have an allergy or sensitivity to a product/medication are clearly identified by having a red identification band in place.
b) Achieve a 50 per cent reduction in the number of patients who are not prescribed analgesia for breakthrough pain when they are prescribed regular opioids for pain management.

a) The audit of red wrist bands only commenced at the end of 2018/19 so we are retaining this target in 2019/20. It is important to reduce and, where possible, eliminate the risk and consequences of exposing a patient who is known to have an adverse reaction or allergy or sensitivity to a medication/product that may be used in their care.

b) Feedback from patient complaints has identified that some patients' pain control is suboptimal. The aim of this work is to ensure that patients receive the lowest effective dose to control their pain and allow both a 'step up and step down approach' to pain management.

How we measure and record this priority and developments planned for 2019/20

a) This information is collected as part of the monthly Quality Indicator monitoring (section 3.3.5)

b) Baseline data was collected during Q1 2019/20 by pharmacists as part of their routine ward visits to inpatient wards. A 'snap-shot' audit tool has been used to record information from inpatient drug charts. No patient identifiable data is recorded. This was followed by a complex intervention combining pharmacist-led feedback and other interventional strategies e.g. education and awareness campaigns, targeted towards nursing, pharmacy and medical staff. Post intervention data collection will then be collected during Q4 2019/20. The variation in prescribing pre- and post- intervention will then be evaluated to identify any improvement. It is assumed that implementing the intervention will improve learning, change in healthcare professional behaviour and improved outcomes for patients.

Developments that occurred in 2019/20

- Educational sessions delivered on pain management to foundation trainee doctors and core medical trainees.
- Education given to pharmacists to encourage prescribing of analgesia that allows drug choice and dosage to be titrated according to patients' individual requirements.
- Chief pharmacist and medication safety officer presented at Emergency Department (ED) team meeting to raise awareness about prescribing the lowest effective dose for pain control for the shortest possible duration.
- 'Audit and feedback' of quantity and duration of opiate prescribing on ED outpatient prescriptions completed.
- Quality improvement project completed on three wards which has enabled inpatients to receive prompter administration of their prescribed analgesia. A governance framework has been developed to facilitate safe implementation on other inpatient wards.

Current status

a) All patients who have a known potential to have an adverse reaction or have an allergy or sensitivity to a product/medication are clearly identified by having a red identification band in place.

Financial Quarter	Percentage
Q1	91.6%
Q2	91.8%
Q3	96.3%
Q4	96.8%
Full Year 2019/20	94.1%

Although there was an improved performance towards the end of the year, overall this target was not achieved. Local ward audits continue monthly and in those areas not achieving 100 per cent the lead nurses are undertaking weekly audits to improve compliance. The divisional chief nurses are addressing this issue at monthly meetings and to further compliance staff are encouraged to complete an incident report when a red wrist band is found not to be in place.

b) Achieve a 50 per cent reduction in the number of inpatients who are not prescribed analgesia for breakthrough pain when they are prescribed regular opioids for pain management.

A baseline snap-shot audit was completed during May 2019 across all inpatient wards receiving a ward-based clinical pharmacy service. Medication charts for 547 patients were reviewed, of which 106 patients were prescribed an opioid on the 'regular section' of the chart for pain management. Of these 106 patients, 20 patients were not prescribed analgesia for breakthrough pain. The audit was repeated post-intervention, during March 2020. Medication charts for 356 patients were reviewed, of which 50 patients were prescribed an opioid on the 'regular section' of the chart for pain management. Of these 50 patients, 13 patients were not prescribed analgesia for breakthrough pain. There was a seven percentage point increase in the number of inpatients who were not prescribed analgesia for breakthrough pain when they were prescribed a regular opioid for pain management and so unfortunately this target was not met. It should be noted that although fewer inpatient charts were reviewed during March 2020 compared to May 2019 both audits included prescribing for inpatients in a range of acute, medical and surgical wards.

Financial Quarter	Number of patients prescribed a regular opioid who were not prescribed PRN analgesia	Number of patients who were prescribed a regular opioid, who were also prescribed PRN analgesia	Percentage of inpatients not prescribed analgesia for breakthrough pain when they are prescribed regular opioids for pain management	Number of inpatients reviewed
Q1	20	106	19%	547
Q4	13	50	26%	356

Board sponsor: Mary Sexton, chief nurse, **operational leads:** Julie Pain and Jenny Bree, divisional chief nurses, matron Sara Davies and lead pharmacist medicines governance Suzanne Cooper.

Priority 6 of 2019/20: Discharge Management (including reduction of inappropriate admissions)

Hospital
a) All patients will have an Expected Discharge Date (EDD) determined by assuming ideal recovery and assuming no unnecessary waiting.
b) All wards will achieve their individually set target for the number of discharges per day.

Community
c) Develop an audit tool, commence monitoring and capture a baseline in Q1.
d) The percentage of patients with an advanced care plan in the community is increased by 10 per cent from the baseline by the end of the year.

Rationale for inclusion

Hospital

- Ensure effective discharge planning starts at the point of admission to ensure patients get the best possible care in the right place.
- Ensure patients feel involved in their discharge planning to ease any anxiety or distress which may be caused by admission to hospital.
- Feedback from patient survey to monitor comments and outcomes from 'Don't waste time this life is mine'.
- Continual use of the Trust electronic discharge database.
- Developments planned with Sunrise with discharge planning proforma.

Community

- Patients dying in place and manner of preference.

- Support for carers in patient's preferred place.
- Reduce unnecessary attendance at Emergency Department.
- Support and implement Gold Standard Framework goals.
- Response to Bewick Report.
- Care coordinated and joined up across the providers.
- Support Dying Matters national initiative.

How we measure and record this priority

Hospital: We measure and record this priority with the estimated discharge date and time of discharge recorded on the electronic patient administration system, which links with the Trust's discharge database. On the database, delays in discharge and the reasons for delays are recorded. These systems make it possible to monitor the above targets.
Community: An audit will be performed to monitor the increase in advance care planning in place as part of the Quality Indicators (see section 3.3.5). This will be undertaken on a monthly basis by the community team. A dataset will be extracted from the computerised patient administration system, comparing the baseline numbers of advance care plans prior to starting the audit.

Developments that occurred in 2019/20

Hospital

- Visual bed states to support effective capacity planning and discharge management rolled out to certain wards as part of a pilot.
- Continued rollout of 'Don't waste time this life is mine' linking with the Red 2 Green principles.
- Further development with the hospital discharge team including social workers and therapists to support effect discharge planning from the point of admission.
- Trusted Assessor service to work across seven days to support productive discharge planning and provide a link to care homes.
- Developed a 'home first' culture across the Trust to ensure all patients have the opportunity to return home.
- Successful new pathway implemented called Transitional Care to support assessments outside of the hospital and allowing people to have time to recover outside of the hospital setting.
- Successful implementation of the 'Long Stay Wednesday' with super stranded reduced significantly.

Community

- Promoted the 'planning for your future care' document.
- Educated and supported patients and relatives to understand the concept of advanced care planning.
- Community team involved in Dudley Improvement Plan to improve the efficiency and effectiveness to core level palliative care with dignity.
- Community team involved in monthly Gold Standard Framework meetings with general practitioners as a multidisciplinary approach.

Current Status

Hospital

a) The number of EDDs set for adult inpatients for each quarter of the year from Q1 to Q4 have been 84.2 per cent, 86.7 per cent, 88.7 per cent and 87.4 per cent. It was realised that the target set at the beginning of the year that all patients would have an EDD would be difficult, especially with patients with complex care needs, but it has helped in improving our performance from last year which had an

overall figure of 73.3 per cent. We will continue next year to emphasise the importance of this so that patients' care is planned in an effective way.

b) Following an assessment of each ward's discharge rates and speciality, two targets per ward were set for weekdays and weekend days. The chart below indicates for each ward the targets for the number of discharges per day with the percentage of times for each quarter (Q1-Q4) that target has been met.

The percentage figures for Q4 have been coloured to indicate whether there has been improved (green) performance compared to Q1 (or compared to Q2 for the wards that were divided at Q2). This indicates there has been an improvement in discharge numbers in 11 of the 18 wards for weekdays and 5 of the 17 wards for weekends.

Surgical Wards			
Ward		Weekday	Weekend
B1	Target	4	4
	Q1	81.5	73.1
	Q2	86.4	61.5
	Q3	86.4	65.4
	Q4	89.2	76.9
B2 Hip	Target	3	3
	Q1	15.4	23.1
	Q2	43.9	34.6
	Q3	75.8	42.3
	Q4	33.8	7.7
B2 Trauma	Target	3	2
	Q1	38.5	57.7
	Q2	69.7	69.2
	Q3	69.7	84.6
	Q4	63.1	53.8
B3	Target	5	4
	Q1	70.8	38.5
	Q2	92.4	61.5
	Q3	86.4	26.9
	Q4	63.1	65.4
B4* B4A/B4B	Target	6 (4/2)	4 (3/1)
	Q1	20	38.5
	Q2	75.8/78.8	15.4/65.4
	Q3	83.3/69.7	19.2/34.6
	Q4	67.7/58.5	42.3/30.8
B5	Target	4	4
	Q1	69.2	57.7
	Q2	93.9	65.4
	Q3	74.2	34.6
	Q4	80	61.5
C6	Target	4	4
	Q1	50.8	46.2
	Q2	87.9	61.5
	Q3	83.3	65.4
	Q4	76.9	34.6
C2	Target	10	9
	Q1	92.3	80.8
	Q2	100	50
	Q3	100	42.3
	Q4	95.4	100

Medical Wards			
Ward		Weekday	Weekend
C1* C1A/C1B	Target	4 (3/1)	3 (2/1)
	Q1	52.3	34.6
	Q2	71.2/47	11.5/34.6
	Q3	54.5/28.8	7.7/57.7
	Q4	23.1/33.8	15.4/15.4
C3* C3/FMNU	Target	5 (4/1)	2 (2/0)
	Q1	67.7	80.3
	Q2	59.1/12.1	50/-
	Q3	66.7/13.6	42.3/-
	Q4	66.2/7.7	30.8/-
C4	Target	2	2
	Q1	15.4	38.5
	Q2	51.5	46.2
	Q3	45.5	34.6
	Q4	44.6	15.4
C5* C5A/C5B	Target	6 (5/1)	4 (3/1)
	Q1	87.7	50
	Q2	71.2/53	26.9/76.9
	Q3	56.1/66.7	34.6/73.1
	Q4	63.1/67.7	26.9/23.1
C7	Target	4	2
	Q1	60	73.1
	Q2	86.4	57.1
	Q3	72.7	57.7
	Q4	63.1	30.8
C8	Target	4	3
	Q1	61.5	53.8
	Q2	87.9	38.5
	Q3	71.2	50
	Q4	36.9	11.5

**A number of wards (B4, C1, C3, C5) were divided after Q1*

The Trust continues to prioritise effective planning of treatment and care and subsequent discharge. This can be seen in initiatives such as work with the Trust improvement team to design 'The Perfect Discharge' to ensure that all patients and family members are aware of the proposed EDD, linking the EDDs with the Trust campaign of 'Don't waste time this life is mine', a front end multidisciplinary model being piloted in Acute Medical Unit, additional morning ward and board rounds to support flow on base wards and agreeing to include this topic in our priorities for next year.

Community

A treatment escalation plan, also known as an Advanced Care Plan (ACP), allows the patient, carers and staff members to all be aware of the agreed most appropriate care and treatment in the event of the patient deteriorating. It also ensures that a patient is not unnecessarily conveyed to hospital and their wishes are being met to die in a preferred place.

In Q1 an audit tool was developed and in the 18 care homes covered by the Trust a baseline of the patients having an ACP in place was found to be 17 per cent. In Q2, in the same care homes there were 675 residents and the audit shows that there had been an increase to 26 per cent of patients having an ACP in place. In the third quarter that increase was sustained; with 28 per cent (177 of the 629) of the residents having an ACP. After further strong endeavours by the team during January to March 2020, over half (347) of the 639 residents had an ACP. As the initial number of patients with an ACP was 17 per cent and this has increased at the end of the year to 54 per cent, the target of an increase of 10 per cent has been well surpassed.

The enhanced care team is continuing to support the care staff to increase their confidence of having discussions with residents and relatives about their future plan of care.

Board sponsor: Karen Kelly, chief operating officer. **Operational leads: Hospital:** Gregg Marson, Trust lead – discharge; Jo Newens, divisional manager; Mushtaq Ahmed, chief of surgery; Mike Healy, chief of medicine and integrated care, and Hassan Paraiso, clinical director of the urgent care directorate. **Community:** Edliz Kelly, lead for enhanced care team.

New priority 2 for 2020/21: Discharge Management

By the end of the year, 20 per cent of patients will be discharged before 10am and 35 per cent before midday.

Rationale for inclusion

Hospital

- It is important that patients are assessed, diagnosed and treated in a timely and effective way and are not in hospital longer than is necessary where there is a greater risk of developing complications.
- At present, 15 per cent of patients are being discharged before midday.
- Ensure effective discharge planning starts at the point of admission to ensure patients get the best possible care in the right place.
- Ensure patients feel involved in their discharge planning to ease any anxiety or distress which may be caused by admission to hospital.

How we measure and record this priority

We measure and record this priority with the time of discharge recorded on the electronic patient administration system, which links with the Trust's discharge database.

Developments planned in 2020/21

- The creation of a system-wide bed bureau to support patients to move into the correct type of community bed first time.
- Implementation of the Transfer of Care document to support a single assessment, which can be shared between agencies to ensure a joined up approach for discharge planning.
- Additional Patient Transport Service to support patients to leave hospital as soon as they are medically fit and safe to transfer.
- Building on the Transitional Care Pathway with therapy and social work to ensure patient's time is valued and no unnecessary delays are encountered.

Board sponsor: Karen Kelly, chief operating officer **Operational lead:** Gregg Marson, Trust lead – discharge; Mushtaq Ahmed, chief of surgery; Mike Healy, chief of medicine and integrated care and Hassan Paraiso, clinical director of the urgent care directorate.

Priority 7 of 2019/20: Incident Management

a) The Trust's reporting rate will increase every quarter, culminating in a five per cent increase for the whole year, and its comparative position on the reporting rate of incidents will improve every six months.

b) To reduce the number of breached incident investigations by 30 per cent.

Rationale for inclusion and how we measure and record this priority

- A positive reporting culture is imperative to ensure learning and the implementation of changes in practice.
- Timely incident investigation is essential to capture and embed learning and the implementation of changes in practice.

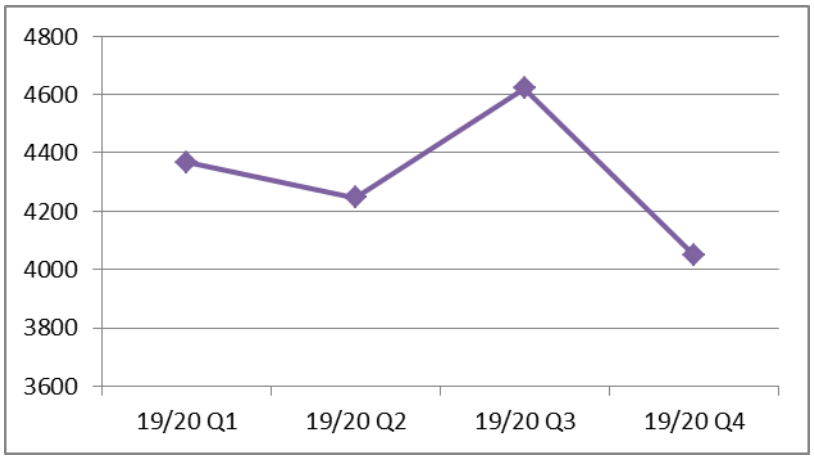
All incidents are recorded within the Trust's incident management system, Datix. Data is extracted from this system monthly and is reported at both an operational level through the respective divisional governance meetings and at a board level through the reporting to the Clinical Quality, Safety and Patient Experience Committee and the board itself. Reported incidents are also recorded within the Trust's integrated performance report and developed ward quality dashboards.

Developments that occurred in 2019/20

- Engaged divisional leaders to understand blockers to complying in timely management of incidents.
- Undertook a scoping exercise of Governance models that would best meet the Trust's requirements.

Current Status

a) Incidents Reported



Although the number of incidents reported increased in the third quarter, there has been a fall in the final quarter. The emergence of the COVID-19 situation occurred in this final quarter which, with the change in patient activity and increased staff sickness and self isolation, may have contributed to this fall. For the whole year, the Trust has seen a five per cent decrease in the number of incidents reported compared to the previous year and therefore the priority has not been achieved. The Trust recognises the need to increase the number of incidents reported as part of its promotion of a safe and open culture. Work continues to reinforce awareness of reporting incidents and embed the subsequent learning.

b) Serious incident investigation timescale breaches

Financial Quarter	Number
Q1	0
Q2	1
Q3	2
Q4	1
Full Year 2019/20	4

In terms of the number of breaches of the timescale to submit a serious incident investigation to the clinical commissioning group, there have been four in total this year so, compared with 50 last year, the fall has been over 90 per cent and so the Trust has achieved this performance measure this year.

Board sponsor: Mary Sexton, chief nurse, **operational leads:** Patient safety manager Justine Edwards, divisional patient safety advisors Helen Hudson, Claire Evans and Alex Thomson.

I would highly recommend the whole department. I went for an initial appointment today and they found I had high pressure in my eye, which was not what I expected. I went for something else, so a complete surprise. Well done everyone, totally professional.

2.2 Statements of assurance from the Board of Directors

2.2.1 Review of services

During 2019/20, The Dudley Group NHS Foundation Trust ('the 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 59 of these relevant health services. The income generated by the relevant health services reviewed in 2019/20 represents 98.3 per cent of the total income generated from the provision of relevant health services by the Trust for 2019/20.

The above reviews were undertaken in a number of ways. With regards to patient experience and safety, the Trust executive and non-executive directors, governors and other senior staff, together with representation from Dudley Clinical Commissioning Group, undertake Quality and Safety Reviews of clinical areas (see section 3.3.2). The Trust has a Mortality Surveillance Group, chaired by the medical director, which reviews all matters relating to mortality including the Trust's mortality tracking system. Dudley Clinical Commissioning Group is invited to join the mortality review process. Every month, each of the three clinical divisions at the Trust has a performance review undertaken when they are assessed by directors on a variety of quality indicators.

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

- Quality Indicators - monthly audits of key nursing interventions and their documentation. Each area has a Quality Dashboard that all staff and patients can view so that the performance in terms of quality care is clear to everyone. The key quality indicators are published, monitored and reported to the Board of Directors every quarter (see section 3.3.5).
- Ongoing patient surveys that give a 'feel' for our patients' experiences in real time allow us to quickly identify any problems and correct them (see section 3.2.2).
- A variety of senior clinical staff attend the monthly three key sub-committees of the board to report and present on performance and quality issues within their area of responsibility: Quality and Safety Committee, Finance and Performance Committee and Workforce and Staff Performance Committee.
- The Trust has an electronic dashboard of indicators for directors, senior managers and clinicians to monitor performance. The dashboard is essentially an online centre of vital information for staff.
- The Trust works with its local commissioners, scrutinising the Trust's quality of care at joint monthly review meetings and the executives from both organisations meet quarterly.
- External assessments of the Trust services, which included the following key ones this year:

With regards to pathology departments, in October 2018, four trusts (ourselves, the Royal Wolverhampton, Walsall and Sandwell and West Birmingham) signed a Partnership Agreement in which the pathology services in the Black Country would be restructured into a hub and spoke model, known as The Black Country Pathology Services BCPS.

The United Kingdom Accreditation Service (UKAS) visits each pathology discipline separately each year and assesses against the international standard for medical laboratories - ISO 15189:2012 Medical laboratories – Requirements for quality and competence. The pathology departments based at the Trust have maintained their accredited status for another year. Haematology, biochemistry, immunology and microbiology had successful surveillance visits in 2019. Cellular pathology had completed its first four year cycle of assessments and has undergone a full reassessment visit in December 2019 retaining accredited status pending submission of evidence to successfully close out findings raised.

With regards to education and training, there have been no review visits this year. Reviews are now conducted using evidence from several sources; the GMC national trainee survey and the new NETS (National Education Training Survey), plus other sources such as trainees' Annual Review of Competency Progression. The annual GMC Trainee Survey asks trainees for their views on the training that they receive in each trust by post specialty and programme group. Each area is scored on: overall satisfaction, clinical supervision, clinical supervision out of hours, reporting systems, workload, team work, handover, supportive environment, induction, adequate experience, curriculum coverage, educational governance, educational supervision, feedback, regional teaching, study leave and rota design. The specialties that performed well in the 2019 survey were core anaesthetics, GP training in paediatrics and rheumatology. Areas that require improvement were general surgery for F1s, GP training in obstetrics and gynaecology and emergency medicine. Actions as necessary are being taken in the latter areas. In terms of NETS survey results the Trust has been asked to respond to issues over the past year that have been reported in geriatric medicine concerning the foundation trainees, in paediatrics reported by a GP trainee and T & O reported by a higher surgical trainee. Again, appropriate action has been taken.

GIRFT (Get it Right First Time) is a national programme designed to improve the quality of care within the NHS by reducing unwarranted variations. It identifies changes that will help improve care and patient outcomes, as well as delivering efficiencies such as the reduction of unnecessary procedures and cost savings. It is led by frontline clinicians who are expert in the areas they are reviewing. This year a number of areas of the Trust have been reviewed by GIRFT. There was a vascular GIRFT revisit on the 8th July 2019 and breast care GIRFT visit on the 26th November 2019. Action plans have been drawn up when necessary.

There was a follow-up visit from Paediatric Critical Care Network regarding WMQRS critically ill child on 3rd October 2019. The final completed action plan was submitted and no further actions identified.

In accordance with EL(97)52 the pharmacy aseptic unit was inspected against Quality Assurance of Aseptic Preparation Services Standards (NHS QA Committee 2016) on 25th November 2019. The unit was assigned 'LOW' risk at the time and the overall comments were: the unit is well managed by knowledgeable and competent staff committed to delivering a quality assured service. An action plan was agreed with the inspection team to further strengthen the minor non-conformances identified. The action plan is managed by monthly review at the pharmacy directorate governance group and joint meetings with the North West Pharmaceutical Quality Assurance team.

During my stay in Russells Hall hospital, the care from the nurses and treatment I received was top quality on ward B3.

2.2.2 Participation in national clinical audits and confidential enquiries

During 2019/20, 45 national clinical audits and three national confidential enquiries covered relevant NHS 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 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 2019/20 are listed below. Tables 1 and 2 show 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. There was no data collection nationally for four national audits.

Table 1

National Clinical Audits	Participation	% submitted
Women		
Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE)	Yes	100%
National Maternity and Perinatal Audit (NMPA)	Yes	100%
Paediatrics and Neonates		
Diabetes (Paediatric) (NPDA)	Yes	100%
National Neonatal Audit Programme (NNAP)	Yes	100%
National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy 12)	Yes	Data collection started
Acute Care		
British Association of Urological Surgeons (BAUS) - Urology Audits - Nephrectomy	Yes	100%
BAUS - Urology Audits - Percutaneous Nephrolithotomy	Yes	100%
Case Mix Programme (CMP)	Yes	100%
National Cardiac Arrest Audit (NCAA)	Yes	100%
National Emergency Laparotomy Audit (NELA)	Yes	100%
Feverish Children - Care in ED (Emergency Department)	Yes	100%
Vital Signs in Ddults - Care in ED	Yes	100%
VTE risk in Lower Limb Immobilisation - Care in ED	Yes	100%
National Audit of Care at the End of Life (NACEL)	Yes	100%
Adult Community Acquired Pneumonia	Yes	100%
Elective Surgery (National PROMS Programme)	Yes	100%
National Audit of Intermediate Care	Yes	100%
Seven Day Hospital Service	Yes	100%
National Mortality Case Record Review Programme	Yes	Feasibility Study

Long Term Conditions		
Inflammatory Bowel Disease (IBD) Registry, Biological Therapies Audit	Yes	100%
National Asthma and COPD Audit Programme	Yes	100%
Learning Disability Mortality Review Programme (LeDeR)	Yes	100%
National Vascular Registry	Yes	100%
National Audit of Dementia	Yes	100%
National Ophthalmology Audit	Yes	100%
National Clinical audit for Rheumatoid and Early Inflammatory Arthritis	Yes	100%
National Diabetes Programme		
National Inpatient Audit Diabetes (Adult)	Yes	100%
National Foot Care Audit	Yes	100%
National Pregnancy in Diabetes Audit	Yes	100%
Cardiovascular Disease		
Cardiac Rhythm Management (CRM)	Yes	100%
Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)	Yes	100%
National Heart Failure Audit	Yes	100%
Sentinel Stroke National Audit Programme (SSNAP)	Yes	100%
Cancer		
Bowel Cancer (NBOCAP)	Yes	100%
Lung Cancer (NLCA)	Yes	100%
National Prostate Cancer Audit	Yes	100%
National Audit of Breast Cancer in Older People (NABCOP)	Yes	100%
Head and Neck Cancer Audit	Yes	100%
Oesophago - Gastric Cancer (NAOGC)	Yes	100%
Trauma		
Major Trauma - The Trauma & Audit Research Network (TARN)	Yes	100%
National Joint Registry (NJR)	Yes	100%
Falls and Fragility Fractures Audit Programme (FFFAP)		
Inpatient Falls	Yes	100%
National Hip Fracture Database	Yes	100%
Blood Transfusion		
National Comparative Audit of Blood Transfusion Programme	Yes	100%
Serious Hazards of Transfusion (SHOT)	Yes	100%

Table 2

National Confidential Enquiries				
Name of Study	**No. of Cases included**	**No. and % of clinical questionnaires submitted**	**No. of case notes submitted**	**No. of organisation questionnaires submitted**
Out of hospital cardiac arrest	9	2	7	1
Dysphagia	4	4/100%	1	1

Table 3

The reports of 18 national clinical audits were reviewed by the Trust in 2019/20 and the Trust intends to take the following actions to improve the quality of healthcare provided:

National Audit Title	Details of actions taken or being taken to improve the quality of local services and the outcomes of care.
NHFD – National Hip Fracture database	Theatre efficiency has improved mainly in obstetrics and trauma theatres. The Trust's case mix adjusted mortality has significantly dropped to 5.4%. This reduction is credited to the extensive work undertaken within the department including: an anaesthetic review of all mortalities, the introduction of a 15 minute spinal rule and 20 minute surgical rule and a re-focus on admission to theatre time.
NNAP (Neonatal Annual Audit programme)	Medical staff/nurse practitioners are now recording consultations with parents within 24 hours from admission in the medical notes and BADGER (electronic system). A magnesium sulphate audit is underway to ensure compliance with the required standard.
National Clinical Audit of Rheumatoid and Early Arthritis	All new patient referrals are triaged to ensure inflammatory arthritis patients are seen within three weeks as per standard. For a new diagnosis of arthritis, all patients will receive Arthritis Research UK patient leaflet. Communication with patients will improve by discussing treatment targets at follow up clinics.
7 Day Review Services	This is ongoing work and to drive up the standards a Seven Day Strategy has been developed and a Standard Operating Procedure and a directory of the services available on weekdays and weekends is being developed.
NADIA (Inpatient Diabetes Audit)	The Trust is in the lowest quartile for diabetes-related incidents. 100% of patients receive the diabetic foot assessment within 24 hours of admission.
NPDA – National Audit Paediatric Diabetes	To improve the Trust's compliance rate, a dedicated person will be employed to input all the data into the 'Twinkle' database and a psychologist will form part of the team.
The National Maternity and Perinatal Audit (NMPA)	There are nine key standards that are measured in this audit and the Trust is non-compliant with two and is taking the necessary action.
SSNAP – Sentinel Stroke Audit	The compliance rate in the audit is one of the best in the country. The targets were achieved and exceeded on the following standards: proportion of patients scanned within one hour, proportion of patients reported as requiring occupational therapy, proportion of applicable patients in atrial fibrillation who are discharged on anticoagulants or with a plan to start anticoagulation. There was a demonstrated improvement in mood and continence recording in the audit.
ICNARC (Intensive Care National Audit and Research Centre) CMP	All discharges are now reviewed by a consultant after leaving ICU.

National Emergency Laparotomy Audit (NELA) (4th National Report)	The Trust is compliant with all standards with the exception of two. An action plan is being formulated and will be monitored. Good practice is that the Trust has the fourth lowest mortality in the region.
National Audit of Dementia	A local action plan is being developed to address the low compliance areas.
National Diabetes Foot Care Audit 2014-2016	The Trust is planning to create patient pathways and work closely with the commissioners to improve foot care services.
Pulmonary Rehabilitation: Steps To Breathe Better	An individualised exercise plan for post-rehabilitation patients has been implemented and care bundles are to be reintroduced.
The National Cardiac Arrest Audit (NCAA).	Our number of cardiac arrest per 1,000 patients is within the national average. Our survival to discharge (alive) rate is 9.6% which is below the national average of 14 - 21%. This may indicate reduced recognition of the deteriorating patient but to ascertain that would require a more in-depth review of cardiac arrest patients' notes and interrogation of observations prior to the arrest. The report may support that there are issues with decision making around DNACPR status and resuscitation of patients where CPR has no realistic chance of success. All necessary actions will be undertaken and will be monitored by the deteriorating patient group.
Royal College of Emergency Medicine (RCEM) Fractured Neck of Femur	The areas of good practice were 90% of ambulance notes available whilst the national comparative was 72%. 72% of the patients were prescribed analgesia pre hospital visit with the national average being 66%. 68% of patients had their pain score taken within 0-5 minutes of arrival. This is much better than the national rate of 23%. There is an issue with the documentation of the cases reviewed and it is important to highlight this. Training sessions for ED staff will occur on the importance of documenting in a timely manner.
RCEM Pain in Children	The areas of good practice that were identified in the audit were that 55% of paediatric patients receive pre hospital administration of analgesia while the national figure is 30%. 99% of patients received an X-ray and 100% were assessed for safeguarding issues around documented evidence that non-accidental injury was considered in the ED. There are issues with prescriptions being completed retrospectively for administration of analgesia and with the triage system capturing pain score information.
RCEM: Procedural Sedation in Adults	The results indicated that only 2% of patients undergoing procedural sedation in the ED did not have documented evidence of pre-procedural assessment. All patients gave informed consent. 60% of cases all had documented monitoring aspects of non-invasive blood pressure, pulse oximetry, capnography and ECG.
COPD – Chronic Obstructive Pulmonary Disease	The national audit for COPD demonstrates that the Trust is doing well in looking after patients with COPD and achieving the Best Practice Tariff (BPT). The key indicators and results for the Trust are below. Oxygen prescribed for the patient – 98% Spirometry result available - 90% Current smokers prescribed smoking cessation pharmacotherapy – 18% Respiratory review with 24 hours – 79% (BPT 60%) Discharge bundle in place – 70% (BPT 60%) There has been a reduction in inpatient mortality from 7.8% in 2008 and 4.3% in 2014 to 3.9%. Respiratory review of admissions within 24 hours has improved from 54.8% in 2017/18. There was a significant improvement in oxygen prescription from 57.3% in 2017/18.

Local clinical audit

The reports of 32 completed local clinical audits were reviewed in 2019/20 and the Trust has taken, or intends to take, the following actions to improve the quality of healthcare provided:

Speciality	Title	Improvements
Safeguarding	Quality of Multi-agency referral forms (MARF)	Regular safeguarding supervision sessions to be provided in the Emergency Department and staff facilitated to attend. This audit to be repeated quarterly with an emphasis on Trust-wide referrals. One focus of the Safeguarding Improvement Plan is to raise awareness and increase referrals as appropriate Trust-wide. Named nurse for safeguarding to arrange meeting with learning and development staff to scope the feasibility of a training package to support staff development in completion of MARFs.
Emergency Medicine	Sepsis Six Data Collection.	This audit has been repeated and the learning is to improve the quality of the documentation recorded on the Sunrise sepsis tool.
Gastro-intestinal Medicine	A retrospective 'snap-shot' audit of compliance with prescribing on the endoscopy recovery chart.	4/6 key standards were compliant. The use of an endoscopy chart as a prompt will improve assurance.
Neurology	An audit measuring the compliance with safety controls to reduce the risk of death or severe harm associated with injectable phenytoin.	Electronic Prescribing and Medicines Administration system (ePMA) will be implemented to encourage the installation of prescriber prompts such as mandatory weight entry with parenteral phenytoin prescribing, easy access to drug history and alerts to set infusion rate start and finish times.
Paediatrics	Audit of compliance of current urinary tract infection (UTI) management practices in the Paediatric Unit against NICE guideline (54) on the management of under 16s with UTI.	Improved documentation of risk factors. Children with upper UTI/Pyelonephritis getting the right length of treatment. Implement a UTI admission sheet and re audit in 6 months.
Vascular Surgery	Venous thromboembolism (VTE) audit in the Vascular Department	The audit was at 91% compliance and the interventions put into place were to educate the juniors on VTE assessments, how to fill the form out, the different aspects of the form and the importance of VTE in surgery and to re-audit.
Vascular Surgery	Re-Audit of VTE in the Vascular Department	The re-audit demonstrated 100% compliance that VTE is completed within 12 hours for vascular patients.

Anaesthetics	Cancellation on the day of surgery – Review of pre-op assessment	Continue to use IT solutions (database) to reduce communication problems. Tick box now easy to record patient not suitable for surgery at the Corbett centre when needs extra time for potential difficult airway.
Diabetes & Endocrinology	Audit of DATIX Incidents relating to Insulin	A safe insulin at discharge policy is being created and will be available by Dec 2020.
Trauma and Orthopaedics	An audit of the Trauma and Orthopaedics weekend handover	Consultant ward rounds have been introduced throughout the week.
Gastro-intestinal Medicine	AQUA - Alcohol Liver Related Disease (ARLD) audit	All doctors in ED/AMU to start using the liver care bundle until electronic copies can be used. Re - audit in Oct 2020.
General Surgery	Audit to assess the current practice of IV fluid prescription	Department protocols to be developed, in-house teaching of junior doctors, liaise with nursing staff to improve the intake/ output recording
Safeguarding	Audit of level of recognition of adult issues that may affect their ability to parent their children or pose a risk of harm to their children e.g. substance misuse, mental health issues and domestic abuse who attend the Emergency Department	HEADSS (Home, Education/Employment, Eating, Activities, Drugs, Sexuality, Suicide/Depression, and Safety) tool to be implemented for standard 3.
Safeguarding	Staff awareness and use of the chaperone policy audit	The policy is currently being updated and study sessions are being offered to health professional from West Midlands police.
Trauma and Orthopaedics	Fractured neck of femur admission pathway audit	A new pathway has been proposed and is currently underway.
Rheumatology	To assess whether the non-pharmacological management of patients with new onset Rheumatoid Arthritis are in accordance with NICE guidance (NG100)	Nurses now using Health Assessment Questionnaire (HAQ) form and the clinicians have been trained to interpret the score.
Rheumatology	Audit of NICE quality standard post fracture for Osteoporosis	Rheumatology, Elderly Care ED, Fracture Liaison Service and Community Falls Team to formulate strategy. Re-audit 2021.
Rheumatology	Quality improvement project to evaluate Dudley Osteoporosis Service	Vitamin D guidelines available on the Trust intranet.
Elderly Care Medicine	Audit on Perioperative Catheterisation in Hip Fracture Patients	To have a urinary catheter passport documenting the date and time of insertion with daily questions to check the indication for the catheter to stay in situ and the appropriateness to try without catheter.

Dermatology	Skin surgery booking list – re-audit of 2019 study	Provision to be made for body maps to be kept on site. Photography should be available at Corbett Hospital – iPads to be made available.
Anaesthetics	Audit on airway and intubation problems during general anaesthesia for C-section	Add Difficult Airway Society (DAS) guidelines to QRH (Quick Reference Handbook) in Obstetric Theatres and teach simulation on obstetric difficult airway.
Anaesthetics	Anaesthesia for C-section: technique and failure rate	Update Obstetric Anaesthesia Handbook to potentially include flowsheets on how to troubleshoot problematic regional anaesthesia.
Anaesthetics	Post Anaesthetic Review Audit	Encourage anaesthetists to hand over high risk patients they have been unable to review to their colleagues. Have already included in post-op anaesthetic review SOP.
Anaesthetics	Audit of Endo-tracheal Cuff Pressures in Theatres	Re-auditing is recommended to ensure adherence to normal cuff pressures.
Paediatrics	Measuring growth parameters and Body Mass Index in the Initial health Assessment for Looked After Children in Dudley	Advise clinicians assessing Looked After Children at the Initial Health Assessment to download the Growth Charts App with UK-WHO growth charts which will give the clinician growth centiles.
Neonates	Neonatal (28 days) admissions to the children's ward	Re-audit to monitor neonatal readmissions, and to analyse improvements and trends
Critical Care	Audit of Vancomycin by continuous infusion in Critical Care	Raise awareness of need to follow Trust guideline for prescriptions, specifically ensuring that an accurate actual body weight is used.
Neonates	Identification of infants at risk of foetal alcohol syndrome	A full alcohol history including volume and frequency if concerns of alcohol use. Documentation of hepatitis C status of mother to be documented and followed up on. If maternal alcohol use the baby should be examined for features of foetal alcohol syndrome.
Maxillo Facial	Quality assurance of lateral cephalograms	Action to be taken to improve the quality of the radiographs, to ensure ALARP. Lateral cephalograms are essential to determine skeletal relationship prior to orthodontic treatment, especially in a hospital setting where patients receive orthognathic treatment and these values are required for planning the surgery.
Acute Medicine	DVT Service Audit (AMU)	SUNRISE has been modified for ease of ordering DVT scans.

Acute Medicine	Waiting time for CTPA/VQ scans in ambulatory patients with suspected pulmonary embolism	Noncompliance with the standards and therefore an action plan is in place to increase the numbers of slots for allocation from one to three, also to be divided into morning and afternoon slots. To introduce CTPA during the weekends.

2.2.3 Research and development (R&D)

The number of patients receiving health services provided or sub-contracted by the Trust in 2019/20 that were recruited during that period to participate in research approved by a research ethics committee was 910.

At the end of the year, all non-essential research activity was put on hold due to the COVID-19 pandemic. We commenced participating in COVID-19 Urgent Public Health Research studies, as our priority, with ISARIC (date collection), UKOSS (data collection) and RECOVERY (interventional) trials. More studies were expected to start. We were performing extremely well in these COVID studies, in comparison with other trusts in the region.

All active West Midlands sites for RECOVERY study, ranked by recruitment rate, from start of trial to date (20/4/20)

Trust	Trial Total	Recruiting Days
University Hospitals Birmingham NHS Foundation Trust	**132**	**26**
University Hospitals Coventry and Warwickshire NHS Trust	**86**	**19**
The Dudley Group NHS Foundation Trust	**64**	**22**
Sandwell and West Birmingham Hospitals NHS Trust	**53**	**25**
Walsall Healthcare NHS Trust	**41**	**21**
The Royal Wolverhampton NHS Trust	**31**	**21**
Shrewsbury and Telford Hospital NHS Trust	**30**	**26**
Worcestershire Acute Hospitals NHS Trust	**17**	**18**
Wye Valley NHS Trust	**16**	**22**
George Eliot Hospital NHS Trust	**15**	**22**
University of North Midlands NHS Trust	**12**	**21**
Birmingham Women's and Children's NHS Foundation Trust	**0**	**5**

Prior to the pandemic, we had a very active, balanced portfolio of clinical research across the majority of specialties (anaesthetics, cancer, cardiology, chemical pathology, critical care, dermatology, diabetes, gastroenterology, genito-urinary medicine (GUM), haematology, maternity, paediatrics, plastic surgery, orthopaedics, ophthalmology, rare diseases, rheumatology, stroke, vascular, general surgery).

The locally designed and sponsored National Institute for Health Research (NIHR) portfolio study 'Recovery after Emergency Laparotomy (REmLap): a prospective, observational, feasibility study' recruited its 50th (final) participant in January 2019. Data analysis is underway and the chief investigator, Dr Julian Sonksen, is preparing for 'REmLap 2'.

Our Anaesthetics Department was also involved in the FLO-ELA study (Fluid Optimisation in Emergency Laparotomy) and we were the top recruiting site with 180 patients recruited by principal investigator (PI) Dr Adrian Jennings with senior research nurse Angela Watts and clinical trial practitioner Stacey Jennings.

Rheumatology continued a long-standing collaboration with the School of Sport and Exercise of Birmingham University; plus a new collaboration with Bangor University. Three PhD students are currently completing their theses with us.

Our research lab recruited a total of 669 participants to the Pathfinder study, looking at rare diseases. The last arm of the study included patients with Gaucher Disease. A double dose of the gene mutation is necessary to cause the disease, which results in a build-up of harmful substances in the liver, bones and spleen. This prevents cells and organs from functioning correctly.

Training and infrastructure

The Research Forum, run by Dr Elizabeth Hale and Dr Gail Parsons, has supported a number of students (allied health professionals, nurses, university students) undertaking degrees or Trust research/audit work. In the last year, at least two candidates have graduated with their PhDs. The student nurse placement programme continues to function well, with student nurses having a one week placement within the Research & Development Department, covering a variety of specialties and introducing the students to research as well as covering a teaching session on their induction programme and to assist with their research module.

We have increased our engagement with all staff groups across the Trust, by introducing and promoting our department at Trust induction for all new staff, presenting at nurse specialist away days, research noticeboards in clinical areas and attending Trust 'Meet the Experts' events. Staff Trust-wide continue to improve their awareness of studies carried out in their own clinical areas, with increasing numbers coming forward to undertake their own project or an educational project or becoming a principal investigator for a study. We continued to host and deliver face-to-face sessions on Good Clinical Practice refresher training, Good Clinical Practice Fundamentals and Principal Investigator Masterclasses.

The R&D administration team continued to use the EDGE clinical research management system and continued to explore improvement and efficiencies by using this system for study management and tracking. We have rolled out a local invoicing system for research studies within the national EDGE database so that income can be more systematically monitored and chased. Staff demonstrated the finance tool aspect of EDGE at a national EDGE Conference March 2020 plus poster presentation. The R&D Department has also been accepted for three poster presentations at the May 2020 NHS R&D Forum national conference (date has now been deferred until later in the year).

The Research and Development team won two awards at the Clinical Research Network West Midlands (CRN WM) awards ceremony held at Everyman Cinema, Birmingham on 7th November 2019. Awards won were for Creative Recruitment and Business Intelligence Leaders. The Business Intelligence Leaders award was given for innovative database work surrounding the management of study finances. The work has been shared as good practice outside of the Trust, locally across the region and at national meetings. The Creative Recruitment award was given for outstanding recruitment in the Pathfinder study, which looked to identify patients with rare diseases from routine pathology results.

Public engagement

The R&D department continues to keep in touch with the Trust's research ambassador (now titled 'Research Champion') who took part in our International Clinical Trials Day event in May 2019 at Russells Hall Hospital's Health Hub and our 'Research Showcase' event in September 2019. He also regularly attends the R&D quarterly departmental meetings to provide a patient presence and perspective.

The department held its very first Listening into Action event in November 2019 for patients who have participated in research in order to collect their views and experiences. The responses were overall very

positive. This is currently being written up to be put into actions for implementation and feedback will be disseminated to those that attended.

Research into practice

The TRACE RA (Trial of Atorvastatin for the primary prevention of Cardiovascular Events in patients with Rheumatoid Arthritis) study has had a lot of media coverage and was recently published in Arthritis & Rheumatology, the official journal of the American College of Rheumatology. This major health study was designed in Dudley, using local patients and has provided evidence on the safety and efficacy of statins for people who have rheumatoid arthritis and are therefore at a higher risk of heart attack and stroke. Professor George Kitas was lead author on the paper. There were 150 volunteers who took part at the Trust, providing the most patients compared to other 100 participating trusts in the country.

Cancer Team - An NIHR supported prostate cancer trial called STAMPEDE made a global impact in how men presenting with advanced prostate cancer are treated. One particular arm of the trial led to a change in NHS clinical practice for men with high risk, locally advanced metastatic prostate cancer who are starting first line hormone therapy (published in The Lancet). The Trust was one of 125 sites and successfully recruited 107 patients (the study as a whole recruited over 9,000 patients).

Anaesthetics Team – The conclusion of the BALANCED study was that among patients at increased risk of complications after major surgery, light general anaesthesia was not associated with lower one-year mortality than deep general anaesthesia. The trial defined a broad range of anaesthetic depth over which anaesthesia may be safely delivered when titrating volatile anaesthetic concentrations using a processed electroencephalographic monitor. The Trust recruited 35 patients into this study.

Publications

Trust publications for the calendar year 2019, including conference posters, were 110.

2.2.4 Commissioning for Quality and Innovation (CQUIN) payment framework

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

The CQUIN payment framework was introduced in 2009 to make a proportion of providers' income conditional on demonstrating improvements in quality and innovation in specified areas of care. This means that some of the Trust's income is conditional on achieving certain targets that are agreed between the Trust and our commissioners (Dudley Clinical Commissioning Group and NHS England).

A proportion of the Trust's income in 2019/20 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 (CQUIN) payment framework. Further details of the agreed goals for 2019/20 and for the following 12 month period are available at: https://www.england.nhs.uk/nhs-standard-contract/cquin/

The value of CQUINs has been set on a 1.25 per cent of activity contract outturn which equates to a potential income of £3.6million. A total of seven CQUIN schemes were agreed with a combination of locally and nationally agreed goals with associated milestones. At the end of the financial year, it is forecast that we will achieve partial payment for a majority of the indicators. For example, we will have

- achieved the national target set for vaccinating frontline staff against flu;
- achieved medicines optimisation, a reduction in waste and utilise better cost effective drugs;

- achieved for ward areas to implement lying and standing blood pressure and perform a risk assessment to reduce the risk of falls in patients over 65;
- achieved improvement in electronic pathway referrals for oral and maxillo-facial dental patients; and
- reduced the antibiotic prophylaxis in colorectal surgery for patients that are aged 18 years and over.

The indicators we are not expecting to fully achieve are listed below. Mitigating actions have been put in place for 2019/20. These include

- To reduce the antimicrobial risk in patients over 65 years with a UTI. The aim is to reduce the use of a urine dipstick which may provide false readings and change working practices to request laboratory results instead. It was accepted that due to the culture and behaviour changes needed, the first year of this project would be used to raise awareness and learning. Mitigating plans are in place and this is being led by one of our specialist pharmacists.

- Providing lifestyle advice and referral to patients that may benefit from changes regarding alcohol, smoking and drug use. This has required the Trust to invest in additional posts to support the delivery and provide teaching and support into making every contact count. Great improvements have been seen and work will continue into 20/21 to embed this via training and education and implementation tools to maintain these requirements as business as usual.

- To improve pathways for same day emergency care for patients that present within the Trust for pulmonary embolism, bradycardia tachycardia and community acquired pneumonia. The audit results of these pathways have demonstrated that we have strengthened our pathways and are supporting for diagnostics tests and equipment to be made available to support same day care, meaning the patients are admitted, treated and discharged without the need to continue the patient as an inpatient. This will help also reduce some of the pressures on emergency departments. The results have shown a clinical variance and action plans have been developed for each scheme to continue to strive for the improvements needed.

The final CQUIN settlement figure for 2018/19 achieved 97 per cent in total; the final figure received was £5.986M against a target of £6.160M. 2019/2020 is estimated at £3.6m and we are forecasting to achieve 70 per cent by year end.

CQUINs 2019/2020

The achievement for CQUINs for 2019/2020 was not a Full Year Effect due to COVID-19. Based on a trajectory of performance over the quarters and the data that has been provided, it was felt that we would have ended the year as rated in the following table; it is anticipated that 90 per cent overall payment would be received.

Acute and community 2019/2020

Goal No.	CQUIN targets and topics	Quality domains	RAG
1a	Antimicrobial Resistance (AMR) – in lower Urinary Tract Infection in older people	Effectiveness	
1b	AMR – in colorectal surgery	Safety Effectiveness	
2	Staff Flu Vaccination	Safety Effectiveness	
3a/b/c	Alcohol and Tobacco Screening/Brief advice	Effectiveness	
7	3 high impact actions to prevent falls in >65year old	Effectiveness	
CCG11a/b/c	Same Day Emergency Care – PE, Tachycardia Bradycardia and Community Acquired Pneumonia	Safety Effectiveness	

NHS England Specialised Services, Public Health & Dental 2019/2020

Goal No.	CQUIN targets and topics	Quality domains	RAG
1	Proms and Prems Dental	Effectiveness	
GE3	Hospital medicines optimisation	Effectiveness	

	Expected to fully achieve & full payment
	Partial achievement/ Payment
	Not achieved and no payment awarded

CQUINs 2020/21

Due to COVID-19 the CQUIN schemes for 20/21 have been suspended and currently we are unable to determine what the plans and requirements will be post COVID-19.

Below is a list of schemes that were provided prior to the outbreak, which may be applicable.

Acute Provider Schemes for 2020/21

Goal No.	CQUIN targets and topics	Quality domains
1	Recording News2 score, escalation time and response time for unplanned critical care	Safety Effectiveness
2	Treatment of community acquired pneumonia in line with BTS care bundle	Effectiveness
3	Appropriate antibiotic prescribing for UTI in adults aged 16+	Effectiveness
4	Cirrhosis and fibrosis tests for alcohol dependent patients	Effectiveness
5	Rapid rule out protocol for ED patients with suspected acute myocardial infarction (excluding STEMI)	Safety Effectiveness
6	Screening and treatment of iron deficiency anaemia in patients listed for major elective blood loss surgery	Safety Effectiveness
7	Adherence to evidenced based interventions clinical criteria	Safety Effectiveness
8	Staff flu vaccinations	Effectiveness

NHS England specialised services (dental and oral still to be advised)

Goal No.	CQUIN targets and topics	Quality domains
1	Hep C elimination	Safety Effectiveness
2	Antifungal stewardship/medicines optimisation	Effectiveness
3	Severe asthma	Effectiveness
4	Shared decision making	Effectiveness

2.2.5 Care Quality Commission (CQC) registration and reviews

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

The Trust was inspected in January/February 2019 and the report published in July 2019, the result of which was an overall rating of 'Requires Improvement'. In arriving at this overall assessment the CQC assessed 56 elements within nine areas (see charts below). Of the 56 elements, 32 were rated as 'Good' which meant that for surgery, critical care, end of life care (hospital) and end of life care (community services) the Trust was in fact rated as 'Good'. In addition, surgery at Russells Hall Hospital and end of life care community services were both given an 'Outstanding' rating for 'Caring'. Two of the cores services, diagnostic imaging and urgent and emergency planning, had two and one element respectively rated as 'Inadequate' resulting in an overall rating for diagnostic imaging of 'Inadequate'.

For the service areas where the Trust was rated as 'Inadequate' or 'Requires improvement', a detailed action plan was put in place. The monitoring of the delivery of this improvement plan was reported to the board and the Clinical Quality, Safety and Patient Experience Committee as well as providing formal feedback to the CQC itself.

The CQC issued four Section 31 enforcement notices during the December 2017/January 2018 inspection but none had placed any restrictions on the Trust's licence. The Trust has had to send enhanced assurance over aspects of urgent and emergency services which the Trust has done on a weekly/monthly basis and therefore the Trust is compliant with the registration requirements of the CQC. One of these notices was retracted by the CQC in July 2019.

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

The full report of the January 2019/February 2019 inspection is available at www.cqc.org.uk/provider/RNA

Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Inadequate ↓ May 2019	Good ↑ May 2019	Good → ← May 2019	Requires improvement → ← May 2019	Requires improvement → ← May 2019	Requires improvement → ← May 2019

The rating for well-led is based on our inspection at trust level, taking into account what we found in individual services. Ratings for other key questions are from combining ratings for services and using our professional judgement.

Ratings for Russells Hall Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Inadequate → ← May 2019	Requires improvement → ← May 2019	Good ↑ May 2019	Requires improvement → ← May 2019	Requires improvement ↑ May 2019	Requires improvement ↑ May 2019
Medical care (including older people's care)	Good → ← Apr 2018	Good → ← Apr 2018	Good → ← Apr 2018	Good → ← Apr 2018	Good → ← Apr 2018	Good → ← Apr 2018
Surgery	Requires improvement ↓ May 2019	Good → ← May 2019	Outstanding ↑ May 2019	Good → ← May 2019	Good → ← May 2019	Good → ← May 2019
Critical care	Good ↑ May 2019	Good ↑ May 2019	Good → ← May 2019	Requires improvement → ← May 2019	Good ↑ May 2019	Good ↑ May 2019
Maternity	Requires improvement ↓ May 2019	Good ↑ May 2019	Good → ← May 2019	Good → ← May 2019	Requires improvement ↓ May 2019	Requires improvement ↓ May 2019
Services for children and young people	Requires improvement → ← May 2019	Good ↑ May 2019	Good → ← May 2019	Requires improvement → ← May 2019	Requires improvement → ← May 2019	Requires improvement → ← May 2019
End of life care	Good ↑ May 2019	Good → ← May 2019	Good → ← May 2019	Good → ← May 2019	Good → ← May 2019	Good → ← May 2019
Outpatients	Requires improvement ↓ May 2019	N/A	Good → ← May 2019	Good ↑ May 2019	Requires improvement ↓ May 2019	Requires improvement ↓ May 2019
Diagnostic imaging	Inadequate May 2019	N/A	Requires improvement May 2019	Requires improvement May 2019	Inadequate May 2019	Inadequate May 2019
Overall*	Inadequate ↓ May 2019	Good ↑ May 2019	Good → ← May 2019	Requires improvement → ← May 2019	Requires improvement → ← May 2019	Requires improvement → ← May 2019

*Overall ratings for this hospital are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Ratings for Corbett Outpatients Centre

	Safe	Effective	Caring	Responsive	Well-led	Overall
Surgery	Requires improvement May 2019	Good May 2019	Good May 2019	Good May 2019	Good May 2019	Good May 2019
Outpatients	Requires improvement May 2019	N/A	Good May 2019	Good May 2019	Requires improvement May 2019	Requires improvement May 2019
Diagnostic imaging	Inadequate May 2019	N/A	Good May 2019	Good May 2019	Inadequate May 2019	Inadequate May 2019
Overall*	Inadequate May 2019	Good May 2019	Good May 2019	Good May 2019	Inadequate May 2019	Inadequate May 2019

*Overall ratings for this hospital are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Ratings for community health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community health services for adults	Good Apr 2018	Good Apr 2018	Good Apr 2018	Requires improvement Apr 2018	Good Apr 2018	Good Apr 2018
Community end of life care	Good May 2019	Good May 2019	Outstanding May 2019	Good May 2019	Good May 2019	Good May 2019
Overall*	Good →← May 2019	Good →← May 2019	Outstanding ↑ May 2019	Requires improvement →← May 2019	Good →← May 2019	Good →← May 2019

*Overall ratings for community health services are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

The staff on A4 are friendly and do their job well. I would recommend A4 staff to my friends and family.

My stay on B1 was made enjoyable by the professionalism of all the staff and friendly manner by everyone.

2.2.6 Quality of data

The Trust submitted records during 2019/2020 to the Secondary Uses Service (SUS) for inclusion in the Hospital Episode Statistics (HES) latest published data.

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

	The Dudley Group	National average
Admitted patient care	99.9%	99.4%
Outpatient care	99.9%	100%
Accident and emergency care	99.8%	98.0%

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

	The Dudley Group	National average
Admitted patient care	100%	98.9%
Outpatient care	100%	97.9%
Accident and emergency care	100%	96.6%

All above figures are for January 2020. Latest available from NHS Digital Data Quality Maturity Indictor DQMI monthly report

The General Data Protection Regulation (GDPR) came into effect last year. It introduces a duty on all organisations to report certain types of personal data breach to the relevant supervisory authority. The Security of Network and Information Systems Directive ("NIS Directive") also requires reporting of relevant incidents to the Department of Health and Social Care (DHSC). The Trust has not had to report a breach of personal data to the National Regulatory Authority during 2019/20.

The Trust was not subject to the Payment by Results clinical coding audit during the reporting period.

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

- The Trust continually monitors data quality externally via Secondary Uses Service (SUS) reporting and University Hospitals Birmingham Hospital Evaluation Data tool (HED).

2.2.7 Learning from deaths

1. During 2019/20, 1,783 of the Trust's patients died. This comprised the following number of deaths that occurred in each quarter of that reporting period: 444 in the first quarter; 348 in the second quarter; 464 in the third quarter; 527 in the fourth quarter.

2. By 31st March 2020, 1,189 case record reviews and 41 investigations have been carried out in relation to 1,783 of deaths included above.

In 41 cases, a death was subjected to both a case record review and an investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out was: 355 in the first quarter; 280 in the second quarter; 338 in the third quarter; 216 in the fourth quarter.

3. Three, representing 0.2 per cent of the patient deaths during the reporting period, are judged to be more likely than not to have been due to problems in the care provided to the patient.

In relation to each quarter, this consisted of: 0 representing 0 per cent for the first quarter; two representing 0.6 per cent for the second quarter; one representing 0.2 per cent for the third quarter; 0 representing 0 per cent for the fourth quarter.

These numbers have been estimated using
a) The Trust's mortality review process which includes an initial (Level 1) peer review of all deaths by the department concerned using a standard questionnaire. This may lead to a Level 2 review performed by a mortality panel using a structured case note review data collection as recommended by the National Mortality Case Record Review Programme, b) Coroner Rule 28 cases when making recommendations about future care and c) root cause analysis reports following investigations if a death is reported as a serious incident if that is clinically appropriate (e.g. death potentially avoidable).

4. A summary of what the provider has learnt from case record reviews and investigations conducted in relation to the deaths identified above.

The Trust has identified the following learning:

- Importance of recognition of deteriorating patients where initial diagnosis is unclear and no clear pathway evident.
- Awareness of need to respond to changing parameters and ensure clear clinical decision making.
- Need to be aware of human factors involved in the process.
- Ensure that all appropriate patients are commenced on EmLap pathway.
- Recognition of potential for diagnostic overshadowing in patients with complex neurological problems and learning disability.
- There is a need to focus efforts on the recognition and management of the deteriorating patient in the context of sepsis but also in the context of other medical conditions for which sepsis screening parameters might flag e.g. heart failure.
- Mortality tracker information with regards to end of life care is demonstrating achievement of clinical indicators and embedding Priorities for Care of the dying person communication document is being pursued with divisions.
- Need to highlight appropriate care in end of life management over the period when death is imminent.
- Need for clear documentation of all results and investigations when patients admitted/ transferred to ensure appropriate prompt management and communication of escalation plans.
- Patients presenting at the end of life to ED may be more appropriately transferred out of the department more promptly to allow more privacy and dignity for patients and families.
- Lack of understanding of DNACPR and the perception that this is the ceasing/withdrawal of all treatment rather than allowing "natural" death to occur.
- ED reviews triggered due to waiting more than four hours in the department.
- Delay in pending external agencies information (coroner, police etc.) affecting child death review timeliness internally.
- Inappropriate admission to hospital from care homes.
- Place of death – some patients do die within the Emergency Department – this may sometimes be because it would have been inappropriate to move them due to End of Life and expected to die within very short period but may be due to lack of beds.

5. A description of the actions which the provider has taken in the reporting period, and proposes to take following the reporting period, in consequence of what the provider has learnt during the reporting period.

From the cases reviewed, the Trust has taken a number of actions.

•Developed a general pathway for the deteriorating patient. This was presented to the senior consultant body and discussions have occurred with the electronic patient record developers to embed this in the electronic patient record.

•Work has taken place on the EPR to further develop systems for identifying the deteriorating patient.

•Ongoing engagement regarding awareness and recognition of sepsis including human factors training and a recent sepsis debate.

•Implementation of the Gold Standards Framework (GSF) ongoing.

•Work has taken place in developing the medical examiner role and work.

•The Trust end of life working group is reviewing policies, education and governance.

•Increased usage of the priorities of care documentation across the Trust.

•A regular patient safety bulletin is issued to all staff with topics arising from lessons learnt across the Trust. Sepsis remains a prominent topic and clear medical handover has been highlighted.

•Grand Rounds have been arranged to share learning on identification of atypical aortic aneurysm and cardiac arrest.

•All cardiac arrest deaths are now being reviewed by the Mortality Panel and Resuscitation Team.

•A Grand Round presentation was undertaken on 23rd January 2020 on the pneumonia pathway.

•Cases with learning are highlighted to the specialty and also discussed at the Joint Mortality Meeting held quarterly with the CCG.

•The Trust is being supported by the Advancing Quality Alliance (AQuA) to look at a number of deteriorating patient pathways. The first condition groups to undertake this work were AKI, sepsis and alcohol related liver disease. Work stream plans have been generated and are in the process of being fully implemented in association with the specific teams and audit department.

•Additional work from our mortality data has revolved around improving pathways for pneumonia. The British Thoracic Society bundle is being implemented.

•The work from the Deteriorating Patient Team and Outreach is giving greater oversight and support for patients with deteriorating parameters. This is ongoing work. Further work around the Hospital at Night team and review of medical handover processes is being undertaken.

•End of life care cell led by Dr Jo Bowen as part of the Dudley Improvement Programme with further work stream to implement RESPECT across Dudley though this is currently delayed due to funding.

•End of Life Care Facilitator – one year fixed term has taken up post to work with community, ED and the wards to implement learning from the Bewick Report.

•A service review to plan integrated services across the health economy was held in November 2019. The feedback was very positive and the success of the service was recognised.

•Gold Standard Framework implementation whole hospital commissioned approach in progress. There is a rolling plan for the remaining adult wards with regards to GSF implementation and accreditation.

6. An assessment of the impact of the actions described above which were taken by the provider during the reporting period.

- Mortality continues to fall and SHMI has reduced to 110. This is in the expected range.
- The Trust has also noted a reduction in crude mortality.
- Further reduction in sepsis mortality.
- Reduction in investigation requests from the coroner.
- Decreased number of serious incidents.
- A positive external assessment of end of life care.

7. 470 case record reviews and 42 investigations were completed after 31st March 2019 which related to deaths which took place before the start of the reporting period.

8. None, representing 0 per cent of the patient deaths before the reporting period, are judged to be more likely than not to have been due to problems in the care provided to the patient.

These numbers have been estimated using
a) The Trust's mortality review process which includes an initial (Level 1) peer review of all deaths by the department concerned using a standard questionnaire. This may lead to a Level 2 review performed by a mortality panel using a structured case note review data collection as recommended by the National Mortality Case Record Review Programme, b) Coroner Rule 28 cases when making recommendations about future care and c) root cause analysis reports following investigations if a death is reported as a serious incident if that is clinically appropriate (e.g. death potentially avoidable).

9. Five representing 0.3 per cent of the patient deaths during 2018/19 are judged to be more likely than not to have been due to problems in the care provided to the patient.

Very pleasant caring experience when admitted to Russells Hall Hospital last year with sepsis, nurses dealt with me straightway with kindness and compassion. 5 stars from me.

2.2.8 Core set of mandatory indicators

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

Mortality			
Topic and detailed indicators	**Immediate reporting period: Dec 2018 – Nov 2019**	**Previous reporting period: Nov 2018 – Oct 2019**	**Statements**
Summary Hospital-level Mortality Indicator (SHMI) value and banding (Comparison is with all non-specialist acute trusts)	**Value** Trust 1.1336 National average 1 Highest 1.1957 Lowest 0.6909 **Banding** Trust 1 National average 2 Highest 1 Lowest 3	**Value** Trust 1.1098 National average 1 Highest 1.1822 Lowest 0.6776 **Banding** Trust 2 National average 2 Highest 1 Lowest 3	The Trust considers that this data is as described for the following reasons: ● it has noted that the SHMI value is in the expected range but has increased. This is due to the change in recording of the assessment of patients admitted via Ambulatory Emergency Care. The Trust has taken the following action to improve this indicator and so the quality of its services by: ● continuing to improve case note reviews of deaths in hospital.
Percentage of patient deaths with palliative care coded at either diagnosis or specialty level (Comparison is with all non-specialist acute trusts)	Trust 22% National average 36% Highest 59% Lowest 11%	Trust 22% National Average 36% Highest 59% Lowest 11%	The Trust considers that this data is as described for the following reasons: ● there remains a very robust system in place to check accuracy of palliative care coding. The data field has been added to the Trust mortality tracker. The Trust has taken the following actions to improve this percentage, and so the quality of its services: ● ensuring this percentage will always be accurate and reflect actual palliative care.

Both the doctor and all the staff were so helpful, you can tell they enjoy their jobs. All my tests were completed straight after my consultation. My mind was put at rest; I have nothing but praise for this hospital. Thank you. Much appreciated.

Patient Reported Outcome Measures (PROMS)					
Topic and detailed indicators	**Immediate reporting period: 2018/19 Final**		**Previous reporting period: 2017/18 Final**		**Statements**
Hip Replacement Surgery	Trust	0.47	Trust	0.50	The Trust considers that this data is as described for the following reasons: • using feedback data (from NHS Digital) we are very pleased with the outcomes that patient report. Patients who said that their problems are better now when compared to before their operation: • Hip replacement: 98% *(national = 95%).* • Knee replacement 88% *(national = 90%)* The Trust has taken the following actions to improve these scores, and so the quality of its services, by: ensuring the Trust regularly monitors and audits the pre and postoperative healthcare of all patients. Surgical operative outcomes are consistently of high quality and safety, with excellent patient satisfaction for these procedures.
	National average	0.46	National average	0.46	
	Highest	0.56	Highest	0.57	
	Lowest	0.35	Lowest	0.36	
Knee Replacement Surgery	Trust	0.34	Trust	0.33	
	National average	0.34	National average	0.34	
	Highest	0.41	Highest	0.42	
	Lowest	0.24	Lowest	0.23	

To all the doctors, nurses, porters, paramedics in the coronary care unit at Russell's Hall Hospital - a massive THANK YOU. I have nothing but praise for every one that helped me through a difficult few days. The professionalism, service and positive attitude shown by all was marvellous.

Readmissions					
Topic and detailed indicators	**Immediate reporting period: 2018/19**		**Previous reporting period: 2017/18**		**Statements**
% readmitted within 30 days **Aged 0-15**	Trust	8.2%	Trust	11.9%	The Trust considers that this data is as described for the following reasons: **Age 0- 15** • The Trust has demonstrated a progressive reduction of 3.7% in paediatrics readmissions from the previous reporting period; 2017/18. • In addition to this the Trust has evidenced that the readmissions performance is 4.4% below the national average in comparison with the previous year which saw a figure above the national average **Aged 16 and over** • The performance in adult readmission rates has improved by 0.2% against the previous reporting period; 2017/18 • This figure is also below the national average by 1.4% The Trust intends to take the following actions to improve these percentages, and so the quality of its services: • Continue to work closely with Community to support the management of patients and avoid readmission • Undertake an audit to identify readmission trends across the patient groups within the Trust • Develop an action plan to address areas for improvement
	National average	12.5%	National average	11.0%	
	Highest	54.9%	Highest	63.6%	
	Lowest	1.7%	Lowest	2.0%	
(Comparison is with all NHS Trusts) **% readmitted within 30 days** **Aged 16 and over**	Trust	13.2%	Trust	13.4%	
	National average	14.6%	National average	14.1%	
	Highest	29.0%	Highest	27.5%	
	Lowest	5.0%	Lowest	5.1%	

Source: https://digital.nhs.uk/data-and-information/publications/clinical-indicators/compendium-of-population-health-indicators/compendium-hospital-care/current/emergency-readmissions-to-hospital-within-30-days-of-discharge/emergency-readmissions-to-hospital-within-30-days-of-discharge

Responsiveness to inpatients' personal needs					
Topic and detailed indicators	**Immediate reporting period: 2018/19**		**Previous reporting period: 2017/18**		**Statements**
Average score from a selection of questions from the National Inpatient Survey measuring patient experience **(Score out of 100)**	Trust	61.3	Trust	64.8	The Trust considers that this data is as described for the following reasons: ● the Trust is disappointed that this indicator remains lower than the national average. The Trust intends to take the following actions to improve this score, and so the quality of its services: ● to continue to focus on responding to the feedback from our patients, families and carers with sustained quality improvement actions.
	National Average	67.3	National average	68.6	
	Highest	85.0	Highest	85.0	
	Lowest	58.9	Lowest	60.5	

Staff views					
Topic and detailed indicators	**Immediate reporting period: 2019**		**Previous reporting period: 2018**		**Statements**
Percentage of staff who would recommend the Trust to friends or family needing care (Comparison is with all combined Acute and Community trusts)	Trust	59.3%	Trust	56%	The Trust considers that this data is as described for the following reasons: • the Trust is pleased there has been an increase in the percentage of staff who would recommend the Trust as a place to receive treatment. The Trust intends to take/has taken the following actions to improve this percentage, and so the quality of its services by: • building confidence in our services by sharing good practice and successes eg through GREATix (see section 3.3.8), and improving our overall CQC rating • continuing to encourage staff to report any concerns about patient care through our Freedom to Speak Up Guardians and other confidential methods • more improvement practice and coaching projects to improve ways of working and therefore patient experience and care • Development of a staff engagement model that ensures continuous improvement cycle engaging staff in the solutions
	National average	71.0%	National average	69.9%	
	Highest	90.5%	Highest	90.3%	
	Lowest	48.8%	Lowest	49.2%	

Venous Thromboembolism (VTE)					
Topic and detailed indicators	**Immediate reporting period: Q3 Oct – Dec 2019**		**Previous reporting period: Q2 Jul – Sep 2019**		**Statements**
Percentage of admitted patients risk-assessed for Venous Thromboembolism (Comparison is with all Acute trusts)	Trust	93.22%	Trust	94.15%	The Trust considers that this data is as described for the following reasons: ● the Trust is pleased to note that it is near the national average in undertaking these risk assessments. The Trust intends to take the following actions to improve this percentage, and so the quality of its services by: ● continuing the educational sessions with each junior doctor intake, ● continuing with a variety of promotional activities to staff and patients,
	National average	95.25%	National average	95.4%	
	Highest	100%	Highest	100%	
	Lowest	71.59%	Lowest	71.72%	

Infection Control					
Topic and detailed indicators	**Immediate reporting period: 2018/19**		**Previous reporting period: 2017/18**		**Statements**
Rate of Clostridium difficile per 100,000 bed days amongst patients aged 2 or over	Trust	12	Trust	12.6	The Trust considers that this data is as described for the following reasons: ● the rate has improved again over last year's figures with the Trust now reporting fewer cases than the average across the NHS. This is especially pleasing in a climate where nationally numbers of cases are increasing. The Trust intends to take/has taken the following actions to improve this rate, and so the quality of its services: ● the process for reviewing C. diff cases is changing this year in line with the new national framework. The apportionment assessment has been reviewed and the trajectory has changed as cases will be apportioned to acute trusts a day earlier than in previous years. In addition cases diagnosed pre-48 hrs and in the community that are associated with an inpatient
	National average	12	National average	13.7	
	Highest	80	Highest	91	
	Lowest	0	Lowest	0	

					admission within the previous 28 days will be considered as part of the apportionment related to the acute trust. The well-functioning antimicrobial guidelines continue to be updated to reflect national objectives including reductions in carbapenem useage and increased prescribing from within the access list of antibiotics which the Trust is achieving. Treatment protocols continue to be updated to ensure they reflect evidence-based practice.

Clinical incidents					
Topic and detailed indicators	**Immediate reporting period: Apr 2019 – Sep 2019**		**Previous reporting period: Oct 2018 – Mar 2019**		**Statements**
Rate of patient safety incidents	Trust	43.3 (number 4869)	Trust	49.12 (number 5709)	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 notes it has improved the average reporting rate and its severe incidents is in line with the national average.
(incidents reported per 1000 bed days)	Average	49.8	Average	46.06	
	Highest	103.8	Highest	95.94	
(Comparison is with 130 acute non-specialist trusts)	Lowest	26.3	Lowest	16.9	The Trust has taken the following actions to improve this rate and the numbers and percentages, and so the quality of its services:
Percentage of patient safety incidents resulting in severe harm or death	Trust	0.1% (number 5)	Trust	0.0% (number 2)	● the Patient Safety Advisors work with the divisions to identify areas where they can improve on the reporting of incidents. ● investment has continued across the year on training staff on incident investigations to enable them to focus on the root cause of the incident and, therefore, develop better action plans.
	National average	0.3%	National average	0.3%	

In addition to the above indicators, NHS England has requested that the Trust includes the latest results of the two following questions that are asked as part of the National Staff Survey:

Staff Survey Results 2019					
Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months	Trust	21%	**Percentage of staff believing that Trust provides equal opportunities for career progression or promotion**	Trust	82%
	National average	19%		National average	85%

2.2.9 Seven day hospital services (7DS)

The 7DS programme aim is to provide a standard of consultant led care to all patients presenting urgently or as an emergency such that their outcomes are optimised and there is equity of access nationwide, but also outcomes are not dependant on the time of day or day of the week patients present. We already track and report the key outcomes related to 7DS and report these in our quarterly learning from deaths paper. We are able to provide assurance that there is no significant increase in mortality in patients admitted over the weekend and the difference in SHMI mortality seen in patients admitted over the weekend at the Trust is lower than peers.

NHS Improvement has identified four standards as clinical priorities on the basis of their potential to positively affect patient outcomes and it is against these which the Trust will be assessed for compliance in March 2020. Audit in November 2019 revealed full compliance with two standards - access to diagnostic tests such as ultrasound, computerised tomography (CT), magnetic resonance imaging (MRI), echocardiography, endoscopy, and microbiology and access to consultant directed interventions such as critical care, interventional radiology, interventional endoscopy, emergency surgery, emergency renal replacement. Significant progress has been made against the two remaining standards, especially time to first consultant review within 14 hours of admission for all non-elective patients with 85 per cent compliance against a standard of 90 per cent.

Through supported business cases to aid service redesign such as embedded acute medical consultants in the Emergency Department, adoption of Consultant of the Week models allowing increased presence of senior decision makers over seven days, and introduction of consultant led board rounds, further improvement is expected.

2.2.10 Raising concerns

The Trust recognises that staff being able to raise concerns about any aspect of their experience of work is vital if the organisation is to learn and move forward. Individuals may be worried to speak up about quality of care, patient safety or bullying and harassment but the Trust actively encourages staff to raise such concerns. It welcomes concerns being raised no matter how big or small and is focused on the benefits from voicing concerns as a way to learn, make changes and improve the working place for our staff and ensure the safety of our patients and visitors.

In many circumstances the easiest way to get a concern resolved will be to raise it formally or informally with a staff member's line manager (or lead clinician or tutor). However, when staff do not think this is appropriate or the line manager does not resolve matters, staff have a number of options open to them to seek support.

Key contacts are our Freedom to Speak Up (FTSU) Guardians who are publicised across the Trust. They are supported by our Freedom to Speak Up and Patient Safety Champions, who are locally based staff within allocated areas of the hospital and community. The Trust has a specific medical consultant whom junior doctors can approach with issues around their working hours. All of these people have been trained in receiving concerns and will give staff information about where they can go for more support. The Trust guidelines also contain a list of external bodies staff can contact. Every effort is made to ensure staff do not suffer detriment when raising the concern and the Guardians are always available to support staff who perceive that this is a possibility in their case. Other routes for raising concerns include the Human Resources Department, the Staff Health and Wellbeing Department, staff governors and staff side representatives with the latter sitting on the Trust-wide Freedom to Speak Up Steering Group.

This year has seen a number of developments to encourage staff to raise concerns and improve our ways of responding to them:

- The appointment of a third FTSU Guardian who will be available 30 hours a week.
- The introduction of a FTSU Steering Group with senior and staff representatives to co-ordinate communication, promotion of the service and relevant training of staff.
- An invitation to John Higgins, the co-author of the book 'Speak Up. Say what needs to be said and hear what needs to be heard', to present to staff the outcome of his research into in this topic.
- Commenced training of all staff across the three groups designed by the National Guardian Office: All staff, managers and directors.

2.2.11 Junior doctor rota gaps and the plan for improvement to reduce these gaps

In 2016 a new set of contractual rules were introduced to ensure rotas are designed and managed in a way that allows doctors to meet their training needs, avoid fatigue and overwork and maintain work-life balance, while allowing employers to deliver the service. These were reviewed and updated in 2019. Rota gaps, long-term staff vacancies and intensifying workload continue to be major issues across the NHS. At the Trust, the following gaps have occurred this year:

Rota Gaps				
Speciality	**April – July 2019**		**August – December 2019**	
	Registrars	**SHO**	**Registrars**	**SHO**
Medicine	12	35	10	30
Surgery	2	7	4	8
Clinical Services	0	0	0	0
Total	14	42	14	38

The Trust has taken and intends to take a number of actions to minimise these gaps. These include

- a medical training initiative (MTI) - a two-year training programme has now been in place for two years and established. These doctors help to cover any ongoing Deanery and Trust vacancies at registrar and SHO level. They also help backfill any shifts unfilled by the increasing number of LTFT (less than full time) trainees we are assigned by the Deanery.
- Increased physician associate roles in a number of areas to support SHO level activity. This has been particularly successful this year in the Acute Medical Unit.

- Initial talks with agencies to assess the cost effectiveness of giving them an increasing role in recruitment to offset our own advertisement costs.
- Increasing our internal bank coverage so that, for example, when junior staff leave due to their rotation elsewhere to undertake research, we are arranging for those staff to remain on our internal staff bank.
- Looking at using bank only apps such as Locums Nest, Patchwork or Lantum to increase our bank across the region.
- The use of headhunting agencies to recruit to hard to fill areas such as urology and radiology.
- More effective rostering using the Medirota system for junior doctors. An implementation plan has commenced across the Surgical, Medical and CSS divisions.

2.2.12 Care of patients with Learning Disabilities

The first learning disability improvement standards for NHS trusts were published in June 2018 and in 2018/19. The Trust participated in the NHS Benchmarking Network which collected data on performance against these standards. This year we continue to undertake and monitor the actions in the plan drawn up after the initial survey and the learning disability team has been strengthened to three nurses (the national survey indicates acute trusts have on average one nurse) which allows the team to see all age groups including children. We are also participating in the 2019/20 national data collection.

The team continues with the core activity of supporting people with learning disabilities to access our hospitals and services by working directly with patients, their families and carers whilst they are inpatients, in our Emergency Department and for planned admissions.

This year the team has celebrated 100 years of learning disability nursing, sharing their work within ward areas and with clinical teams. The team has evidenced that their work has addressed some of the health inequalities that people with a learning disability experience when accessing health care by improving patient communication and providing accessible information. They have continued to work in partnership with people with a learning disability by co-production of training sessions and consultations with the experts by experience. The Trust was fortunate to have Paula McGowan attend to deliver a powerful session. Following the untimely death of her youngest child Oliver, Paula has dedicated her life to campaigning for better healthcare for people who have autism and learning disabilities.

Part 3: Other quality information

3.1 Introduction

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

In addition, continual monitoring of a variety of aspects of quality of care includes weekly reports sent to senior managers and clinicians which include the Emergency Department, Referral to Treatment and stroke and cancer targets. Monthly reports which include a breakdown of performance by ward based on Nursing Care Indicators, ward utilisation, adverse incidents, governance and workforce indicators, and patient experience scores, are also sent to all wards. In the interests of transparency, each ward now displays its quality comparative data on a large information board (see section 3.3.5) for staff, patients and their visitors.

We compare ourselves against other trusts, and use Healthcare Evaluation Data (HED) – a leading UK provider of comparative healthcare information – as a business intelligence monitoring tool.
To ensure quality improvement, the Trust has multiple organisation-wide frameworks from which it shares learning from patient feedback, clinical reviews and incidents. These include:

- **Quarterly Learning Report:**
  A quarterly learning report is produced outlining learning that has occurred across the organisation from all sources; incidents, complaints and reviews. This is presented to the directors and uploaded to the Trust intranet for all staff and shared with Dudley Clinical Commissioning Group.
- **Incident Reporting Database:**
  Every incident that occurs is reported in a central database which is designed to capture changes in practice, learning and good practice to share across the organisation. This data is included in the quarterly learning report and cascaded through divisional meetings.
- **Intranet Learning Page:**
  The Trust has a designated intranet page to which all staff have access.
- **Patient Safety and Experience Bulletin:** This commenced in 2017 and consists of a weekly email sent to all staff on a wide range of topical subjects that have arisen from local incidents and national initiatives. Examples of issues covered include diabetes care, malnutrition in hospital and correct usage of oxygen cylinders.

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 chief executive's initial statement:

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

Patient Safety
Are patients safe in our hands?

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

The final section includes indicators and performance thresholds set out by NHS Improvement, the Trust regulator, in its Risk Assessment Framework.

Patient Experience

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

3.2.1 Introduction

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

3.2.2 Trust-wide initiatives

We gather feedback in a number of ways, some of which are described in other parts of this report (e.g. complaints, concerns, compliments, quality and safety reviews) and some in more detail below:

- Real-time surveys (face-to-face surveys)
- Patient stories
- The Friends and Family Test (FFT)
- NHS Choices and Patient Opinion online reviews
- National surveys including the National Inpatient Survey
- Listening events and focus groups

Real-time surveys

During the year 1,006 inpatients participated in our real-time surveys. These surveys complement the Friends and Family Test and the results are reported in a combined report to wards and specialties, allowing them to use valuable feedback from patients in a timely manner. The data from these surveys also allows us to react quickly to any issues and to use patient views in our service improvement planning.

Patient stories

The continued use of patient and staff stories at the Board of Directors' meetings during the year enables the patient voice to be heard at the highest level. These stories are circulated to senior managers and shared with frontline staff and used for service development planning and training purposes.

*During the year, **social media** usage has expanded to a point where the Trust now has 4,839 Twitter followers and in a 44 day period had 1,800 likes.*

The Dudley Group Facebook page has accumulated 10,300 'likes' to date and 10,838 Facebook followers.

Below are some examples of the quantity of feedback we received during 2019/20 and more detailed information about some of the methods. These methods alone highlight more than 53,461opportunities for us to listen to our patients' views.

Method	Total
FFT – Inpatient (inc. daycase)	**21,827**
FFT – Emergency department	**9,485**
FFT – Maternity	**2,563**
FFT – Community	**6,067**
FFT – Outpatients	**15,084**
Community patient survey	**86**
Real-time surveys (inpatient 998, AMU 84, maternity 29)	**1,111**

Method	Total
NHS Choices/Patient Opinion	**132**
National surveys Maternity 2019	**87**
National surveys Adult Inpatient 2019	**493**
National surveys Urgent and Emergency Care 2018	**366**
National surveys Children and Young People 2018	**215**
National surveys Cancer Patient Experience	**479**
Other local/department surveys	**589**
Inpatient food surveys	**1,206**

Listening events and focus groups

The Trust has continued to support a growing number of listening events and focus groups hosted by departments and teams across the organisation. This enables the individual areas to use triangulated

performance and feedback information to raise awareness with a focused group of patients, their carers and families. The feedback from these events and the suggestions for improvement are used to develop action plans that provide a continual improvement approach to the patient experience.

During 2019/20 the Trust has hosted events with the following departments and teams: cardiology, dementia services, Dudley Rehabilitation Service, maternity, ophthalmology, pain management, cancer services, stroke services, trauma and orthopaedics, diabetes, respiratory and volunteers. We held a number of drop-in sessions for patients/public to share their ideas and help shape the plans for our Emergency Department redesign which aims to improve patient and visitor flow, enhance patient safety and provide a better environment for staff to give and patients to receive treatment.

Friends and Family Test (FFT)

The Friends and Family test asks patients to answer a simple question 'How likely are you to recommend (the particular service or department) to friends and family if they needed similar care or treatment?' with answers ranging from extremely likely to extremely unlikely. This is followed up with a question asking 'Please tell us why you gave that response'. The results are published on the national NHS England website. The scores, which are updated monthly, are displayed on our website and prominently in our wards/departments for all patients, staff and visitors to see.

We monitor our performance compared to that of our neighbours in the Black Country. The table below shows our FFT scores for the year which indicates our performance together with that of local Trusts. Where organisations have collected fewer than five responses, the figures are not made public.

Inpatients FFT	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20*
Sandwell & West Birmingham	*	90%	92%	91%	91%	89%	89%	89%	86%	89%	90%	
Dudley Group	95%	95%	94%	94%	95%	95%	96%	95%	95%	95%	94%	
Royal Wolverhampton	93%	94%	92%	93%	95%	93%	93%	94%	95%	94%	93%	
Walsall	96%	96%	96%	96%	93%	95%	94%	94%	95%	96%	94%	
Worcester Acute	94%	94%	96%	96%	95%	95%	96%	96%	95%	95%	95%	
National average	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%	
A&E FFT	**Apr-19**	**May-19**	**Jun-19**	**Jul-19**	**Aug-19**	**Sep-19**	**Oct-19**	**Nov-19**	**Dec-19**	**Jan-20**	**Feb-20**	**Mar-20***
Sandwell & West Birmingham	75%	76%	74%	76%	79%	71%	71%	68%	73%	75%	72%	
Dudley Group	72%	72%	73%	80%	76%	79%	77%	91%	75%	76%	76%	
Royal Wolverhampton	84%	87%	84%	86%	87%	88%	87%	85%	84%	85%	85%	
Walsall	71%	79%	74%	72%	77%	79%	74%	72%	73%	77%	74%	
Worcester Acute	86%	83%	82%	76%	87%	83%	81%	82%	81%	83%	85%	
National average	85%	86%	86%	85%	86%	85%	85%	84%	84%	85%	85%	
Maternity Antenatal FFT	**Apr-19**	**May-19**	**Jun-19**	**Jul-19**	**Aug-19**	**Sep-19**	**Oct-19**	**Nov-19**	**Dec-19**	**Jan-20**	**Feb-20**	**Mar-20***
Sandwell & West Birmingham	NA	NA	NA	NA	NA	NA	90%	97%	100%	75%	83%	
Dudley Group	100%	100%	100%	100%	93%	94%	90%	99%	98%	100%	100%	
Royal Wolverhampton	*	*	*	100%	NA	92%	83%	88%	69%	84%	100%	
Walsall	92%	90%	100%	98%	100%	NA	100%	86%	*	94%	99%	
Worcester Acute	97%	96%	95%	97%	97%	98%	97%	99%	98%	99%	99%	
National average	95%	95%	95%	95%	94%	95%	95%	95%	95%	95%	95%	

Maternity Birth FFT	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20*
Sandwell & West Birmingham	100%	94%	95%	91%	67%	100%	94%	97%	94%	95%	97%	
Dudley Group	98%	100%	97%	100%	100%	93%	99%	97%	97%	97%	94%	
Royal Wolverhampton	99%	100%	100%	100%	100%	97%	99%	94%	91%	97%	94%	
Walsall	100%	91%	89%	100%	100%	100%	100%	100%	93%	100%	100%	
Worcester Acute	99%	100%	99%	97%	99%	99%	98%	97%	98%	99%	100%	
National average	96%	97%	97%	97%	96%	97%	97%	96%	97%	97%	97%	
Maternity Postnatal Ward FFT	**Apr-19**	**May-19**	**Jun-19**	**Jul-19**	**Aug-19**	**Sep-19**	**Oct-19**	**Nov-19**	**Dec-19**	**Jan-20**	**Feb-20**	**Mar-20***
Sandwell & West Birmingham	*	*	NA	100%	*	100%	94%	93%	NA	97%	94%	
Dudley Group	100%	99%	89%	100%	96%	89%	94%	91%	90%	97%	91%	
Royal Wolverhampton	100%	100%	100%	96%	91%	89%	93%	96%	92%	88%	92%	
Walsall	87%	90%	*	96%	95%	94%	92%	86%	100%	100%	93%	
Worcester Acute	98%	98%	97%	97%	98%	96%	92%	99%	98%	97%	99%	
National average	95%	95%	95%	95%	96%	95%	96%	94%	95%	95%	95%	
Maternity Postnatal Community FFT	**Apr-19**	**May-19**	**Jun-19**	**Jul-19**	**Aug-19**	**Sep-19**	**Oct-19**	**Nov-19**	**Dec-19**	**Jan-20**	**Feb-20**	**Mar-20***
Sandwell & West Birmingham	NA	NA	NA	NA	NA	NA	92%	NA	NA	NA	NA	
Dudley Group	100%	100%	100%	100%	92%	97%	100%	100%	91%	100%	100%	
Royal Wolverhampton	100%	100%	100%	100%	100%	92%	100%	85%	97%	94%	86%	
Walsall	87%	NA	100%	100%	100%	96%	100%	98%	100%	100%	99%	
Worcester Acute	100%	100%	100%	97%	100%	100%	100%	100%	100%	97%	100%	
National average	98%	98%	98%	98%	98%	89%	98%	98%	98%	95%	98%	
Community	**Apr-19**	**May-19**	**Jun-19**	**Jul-19**	**Aug-19**	**Sep-19**	**Oct-19**	**Nov-19**	**Dec-19**	**Jan-20**	**Feb-20**	**Mar-20***
Sandwell & West Birmingham			-	-	-	-	-	-	-	-	-	
Dudley Group	94%	93%	93%	90%	92%	91%	93%	95%	91%	94%	92%	
Royal Wolverhampton	91%	89%	90%	91%	89%	89%	90%	91%	92%	92%	91%	
Walsall	98%	98%	98%	97%	97%	99%	95%	95%	98%	97%	98%	
Worcester Acute	97%	94%	95%	94%	93%	95%	92%	95%	95%	95%	92%	
National average	95%	95%	95%	95%	96%	95%	96%	96%	95%	95%	96%	
Outpatients	**Apr-19**	**May-19**	**Jun-19**	**Jul-19**	**Aug-19**	**Sep-19**	**Oct-19**	**Nov-19**	**Dec-19**	**Jan-20**	**Feb-20**	**Mar-20***
Sandwell & West Birmingham	90%	90%	90%	88%	89%	87%	87%	89%	89%	89%	89%	
Dudley Group	89%	90%	89%	89%	90%	89%	90%	90%	90%	90%	92%	
Royal Wolverhampton	95%	95%	94%	95%	94%	94%	95%	95%	95%	95%	95%	
Walsall	91%	92%	92%	92%	92%	90%	91%	92%	92%	91%	92%	
Worcester Acute	92%	93%	92%	93%	92%	92%	93%	93%	94%	94%	94%	
National average	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	

*Figures not yet available

NHS Choices and Patient Opinion

Patients can give feedback about their experience of any of our services on the NHS Choices and Care Opinion websites. Patients can post comments anonymously or choose to give their name. All comments are responded to online.

In the year 2019/20, the Trust received 132 pieces of feedback via NHS Choices and Care Opinion. We actively encourage patients to engage in this way and consistently attract more comments than neighbouring trusts. NHS Choices operates a star rating system where patients can also rate their experience from one to five stars. Not everyone chooses to award a star rating. The average star rating for each of the Trust sites was 4.0 stars. More than 68 per cent all comments received have been positive.

Overall star ratings as per NHS Choices website as at January 2020	
Location	**Overall star rating**
The Dudley Group (no location specified)	 4 stars based on 20 ratings

3.2.3 National survey results

In 2019/20, the Trust participated in the CQC national surveys programme with the following national patient surveys published during the period.

Participants for all national surveys are selected against the sampling guidance issued by the Care Quality Commission (CQC) for the months indicated in the table below:

Survey name	Survey sample month	Trust response rate	National average response rate
2018 Adult Inpatient	July 2018	41%	45%
2018 Cancer Patient Experience Survey	April – June 2018	60%	64%
2019 Women's Experiences of Maternity Services	February 2019	28%	36%
2018 Children and Young People Survey	November – December 2018	24%	26%
2018 Urgent and Emergency Care Survey	October 2018 – March 2019	30%	-

What the results of the surveys told us

Adult Inpatient Survey 2018

The results of the 2018 Adult Inpatient Survey were published on the CQC website on 20 June 2019 and overall show a declining picture when compared to our previous year's performance.

The Trust is ranked 131 out of 144 Trusts (compared to 134 out of 148 trusts in 2017) based on the Overall Patient Experience Score (OPES). The OPES ranged from the lowest trust score in England of 7.3 to the highest trust score in England of 9.1. The Trust score was 7.7 in comparison to 7.9 in 2017.

The Trust response rate is 41 per cent compared to a national response rate of 45 per cent which sampled 1,190 patients discharged from hospital during July 2018. The Trust maintained 'about the same' in the majority of sections with notable exceptions of the Emergency Department, nurses, operations and procedures and leaving hospital, where the Trust scored 'worse' compared to most other trusts that took part in the survey.

Cancer Patient Experience Survey 2018

The National Cancer Patient Experience Survey 2018 was commissioned and managed by NHS England and is the eighth iteration of the survey. The Trust received a 60 per cent response rate compared to the national response rate of 64 per cent.

Scores were provided for questions that relate directly to patient experience. The Trust's performance was comparable to national results. There are a number of areas where the Trust is performing well and scores have remained above the national average.

Women's Experiences of Maternity Services 2019

The CQC published the results of the 2019 Women's Experiences of Maternity Services survey in January 2019. It sampled women who had given birth during February 2018. The Trust response rate was 28 per cent based on 87 women completing the survey. The national response rate was 36 per cent.

The total number of questions requiring subjective responses totalled 37. The Trust scored better compared to the previous survey for 24 questions, worse for 10 and about the same for three.

Overall we were rated as 'about the same' as other trusts for the questions relating to labour and birth, staff and care in hospital after birth.

Children and Young People Survey 2018

The results were published on 29 November 2019. The survey is comprised of three age-appropriate versions: parent version, child version and a young person version. The Trust response rate was 24 per cent for 2018 compared to 20% in 2016. The average response rate for all organisations was 26 per cent.

A total of 64 questions from the survey could be positively scored. The Trust scored better compared to the previous survey for 31 questions, remained the same for nine questions and worse for 16 questions. There were eight questions in the 2018 survey where no data for comparison was available.

Urgent and Emergency Care Survey 2018

The Trust response was 30 per cent (366 usable responses from a usable sample of 1231 patients who were seen during September 2018). Scores were provided for questions that relate directly to patient experience. The Trust's performance was comparable to national results. The Trust maintained 'about the same' in the majority of sections with notable exceptions of the section on leaving Emergency Department.

Acting on feedback received

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

- Our orthopaedic Listening to Action event has enabled us to make changes to our services based on direct feedback from patient on what is important to them:
    - The patient information presentation at 'joint school' has been updated to include 'expectations of surgery', hospital stay, wound care and pain management.

- The time from pre-operative assessment to surgery has been monitored closely to ensure all patients are seen at 'joint school' within two weeks of forthcoming surgery.
- Post-operative retention of urine has been included in the risks/complications discussion prior to surgery.
- Nurse-led discharge has been implemented and supported by all surgeons to address any delays in discharge home.

- We launched our ‘What Matters To You’ campaign in early January. This campaign aims to raise the profile of patient experience across the Trust and capture feedback using a wide range of mechanisms and reporting on this activity to facilitate organisational learning and improvement. This is a great way for us to listen to patients’ thoughts and implement changes to improve the services that we offer.

3.2.4 Examples of specific patient experience initiatives

One Stop Pre-operative assessment service

In January 2020 a One Stop Pre-operative assessment service commenced at the Trust. Patients for surgery are now referred directly from their surgical outpatient appointment. This enables the clinicians to timely optimise patients before surgery (both in terms of assessing chronic medical conditions and detecting any new problems). Benefits of this include reduced on the day of surgery cancellations, better post-operation planning and improved patient experience. This one stop service has helped to reduce the number of times patients have to come to the hospital as the majority of assessments can be completed at the initial visit. Consultant presence throughout the week has ensured that patients receive senior anaesthetic input regarding the risks, benefits and overall decision making regarding the suitability of surgery. The service has also managed to clear a backlog of patients requiring a pre-operative assessment who were awaiting surgery by running additional "Super Sunday" clinics. In addition, there is direct access to a designated frailty clinic for elderly patients and an urgent referral pathway for patients with renal problems, both of which help avoid post-surgery complications for these two groups of patients.

Reducing potential concerns of young people when moving from children to adult services.

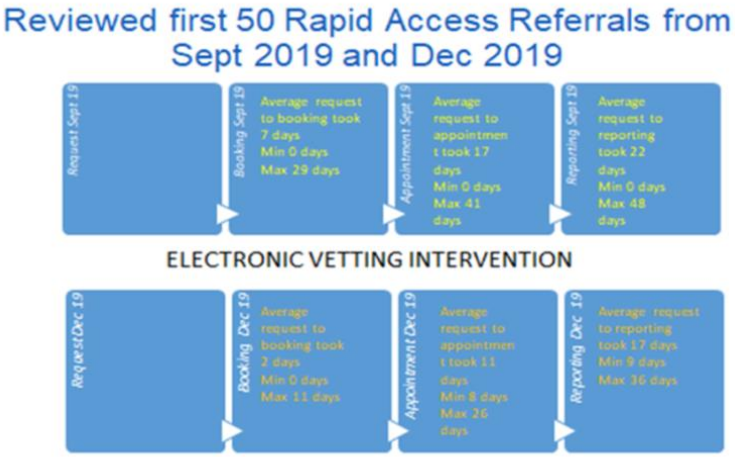
Children and young people with lifelong and life limiting conditions face significant challenges as they move from children's to adult services. Services for paediatric and adults are often very different and can leave young people, their parents and carers struggling to deal with completely new systems of care and treatment with no-one to assist in co-ordinating the move into adult services. In order to improve their experiences we have worked with our specialist nurses to develop clear pathways which will empower young people, parents and carers to understand and take their own decisions for their healthcare but also to move through the process seamlessly. One example is the use of a 'Ready, Steady, Go' document that the young adult is given which explains what to expect.

Courtyard Garden

A new courtyard garden has been created at Russells Hall Hospital to provide patients with a quiet space for relaxation and contemplation during their care and treatment. Funded by The Leukaemia Unit Appeal Fund, the Forget-me-not Garden was officially opened by the Mayor of Dudley, Councillor David Stanley, in November 2019. Special guests at the unveiling were local metal sculptor and furniture maker Lee Woodall from Hausform who made and donated an outdoor sculpture as a thank you for the care his partner received on the Georgina Unit. "My partner Richie spent almost four months on the Georgina Unit last summer, and was not expected to come out," said Lee. "However, he did, and has now made a full recovery thanks to his limitless positivity and the amazing care of all staff on the Georgina Unit. This sculpture is my way of showing my gratitude and thanks." Other guests included representatives from the Leukaemia Appeal Fund, Pro Seal Property Management for constructing the garden and Summit Healthcare for providing ongoing maintenance and extra planting.

Cancer Improvement Collaborative

We participated in the NHS England National Cancer Improvement Collaborative programme for local clinical teams to improve their cancer services. Based on the findings from the National Cancer Patient Experience Survey 2018, the Trust aim was to improve the cancer pathway by working to reduce the diagnostic 'blockers' and acting upon patient feedback to reduce the timescale for receiving the referral to booking the appointment by one day for the first 50 CT patients in December 2019. A correlation can clearly be seen from the data collected in September that the earlier an investigation is booked then appointment and reporting follow suit. See table below.



3.2.5 Complaints, concerns and compliments

Total number of complaints, PALS concerns and compliments

Complaints

In the period April 2019 to March 2020, the Trust received a total of 678 complaints compared to the year total of 566 in 2018/19. The number of complaints received are increasing year on year.

Complaints to the Parliamentary and Health Service Ombudsman (PHSO)

During the year, the PHSO received two new cases about the Trust. Seven cases were carried over from the previous year and all seven were closed within the year. One of the two new cases remains under investigation and the other case has received the draft report indicating that the complaint will be upheld.

Complaints to the Local Government Ombudsman (LGO)

During the year, there have been no new LGO cases. Two were carried over from the previous year. One has been closed (not upheld) and the other was partially upheld. Both cases are now closed and there are currently no LGO cases.

Complaints by type

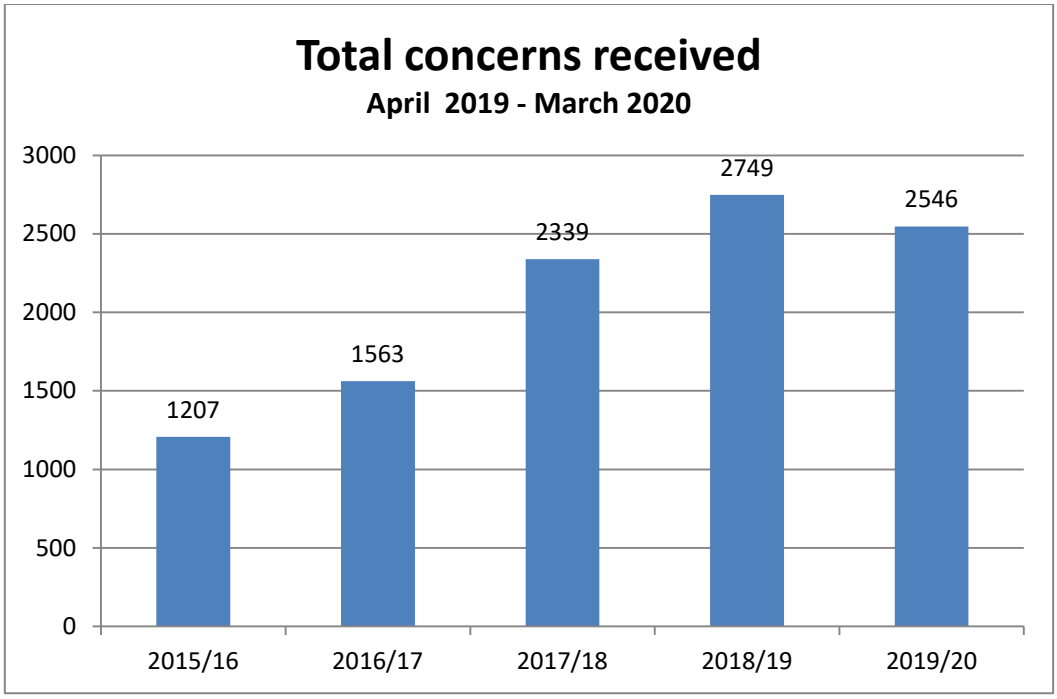
The chart below show the top five types of complaints received in each quarter during the year. The themes of complaints we receive remain similar to last year, reflecting the importance that patients place on effective treatment and communication to help them understand their treatment and patient journey.

Quarter 1, 2019/20	Quarter 2, 2019/20	Quarter 3, 2019/20	Quarter 4, 2019/20
Communications	Communications	Communications	Appointments including delays and cancellations
Clinical treatment – surgical	Values and behaviours – staff	Patient care including nutrition and hydration	Communications
Values and behaviours – staff	Patient care including nutrition and hydration	Values and behaviours – staff	Values and behaviours – staff
Patient care including nutrition and hydration	Clinical treatment – surgical	Clinical treatment – surgical	Clinical treatment – surgical
Admissions/discharges and transfers (excl. delayed discharge due to absence of package of care)	Clinical treatment – Accident and Emergency	Admissions/discharges and transfers (excl. delayed discharge due to absence of package of care)	Clinical treatment – general medicine

Patient Advice and Liaison Service

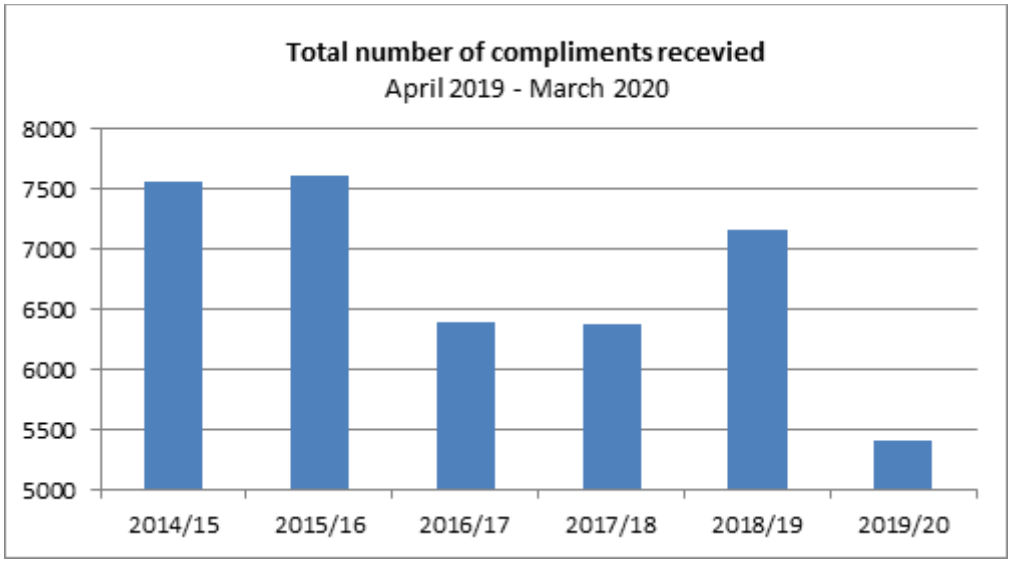
The table below details the total number of concerns and comments raised over the last five years with the Patient Advice and Liaison Service (PALS) with 2019/20 showing the total number of concerns, comments and signposting activity. The Trust places importance on the value of feedback and has worked hard to raise awareness of the PALS services to our patients, carers and their families.

The types of concerns and comments received relate to appointment delays (lack of follow-up appointments being offered, length of time taken for appointments to be offered and cancellations) and communications with patients and relatives. As with the types of complaints received, the themes of concerns reflect the importance that patients place on communication.



Compliments

The table below details the total number of compliments received during the year compared with previous years. It is very pleasing to see how many patients take the time to tell us of their good experiences, with 5,415 compliments received during the year. All compliment letters received by the chief executive and chief nurse are personally acknowledged and shared directly with the individual and teams as appropriate accompanied with a personal letter of thanks.



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

Issue raised by patient/carer	Learning and actions taken
The length of time a patient had been waiting for a 32 day cardiac monitoring investigation.	The demands on the service have increased and due to a shortage of equipment delays have occured. Additional cardiac monitors have been purchased along with an additional analyser. The additional equipment has supported the cardiac physiologists in completing investigations and analysing results in a timelier manner thereby reducing waiting times. There is a business plan to invest further in more equipment to manage the ever increasing demand.
A patient who had mouth pain when eating which was not identified on admission.	The Trust accepted how oral thrush should have been identified on admission to hospital; treatment could have been started earlier thereby reducing the patient's pain and discomfort. It was explained how we recognise mouth care as a vital part of patient care though acknowledged it is not always prioritised by staff. A mouth care screening tool had been introduced on this particular ward. The mouth care screening tool is a new initiative. The use of the tool has been promoted at the twice daily huddle board meetings with the aim for 100% of staff to receive training.
A missed hip fracture in the Emergency Department (ED).	Difficulties can arise in interpreting x-rays. The Painful Hip Protocol was reviewed regarding the safety net for patients who present to ED with a painful hip following a fall. All ED doctors have been cautioned to have a low threshold for CT imaging of a patient's hip in those patients who present with persistent hip pain after falling and a previous clear x-ray.
The breaking of bad news to a palliative care patient.	The doctor acknowledged that he could have waited for the family to arrive before breaking bad news to a patient and should have taken a nurse with him to support the patient. The consultant arranged for the doctor to complete the e-learning in palliative care module and agreed for some time to be spent with the specialist palliative care team. In addition the doctor was asked to reflect on their practice of breaking bad news. The doctor has completed both additional training and reflection.
The length of time an elderly patient was left waiting to be seen in the haematology clinic.	It is acknowledged the impact overbooked clinics has on waiting times. It was identified that the morning clinic on this day was excessively busy and overbooked which impacted on the afternoon clinic. The department has vacancies within the medical workforce which contributed to the inability to provide additional support. The clinic templates were reviewed to ensure clinics can run effectively. The recruitment process for the consultant vacancy is underway with plans to advertise into their clinical fellow post which will assist with clinics. The longer term aspiration is for the team to progress with moving more clinics to the community.

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

PLACE is the national system which focuses exclusively on the environment in which care is delivered; it does not cover the clinical care provision. The PLACE collection underwent a national review which started in 2018 and concluded in summer 2019, which resulted in the question set being refined. Due to the extensive changes, it is important to note that the results of the 2019 assessments are not comparable to earlier assessments.

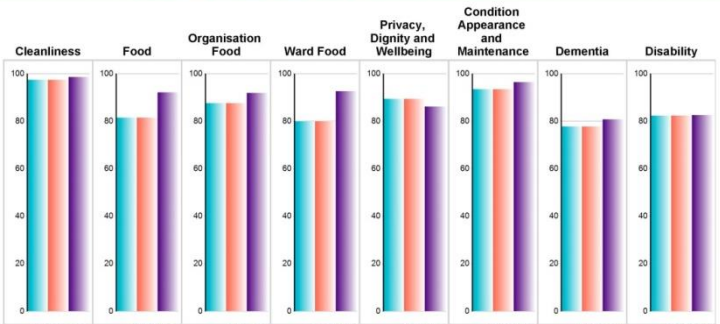
The PLACE team is led by patient assessors (not employed by the Trust) who make up at least 50 per cent of the assessment team. In 2019, the patient assessors who took part where made up of several organisations including Healthwatch, local charities and students from local colleges, along with governors of the Trust. The remaining 50 per cent were staff assessors from the Trust and Summit Healthcare including representation from clinical, patient experience and facilities teams.

The inspection requires 10 wards, outpatient areas, Emergency Department, communal areas and external areas to be assessed for:

- cleanliness,
- the condition, appearance and maintenance of the buildings and fixtures (inside and out),
- how well the building meets the needs of those who use it, e.g. signage,
- the quality and availability of food and drinks,
- how well the environment protects people's privacy, dignity and wellbeing, and
- how the premises are equipped to meet the needs of patients with disability and dementia.

The 2019 scores are identified below.

RUSSELLS HALL HOSPITAL- Collection: 2019



	Cleanliness	Food	Organisation Food	Ward Food	Privacy, Dignity and Wellbeing	Condition Appearance and Maintenance	Dementia	Disability
Achieved Score (Actual)	2160.0000	361.8333	78.8333	283.0000	461.3333	811.0000	685.5000	503.5000
Available Score (Actual)	2218.0000	444.0000	90.0000	354.0000	516.0000	868.0000	882.0000	612.0000
Site Score	97.39%	81.49%	87.59%	79.94%	89.41%	93.43%	77.72%	82.27%
Organisation Average	97.39%	81.49%	87.59%	79.94%	89.41%	93.43%	77.72%	82.27%
National Average	98.60%	92.19%	91.92%	92.62%	86.09%	96.44%	80.70%	82.52%

Apart from the privacy, dignity and wellbeing category the Trust scored lower than the national average in other domains. A Trust action plan has been developed following the assessment. Many actions have been completed associated with cleaning and also the condition, appearance and maintenance of the hospital but the remaining Trust actions are currently being worked through with executive lead involvement.

3.2.7 Single-sex accommodation

We are compliant with the Government's requirement to eliminate mixed-sex accommodation. Sharing with members of the opposite sex only occurs when clinically necessary (for example, where patients need specialist care such as in the critical care unit), or when patients actively choose to share (for instance in the renal dialysis unit). During the year, the Trust has reported 133* breaches of same-sex accommodation. All of these patients were those who were cared for in a specialised unit, such as the intensive care unit or high dependency unit. Following improvement in their condition, the patients were assessed as being able to be moved to a general ward but had to stay in the specialised unit longer than necessary due to there being no general ward beds immediately available. All of these occurred when capacity issues were a major problem both at the Trust and in the NHS generally. (* Due to COVID-19 and the need to release capacity across the NHS to support the response, the collection and publication of this information was suspended in March 2020 and so this figure is from April 2019 to February 2020).

As part of our real time survey programme, patient perception is measured by asking patients whether they shared a room or bay with members of the opposite sex when they were admitted to hospital. Across the year, of the 837 patients who responded to this question, 64 (less than 7.6 per cent) had the perception that they shared a room/bay with members of the opposite sex. This excludes emergency and specialist areas.

3.2.8 Patient experience measures

	Actual 2015/16	Actual 2016/17	Actual 2017/18	Actual 2018/19	Actual 2019/20*	Comparison with other Trusts 19/20
Patients who agreed that the hospital room or ward was clean	9.0	8.8	8.7	8.6	8.8	About the same
Rating of overall experience of care (on a scale of 1-10)**	8.0	7.8	7.9	7.8	7.8	About the same
Patients who felt they were treated with dignity and respect	8.9	8.9	8.8	8.6	8.8	About the same

*The above data is from national inpatient surveys conducted for CQC. ** National range lowest to highest score.*

Patient safety

3.3 Are patients safe in our hands?

3.3.1 Introduction

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

3.3.2 Quality and safety reviews

The Trust is committed to the delivery of high quality, safe patient care and has established a system of quality and safety reviews which assess if the areas are 'Safe', 'Effective', 'Caring', 'Responsive' and 'Well-led' (CQC Fundamental Standards). The reviews provide assurance of these areas to the board. They utilise a set of tools that enable a full review of a clinical area and identify both good practice and topics where improvement is required. The wards and departments reviewed are provided with CQC style ratings for each domain and an overall rating, allowing them to prioritise the actions for improvement required. The reviews occur every two weeks and are undertaken by a wide multidisciplinary team. The team also includes non-executive directors, members of the Board of Governors and representation from our CCG. The diversity of the team members allows a broader perspective to be gained during the review. Feedback is provided on the same day following aggregation of the review team's findings. A formal report of the review is sent within one week of the review to the ward manager, matron and divisional chief nurse. Action plans should be produced within 14 days of receiving the report if required and are managed through the relevant division.

In the instance where a poor rating is applied this results in a follow up visit by the team within four weeks to ensure improvements have been made. This multi-dimensional view of our services, coupled with executive director and non-executive director 'back to the floor' walk rounds, ensures that we maximise our opportunity to learn and improve our services for the benefit of our patients and staff.

Some of the findings of the reviews included:

- Staff were able to describe how they have learned from incidents and made changes to improve the patient experience.
- Staff were able to accurately describe the process of staffing escalations.
- Patients' privacy and dignity was maintained during delivery of personal care and during discussions with medical staff.
- Staff were able to describe the correct action to take if they had a safeguarding concern.
- All acute wards displayed a quality dashboard that was visible to the public.
- Evidence of the introduction of daily safety huddles to improve communication.
- Excellent use of noticeboards throughout the areas visited
- Staff were able to articulate the risks for their area

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."

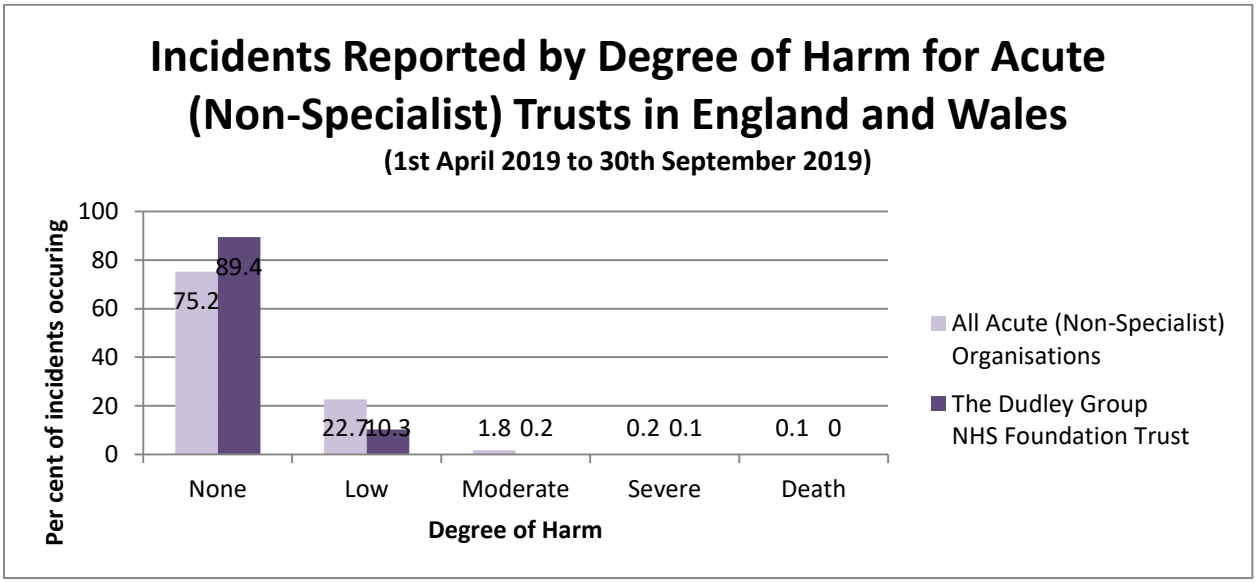
As a Trust, we are committed to learning from incidents. This is supported by an open culture which encourages any incident regardless of the level of harm (including 'near misses') to be reported through the Trust's electronic incident management system Datix. During 2019/2020 the Weekly Meeting of Harm membership has been increased to include the chiefs of division and key individuals are invited to present a potential serious incident to the group. The meeting has been formalised and a terms of reference developed.

The process for the investigation of serious incidents has been reviewed to support the timely completion of investigations. The improvements include ensuring reports are now written by the patient safety team and they are supported by an independent specialist. Regular meetings are held with the investigation team to drive the investigation forward.

The process of the investigation of less serious incidents in the divisions has been reviewed. This has led to the closure of a significant number of these incidents. The process for their identification has also been reviewed and these are now identified through the weekly meeting of harm or review by the speciality leads/deputy chief (i.e. falls/pressure ulcers).

The Integrated Governance report has been reviewed to provide the divisions and directorates a more constructive review of incidents, risks, procedural documents, CAS alerts and inquests/claims. The revised report was agreed within the divisions and launched in October 2019.

The chart below shows the percentage of incidents reported by degree of harm at the Trust and for all acute (non-specialist) trusts in England and Wales, from 1st April 2019 to 30th September 2019.



With regards to the impact of the reported incidents, it can be seen from the chart that the Trust reported similar proportions of incidents to comparable trusts. Nationally, across all acute (non-specialist) trusts 75.2 per cent of incidents are reported as no harm (the Trust reported 89.4 per cent) and 0.1 per cent as death (the Trust reported zero per cent).

During the year, the Trust has had four never events (a special class of serious incident that is defined as a serious preventable adverse incident that should not occur if the available preventative measures have

been implemented). The Trust had 39 serious incidents, all of which underwent investigation in line with the Trust's policy which is based on national requirements and, when relevant, action plans were initiated and changes made to practice. Serious incidents are events in healthcare where the potential for learning is so great, or the consequences to patients, families and carers, staff or organisations are so significant, that they warrant using additional resources to mount a comprehensive response.

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

- A number of serious incidents have been reported in ED relating to the management of patients presenting to the department with chest pain. This led to the development of a Task and Finish group involving key individuals to look at themes, commonalities and to review the current process for the management of these patients. The group identified a number of improvements were required to improve the pathway for such patients. This has included the development and introduction of a standardised assessment tool. The chest pain pathway has been reviewed and updated providing clear guidance on the management of patients that present with chest pain, clearly identifying the correct management of patients with cardiac and non-cardiac chest pain. The working hours of the cardiac assessment nurse have been extended to provide a service 12 hours per day, seven days a week.
- A never event relating to "wrong body part treated" identified a lack of process in relation to marking the site of removal and this has led to the development and implementation of a Standard Operating Procedure for the marking of the site which clarifies the process of marking a patient's skin prior to a surgical intervention. iPads have been purchased to enable photographs to be taken of the site and staff training has been provided.
- A never event relating to a "retained stylet" in a long intra-arterial line identified that there was a lack of awareness of the Product Evaluation in the Clinical Area Standard Operating Procedure (SOP) for ordering a piece of new equipment. The SOP has been shared with all the divisions and a Patient Safety Bulletin is being completed which will be shared Trust-wide.
- There have been a number of incidents reported in relation to delay in the Surgical Ambulatory Emergency Care (SAEC) area. This has led to a number of improvements to ensure that patients are well informed should there be any delays. Improvements include the introduction of a triage dashboard which will provide the staff with oversight of the patients waiting and ensure that they are seen within timescale. An additional clinical support worker (CSW) has been secured and is based in the waiting area. The CSW is visible to the patients and can answer any concerns and can pass on any concerns to the triage nurse. The area has appointed two advanced care practitioners who will help to improve the flow through the unit. Work is ongoing to move the unit to the front door as part of the ED redesign. This will help to improve efficiency and improve the pathway for patients requiring assessment in this area.
- The Discharge Lounge Standard Operating Procedure has been reviewed which includes ensuring the discharge checklist is fit for purpose. The completion of the discharge checklist has been added to the Perfect Ward audit to ensure compliance is embedded.
- A number of medication incidents have occurred involving drug fridges being unintentionally switched off or unplugged. Drugs that have not been stored in accordance with manufacturers' recommendations may have to be discarded or have their expiry dates shortened. Incidents were also having an impact on the workforce due to the staff time needed to provide advice about whether medicines could be reused or destroyed and carry out tasks such as emptying the fridge, quarantining stock, replacing stock etc. This topic was place on the risk register and an audit has been completed to identify the number of drug fridges and their location. Pharmacy staff have worked with estates staff to establish options to prevent fridges being unplugged e.g. spur or tamper proof cover and costings for these. Options have been discussed at the Safe Medicines Practice Group and it has been agreed that tamper proof covers will be fitted to drug fridges to cover sockets and reduce the risk of fridges being switched off or unplugged.
- A sub category has been added into the Datix system to allow for the pressure ulcers that are related to medical devices to be specifically reported and to allow collation of numbers. A Patient

Safety Bulletin was completed to define what a medical device related pressure ulcer was, detailing examples of these devices and the preventative measures that should be taken, alongside the pressure relieving intervention already available.

- The Trust is one of the top 10 performing acute Trusts nationally for Referral to Treatment (RTT), however unfortunately the Trust has identified two 52 week RTT breaches and these were reported as incidents. Such breaches potentially result in: clinical risk to patients, poor patient experience, financial implications to the organisation and poor organisational reputation. In response immediate actions were taken and internal specialty to specialty referrals are now undertaken electronically and no paper internal referrals are accepted for an outpatient appointment. This is in line with the "national paper switch off" and follows the process already implemented for GP referrals.

3.3.4 Duty of Candour

The aim of this regulation is to ensure that staff are open and honest with patients when things go wrong with their care and treatment. This includes any event when a patient has been harmed. To ensure compliance to the regulation and to ensure this framework is embedded in the organisation, the Trust has taken the following actions to further ensure compliance and improve completion of the necessary documentation:

- The central patient safety team liaises with the lead investigator of an incident to ensure that the duty is completed within the 10 day framework and then on closure of the investigation. The team notify the lead investigator if the patient requires feedback following the completion of the investigation and co-ordinates any written feedback requests.
- Our commissioners are provided with evidence of the completion of the aspects of the initial discussion with families through the national serious incident reporting system (STEIS).
- Duty of Candour training is provided on request to the patient safety team.
- A Standard Operating Procedure is in place detailing the process of how to complete the Duty of Candour documentation and this is available to staff on the Trust's intranet.

3.3.5 Quality Indicators

Every month, nursing records and supporting documentation are audited at random in all general inpatient areas and specialist departments in the hospital, and in every nursing team in the community. A total of 36 wards and departments (approximately 370 records) are audited each month. The purpose of this audit is to ensure nursing staff are undertaking risk assessments, performing activities that patients require and accurately documenting what has taken place. The results of the audit for each area of the Trust compared to the last two years are shown below. In February 2019 the Trust commenced the implementation of 'Perfect Ward'. This is a smart inspection app which is installed on handheld devices. It allows nurses to spend less time on data collection. It also allows nurses to take photographs as a visual aid of both good and poor practice. As soon as an inspection has been undertaken and submitted within the handheld device the results are visible. This means that the key findings can be reviewed immediately by the lead nurse so any required improvements can be addressed straight away.

The results generally show improvement although direct comparison is difficult due to changes in the tools with the introduction of Perfect Ward. Community are currently not undertaking their audits via Perfect Ward, they continue to carry out audits via Snap.

In addition to the above indicators, a number of other more specific audits, such as assessing the care of diabetes, pressure ulcer care and patients at risk of falls, are conducted monthly. The audit tools are reviewed regularly to reflect learning from incidents and changes in practice. These audits have an escalation framework to ensure that issues that could be improved are addressed by the lead nurse and

matron for that area. As well as the monthly audit system, spot checks occur in all areas alongside the wider quality and safety reviews (see section 3.3.2).

(Red=< 85%, Amber 85%-94%, Green ≥95%)

Area of Audit	2017/2018	2018/2019	2019/2020
Community Children's	100%	100%	99%
Community Neonatal	100%	100%	99%
Critical Care	95%	97%	95%
District Nurses	95%	97%	96%
EAU/AMU	86%	91%	80%
ED	90%	94%	88%
General Wards	93%	96%	93%
Maternity	96%	94%	94%
Neo Natal	99%	98%	98%
Paediatric	97%	96%	95%
Renal	98%	97%	94%

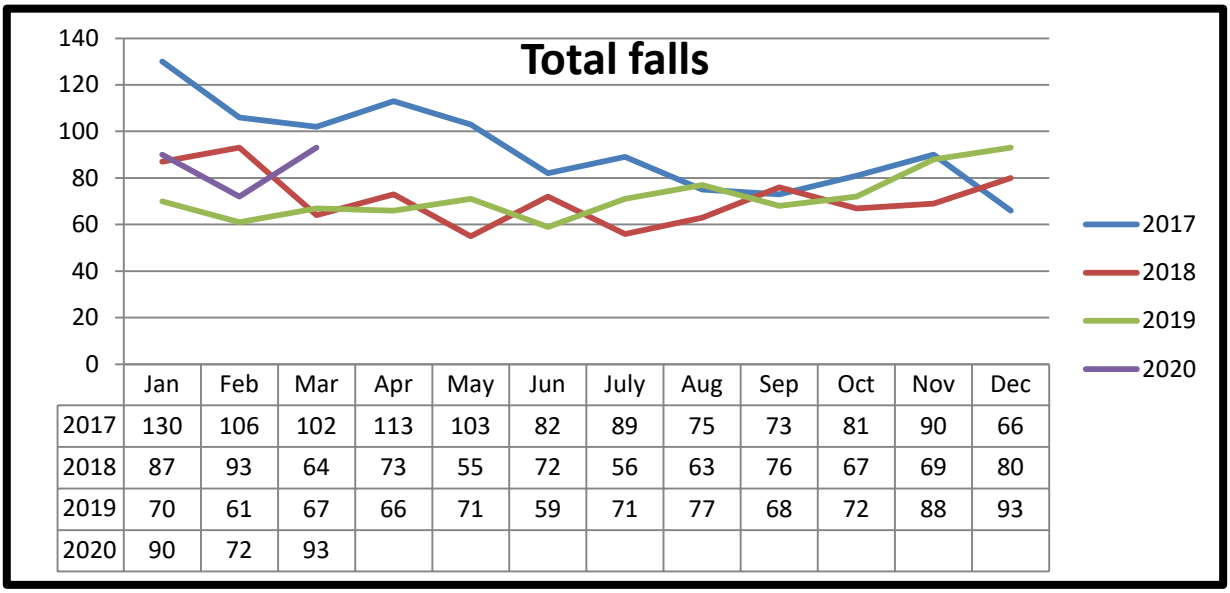
3.3.6 Falls Prevention

In 2019, the Trust continued to work with NHS Improvement as part of their National Falls Practitioner Network which enables trusts to discuss and share ideas and learning. The Trust falls lead was elected as the chair of the network for 2020. The Midlands Regional Falls Network is now well established and there were a number of meetings held in 2019 with the Trust falls lead acting as deputy chair. The main members of this network are from our neighbouring trusts.

A CQUIN (see section 2.2.4) was introduced in 2019 entitled 'Three high impact actions to prevent hospital falls' and additional support was introduced to the falls team to help embed these. The first action related to the recording of lying and standing blood pressure in all applicable patients aged over 65. This is something which was not routinely undertaken prior to the CQUIN introduction but following support from the falls team we successfully achieved the standard required by the CQUIN. The other two actions relate to the risk of falls risk medications and the use of walking aids for inpatients. Both of these areas already have robust systems in place and there are no anticipated difficulties in achieving the CQUIN target.

The Trust had seven serious incidents for falls with harm in 2019. This compares favourably with the 12 serious incidents which occurred in 2018.

The end of 2019 and beginning of 2020 has demonstrated a spike in both falls with and without harm. This may be attributed to the higher dependency of patients in the winter months. Falls figures in February were more in keeping with what the Trust would normally expect but an increase is noted in March – this is being monitored for trends. No falls, with harm, were reported in February with two occurring in March.



	Jan	Feb	Mar	Apr	May	Jun	July	Aug	Sep	Oct	Nov	Dec
2017	130	106	102	113	103	82	89	75	73	81	90	66
2018	87	93	64	73	55	72	56	63	76	67	69	80
2019	70	61	67	66	71	59	71	77	68	72	88	93
2020	90	72	93									

There has been an emphasis on training for the small number of wards where staff have not completed falls prevention training.

3.3.7 Harm Free Care and NHS Safety Thermometer

The NHS Safety Thermometer used for adult patient care was 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 available across the whole of the NHS.

Each month, on a set day, an assessment is undertaken consisting of interviews with patients, accessing the patient’s bedside nursing documentation and, when required, examining the main health record. On average, 480 adult inpatients (excluding day case patients and those attending for renal dialysis), and 580 patients being cared for in the community are assessed.

To ensure accuracy of audits submitted as well as improved lines of communication, access to the database has been restricted to staff who have received training.

The Children and Young People's Services Safety Thermometer is a national tool that has been designed to measure commonly occurring harms in people that engage with children and young people's services. It is a point of care survey that is carried out on one day per month which supports improvements in patient care and patient experience, prompts immediate actions by healthcare staff and integrates measurement for improvement into daily routines. This process is led by the clinical governance lead for paediatrics. The Maternity Safety Thermometer allows maternity teams to take a temperature check on harm, and records the proportion of mothers who have experienced harm free care, but also records the number of harm(s) associated with maternity care. It supports improvements in patient care and patient experience, prompts immediate actions by healthcare staff and integrates measurement for improvement into daily routines. This process is led by the maternity matron.

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

As of March 2020, the collection of data for all Safety Thermometers has ceased and the Trust awaits instruction as to a new national data collection tool.

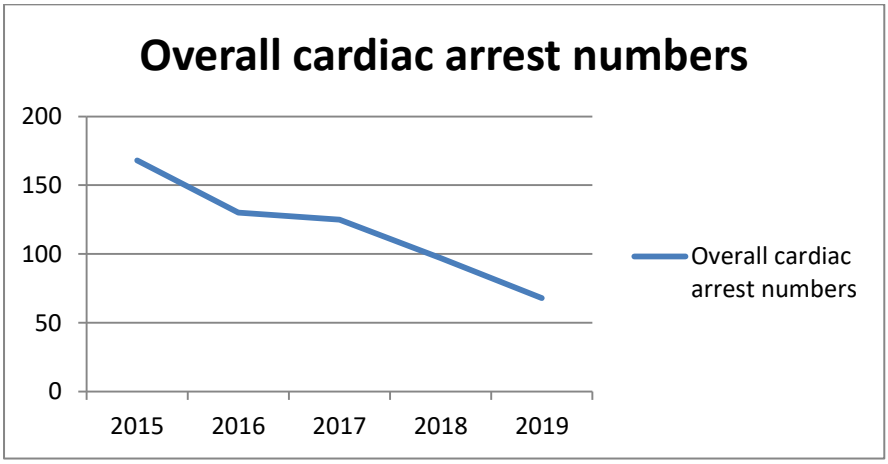
3.3.8 Examples of specific patient safety initiatives

Deteriorating Patient/Sepsis Improvements

The management of the deteriorating patient is a key priority for all our patients in maintaining a safe and holistic approach to care. To achieve this we have worked significantly on the early identification of the cause of deterioration and the appropriate use of trigger tools and care pathways while always accepting some patients may have more than one problem so ensuring that all deteriorating patients have early senior review.

The improvement in our sepsis recognition across the whole organisation and treatment is evident of this. In February 2019 the undertaking of the Sepsis 6 (a bundle of diagnostic and therapeutic steps – all to be delivered within one hour of the initial diagnosis of sepsis) was 53.9 per cent and treatment started within 60 minutes was 67.2 per cent. This has improved to 70 per cent of Sepsis 6 being undertaken and 90 per cent of treatment started within 60 minutes in March 2020. In March 2020, 93 per cent of observations were recorded within the time as indicated by escalation.

Our performance is under continual review and support from a multi-professional approach including the deteriorating patient team (sepsis and resuscitation practitioners), critical care outreach team, Hospital@Night staff alongside parent teams/ward staff and on call teams. We can also see we are recognising the deteriorating patient early by the overall reduction in cardiac arrest events over time.



We achieved early adoption of the NEWS 2 (National Early Warning Score) before the April 2019 national deadline and are working to ensure we do the same with the new national sepsis management guidance.

We see this work as ongoing and are continually asking what more can be done to create the safest environment for our patients. This means also ensuring we learn from critical incidents, have open candour and all cardiac arrest cases are subject to multidisciplinary review.

Hospital@Night

To support sick or deteriorating patients in the hospital and support the junior doctor workforce, we have set up a new service - Hospital@Night. This is a group of nurses with advanced skills in health assessment and management who support our junior doctors out of hours (overnight and weekends). There are six senior nurses who work through the night and on twilight shifts to capture the peaks of activity. They come with a unique skill set and will build on this as their training progresses so that they possess the skills equivalent to our junior doctor workforce and are able to respond quickly to patients who are clinically deteriorating or where nursing staff require support. They carry a mobile device which informs them of the priority of tasks that are required across the hospital.

GREATix

While we learn from when things go wrong, too often we miss the opportunity to learn from when things go right. The aim is to shift our learning from retrospective negative events to prospective learning where we aim to always get things right, resulting in fewer negative events. At the Trust GREATix has been introduced. This is a reporting system which staff can use to report when an individual has done that little bit extra for a patient, a team has worked well together or a system of working/patient episode of care has been especially effective.

The GREATix system is user friendly, easy and quick to complete and can be accessed from inside and outside the Trust via desktops, laptops and mobile phones. The reporter receives a thank you email for submitting the form and the person or team that is being recognised receives an email thanking them for their actions. Submitted forms, which have wider learning for other teams, will be followed up with a learning conversation with a patient safety champion to enable the wider sharing of best practice.

3.3.9 Patient safety measures

	Actual 2015/16	Actual 2016/17	Actual 2017/18	Actual 2018/19	Actual 2019/20
Patients with MRSA infection per 1000 bed days* Trust Vs. national	0.009 Vs. 0.009	0 Vs. 0.009	0 Vs 0.008	0.004 Vs 0.008	0.004 Vs *
Never events – events that should not happen whilst in hospital Source: adverse incidents database+	1	1	3	0	4
Number of cases of deep vein thrombosis presenting within three months of hospital admission+ Source: see below**	130	138	122	116	136

*Data source: For 2015/16 to 2018/19 from National Statistics on www.gov.uk For 2019/20, for Trust figure, numerator data taken from infection control data system and denominator from the occupied bed statistics in patient administration system. No national figure yet available.

**We review all diagnostic tests for deep vein thrombosis and pulmonary embolism (PE), cross referencing positive tests with past admissions. This methodology is only undertaken by relatively few hospitals as it is labour intensive, but is recognised as giving a more accurate figure for hospital acquired thrombosis. As a further check, we receive notification from the bereavement officer if PE was identified as the primary cause of death.

+ For these two indicators benchmarking data is not available.

3.4 Do patients receive a good standard of clinical care?

3.4.1 Introduction

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

3.4.2 Examples of awards received in improving the quality of care

Nursing Times and Forward Healthcare Awards.

During the year our Cardiac Assessment Unit (CAU) team was shortlisted in the Nursing Times Awards and also won the Initiative of the Year Award as part of the Forward Healthcare Awards. The unit has greatly reduced the time patients wait to be seen and has led to the early diagnosis of several myocardial infarctions (MIs) and reduced admissions.

CAU is a six-chaired specialist area near the Emergency Department run by our cardiac nurse specialists and supported by the on-call cardiology consultant/registrar. It sees patients with chest pain and a low to intermediate suspicion of having an acute coronary syndrome (ACS) or other cardiac conditions where patients are ambulant, such as newly-discovered atrial fibrillation (AF) or other arrhythmias. All of these patients get seen within an hour with the current average being 30 minutes. This has led to the early diagnosis of several MIs, the outpatient management of many arrhythmias that historically would have been admitted, and the safe discharge of the majority of patients, many with further outpatient tests.

Cavell Star Award

Midwives Julie Hughes and Tracey Jones were awarded this national award after their intervention proved life-saving for a dad-to-be who was attending a routine antenatal appointment. They noticed that Sam Hutchins was clearly poorly and insisted he was seen by a doctor straight away. He was diagnosed with aplastic anaemia.

The award is given for exceptional care by The Cavell Nurses' Trust. They were nominated by Sam's mum.

Owen Wade Prize

Two of our trainee doctors, Dr Nikita Goel and Dr Carol Wong, won this prize for their medical case presentation on anaphylaxis to the West Midlands Physicians Association meeting. The panel of judges praised them for presenting data on an important clinical issue and explaining the logic followed to reach their diagnosis well. The trainees were mentored by Dr Prasad Rajendran and Dr Darshan Pandit, who both work in the medical high dependency unit and the case related to a rare case in which a patient was allergic to dialysis.

The Owen Wade Prize is awarded for the best case report and is presented in remembrance of the former dean of Birmingham Medical School who was considered one of the founding fathers of clinical pharmacology and therapeutics in the UK.

Clinical Research Network WM (CRN WM) awards

Our research and development team won two awards at the annual Clinical Research Network WM (CRN WM) awards ceremony. The awards celebrate the wide range of high quality clinical research taking place throughout the West Midlands – improving the health and the wealth of the nation through research. The Trust was presented with the awards for both Creative Recruitment and Business Intelligence Leaders. The first award was for our part in the Pathfinder study which looked for rare diseases from routine pathology results. The Trust had committed to recruiting 50 patients and actually recruited 675 – finding three with rare metabolic diseases who were referred for treatment. The Business Intelligence Leaders award was for our innovative database work which has been shared as good practice outside the Trust, locally across the region and at national meetings and conferences.

Dudley Respiratory Assessment Service (DRAS) and Best Use of Sepsis Data

Two of our teams were named as finalists in the Leading Healthcare Awards 2020. Dudley Respiratory Assessment Service (DRAS) and our sepsis screening EPR tool were both up for awards.

The Trust was successful in winning the award in the category of Best Use of Data for our use of data to improve outcomes for sepsis patients. Introducing a sepsis screening EPR tool increased our sepsis screening of eligible Emergency Department patients from 71 per cent to 97.7 per cent, improving our identification and management of sepsis patients, reducing mortality to a historical low and below national average.

The DRAS service was highly commended. This multi-professional team is dedicated to improving the care and quality of life for respiratory patients. By utilising a forward-thinking, innovative approach to respiratory health they are able to integrate services across secondary, primary and community settings ensuring accessible, holistic care for respiratory patients.

3.4.3 Examples of innovation

Intravenous Iron Injections in the Community

International consensus recommends treating all surgical patients who have pre-operative iron deficiency anaemia. National Institute for Health and Care Evidence (NICE) standards state if oral iron is not appropriate, intravenous (IV) iron should be given. Due to capacity issues, The Dudley Group has developed a unique IV iron service with community based administration. Patients due to have major surgery are identified in a consultant-led surgical pre-assessment clinic, and if required, the patient is referred to the community IV team. The referral for a single dose of IV iron is then administered at Brierley Hill Health and Social Care Centre by registered nurses within the community IV team. This dose of IV therapy replenishes the entire body store of iron. We are the first Trust nationally to deliver IV iron in this community setting. It has been popular with patients and ensures we can treat patients promptly. We have demonstrated that this raises the blood count before surgery, making patients fitter for surgery and also reducing the chances of needing a blood transfusion. All doses have been administered successfully and with no adverse reactions. The additional work has increased the knowledge and skills of the community IV

nurses and developed an integrated pathway between hospital and community services to benefit patient care.

Frailty Assessment Unit

On 1st October 2019 the Trust transformed the way we assess frail elderly patients who arrive at the Emergency Department, ensuring they receive optimal care from a dedicated frailty team providing a comprehensive assessment. The changes enable patient to get home sooner while maintaining their independence. In the past, older frail patients would often be admitted to a frailty ward. This could be a lengthy process, time consuming and repetitive. Also, in a ward such patients are at risk of falls as well as immobility, delirium and loss of independence. Now, a specialist consultant, specialist nurses, physio and occupational therapists, dieticians, discharge co-ordinators and social services provide comprehensive assessment and help them return to their place of residence. From 1st October 2019 to 16th January 2020, 621 patients were discharged back to their place of residence on the same day (75.5 per cent discharges).

Giant Cell Arteritis (GCA)/Temporal Arteritis Diagnosis

Since August 2019 we have a same-day diagnostic ultrasound scanning service for patients with suspected Giant Cell Arteritis (GCA)/Temporal Arteritis who we see as urgent referrals in rheumatology outpatients.

Same-day certainty about the diagnosis of GCA/Temporal Arteritis has improved, thus reducing the need for temporal artery biopsy, the previous gold standard of diagnosis.

Physiotherapist-led balance clinics

Physiotherapist-led balance clinics have been introduced this year. These clinics have provided an improved experience for patients with balance problems, seeing shorter waits and fewer investigations. They also free up ear, nose and throat medical staff time in other areas. The six month pilot of the clinics ran from July - December 2019 with two clinics a week. The results were very positive with 159 patients being seen and only 15 requiring referral to an ENT consultant (11 of which were for non-vestibular problems). The median wait for a clinic appointment was 62 days, with a mean assessment to discharge time of 61 days. 98 per cent of patients who completed their treatment improved in one or more outcome measures, with 65 per cent improving in four or more of the five outcome measures completed. 18/18 cases of benign paroxysmal positional vertigo (BPPV) were successfully treated. Patient satisfaction with the service was extremely positive.

The pilot demonstrated the numerous benefits of allied health professionals being the first and effective point of patient contact: firstly that the vast majority of this caseload can be managed within this setting, secondly that it provides significant clinical benefit to patients and also that patients' experience of this clinic is overwhelmingly positive. This example of multidisciplinary working brings together different skillsets and approaches, which broadens the toolkit any service has to offer patients accessing it. The time and expertise physiotherapists have to offer this caseload of patients with problems with dizziness and/or imbalance fill a gap within existing provision, which often results in patients having to access multiple services with associated waits, which often increases the time it then takes for that patient's condition to improve.

3.4.4 Examples of specific clinical effectiveness initiatives

Stroke service success

The Trust is officially the best in the West Midlands for stroke care, according to a major national healthcare quality improvement programme. It placed us in the top 40 trusts nationally.

The Sentinel Stroke National Audit Programme (SSNAP) measures the quality and organisation of stroke care in the NHS and is the single source of stroke data in the UK. It assesses both the clinical processes of care provided to stroke patients, as well as the structure of stroke services against evidence-based standards, including the 2016 National Clinical Guideline for Stroke. It aims to provide timely information to clinicians, commissioners, patients and the public on how well stroke care is being delivered so it can be used as a tool to improve the quality of care that is provided to patients. Our score makes us the best in the West Midlands. This has been achieved through a number of initiatives such as:

- Twice daily consultant-led ward rounds where important clinical decisions are made.
- A 24-hour stroke specialist nurse-led bleep cover for all stroke referrals including pre-notification from the ambulance crew.
- The stroke co-ordinator ensuring that the targets prescribed in the national audit are achieved for patients from admission to discharge, and getting the team together to put action in place where improvement is needed.
- Imaging of stroke patients in the time specified in the national clinical guidelines for stroke, which has improved our performance to Level A.
- Secretaries bringing all Transient Ischaemic Attack (TIA) referrals to the consultant's attention and with the assistance of the specialist stroke nurse team, referrals are triaged appropriately.
- Dudley Stroke Association providing support to the patients and families after discharge from hospital.

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Anaesthetics Accreditation

Our Anaesthetic Department has been recognised for providing the highest quality care to patients by achieving the prestigious Anaesthesia Clinical Services Accreditation (ACSA).

ACSA from the Royal College of Anaesthetists promotes quality improvement and the highest standards of anaesthetic service. To receive accreditation, departments have to demonstrate high standards in areas such as patient experience, patient safety and clinical leadership, meeting 100 per cent in all areas. It means our patients can be assured they are receiving outstanding service. We are the first Trust in the West Midlands to become accredited and only the 33rd in the UK.

Achieving the Joint Advisory Group on Gastrointestinal Endoscopy (JAG) Standards

The GI Unit was awarded the prestigious JAG accreditation on the same day as the actual inspection in June 2019. This is rarely given on the day of inspection, as there is usually a discussion prior to giving this award. JAG shows that the endoscopy services run at the Trust meet with their criteria for service standards in endoscopy. They are marked against four domains: clinical quality, quality of the patient experience, workforce and training. We have two staff members that are now trained as JAG faculty and can deliver JAG accredited courses on endoscopy externally or they can be run from this Trust at cost to attendees.

Dudley Improvement Practice Events

A number of these events have taken place. For example, in ophthalmology the department started their quality improvement journey with a week-long event to understand and implement improvement ideas. The team ensured they put the patient at the centre of the improvement work by using feedback in person from a regular ophthalmology patient. The aim was to optimise machine utilisation and reduce patient appointment time door to door.

Following the event, OCT machine utilisation jumped from 48 per cent to 71 per cent. Quicker patient journeys occurred – a reduction from two hours seven minutes to 50 minutes in the macular clinic. Adapting rooms improved patient experience – 85 per cent of patients stated they had more privacy with the new room layout. There was improved staff efficiency – using specific outcome trays saves 3.6 hours of work a week. The team have maintained their improvement momentum by having regular huddles, using an improvement visual control board and continually involving the team in decisions and changes.

3.4.5 Clinical effectiveness measures

	Actual 2015/16	Actual 2016/17	Actual 17/18	Actual 18/19	Actual 19/20
Trust readmission rate for Medicine and Integrated Care Division *Vs.* National peer group (acute and specialist trusts) *Source: UHB Hospital Healthcare Evaluation Data (HED)*	8.82% Vs. 8.39%	10.37% Vs. 9.38%	8.76% Vs. 9.30%	8.53%* Vs 9.03%*	9.00%** Vs 9.03%**
Number of cardiac arrests*** *Source: Logged switchboard calls*	144	136	118	97	68
% of patients admitted as emergency for fractured neck of femur operated on within 36 hours *Vs.* National average+ *Source: NHFD (National Hip Fracture Database)*	82.3% Vs. 73.8%	82.5% Vs. 71.7%	80.5% Vs. 70.4%	84.0% Vs. 70.8%	75.7% Vs. 67.5%

*These updated figures are for the whole year. Last year's report included the figures available at the time of printing.

** Both Trust and National Peer Figures are April 2019 to January 2020, the latest HES period available.

+ In 2019/20 the indicator was amended from surgery within 36 hours to 'prompt surgery', with prompt surgery being on the same day or the day following the patient presented with the fracture. This new measure is consistent with NICE clinical guidelines (CG124). The results are also now provided by calendar not financial year so the figures for 2019/20 are for the calendar year 2019.

*** For this indicator, benchmarking data is not available.

3.5 Our performance against the thresholds set out in the Risk Assessment and Single Oversight Frameworks of NHS Improvement*

National targets and regulatory requirements	Trust 2015/16	Trust 2016/17	Trust 2017/18	Trust 2018/19	Target 2019/20	National 2019/20**	Trust 2019/20	Target Achieved ?
Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate – patients on an incomplete pathway	95.06%	95.43%	94.0%	93.64%	92%	85.8%	93.19%	☺
A&E: maximum waiting time of 4 hours from arrival to admission, transfer, discharge	98.18%	94.16%	86.56%	83.96%	95%	84.2%	81.98%	☹
All cancers: 62 day wait for first treatment from urgent GP referral for suspected cancer	84.3%	85.3%	86.3%	82.9%	85%	N/A	78.3%	☹
All cancers: 62 day wait for first treatment from NHS Cancer Screening Service referral	96.2%	98.2%	98.3%	98.1%	90%	N/A	91.2%	☺
Maximum 6 week wait for diagnostic procedures	98.97%	97.41%	97.86%	98.82%	99%	88.91%	96.69%	☹
Venous Thrombolism (VTE) Risk Assessment	95.96%	94.75%	93.38%	94.89%	95%	N/A	93.85%	☹

* Thresholds are also set out for two other indicators the data of which can be found in the following sections: SHMI (section 2.2.8) and C. Difficile (sections 2.1.3/2.2.8)
☺ = Target achieved ☹= Target not achieved
**2019/20 National Figures taken from NHS Statistics and Cancer Waiting Times Database (quarterly figures averaged)
N/A= Not available

3.6 Glossary of terms

A&E	Accident and Emergency (also known as ED)
AAA	Abdominal Aortic Aneurysm
AKI	Acute Kidney Disease
ALARP	As Low As Reasonably Practicable principle
AMU	Acute Medical Unit
ANP	Advance Nurse Practitioner
App	A computing application, especially as downloaded by a user to a mobile device.
Bed Days	Unit used to calculate the availability and use of beds over time
BFI	Baby Friendly Initiative
CAMHS	Child and Adult Mental Health Service
C. diff	Clostridium difficile (C. difficile)
CCG	Clinical Commissioning Group
CMP	Case Mix Programme
CNS	Clinical Nurse Specialist
CPR	Cardio Pulmonary Resuscitation
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation payment framework
CT	Computed Tomography
CTG	Cardiotocograph
CTPA scan	CT pulmonary angiogram is a CT scan that looks for blood clots in the lungs
DATIX	Company name of incident management system
DNACPR	Do Not Attempt Cardio Pulmonary Resuscitation
DVD	Optical disc storage format
DVT	Deep Vein Thrombosis
EAU	Emergency Assessment Unit
ECG	Electrocardiograph
ED	Emergency Department (also known as A&E)
EmLap	High Risk Emergency Laparotomy Pathway
ENT	Ear, Nose and Throat
FCE	Full Consultant Episode (measure of a stay in hospital)
FFT	Friends and Family Test
FY1/FY2	Foundation Year Doctors
GI	Gastrointestinal
GMC	General Medical Council
GP	General Practitioner
HCAI	Healthcare Associated Infections

HDU	High Dependency Unit
HED	Healthcare Evaluation Data
HES	Hospital Episode Statistics
HQIP	Healthcare Quality Improvement Partnership
HSCIC	Health and Social Care Information Centre
ICNARC	Intensive Care National Audit & Research Centre
IPC	Infection Prevention and Control
IPCS	Intermittent Pneumatic Compression
ISO	International Organization for Standardization
KPI	Key Performance Indicator
LocSSIPS	Local Safety Standards for Invasive Procedures
MBC	Metropolitan Borough Council
MCP	Multispecialty Community Provider (now called Integrated Community Provider)
MDT	Multidisciplinary Team
MRI	Magnetic Resonance Imaging
MRSA	Methicillin-resistant Staphylococcus aureus
MUST	Malnutrition Universal Screening Tool
NatSSIPS	National Safety Standards for Invasive Procedures
NBM	Nil By Mouth
NCEPOD	National Confidential Enquiry into Patient Outcome and Death
NEWS	National Early Warning System
NHSI	NHS Improvement
NICE	National Institute for Health and Care Excellence
NIHR	National Institute for Health Research
NMC	Nursing and Midwifery Council
NPSA	National Patient Safety Agency
NRSA	National Research Service Award
NVQ	National Vocational Qualification
PE	Pulmonary Embolus
PFI	Private Finance Initiative
PHE	Public Health England
PLACE	Patient-led Assessments of the Care Environment
PROMs	Patient Reported Outcome Measures
RAG	Red/Amber/Green
RCA	Root Cause Analysis investigation
RCPCH	Royal College of Paediatrics and Child Health
RECOVERY	Randomised Evaluation of COVID-19 Therapy

SHMI	Summary Hospital-level Mortality Indicator
SMS	Short Message Service is a text messaging service
SOP	Standard Operating Procedure
STEIS	Strategic Executive Information System is the national database for serious incidents
STEMI	ST-Elevation Myocardial Infarct
SUNRISE	Trust electronic patient record system
SUS	Secondary Uses Service
TTO	To take out medications once discharged as an inpatient
UKOSS	UK Obstetric Surveillance System
VQ scan	A ventilation–perfusion (VQ) scan is a nuclear medicine scan that uses radioactive material (radiopharmaceutical) to examine airflow (ventilation) and blood flow (perfusion) in the lungs.
VTE	Venous Thromboembolism
YTD	Year To Date

Annex

Comment from the Trust's Council of Governors (received 18/05/2020)

The Council of Governors have reviewed the 2019/20 Quality Account and acknowledge the Trusts focus on delivering high quality services during another challenging year.

Governors fully support the chief executive's statement in Section 1 of this report.

During yet another challenging year for the NHS and in particular The Dudley Group, the Council of Governors has closely monitored performance and with regular updates and briefings from the Board of Directors. This has provided the Council with the assurance that where effective actions have been taken there has been sufficient evidence to show improvement trajectories or where further action is required.

The governors have supported the board to expand the non-executive cohort to strengthen the skills and expertise with an emphasis on bolstering the clinical leadership of the Trust. Governors have continued to maintain a close working relationship with the non-executive directors in holding them to account for the performance of the Trust in a year that saw a sustained increase in demand on resources.

There has been a particular focus on its registrations and CQC reviews. It was evident that whilst there were many areas in which the Trust was performing well, there were others such as the Emergency Department that the CQC highlighted was performing below the requirements for improved triage time, managing the deteriorating patient and sufficient staffing levels. The Council has continued to challenge the Board and have noted the ongoing and sustained efforts and is assured that whilst the Trust is now performing well in these areas, continual improvements and monitoring remains in place and is under Council scrutiny. The Council acknowledge and endorse the need for the local health economy to work together to ensure effective patient flow is achieved and those patients receive the most appropriate care in the most appropriate setting.

The Council of Governors continue to support the identification and simplification of the quality indicators for 2020/21 and during the year had sought feedback from Foundation Trust members and the wider community at a series of engagement events. Governors participated in a Listening into Action event and used this feedback to identify and support the selection of the Quality Indicators to take forward in to 2020/2021.

The Council have continued to review the performance data over the year against each of the indicators set and for the constitutional performance standards. Regular detailed reports are provided to the full Council and to its sub committees that provide an opportunity to make comments on specific examples of good performance and areas that have performed less well. Governors maintain a regular attendance at the monthly board meetings. Once again governors have been involved in supporting the Trust with its annual planning cycle.

The governors fully support the Trust's ongoing commitment to Dudley Improvement Practice and acknowledge the fantastic developments and achievements the Trust has made including its launch of a one-stop pre-op assessment service, demonstrated acting on feedback received, introducing Greatix and setting up of the frailty assessment unit and improved pressure ulcer management that has positively impacted the lives of many patients.

Governors have played an active role in undertaking quality audits and have supported the Trust with governors attending many of the quality and safety audits by visiting wards, outpatients and community

settings. Again, where areas for improvements are identified, the Council is assured that there are robust mechanisms and processes in place to ensure action is taken and quality sustained.

Members of the Council of Governors have also participated in a wide range of Trust activities including PLACE assessments, observing committees of the Board, supporting patient care and experience initiatives such as Nutrition and Hydration Week, pressure ulcer and sepsis awareness weeks. Governors have also supported the five public facing engagement events held during the year at Russells Hall Hospital, Corbett and Guest outpatient centres and Brierley Hill Health & Social Care Centre.

We have continued to actively engage and participate in a range of community events across the Dudley borough and surrounding areas with regular attendance at the Dudley Public Healthcare forums and attending community and support groups in the Dudley borough, all of which provide an opportunity to gain feedback directly from patients and their families and carers.

The council have been focused on workforce matters and have championed the importance of using the results from the national staff survey to support the development of initiatives to increase staff satisfaction with their work place. The council closely monitor the key performance metrics and seek assurance on the effectiveness of improvement actions. In the Year of the Nurse it is good to see many awards being won by Trust staff.

The Council of Governors wish to place on record their thanks to all staff for their hard work, commitment and dedication to ensuring that the Trust is delivering safe, effective and high quality services to the people of Dudley and those in the surrounding areas.

Comment from the Dudley Clinical Commissioning Group (received 09/06/2020)

We are pleased to comment on the Trust's 2019/20 Quality Account.

The Trust during 2019/ 20 outlined the intention to focus on improving the experience of the patient. The CCG notes key areas for improvement, and it is encouraging to recognise the work undertaken to improve the outcomes for patients with sepsis. This was a key area of focus following the CQC inspection report.

The Trust has demonstrated that they have worked hard to improve the experience of patients who attend the ED department. The CCG particularly recognises the efforts being made to support patients with a learning disability and/or autism, reinforced by working closely with the patient, their families and their carers.

The CCG is pleased that the Trust has reduced the occurrence of pressure ulcers, both in the acute and community settings, this is a positive achievement and will lead to improved patient outcomes. We understand that the introduction of the 'lunch and learn' exercise has been pivotal in achieving these improvements for staff teams. The Trust supported a CCG assurance review in this area.

The CCG welcomes the Trust's commitment to review all deaths as part of the joint mortality group. The Trust has demonstrated that learning from the mortality review process has been of significant benefit and has taken required actions forward to embed the lessons identified.

The ongoing challenge to address the pathway for patients from referral to booking has been a feature for the Trust. It is pleasing to acknowledge the work of the Trust with the cancer collaborative which has served to enhance the clinical pathway for treatment for cancer. Reducing diagnostic blockers and improving the time between referrals and bookings for treatment has been an identified priority. The CCG will require assurance that newly embedded systems and processes are in place to ensure that this area continues to receive focus.

The Trust has continued to achieve a reduction in the number of patients with Clostridium difficile during 2019/20, with one Trust assigned MRSA bacteraemia during this period.

The CQC inspected the Trust during 2019/20 with the Trust receiving an overall rating of 'Requires Improvement'. The CCG commends the work of the Trust during this period which resulted in end of life care and community services achieving an 'Outstanding' rating for 'Caring'. Conversely, diagnostic imaging and urgent and emergency planning was rated as 'Inadequate' and the Trust will need to continue to prioritise these areas identified for improvement.

It is positive to note the awards presented to the dedicated staff who have excelled in service delivery, both in practice, research and innovation. The staff survey, however, shows evidence that there has been a decrease in the percentage of staff who would recommend the Trust as a place to receive treatment from 70 per cent in 2017, although it increased slightly from 56 per cent in 2018 to 59 per cent in 2019. The CCG will be keen to follow the Trust's outlined plans to amend this view held by staff.

The CCG looks forward to the Trust remaining an integral part of the newly introduced Integrated Community Provider (ICP) in Dudley. We will continue to work in partnership with the Trust to improve outcomes for patients.

Neill Bucktin
Dudley Managing Director – Black Country and West Birmingham Clinical Commissioning Groups

Comment from Healthwatch Dudley (received 27/04/2020)

COVID-19

We appreciate that the draft Quality Report and Account 2019/20 was written before the start of the COVID-19 crisis and its huge impacts on the Trust and all of the staff who work there. We want to thank all NHS staff for their outstanding commitment and effort to providing healthcare services for people during a period of unprecedented demand for advice and help.

We acknowledge that much good work has been done to improve services and we make some comments on this work specifically. But, for the most part the remainder of this review of the Quality Report and Account focuses on the opportunities that exist for continuing to improve health and care services for people.

In 2020 there will also be exciting new opportunities to reconfigure and improve how healthcare services work for people when the new Integrated Care Provider organisation becomes fully operational.

Achievements and more to do

We welcome the decision to include a new focus for 2020/21 on improving people's experience of accessing help and care in hospital and on discharge management. At the same time, we acknowledge all of the good work that has been done to deliver on actions designed to improve diagnostic imaging services that were deemed to be inadequate and also sepsis recognition and treatment services. We note that this improvement has occurred against a background of CQC inspection in 2019 which resulted in a disappointing overall rating of Requires Improvement for the Trust.

It is also noted though that recent National Inpatient Survey patient experience indicators that are referred to in the Quality Report and Account document are lower than the national average figures for Trusts. In

turn the percentage of staff who would recommend the Trust to friends or family needing care stands at 59 per cent of those who responded to the question. On the Friends and Family Test the percentage of respondents recommending a service to others was below what would be expected for inpatient, accident and emergency, community, maternal postnatal ward and outpatients services from October 2019 through December 2019. We would like to see evidence of improvement in these indicators for the next Quality Report and Account in 2020/21.

We recognise the range of developments that have occurred to improve patient experience during 2019/20 such as the increased involvement of patient experience volunteers to carry out ward visits and promote the Friends and Family Test.

In the Friends and Family Test response rates we note that in quarter three there was a fall in number of people saying that they had received a 'Welcome to Russells Hall' booklet when they reached the ward. We recognise that this was due to a lack of supplies of booklets during November 2019. We find this disappointing, as Healthwatch Dudley has received feedback from the public on how a lack of information and poor communication impacts on their experience of accessing healthcare services and hope this can be addressed in 2020/21.

Priorities for Improvement

We note the good progress made on reducing the incidence of pressure ulcers in hospital and out in the community. And the work the Trust has been doing to maintain good infection control practice.

- *Patient experience:* This is a welcome new priority with a focus on improving communications and engagement work with the wider public and people accessing hospital services – with the establishment of a Citizens Panel and an Expert Volunteers group. Healthwatch Dudley supported the Trust with two community engagement events in February 2020, where local people discussed their role in helping to shape hospital services. We look forward to seeing how the Trust develops these panels moving forward to ensure the voice of the public is heard, taken seriously and acted upon.

- *Nutrition and hydration:* It would be good to see the system of supported mealtimes adopted throughout the hospital as soon as possible. At the same time, ensuring every person admitted for acute care has a nutritional assessment within 24 hours unless there are very exceptional reasons why this cannot happen. It is good that there is a strong desire to get people's views on mealtimes, using an audit, and to increase volunteer assistance at mealtimes. We want to see evidence of how this is happening in the Quality Report and Account for 2021/22.

- *Medications:* We note there is still more work that can be done to further increase the percentage of people who are known to be at risk of having an adverse reaction to a medication who are identified.

- *Discharge management:* There has been much welcome improvement in the number of Expected Discharge Dates set for adults. There is though still an opportunity to continue to improve on the numbers and we would like to see this happening and reported on. This work could happen alongside the work being done to develop the 'Perfect Discharge' designed to keep people accessing hospital services and their family members informed about what is happening. This has been an area where Healthwatch Dudley has received comments from people on how information, communications and procedures have not always worked as well for them.

Healthwatch Dudley, April 2020

Comment from Dudley MBC Health and Adult Social Care Scrutiny Committee (received 25/06/2020)

Dudley's Health and Adult Social Care Scrutiny Committee is pleased to have been allowed the opportunity to review Dudley Group NHS Foundation Trust's Quality Accounts for 2019-20. Due to restrictions brought about by the COVID-19 pandemic a formal Scrutiny meeting was not possible so the review has been undertaken through Members' written questions and comments. In turn, clarifications by the Trust have been incorporated into the final version of the Quality Accounts.

Within the domain of Patient Experience, Members would like to know more about the experience of patients (and their carers) with dementia when the 2020-21 Quality Accounts are written.

Under Discharge Management, further information about the new multi-disciplinary model in the Acute Medical Unit would be very welcome. Members noted that a relatively low proportion of patients had been discharged in the morning and are pleased to understand that increasing this is a priority for 2020-21.

Members noted that the audit of the exercise program for patients with intermittent claudication had suggested that the current approach is ineffective. We would welcome further work to understand any barriers to patients and so that a service model can be developed that improves patient outcomes.

It is reassuring to see that the total number of reported incidents is increasing which can be the sign of an open and honest culture. We are pleased that the Trust supports staff to join a relevant trade union and would welcome greater visibility to the various ways in which staff could raise concerns.

In subsequent Quality Accounts, Members would be pleased to learn more about medical research that the Trust is undertaking and any awards that have been granted. Members would like to understand more about how the Trust considers its role as an "anchor" organisation in supporting the health, wellbeing, employment and economy of Dudley. Finally, being mindful of the COVID-19 pandemic, Members would like to understand how Dudley Group has mitigated the massive and unexpected challenges brought by the pandemic.

Dr David Pitches, Head of Service, Healthcare Public Health and Consultant in Public Health, Dudley Metropolitan Borough Council

Statement of directors' responsibilities in respect of the Quality Report 2019/20

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.

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

In preparing the Quality Report, directors are required to take steps to satisfy themselves that:
• the content of the Quality Report meets the requirements set out in the *NHS foundation trust annual reporting manual 2018/19* and supporting guidance *Detailed requirements for quality reports 2019/2020*
• 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 2019 to May 2020
- papers relating to quality reported to the board over the period April 2019 to May 2020
- feedback from commissioners Dudley Clinical Commissioning Group dated 9/06/2020
- feedback from governors dated 18/05/2020
- feedback from local Healthwatch organisation Healthwatch Dudley dated 27/04/2020
- feedback from Overview and Scrutiny Committee Dudley Metropolitan Borough Council Health and Adult Social Care Scrutiny Committee dated 25/06/2020
- the Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 2019/20
- the latest national patient survey 2019
- the latest national staff survey 2019, dated June 2019
- the Head of Internal Audit's annual opinion over the Trust's control environment dated May 2020
- CQC inspection report dated 12th July 2019

• 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
• the Quality Report has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report.

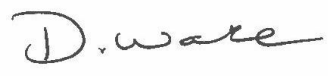
The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Report.

By order of the board

Signed: Date: July 2020

Dame Yve Buckland
Chairman

Signed: Date: July 2020



Diane Wake
Chief Executive